



2011 External Quality Review Annual Report

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

December 2011

Presented by

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ACRONYMS USED IN THIS REPORT

ADSA	Aging and Disability Services Administration
ALOS	average length of stay
BBA	Balanced Budget Act of 1997
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children’s Health Insurance Program
CIT	Crisis Intervention Training
CLIP	Children’s Long-term Inpatient Programs
CMS	Centers for Medicare & Medicaid Services
DBHR	Division of Behavioral Health and Recovery
DMHP	designated mental health professional
DOH	Department of Health
DRP	disaster recovery plan
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
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 66, 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. Aumentra Health produced this EQR annual report on behalf of the Washington Department of Social & Health Services (DSHS) and the Health Care Authority (HCA).

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, HCA oversees the MCO contracts and monitoring functions, and the Division of Behavioral Health and Recovery (DBHR), within the Aging and Disability Services Administration (ADSA), oversees the RSNs.

This report also presents quality measurements for the Washington Medicaid Integration Partnership (WMIP), a pilot program overseen by HCA for enrollees in Snohomish County who are eligible for both Medicaid and Medicare.

To evaluate the services delivered to Medicaid enrollees, Aumentra Health analyzed data related to a variety of performance indicators and compliance criteria. This analysis reflects MCO and RSN performance in contract year 2010.

State-level strengths

- The Healthy Options MCOs generally are complying with federal and state standards related to access, timeliness, and quality. In the most recent year, the MCOs, as a group, strengthened their compliance with most of the relevant standards.

- Enrollees of the Healthy Options MCOs continue to visit emergency rooms at a significantly lower rate compared with Medicaid enrollees nationwide. Service utilization rates also remain below the U.S. average in all categories except for maternity care.
- The RSNs typically provide timely access to outpatient mental health care, and most RSNs deploy well-developed crisis and stabilization resources. All RSNs monitor their provider agencies to determine whether they offer timely access to specialist consultations.
- The RSNs' use of peer support has significantly helped to reduce the stigma associated with mental health care and has increased consumer participation in improving mental health services.
- The RSNs monitor clinical records for evidence that consumers are actively involved in developing their individual service plans, and that treatment goals are expressed in the consumer's words.

Recommendations

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

Mental health care delivered by RSNs

These recommendations arose from Aumentra Health's 2011 compliance reviews, which focused on Enrollee Rights and Grievance Systems.

Enrollee information needs. Enrollees have the right to be informed at least annually that they may request and obtain names, specialties, locations, telephone numbers of, and non-English languages spoken by mental health professionals in each RSN's network. However, in 2010, only two of the 13 RSNs notified their enrollees about this right.

- ***DBHR needs to ensure that RSNs notify enrollees at least annually of their right to request information about individual practitioners in the RSN's service area.***

The majority of RSNs do not track requests at the provider agencies for translation or interpreter services and for written information in alternative formats. Monitoring such requests can help RSNs identify changes in their service populations and potential needs associated with those changes.

- ***DBHR needs to ensure that all RSNs consistently monitor requests at the provider agencies for translation or interpreter services and for written information in alternative formats.***

Access to culturally competent services. Many RSNs continue to report a shortage of bilingual and bicultural staff among their community mental health agencies.

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

Seclusion and restraint. Many RSNs did not understand the importance of requiring all contracted providers—not merely the evaluation and treatment (E&T) centers—to have in place policies and procedures on the use of seclusion and restraint. Enrollees have the right to be free from seclusion and restraint at all provider facilities.

- ***DBHR needs to ensure that the RSNs require all contracted providers to follow policies and procedures on the use of seclusion and restraint, and that the RSNs review providers' use of seclusion and restraint at the time of credentialing and recredentialing.***

Advance directives. The state benefits booklet and many RSNs' handbooks and websites inform enrollees and their families or surrogates about how to develop advance directives. However, these sources generally do not inform enrollees

that complaints about noncompliance with advance directives may be filed with the Department of Health (DOH), the state survey and certification agency.

- ***DBHR needs to inform enrollees, or their families or surrogates, that they may file complaints with the state regarding noncompliance with advance directives.***

Enrollees need to be informed about both medical and mental health advance directives. Most RSNs do not notify enrollees of their rights in both areas.

- ***Each RSN needs to ensure ongoing community education and staff training regarding both medical and mental health advance directives. DBHR needs to ensure that RSN responsibilities related to advance directives include medical advance directives.***

Tracking and analyzing enrollee grievances and complaints. Analyzing complaints, grievances, and appeals can help the RSNs identify concerns about access, timeliness, and quality. The RSNs can then implement changes to improve enrollee satisfaction and/or outcomes. The RSNs typically follow policies and procedures that meet federal requirements in this area, but they do not consistently incorporate analysis of grievances and appeals into their quality assurance and performance improvement (QAPI) work plans.

- ***DBHR needs to ensure that all RSNs' QAPI programs incorporate analysis of consumer complaints, appeals, and grievances.***

Each RSN's Ombuds reports enrollee complaints about care to the RSN. However, many of the reports submitted by the RSNs to DBHR omit complaints filed at the provider agency level.

- ***DBHR needs to require each RSN, as part of the QAPI process, to collect and review all complaints—not only grievances—from providers, Ombuds, and the RSN's own grievance system.***

Because many RSNs remain uncertain as to the difference between a complaint and a grievance, the tracking and monitoring of complaints and grievances varies among RSNs. Some RSNs require their agencies to record all verbal and written expressions of dissatisfaction from enrollees, while other RSNs require agencies only to track written complaints that have escalated to grievances. Confusion exists as to how to record multiple issues within a single complaint.

- ***DBHR needs to delineate in the RSN contract the difference between a complaint and a grievance, to guide the RSNs in tracking and monitoring enrollees' verbal and written expressions of dissatisfaction with quality, access, or timeliness of care and services.***

PIP topics. Some RSNs find it hard to identify meaningful topics for performance improvement projects (PIPs) that could lead to important system changes and sustained improvement. The RSN may select a PIP topic that does not represent a major problem for its enrollee population, or the RSN may fail to identify the root causes of performance that might be addressed by a particular intervention strategy.

Many RSNs have begun new PIPs, or are identifying new topics, as they retire the statewide PIP and complete projects begun in 2008. In October 2011, DBHR sponsored training for RSNs that focused on selecting PIP topics and developing intervention strategies, using barrier analysis and data analysis as primary tools.

- ***DBHR should continue to sponsor follow-up training and technical assistance related to PIPs, to support the RSNs in selecting and developing appropriate study topics and intervention strategies.***

Physical health care delivered by MCOs

Some recommendations presented in previous annual reports continue to apply. Acumentra Health offers these “priority” recommendations.

Compliance with standards. No MCO fully met the standard for QAPI programs in 2011, and the MCOs as a group met fewer than half of the required elements. This standard calls for MCOs to measure and report performance on standardized measures, monitor for over- and underutilization of services, conduct PIPs, assess care furnished to enrollees with special healthcare needs, and evaluate the QAPI program annually. Common deficiencies, as reported by TEAMonitor, include incomplete work plans and QI evaluations and limited evaluation of behavioral health programs.

- ***HCA should consider providing technical assistance training in QI principles for the MCOs.***
- ***MCOs are encouraged to examine their allocation of QAPI resources—especially for sufficient numbers of qualified staff—to ensure that they can meet the needs of a successful quality management program.***

TEAMonitor reviewed the MCOs for continuity and coordination between medical and behavioral health goals and objectives for Healthy Options enrollees. Results indicated that the MCOs are struggling to incorporate behavioral health into their QAPI programs. Most MCOs struggle with contract requirements to provide outpatient mental health benefits, such as reviewing psychotropic medications of children and ensuring that primary care providers (PCPs) have access to consultation with child psychiatrists.

- ***HCA should consider providing technical assistance training for MCOs in physical and behavioral health coordination.***

PIPs. TEAMonitor’s review of PIPs found that the MCOs often failed to document a correlation between their interventions and subsequent performance; i.e., many PIPs lacked sufficient analysis of the effect of interventions.

- *HCA should consider providing PIP training to help ensure a source of technical assistance for MCO staff.*

Data completeness. In 2011, no MCO was able to report complete race/ethnicity data. Ethnicity was categorized as “unknown” for half of all enrollees statewide, and race was unknown for almost 42% of enrollees. A primary reason for the gaps in reporting these data is underreporting at the state level. These self-reported data are optional when new clients enroll in Medicaid.

- *HCA should conduct a barrier analysis to identify effective ways to increase self-reporting of race/ethnicity data when new enrollees sign up for Medicaid.*
- *MCOs should continue to explore new data sources to augment the state-supplied race/ethnicity data.*

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.

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

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 accelerate the state’s progress toward that goal.

TEAMonitor’s 2011 review of WMIP found deficiencies surrounding timely and complete initial intake screenings and in comprehensive assessment of high-risk enrollees.

- *Molina Healthcare of Washington, the WMIP program contractor, should continue to explore effective approaches to help facilitate timely care assessments for WMIP enrollees.*

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 nearly 4,000 beneficiaries are enrolled in the WMIP.

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

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

EQR requirements

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

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

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

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. Washington Medicaid (Title XIX) coverage for children extends to 200% of the Federal Poverty Level (FPL), or \$44,700 annually for a family of four. Washington CHIP (Title XXI) coverage extends to 300% of the FPL, or \$67,056 annually for a family of four. Under CHIP, families must pay a small premium for coverage.

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% 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

Approximately 1 million Washingtonians are enrolled in managed mental health care, delivered through the 13 RSNs.

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 December 2010, nearly 4,000 beneficiaries were enrolled in WMIP.

State quality improvement activities

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

Managed Care Quality Strategy

HCA's Managed Care Quality Strategy incorporates elements of the managed care contract, state and federal regulations, and CMS protocols related to assessing and improving the quality of services for Medicaid enrollees. Aumentra 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.

HCA 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

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. HCA validates the PIPs' compliance with CMS standards through the TEAMonitor reviews.

For the WMIP program, MHW conducted five PIPs in 2010. All five projects were carried over from 2010, including two contractually required PIPs on chemical dependency topics.

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 2011, 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, HCA 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 2011, HCA 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 six HEDIS measures for the WMIP population:

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

To ensure data integrity, NCQA requires certification of each health plan's data collection process by a certified HEDIS auditor. HCA funded the 2011 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 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.

In 2010, the CAHPS survey 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. The next survey will occur in 2012.

Mental health performance measures

Each RSN is required by contract to demonstrate improvement on a set of performance measures calculated and reviewed by the state. If the RSN does not meet defined improvement targets on any measure, the RSN must submit a performance improvement plan. For 2011, three performance measures were in effect (see page 45).

In 2011, Acentra Health conducted a full state-level ISCA, as well as an ISCA for each RSN, to evaluate the extent to which the information technology infrastructure supported the production and reporting of valid and reliable measures.

Compliance monitoring

HCA participates in TEAMonitor with ADSA and DOH in overseeing the MCO 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. TEAMonitor evaluates the MCOs' compliance with approximately 80 required elements of access, timeliness, and quality of care.

Acentra Health monitors the RSNs' compliance with regulations and contract provisions during annual site visits, using review methods adapted from the CMS protocol. In 2011, Acentra Health reviewed each RSN's compliance with provisions related to Enrollee Rights and Grievance Systems, and the RSNs' response to the specific 2010 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, HCA 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 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
<i>Required</i>		
Validation of PIPs	TEAMonitor audits	EQRO onsite reviews
Validation of performance measures	HEDIS audit	Performance measure validation and ISCA by EQRO
Health plan compliance with regulatory and contractual standards	TEAMonitor audits	EQRO onsite reviews
<i>Optional</i>		
Administration or validation of consumer or provider surveys of quality of care	CAHPS survey by EQRO (not conducted in 2011)	MHSIP survey

METHODS

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

- 2011 HEDIS report of MCO performance in key clinical areas¹
- 2011 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 2011

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

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

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

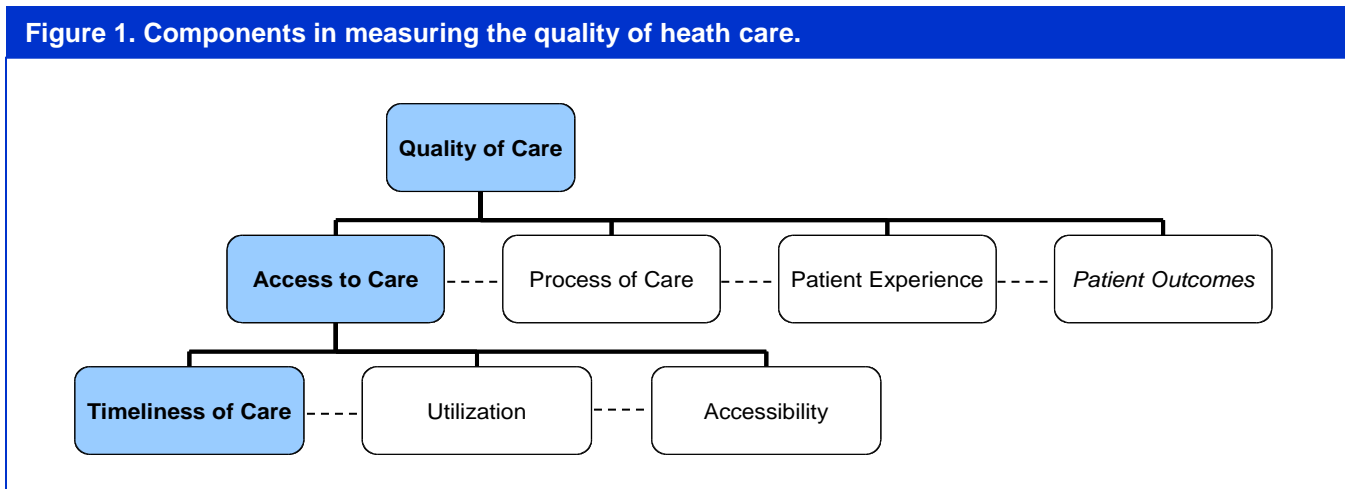
Quality of care encompasses access and timeliness as well as the *process* of care delivery (e.g., using evidence-based practices) and the *experience* of receiving care. Although enrollee outcomes also can serve as an indicator of quality of care, outcomes depend on numerous variables that may fall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

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

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

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

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



Certain performance measures lend themselves directly to the analysis of quality, access, and timeliness. For example, in analyzing physical health care, Acentra 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.

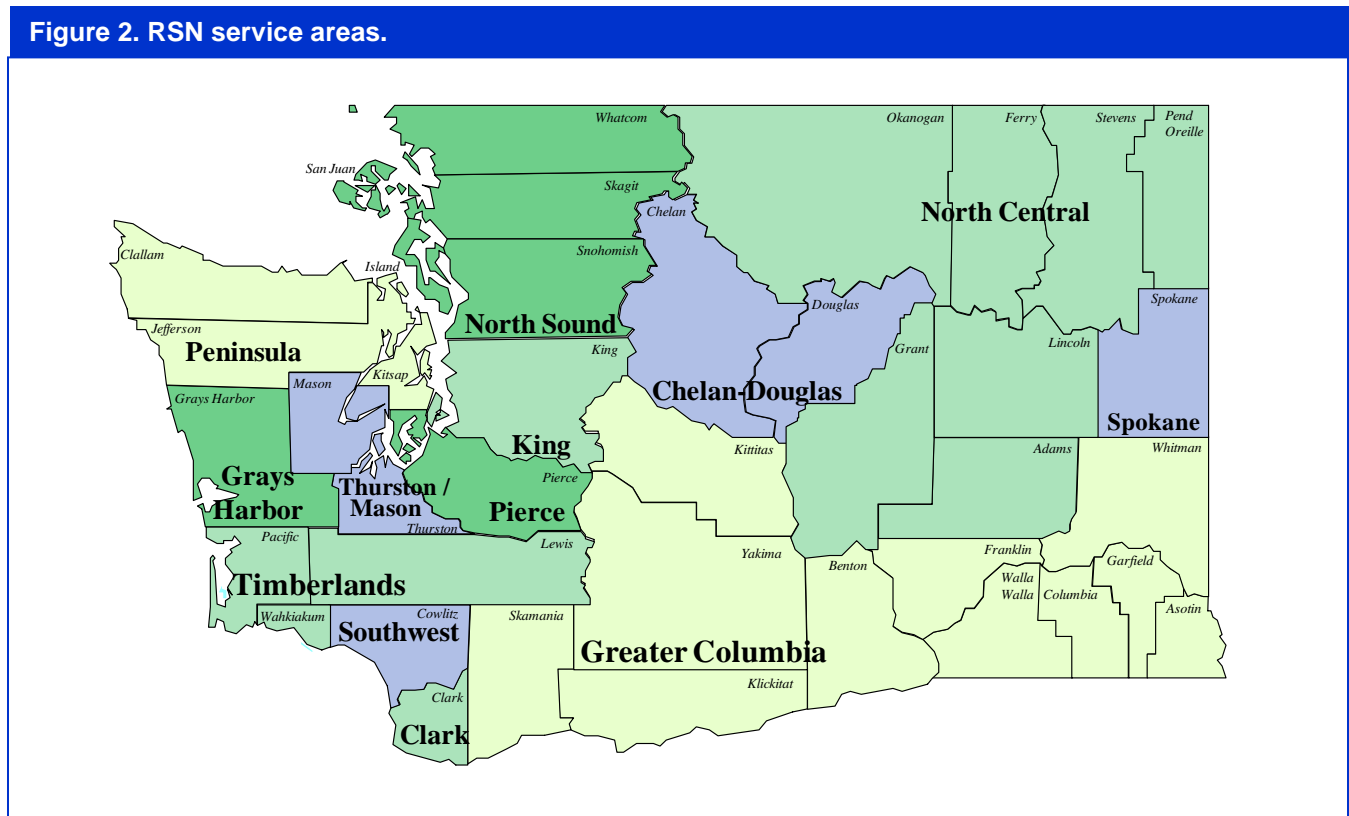
Table 2 shows the approximate number of enrollees assigned to each RSN and the RSN's percentage of statewide enrollment as of December 2010.

Table 2. Mental health regional support networks and enrollees, December 2010.^a

Health plan	Acronym	Number of enrollees	% of all enrollees
Chelan-Douglas RSN	CDRSN	23,139	2.2
Clark County RSN	CCRSN	70,496	6.7
Grays Harbor RSN	GHRSN	15,954	1.5
Greater Columbia Behavioral Health	GCBH	158,620	15.0
King County RSN	KCRSN	225,138	21.3
North Central Washington RSN	NCWRSN	57,568	5.5
North Sound Mental Health Administration	NSMHA	152,765	14.5
Peninsula RSN	PRSN	45,896	4.3
OptumHealth Pierce RSN	OPRSN	129,258	12.2
Southwest RSN	SWRSN	22,636	2.1
Spokane County RSN	SCRSN	88,199	8.4
Thurston-Mason RSN	TMRSN	44,265	4.2
Timberlands RSN	TRSN	21,196	2.0
Total		1,055,130	100.0

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

Figure 2 shows the counties served by each RSN.



Acumentra Health conducted the compliance review, PIP validation, and full ISCA for each RSN during 2011. Together, these activities addressed the following questions:

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

Review procedures for 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 2011. These results represent established measurements against which DBHR will compare the results of future reviews to assess the RSNs' improvement. Individual RSN reports delivered to DBHR during the year present the specific review results in greater detail.

Access to mental health care

These observations and recommendations arose from the RSN site reviews during 2011.

Strengths

- Several RSNs have integrated peers and “parent partners” into their crisis response teams.
- To facilitate enrollees’ choice of providers, many RSNs have developed a list of individual practitioners within the network who have specialized training in evidence-based practices or who work with specific diagnoses or issues.
- All RSNs require their providers to post a multilingual notice in prevalent languages defined by DSHS, advising consumers on how to obtain information in these languages.
- SCRSN is conducting two PIPs aimed at improving access to mental health care for children, through community-based care and the Children’s Long-Term Inpatient Programs.

Opportunities for improvement

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

Timeliness of mental health care

These observations and recommendations arose from the RSN site reviews during 2011.

Strengths

- All RSNs monitor their provider agencies to determine whether they offer timely access to specialist consultations.
- 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. GHRSN reported success in improving its rate of timely follow-up, and its PIP received a Fully Met score.
 - NSMHA's clinical PIP seeks to improve the timeliness of enrollees' access to medication evaluation appointments.
 - TMRSN's nonclinical PIP focuses on ensuring access to routine services within 14 days of a service request.

Opportunities for improvement

- Enrollees have the right to be informed at least annually that they may request and obtain names, specialties, locations, telephone numbers of, and all non-English languages spoken by mental health professionals in the RSN's service area. During 2010, only two of the 13 RSNs notified their enrollees of this right.
 - ***DBHR needs to ensure that all RSNs notify enrollees at least once a year of their right to request and obtain names, specialties, locations, telephone numbers of, and all non-English languages spoken by mental health professionals in the RSN's service area.***

Quality of mental health care

These observations and recommendations arose from the RSN site reviews in 2011.

Strengths

- During clinical record reviews, RSNs look for evidence that consumers are actively involved in developing their individual service plans, and, at a minimum, that treatment goals are expressed in the words of the individual receiving services.
- 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.
- RSNs' use of peer support has significantly helped to decrease the stigma associated with mental health care and has increased consumer participation in improving mental health services.
- Several RSNs have active advisory boards and consumer committees that provide input on RSN policies and procedures, websites, and consumer materials.
- Several RSNs analyze trends in grievances and appeals and forward this information to their internal quality committees for use in evaluating system improvements.
- NSMHA's website highlights a campaign to promote the concept that all consumers deserve dignity and respect. Since beginning this initiative, NSMHA has seen a decrease in complaints related to dignity and respect.
- TMRSN and OPRSN have developed handheld booklets for consumers to use before and during a crisis. The booklets include the consumer's crisis plan, a wellness plan, emergency contacts, advance directive, list of medications, and durable power of attorney and/or guardianship, if appropriate.
- GCBH sponsors community forums on recovery and self-empowerment that are open to the public, and has made presentations to enrollee clubhouses and National Alliance for the Mentally Ill groups across its service region.
- If GHRSN detects complaints about a particular clinician, the RSN makes further inquiries and may request a corrective action plan from the provider.
- KCRSN's incentive program for providers encourages better performance on specific quality measures. The measures are structured to encourage services that are developmentally appropriate and focused on resilience and recovery.
- KCRSN's website presents a matrix to inform enrollees about how to protect their rights.
- NCWRSN's website makes available a well-written training program for providers regarding grievances and appeals.
- NSMHA promotes a "no-blame" culture in which consumer complaints point to opportunities for improvement in a recovery-based system.
- To ensure that staff are aware of all state and federal guidelines, SWRSN's HIPAA compliance officer trains the staff on policies and performs an annual audit.
- The RSNs are conducting PIPs with a variety of interventions aimed at improving the quality of mental health care.
 - PRSN and KCRSN focused their clinical PIPs on identifying and screening enrollees who are at risk for developing metabolic syndrome as a result of taking atypical antipsychotic medications. PRSN's PIP received a Fully Met score in 2011.

- TMRSN's clinical PIP implemented Multisystemic Therapy, a family-centered intervention for enrollees under age 18 with chronic violent and/or substance-abusing behaviors. Over a three-year measurement period, TMRSN reported statistically significant improvement in the indicators for school attendance, substance abuse, arrests, and suicide attempts. This PIP received a Fully Met score in 2011.
- GCBH's clinical PIP seeks to reduce hospital utilization through use of the Program of Assertive Community Treatment (PACT) team. This PIP earned a Fully Met score.
- CCRSN's clinical PIP aims to increase the percentage of enrollees who have full or part-time employment. This PIP earned a Fully Met rating.
- GHRSN's and TRSN's clinical PIP focus on reducing symptomology for enrollees with major depressive disorder by implementing a practice guideline. GHRSN achieved a Fully Met score on its PIP.

Opportunities for improvement

- Analyzing complaints, grievances, and appeals can help the RSNs identify concerns with the quality of mental health care and services. This enables the RSNs to implement PIPs or other changes to improve enrollee satisfaction and/or outcomes. The RSNs typically follow policies and procedures that meet federal requirements regarding grievances and appeals, but they do not consistently incorporate analysis of grievances and appeals into their QAPI work plans.
- ***DBHR needs to ensure that all RSNs' QAPI programs incorporate analysis of consumer complaints, appeals, and grievances.***

Mental health regulatory and contractual standards

Acumentra Health's 2011 review of RSN compliance addressed federal and state standards related to Enrollee Rights and Grievance Systems. The Enrollee Rights section of the review protocol assesses the degree to which the RSN has written policies in place on enrollee rights; communicates those rights to enrollees annually; makes that information available in accessible formats and in language that enrollees can understand; and monitors its provider agencies to ensure full implementation of enrollee rights. The Grievance Systems section evaluates the RSN's policies and procedures regarding grievance and appeal processes and the RSN's process for monitoring adherence to mandated timelines.

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

The provisions of Washington's Medicaid waiver and the RSN contract are such that some parts of the federal RSN 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.

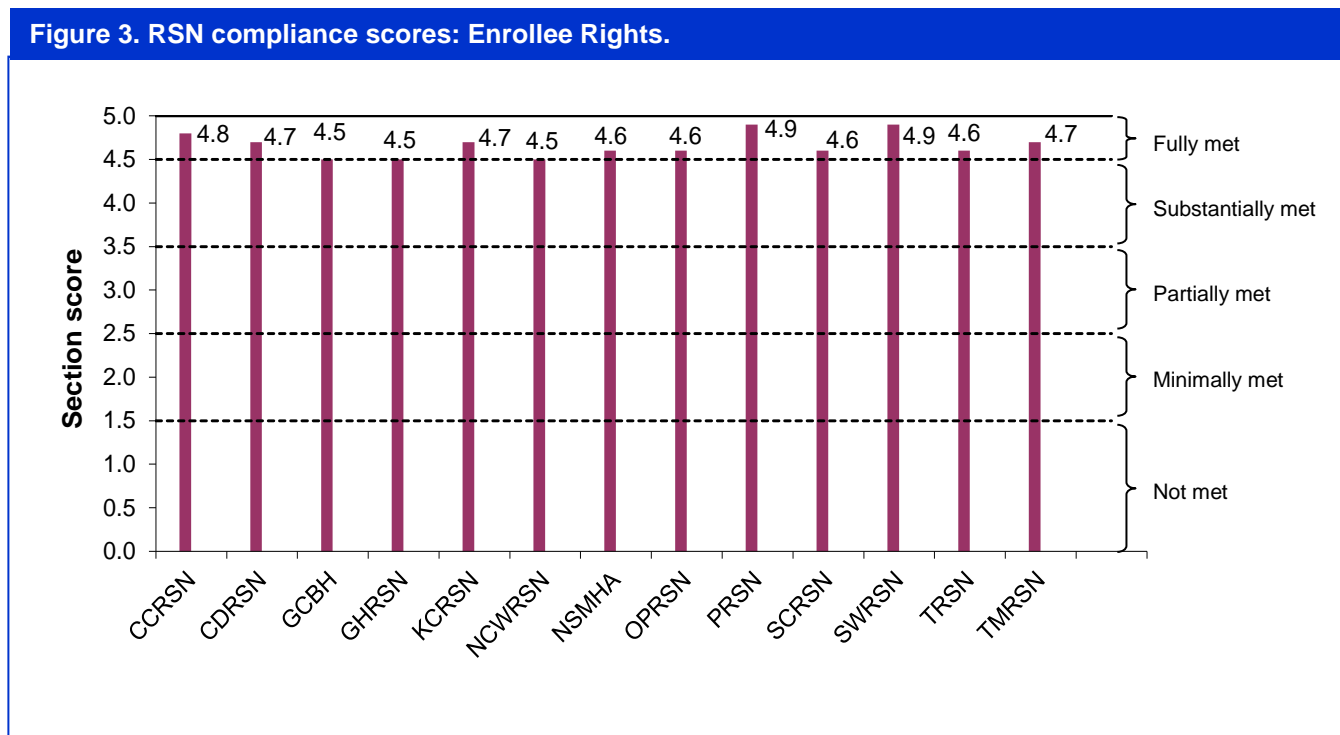
Within each review section, Acumentra Health used the written documentation provided by the RSN and the answers to interview questions to score the RSN's performance on each review element on a range from 1 to 5.

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

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

Enrollee rights

As shown in Figure 3, all 13 RSNs fully met this standard in 2011, though all RSNs were deficient in at least one program element. Some of the deficiencies require corrective action.



Strengths

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

Several RSNs provide comprehensive materials on enrollee rights, including handbooks with detailed descriptions of local service delivery systems. Some RSNs operate customer service lines to facilitate referrals to appropriate services and to manage complaints, grievances, and appeals. The Ombuds typically provides additional information. Most RSNs also maintain websites to inform the general public about mental health services.

- RSNs inform enrollees about grievance, appeal, and fair hearing procedures and time frames by distributing the state benefits booklet, their own handbooks, and other information at RSN facilities, at provider agencies, and through the Ombuds. Many RSNs also post the procedures on their websites. The RSNs require their provider agencies to inform

enrollees at the intake assessment about their rights regarding grievances, appeals, and fair hearings.

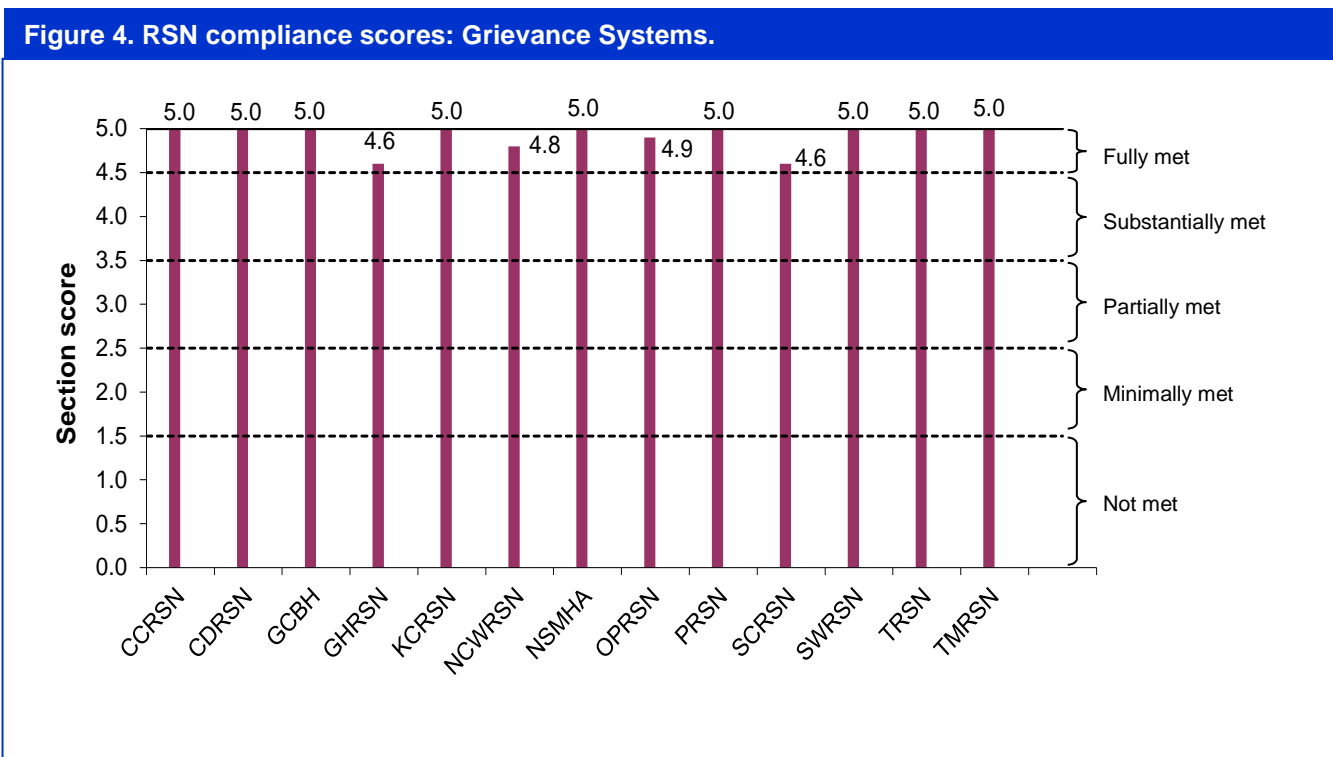
- The RSNs monitor for enrollee rights notifications at the time of the initial assessment. The majority of RSNs also monitor for other rights issues, including advance directives, referral for cultural assessments, and use of second opinions. Some RSNs have developed specific quality assurance activities related to enrollee rights.

Opportunities for improvement

- Many of the RSNs reviewed in 2011 did not understand the importance of requiring all contracted providers—not merely the E&T centers—to have in place policies and procedures on the use of seclusion and restraint. Enrollees have the right to be free from seclusion and restraint at all provider facilities.
 - *DBHR needs to ensure that the RSNs require all contracted providers to follow policies and procedures on the use of seclusion and restraint, and that the RSNs review providers' use of seclusion and restraint at the time of credentialing and recredentialing.*
 - Enrollees have the right to be informed at least annually that they may request and obtain names, specialties, locations, telephone numbers of, and all non-English languages spoken by mental health professionals in the RSN's service area. During 2010, only two of the 13 RSNs notified their enrollees of this right.
 - *DBHR needs to ensure that all RSNs notify enrollees of their right to request and obtain names, specialties, locations, telephone numbers of, and all non-English languages spoken by mental health professionals in the RSN's service area.*
- Federal regulations require that enrollees have access to a detailed list of individual staff at provider agencies, noting specialties and languages spoken. Only a few RSNs maintain the required list. To facilitate consumer choice, the RSNs need to make this information available to enrollees.
- The majority of RSNs do not track requests at the provider agencies for translation or interpreter services and for written information in alternative formats. Monitoring such requests can help RSNs identify potential needs associated with changes in their service populations.
 - *DBHR needs to ensure that all RSNs consistently monitor requests at the provider agencies for translation or interpreter services and for written information in alternative formats.*
 - The state benefits booklet and many RSNs' handbooks and websites inform enrollees and their families or surrogates about how to develop advance directives. However, these information sources generally do not inform enrollees that complaints about noncompliance with advance directives may be filed with DOH.
 - *DBHR needs to inform enrollees, or their families or surrogates, that they may file complaints with the state regarding noncompliance with advance directives.*
 - Enrollees need to be informed about both medical and mental health advance directives. Most RSNs do not notify enrollees of their rights in both areas.
 - *Each RSN needs to ensure ongoing community education and staff training regarding both medical and mental health advance directives. DBHR needs to ensure that RSN responsibilities related to advance directives include medical advance directives.*

Grievance systems

As shown in Figure 4, all 13 RSNs fully met this standard, some with minor deficiencies that required corrective action.



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

Across the state, RSNs report few grievances. Not all complaints at the provider agency level are monitored and reported, because the Exhibit N forms report only formal grievances. As a result, some RSNs find it difficult to identify issues that may need action at the agency or RSN level.

Similarly, very few appeals occur across the system because the RSNs seldom deny service authorization. An enrollee who is denied a service

may request a second opinion. If the enrollee is not satisfied with the second opinion, he or she may file an appeal.

Strengths

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

Opportunities for improvement

- The RSNs typically follow policies and procedures that meet federal requirements regarding grievances and appeals, but they do not consistently incorporate analysis of grievances and appeals into their QAPI work plans.
 - ***DBHR needs to ensure that all RSNs' QAPI programs incorporate analysis of consumer complaints, appeals, and grievances.***
- Each RSN's Ombuds reports enrollee complaints about care to the RSN. However, many of the Exhibit N forms submitted by the RSNs omit complaints filed at the provider agency level.
 - ***DBHR needs to require each RSN, as part of the QAPI process, to collect and review all complaints—not only grievances—from providers, Ombuds, and the RSN's own grievance system.*** This would provide a more robust source of data from which to analyze trends and identify areas for system improvement.
- Because many RSNs remain uncertain as to the difference between a complaint and a grievance, the tracking and monitoring of complaints and grievances varies among RSNs. Some RSNs require their agencies to record all verbal and written expressions of dissatisfaction from enrollees, while other RSNs require agencies only to track written complaints that have escalated to the level of grievances. Also, confusion exists as to how to record multiple issues within a single complaint.
 - ***DBHR needs to continue its efforts to delineate in the RSN contract the difference between a complaint and a grievance, to guide the RSNs in tracking and monitoring enrollees' verbal and written expressions of dissatisfaction with quality, access, or timeliness of care and services.***

Issues identified in RSN compliance reviews

Table 3 summarizes the primary issues identified in the 2011 RSN compliance reviews.

Table 3. Issues identified in RSN compliance reviews, 2011.		
Compliance area	42 CFR citation (see Appendix C)	Number of RSNs with issues identified
Enrollee Rights		
Information requirements: Track enrollee requests for translation/interpreter services and for written information in alternative formats	438.100(b); 438.10(c)	8
General information for all enrollees: Timing—Notify enrollees at least annually of their right to obtain detailed information about network practitioners	438.100(b); 438.10(f)(2–6)	11
General information for all enrollees: Content	438.100(b); 438.10(f)(2–6)	4
Information on crisis and post-hospitalization follow-up services	438.100(b); 438.10(f)(2–6)	3
Advance directive policies and procedures	438.100(b)(2)(iv)	4
Seclusion and restraint	438.100(b)(2)(v)	4
Grievance Systems		
General rule	438.228	1
General requirements and filing requirements	438.402(a)–(b)	2
Expedited resolution of appeals	438.408(a)–(c)	1
Action following denial of request for expedited resolution	438.410(a)–(c)	1
Information to providers and subcontractors	438.414	2
Record keeping and reporting requirements	438.416	3

Mental health PIP validation

Acumentra Health has evaluated the RSNs' PIPs each year since 2008. Because RSNs begin their PIPs at different times, and because PIPs are typically multi-year projects, these projects may be in different stages at the time of the EQR evaluation.

Per the protocol approved by DBHR, Acumentra Health scores all PIPs 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 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 2011 were scored on the 80-point scale. However, five RSNs had at least one PIP scored on the 100-point scale.

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 2011.

Table 6. PIP topics by RSN, 2011.	
RSN	PIP topic
CCRSN	Clinical: Employment Outcomes for Adult Consumers
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
CDRSN	Clinical: Permanent Supported Housing
	Nonclinical: Increased Penetration Rate for Older Adults Enrolled in the Medicaid Program
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: Follow-up Appointment Within Seven Days of Discharge from Eastern State Hospital
	Nonclinical: Reauthorization Timelines
NSMHA	Clinical: Decrease in the Days to Medication Evaluation Appointment After Request for Service
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
OPRSN	Clinical: Consumer Partnership in Treatment Planning
	Nonclinical: Resident Satisfaction in Transfer to Integrated Permanent Housing
PRSN	Clinical: Metabolic Syndrome Screening and Intervention
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
SCRSN	Clinical: Improved Access to Children’s Long-Term Inpatient Care
	Nonclinical: Improved Access to Community-Based Least Restrictive Care for Children with Intensive Needs
SWRSN	Clinical: Using Dialectical Behavioral Therapy to Decrease Inpatient Psychiatric Admissions
	Nonclinical: Increased Incident Reporting Compliance
TMRSN	Clinical: Multisystemic Therapy
	Nonclinical: Improving 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 2011 PIP validation results

During 2011, most RSNs continued the same projects that Acumentra Health reviewed in 2010. However, CCRSN, NCWRSN, OPRSN, and SCRSN, began work on new nonclinical PIP topics, and CDRSN, NCWRSN, SCRSN, and SWRSN began work on a new clinical topic.

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. CCRSN presented this PIP for EQR evaluation for the first time in 2011. The statewide performance measure calls for discharged Medicaid enrollees to be offered noncrisis services within seven days of discharge from an inpatient setting. However, NCWRSN chose to focus its PIP on discharges from Eastern State Hospital.

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 reported on this PIP in 2011, one elected to use the data provided by DBHR to calculate its study indicators; four elected to use local or other data sources (e.g., DBHR intranet files); and one used DBHR data at baseline and local data at remeasurement.

As of 2011, 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
 - one RSN used marketing strategies to inform hospitals and consumers of the RSN's outpatient service availability, including how to obtain services

- 5 had reported baseline data
- 4 had reported remeasurement data, and 3 had reported results of a statistical analysis
- GHRSN and NSMHA had reported second and third remeasurements
 - GHRSN concluded that its PIP achieved statistical *and* clinical improvement at the first remeasurement, but not at the second. During 2011, the RSN successfully implemented its intervention strategy and observed statistically significant improvement based on a third remeasurement.
 - NSMHA tried three different interventions. The RSN concluded that it achieved statistical improvement at all three remeasurements, but that it did not achieve clinical improvement, since performance remained below DBHR's benchmark and the RSN could not attribute the improvement to its intervention strategies.

GHRSN, NSMHA, and PRSN made important progress toward determining whether a given intervention strategy could improve the timeliness of outpatient follow-up. GHRSN successfully improved follow-up rates, whereas NSMHA and PRSN made substantial efforts to implement interventions but concluded that the interventions did not result in significant improvement. All three RSNs plan to retire this PIP topic in 2011.

The status of the remaining three RSNs varies. CCRSN is only in its first year of this PIP. KCRSN is awaiting remeasurement data. NCWRSN has yet to demonstrate a problem related to outpatient follow-up after hospital discharge or select a valid intervention strategy.

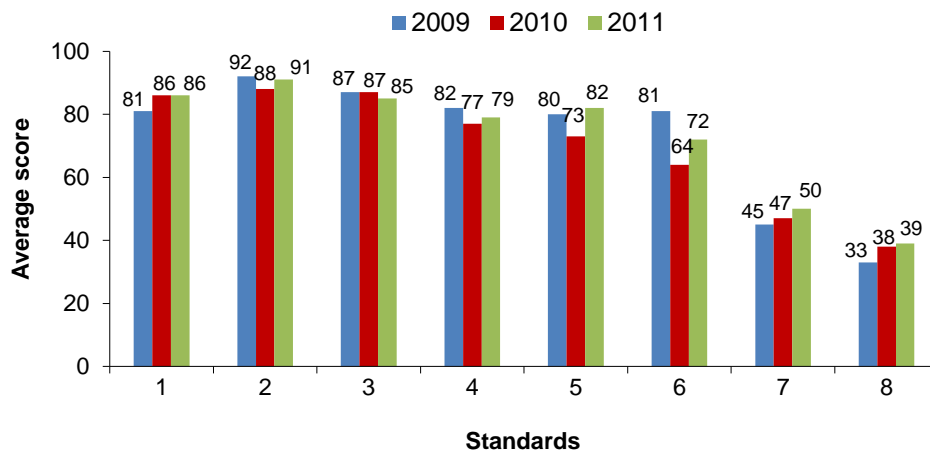
PIP scores by validation standard: Figure 5 shows the change in average scores by individual validation standard for all RSNs’ PIPs from 2009 through 2011.

Across most standards, the RSNs have considerably improved their study documentation and, thus, their scores since 2008. As a group, the RSNs in 2011 *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, related to describing intervention goals and strategies and interpreting the study results. RSNs continued to

improve their documentation of Standards 7 and 8. On average, however, the RSNs only *minimally met* Standard 8, which involves demonstrating whether the PIP achieved 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. During the 2011 review year, half of all PIPs had progressed to a first remeasurement, and seven PIPs had progressed to the stage at which they would be scored on 10 standards.

Figure 5. Average scores by validation standard for clinical and nonclinical PIPs, 2009–2011.



Overall PIP scores: Figures 6 and 7 depict the change in overall scores from 2010 to 2011 for the RSNs’ clinical and nonclinical PIPs that were graded on the 80-point scale. As shown, most RSNs improved their clinical and nonclinical PIP scores, demonstrating significant improvements in the PIP documentation overall.

Figure 6. RSN scores on clinical PIPs, 2010–2011.

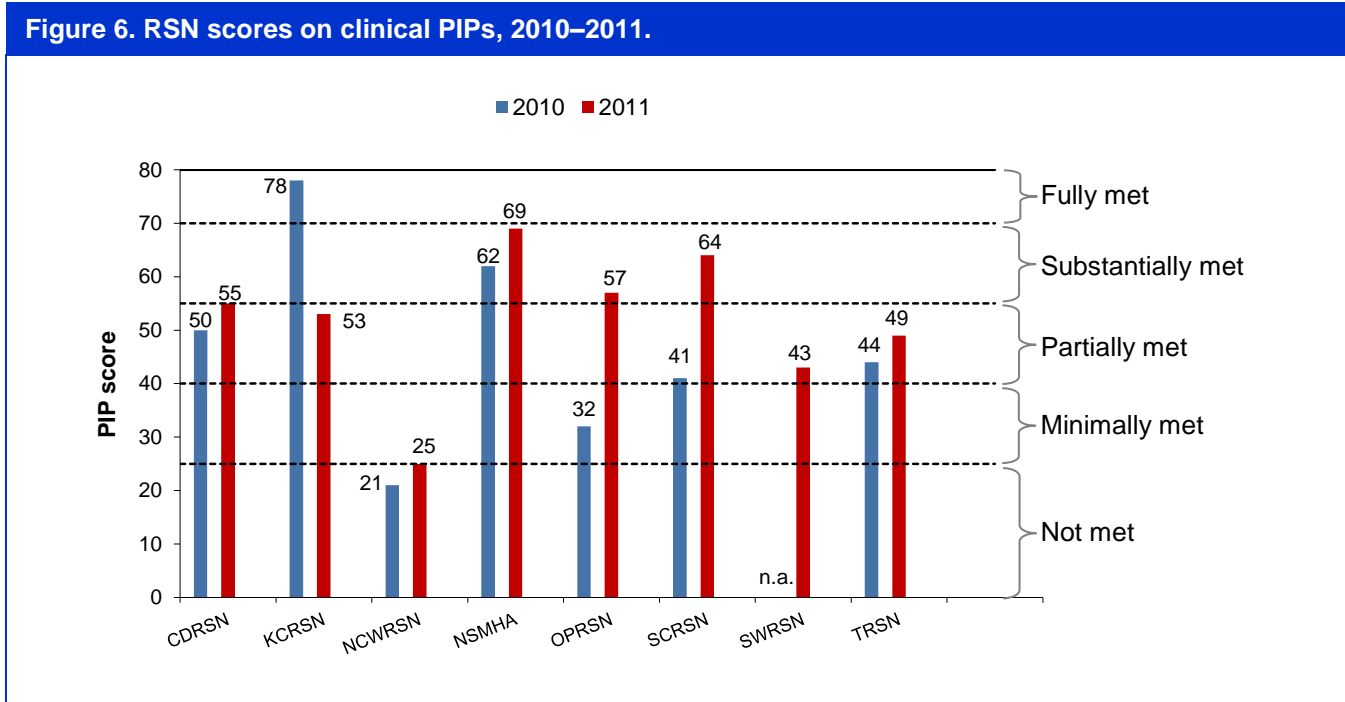
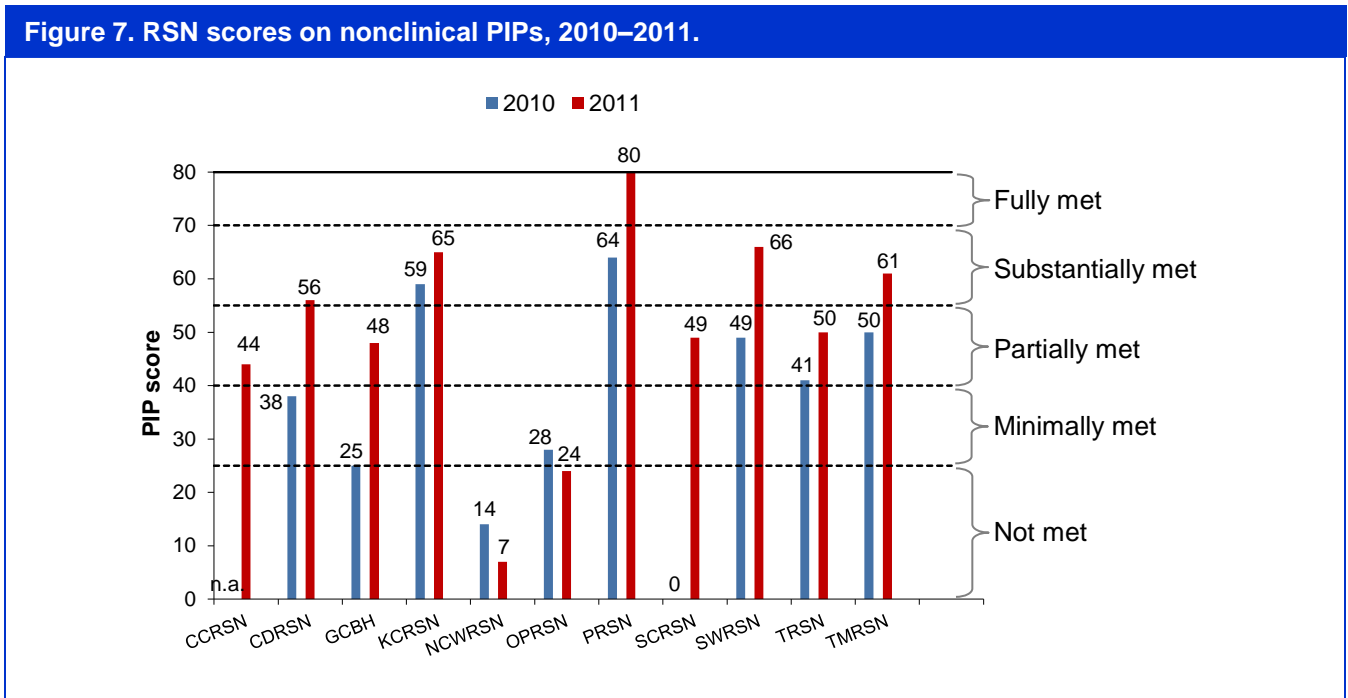


Figure 7. RSN scores on nonclinical PIPs, 2010–2011.



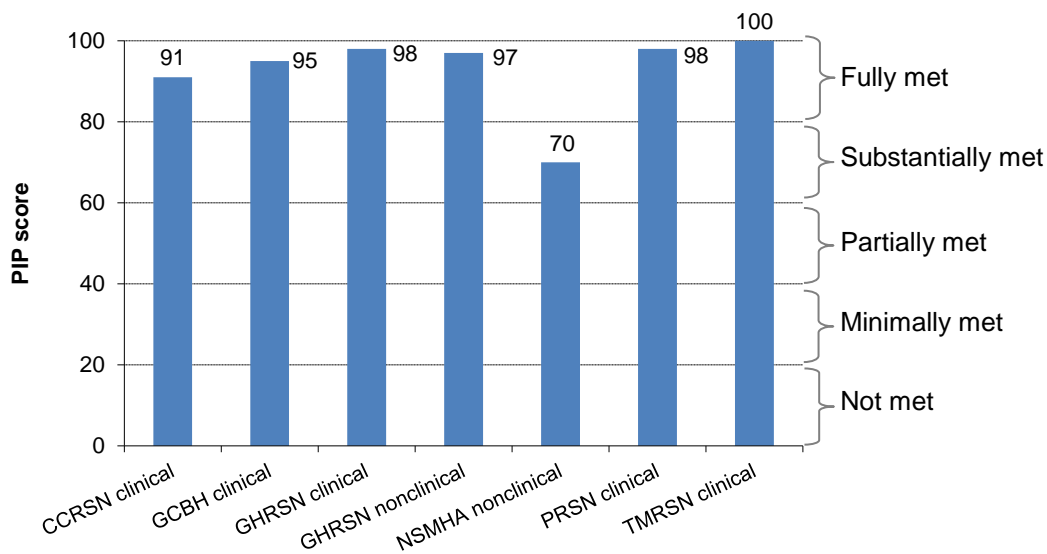
Only three RSNs scored worse in 2011 than in 2010, because the RSN

- refocused its PIP so that its provider agencies were more involved in data collection, development of interventions, and reporting of data; this strategy likely increased stakeholder buy-in, but raised concerns in terms of robust and consistent documentation (KCRSN)
- submitted new documentation for 2011 that did not adequately address the standard(s) or comply with the CMS protocol (NCWRSN)

- began a new PIP in 2011 and had not progressed beyond initial planning at the time of the PIP review (OPRSN)

Figure 8 depicts the scores for PIPs that were scored on the 100-point scale in 2011. As shown, both of GHRSN’s PIPs fully met the CMS standards, as did the clinical PIPs submitted by CCRSN, GCBH, PRSN, and TMRSN, while NSMHA’s nonclinical PIP substantially met the standards.

Figure 8. RSN scores on PIPs scored on 100-point scale, 2011.



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

General recommendations

- When selecting PIP topics, each RSN needs to consult its quality management plan and systematically identify areas that need improvement. Use a variety of data sources to better understand system performance, including complaints and grievances, satisfaction surveys, focus groups, and mining of administrative and claims data. Invite input from consumers, advocates, families, and other stakeholders to understand system performance and identify current barriers.
- Before selecting or developing an intervention strategy, RSNs should conduct root cause analysis and data analysis to illuminate the causes of poor performance relative to potential PIP topics. Use a variety of QI tools and methodologies, including brainstorming with stakeholders and using available data, to confirm potential barriers. Examine performance for specific subgroups (e.g., gender, diagnosis) and/or stratifying data (e.g., by provider agency or ZIP code). Select and develop intervention strategies based on this information.

Recommendations related to PIP documentation

- Discuss the factors that contributed to prioritizing the selected PIP topic over other possible topics, considering both quality and feasibility issues. Quality considerations include the importance of the topic for the Medicaid population (e.g., high risk, high prevalence). Feasibility considerations include availability of resources, alignment with the RSN's strategic goals, data availability, etc.

- Explain how the study topic addresses enrollee outcomes, satisfaction, or quality of care. Demonstrate this relationship by citing published studies, evidence-based practices, standards of care, or other documentation.
- Clearly define the study indicator, including the numerator and denominator, and refer to the relevant metric (e.g., average, percentage) in the study question so it is clear which data will be collected and how the indicator will be calculated.
- Describe in detail the data sources and the procedures used to collect and validate the data for identifying the study population and calculating the indicators. Robust documentation will help the RSN follow consistent methodology in the event of staff changes. Creating a complete record of data collection also will ensure that results can be replicated.
- Identify process measures to track the implementation of study interventions. Measuring the success of implementation enables the RSN to link its interventions with improvement, or identify potential barriers if improvement is not observed. Report on the process measures once data are available, and evaluate the success of implementation when interpreting study findings.
- When reporting study results, report the raw and calculated study indicator(s) for baseline and remeasurement periods, the value of the statistic for the test used (e.g., chi-square or t-test, the standard deviation if applicable, and the probability value.
- Consider any variations or changes in methodology (e.g., data collection), successes, barriers, and confounding factors when discussing whether observed statistical and/or clinical improvement is actual and can be attributed to the PIP.

PIP descriptions and discussion

Clark County RSN

Clinical: Employment Outcomes for Adult Consumers. This PIP, initiated in 2008, seeks to increase employment among RSN enrollees. The intervention strategy targets enrollees, providers, and community employers to increase awareness of, and influence attitudes toward, hiring people served by the mental health system. Data from eight quarterly remeasurements showed a slight increase in employment, from which CCRSN concluded that it had achieved clinical improvement. CCRSN received Fully Met scores on Standards 1–8. The RSN needed to discuss whether it had modified its interventions throughout the project and whether it sustained clinical improvement in the absence of statistical improvement and in light of current barriers.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization. CCRSN adopted this PIP in August 2010 and has identified several factors related to lack of timely follow-up. The intervention strategy likely will focus on “best practice discharge planning” for the inpatient delivery system and on continuity of care for the outpatient delivery system. “Pre-baseline” data from 2010 show that 63% of enrollees discharged from inpatient care received an outpatient service within seven days. CCRSN submitted thorough documentation for Standards 1–5 in 2011, with only minor deficiencies, and is in the process of developing its intervention strategy.

Chelan-Douglas RSN

Clinical: Permanent Supported Housing. This PIP aims to reduce the percentage of homelessness among mental health service recipients. CDRSN data indicate that homeless people represent about 10% of those who received noncrisis outpatient services in 2010. CDRSN’s intervention implements a grant from the Substance Abuse and Mental Health Services Administration for a five-year project to provide housing and support services through a

coordinating team. CDRSN completed its baseline measurement. Documentation for Standards 1–6 achieved Substantially Met scores with minor deficiencies related to data collection and validation procedures. The RSN has yet to implement its intervention strategy.

Nonclinical: Increased Penetration Rate for Older Adults Enrolled in the Medicaid Program.

This PIP addresses an issue with access to mental health services by older adults, indicated by a low Medicaid penetration rate for older adults. CDRSN seeks to improve the penetration rate by promoting a local “gatekeeper” program, in which community members in key locations are expected to encourage mental health service referrals for older adults. At the time of the PIP evaluation, CDRSN had completed only project planning and a baseline measurement. The RSN achieved high scores on its documentation for Standards 1–5, but needed to report more detailed information about its intervention strategy.

Grays Harbor RSN

Clinical: Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder. GHRSN implemented a treatment guideline and monitored the clinical outcomes of enrollees treated for major depressive disorder (MDD). The first phase of this PIP sought to increase the use of a standardized questionnaire to measure depressive symptoms at intake and six weeks post-treatment. The second phase aimed to determine whether implementing the treatment guideline would reduce enrollees’ clinical symptomology. GHRSN collected data from three cohorts of enrollees and noted a significant reduction in symptomology for the second and third cohort, demonstrating sustained improvement. GHRSN concluded that its intervention had improved clinical outcomes for the enrollees involved. GHRSN achieved high scores across all 10 PIP standards and earned a high confidence rating for its PIP methodology overall.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. Since 2008, GHRSN has sought to improve timeliness of outpatient follow-up after hospital discharge by assigning a clinician at the time of hospital admission to arrange discharge planning, including outpatient follow-up, for the enrollee. GHRSN observed significant improvement during the first remeasurement period, but reported a decline at the second remeasurement due to poor adherence to the intervention protocol. After bolstering the intervention to improve the fidelity of implementation, GHRSN once again reported a significant improvement in the study indicator at the third remeasurement. GHRSN achieved high scores on all PIP standards with only minor deficiencies related to explaining how parts of its intervention strategy are monitored and are expected to improve the study indicator. GHRSN earned a high confidence rating for its PIP methodology overall.

Greater Columbia Behavioral Health

Clinical: Impact of Implementing the PACT Model on the Use of Inpatient Treatment. GCBH first reported this project in 2008 and is now in its fourth and final year of the project. The PIP involves implementing a PACT model of care to reduce the number of inpatient days for program participants. Over three measurement periods, GCBH collected hospitalization data on PACT participants who completed 12 months in the program, and compared these data with the 12 months preceding the start date. The RSN reported statistically significant reductions in the number of hospital days for all three cohorts. GCBH fully met Standards 1–6, but provided no information on the operations, challenges, and improvements experienced by the PACT team. GCBH needs to expand its discussion of program success, including challenges or modifications to the PACT program, and track enrollees who did not complete the program.

Nonclinical: Improving Early Engagement in Outpatient Services. GCBH began this PIP in 2010 and made substantial progress in 2011. GCBH defined “engagement” as at least six events of routine outpatient services within 90 days of the first routine service event. The intervention involved a walk-in intake model at one provider agency, whereby enrollees were directed to come to the clinic any time at their convenience during office hours. GCBH assembled a control group from an equivalent period prior to the intervention and matched enrollees by age and gender. As of the review date, GCBH had yet to collect remeasurement data or present the study results. GCBH fully or substantially met Standards 1–5, but the PIP documentation omitted specific details about the intervention.

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. KCRSN implemented a policy and procedure requiring providers to perform annual metabolic screening for all such enrollees, and worked with each provider agency independently to develop interventions. Agencies were given a choice to focus on evidence-based “wellness” interventions or on creating stronger linkages to primary care. At the time of the review, KCRSN had collected baseline data from each agency and was following up with the agencies to determine whether their interventions were implemented successfully. The RSN plans to have collected remeasurement data from most agencies by the end of 2011. KCRSN’s persistent focus on improving enrollee health related to metabolic syndrome is commendable, and the decision to allow provider agencies to develop their own PIPs is likely to increase buy-in. However, the PIP documentation reflects methodological difficulties related to how data are collected from individual agencies and aggregated to evaluate RSN-wide indicators.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. To improve the timeliness of follow-up care for enrollees discharged from inpatient psychiatric facilities, KCRSN formed a Cross-System Diversion Team to review discharge planning, identify needed resources, and ensure continuity of care. In January 2010, KCRSN began a pilot intervention with Navos, the provider with the majority of Medicaid enrollee hospital discharges. As of the review, KCRSN had collected six months of remeasurement data and conducted a preliminary analysis. Although the study has not demonstrated improvement at this point, KCRSN and its stakeholders feel that the process has been valuable. The RSN achieved Fully Met scores on Standards 1–6, but progress on this PIP has been slow and the RSN has not yet been able to document improvement.

North Central Washington RSN

Clinical: Follow-up Appointment Within Seven Days of Discharge from Eastern State Hospital. Regional Performance Measures (RPMs) had shown that NCWRSN did not meet the minimum standard for post-discharge follow-up with enrollees hospitalized at Eastern State Hospital. After an intervention in mid-2010 that involved reviewing the RPM results with contracted providers, NCWRSN reported that the percentage of discharged enrollees seen within seven days rose from 77% in early 2010 to 86% after the intervention. NCWRSN’s documentation was poor overall, with only one of eight standards partially met. This PIP resulted in a finding, in that it was not designed to achieve significant improvement in areas that would be “expected to have a favorable effect on health outcomes and enrollee satisfaction,” per the CMS protocol.

Nonclinical: Reauthorization Timelines.

NCWRSN identified an administrative problem, the lateness or absence of service reauthorization requests from contracted providers. After direct communication with providers failed to improve timeliness, the RSN conducted onsite training on

“secondary authorizations” for agency staff. The training took place in May 2009, and NCWRSN continued to monitor timeliness through January 2011. The first remeasurement showed that the portion of authorization requests “not timely and accurate” fell from 69% at baseline to 49% following the intervention. This PIP also resulted in a finding, in that NCWRSN failed to select a study topic that goes beyond the oversight of medical necessity for services, an activity required by its contract with DBHR. The intervention sought to improve an administrative process not related directly to enrollee outcomes, satisfaction, or quality of care.

North Sound MHA

Clinical: Decrease in the Days to First Prescriber Appointment After Request for Service. This PIP, begun in 2009, aims to reduce the number of days from a request for service to a medication evaluation appointment. NSMHA developed a decision tree as an intervention at the first ongoing appointment following intake. The tool is intended to help clinicians identify a need and make a timely referral to a medication evaluation. Partial remeasurement data showed that the interval from request for service to medication evaluation actually rose from an average of 69.9 days at baseline to 72.8 days at remeasurement. NSMHA suggested the increase could be due to providers implementing independent review steps to reduce inappropriate referrals. NSMHA fully or substantially met Standards 1–6, but the RSN is advised to strengthen the study design before embarking on a new intervention in 2012.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. This PIP, first reported in 2008, aims to increase the number of individuals who receive a noncrisis outpatient service within seven days of discharge from a psychiatric hospital. For 2011, NSMHA developed a third intervention involving a marketing strategy to inform hospital staff and enrollees about RSN services. Only one of seven hospitals agreed to an onsite presentation;

materials were emailed to the remaining hospitals. Partial remeasurement data showed no change from previous years, but the original increase from baseline, demonstrated in 2009, was maintained. NSMHA did not feel confident in attributing any changes to the series of interventions to date, as none were implemented effectively. The RSN needs to discuss its intervention more fully, present complete data in a clear manner, and evaluate the study results.

OptumHealth Pierce RSN

Clinical: Consumer Partnership in Treatment Planning. This PIP aims to increase consumer participation in treatment planning. A chart review indicated that OPRSN's provider agencies were performing below the 90% benchmark set by DBHR in terms of including enrollee and family voice in the treatment plan. Performance ranged from 76% to 92%, with only one agency meeting the benchmark. OPRSN identified barriers to including enrollees in this process, and hired two experts in patient-centered care to train clinical staff and provide technical assistance to overcome the barriers. The trainings have begun, and OPRSN plans to begin collecting remeasurement data in June 2012. OPRSN fully or substantially met Standards 1–6. The PIP documentation had minor deficiencies in identifying the appropriate sample size for the study population and in documenting the data validation procedures.

Nonclinical: Resident Satisfaction in Transfer to Integrated Permanent Housing. OPRSN intends to transfer 147 Medicaid enrollees living in large residential facilities to smaller facilities, with a majority going to community-based settings in integrated permanent housing. This project follows a state imperative to downsize psychiatric hospitals. OPRSN conducted a needs assessment and found that three-fourths of those surveyed expressed a desire to live elsewhere. The RSN plans to measure enrollee satisfaction before and after the move. OPRSN fully met Standard 1, clearly explaining the importance of this topic to its enrollees, and outlined a solid study question. However, many details of the project remain

unclear, including details of the study indicator, inclusion criteria for the study population, and specific community housing options available to enrollees. Due to uncertainty surrounding state and federal budgets, OPRSN has temporarily delayed implementation of the project.

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 directed its providers to screen eligible enrollees for symptoms of metabolic syndrome and, where necessary, to intervene with a range of strategies that included educating enrollees on a healthy lifestyle, diet, exercise, and tobacco use, and linking enrollees with primary care physicians. Following its second remeasurement, PRSN reported no significant change in the study indicators. PRSN identified and discussed many barriers to improvement, including issues with the fidelity of the agency interventions, and confounding factors that compromised the RSN's ability to draw clear conclusions about the impact of the interventions. PRSN received Fully Met scores on all standards, with minor deficiencies related to how its intervention strategies were implemented and monitored. The RSN achieved a high confidence rating on its PIP methodology overall.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. This PIP aimed to increase the percentage of enrollees receiving follow-up care after discharge from an inpatient psychiatric facility. To improve its performance on this measure, PRSN asked each provider agency to assign a hospital liaison to coordinate discharge planning for hospitalized enrollees. Agency interventions have been in place since January 2009. Data for the first remeasurement period showed a statistically significant decrease in timely follow-up care for enrollees discharged from community hospitals. Barrier analysis indicated that many enrollees who were not seen

within seven days either were transferred to the Western State Hospital or chose not to participate in PRSN-funded services. Although the RSN was not able to demonstrate improvement, it achieved Fully Met scores on all eight standards completed. PRSN plans to discontinue this PIP.

Southwest RSN

Clinical: Using Dialectical Behavioral Therapy to Decrease Inpatient Psychiatric Admissions. From 2007 through 2010, SWRSN's clinical PIP used the PACT model in an effort to reduce psychiatric hospitalizations of high-risk enrollees. This year, SWRSN submitted a clinical PIP on the same topic but with a new intervention, Dialectical Behavior Therapy. Although SWRSN received Substantially Met scores or above on four of the eight standards scored, this PIP resulted in a finding. For over four years, SWRSN has elected to focus its clinical PIPs on reducing inpatient hospital utilization. CMS guidance maintains that RSNs PIP topics need to "address the full spectrum of clinical and nonclinical areas" (*Conducting Performance Improvement Projects*, Final Protocol Version 1.0, May 1, 2002, page 4.) SWRSN needs to identify and select a new topic for its clinical PIP.

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; reviewed reporting requirements with provider agency directors, managers, and staff; and required corrective actions by agencies out of compliance. SWRSN's remeasurement data showed that compliance rose from 82% in 2009 to 93% in 2010, though the increase was not statistically significant. SWRSN received Substantially Met scores on seven of eight standards, but questions remain about whether the topic will have significant benefit for the Medicaid population, and specifically how it will influence enrollee outcomes, satisfaction, or quality of care.

Spokane County RSN

Clinical: Improved Access to Children's Long-Term Inpatient Care. This PIP seeks to determine whether providing rehabilitation case management services will reduce the average wait-list time and increase the discharge rate for children and adolescents accepted into Children's Long-term Inpatient Programs (CLIP). Under the new model, the RSN's contracted providers take part in treatment and discharge planning and community transition. After the first remeasurement, SCRSN reported an increase in the discharge rate but could not demonstrate a significant reduction in waiting time. The RSN achieved Substantially Met scores on six of the eight standards reviewed. Deficiencies remain, however, related to how the study indicators are defined, how data are collected and validated, the extent to which the intervention was successfully implemented, and how data were analyzed to determine statistical improvement.

Nonclinical: Improved Access to Community-Based Least Restrictive Care for Children with Intensive Needs. SCRSN formed a new task force in response to stakeholder complaints about the process for determining enrollee admission to CLIP. The task force met to review requests for referrals to CLIP and to recommend admission or diversion to less restrictive community-based alternatives. SCRSN assessed the monthly rate of CLIP admissions before and after the initiation of the task force, and reported a statistically significant decline in admissions. However, the PIP documentation lacks validity in a number of respects. SCRSN achieved Substantially Met scores on standards 6 and 7, and received Partially Met and Minimally Met scores on Standards 1–5 and 8, indicating that the PIP documentation did not present a solid study framework, adequate data collection procedures, or a comprehensive discussion about whether improvement was real.

Thurston-Mason RSN

Clinical: Multisystemic Therapy. This PIP seeks to improve outcomes for young enrollees served by multiple systems—e.g., mental health, juvenile justice, and chemical dependency services—through use of Multisystemic Therapy. Over the three-year measurement period (7/1/2007 to 6/30/2010), data for 111 enrollees showed statistically significant improvement in the indicators for school attendance, substance abuse, arrests, and suicide attempts. TMRSN received a Fully Met score on all standards and a high confidence rating overall.

Nonclinical: Increasing Percentage of Medicaid Clients Who Receive an Intake Service Within 14 Days of Service Request. TMRSN continued this multi-year PIP aimed at reducing the interval between a request for service and intake for enrollees served by the RSN’s primary provider of outpatient services. TMRSN modified its intervention to focus on a “walk-in” model, whereby enrollees who request services are encouraged to visit for an intake as soon as possible without an appointment. The new intervention began in February 2011. Baseline data showed that 71% of enrollees received an intake within 14 days of requesting service. TMRSN scored Fully Met on Standards 1–5 and Substantially Met on Standard 6, and plans to finish collecting remeasurement data in 2012.

Timberlands RSN

Clinical: Improving Treatment Outcomes for Adults Diagnosed With a New Episode of Major Depressive Disorder. TRSN adopted a practice guideline for treating MDD and is monitoring the clinical outcomes of adult enrollees with MDD. The first phase of this PIP

aimed to encourage the use of the 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, as indicated by PHQ-9 scores. TRSN implemented its second-phase intervention in September 2010, conducting training for network mental health providers in applying the MDD guideline. TRSN has not reported baseline data for either of its study indicators. The RSN Substantially Met five of the eight standards scored. However, deficiencies remain related to how the study indicators are defined, and how data are collected and validated.

Nonclinical: Improving Coordination of Care and Outcomes. This PIP, begun in 2009, seeks to increase the percentage of RSN enrollees who benefit from care coordination between mental health and primary care providers. Mental health agency clinicians are to identify enrollees’ medical goals and objectives, including care coordination needs, on the enrollees’ Individual Support Plans. Direct service interventions began in September 2010. Data on care coordination for the six-month baseline period, ending in February 2011, showed mixed results in comparison with previous chart review data. TRSN has not yet reported remeasurement data for the study indicator. TRSN achieved Fully Met scores on the first four PIP standards. However, questions remain regarding how care coordination data are validated, how the RSN calculates the study indicator, how the intervention is expected to increase care coordination, and how it is monitored. TRSN finished collecting baseline data, but did not report these data.

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. DBHR transfers data to Looking Glass electronically each month.

Three statewide core performance measures were in effect for 2011:

1. Consumers receiving intake services within 14 days of service request
2. Consumers receiving first routine service within 7 days of discharge from an inpatient setting
3. Consumers receiving first routine service within 28 days of service request

In 2010, five core performance measures were in effect, including the three measures above. The 2010 performance measure validation resulted in a finding, since DBHR calculated only one of the five measures. In 2011, DBHR calculated all three core measures, and Aumentra Health was able to validate all three.

Aumentra 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. 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?

Review procedures

Following the CMS protocol for this activity,² Aumentra Health typically conducts performance measure validation in three phases.

1. Aumentra Health requests relevant documents from the state agency in advance of an onsite interview.
2. Aumentra Health uses the documents to refine the questions to be asked at the onsite interview.
3. Aumentra Health uses oral responses and written materials to assign compliance ratings for each performance measure.

Due to the late submission of the documentation and code used in calculating each performance measure, Aumentra Health was not able to schedule an onsite interview, and so completed only Phase 1 and part of Phase 3 after the submission of the performance measures.

The compliance ratings, also adapted from the CMS protocol, are:

Fully compliant: Measure is complete as reported, accurate, and can be easily interpreted by the casual reader.

Partially compliant: Measure is either complete as reported or accurate, but not both, and has deficiencies that could hamper the reader's ability to understand the reported rates.

Not valid: Measure is either incomplete as reported or inaccurate.

² U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Validating Performance Measures*. Final Protocol, Version 1.0. May 1, 2002.

Validation results

DBHR submitted for review the SAS programs Looking Glass uses to calculate each performance measure, including SAS code that processes and moves the data to the Looking Glass web servers. DBHR also submitted documentation describing the variables and datasets Looking Glass should use in calculating the measures. However, the documentation did not explain the data flow from DBHR through the layers of processing Looking Glass performs to make the data ready for the programs that calculate each measure. This makes it difficult to tell what checks occur to ensure that Looking Glass uses accurate and complete data—e.g., whether Looking Glass has checked DBHR’s submission for missing and out-of-range data and logic errors, and how Looking Glass ensures the accuracy of its data manipulation. In addition, the SAS programs that calculate each performance measure contain no notes to explain what a particular portion of code does.

Acumentra Health verified the lines of calculations that build each of the performance metrics, but could not verify that the calculations are based on complete and reliable data.

Generally, the algorithm the state specified to build each measure would appear to measure what it is intended to measure. The state provided thorough documentation describing which datasets and variables to use, and how to calculate the metrics and apply exclusions. One exclusion could be more clearly defined, as noted below.

The reports Looking Glass produces can be used to compare performance among RSNs and show RSN performance for a particular time period.

Because of the issues with data completeness and reliability, the measures remain only *partially compliant* for 2011 (see Table 7).

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

Performance measure	Status	Rating
Consumers receiving intake services within 14 days of service request	Calculated	Partially compliant
Consumers receiving first routine service within 7 days of discharge from an inpatient setting	Calculated	Partially compliant
Consumers receiving first routine service within 28 days of service request	Calculated	Partially compliant

Strengths

- The documentation describing how to construct each performance measure is thorough. For each measure, a separate document describes the dataset, variables, exclusions, and algorithms used to build each component of the measure. Actual SAS code that performs the calculations and exclusions is provided. The layout of the report showing the measure is described, and additional useful variables, like the median and mean, are requested.
- The website displaying each measure is simple to use and provides layers of useful details. RSNs can see their performance in different periods (quarter, calendar year, fiscal year) and in various formats (.pdf, .html, and .rtf). Performance measure rates are easily interpreted from the tables, and details about the overall distribution of the performance measure (median, averages), are displayed.

- Looking Glass code that performs the initial processing of the state data, automatically unzipping state files and placing them on Looking Glass servers, has built-in quality checks to alert staff if the downloads are unsuccessful.

Opportunities for improvement

A key feature of a valid performance measure is that it can be used to monitor the performance over time of health plans providing similar services, both within the state and nationally. The current reporting system lets the user select the period for analysis—quarter, calendar year, or fiscal year—and select statistics on each measure. However, it does not make multiple quarters or years available in a single report.

- ***DBHR should work with Looking Glass to extend the functionality of its performance measure reporting.***
 - Allow users to select a range of years or quarters for a specific RSN.
 - Use statistical tests to identify significant changes in performance measures from one time period to the next—e.g., changes in the percentage of enrollees who have intakes within 14 days of service request. Test trends to detect shifts in rates over more than two time periods.
- ***DBHR should have a system in place to replicate the performance measure analyses performed by Looking Glass. For example, DBHR should develop query language to reproduce the numerator and denominator for the percentage of intakes completed within 14 days of service request by RSN for a select time frame. This would allow DBHR to validate the Looking Glass calculations, creating greater confidence in the reported results.***
- ***Looking Glass should develop detailed documentation of the calculation of each performance measure, if it does not exist already. Data flow diagrams should be created for each metric, showing the state data source, which variables are extracted and calculations performed, which new datasets are created and where they are stored, and which program uses those new datasets to calculate the measure. SAS code used to process the data and calculate the measures should include notes explaining what each portion of code does.***

An issue of concern is the performance measure relating to routine service after discharge from an inpatient setting. This measure could be affected by how the data are collected. RSNs indicated that the E&T facilities report encounters for those enrolled in the RSN where the E&T is located, regardless of where the enrollee resides. This limits this performance measure to showing only statewide outcomes, and does not allow individual RSNs to understand their contribution to the performance measure.

Extensive documentation of data processing before and during performance measure analyses is essential to help outside reviewers understand the calculation process. It is also invaluable to internal staff when they need to modify the existing data management system.

Information Systems Capabilities Assessment

Acumentra Health conducted a full ISCA for DBHR and for all RSNs in 2011. These reviews examined the state and RSN 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 as outlined below.

Phase 1 involved collecting standard information about information systems through completion of the ISCA data collection tool (ISCA-T) and submission of other relevant documents.

In **Phase 2**, Acumentra Health reviewed the completed ISCA-T and other documents. Where an answer seemed incomplete or indicated an inadequate process, Acumentra Health marked that section for follow-up.

Phase 3 activities included a data center security walkthrough and in-depth interviews with knowledgeable RSN staff. Provider agency interviews, also performed at this time, asked about each agency’s information systems, encounter/claims processing, and handling of enrollment data.

Phase 4 involved post-onsite analysis of the review results and the implications of the results regarding:

- the completeness and accuracy of any claims and encounter data collected and submitted to DBHR
- the RSN’s capacity to conduct QAPI initiatives
- the RSN’s capacity to oversee and manage the delivery of health care to its enrollees

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

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

After scoring the individual elements, Acumentra Health combined the scores and calculated a weighted average score for each subsection. The detailed criteria for scoring are available from Acumentra Health upon request.

Table 8. Scoring scheme for ISCA elements.

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

DBHR information systems

In 2009, Acumentra Health conducted a full ISCA of DBHR’s Medicaid encounter data system. At that time, DBHR used a Microsoft SQL Server database management system to collect and process encounter data submitted by the RSNs.

Acumentra Health conducted a full ISCA of the DBHR system again in 2011. During the year under review (January–December 2010), DBHR implemented the ProviderOne Production Data Warehouse and Decision Support System (ProviderOne), a new software application for processing Medicaid claims and encounter data. DBHR used the legacy system until May 2010,

which, for all intents and purposes, had remained unchanged since the 2009 review.

The current ISCA review focuses on the ProviderOne system implemented in 2010. The results reflect DBHR’s information systems and data processing procedures, as well as DBHR’s oversight and monitoring of Looking Glass and RSN-contracted activities.

Acumentra Health’s review found that in 2010, DBHR *fully met* federal standards related to data processing procedures and personnel, and *fully met* the data acquisition capabilities standards. Table 9 summarizes the ISCA scores and ratings.

Table 9. Weighted average scores and ratings on DBHR ISCA sections, 2011.		
Review section/subsection	Score	Compliance rating
Section 1: Data Processing Procedures and Personnel		
A. Information Systems	2.9	Fully met
B. Staffing	3.0	Fully met
C. Hardware Systems	2.6	Fully met
D. Security	3.0	Fully met
Section 2: Data Acquisition Capabilities		
A. Administrative Data (claims and encounter data)	2.9	Fully met
B. Enrollment System (Medicaid eligibility)	2.6	Fully met
C. File Consolidation	2.6	Fully met
D. Performance Measure Repository	2.0	Partially met
E. Report Production	2.4	Partially met

State data processing procedures and personnel

ProviderOne hardware is housed in an Equinix co-location facility in Ashburn, VA, where it is operated and maintained by CNSI of Rockville, MD. This facility is certified and has a current SAS-70 Type 2 audit. CNSI also operates a replicated (mirrored) system with a copy of the production data in the Integrated Testing Facility (ITF), housed at a co-location facility in San Jose, where it tests patches and changes to ProviderOne.

The state's Automated Client Eligibility System (ACES) updates Medicaid enrollee eligibility data in ProviderOne nightly. ProviderOne uses these data when processing Medicaid claims and encounter data.

DBHR exports data from ProviderOne to CIS, DBHR's legacy management information system, which remains in use to support existing reporting services. DBHR extracts data from ProviderOne that Looking Glass uses to calculate the statewide performance measures. In addition, DBHR uses two data warehouses for reporting: one at the ProviderOne facility, the other in Boston.

DBHR servers, ProviderOne production servers, and testing servers are interconnected by Global Crossing's Multiple Protocol Label Switching service, which uses an Internet "cloud" and connects to the State Governmental Network.

ACES eligibility data. ACES hardware at the state's data center in Olympia is maintained by Department of Information Systems (DIS) staff. An assessment of ACES was beyond the scope of this review. Eligibility data originate from each Community Services Office (CSO) throughout the state, where caseworkers determine the eligibility of Washington residents for Medicaid services. The CSO is the only entity authorized to make eligibility determinations and to update eligibility data in ACES.

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

The ProviderOne application resides on Oracle Sun T2000 servers with a Solaris 10 operating system. CNSI reported that testing servers were purchased in 2006, and production servers in 2009. DBHR provided Acumentra Health with the manufacturer and model numbers of the servers for ProviderOne. Using this information, Acumentra Health determined that these products have reached end of life (EOL). Other servers that provide various functions are also at EOL, as shown below.

Server model	EOL date
Sun T2000	November 2009
Sun V445	April 2008
Sun X4200	May 2008
Sun E2900	January 2009
Sun V890	January 2009
Sun X4100	May 2008
Sun X4600	August 2007

In July 2011, Oracle decommissioned the Sun Download Center, which provided all continuing support for Sun products.

CNSI provides all maintenance for ProviderOne hardware and software. CNSI programmers have an average 10 to 12 years of experience. The majority of programming staff leads are still in place after more than three years of ProviderOne application development. Programmers receive professional training each year. Changes to the application are developed on testing servers located at the ITF. Data from the production server are replicated to the testing servers in near real time. DBHR must approve all changes to the application before implementation. Patches are also tested before implementation. CNSI uses ClearQuest version control software.

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

CNSI performs full backups of ProviderOne data weekly. Backup tapes are stored onsite in a closed

tape library. CNSI also replicates ProviderOne data to the ITF in near real time.

DBHR developed a robust Disaster Recovery Plan (DRP) that includes using the ITF as a potential recovery site that can be brought up quickly, since it has a copy of production data. CNSI tested the DRP before the ProviderOne “go-live” date. However, the plan has not been updated since September 2009 and has not been tested by DBHR. CNSI is required by contract to submit proof that ProviderOne systems were recovered during DRP tests.

DBHR receives daily reports from CNSI about the health and maintenance of ProviderOne systems and network. It also receives the list of implemented patches. However, DBHR has not formally audited CNSI.

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

Acumentra Health did not re-examine CIS in 2011. As of the 2009 review, the CIS database ran on a Dell PowerEdge 6850/Microsoft Windows Server 2003 rack server, with redundant configuration. Dell states that it provides lifetime support of its servers. However, at six years old, this server would generally be expected to have been replaced by this time.

DIS staff with an average of seven years experience maintain CIS. No training budget exists for programmers because of state budget constraints.

DIS performs full backups of DIS data weekly. Backup tapes are stored onsite. Acumentra Health did not review the DRP for the CIS facility as part of the 2011 review.

Looking Glass Analytics. Looking Glass calculates three performance measures for DBHR and reports the measures on a public website. According to Looking Glass, the infrastructure for the web application includes secure Internet

connections, a web server, a web report server (SAS software), and a SAS server for processing incoming data and preparing the data for the web servers. Source data for this process are extracted from CIS and ProviderOne databases.

The web server, database server, and two SAS software servers are housed on two virtual machine hosts in a VMware ESX 4.0 environment. Acumentra Health did not review the manufacturer and model numbers of the host machines, and cannot determine whether they are still supported by manufacturer warranties.

The virtual servers are fully backed up monthly or as major changes occur. Encrypted backup media are stored offsite. The DRP, as outlined by Looking Glass, includes using existing in-house equipment as hosts in the event that both virtual server hosts fail, and, if the building were lost, uploading offsite backups to “one of many” VMware hosting providers. Looking Glass listed several such providers, which would indicate that it has no contract in place with a provider. This could delay restoration of the servers. Looking Glass estimates that this would take three to six days.

Looking Glass tests all data backups monthly, and tests backups to tape weekly. In December 2010, it successfully tested restoration of the virtual server hosts to alternate hosts.

Transition from legacy system to ProviderOne. DBHR supplied RSNs and their provider agencies with a ProviderOne test database to prepare for the implementation of the new application. Some users had to obtain new software to meet ProviderOne requirements.

DBHR “cut over” to ProviderOne without continuing to operate the legacy system. ProviderOne was continuously available for data submission after cutover, except for an initial two-week suspension period to allow large health plans and hospitals to submit data. Generally, RSNs were able to submit all backlogged encounter data within two weeks.

Section 1A: Information Systems**Score: 2.9 (Fully met)**

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

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

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

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

- good documentation

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

Strengths

- DBHR and CNSI use software configuration and source code (version control) management software.
- DBHR's and CNSI's software programming, QA, and IT staff are highly trained and experienced.
- CNSI's software programmers receive formal training annually.
- CNSI provides DBHR with daily reports on the health and maintenance of ProviderOne systems and network.

Opportunities for improvement

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

Recommendations

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

Section 1B: Staffing **Score: 3.0 (Fully met)**

This section assesses the physical access by DBHR staff to IT assets, as well as specific training requirements for programmers and new staff. Best practices for sustaining quality in processing encounter data include

- adequately trained staff for processing and tracking errors in encounter data submission
- a comprehensive, documented formal training process for new hires and experienced professionals

- refresher courses for staff when updates occur and when new systems are implemented
- established and monitored productivity goals
- low staff turnover

Strengths

- ProviderOne is a fully automated auto-adjudication application.

Section 1C: Hardware Systems **Score: 2.6 (Fully met)**

This section assesses DBHR’s network infrastructure and hardware systems.

Best practices for sustaining quality hardware systems include

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

Strengths

- DBHR’s and CNSI’s data center facilities and hardware systems are well designed and maintained.
- DBHR receives daily reports from CNSI on the health and maintenance of ProviderOne systems and network. It also receives the list of implemented patches.

Opportunities for improvement

- DBHR has not formally audited CNSI.

Recommendations

- DBHR needs to conduct a formal audit of CNSI to review business needs and technical requirements.

Section 1D: Security **Score: 3.0 (Fully met)**

This section assesses DBHR’s information systems in terms of integrity and the capacity to prevent data loss and corruption. Acumentra Health conducts a security walkthrough of the computer area and/or data center to assess the possibility of a breach in security measures. Best practices for securing data are summarized below.

- A well-run security management program includes IT governance, risk assessment, policy development, policy dissemination,

and monitoring. Each activity should flow into the next in a cycle of activity to ensure that policies remain current and that important risks are addressed.

- Computer systems and terminals should be protected from unauthorized access through use of a password system and security screens. Passwords should be changed frequently and reset whenever an employee terminates.

- Paper-based claims and encounters should be in locked storage facilities when not in use.
- Data transferred between systems/locations should be encrypted.
- A comprehensive backup plan includes, but is not limited to, scheduling, rotation, verification, retention, and storage of backups to provide additional security in the event of a system crash or compromised integrity of the data. Managers responsible for processing claims and encounter data must be knowledgeable of their backup schedules and of retention of backups to ensure data integrity.
- To ensure integrity, backups should be verified periodically by performing a “restore” and comparing the results. Ideally, annual backups would be kept for seven years or more in an offsite climate-controlled facility.
- Databases and database updates should include transaction management, commits, and rollbacks. Transaction management is useful when making multiple changes in the database to ensure that all changes work without errors before finalizing the changes. A database commit is a command for committing a permanent change or update to the database. A rollback is a method for tracking changes before they have been physically committed to disk. This prevents corruption of the database during a sudden crash or some other unintentional intervention.
- Formal controls in the form of batch control sheets or assignment of a batch control number should be used to ensure a full accounting of all claims received.

Strengths

- CNSI replicates ProviderOne to the ITF in near real time, providing quick and easy access to nearly complete backup data.
- DBHR, CNSI, and Looking Glass implement security measures that make it difficult for unauthorized users to gain access to data and other network resources.
- CNSI performs regular network scanning for potential vulnerabilities that may result from poor or improper system configuration.
- Looking Glass performs full backups of its virtual server monthly. Encrypted backup media are transported to a secure offsite location.
- CNSI tested the ProviderOne DRP before the application was implemented.

State data acquisition capabilities

DBHR accepts encounter data from the RSNs in a HIPAA-compliant 837 electronic format only. At least monthly, the RSNs connect to ProviderOne via a secure service on the ProviderOne network to transmit batched encounter data. RSNs also may submit individual encounters through the ProviderOne web portal. Community hospital claims may be submitted by paper directly to DBHR, where workers enter these data manually via the ProviderOne web portal.

ProviderOne loads each batch and uses Edifecs software (Bellevue) to confirm that the batch meets HIPAA format requirements. A batch that fails this screening is not processed further, and the RSN receives notice. If the batch passes the screening, the encounters are translated and loaded to ProviderOne data tables. ProviderOne adjudicates these data nightly, marking each encounter “accepted” or “rejected.” The submitting RSN receives a report showing the acceptance of each encounter or a detailed reason for its rejection. RSNs resubmit batches or encounters when they are corrected. DBHR manages and monitors RSN encounter data certifications for accuracy and completeness.

Auditing and monitoring of data processing. DBHR performs monthly reconciliation activities to verify provider credentials, eligibility files, member ID codes, and income source and program codes. DBHR uses monthly summaries of encounter data submissions, error reports, and certification reports for these reviews. During processing, DBHR does not conduct audits of its encounter data to ensure the accuracy and completeness of electronic data interchange (EDI) and adjudication processes, or to identify issues that were not anticipated when the EDI rules were developed.

Submission of diagnoses. The RSNs submit demographic and periodic data about Medicaid enrollees (including diagnoses) to CIS via the SGN. Diagnosis can be reported in two separate files; one file requires the diagnosis to be submitted and the other does not. These fields

accept only one diagnosis. RSNs also can use a diagnosis field on the 837 encounter data record to report the specific diagnosis treated at the time of service (i.e., more than one diagnosis can be reported). Several RSNs reported that they submit only the primary diagnosis when submitting any data. This practice introduces inaccuracy in the encounter data—i.e., a reported service provided may treat a condition other than the reported diagnosis. This exposes agencies to a significant risk of revenue take-backs.

Management reports. DBHR generates monthly timeliness reports (performance measures) from the encounter data in the warehouse, and sends these reports to the RSNs. These reports review all encounters submitted each month.

The DBHR staff also develops ad-hoc reports to evaluate the completeness and accuracy of data in each field. These reports are based on a sample of the encounter data.

RSN encounter data validation. DBHR requires the RSNs by contract to perform encounter data validation audits of contracted provider agencies, and to report the results of these audits to DBHR.

Eligibility data issues. ACES updates ProviderOne eligibility files with new enrollees every 15 minutes, and uploads a full eligibility file nightly. DBHR sends a full eligibility file to each RSN monthly, and update files weekly. RSNs and their contracted provider agencies can verify enrollee eligibility by viewing these data in ProviderOne via the web portal, but neither the RSNs nor their providers can make changes to these data (e.g., address or name). DBHR developed a process that allows RSNs to inform DBHR staff of potential errors in the eligibility data (particularly important in the case of change of address). Once notified of a potential error, the DBHR staff contacts the appropriate CSO, which can investigate and make necessary corrections. However, the RSNs report little or no knowledge of this new process, and errors in the eligibility file remain an issue.

Many RSNs cannot upload eligibility files to their claims/encounter processing applications, which limits the completeness of the adjudication. Several RSNs address this by using an MS Access application to compare DBHR eligibility files with a file of enrollees for whom encounters are submitted. Because this approach uses two datasets, it introduces risk of duplication or loss. A few RSNs rely solely on their providers checking enrollee eligibility on the ProviderOne web portal at the time of service, and do not independently verify enrollee eligibility.

ProviderOne uses an enrollee's ZIP code of residence to assign the RSN. However, several RSNs share ZIP codes. In some cases, an enrollee may receive services from a particular RSN, but the encounter data show that another RSN provided the services. This presents a particular problem in determining RSN responsibility for community hospitalization.

CIS data issues. The ProviderOne file format is not fully compatible with the CIS file format. Data extraction and translations programs were developed to convert ProviderOne encounter data into the CIS format so that existing reporting programming could continue to be used.

Following this conversion, the data are aggregated by Looking Glass Analytics using SAS routines, and this data set is used to develop performance indicator reports. At the time of the ISCA review, this file consolidation project was not complete.

By design, ProviderOne does not include all fields that were included in CIS—e.g., ethnicity. These data are missing in current reports. DBHR plans to restore these fields in future versions of ProviderOne.

Performance measurement and report production. DBHR's performance measurement and report production system has improved since the 2009 ISCA review. As noted in the Performance Measure Validation section of this report, DBHR has documented the methods for calculating its three core performance measures, and Looking Glass uses the state-supplied methodology to calculate the measures.

DBHR facilitates the statewide Performance Indicator Workgroup, representing DBHR, RSNs, and provider agencies. Members work to improve methodology to clarify the interpretation of performance targets and results.

Section 2A: Administrative Data**Score: 2.9 (Fully met)**

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

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

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

Strengths

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

Opportunities for improvement

- DBHR performs only ad-hoc audits of post-adjudicated encounter data stored in the data warehouse.
- DBHR uses a HIPAA-compliant 837 electronic format that accepts more than one diagnosis. However, some RSNs report that they submit only the primary diagnosis or do not submit diagnoses on the 837. DBHR has no method in place to ensure that the diagnosis being treated at the time of service is reported on the 837.

Recommendations

- DBHR needs to perform routine post-adjudication audits of encounter data based on lessons learned from its ad-hoc audits of adjudicated data.
- DBHR needs to develop a method to ensure that the diagnosis being treated at the time of service is reported on the 837.

Section 2B: Enrollment System**Score: 2.6 (Fully met)**

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

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

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

Strengths

- DBHR receives full eligibility data from ACES each night, and updates daily.
- DBHR provides RSNs with full eligibility data files monthly and updates weekly.

Opportunities for improvement

- Although DBHR developed a process that RSNs can use to update eligibility data (e.g., change of address or name), RSNs are not sufficiently aware of this new process to use it effectively.
- ProviderOne uses an enrollee's ZIP code of residence to assign the RSN. However, several RSNs share ZIP codes. In some cases, an enrollee may receive services from a particular RSN, but the encounter data show that another RSN provided the services.

- RSNs report concern about the quality of 834 enrollment data. This concern arises from multiple issues, including retroactive enrollment changes, changes from one RSN to another, and frequent updates to enrollees' status. Many RSNs report that frequent data changes for an enrollee make it difficult to determine eligibility at any moment with certainty.
- The majority of RSNs do not verify Medicaid eligibility before submitting encounters to DBHR, making it difficult to determine what services are paid by Medicaid, as opposed to state-only funds.

Recommendations

- DBHR needs to provide direction for the RSNs about the new process that is available to update eligibility data.
- DBHR needs to work to address enrollment issues for RSNs that share ZIP codes.
- DBHR needs to work with RSNs to resolve issues related to the quality of 834 enrollment data.
- DBHR needs to work with RSNs to define expectations for checking enrollee eligibility when submitting encounters.

Section 2C: File Consolidation**Score: 2.6 (Fully met)**

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

An ideal file consolidation system includes:

- use of appropriate data, including linked data from separate data sets
- procedures to avoid or eliminate double-counting enrollees or numerator events
- procedures for frequent review of the programming logic or for demonstration of the program, to confirm that non-standard codes are mapped to standard codes in a consistent, complete, and reproducible manner
- adherence to the parameters required by the specifications of the performance measure
- assurance that the process of integrating administrative and medical record data for the purpose of determining the numerator is consistent and valid

Strengths

- ProviderOne receives full eligibility data from ACES each night, and updates daily.
- DBHR uses one data warehouse to calculate the timeliness performance measures.

Opportunities for improvement

- At the time of the state ISCA review, the ProviderOne/CIS file consolidation project was not complete and thus was not included in the review. This project was completed subsequently, but documentation was not available at the time of review.

Recommendations

- DBHR needs to fully document the process used to extract source data from CIS, how these data will be aggregated and uploaded to DBHR's SAS server, and how it will be available for Looking Glass to use.

Section 2D: Performance Measure Repository**Score: 2.0 (Partially met)**

The advantages of a repository for performance measure data include:

- streamlining the association of data from different sources and periods to find correlations and trends
- allowing analysts to test new programming code against old data pulls
- enabling quality control checks or periodic audits of performance measure data

The repository may be an integrated database or an organized set of files. It may include functionality for archiving benchmark data; current and past

performance measurement results; source data for each report or the ability to link to the source data (e.g., through a unique key or claim number); measure definitions, including numerators and denominators; and a copy of each report.

Strengths

- Looking Glass stores a snapshot of the dataset used to calculate each performance measure (i.e., it keeps a frozen dataset).
- DBHR uses two data warehouses (one at the ProviderOne facility in Ashburn, VA, and a flat file database in Boston) to produce management reports and ad-hoc reports.

Opportunities for improvement

- DBHR does not keep a frozen data set for the timeliness performance measures it calculates. ProviderOne data are dynamic, preventing replication of these reports in the event they are lost.

Recommendations

- In the absence of a frozen data set, DBHR needs to determine procedures to validate the integrity of the data undergoing formatting changes during the move from ProviderOne to Looking Glass.

Section 2E: Report Production

Score: 2.4 (Partially met)

The performance measure production process should be well documented, subject to rigorous quality control, and capable of being completed by more than one analyst.

Strengths

- DBHR produces performance measure timeliness reports quarterly and distributes them to RSNs.
- DBHR has the infrastructure in place (through its contract with Looking Glass) to display performance measure data in a high-quality, web-based dynamic format for RSN and public use.

Opportunities for improvement

- At the time of the ISCA review, DBHR relied on one staff person to generate two performance measures. DBHR relied on institutional knowledge to produce reports, and had not documented the process for producing the two timeliness performance measure reports and the three web-based performance measure reports, produced by Looking Glass.

Recommendations

- DBHR needs to train more than one staff programmer how to generate its timeliness performance measures.
- DBHR needs to fully document each process that produces performance measures.

RSN information systems

In addition to the state-level ISCA, Acentra Health conducted a full ISCA for each RSN during 2011, identifying strengths, challenges, and recommendations at the RSN level. These reviews (examining the status of RSNs' information systems during 2010) revealed the following major themes.

- RSNs' overall performance has improved since the 2009 review, with many more RSNs meeting the requirements of various sections. All RSNs earned scores in the Fully Met range for Staffing, Administrative Data, Vendor Data Integrity, and Provider Data.
- A few RSNs have made improvements in IT governance, but most are still working to implement IT control frameworks, IT steering committees, and management reports.
- RSNs have improved their oversight of support functions outsourced to third-party data administrators, application service providers, and vendors. Two RSNs still have oversight issues to resolve.
- All RSN have worked successfully with their providers to eliminate use of paper encounters and claims for all outpatient services. This reduces the probability of error and increases throughput.
- RSNs have made progress in creating DRPs, though many still struggle with keeping the plans current. Six RSNs have not completed initial testing of plans.
- During 2009, many RSNs maintained incomplete provider profile directories. By 2011, most RSNs had enhanced these 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

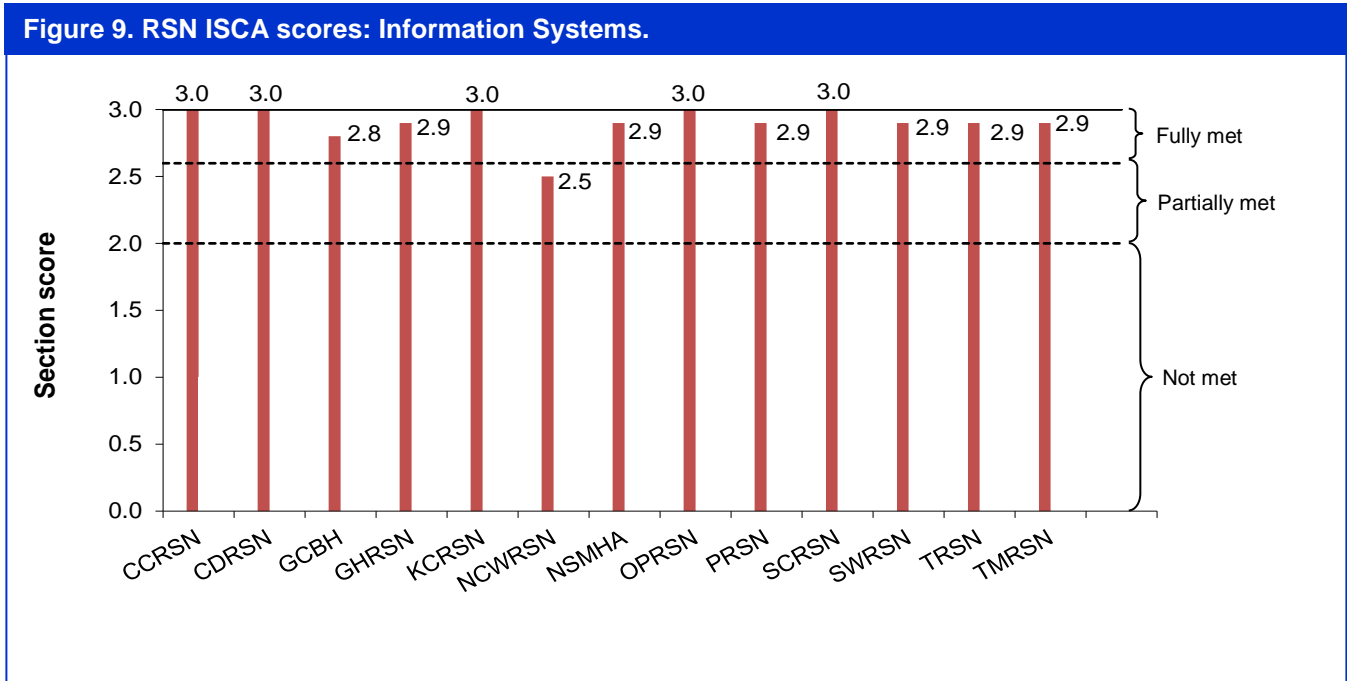
documentation can create problems related to data recovery, staff turnover, and overall system supportability.

- Most RSNs have successfully addressed the previously identified issues with regard to encrypting and securely transporting backup data files. However, many provider agencies still are not encrypting offsite backup media. RSNs and provider agencies need to begin addressing encryption of personal hardware, USB drives, and other removable media.
- RSNs generally need to ensure that they update hardware at regular intervals to avoid disruption of services caused by hardware failures. Three RSNs have specific issues with older hardware that needs to be updated.

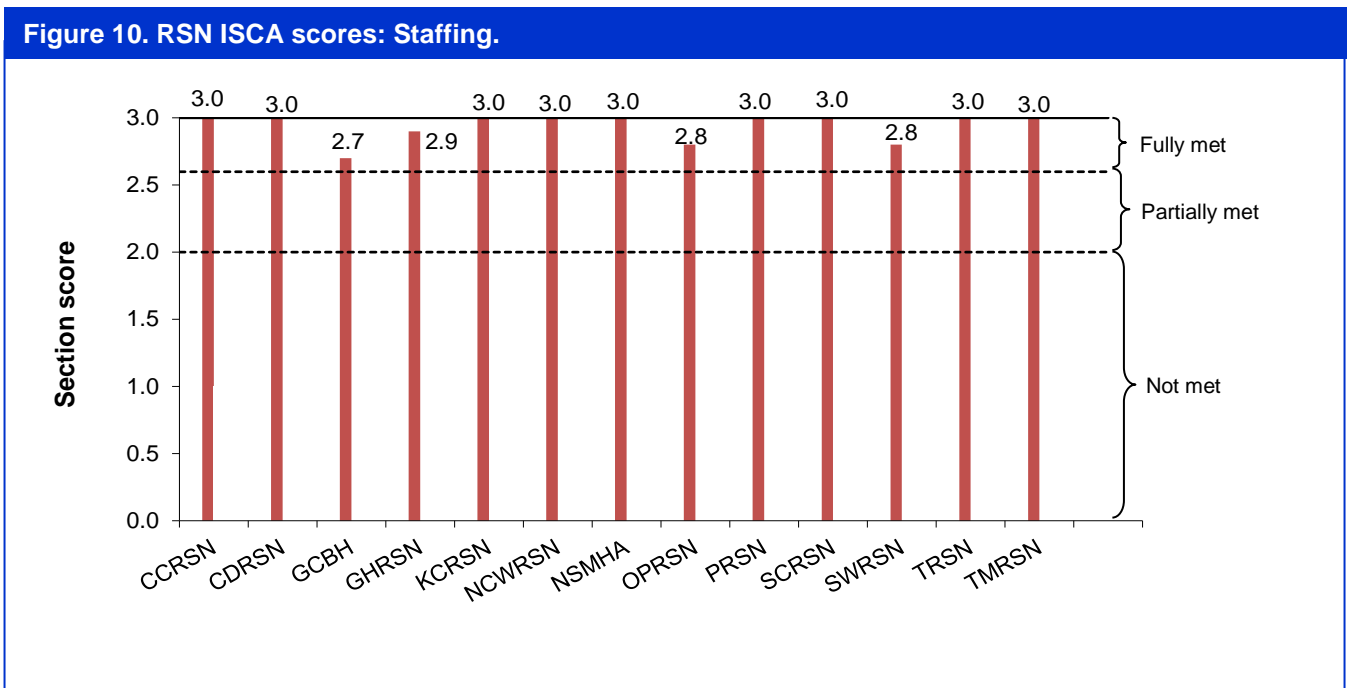
The following pages present the scores for individual RSNs on each subsection of the ISCA review protocol. The subsections and criteria for the RSN reviews are similar to those used for the state-level ISCA. However, the RSNs are not evaluated for File Consolidation, Performance Measure Repository, or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

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

Information Systems: As shown in Figure 9, 12 RSNs fully met the criteria for this subsection, and NCWRSN partially met the criteria.

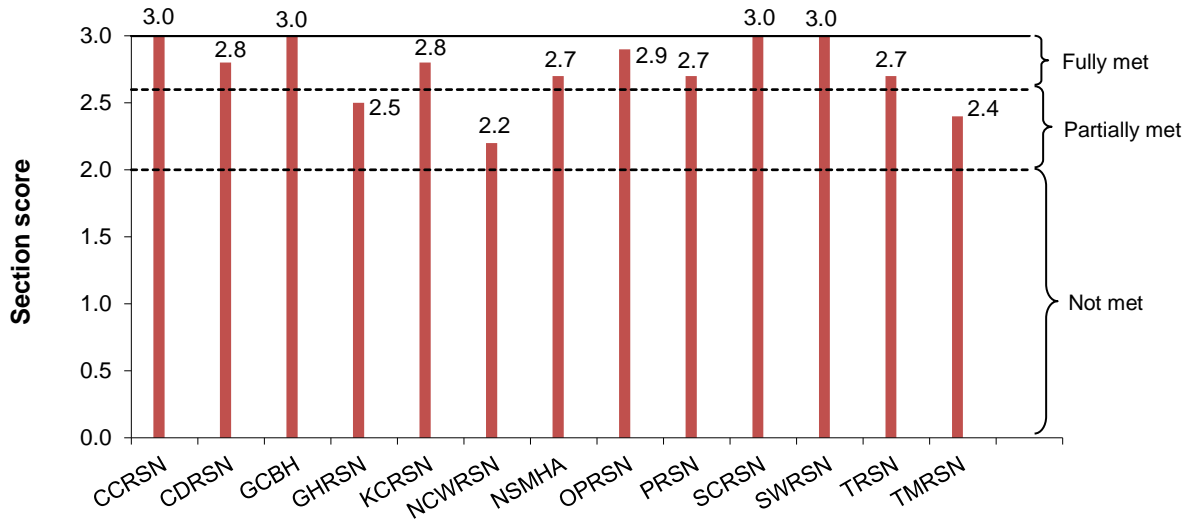


Staffing: As shown in Figure 10, all RSNs fully met the criteria for this subsection.



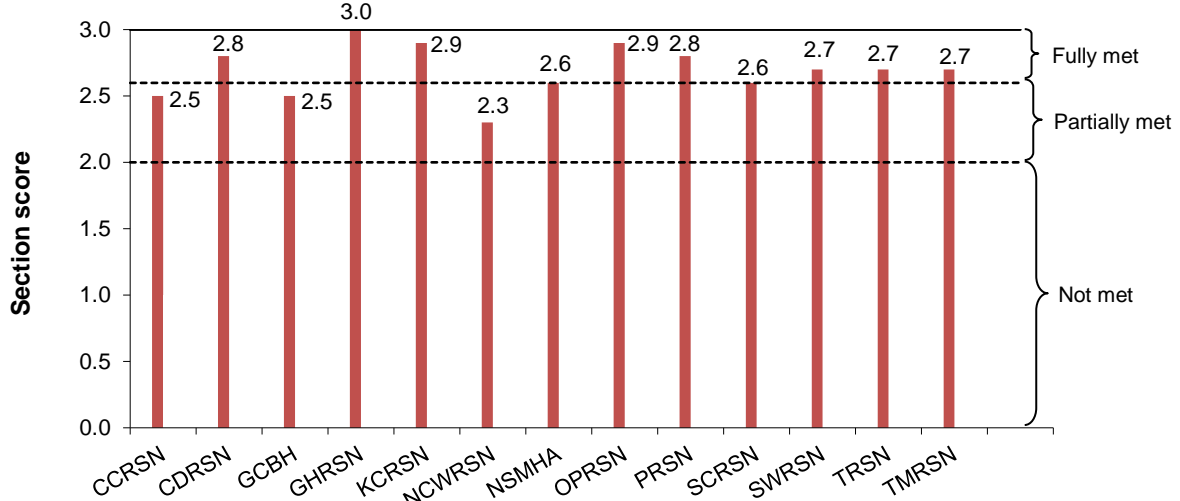
Hardware Systems: As shown in Figure 11, 10 RSNs fully met the criteria for this subsection, and 3 RSNs partially met the criteria.

Figure 11. RSN ISCA scores: Hardware Systems.

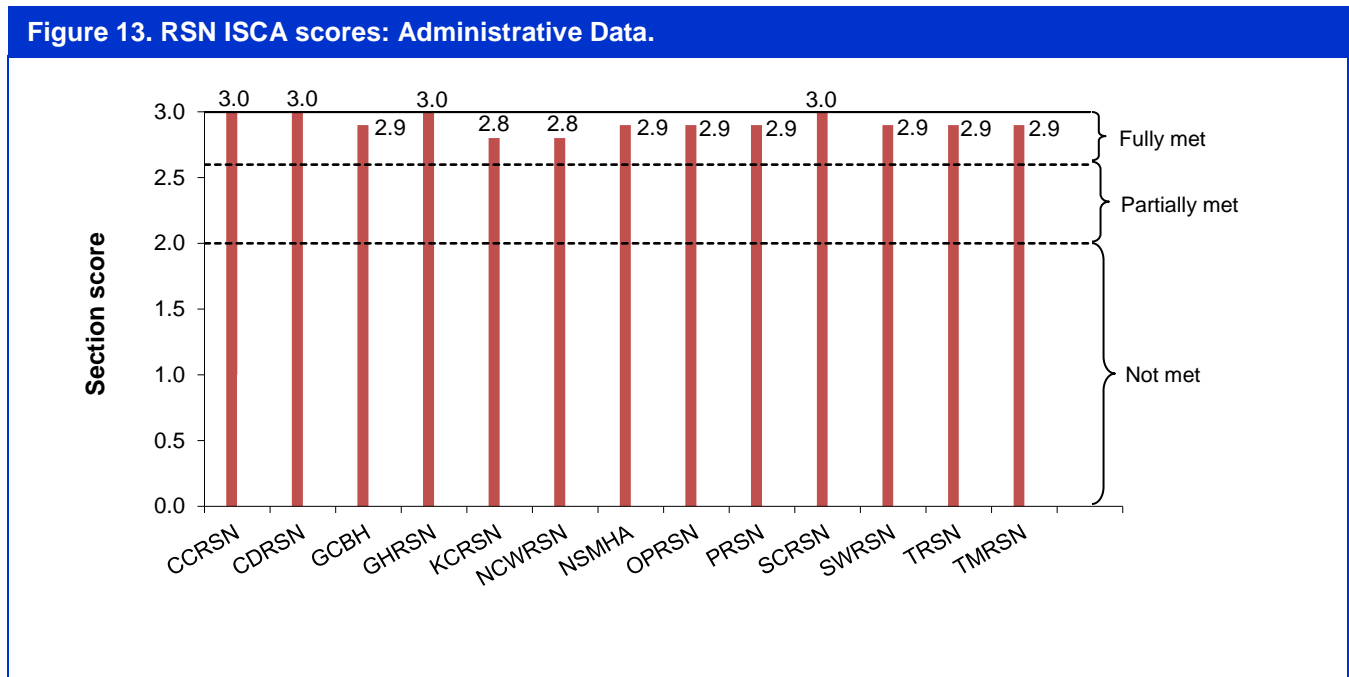


Security: As shown in Figure 12, 10 RSNs fully met the criteria for this subsection, and 3 RSNs partially met the criteria.

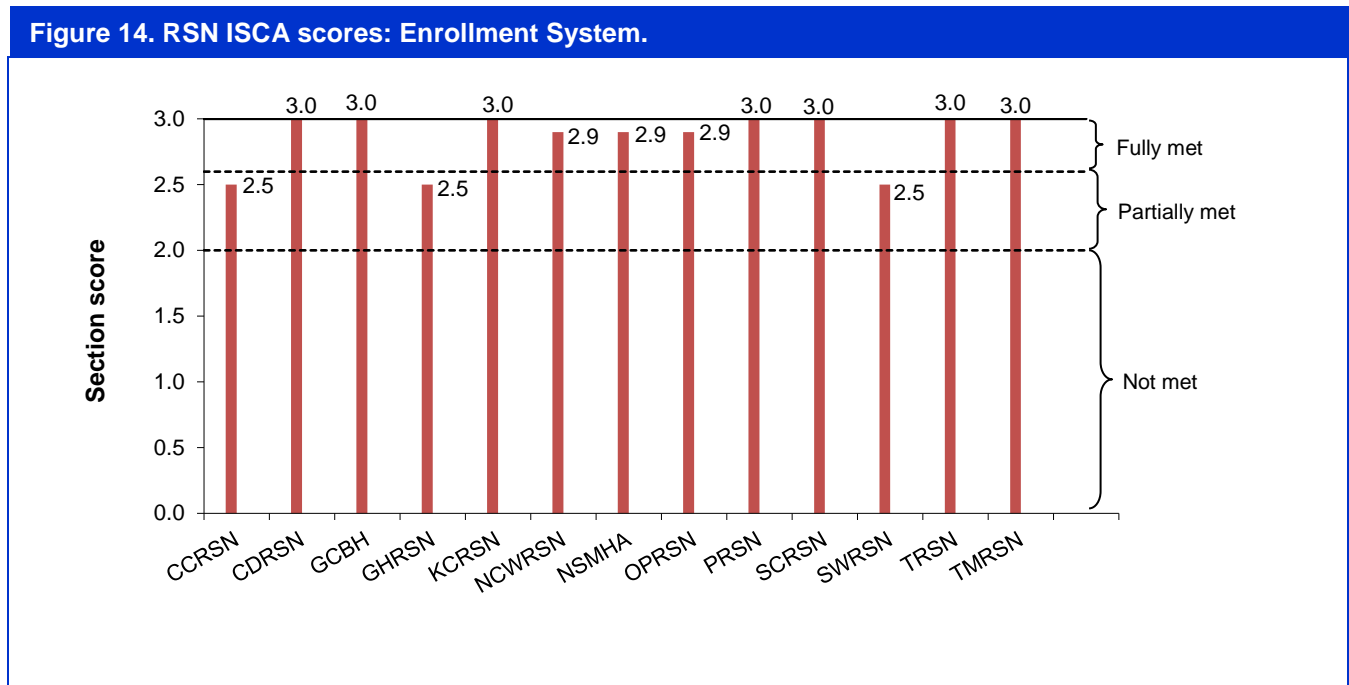
Figure 12. RSN ISCA scores: Security.



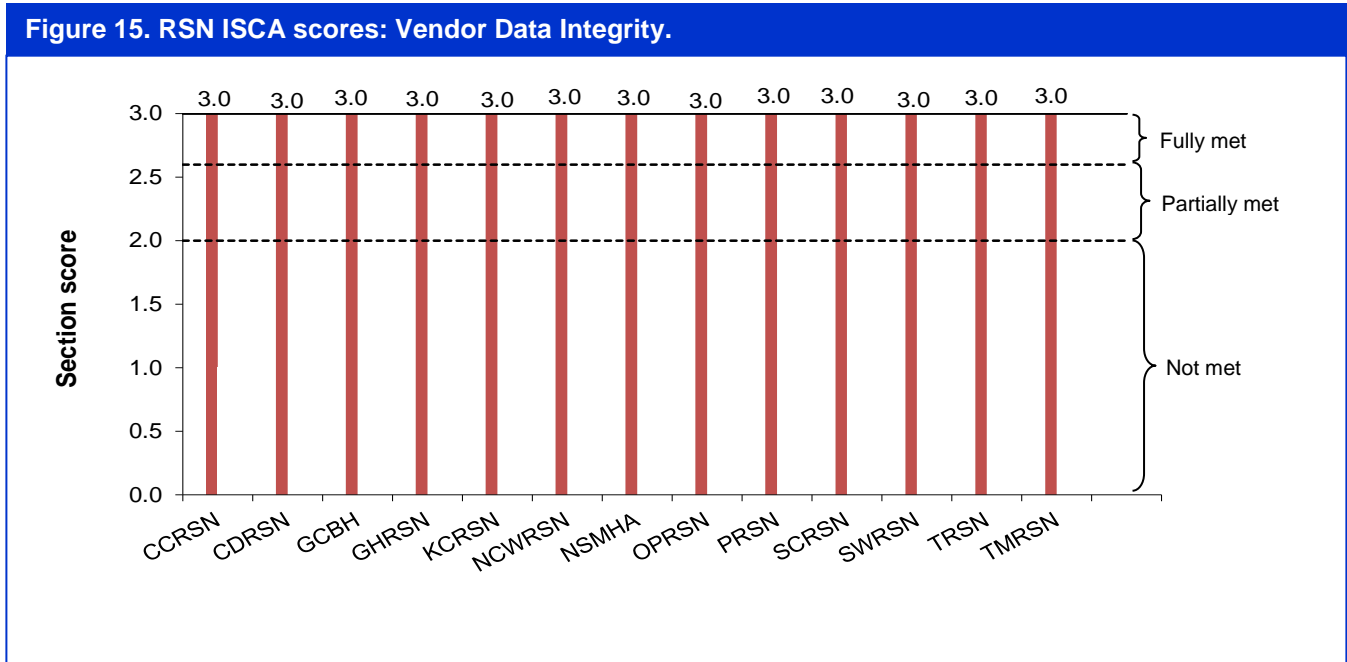
Administrative Data: As shown in Figure 13, all RSNs fully met the criteria for this subsection.



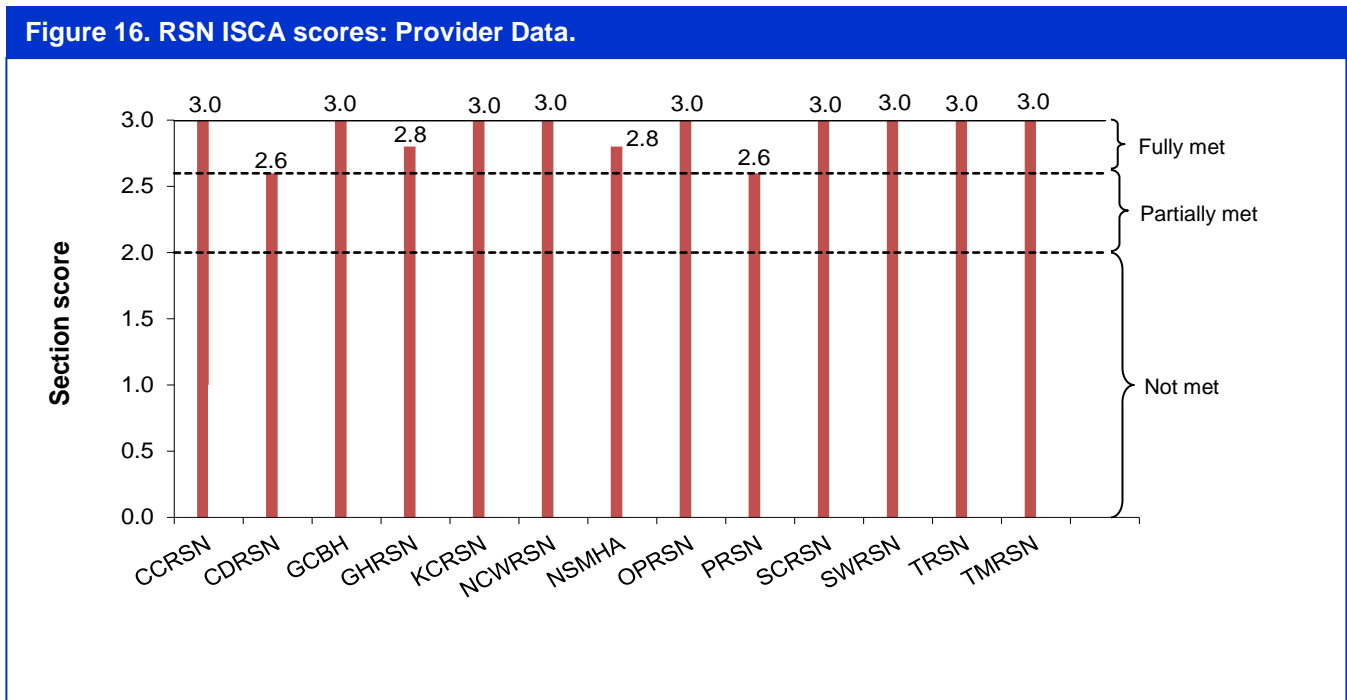
Enrollment System: As shown in Figure 14, 10 RSNs fully met the criteria for this subsection, and 3 RSNs partially met the criteria.



Vendor Data Integrity: As shown in Figure 15, all RSNs fully met the criteria for this subsection.



Provider Data: As shown in Figure 16, all RSNs fully met the criteria for this subsection.



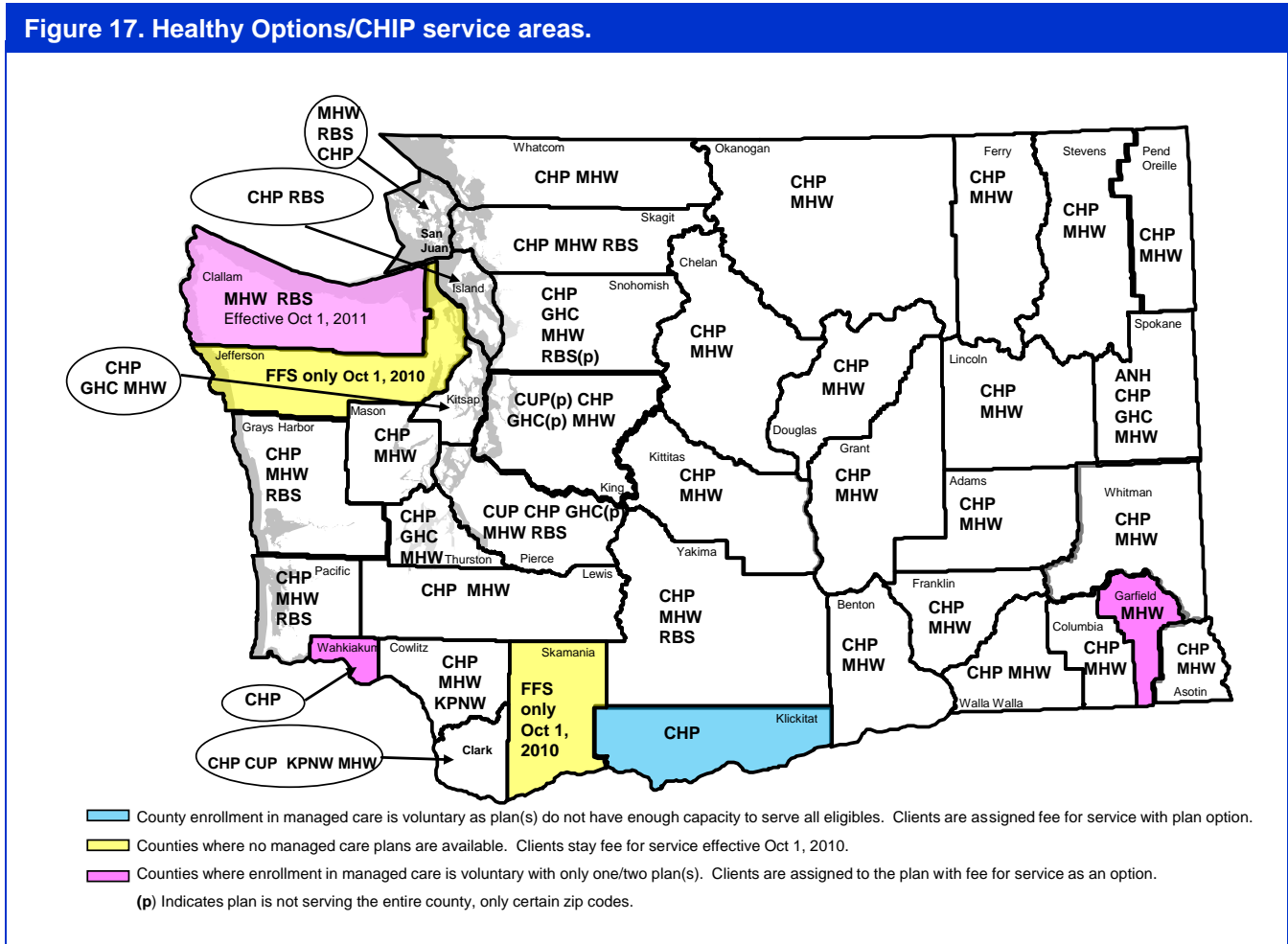
PHYSICAL HEALTH CARE DELIVERED BY MCOs

HCA contracts with seven MCOs to deliver physical healthcare services to Medicaid managed care enrollees. Table 10 shows the approximate number and percentage of enrollees assigned to each health plan as of December 2010. Figure 17 shows the counties served by each plan.

Table 10. Managed care organizations and Medicaid enrollees, December 2010.^a

Health plan	Acronym	Number of enrollees	% of all enrollees
Asuris Northwest Health	ANH	3,082	0.5
Community Health Plan	CHP	221,665	33.1
Columbia United Providers	CUP	44,041	6.6
Group Health Cooperative	GHC	23,424	3.5
Kaiser Permanente Northwest	KPNW	614	0.1
Molina Healthcare of Washington	MHW	338,179	50.4
Regence BlueShield	RBS	39,505	5.9
Total		670,510	100.0

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



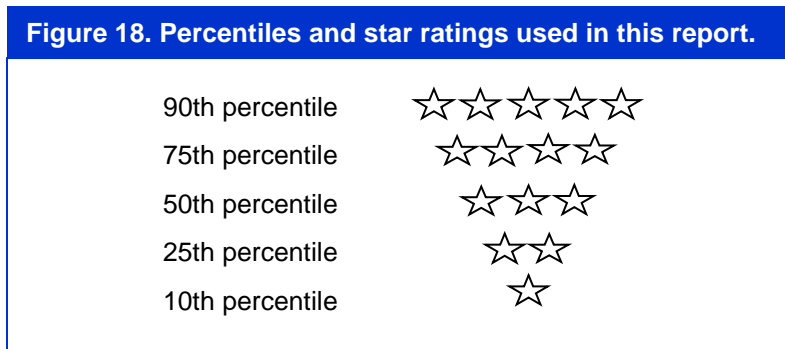
At least one Healthy Options plan is active in 37 of the state’s 39 counties. Enrollment is voluntary in some counties, either because only one health plan serves the county or because the contracted plans lack the provider network to accept new enrollees.

HCA uses the annual HEDIS measures to gauge the MCOs’ clinical 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 2011 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 the statewide Healthy Options 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 referred to the 2011 Medicaid averages from the NCQA *Quality Compass*.⁶

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 18 shows the stars and the percentile ranges.



Access to physical health care

HCA has several mechanisms in place to monitor MCOs’ success in providing access to care for Healthy Options enrollees. Through TEAMonitor, HCA assesses the MCOs’ compliance with regulatory and contractual requirements related to access. (See Appendix C.) HCA 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 2011 review found:

- As a group, the MCOs strengthened their compliance with most access standards, compared with 2010. The health plans met all elements of Availability of Services and Furnishing of Services, and 92% of the elements of Additional Services for Enrollees with SHCN.

- Compliance improved but remained incomplete with regard to Coverage and Authorization of Services, Primary Care and Coordination, and Emergency and Post-stabilization Services. The main deficiencies involved inadequate and/or conflicting documentation of MCO policies and procedures.

Performance on access measures

Three HEDIS measures assess health plans’ success in providing access to WCC, expressed as the percentage of enrollees in each age group who received the recommended numbers of 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 11 compares access to WCC in Washington with the national Medicaid averages. The Healthy Options plans’ average rate of delivering WCC visits for infants rose slightly in 2011 but remained significantly below the national average. About 54% 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% and 37%, respectively, also remained significantly below the national averages.

Table 11. Washington scores and national averages for physical health access measures, 2011.

Measure	National average	Washington score	Washington rating
Infant WCC Visits (6 or more)	60%	54%*	☆☆☆
WCC Visit, 3–6 years	72%	62%*	☆☆
Adolescent WCC Visit	48%	37%*	☆☆

Stars represent Washington’s performance compared with the 2011 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 12). Overall, MHW was the best performing plan, with WCC visit rates significantly exceeding the state aggregates for all three age groups. MHW also has sustained the highest average visit rate for all groups over the past five years.

Infants: About 61% of infants enrolled in MHW received at least six WCC visits in 2011, as did 56% of GHC enrollees. GHC significantly improved its visit rate over 2010.

Ages 3–6: KPNW again reported the highest percentage of WCC visits for children in this age group—75%, significantly higher than the state average. MHW also significantly exceeded the state average at 69%. The visit rates for ANH and CUP were significantly below average.

Adolescents: MHW, at 44%, was the best performer in getting adolescents seen for a WCC visit, while CUP was significantly below average at 28%. Only CHP reported a significant change from 2010, improving its rate to 39%.

Table 12. MCO and state scores for physical health access measures, 2011.

Measure	ANH	CHP	CUP	GHC	KPNW	MHW	RBS	State
Infant WCC (6+ visits)	—	51%	46% ▼	56%	—	61% ▲	54%	54%
Child WCC, 3 to 6 Years	55% ▼	64%	54% ▼	59%	75% ▲	69% ▲	62%	62%
Adolescent WCC Visit	36%	39%	28% ▼	39%	34%	44% ▲	34%	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.) HCA 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 2011 review found that all Healthy Options MCOs demonstrated compliance with the standards for timely access to services.

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 13 shows that the 2011 statewide average for this measure, 64%, was higher than the 2010 average, but not significantly so, and was equivalent to the national Medicaid average. Statewide performance on this measure has remained static for nearly 10 years, while the national average has improved steadily, from 52% in 2002 to the current 64%.

Table 13. Washington scores and national averages for physical health timeliness measure, 2011.

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

Stars represent Washington's performance compared with the 2011 NCQA percentile rankings for Medicaid HEDIS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.

MCO results: Table 14 compares the performance of individual health plans with the statewide score on the timeliness measure. Rates for timely postpartum care ranged from CUP's 52% to GHC's 71%. GHC's average once again significantly exceeded the statewide average,

while CUP's average came in significantly below average. No plan reported a significant change from 2010. However, GHC, MHW, and RBS reported rates higher than the national average in 2011.

Table 14. MCO and state scores for physical health timeliness measure, 2011.

Measure	CHP	CUP	GHC	KPNW	MHW	RBS	State
Postpartum Care	63%	52% ▼	71% ▲	—	65%	68%	64%

▲ 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. HCA 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 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 2011 review found that the MCOs, as a group, strengthened their compliance with quality standards compared with 2010. The MCOs met all elements of Provider Selection, ensuring that their policies and procedures were based on NCQA guidelines, and met more than 80% of the elements of Practice Guidelines, Enrollee Rights, and Grievance Systems.

The most notable area of weakness remained the QAPI standard, which calls for MCOs to measure and report performance on standardized measures, monitor for over- and underutilization of services, conduct PIPs, assess care furnished to enrollees with SHCN, and evaluate the QAPI program annually. No MCO fully met this standard in 2011, and the MCOs as a group met fewer than half of the required elements, though many elements were partially met.

Among health plans, KPNW met all 19 elements of the Grievance Systems standard. CUP met 95% of the Grievance Systems elements and 93% of the Enrollee Rights elements.

Performance on quality measures

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

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

- four diphtheria, tetanus, and pertussis (DTaP)
- three polio (IPV)
- one measles, mumps, and rubella (MMR)
- three Haemophilus influenzae type b (HiB)
- three hepatitis B (Hep B)
- one varicella-zoster virus (VZV) or chicken pox

The second measure, 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* the 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% 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 15 compares Washington’s performance on these quality measures with the nationwide performance.

Washington’s Combo 2 immunization rate fell significantly in 2011, to 69%, significantly below the national Medicaid average of 74%, though the statewide average shows a significant gain over the past five years. Average rates for all individual

vaccines in Combo 2 are now below 90%. The federal benchmarking report, *Healthy People 2010*, sets 80% 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.

The 2011 statewide average for Combo 3 was 66%, down significantly from 2010 and

significantly below the 2011 national average of 70%. The PCV vaccination rate fell to 77%, well below the federal benchmark.

The statewide average for the diabetes care indicator in 2011 was about 84%, equivalent to the 2010 statewide rate and to the national Medicaid average in 2011.

Table 15. Washington scores and national averages for physical health quality measures, 2011.

Measure	National average	Washington score	Washington rating
Childhood Immunizations (Combo 2)	74%	69%*	☆☆☆
Childhood Immunizations (Combo 3)	70%	66%*	☆☆☆
Diabetes Care (annual HbA1c test)	82%	84%*	☆☆☆☆

Stars represent Washington’s performance compared with the 2011 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 16 compares individual health plans’ performance with the statewide scores on the quality measures.

Combo 2 immunizations: From 2010 to 2011, Combo 2 rates declined significantly for all MCOs except CHP, which significantly outperformed the statewide average at 78%. CUP, GHC, MHW, and RBS all reported significant declines from 2010.

Combo 3 immunizations: As with Combo 2, CHP significantly outperformed all other MCOs in 2011, with a rate of 74%. GHC and RBS reported significant declines from 2010, and CUP remained significantly below the state average.

Diabetes care: Plan performance in 2011 varied around the statewide average of 84%. CHP reported the highest rate at 87%, while CUP’s rate fell significantly to 78%.

Table 16. MCO and state scores for physical health quality measures, 2011.

Measure	CHP	CUP	GHC	KPNW	MHW	RBS	State
Childhood Immunizations (Combo 2)	78% ▲	63% ▼	63% ▼	—	71%	72%	69%
Childhood Immunizations (Combo 3)	74% ▲	58% ▼	62%	—	68%	68%	66%
Diabetes Care (annual HbA1c test)	87%	78% ▼	85%	—	83%	80%	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 2011, TEAMonitor reviewers scored MCOs on their compliance with approximately 80 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, HCA and ADSA reviewed the WMIP program contractor's compliance with relevant regulations and contract provisions (see page 89).

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 17 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 17 breaks out the 2011 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 19 shows the change in compliance scores on selected standards from 2009 through 2011.

For the MCOs as a group, the 2011 scores indicate better performance on almost all standards compared with 2010. The MCOs met all elements of Availability of Services, Furnishing of Services, Program Integrity, Enrollment and Disenrollment, and Provider Selection, and met 92% of the elements of Additional Services for Enrollees with SHCN. The health plans also improved their compliance with elements of Enrollee Rights, Grievance Systems, and Patient Review and Coordination.

The most notable decline occurred in compliance with the QAPI standard; the MCOs met fewer than half of the QAPI elements, though many elements were partially met. Common areas of weakness were program evaluation and detection of under- and overutilization of services.

Only half of the MCOs met the standards for Claims Payment and for Primary Care and Coordination. Also, most MCOs struggled with contract requirements to provide outpatient mental health benefits, such as reviewing psychotropic medications of children and providing PCPs with access to consultation with child psychiatrists.

As in 2010, KPNW led all other MCOs in 2011 by complying fully with 11 of the 16 standards reviewed. Most notably, KPNW met all 19 elements of the Grievance Systems standard. CUP complied fully with 10 standards, including 93% of the Enrollee Rights elements.

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 17 may not reflect the status of plan performance as of December 2011.

Table 17. MCO compliance scores for physical health regulatory and contractual standards, 2011.

Percentage of elements Met, Partially Met, and Not Met																					
Standard (# of elements)	CHP			CUP			GHC			KPNW			MHW			RBS/ANH			State average		
	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM
Availability of Services (5)	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0
Furnishing of Services (2)	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0
Program Integrity (2)	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0
Claims Payment (1)	0	0	100	100	0	0	100	0	0	100	0	0	0	100	0	0	100	0	50	33	17
Primary Care and Coordination (1)	100	0	0	0	100	0	100	0	0	0	100	0	100	0	0	0	100	0	50	50	0
Additional Services for Enrollees with SHCN (5)	100	0	0	100	0	0	100	0	0	100	0	0	50	0	50	100	0	0	92	0	8
Patient Review and Coordination (8)	75	12	12	100	0	0	63	12	25	100	0	0	12	50	37	100	0	0	75	12	12
Coverage and Authorization of Services (4)	75	0	25	75	0	25	50	50	0	75	25	0	50	0	50	75	0	25	67	12	21
Emergency and Post-stabilization Services (2)	50	0	50	100	0	0	50	50	0	50	50	0	50	50	0	50	50	0	58	33	8
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 (15)	80	13	7	93	7	0	87	13	0	86	7	7	86	7	7	73	27	0	84	13	3
Grievance Systems (19)	79	10	10	95	5	0	89	0	10	100	0	0	63	21	16	68	21	10	82	9	8
Practice Guidelines (3)	100	0	0	100	0	0	100	0	0	100	0	0	67	0	33	33	0	67	83	0	17
Provider Selection (3)	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0
QAPI Program (5)	40	60	0	20	40	40	80	20	0	80	20	0	20	80	0	40	40	20	47	43	10
Subcontractual Relationships and Delegation (4)	100	0	0	50	50	0	75	25	0	100	0	0	100	0	0	100	0	0	88	12	0

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

^a These standards were scored over the course of 2011. Some "Partially Met" or "Not Met" for any standard have submitted corrective actions plans; therefore, the above scores may not reflect the status of plan performance as of December 2011.

NOTES:

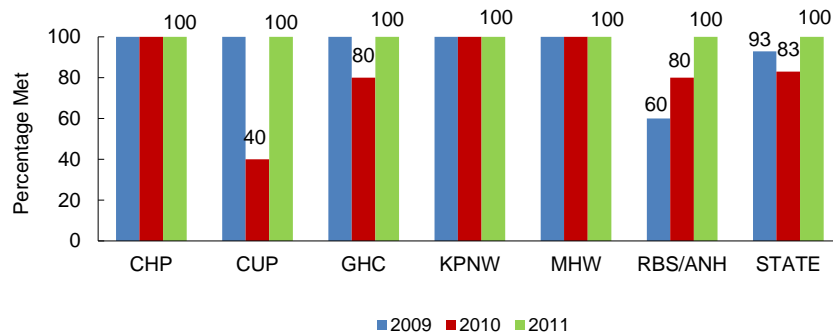
Additional Services for Enrollees with SHCN: CHP and GHC were scored on 5 elements; CUP, MHW, KPNW, and RBS were scored on 5 elements.

Enrollee Rights: CHP, GHC, and RBS were scored on 15 elements; CUP, KPNW, and MHW were scored on 14 elements.

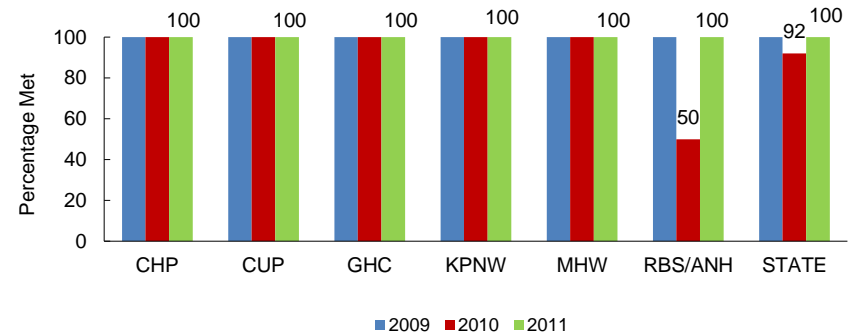
Figure 19. Changes in compliance scores for selected physical health regulatory standards by MCO, 2009–2011.

Access Standards

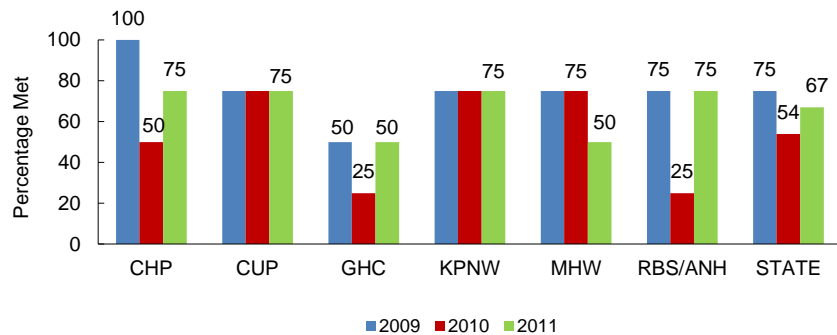
Availability of Services



Furnishing of Services



Coverage and Authorization of Services



Additional Services for Enrollees with SHCN

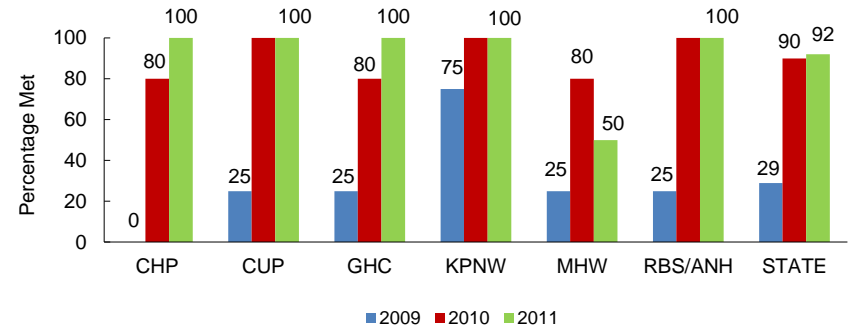
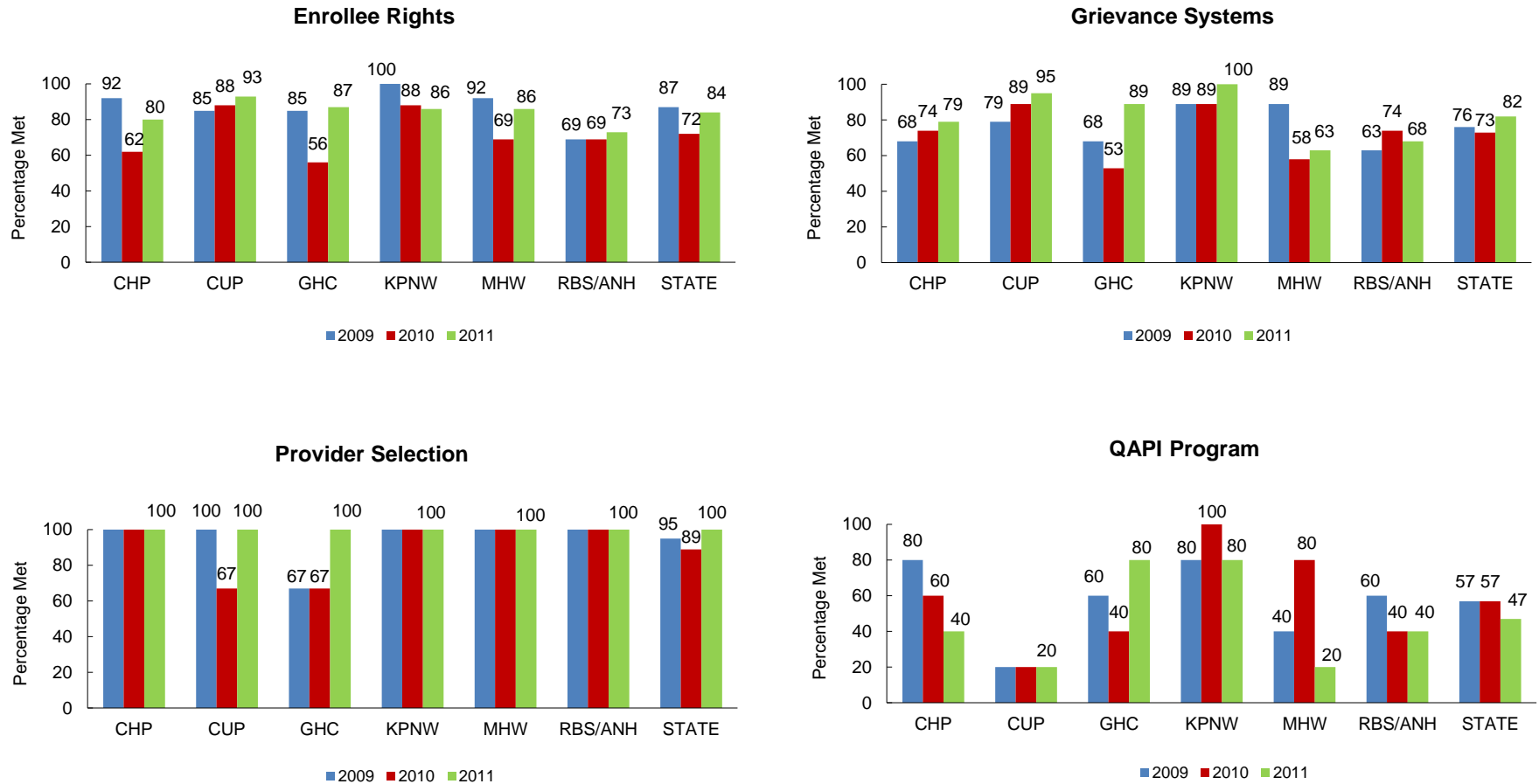


Figure 19. Changes in compliance scores for selected physical health regulatory standards by MCO, 2009–2011 (cont.).

Timeliness and Quality Standards



Corrective action plans

In 2011, TEAMonitor reviewed the MCOs’ 2010 corrective action plans (CAPs), documenting how the health plans resolved corrective action arising from the review process. If, as part of the 2011 review, old or new findings were observed, TEAMonitor documented those findings and required corrective action. The state required a 2011 CAP from MCOs that scored Partially Met or Not Met on the majority of elements reviewed, or on any element left unresolved or incomplete as a result of the 2010 CAP.

MCOs had to submit their CAPs within 30 days of their final TEAMonitor report. TEAMonitor staff reviewed the corrective action once. If the

reviewers did not accept any part of a health plan’s CAP, follow-up was delegated to the assigned state contract manager.

Table 18 shows the disposition of CAPs required in 2011. In all, TEAMonitor assigned 102 CAPs to the MCOs (compared with 179 the previous year), and accepted 94, or 92%.

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 18. Disposition of MCOs’ corrective action plans.

Health plan	2011 CAPs required	2011 CAPs accepted	2011 percentage accepted	2010 CAP status not resolved
CHP	16	14	88%	1
CUP	12	11	92%	3
GHC	13	11	85%	5
KPNW	6	6	100%	0
MHW/WMIP	28	28	100%	9
RBS/ANH	21	19	95%	7

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 2011 review evaluated the PIPs each MCO conducted during 2010.

Table 19 shows the topics of each MCO’s PIPs and the scores assigned by TEAMonitor. As required by contract, all MCOs addressed WCC visits through their clinical PIPs, and CUP and RBS/ANH each conducted an immunization PIP. The nonclinical PIP topics varied as shown. KPNW earned a “Met” score for both PIPs reported, while other MCOs achieved varying degrees of success.

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

Table 19. PIP topics and scores by MCO, 2011.

Plan	PIP topic	Score
CHP	Clinical: Well-Child Exams: Improving HEDIS Rates	Partially Met
	Nonclinical: Improving Mental Health Support Services	Not Met
CUP	Clinical: Improving Well-Child Visit Rates	Partially Met
	Clinical: Improving Childhood Immunization Rates	Partially Met
	Nonclinical: Decreasing Inappropriate Emergency Department Utilization	Partially Met
GHC	Clinical: Improving Well-Child and Well-Adolescent Visit Rates	Met
	Nonclinical: Reducing Healthy Options/Basic Health Plus Member Complaints	Partially Met
KPNW	Clinical: Improving Well-Child Visit Rates	Met
	Nonclinical: Regional Appointment Center Call Answer Timeliness	Met
MHW	Clinical: Improving Well-Child Visit Rates	Partially Met
	Nonclinical: Healthy Options 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 Childhood Immunizations	Partially Met
	Nonclinical: Improving Employees’ Understanding of Cultural Competency and Health Disparities	Partially Met

Community Health Plan

Table 20 displays the topics and scores of CHP’s PIPs in the past three years. CHP carried over one clinical project from 2008 through 2011, aimed at improving WCC visit rates, as required by contract. The plan reported a new nonclinical PIP, Improving Mental Health Support Services, in 2011. This PIP seeks to determine whether structuring the Mental Health Integration Program (MHIP) with incentives for process deliverables and outcomes improves the clinical outcomes for high-risk participants.

Strengths

- CHP’s clinical PIP has shown consistent execution and strong interventions over time. Additional data from the project are incorporated at the plan and provider levels to improve monitoring of performance.
- CHP used appropriate measurements to assess the impact of its nonclinical PIP.

Opportunities for improvement

- For the clinical PIP, statistical tests showed no significant improvement in WCC visit rates from the previous year. CHP presented no trend graphs. CHP proposed new interventions, but needs to provide more details about implementation and anticipated effects on rates. CHP received a “Partially Met” score on this PIP after receiving “Met” scores in the previous two years.
- For the nonclinical PIP, CHP needs to clearly identify the high-risk participants and their outcomes separate from the rest of the MHIP population. CHP also needs to present more background information on the program itself for readers who may be unfamiliar with it.

Table 20. Community Health Plan PIP topics and scores, 2009–2011.			
Topic	2009	2010	2011
Clinical: Well-Child Exams: Improving HEDIS Rates	Met	Met	Partially Met
Nonclinical: Improving Mental Health Support Services	Not reported	Not reported	Not Met
Nonclinical: Improving Call Resolution Performance	Not conducted	Not Met	Not reported
Nonclinical: Improving Access to Primary Care	Met	Not reported	Not reported

Columbia United Providers

Table 21 displays the topics and scores of CUP’s PIPs in the past three years. For 2011, as for the previous two years, CUP submitted clinical PIPs related to immunizations and WCC, as required by contract. The nonclinical topic, Decreasing Inappropriate Emergency Department Utilization, was new for 2011.

Strengths

- CUP used well-documented methods and sound measurement for both clinical PIPs.
- Data collection methods for the nonclinical PIP appear sound.

Opportunities for improvement

- An ongoing area of weakness for both clinical PIPs is CUP’s analysis of the impact of multiple interventions on each HEDIS rate.
- Interventions for the child immunization PIP appear nonspecific, making it difficult to measure their impact.
- CUP needs to reduce the number of interventions for the well-child PIP, then reassess the interventions over time.
- The nonclinical PIP lacks sufficient written analysis regarding the effect of interventions.

Table 21. Columbia United Providers PIP topics and scores, 2009–2011.			
Topic	2009	2010	2011
Clinical: Improving Childhood Immunization Rates	Partially Met	Not Met	Partially Met
Clinical: Improving Well-Child Visit Rates	Partially Met	Not Met	Partially Met
Nonclinical: Decreasing Inappropriate Emergency Department Utilization	Not reported	Not reported	Partially Met
Nonclinical: HEDIS Process Quality Improvement	Not reported	Not Met	Not reported

Group Health Cooperative

Table 22 displays the topics and scores of GHC’s PIPs in the past three years. GHC has carried over its clinical PIP on WCC visit rates since 2008, as required by contract. The nonclinical PIP topic of reducing member complaints was new for 2011.

Strengths

- GHC’s clinical PIP has earned a “Met” score in each of the past three years.
- The clinical PIP demonstrates generally robust and system-oriented interventions to improve care over time. These include a Panel Support Tool instituted in 2010. Data display and tables are of good quality and include trend lines where required.
- The nonclinical PIP shows statistically significant improvement in reducing member complaints. GHC provided sufficient criteria for the topic selection and accurately linked the study question to the outcome.

Opportunities for improvement

- While five-year data for the clinical PIP show significant improvement in WCC visit rates, more recent three-year data show a plateau or downward trend. GHC may need to implement stronger outreach activities to sustain improvement.
- TEAMonitor cited two major problems with the nonclinical PIP:
 - The design is limited to a quantitative analysis of complaints and does not measure the sources of complaints—e.g., dissatisfaction with PCP, rudeness of office staff, etc.
 - Documentation contains inconsistencies in describing the study population.

Table 22. Group Health Cooperative PIP topics and scores, 2009–2011.			
Topic	2009	2010	2011
Clinical: Improving Well-Child and Well-Adolescent Visit Rates	Met	Met	Met
Nonclinical: Reducing Healthy Options/Basic Health Plus Member Complaints	Not reported	Not reported	Partially Met
Nonclinical: Improving Practitioner Communication with Members	Not reported	Not Met	Not reported
Nonclinical: Improving Member Utilization of Online Services	Not Met	Not reported	Not reported

Kaiser Permanente Northwest

Table 23 displays the topics and scores of KPNW’s PIPs since 2009. The WCC-related PIP is required by contract.

Strengths

- KPNW’s clinical PIP is a well-documented project exhibiting consistent execution over time. Interventions with providers are a best practice and include
 - a web-based Panel Support Tool that graphically displays “care gaps” on an intranet website
 - bundled incentives for providers to improve WCC measures
 - interactive voice response (IVR) telephone contact in conjunction with a second reminder mailing after missed appointments

- The nonclinical PIP has implemented varied interventions over time in an effort to shorten call-wait times for enrollees.

Opportunities for improvement

- Although the clinical PIP focuses on improving visit rates for adolescents, the documentation does not make clear whether the bundled incentive package applies to care for adolescents. Also, the documentation omits adequate analysis of the IVR intervention related to barriers that were identified. Visit rates for adolescents continue to show need for improvement.
- In the nonclinical PIP, the percentage of calls handled within 30 seconds has reverted back to response times observed in the 2008 baseline year.

Table 23. Kaiser Permanente Northwest PIP topics and scores, 2009–2011.

Topic	2009	2010	2011
Clinical: Improving Well-Child Visit Rates	Partially Met	Met	Met
Nonclinical: Regional Appointment Center Call Answer Timeliness	Met	Met	Met

Molina Healthcare of Washington

Table 24 displays the topics and scores of MHW’s PIPs since 2009. MHW has conducted both its clinical PIP, on WCC visit rates, and its nonclinical PIP, on pharmacy turnaround times, over the past three years.

Strengths

- MHW’s use of tables and tools in the clinical PIP to document performance, interventions, and barriers over time is a best practice. TEAMonitor noted some strong active interventions, such as the use of bicycle helmets and video-store cards as incentives for WCC visits.
- The nonclinical PIP is well designed and observed significant improvement in turnaround times in 2008 and 2009, with an apparent drop in 2010.

Opportunities for improvement

- Ongoing interventions for the clinical PIP are mostly passive, involving educational and reminder information sent to PCPs and members. MHW needs to revisit its interventions and consider using more active interventions to achieve and sustain improvement in WCC measures. This PIP received a “Partially Met” score in 2011 after earning “Met” scores in the previous two years.
- Since turnaround time is a proxy for member and provider satisfaction, MHW should consider aligning the PIP results with its separate satisfaction measurements. Additional data sources to support the PIP, such as satisfaction surveys, could increase the validity of observed improvements.

Table 24. Molina Healthcare of Washington PIP topics and scores, 2009–2011.

Topic	2009	2010	2011
Clinical: Improving Well-Child Visit Rates	Met	Met	Partially Met
Nonclinical: Healthy Options Pharmacy Average Turnaround Time	Met	Met	Met
Clinical: Improving Childhood Immunization Rates	Not reported	Met	Not reported

**Regence BlueShield/
Asuris Northwest Health**

Table 25 displays the topics and scores of RBS/ANH’s PIPs since 2009. RBS/ANH carried over the contractually required PIPs on WCC and immunizations from previous years, and reported its nonclinical PIP for the second year.

Strengths

- TEAMonitor commended RBS/ANH’s important work in addressing issues of cultural competency and health disparities through the nonclinical PIP. Progress in these areas can have significant positive impact for many enrollees.
- Staff training materials for the nonclinical PIP present interesting and thought-provoking material that should result in more positive interaction with enrollees. Online format makes these materials more accessible to employees and others.

Opportunities for improvement

- For the childhood immunization PIP, RBS/ANH reported a statistically significant improvement in Combo 3 rates, but failed to link the results satisfactorily to the PIP interventions.
- For the WCC-related PIP, RBS/ANH needs to implement more active interventions to drive future improvement. The rationale for this study is weak; literature citations are outdated and need to be refreshed.

Table 25. Regence BlueShield/Asuris Northwest Health PIP topics and scores, 2009–2011.

Topic	2009	2010	2011
Clinical: Well-Child Visits With a Disparity Aspect Involving the Hispanic Population	Not Met	Partially Met	Partially Met
Clinical: Improving the Rate of Childhood Immunizations	Partially Met	Partially Met	Partially Met
Nonclinical: Improving Employees’ Understanding of Cultural Competency and Health Disparities	Not conducted	Partially Met	Partially Met
Nonclinical: Improving Response Time of Pharmacy Prior-Authorization Denials	Partially 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 and HCA's client base. Intermediate goals of the WMIP include improving the use of mental health and substance abuse services, which account for a large portion of total healthcare costs. Longer-term objectives are to improve the 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. 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 December 2010, WMIP enrollment totaled nearly 4,000.

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

WMIP performance measures

For 2011, MHW reported six HEDIS measures for the WMIP population: comprehensive diabetes care, general hospital/acute 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.

Table 26 on the next page presents the WMIP results for comprehensive diabetes care over the past three years. The 2011 results generally reflect positive changes from 2010. The percentage of enrollees with good control of their HbA1c levels increased significantly to 60.00%, while the percentage of those with poor control fell significantly to 31.03% (a positive trend). In addition, the percentage of those with LDL-C levels controlled below 100 mg/dL rose significantly to 39.23%. Most other measures moved in a positive direction, though not significantly so.

Table 27 presents WMIP results for inpatient utilization, general hospital/acute care in reporting years 2009–2011. In 2011, discharges rose slightly for total inpatient acute care and for medical care, and declined slightly for surgical care, but the changes were not statistically significant. Total inpatient acute and surgical days continued a downward trend in 2011, declining significantly from 2010, while medical days rose at a

statistically insignificant rate. The average length of stay (ALOS) for WMIP enrollees fell slightly in all care categories in 2011, though the changes were not statistically significant.

Table 28 presents the results for ambulatory care utilization. Both outpatient and emergency room visit rates for WMIP enrollees declined significantly from 2010 to 2011.

Table 26. WMIP comprehensive diabetes care measures, 2009–2011.

	2009	2010	2011
HbA1c tests (percentage tested)	86.67	86.84	87.95
Enrollees with poor control of HbA1c levels (percentage >9.0%)	37.00	42.40	31.03 ↓
Enrollees with good control of HbA1c levels (percentage <8.0%)	n/a	50.58	60.00 ↑
Dilated retinal exams (percentage examined)	63.00	55.26	59.49
Lipid profile (LDL-C) performed (percentage profiled)	82.00	78.65	76.92
Lipids controlled (percentage with <100mg/dL)	39.00	31.58	39.23 ↑
Nephropathy monitored annually (percentage monitored)	84.67	81.58	86.41
Blood pressure control (percentage with <140/90 mm Hg)	37.00	61.11	64.36

↓↑ Indicates statistically significant difference in percentages from 2010 to 2011 ($p \leq 0.05$).

Table 27. WMIP inpatient utilization, general hospital/acute care measures, 2009–2011.

	Discharges/1000MM ^a			Days/1000MM ^a			ALOS ^b		
	2009	2010	2011	2009	2010	2011	2009	2010	2011
Total inpatient	15.86	15.14	15.55	80.71	76.73	72.54 ↓	5.09	5.07	4.67
Medical	9.18	8.48	9.33	32.27	32.79	35.31	3.51	3.86	3.79
Surgical	5.67	5.95	5.55	45.09	42.28	35.15 ↓	7.96	7.11	6.33

^a1000MM = 1000 member months. ^bALOS = average length of stay in days.

↓↑ Indicates statistically significant difference in percentages from 2010 to 2011 ($p \leq 0.05$).

Table 28. WMIP ambulatory care measures, 2009–2011.

	Visits/1000MM ^a		
	2009	2010	2011
Outpatient visits	543.83	563.98	539.06 ↓
Emergency room visits	120.46	119.94	109.83 ↓

^a1000MM = 1000 member months.

↓↑ Indicates statistically significant difference in percentages from 2010 to 2011 ($p \leq 0.05$).

Tables 29 and 30 present WMIP results for behavioral health measures. The antidepressant medication management measure (Table 29) examines the percentage of patients beginning antidepressant drug treatment who received an effective acute-phase trial of medications (three months) and the percentage who completed six months of continuous treatment for major depression. The percentage of WMIP enrollees receiving effective acute phase treatment and effective continuation phase treatment showed positive change in 2011, though the increases were not statistically significant.

The follow-up measure (Table 30) 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 percentage of WMIP enrollees receiving follow-up care within 7 days increased significantly from 2010 to 2011, reaching 55.56%. The change in the 30-day follow-up rate also showed a positive trend, though not statistically significant.

Table 31 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 trended down each year since 2007, pointing to better management of these medications for WMIP enrollees.

Table 29. WMIP antidepressant medication management measures, 2009–2011.

	Effective acute-phase treatment			Effective continuation-phase treatment		
	2009	2010	2011	2009	2010	2011
Percentage of patients receiving medication management	52.08	52.78	56.86	33.33	36.11	47.06

No statistically significant differences in percentages from 2010 to 2011 ($p \leq 0.05$).

Table 30. WMIP follow-up after hospitalization for mental illness measures, 2009–2011.

	30-day follow-up			7-day follow-up		
	2009	2010	2011	2009	2010	2011
Percentage of patients receiving follow-up	69.81	48.84	64.81	47.17	32.56	55.56 ↑

↓↑ Indicates statistically significant difference in percentages from 2010 to 2011 ($p \leq 0.05$).

Table 31. WMIP use of high-risk medications for the elderly measures, 2009–2011.

	One prescription			At least two prescriptions		
	2009	2010	2011	2009	2010	2011
Percentage of patients receiving medication	16.16	12.81	11.94	3.01	2.23	2.11

No statistically significant differences in percentages from 2010 to 2011 ($p \leq 0.05$).

WMIP compliance review

HCA and ADSA reviewed MHW’s compliance with managed care regulations and contractual provisions. This review addressed many of the same standards addressed by TEAMonitor’s MCO compliance reviews, as well as elements related to specific WMIP contract provisions. Table 32 reports the WMIP compliance scores for each of 13 standards.

As shown, MHW fully met all elements of five of the 13 standards, and met the majority of elements for four other standards, including 86% of the elements of Enrollee Rights.

MHW fully met only 4 of the 19 elements of Coordination and Continuity of Care, which includes requirements of the Patient Review and Coordination program. TEAMonitor identified similar issues to those cited in 2010, including incomplete documentation of enrollees’ care plans and clinical history; lack of assurance of timely initial screening, ongoing assessments, and mental health intake evaluations; and several incomplete corrective actions. Shortcomings under the QAPI Program standard included a lack of behavioral health components, along with opportunities to improve care management.

Table 32. WMIP compliance scores, 2011.

Standard (# of elements)	Percentage of elements Met (M), Partially Met (PM), Not Met (NM)		
	M	PM	NM
Availability of Services (8)	100	0	0
Program Integrity (2)	100	0	0
Claims Payment (1)	0	100	0
Coordination and Continuity of Care (19)	21	37	42
Coverage and Authorization of Services (5)	60	0	40
Enrollment and Disenrollment (1)	100	0	0
Enrollee Rights (14)	86	7	7
Grievance Systems (19)	63	21	16
Performance Improvement Projects (2)	50	0	50
Practice Guidelines (3)	67	0	33
Provider Selection (3)	100	0	0
QAPI Program (5)	20	80	0
Subcontractual Relationships and Delegation (4)	100	0	0

WMIP PIP validation

For 2011, MHW submitted five PIPs targeting improvements in clinical care and nonclinical services for WMIP enrollees. All five projects were carried over from 2010, including two on chemical dependency topics, as required by contract. Table 33 shows the PIP topics and the scoring by TEAMonitor.

Strengths

- **Projects 2 and 3:** TEAMonitor cited as a best practice the tables and tools MHW used to document performance, barriers, and interventions over time. For Project 2, at least one intervention (reduction of handoffs to conduct screening) likely had a meaningful impact on performance.
- **Project 4:** MHW has made strides in improving the contact rate and the identification of enrollees at high risk for chemical dependency.
- **Project 5:** The PIP narrative supports a current redesign of the WMIP program, which may help increase care coordination contacts for WMIP enrollees.

Opportunities for improvement

- **Project 1:** The inability to connect the screening, referral, and assessment process to an actual outcome has reduced the effectiveness of this PIP. MHW will retire this PIP and will not be required to submit it in 2012.
- **Project 2:** PIP documentation provided limited details on data collection methods and did not clearly identify interventions. Analysis compared quarterly measurements with baseline annual data, though enough data points were available to annualize the measurement.
- **Project 3:** Decreases in one measure may reflect challenges with data capture. Interventions have stagnated; MHW needs to strengthen the interventions to improve the vaccination rate.
- **Project 4:** Interventions do not always correlate with reported improvements, leaving the validity of this PIP in question. MHW will retire this PIP and will not be required to submit it in 2012.
- **Project 5:** MHW needs to reevaluate its barrier analysis and interventions to determine the possible cause of declines and what might improve the contact rate and sustain improvement.

Table 33. WMIP PIP topics and scores, 2010–2011.

Topic	2010	2011
1. Clinical: Improving Compliance with Chemical Dependency Assessment and Follow-Up Referrals for Chemical Dependency	Not Met	Not Met
2. Clinical: Increasing Depression Assessments	Not Met	Partially Met
3. Clinical: Increasing Influenza Vaccine Participation	Met	Partially Met
4. Nonclinical: Improving Identification of Members at High Risk for Chemical Dependency Issues	Partially Met	Partially Met
5. Nonclinical: Increasing Successful Initial Contacts Between WMIP Members and the Care Coordination Team	Not Met	Partially Met

Recommendations for WMIP

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

The 2011 results for the WMIP program generally showed positive changes from 2010. Looking at diabetes care, the percentage of enrollees with good control of their blood-sugar and cholesterol levels increased significantly. Total inpatient

acute care utilization fell significantly from 2010, as did emergency room visits. Higher percentages of enrollees received effective management of their antidepressant medications in 2011, and the percentage of those receiving outpatient care within 7 days after discharge from hospitalization for mental illness rose significantly.

TEAMonitor's 2011 review of WMIP found deficiencies surrounding timely and complete initial intake screenings and in comprehensive assessment of high-risk enrollees.

- ***MHW should continue to explore effective approaches to help facilitate timely care assessments for WMIP enrollees.***

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 the state define QI expectations for the MCOs and RSNs and design effective incentives for improvement.

Ongoing budget pressures are likely to continue to affect the scope of EQR activities. State agencies have been asked to produce 5% and 10% budget-reduction scenarios. HCA's proposed reductions, aimed at saving as much as \$446 million, would eliminate pharmacy payments for adults, affecting 500,000 Washingtonians, and other programs including, but not limited to, Basic Health, the Children's Health Insurance Program, and non-emergency dental services. Thus, resource constraints facing the Washington Medicaid program are likely to affect the feasibility of many recommendations in this section.

In September 2011, HCA issued a Request for Proposals (RFP) seeking bidders to serve as MCOs for Medicaid clients from July 2012 through 2013. The RFP defines new requirements for care management, a Transitional Care PIP, and MCO/RSN working agreements. HCA expects the new contract to save money by consolidating the Healthy Options managed care program with the Basic Health Plan, which covers the working poor. HCA has announced five apparently successful bidders for the 2012–2013 contract, including two current MCOs.

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.

Current state law requires 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. Ongoing 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.⁷

DSHS is also working under legislative mandate to improve children's mental health services through increased access, family-centered services, early identification and intervention, and greater reliance on evidence-based practices. State law directs DSHS to provide up to 20 outpatient therapy visits annually for Medicaid-enrolled children.

Care integration. HCA's ongoing care integration efforts include a planning grant for health homes and a grant to design a new care delivery model for dual-eligible (Medicare-Medicaid) clients. The RFP issued for the new MCO contract required bidders to demonstrate experience in integrating physical and behavioral health care and creating health homes.

In mid-2009, DOH began a Patient-Centered Medical Home Collaborative, aimed at implementing medical homes in a variety of primary care clinics. A total of 33 clinics took part in the collaborative, which concluded in September 2011. Negotiations are underway with DOH to extend the program.

DSHS and HCA have developed new payment options to support development and maintenance of medical homes in primary care settings.⁸ In 2011, DSHS and HCA implemented a medical home reimbursement pilot project, seeking to establish performance measures for clinical quality, chronic care management, cost, and patient experience. Eight health plans (including RBS, CHP, GHC, and MHW) are participating in the pilot project.

HCA has appointed GHC as the lead organization to support accountable care organization (ACO)

pilot projects to be implemented by 2012. GHC is to coordinate with existing medical home projects and report to the legislature by 2013 on the ACOs' progress.

Access to care. The Healthy Options MCOs generally are complying with federal and state standards related to access and timeliness. TEAMonitor's review found that the MCOs, as a group, strengthened their compliance with most standards, compared with 2010. The health plans met all elements of Availability of Services and Furnishing of Services, and 92% of the elements of Additional Services for Enrollees with SHCN. The main deficiencies in other standards involved inadequate and/or conflicting documentation of MCO policies and procedures.

The RSNs typically provide timely access to outpatient mental health care, and most RSNs deploy well-developed crisis and stabilization resources. All RSNs monitor their provider agencies to determine whether they offer timely access to specialist consultations.

The state-funded Partnership Access Line (PAL) provides rapid telephone-based psychiatric consultation to PCPs across the state regarding children with psychiatric problems. Child psychiatrists, psychologists, and social workers affiliated with Seattle Children's Hospital deliver PAL consultation services.

Several pilot projects are underway to improve access to mental health care for specific Medicaid enrollee populations.

- **Mental health wraparound:** NSMHA, SWRSN, and GHRSN are operating pilot sites that deliver wraparound mental health services for children. Through December 2010, the wraparound pilots in Skagit, Cowlitz, and Grays Harbor counties had served 147 families.
- **PACT teams:** Ten PACT teams across the state are serving RSN enrollees, with priority given to state hospital patients. The teams have achieved full enrollment capacity, serving as many as 800 enrollees

statewide. More than 90% of consumers have reported being highly satisfied with PACT services.

Quality of care. TEAMonitor's 2011 review found that the Healthy Options MCOs, as a group, strengthened their compliance with quality standards compared with 2010. The MCOs met all elements of Provider Selection, ensuring that their policies and procedures were based on NCQA guidelines, and met more than 80% of the elements of Practice Guidelines, Enrollee Rights, and Grievance Systems. The most notable area of weakness remained the QAPI standard; common deficiencies included program evaluation and analysis of service utilization.

Acumentra Health's compliance reviews found that the RSNs monitor clinical records for evidence that consumers are actively involved in developing their individual service plans, and that treatment goals are expressed in the consumer's words. The RSNs' use of peer support has helped to reduce the stigma associated with mental health care and has increased consumer participation in improving mental health services.

Improving clinical care. The 2011 results present a mixed picture of the care received by Healthy Options enrollees. Aggregate performance by the MCOs turned downward on many measures of preventive care. Average *immunization rates* fell for almost every individual vaccine and are now significantly lower than the national Medicaid averages for most vaccines. Performance on the *diabetes care* indicators showed no significant changes in the aggregate, but the MCOs as a group significantly underperformed the national averages for five of eight indicators. The rate of *WCC visits* for Healthy Options enrollees continued to lag behind the national performance, as in previous years.

Among more positive results, Healthy Options enrollees continue to visit emergency rooms at a significantly lower rate compared with Medicaid enrollees nationwide. Service utilization rates also remain below the U.S. average in all categories except for maternity care.

Performance measurement. HCA 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. HCA’s contract incentives for MCO performance on childhood immunization and WCC measures, coupled with the requirement for MCOs to conduct PIPs in areas where their performance falls 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.

Enrollee information needs. Enrollees have the right to be informed at least annually that they may request and obtain names, specialties, locations, telephone numbers of, and non-English languages spoken by mental health professionals in the RSN’s service area. However, during 2010, only two of the 13 RSNs notified their enrollees about this right.

- ***DBHR needs to ensure that RSNs notify enrollees at least annually of their right to request information about individual practitioners in the RSN’s service area.***

The majority of RSNs do not track requests at the provider agencies for translation or interpreter services and for written information in alternative formats. Monitoring such requests can help RSNs

identify changes in their service populations and potential needs associated with those changes.

- ***DBHR needs to ensure that all RSNs consistently monitor requests at the provider agencies for translation or interpreter services and for written information in alternative formats.***

Access to culturally competent services. Many RSNs continue to report a shortage of bilingual and bicultural staff among their community mental health agencies.

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

Seclusion and restraint. Many RSNs did not understand the importance of requiring all contracted providers—not merely the E&T centers—to have in place policies and procedures on the use of seclusion and restraint. Enrollees have the right to be free from seclusion and restraint at all provider facilities.

- ***DBHR needs to ensure that the RSNs require all contracted providers to follow policies and procedures on the use of seclusion and restraint, and that the RSNs review providers’ use of seclusion and restraint at the time of credentialing and recredentialing.***

Advance directives. The state benefits booklet and many RSNs’ handbooks and websites inform enrollees and/or their families or surrogates about how to develop advance directives. However, these sources generally do not inform enrollees that complaints about noncompliance with advance directives may be filed with DOH, the state survey and certification agency.

- ***DBHR needs to inform enrollees, or their families or surrogates, that they may file complaints with the state regarding noncompliance with advance directives.***

Enrollees need to be informed about both medical and mental health advance directives. Most RSNs do not notify enrollees of their rights in both areas.

- ***Each RSN needs to ensure ongoing community education and staff training regarding both medical and mental health advance directives. DBHR needs to ensure that RSN responsibilities related to advance directives include medical advance directives.***

Tracking and analyzing enrollee grievances and complaints. Analyzing complaints, grievances, and appeals can help the RSNs identify concerns about access, timeliness, and quality. The RSNs can then implement changes to improve enrollee satisfaction and/or outcomes. The RSNs typically follow policies and procedures that meet federal requirements in this area, but they do not consistently incorporate analysis of grievances and appeals into their quality assurance and performance improvement (QAPI) work plans.

- ***DBHR needs to ensure that all RSNs' QAPI programs incorporate analysis of consumer complaints, appeals, and grievances.***

Each RSN's Ombuds reports enrollee complaints about care to the RSN. However, many of the reports submitted by the RSNs to DBHR omit complaints filed at the provider agency level.

- ***DBHR needs to require each RSN, as part of the QAPI process, to collect and review all complaints—not only grievances—from providers, Ombuds, and the RSN's own grievance system.*** This would provide more robust data from which to analyze trends and identify areas for system improvement.

Because many RSNs remain uncertain as to the difference between a complaint and a grievance, the tracking and monitoring of complaints and grievances varies among RSNs. Some RSNs require their agencies to record all verbal and written expressions of dissatisfaction from

enrollees, while other RSNs require agencies only to track written complaints that have escalated to grievances. Confusion exists as to how to record multiple issues within a single complaint.

- ***DBHR needs to delineate in the RSN contract the difference between a complaint and a grievance, to guide the RSNs in tracking and monitoring enrollees' verbal and written expressions of dissatisfaction with quality, access, or timeliness of care and services.***

PIP topics. Some RSNs find it hard to identify meaningful topics for performance improvement projects (PIPs) that could lead to important system changes and sustained improvement. The RSN may select a PIP topic that does not represent a major problem for its enrollee population, or the RSN may fail to identify the root causes of performance that might be addressed by a particular intervention strategy.

Many RSNs have begun new PIPs, or are identifying new topics, as they retire the statewide PIP and complete projects begun in 2008. In October 2011, DBHR sponsored training for RSNs that focused on selecting PIP topics and developing intervention strategies, using barrier analysis and data analysis as primary tools.

- ***DBHR should continue to sponsor follow-up training and technical assistance related to PIPs, to support the RSNs in selecting and developing appropriate study topics and intervention strategies.***

Response to 2010 recommendations

The 2010 EQR report offered recommendations as to how DBHR and the RSNs could work together to improve access to mental health care and the quality and timeliness of care. Table 34 outlines DBHR's response to those recommendations to date.

Table 34. DBHR response to 2010 EQR recommendations for mental health.		
2010 recommendation	DBHR response	EQRO comments
<i>Mental health specialists</i>		
<i>Work with RSNs to ensure an adequate number of certified mental health specialists to provide consultation for enrollees in special populations, or revise the mental health specialist certification requirements.</i>	DBHR commissioned a workgroup to assess the continued need for specialists, the need for practice education on delivering culturally competent services, and assessment of the current system capacity. DBHR has received the reports required under Phase 2 of this project. Phase 3 will focus on changes necessary to accomplish the goals identified in Phase 2 and will address gaps identified in Phases 1 and 2.	The EQRO considers this action responsive and will review the final changes necessary to accomplish the goals and address the gaps.
<i>Culturally and linguistically appropriate services</i>		
<i>Work with RSNs to build capacity for services delivered by minority-specific providers who are bilingual and/or bicultural.</i>	See answer above.	The EQRO considers this action responsive and will review DBHR's success in building capacity once the changes are put into effect.
<i>Services for children and transition-age youth</i>		
<i>Work with RSNs and community mental health agencies to provide adequate community-based services as an alternative to acute care for children in the RSN system.</i>	DBHR is redesigning the children's mental health system under the direction of the DSHS secretary. Part of this effort is a targeted focus on rebalancing the system, improving access to community-based alternatives to acute care, and managing transitions.	The EQRO will review the plan for redesign and the effect of the changes that DBHR puts into place.
<i>Encourage RSNs to develop resources for transition-age youth.</i>	This is an identified issue across DSHS systems. A complicating factor is the categorical variation in age eligibility across systems. DBHR is committed to working with the RSNs to embed a common definition of this life stage and relevant treatment protocols related to developmental needs and system barriers.	The EQRO requests to review the steps DBHR has taken or will take to enhance resources for transition-age youth.
<i>Services for geriatric consumers</i>		
<i>Coordinate with other state agencies and geriatric facilities to ensure that enrollees discharged from the State Hospital and community hospitals receive long-term care.</i>	DBHR has formed a Barriers to Discharge Committee to address lengthy hospital stays for geriatric enrollees. ADSA has written a Chronic Care proposal to create PACT-like teams to assist in the transition and maintenance of these enrollees in the community.	The EQRO will review the status of the Chronic Care proposal during the 2012 compliance review.
<i>RSN board and committee representation</i>		
<i>Work with RSNs to ensure that RSN advisory boards represent all enrollees and, as needed, represent allied agencies.</i>	The Office of Consumer Partnership (OCP) is offering technical assistance to RSNs on improving board membership.	The EQRO considers this action responsive.

Table 34. DBHR response to 2010 EQR recommendations for mental health (cont.).		
2010 recommendation	DBHR response	EQRO comments
Consumer voice in system planning		
<i>Facilitate discussion between RSNs and Quality Review Teams (QRTs) to determine how to incorporate QRT input into the RSN delivery system.</i>	DBHR is redefining the role of QRTs and is developing a Joint Behavioral Health Advisory Board to conduct quality/peer review of mental health programs. The OCP is assigning staff to survey consumer groups, including QRTs, with the goal of creating standardization across the QRTs.	The EQRO considers this action responsive and will review DBHR's redefinition of the role of the QRTs and the progress of the advisory board during the 2012 compliance review.
Least restrictive environment		
<i>Work with RSNs and Healthy Options MCOs to improve collaboration and ensure that Medicaid enrollees receive mental health care in the least restrictive environment.</i>	DBHR will work with RSNs to reinforce guiding clients to the least restrictive environment at the time of the designated mental health professional (DMHP) screening. DBHR/HCA will work with RSNs/MCOs on cross system coordination and transition of care. DBHR will strengthen its contract language. HCA has developed language for transitional health care for 2012.	EQRO requests the status of the changes in the DBHR contract language and will review progress in guiding clients to the least restrictive environment during the 2012 compliance review.
<i>Work with 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.</i>	DBHR is heading several efforts to ensure that least restrictive alternatives are employed wherever possible. The hospital discharge workgroup is seeking Affordable Care Act opportunities to increase step-down services, and is sharpening data collection efforts regarding diversion prior to inpatient placement.	The EQRO considers this action responsive and will review the implementation of these measures during the 2012 compliance review.
<i>Work with RSNs, providers, and consumers to build consensus about effective crisis plans.</i>	DBHR hosted training in April 2011 on developing effective crisis plans.	The EQRO considers this action responsive.
<i>Encourage all RSNs to implement Crisis Intervention Training (CIT) to help ensure that law enforcement officers can intervene effectively with consumers in crisis.</i>	DBHR staff involved with the DMHP Association strongly endorse CIT training and relationship building with law enforcement. Some law enforcement agencies, particularly in rural areas, have difficulty participating in the training due to staff shortages.	DBHR should continue to explore opportunities to increase CIT training and relationship building with law enforcement. The EQRO will review progress during the 2012 compliance review.
Recovery and resilience		
<i>Identify creative solutions, such as cross-system funding, to ensure the availability of supported employment programs and peer-run services.</i>	DBHR is working with the Department of Vocational Rehabilitation (DVR) on a grant to expand peer employment services, per DVR's strategic plan.	The EQRO considers this action responsive.

Table 34. DBHR response to 2010 EQR recommendations for mental health (cont.).

2010 recommendation	DBHR response	EQRO comments
<i>Timeliness of assessments</i>		
<i>Work with RSNs to ensure timely assessment of enrollees' skills, strengths, and needs.</i>	DBHR training for RSNs in October 2011 addressed timely assessments.	The EQRO considers this action responsive, and encourages DBHR to develop contractual requirements for policies and procedures that specifically address the frequency of comprehensive reassessments.

The path to future improvements: Physical health care

Some recommendations presented in previous annual reports continue to apply. Acumentra Health offers these “priority” recommendations.

Compliance with standards. No MCO fully met the standard for QAPI programs in 2011, and the MCOs as a group met fewer than half of the required elements. This standard calls for MCOs to measure and report performance on standardized measures, monitor for over- and underutilization of services, conduct PIPs, assess care furnished to enrollees with special healthcare needs, and evaluate the QAPI program annually. Common deficiencies, as reported by TEAMonitor, include incomplete work plans and QI evaluations and limited evaluation of behavioral health programs.

- *HCA should consider providing technical assistance training in QI principles for the MCOs.*
- *MCOs are encouraged to examine their allocation of QAPI resources—especially for sufficient numbers of qualified staff—to ensure that they can meet the needs of a successful quality management program.*

TEAMonitor reviewed the MCOs for continuity and coordination between medical and behavioral health goals and objectives for Healthy Options enrollees. Results indicated that the MCOs are struggling to incorporate behavioral health into their QAPI programs. Most MCOs struggle with contract requirements to provide outpatient mental health benefits, such as reviewing psychotropic medications of children and ensuring that PCPs have access to consultation with child psychiatrists.

- *HCA should consider providing technical assistance training for MCOs in physical and behavioral health coordination.*

TEAMonitor’s review of PIPs found that the MCOs often failed to document a correlation between their interventions and subsequent performance; i.e., many PIPs lacked sufficient analysis of the effect of interventions.

- *HCA should consider providing PIP training to help ensure a source of technical assistance for MCO staff.*

Data completeness. In 2011, no MCO was able to report complete race/ethnicity data. Ethnicity was categorized as “unknown” for half of all enrollees statewide, and race was unknown for almost 42% of enrollees. A primary reason for the gaps in reporting these data is underreporting at the state level. These self-reported data are optional when new clients enroll in Medicaid.

- *HCA should conduct a barrier analysis to identify effective ways to increase self-reporting of race/ethnicity data when new enrollees sign up for Medicaid.*
- *MCOs should continue to explore new data sources to augment the state-supplied race/ethnicity data.*

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.

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

Response to 2010 recommendations

The 2010 EQR report offered recommendations as to how HCA and the MCOs could work together to improve access to physical health care and the quality and timeliness of care. Table 35 outlines HCA’s response to those recommendations to date.

Table 35. HCA response to 2010 EQR recommendations for physical health.		
2010 recommendation	HCA response	EQRO comments
Performance measure feedback to clinics		
<i>Require MCOs to provide performance measure feedback to clinics and providers on a frequent and regular schedule.</i>	HCA 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.
Technical assistance for providers		
<i>Encourage MCOs to identify providers that need technical assistance with quality improvement and to implement training at the clinic level.</i>	HCA is working with DOH to educate providers in quality improvement principles. Funding for this activity is underwritten by the MCOs.	The EQRO considers this action responsive and encourages HCA to develop guidelines to identify providers in need of technical assistance.
Care coordination		
<i>Consider requiring MCOs to conduct a PIP focusing on Primary Care Coordination and Emergency and Post-Stabilization Services.</i>	HCA has developed language for a transitional healthcare PIP effective July 2012. HCA has modified care coordination requirements in the July 2012 MCO contract language.	The EQRO considers this action responsive.
<i>Work with DBHR to ensure that an MCO is notified when a Healthy Options enrollee receives inpatient mental health services through an RSN.</i>	HCA has developed language for a transitional healthcare PIP effective July 2012. Access to the Predictive Risk Intelligence System (PRISM) data on high-risk Medicaid clients will help facilitate coordination of care between RSNs and MCOs.	The EQRO considers this action responsive and encourages HCA to contractually require MCOs to develop policies and procedures to address inpatient mental health transition of care for Healthy Options enrollees.
Data completeness		
<i>Healthy Options MCOs should evaluate expected claims or encounter volumes by provider type to help identify missing data.</i>	Milliman obtains cost reports from MCOs, compares reported costs with encounter data and audited financial data, and addresses any discrepancies before completion of rate setting. HCA will take additional action to address this recommendation in the 2012 procurement with the MCOs.	The EQRO will continue to monitor this issue through the HEDIS performance measure audits.
<i>MCOs should 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.</i>	See answer above.	The EQRO will continue to monitor this issue through the HEDIS performance measure audits.

Table 35. HCA response to 2010 EQR recommendations for physical health (cont.).		
2010 recommendation	HCA response	EQRO comments
<i>HCA 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.</i>	All MCOs not meeting this data reporting requirement have taken steps to address this issue. HCA regards this as completed.	In 2011, no MCO was able to report complete race/ethnicity data. The EQRO will continue to monitor this issue through the HEDIS audits.
Washington Medicaid Integration Partnership		
<i>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.</i>	MHW's redesign in 2010 addressed coordination issues between Compass Health, the chemical dependency/mental health service provider, and the MCO. <ol style="list-style-type: none"> 1. Co-location of medical clinic onsite with Compass 2. Care transition coach for discharge and transition planning for all inpatient care—medical, chemical dependency, mental health 3. Community health workers out-stationed at Molina Medical and Compass to provide direct access to services—homeless shelters, soup kitchens, etc. They are working with Providence Hospital in Everett to facilitate appropriate care and have hired the care transition coach. This could serve as a best practice and be the focus of a clinical PIP. DBHR has representatives on the WMIP contract monitoring team and advisory committee to provide education for the Recovery Model.	The EQRO considers this action responsive and encourages HCA and DBHR to continue to promote this collaboration.
<i>WMIP program managers in HCA 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.</i>	See answer above.	The EQRO considers this action responsive and encourages HCA and DBHR to continue to promote this collaboration.
<i>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 series after psychiatric hospitalizations.</i>	See answer above.	The EQRO considers this action responsive and encourages HCA and DBHR to continue to promote this collaboration.
<i>HCA should explore opportunities to promote the WMIP program as an approach that supports the medical or health home model.</i>	HCA will take this recommendation under consideration.	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 accelerate the state's progress toward that goal.

TEAMonitor's 2011 review of WMIP found deficiencies surrounding timely and complete initial intake screenings and in comprehensive assessment of high-risk enrollees.

- *Molina Healthcare of Washington, the WMIP program contractor, should continue to explore effective approaches to help facilitate timely care assessments for WMIP enrollees.*

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