2017 Annual Technical Report

Washington Apple Health
Washington Health Care Authority
Department of Social and Health Services
Division of Behavioral Health and Recovery

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QUALIS HEALTH™

As Washington's Medicaid external quality review organization (EQRO), Qualis Health provides external quality review and supports quality improvement for enrollees of Washington Apple Health managed care programs and the State's managed behavioral healthcare services.

This report was prepared by Qualis Health under contract K1324 with the Washington State Health Care Authority to conduct External Quality Review and Quality Improvement Activities to meet 42 CFR Part 438, Managed Care, Subpart E, External Quality Review, and the Washington State Department of Social and Health Services Division of Behavioral Health and Recovery under contract 1534-28375.

Qualis Health is one of the nation's leading population health management organizations, and a leader in improving care delivery and patient outcomes, working with clients throughout the public and private sectors to advance the quality, efficiency and value of healthcare for millions of Americans every day. We deliver solutions to ensure that our partners transform the care they provide, with a focus on process improvement, care management and effective use of health information technology.

For more information, visit us online at www.QualisHealth.org/WAEQRO.
PO Box 33400
Seattle, Washington 98133-0400
Toll-Free: (800) 949-7536
Office: (206) 364-9700

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Executive Summary

Washington's Medicaid program for physical and behavioral healthcare services provides benefits for more than 1.5 million residents. The Washington State Health Care Authority (HCA) administers services for physical healthcare through contracts with managed care organizations (MCOs), which facilitate delivery of physical healthcare services. The Washington State Department of Social and Health Services Division of Behavioral Health and Recovery (DBHR) administers services for mental healthcare and substance use disorder (SUD) treatment through contracts with Behavioral Health Organizations (BHOs), which facilitate behavioral healthcare services.

Federal requirements mandate that every state Medicaid agency that contracts with managed care organizations provide for an external quality review (EQR) of healthcare services provided to enrollees, to assess the accessibility, timeliness, and quality of care they provide. As Washington's Medicaid external quality review organization (EQRO), Qualis Health conducted this 2017 review. This technical report describes the results of this review.

Information in this report was collected from MCOs and BHOs through review activities based on Centers for Medicare & Medicaid Services (CMS) protocols. Additional activities may be included as specified by contract.

Washington's Medicaid Program

Washington continues on a path to transform the way healthcare is furnished in the state through multiple initiatives connected to the State Health Care Innovation Plan, Healthier Washington. The changes resulting from Healthier Washington programs will ultimately include integration of behavioral and physical healthcare services, introduction of value-based payments, greater community and consumer empowerment through Accountable Communities of Health (ACHs), and practice transformation throughout the state. By 2020, the State will fully integrate the financing and administration of physical health, mental health, and substance use disorder treatment services in one Medicaid managed healthcare program.

In 2016, the State launched the following efforts:

- **Earlier Enrollment:** This is a mechanism that allows members to enroll with a managed care plan the day they become eligible for Medicaid. Previously, new or returning Apple Health members had to wait up to six weeks to be enrolled in a managed care plan. This change allows for faster healthcare coordination for enrollees, potentially resulting in better outcomes.

- **Integrated Managed Care (IMC) in Southwest Washington:** This model, which coordinates physical health, mental health, and substance use disorder treatment under one health plan, took effect in the Southwest Washington region in April 2016. This whole-person care approach is expanding in 2018 to the North Central region, which includes Chelan, Douglas, and Grant Counties.

- **Apple Health Foster Care:** Administration of the State's managed care program for children and youth in foster care, adoption support, extended foster care, and young adults previously enrolled in foster care was assumed by one MCO, Coordinated Care of Washington (which refers to the program as Apple Health Core Connections). Apple Health Foster Care provides physical health

benefits, lower-intensity outpatient mental health benefits, and care coordination; enrollees receive needed inpatient services and higher-level outpatient mental health services through Behavioral Health Organizations (BHOs) or Behavioral Health Services Only (BHSO) organizations, depending on the region in which they live.

Collectively, these efforts contribute to an overall program that will better meet the needs of the whole person, providing better-coordinated care for Medicaid enrollees as well as more fluid access to physical and behavioral healthcare services.

Description of External Quality Review Activities

EQR federal regulations under 42 CFR Part 438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with CMS protocols. The 2017 report includes strengths, opportunities for improvement, and recommendations reflecting the results of the following:

- **MCOs**
  - audits of Healthcare Effectiveness Data and Information Set (HEDIS®[1]) measures of clinical services
  - validation of performance measures
  - compliance monitoring, including follow-up of the previous year's corrective action plans
  - validation of performance improvement projects (PIPs)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) consumer satisfaction surveys

- **BHOs**
  - readiness review and transition plan follow-up assessing each BHO's progress in transitioning from the RSN to the BHO structure and in integrating SUD treatment services
  - compliance monitoring
  - mental health care coordination clinical record review
  - encounter data validation (EDV)
  - follow-up of the previous year's corrective action plans
  - Information Systems Capabilities Assessment (ISCA)
  - validation of PIPs
  - Golden Thread focus study

Description of Access, Timeliness, and Quality

Through assessment of the review activities described above, this report demonstrates how MCOs and BHOs are performing with regard to the delivery of quality, timely, and accessible care. These concepts are summarized here.

Quality: Quality of care encompasses access and timeliness as well as the process of care delivery and the experience of receiving care. Although enrollee outcomes can also serve as an indicator of quality of care, outcomes depend on numerous variables that may fall outside the provider's control, such as

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

patients' adherence to treatment. CMS describes quality as the degree to which a managed care organization increases the likelihood of desired health outcomes for its enrollees through its structural and operational characteristics as well as through the provision of health services that are consistent with current professional knowledge.

Access: Access to care encompasses the steps taken for obtaining needed healthcare and reflects the patient's experience before care is delivered. Access to care affects a patient's experience as well as outcomes and thus the quality of care received. Adequate 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.

Timeliness: Timeliness of care reflects the readiness with which enrollees are able to access care, a factor which ultimately influences quality of care and patient outcomes. It also reflects the health plan's adherence to timelines related to authorization of services, payment of claims, and processing of grievances and appeals.

Physical Health

Qualis Health's review of physical healthcare services delivered by Apple Health MCOs included an assessment of the compliance review and performance improvement project validation conducted by the State interagency TEAMonitor and HCA, respectively; a validation and analysis of performance measures reported by the MCOs, which included HEDIS data and CAHPS survey results; and a review of prior-year EQR recommendations.

Compliance Review
The State's MCOs are evaluated by TEAMonitor, the interagency unit of the Health Care Authority and the Department of Social and Health Services, on their compliance with federal and State regulatory and contractual standards. TEAMonitor's review assesses activities for the previous calendar year and evaluates MCOs' compliance with the standards set forth in 42 CFR Part 438, as well as those established in the MCOs' contract with HCA.

Performance Improvement Project Validation
MCOs are required to have an ongoing program of clinical and non-clinical performance improvement projects that are designed to improve processes, health outcomes, and enrollee satisfaction. HCA assesses and validates the MCOs' performance improvement projects to ensure they meet State and federal guidelines and are designed, conducted, and reported in a methodologically sound manner.

Performance Measure Validation
This report includes assessment of two sets of performance measure results: HEDIS measures and CAHPS survey results.

HEDIS is a widely used set of healthcare performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over eight domains of care; they also allow MCOs to determine where quality improvement efforts may be needed. For the 2017 reporting year (RY, measuring 2016 data), MCOs submitted data on 46 specific measures representing 168 submeasures.

Qualis Health used this data to perform comparisons among MCOs and against national benchmarks. Summary results from this analysis can be found in the Performance Measure Review chapter of the Physical Healthcare section of this report. The full analysis is available in the *2017 Comparative Analysis Report*.[3]

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
The CAHPS survey assesses consumers' experiences with healthcare services and support. Developed by the U.S. Agency for Healthcare Research and Quality (AHRQ), the surveys address such areas as the timeliness of getting care, how well doctors communicate, global ratings of healthcare, access to specialized services, and coordination of care. In 2017, the Apple Health MCOs conducted the CAHPS 5.0H Child Medicaid with Chronic Conditions survey, collecting survey data from parents/guardians of children enrolled in Apple Health. The full analysis is available in the *2017 Apple Health Managed Care CAHPS® 5.0H Child Medicaid with Chronic Conditions Report*.[4]

Behavioral Health

As stated previously, the State is moving forward to integrate behavioral healthcare benefits into the Apple Health managed care program to provide clients with access to both physical and behavioral healthcare services through a single managed care plan. Although the integration is scheduled to be completed no later than 2020, the legislation allows regional county authorities to elect to move forward with the integrated managed care transition on an earlier timeline, if desired. A few regions have begun this transition, in which behavioral healthcare services purchased and administered by regional BHOs have been transferred to Apple Health MCOs through the IMC contracts administered by the HCA. North Central Behavioral Health Organization (NCBHO) chose to begin the process of moving forward as an integration "mid-adopter," beginning the transition in 2017 with the intention of fully transferring the administration of behavioral healthcare services in its region to MCOs by December 31, 2017.

Qualis Health's external quality review of eight of the state's nine BHOs consisted of a compliance review assessing the BHOs' adherence to State and federal regulatory and contractual requirements, encounter data validation, an evaluation of the BHOs' performance improvement projects, an ISCA review, mental health care coordination review, and a review of prior-year EQR recommendations. In addition, DBHR requested that Qualis Health focus its 2017 EQR for the mid-adopter BHO, NCBHO, on the BHO's status in coordinating close-out activities with the behavioral health agencies (BHAs) and its administrative services organization (ASO), Behavioral Healthcare Options, as well as knowledge transfers with the MCOs in conjunction with HCA following DBHR's transition outline.

The 2017 review also included a focus study to evaluate SUD treatment providers' clinical chart documentation for the presence of clear, consistent care linkages between an individual's needs, diagnosis, and treatment. Additionally, reviewers followed up on the readiness review conducted in 2016 evaluating each BHO's status in transitioning from an RSN and integrating SUD treatment services.

Compliance Review
Qualis Health's compliance review assessed each BHO's compliance with federal Medicaid managed care regulations and applicable elements of the BHOs' contract with the State in eight key areas, including quality assessment and performance improvement programs. Each section of the compliance

[3] *2016 Comparative Analysis Report* link to be provided with final report.
[4] *2017 Apple Health Managed Care CAHPS® 5.0H Child Medicaid Report* link to be provided with final report.

review protocol contains elements corresponding to relevant sections of 42 CFR Part 438, DBHR's contract with the BHOs, the Washington Administrative Code (WAC), and other State regulations where applicable.

Performance Improvement Project Validation
BHOs are required to have an ongoing program of performance improvement projects that are designed to assess and improve the processes and outcomes of the healthcare the BHOs provide. BHOs were required to implement three PIPs, one each focused on clinical, non-clinical, and substance use disorder treatment areas. One of the three PIPs must focus on children. Performance improvement projects are evaluated and validated each year to ensure they meet State and federal standards.

Information Systems Capabilities Assessment
The ISCA evaluates the ability of the BHOs' information systems to accurately and reliably produce performance measure data, encounter data, and reports to assist with management of the care provided to BHO enrollees. The ISCA procedures were based on the CMS protocol for this activity, as adapted for the BHOs with DBHR's approval. For each ISCA review area, reviewers used the information collected in the ISCA data collection tool, responses to interview questions, and results of the claims/encounter and security walkthroughs to rate the BHO's performance for seven review areas, including IT infrastructure; information security; encounter, eligibility and provider data management; and performance measures and reporting.

Performance Measure Validation
42 CFR §438.358 requires the annual validation of performance measures for managed care entities that serve Medicaid enrollees. During the previous review year, DBHR retired the previous performance measures and is now in the process of establishing performance measure targets with new data as they are collected.

Encounter Data Validation
EDV is a process used to validate encounter data submitted by BHOs to the State. Encounter data are the electronic records of services provided to BHO enrollees by both institutional and practitioner providers (regardless of how the providers were paid), when the services would traditionally be a billable service under fee-for-service (FFS) reimbursement systems. Encounter data provide substantially the same type of information found on claim forms but not necessarily in the same format. States use encounter data to assess and improve quality, monitor program integrity, and determine capitation payment rates. As federal programs transition toward payment reform for demonstrated quality of care, validation of encounter data in the use of performance data becomes increasingly significant. Transparency of payment and delivery of care is an important part of health reform. Validation of encounter data can help the State reach the goals of transparency and payment reform to support its efforts in quality measurement and improvement.

DBHR requires each BHO to ensure the accuracy of encounters submitted to DBHR by conducting an annual EDV, per DBHR guidelines. Qualis Health's audit then verifies each BHO's EDV process by conducting an independent check of the BHO's EDV results.

Qualis Health obtained each BHO's encounter data validation report submitted to DBHR as a contract deliverable for calendar year 2016, and reviewed the BHOs' encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates, and fields selected for validation for conformance with the CMS protocol standards and the DBHR contract requirements.

Golden Thread Focus Study

For the 2017 EQR focus study, Qualis Health examined the degree to which SUD treatment providers' clinical records demonstrated adherence to what the healthcare quality improvement community often refers to as the "golden thread," a series of clear, consistent care linkages between an individual's needs, diagnosis, and treatment. Qualis Health reviewed 18–31 adult patient charts randomly selected from each BHO's EDV sample. Reviewers specifically evaluated documentation in three areas: assessments and re-assessments, individual service planning, and progress notes.

Summary of Recommendations

In its assessment of the degree to which MCOs and BHOs provided Medicaid enrollees with accessible, timely, quality care, this *2017 Annual Technical Report* explains to what extent the State's managed care plans are meeting federal and State regulations, contract requirements, and statewide goals, and where they need to improve. Following are Qualis Health's recommendations to the State intended to help guide HCA and DBHR in improving Washington's overall Medicaid system of care. Subsequent sections offer further discussion.

Overall Recommendations

As the State continues to coordinate physical health, mental health, and substance use disorder treatment integration, collaboration and communication among service networks will be of importance in ensuring continued quality care.

- The State needs to ensure there is communication and collaboration between MCOs, BHOs, and BHAs to create transparency and ensure best practices for ensuring continued quality care.

In 2017, HCA and DBHR collaborated on a draft State quality strategy and submitted the plan to CMS for approval. However, CMS has not yet approved the plan. Having a CMS-approved State quality strategy in place is a federal regulatory requirement.

- Once CMS has approved the State's quality strategy, per federal requirements the State needs to distribute the plan to MCOs and BHOs, post the plan to the State's website, and ensure the plan is evaluated for effectiveness yearly, either by the EQRO in the EQR annual technical report, or by the State via a report submitted to CMS.

Physical Health

Recommendations

Apple Health MCOs showed statewide improvement in several performance areas in 2017 RY, including sections of the compliance review and numerous HEDIS measures. However, despite improvement, certain areas continue to pose difficulty for MCOs and lag behind national performance. Going forward, the State will need to prioritize these areas in its continued efforts to improve delivery of care to the state's Medicaid population.

Performance Measures

The most substantive needs for improvement for MCOs that surfaced during the 2017 external quality review centered on low HEDIS measure and CAHPS survey performance. HEDIS measure results reflected low Apple Health performance on adult access to primary care, well-child visits for children ages 3–6, maternal health measures, children/adolescents' BMI percentile and nutrition/physical activity counseling measures, and women's health screenings. The following recommendations are intended to help identify the causes of low performance and take steps to remedy low scores.

- HCA needs to monitor rates of adult access to primary care, which have shown improvement but are still considerably lower than national rates. Specifically, HCA should seek root causes for low access rates for 20–44-year-olds in Apple Health Adult Coverage and Integrated Managed Care, which are much lower than rates for other members of the Medicaid population, and determine

whether action is needed. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.
- Examine barriers to well-child visits for children ages 3–6, and determine whether statewide action is necessary. This measure did not show improvement in 2017 RY and is still below the national 50th percentile. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.
- To sustain improvements demonstrated by plans in 2017 RY, HCA should continue to monitor and emphasize maternal health measures, weight assessment and counseling for children/adolescents measures, women's health screenings, and antidepressant medication management. While performance on many of these measures improved from 2016 RY to 2017 RY, rates are all considerably below national averages, and plans should strive for continued improvement. To bring statewide performance in line with national standards, HCA should consider setting statewide performance benchmark goals for MCOs.

MCOs performed below the 20th percentile nationwide for four out of eight reported CAHPS survey questions. Given the interconnectedness of the variables impacting these scores, improvement efforts directed toward one or two process measures are likely to positively impact CAHPS results as a whole.
- HCA needs to encourage MCOs to increase focus on improving two easily definable CAHPS measures, Getting Needed Care and Getting Care Quickly, in an effort to improve CAHPS survey results globally.

Compliance
In this year's review, MCOs' scores demonstrated overall slight improvement, notably with enrollee rights and coordination and continuity of care standards. However, coordination and continuity of care, coverage and authorization, and grievance system standards continue to be areas of weakness.
- HCA needs to consider education or training efforts to address coordination and continuity of care, and transitional care with MCOs. These areas have been historically problematic, and additional efforts may be needed to ensure adequate care for enrollees, particularly given the integration of physical and behavioral healthcare services.

Opportunity for Improvement

MCOs received scores of Partially or Not Met on the majority of the PIPs they were assigned in 2016 CY. While identified topics generally targeted important enrollee needs or gaps in service delivery, PIP design was frequently lacking in clarity and specificity, and data and results analysis was often insufficient.
- HCA should continue to provide trainings and possibly technical assistance to the MCOs and their staff on PIP study design and implementation.

Behavioral Health

Recommendations
For the following recommendations, Qualis Health recommends that DBHR follow up with each BHO and corresponding contract manager to reiterate the Code of Federal Regulations (CFR), contract, and WAC requirements pertaining to the respective findings.

Compliance

Many of the BHOs are not ensuring that out-of-network providers are appropriately credentialed and that the referring BHA requesting out-of-network services is verifying and retaining documentation evidencing that the out-of-network provider has the credentials necessary to provide the services and that the provider is not debarred/excluded from receiving federal funds. This information should be provided to the BHO prior to the BHO's authorization of the out-of-network services.

- DBHR needs to include in its BHO contracts a requirement that BHOs develop policies and procedures for verifying that out-of-network providers are appropriately credentialed and that the BHA requesting out-of-network services is verifying and retaining documentation evidencing that the out-of-network provider has the credentials necessary to provide the services and that the provider is not debarred/excluded from receiving federal funds.

All of the BHOs require the BHAs to assess and coordinate care and services by:

- asking about other systems or providers the individual may also be receiving services from or has received services from in the recent past
- attempting to obtain releases of information in order to coordinate care
- asking the enrollee if they need a primary care physician, providing a referral, and helping them obtain an appointment
- tracking and coordinating care with an assigned primary care provider through the treatment plan and progress notes

However, the results from Qualis Health's mental health clinical record reviews indicated a lack of documentation demonstrating care coordination, with the majority of BHAs' results reflecting poor to very poor care coordination.

- The BHOs need to continue their efforts to train, educate, and monitor the BHAs on coordination of care and services to ensure enrollees are receiving appropriate and medically necessary services and that documentation of these services is present in the progress notes.

Many BHOs stated they were not monitoring out-of-network providers for coordination of care and services; instead, the BHOs were relying on the BHO in whose region the BHA was located to monitor the BHA and submit results of its review to all BHOs that have contracts with the BHA. Many of the contracts for out-of-network providers have been in effect for over a year and were not subject to any pre-contractual monitoring or other monitoring since the contracts have been in place. Even though the BHOs had made agreements with other BHOs to share monitoring results for providers who are out of network, the BHOs contracting with the out-of-network providers are ultimately responsible for ensuring that the care and services provided are appropriate and meet all State contract, WAC, and CFR requirements.

- To ensure BHAs are meeting all WAC, State contract, and CFR requirements and that the care furnished to enrollees is appropriate, the State needs to ensure that BHOs are monitoring out-of-network providers in cases when the BHO has not received a monitoring report from the BHO in whose region the provider is located.

Many of the BHOs lacked documented policies and procedures to audit BHAs' accessibility considerations with regard to providing physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities, stating instead that the State licensing agency was responsible for assessing the BHAs' compliance with these requirements. During Qualis Health's on-site reviews, reviewers discovered that several of the mental health and SUD treatment agencies lacked appropriate physical access and reasonable accommodations, despite being licensed by the State.

- The BHOs are ultimately responsible for ensuring their contracted BHAs maintain accessible

facilities, including providing physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. The BHOs need to conduct thorough assessments of all contracted providers at the time of initial contracting and re-contracting to ensure adequate access is provided.

Many of the BHOs lack a mechanism to track and monitor requests for standard and expedited service authorizations.

- The BHOs need to develop and implement a process for tracking and monitoring requests for standard and expedited service authorizations.

Several BHOs lack a policy and procedure that describes a formal process for conducting inter-rater reliability monitoring to ensure there is consistent application of review criteria pertaining to the initial and continuing authorization of services.

- DBHR needs to ensure that all BHOs have a policy and procedure that describes a formal process for conducting inter-rater reliability monitoring to ensure there is consistent application of review criteria pertaining to the initial and continuing authorization of services.

Many of the BHOs are not ensuring that the BHAs are conducting, for all staff, a Washington State Patrol background check and excluded provider check before hire, as well as monthly excluded provider checks.

- DBHR needs to make sure that all BHOs have implemented a process for ensuring that the BHAs are consistently conducting, for all staff, a Washington State Patrol background check and excluded provider check before hire, as well as monthly excluded provider checks.

Many of the BHOs are not consistently monitoring and verifying their contracted BHAs' credentialing and re-credentialing processes.

- The State needs to enforce the BHOs' completion of CAPs related to ensuring the BHOs are all monitoring and verifying their contracted BHAs' credentialing and re-credentialing processes.

Several BHOs stated that while they require the BHAs to apply the same CFR criteria to any services the BHAs delegate to other entities, the BHOs are not monitoring their BHAs' delegation agreements with their subcontractors.

- DBHR needs to ensure that all BHOs are monitoring their BHAs' delegation agreements with subcontractors to ensure the delegates are following the same CFR criteria required of the BHAs.

Although all BHOs have practice guidelines, many of the BHOs have had the same practice guidelines in place for several years without knowing whether the practice guidelines are still meeting the needs of their enrollees and functioning to improve enrollee outcomes.

- The State needs to make sure the BHOs are choosing practice guidelines based on valid and reliable clinical data in order to meet the needs of their enrollees. The BHOs then need to include in their QAPI program how the practice guidelines are incorporated into the administration and monitoring of services.

Several BHOs lack both policies and procedures for identifying, monitoring, and detecting underutilization and overutilization of services as well as processes for taking corrective action to address underutilization and overutilization.

- DBHR needs to ensure that all BHOs have and follow policies and procedures for identifying, monitoring, and detecting underutilization and overutilization of services.

Although the State completed a draft of the State's quality strategy plan and submitted the plan to CMS, CMS has not yet approved the plan.

- Once the State receives CMS's approval for the quality strategy plan and distributes the final plan to the BHOs, DBHR will need to ensure the BHOs comply with the quality strategy plan.

Several BHOs did not complete an annual evaluation of the impact and effectiveness of their QAPI program, including accomplishments, progress toward meeting identified objectives and goals, and the results of QM work plan indicators.

- DBHR has included this requirement in an amendment to its BHO contracts but will need to ensure that all BHOs follow through by completing an annual evaluation of the impact and effectiveness of their QAPI program, including accomplishments, progress toward meeting identified objectives and goals, and the results of QM work plan indicators.

Several BHOs lack a policy and procedure to ensure their BHAs are checking their data for quality and integrity before submitting them to the BHO. The policy should include:

  - the requirement for providers to submit written attestations of data accuracy
  - a form letter for providers to complete attesting to data accuracy
  - a system for the form letters to be transmitted electronically to the BHO
- DBHR needs to make sure all BHOs have a policy and procedure to ensure BHAs are checking their data for quality and integrity before submitting them to the BHO.

PIP Validation

This is the second year DBHR has required BHOs to have a pre-approved and implemented third PIP focusing on SUD treatment services. Many BHOs still face challenges regarding collecting SUD data and identifying potential topics based on that data. Without complete and accurate data, the BHOs found it difficult to fully understand the needs of enrollees related to substance use disorder treatment and what gaps might exist in the SUD program, outside of contract requirements. The formulation of a PIP needs to include the collection and analysis of internal and external data related to the study topic. Without this data, the BHOs are unable to analyze the data and identify a study topic.

- DBHR needs to continually develop procedures to ensure the BHOs are able to receive reliable historical SUD treatment service data.

Some BHOs did not involve enrollee/stakeholder input at the onset of the selection of the PIP study topic.

- DBHR needs to ensure that input from enrollees, family members, peers, and/or advocates are considered during the selection of the BHOs' PIPs.

Some BHOs struggled with choosing new PIP topics.

- DBHR needs to ensure that when selecting a PIP study topic, the BHOs:
  - ensure there are data that can be collected and analyzed to support the focus of the PIP as an area that truly needs improvement
  - do not attempt to create a PIP around a program or process that does not show evidence of needing improvement. PIPs are meant to improve the care and treatment of enrollees in areas that are in need of advancement, not highlight programs or processes that are successful.
  - fully and clearly define the intended intervention(s)

A few BHOs' PIPs were in place for extended measurement periods with only minimal explanation or updates to the PIP submission.

- DBHR needs to ensure that the BHOs' PIP measurement periods are clearly stated and appropriate in length.
- Data need to be reviewed at least on a quarterly basis to ensure the PIP is moving in a successful direction.
- Any changes in the study periods need to be clearly documented with thorough and valid explanations of deviations from the initial plan.

Several of the BHOs have staff who are unfamiliar or unsure of the PIP process. Many of these staff need continued technical assistance with understanding the CMS protocol for conducting performance improvement projects.

- DBHR and the EQRO need to continue to provide technical assistance to the BHOs and their staff on the CMS protocol and PIP study design.
- DBHR and the EQRO need to continue to provide technical support to ensure BHOs understand how to utilize core improvement concepts and tools when implementing PIPs.

ISCA

Best practice guidelines recommend that all data centers and business-critical applications have off-site disaster recovery capabilities that will meet the organization's needs. An off-site disaster recovery location is maintained for ProviderOne, but not for BHDS. A prolonged outage at the SDC would have a detrimental effect on day-to-day operations at DBHR.

- DBHR needs to continue to work with the SDC to establish an off-site disaster recovery location for BHDS in the event of a catastrophic outage.

The last penetration test on DSHS applications was completed in 2012. Issues identified during that test are still not resolved. Penetration testing should be completed at least annually, per NIST standards.

- DSHS needs to complete work on the corrective action plan created as a result of findings identified in the last penetration test in 2012.
- DSHS needs to re-institute routine penetration testing on the DSHS network.

ProviderOne has minimal data quality edits in place for encounter data in order to maximize the amount of data collected. Some of the edits produce warning messages instead of rejecting the encounters.

- DBHR needs coordinate with HCA to implement processes for creating edits in ProviderOne to reject encounters that are submitted incorrectly to the State.

DBHR requires the BHOs to monitor two performance measures but has not set performance goals or targets, which could be used to improve client outcomes.

- DBHR needs to set benchmarks for each of the required performance measures and measure the BHOs' outcomes.
- DBHR needs to share the performance measure data it collects with each of the BHOs.

Many of the BHAs did not have documented business continuity and disaster recovery (BC/DR) plans in place.

- DBHR needs to work with and monitor the BHOs to ensure that all of the BHOs and their contracted BHAs have written BC/DR plans. The BHOs should collect the BC/DR plans from the agencies and ensure that the plans are updated and tested annually.

Several BHOs received recommendations for corrective action plans to address issues of privacy and security.

- DBHR needs to work with the BHOs to ensure that all of the corrective action plans from the 2017 ISCA related to security and privacy are completed as soon as possible.

EDV

In reviewing the EDV deliverables the BHOs submitted to the State, it was noted that the BHOs' data collection and analytical procedures for validating encounter data were not standardized.

- In order to improve the reliability of encounter data submitted to the State, DBHR needs to continue to work with the BHOs to standardize data collection and analytical procedures for encounter data validation.

Qualis Health discovered encounters in which services were bundled incorrectly as well as other numerous errors. These errors further suggest that the BHOs and providers need information or further training about how to correctly code encounters prior to submission to the State. Additionally, many of the BHOs and providers were unfamiliar with the terms of EDV in the State contracts and with the specifics of the SERI.

- DBHR needs to provide guidance to the BHOs on how to bundle services correctly, review the numerous errors in encounter submission that were found in the clinical chart review, and revise the SERI to further clarify proper coding for clinicians. DBHR also needs to ensure the BHOs know and understand the content of the State contract, SERI, and standards for documentation. DBHR may consider providing further training on the contract, SERI, and documentation to the BHOs and/or the BHAs, in particular, the SUD treatment BHAs.

Many BHOs are submitting coding errors to ProviderOne. The State reported that ProviderOne does not contain any edits to reject any coding errors and therefore accepts all codes whether they are submitted correctly or not.

- DBHR needs to coordinate with HCA to establish processes by which ProviderOne creates edits to reject encounters that are submitted incorrectly to the State.

BHOs report different internal protocols for handling encounter errors. The BHOs have not received any identified protocol from the State for how to address identified encounter errors.

- DBHR needs to create expectations or protocols for BHOs on how to address errors identified in encounters.

Physical Healthcare and Integrated Managed Care Provided by Apple Health Managed Care Organizations

Introduction

Throughout calendar year (CY) 2016, five managed care organizations (MCOs) delivered physical healthcare services to Apple Health managed care (Medicaid) enrollees across the State of Washington:

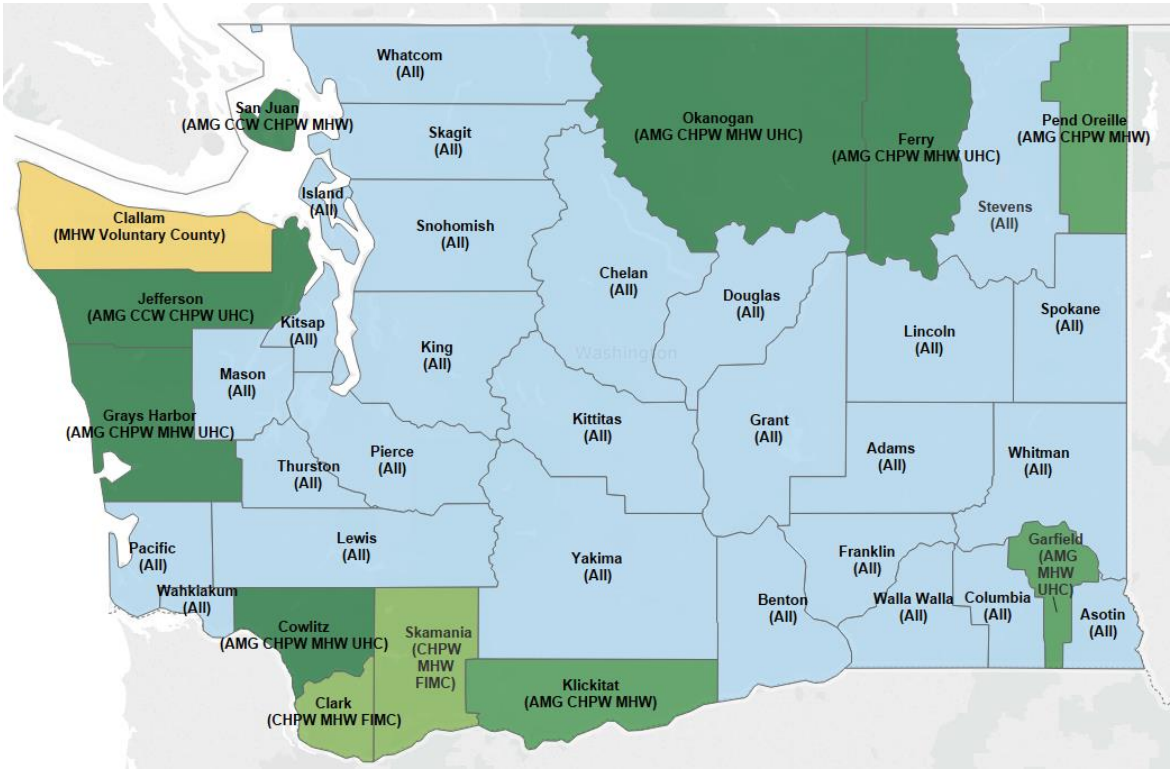
- Amerigroup Washington, Inc. (AMG)
- Community Health Plan of Washington (CHPW)
- Coordinated Care of Washington (CCW)
- Molina Healthcare of Washington (MHW)
- United Healthcare Community Plan (UHC)

The Integrated Managed Care (IMC) program in Southwest Washington took effect in April 2016. For Medicaid enrollees in this region, physical healthcare, mental healthcare, and substance use disorder treatment are coordinated through CHPW and MHW.

Figure 1, next page, identifies the MCOs and the counties they serve, as of December 31, 2016. In Clallam, Skamania, and Klickitat counties, enrollment was voluntary because only one MCO was in operation or because the contracted MCOs did not have sufficient capacity to serve all enrollees.

Note: For clarity, results of all review activities collected or reported during the 2017 calendar year are indicated with 2017 RY.

Figure 1: Washington Apple Health MCO Coverage, by County



Overview of Apple Health Enrollment Trends

It is important to note that MCOs' members are not homogenous. MCOs serve different populations with a varying mix of demographics and program enrollment. Depending upon the HEDIS measure, the impact of members enrolled in Apple Health Adult Coverage (Medicaid expansion) or Integrated Managed Care (IMC) on measure performance will vary.

It is interesting to note that most members in the Apple Health Family program (traditional Medicaid) are under the age of 20 (82.5 percent), while the majority of members in the Apple Health Adult Coverage program (Medicaid expansion) are between the ages of 20 and 50 (73 percent), and 30 percent of members in that program are between the ages of 20 and 30. With this influx of members highly concentrated in the 20–50 age range, it is reasonable to see limited to no improvement for adult-focused measures while MCOs adjust to the changing demographics and increase capacity to care for this new population.

Another population to monitor is the IMC program population. While this program is relatively new in the Southwest region of the state, affecting only CHPW and MHW, eventually all plans and populations will transition to the IMC model, which incorporates administration of physical healthcare, mental health services, and substance use disorder treatment under one health plan. Currently, the IMC population accounts for 4.7 percent of all Medicaid enrollees in Washington, and the age distribution for this population is relatively evenly distributed, with a higher concentration only for enrollees under the age of 10 (26 percent).

Tables 1, 2, and 3 show the distribution of Apple Health enrollees by program, age, and both program and age. Note that these data are sourced from the member-level data submitted by MCOs and are based on the total number of enrollees.

Table 1: 2017 RY Enrollee Population by Apple Health Program
1,318,385 Enrollees in Total

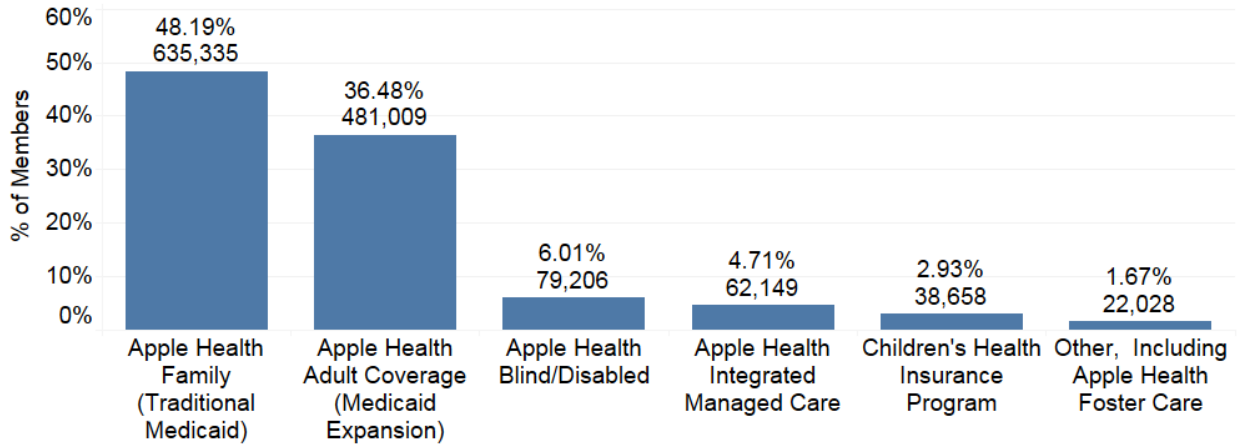


Table 2: 2017 RY Enrollee Population by Age

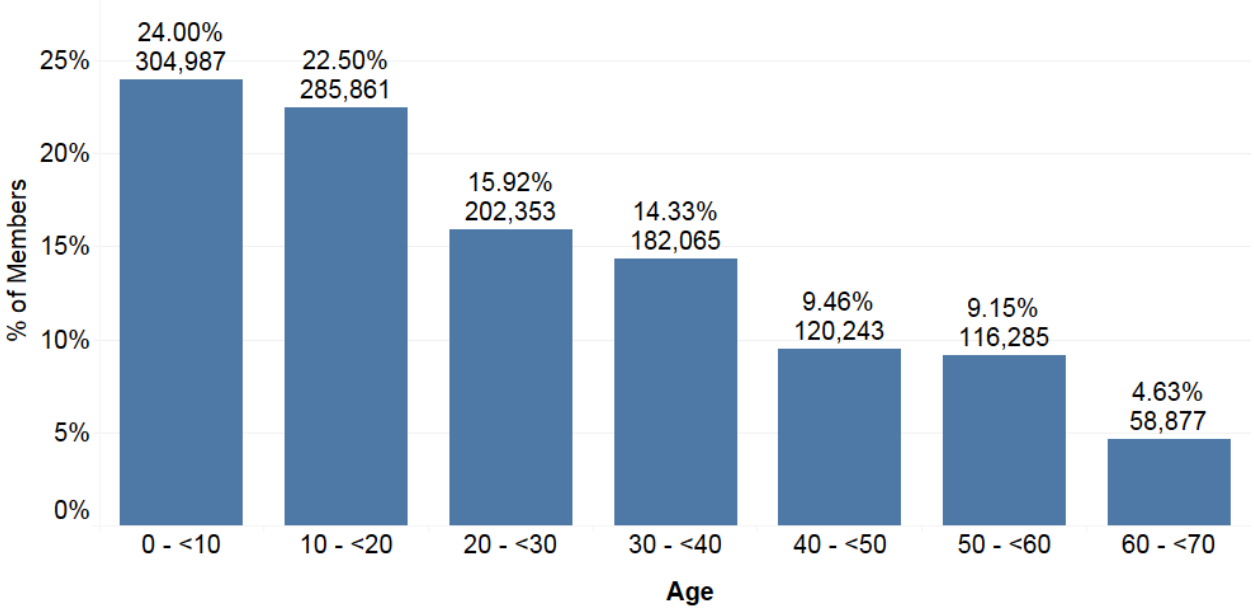
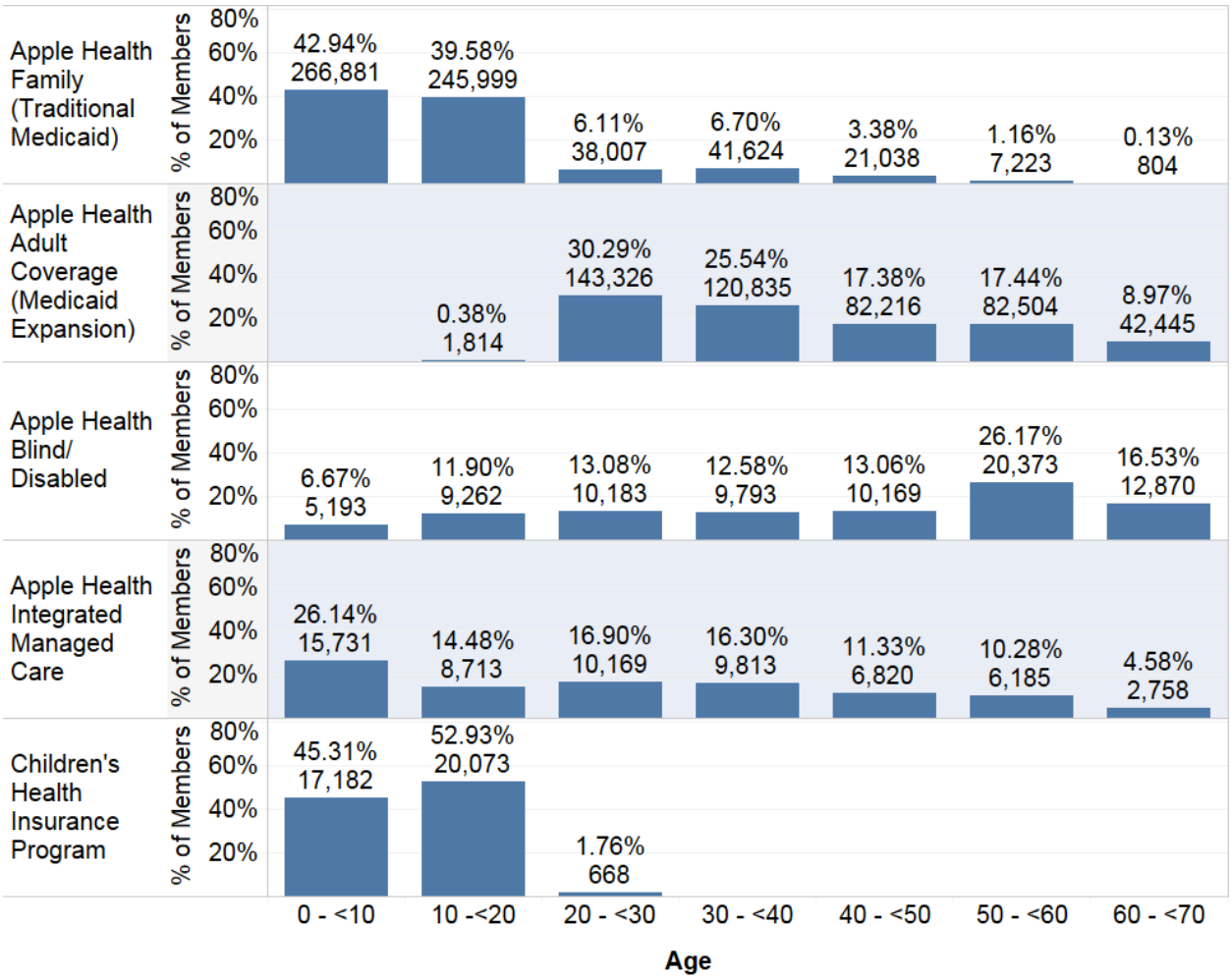
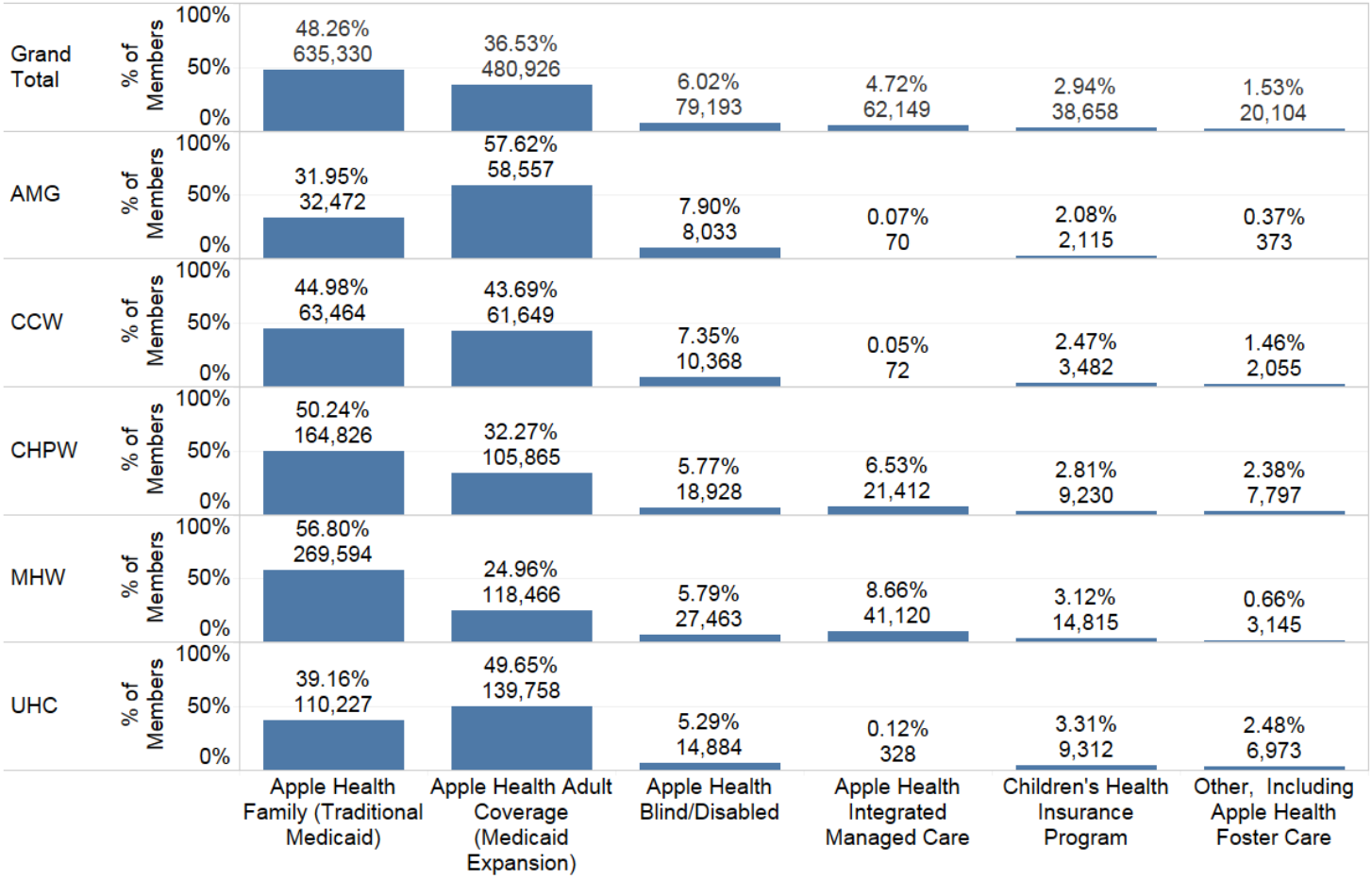


Table 3: 2017 RY Enrollee Population by Apple Health Program and Age



Note that the relative distribution of these members is not uniform across MCOs. For example, 57.6 percent of AMG's members are enrolled in Apple Health Adult Coverage (Medicaid expansion), while only 24.96 percent of MHW members are enrolled in that program. Additionally, only CHPW and MHW administered IMC in 2016. (Note that while other MCOs reflect some IMC enrollment, this likely reflects enrollees who relocated to different regions during the data pull.) This variation in Medicaid program mix by MCO can affect HEDIS performance outcomes, so it is important to monitor performance at both the plan level and at the plan and program level. Table 4 shows Apple Health enrollee population distribution by program and plan.

Table 4: 2017 RY Enrollee Population by Apple Health Program and Plan



Overall, Apple Health MCOs experienced a total growth rate of 8.35 percent from December 2015 to December 2016 CY. The largest MCO, MHW, grew by over 18 percent during this time. CCW's enrollee population also grew by more than 12 percent. Note that MHW (the largest MCO) is over four times the size of the smallest MCO (AMG), and MHW is more than double the size of the second-largest MCO (CHPW). Table 5 shows Apple Health enrollment by plan for the 2014, 2015, and 2016 calendar years.

Table 5: Apple Health Enrollment, December 2014, December 2015, December 2016 CY[5]

	December 2014 Enrollment	December 2015 Enrollment	December 2016 Enrollment	Percent Change Dec 2015 to Dec 2016
AMG	128,369	141,571	149,314	5.19%
CHPW	332,456	294,141	297,725	1.20%
CCW	175,353	181,801	207,342	12.31%
MHW	486,524	566,201	697,392	18.81%
UHC	180,225	204,078	224,973	9.29%
Total	1,302,927	1,445,093	1,576,746	8.35%

[5] www.hca.wa.gov/about-hca/apple-health-medicaid-reports

Summary of Results

Qualis Health's review of physical healthcare delivered by Apple Health MCOs included an assessment of TEAMonitor's compliance review and corrective action plan (CAP) follow-up, HCA's performance improvement project validation, and a validation and analysis of performance measures reported by the MCOs, which included HEDIS measure and CAHPS survey results.

The performance measure review reflects data collected in 2017 measuring the experience of members in 2016. To be consistent with NCQA methodology, the resulting scores are indicated in this report by 2017 reporting year (RY) and 2016 calendar year (CY), respectively. For clarity, results of all other review activities collected or reported during the current calendar year, including compliance review and PIP validation, are also indicated with 2017 RY.

As in 2016 RY, MCOs generally performed well in the compliance portion of the review, with scores steady in most areas and some improvement in other areas, including continuity and coordination of care. However, coordination of care continues to be an area of weakness, as well as coverage and authorization, grievance system, and Health Homes.

Performance measure data showed improvements in several areas, including well-child visits, women's health screenings, child/adolescent nutrition/activity counseling, and maternal health measures. However, statewide rates are still considerably below national averages for these measures. Additionally, plan performance on four of the eight CAHPS domains were below the 20th percentile of national performance.

Going forward, the State will need to prioritize these areas in its continued efforts to improve delivery of care to Washington's Medicaid population.

Compliance Review

The State interagency TEAMonitor annually evaluates Washington's managed care organizations (MCOs) on their compliance with federal and State regulatory and contractual standards, including those set forth in 42 CFR Part 438, as well as those established in the MCOs' contract with HCA. Compliance with these standards reflects accessibility, timeliness, and quality of care.

For a listing of regulatory standards by which MCOs are evaluated, see Appendix E.

Methodology

TEAMonitor's assessments consist of desk audits of files submitted electronically by the MCOs, followed by on-site visits and/or collaboration calls in which TEAMonitor staff share results with MCO leadership. For review standards on which MCOs are not compliant (receiving a score of Partially Met or Not Met), TEAMonitor requests submission of corrective action plans (CAPs) for follow-through during the subsequent year, before the next year's review. The review team also works with MCOs to develop and refine processes that will improve accessibility, timeliness, and quality of care for Medicaid enrollees.

Scoring

TEAMonitor scores the MCOs on each compliance standard according to a metric of Met, Partially Met, and Not Met, each of which corresponds to a value on a point system of 0–3. Scores of 0 and 1 indicate Not Met (with 0 points indicating that the MCO additionally did not fulfill a corrective action plan from the previous year's review), 2 indicates Partially Met, and 3 indicates Met. Final scores for each section are denoted by a fraction indicating the points obtained (the numerator) relative to all possible points (the denominator). For example, in a section consisting of four elements in which the MCO scored a 3, or Met, in three categories and a 1, or Not Met, in one category, the total number of possible points would be 12, and the MCO's total points would be 10, yielding a score of 10/12. In the following presentation of results, total scores have been converted to percentages, which, for the above score of 10/12, would produce a score of 83 percent.

Summary of Compliance Results

Table 6 provides a summary of all MCO scores by compliance standard. Bars and percentages reflect total scores for each standard (total scores for all elements combined, converted to percentages). MCOs with elements scored as Partially Met or Not Met were required to submit CAPs to HCA. MCOs were scored on these elements in the first half of the review year. MCOs may have implemented corrective action plans since that time to address specific issues, and therefore scores may not be indicative of current performance.

Table 6: MCO Compliance with Regulatory and Contractual Standards, by Plan

Standard	# of Elements	MCO	# Met or NR 3 points	# Partially Met 2 points	# Not Met 1 point	# Not Met 0 points	Total Score (% of points attained)
Availability of Services	7	AMG	7	0	0	0	100
		CCW	7	0	0	0	100
		CHPW	7	0	0	0	100
		MHW	7	0	0	0	100
		UHC	7	0	0	0	100
Program Integrity Requirements	5	AMG	5	0	0	0	100
		CCW	5	0	0	0	100
		CHPW	5	0	0	0	100
		MHW	5	0	0	0	100
		UHC	5	0	0	0	100
Timely Claims Payment	2	AMG	2	0	0	0	100
		CCW	2	0	0	0	100
		CHPW	2	0	0	0	100
		MHW	2	0	0	0	100
		UHC	2	0	0	0	100
Coordination and Continuity of Care	10	AMG	6	3	0	1	80
		CCW	8	2	0	0	93
		CHPW	8	0	1	1	87
		MHW	9	1	0	0	97
		UHC	10	0	0	0	100
Patient Review and Coordination	5	AMG	3	2	0	0	100
		CCW	5	0	0	0	100
		CHPW	5	0	0	0	100
		MHW	5	0	0	0	100
		UHC	5	0	0	0	100
Coverage and Authorization	10	AMG	8	2	0	0	93
		CCW	7	3	0	0	90
		CHPW	6	2	2	0	80
		MHW	7	3	0	0	90
		UHC	8	2	0	0	93
Enrollment/ Disenrollment	2	AMG	2	0	0	0	100
		CCW	2	0	0	0	100
		CHPW	2	0	0	0	100
		MHW	2	0	0	0	100
		UHC	2	0	0	0	100

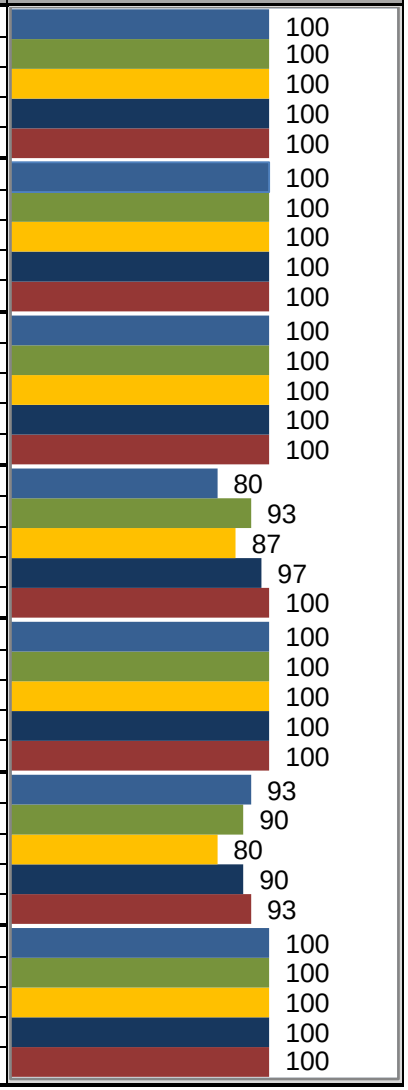
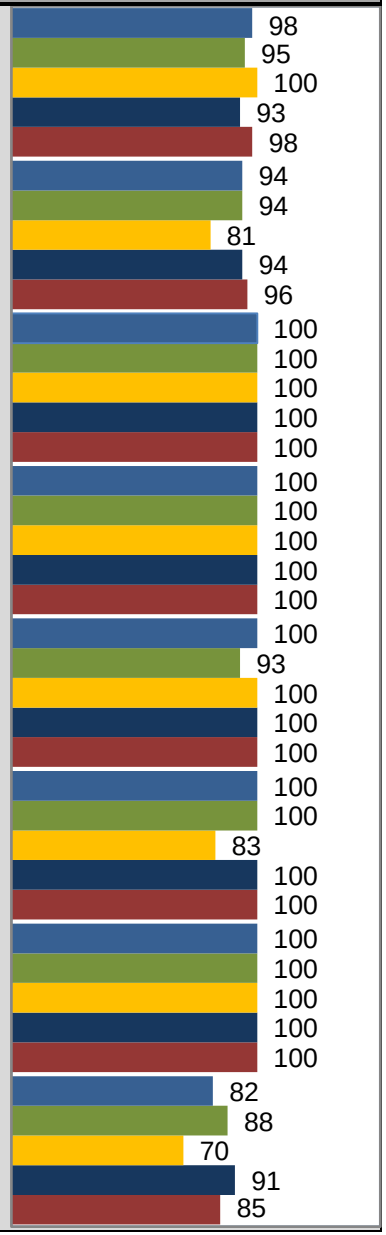


Table continues on next page.

Standard	# of Elements	MCO	# Met or NR 3 points	# Partially Met 2 points	# Not Met 1 point	# Not Met 0 points	Total Score (% of points attained)
Enrollee Rights	14	AMG	13	1	0	0	98
		CCW	12	2	0	0	95
		CHPW	14	0	0	1	100
		MHW	12	0	1	1	93
		UHC	13	1	0	0	98
Grievance System	18	AMG	16	1	1	0	94
		CCW	16	1	1	0	94
		CHPW	11	4	3	0	81
		MHW	17	0	0	1	94
		UHC	16	2	0	0	96
Practice Guidelines	3	AMG	3	0	0	0	100
		CCW	3	0	0	0	100
		CHPW	3	0	0	0	100
		MHW	3	0	0	0	100
		UHC	3	0	0	0	100
Provider Selection	4	AMG	4	0	0	0	100
		CCW	4	0	0	0	100
		CHPW	4	0	0	0	100
		MHW	4	0	0	0	100
		UHC	4	0	0	0	100
QA/PI Program	5	AMG	5	0	0	0	100
		CCW	4	1	0	0	93
		CHPW	5	0	0	0	100
		MHW	5	0	0	0	100
		UHC	5	0	0	0	100
Subcontractual Relationships/ Delegation	4	AMG	4	0	0	0	100
		CCW	4	0	0	0	100
		CHPW	3	0	1	0	83
		MHW	4	0	0	0	100
		UHC	4	0	0	0	100
Health Information Systems	3	AMG	3	0	0	0	100
		CCW	3	0	0	0	100
		CHPW	3	0	0	0	100
		MHW	3	0	0	0	100
		UHC	3	0	0	0	100
Health Homes	11	AMG	6	4	1	0	82
		CCW	9	1	0	1	88
		CHPW	5	3	2	1	70
		MHW	9	1	1	0	91
		UHC	7	3	1	0	85



In this year's review, MCOs' compliance scores demonstrated overall stability, with some performance declines and improvements in a few specific areas. Compliance with standards related to program integrity, timely claims payment, patient review and coordination, enrollment/disenrollment, practice guidelines, provider selection, QAPI, and subcontractual relationships and delegation remained steady compared to previous years, with all MCOs performing well. Coordination and continuity of care, coverage and authorization, grievance system, and Health Homes standards continue to be areas of weakness. Overall compliance with standards related to enrollee rights and protections declined slightly.

Enrollee rights and protections: One area that posed problems for MCOs was the liability for payment standard; in all cited cases, MCOs submitted missing or incomplete information to the State that did not correspond with the MCOs' other records on enrollees who had reported issues related to payment liability, balance billing, and inappropriate billing for covered services. Two MCOs also experienced difficulties meeting contractual customer service call center requirements.

Coordination and continuity of care: Although MCOs still experienced issues across this area of review in 2017 RY, most plans showed some improvement. UHC received a score of Met in all areas, and MHW received a score of Met in all but one. Particular findings included a lack of documented processes in several areas: identification (for identifying existing enrollees as having special healthcare needs); transitional care (for identifying discharge dates for enrollees in facilities); and skilled nursing facility coordination (for detailing care coordination activities for enrollees moving from acute hospital facilities to nursing care).

The principal area of difficulty for MCOs, as in years past, was assessment and treatment plans. Three MCOs received scores of Partially or Not Met in this section. Issues centered around a lack of documentation in clinical charts supporting the occurrence of a variety of essential care coordination activities: conducting an initial health assessment within 60 days of the initial health screen; developing and maintaining care coordination goals and interventions and a care coordination plan for each enrollee; and including assistance with accessing mental health, SUD, or other external services in routine care coordination activities.

CCW and MHW both received distinctions for best practices in two areas of care coordination: skilled nursing facility coordination and care coordination with BHOs, which included examples of data sharing and quarterly meetings with BHOs, and identification of barriers to skilled nursing facility placement, as well as strategies to address them.

Coverage and authorization: This year's review showed declining scores for all plans, to varying degrees. CHPW scored particularly poorly in this area. All plans received findings for the authorization of services standard. MCOs either did not consistently consult with the requesting provider prior to denying services, did not always provide evidence of medical necessity in making decisions, did not provide evidence of the decision-maker's expertise necessary to make or deny authorizations, did not provide transitional care services, or did not always refer individuals with special healthcare needs to care coordination services. In several cases, the MCO's utilization program evaluation did not include an analysis of trends in denials and appeals, demonstrating thorough assessment of the UM program.

MCOs also continue to have issues with the administration of the notice of adverse action, both with regard to the content and submission of the notice. Two MCOs consistently sent letters to enrollees that did not meet HCA criteria for readability and clarity, and three MCOs did not provide evidence that notifications were sent to the enrollee in writing, or that the enrollee and provider were always notified of the adverse determination.

Grievance system: Overall, MCOs showed little performance change in this area, with considerable room for improvement. Three MCOs received a score of Not Met for the handling of grievances and appeals, either for using outdated materials, failing to send appeal acknowledgment letters to the provider or sending them late, or failing to send an appeal insert with an acknowledgement letter offering the MCO's assistance in completing appeal-related forms. One MCO additionally received a Not Met score for lack of evidence that the MCO consistently informed enrollees of the right to present their case or the right to examine the case file during the appeal process.

Four MCOs received findings for issues related to resolution and notification of grievances and appeals: TEAMonitor's review of appeal files indicated that MCOs either did not always attempt to provide oral notice of a resolution, or did not always handle grievances within 45 days. Reviewers also noted appeal files that were missing crucial information, such as the date the appeal was resolved, the reason for the decision, or whether the enrollee was liable for payment.

Health Homes: This year's review of the standards related to Health Homes showed more plans experiencing more issues in this area than in 2016 RY. The contractual standard for which every plan received a finding was related to HCA encounter data reporting. Issues centered on failing to consistently reconcile and correct encounter data related to Health Homes services, and encounter data submissions that did not always match the service tier provided by the MCO.

Additionally, three MCOs received findings related to the Health Action Plan standard, and two MCOs received several findings for the New Health Homes contractual standards.

Corrective Action Plans

All compliance elements scored as Partially Met and Not Met require a corrective action plan. In addition to scoring current-year compliance efforts, TEAMonitor's assessment includes reviewing the CAPs assigned in the previous review year and determining if CAPs have been completed. MCOs are not eligible to receive a score of Met for elements for which a previous-year CAP was incomplete or inadequately completed.

Table 7 identifies the number of MCOs required to submit CAPs as a result of the 2017 review. The numbers preceding each element below denote the section within the Code of Federal Regulations (CFR) in which the element appears. The numbers that follow each element denote the corresponding Apple Health Managed Care contract requirement.

Table 7: TEAMonitor Compliance Review Summary of Issues

Compliance Area	42 CFR and Apple Health Contract Citation	Number of Plans with Findings
Availability of Services		
	438.206 (b)(1)(i-v) Delivery network 438.207(b)(1)(2) Assurances of adequate capacity and services, 6.1. 6.2, 6.3, 6.5	0
Program Integrity		
	438.608(a)(b) Program integrity requirements, 12.6	0

Care Coordination and Continuity of Care		
	438.208(c)(1) Identification, 14.2	2
	438.208(c)(26) Assessment and treatment plans and care coordination for individuals with special health care needs, 14.3 and 14.12	3
	Apple Health—Continuity of care, 14.1	0
	Apple Health—Coordination between contractor and external entities, 14.4	1
	Apple Health—Transitional care, 14.5	1
	Apple Health—Skilled nursing facility coordination, 14.6	1
	Apple Health—Care Coordination Oversight, 14.10	1
	Apple Health—07-02–Patient Review and Coordination (PRC), 16.12.1	1
	Apple Health—07-05–Patient Review and Coordination,16.12.4—Notice to Member and 16.12.8	1
Coverage and Authorization		
	438.210(b)(1)(2)(3) Authorization of services, 11.1, 11.3	5
	438.210(c) Notice of adverse action, 11.3.4.2	3
	438.210(d) Timeframe for decisions (1) (2), 11.3.5	2
	Apple Health—Outpatient mental health,16.5.13	1
	Apple Health—Emergency contraceptives, 16.8.16.1.7.1 (new in 2017)	3
Enrollee Rights		
	438.100(a) General rule, 10.1.1	0
	438.10(b) Basic rule, 3.4.2	0
	438.10(f) (2-6) General information, 3.2 and 6.17	1
	438.106 Liability for payment, 2.13 and 10.5	3
	Apple Health—Customer service, 6.6	2
Grievance Systems		
	438.402(a) The grievance system, general requirements	0
	438.402(b)(1) Filing requirements—Authority to file, 13.3.1	2
	438.402(b)(3) Filing requirements—Procedures	0
	438.404(b) Notice of action—Language and format,11.3.4.2.1	0
	438.404(b) Notice of action—Content of notice,11.5	1
	438.404(c) Notice of action—Timing of notice, 11.3.5 and 13.3.9	1
	438.406(a) Handling of grievances and appeals—General requirements, 13.1	3

	438.406(b) Handling of grievances and appeals—Special requirements for appeals, 13.4	1
	438.408(a) Resolution and notification: Grievances and appeals—Basic rule, 11.4.5 and 13.3.10	1
	438.408(b) and (c) Resolution and notification: Grievances and appeals—Specific timeframes and extension of timeframes, 13.3.10 and 13.4.3	2
	438.408(d) and (e) Resolution and notification: Grievances and appeals—Format of notice and content of notice of appeal resolution, 13.3.11	3
Quality Assessment and Performance Improvement (QAPI)		
	438.240(e) Basic elements of MCO and PIHP quality assessment and performance improvement—Evaluating the program, 7.1.1.2.4 and 7.3.9	1
Subcontractual Relationships and Delegation		
	438.230(b)(2) Subcontractual relationships and delegation— written agreement, 9.4	1
Apple Health Contract—Health Homes		
	Health Care Authority Encounter Data Reporting Guide (Administrative), (Apple Health Contract Exhibit C 2.1.3)	4
	Administrative (Apple Health Contract Exhibit C Section 3)	2
	Administrative (Apple Health Contract Exhibit C Section 2.3)	1
	Administrative (Apple Health Contract Exhibit C Section 2.1.7)	1
	Health Action Plan (HAP) (Apple Health Contract Exhibit C 5.1, 5.3, 5.5 and 5.5.7)	5
	Comprehensive Care Management (Apple Health Contract Exhibit C 5.6)	2
	Care Coordination and Health Promotion (Apple Health Contract Exhibit C 5.7)	1
	Transitional Care (Apple Health Contract Exhibit C 5.8)	1
	Individual and Family Support (Apple Health Contract Exhibit C 5.9)	1

Recommendation

In this year's review, MCOs' scores demonstrated overall slight improvement, notably with enrollee rights and coordination and continuity of care standards. However, coordination and continuity of care, coverage and authorization, and grievance system standards continue to be areas of weakness.

- HCA needs to consider education or training efforts to address coordination and continuity of care, and transitional care with MCOs. These areas have been historically problematic, and additional efforts may be needed to ensure adequate care for enrollees, particularly with the integration of physical and behavioral healthcare services.

Performance Improvement Project Validation

Medicaid managed care organizations (MCOs) are federally required to design and implement a series of performance improvement projects (PIPs) intended to effect sustaining improvements in care delivery.

Apple Health MCOs were required to conduct the following PIPs in 2016 CY:

- one clinical PIP piloting a mental health intervention that is evidence-based, research-based, or a promising practice and is recognized by the Washington State Institute for Public Policy (WSIPP)
- one collaborative clinical statewide PIP, conducted in partnership between the Department of Health and the Apple Health MCOs, focused on improving well-child visit rates in infants, young children, and adolescents
- additional clinical PIPs if the MCO's HEDIS rates were below the contractually required threshold for 2016 RY
- one non-clinical PIP of the MCO's choosing

In addition to the PIPs referenced above, the Apple Health Foster Care plan, CCW, was required to complete the following PIPs related to that program's population:

- one clinical or non-clinical PIP of the MCO's choosing
- one non-clinical PIP in partnership with MCOs, DSHS, and HCA

Integrated Managed Care plans were required to complete the following additional PIPs for the IMC and Behavioral Health Services Only (BHSO) enrollees:

- one clinical PIP piloting a behavioral health intervention for adults that is evidence-based, research-based, or a promising practice and is recognized by the Washington State Institute for Public Policy (WSIPP).
- one clinical PIP piloting a behavioral health intervention for children that aligns with the goals of the Children's Behavioral Health Measures of Statewide Performance

As a component of its review, HCA conducted a validation of the MCOs' PIPs. Table 8 displays the MCOs' PIP study topics. N/A in the results column indicates the MCO was not required to complete the given PIP. For a full description of HCA's methodology for PIP validation, please see Appendix D.

Table 8: MCO PIP Study Topics

MCO	Study Topic		Result
AMG	Clinical PIP: WSIPP	Clinical Mental Health Intervention Adult PIP—evidence-based collaborative effort for depression, anxiety comorbid depression, and chronic health	Not Met
	Clinical, Collaborative PIP	Improving Well-child Visit Rates in Infants, Young Children, and Adolescents	Met
	Non-clinical PIP	Improving Member Engagement and Satisfaction	Partially Met
	HEDIS PIP	Child Immunizations—Combo 2	Partially Met
	HEDIS PIP	Well-child Visits—0–15 months	N/A
	HEDIS PIP	Well-child Visits—3–6 years	Partially Met
	HEDIS PIP	Well-child Visits—adolescents	Partially Met

CCW	Clinical PIP: WSIPP AHMC and AHFC	Integrated Children's ADD Wellness Initiative	Not Met
	Clinical, Collaborative PIP	Improving Well-child Visit Rates in Infants, Young Children, and Adolescents	Met
	Non-clinical PIP	Improving Adult Male Access to Preventive/Ambulatory Health Services in Members Ages 20–64.	Not Met
	HEDIS PIP	Child Immunizations—Combo 2	Not Met
	HEDIS PIP	Well-child visits—0–15 months	N/A
	HEDIS PIP	Well-child visits—3–6 years	Partially Met
	HEDIS PIP	Well-child Visits—adolescents	Not Met
	Foster Care PIP	Improving Resiliency in Members 18–26 with an Adverse Childhood Experiences (ACEs) score ≥ 4	Not Met
	Foster Care: Non-clinical PIP in partnership with MCO/DSHS/HCA	Improving Access to Preventive Care for Members in Relative-care Placement	Not Met
CHPW	Clinical PIP: WSIPP	Proactive Prior Authorizations for Antidepressant Medication Adherence	Partially Met
	Clinical, Collaborative PIP	Improving Well-child Visit Rates in Infants, Young Children and Adolescents	Met
	Non-clinical PIP	Improving Utilization for High-Risk Members through Community Care Coordination	Partially Met
	HEDIS PIP	Child Immunizations—Combo 2	Partially Met
	HEDIS PIP	Well-child Visits—0–15 months	Partially Met
	HEDIS PIP	Well-child Visits—3–6 years	Partially Met
	HEDIS PIP	Well-child Visits—adolescents	Partially Met
	IMC Clinical PIP: WSIPP, Adults	Out-patient Engagement Post Psychiatric Inpatient Hospitalization	Met
	IMC Clinical PIP: WSIPP, Children	Caregiver Attachment in Young Children Exposed to Trauma	Partially Met
MHW	Clinical PIP: WSIPP	Effective Provider Collaboration: Enhancing Behavioral Parent Training (BPT) for Parents of Children with Attention-Deficit/Hyperactive Disorder (ADHD)	Partially Met
	Clinical, Collaborative PIP	Improving Well-child Visit Rates in Infants, Young Children and Adolescents	Met
	Non-clinical PIP	Bridging the Gap: Level of Provider Engagement and Quality Improvement	Not Met
	HEDIS PIP	Child Immunizations—Combo 2	Partially Met
	HEDIS PIP	Well-child Visits—0–15 months	Met
	HEDIS PIP	Well-child Visits—3–6 years	Partially Met
	HEDIS PIP	Well-child Visits—adolescents	Partially Met
	IMC Clinical PIP: WSIPP, Adults	Collaborative Primary Care for Depression	Partially Met
	IMC Clinical PIP: WSIPP, Children	Effective Provider Collaboration: Enhancing Behavioral Parent Training (BPT) for Parents of Children with Attention-Deficit/Hyperactive Disorder (ADHD)	Partially Met

UHC	Clinical PIP WSIPP	Increase Anti-Depressant Treatment Plan Compliance for Adult, Female, TANF members diagnosed with depression (anti-depressant medication management)	Partially Met
	Clinical, Collaborative PIP	Improving Well-child Visit Rates in Infants, Young Children and Adolescents	Met
	Non-clinical PIP	Increasing the Rate of Members Receiving Diabetic Education Services	Not Met
	HEDIS PIP	Child Immunizations—Combo 2	Not Met
	HEDIS PIP	Well-child Visits—0–15 months	Met
	HEDIS PIP	Well-child Visits—3–6 years	Partially Met
	HEDIS PIP	Well-child Visits—adolescents	Partially Met

Source: Washington State Health Care Authority

Scoring

In scoring the MCOs' PIPs, TEAMonitor used the following criteria:

To achieve a score of Met, the PIP must demonstrate all of the following 12 elements:

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

To achieve a score of Partially Met, the PIP must demonstrate all of the following seven elements:

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

A Not Met score results from demonstrating any one of the following:

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

Summary of PIP Validation Results

HCA's review of the MCOs' PIPs found that overall, while plans generally identified topics important in addressing enrollee needs or gaps in service delivery, they struggled with presenting the details of study design, implementation, and data analysis clearly and in sufficient detail.

For the required clinical WSIPP PIP, all plans received a score of Not Met or Partially Met. Topics centered on improving enrollee compliance with medication management, including antidepressant, attention deficit disorder (ADD), and attention deficit hyperactivity disorder (ADHD) medication management. Several plans received deductions for providing insufficient detail regarding the chosen intervention(s), for choosing interventions not clearly linked to the barrier analysis, or for lack of evidence that a robust barrier analysis had been conducted. One PIP included an indicator in the study description but did not include data indicating that the indicator had been used in the study as designed. Additionally, in most cases the MCO did not explicitly address whether the PIP's interventions were recognized by WSIPP; in future, this will be a required element.

Reviewers found similar issues with the IMC WSIPP PIPs conducted by MHW and CHPW, although CHPW's adult-focused PIP on improving outpatient engagement post-psychiatric inpatient hospitalization for better long-term outcomes received a score of Met.

The MCOs' non-clinical PIP topics also all received scores of Partially Met or Not Met. In some cases, reviewers noted that chosen topics, such as increasing the rate of members receiving diabetic services or using the community care coordination model to reduce high-risk enrollee utilization, were worthwhile. However, in most cases, the PIPs lacked an identified connection between barriers and the chosen intervention or an analysis of the connection between the intervention and the outcome. Others lacked detail around crucial study design elements, such as study indicators and study population. Additionally, three non-clinical PIPs did not undergo a full year of intervention implementation and measurement, as assigned.

For the 18 HEDIS PIPs MCOs were required to complete, HCA issued two scores of Met. For those two, completed by MHW and UHC, reviewers cited strong analysis of interventions and results, a thorough data analysis plan, and an explanation of changes made to the interventions as strong points. A number of these PIPs were scored down to Partially Met as a result of lack of improvement in HEDIS scores, which serve as the PIP indicator, despite sound construction and thorough documentation. However, other PIPs received deductions for insufficiently interpreting results, for failing to change the intervention

after the previous measurement cycle yielded no improvement, or neglecting to describe planned changes for the next measurement period's intervention.

The PIPs CCW conducted for the Apple Health Foster Care program were also both scored as Not Met. While HCA acknowledged value in the study topics, the study design for both PIPs was poorly described, and interventions were not linked to a robust barrier analysis.

MCOs produced the best results on the collaborative PIP designed to improve well-child rates in infants, children, and adolescents. Although this PIP has not undergone a full measurement period, its design and essential components were well articulated and clear. On this PIP all MCOs received a score of Met.

Opportunity for Improvement

MCOs received scores of Partially or Not Met on the majority of the PIPs they were assigned in 2016 CY. While identified topics generally targeted important enrollee needs or gaps in service delivery, PIP design was frequently lacking in clarity and specificity, and data and results analysis was often insufficient.

- HCA should continue to provide trainings and possibly technical assistance to the MCOs and their staff on PIP study design and implementation.

Performance Measure Review

The performance of Apple Health MCOs with respect to the accessibility, timeliness, and quality of care and services furnished to enrollees can be measured quantitatively through two nationally recognized and standardized data sources. The first source is the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA), which is a widely used set of healthcare performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over eight domains of care; they also allow MCOs to determine where quality improvement efforts may be needed[6]. The HEDIS data are derived from provider administrative and clinical data. The second source is the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which was developed under direction of the U.S. Agency for Healthcare Research and Quality (AHRQ). The CAHPS data measure member experience through a survey of plan members.

Healthcare Effectiveness Data and Information Set (HEDIS)

Qualis Health assessed audited MCO-level HEDIS data for the 2017 reporting year (RY) (measuring enrollee experience during calendar year 2016), including 46 measures comprising 168 specific indicators. Many measures include more than one indicator, usually for specific age groups or other defined population groups. Of the 46 measures, 39 relate to effectiveness of care, and 7 relate to utilization.

The HEDIS effectiveness of care measures (broken into categories of access, prevention, chronic care management, and appropriateness of care in the following section) are considered to be unambiguous performance indicators, whereas the utilization measures are more indicative of the overall risk profile of the population and can vary based on characteristics outside the control of the MCO.

It should be noted that the HEDIS measures are not risk adjusted and may vary from MCO to MCO because of factors that are out of a health plan's control, such as medical acuity, demographic characteristics, and other factors that may impact enrollees' interaction with healthcare providers and systems. NCQA has not developed methods for risk adjustment of these measures.

Many of the HEDIS measures are focused on a narrow eligible patient population for which the measured action is almost always appropriate, regardless of disease severity or underlying health condition.

Data Collection and Validation

In the first half of 2017, each MCO participated in an NCQA HEDIS Compliance Audit™ to validate accurate collection, calculation, and reporting of HEDIS measures for the member populations. This audit does not analyze HEDIS results; rather, it ensures the integrity of the HEDIS measurements.

Using the NCQA-standardized audit methodology, NCQA-certified auditors assessed each MCO's information systems capabilities and compliance with HEDIS specifications. HCA and each MCO received

[6] http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx

an on-site report and final report of all audit activity; all Apple Health MCOs were in compliance with HEDIS specifications.

Administrative Versus Hybrid Data Collection
HEDIS measures draw from clinical data sources, utilizing either a fully "administrative" collection method or a "hybrid" collection method. The administrative collection method relies solely on clinical information that is collected from the electronic records generated in the normal course of business, such as claims, registration systems, or encounters, among others. In some delivery models, such as undercapitated models, healthcare providers may not have an incentive to report all patient encounters, so rates based solely on administrative data may be artificially low. For measures that are particularly sensitive to this gap in data availability, the hybrid collection method supplements administrative data with a valid sample of carefully reviewed chart data, allowing health plans to correct for biases inherent in administrative data gaps. Hybrid measures therefore allow health plans to overcome missing or erroneous administrative data by using sample-based adjustments. As a result, hybrid performance scores will nearly always be the same or better than scores based solely on administrative data.

Supplemental Data
In calculating HEDIS rates, the Apple Health MCOs used auditor-approved supplemental data, which is information generated outside of a health plan's claims or encounter data system. This supplemental information included historical medical records, lab data, immunization registry data, and fee-for-service data on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provided to MCOs by HCA. Supplemental data was used in determining performance rates for both administrative and hybrid measures. For hybrid measures, supplemental data provided by the State reduced the number of necessary chart reviews for MCOs, as MCOs were not required to review charts for individuals who, per HCA's supplemental data, had already received the service.

Member-level Data
Additionally, HCA required MCOs to submit de-identified member-level data for all administrative and hybrid measures. Member-level data enable HCA and Qualis Health to conduct analyses relating to racial and geographic disparities to identify quality improvement opportunities. Analyses based on member-level data are included in the *2017 Comparative Analysis Report* and the *2017 Regional Analysis Report*.

Calculation of the Washington Apple Health Average
This report provides estimates of the average performance among the five Apple Health MCOs for the four most recent reporting years, 2014, 2015, 2016, and 2017 RY. The state average for a given measure is calculated as the weighted average among the MCOs that reported the measure (usually five MCOs), with MCOs' shares of the total eligible population used as the weighting factors.

Summary of HEDIS Performance Measure Results

The following results present the Apple Health MCO average (the state rate) compared to national benchmarks, derived from the Quality Compass[7], the NCQA's database of HEDIS results for health plans. For comparative plan performance, readers may refer to the *2017 Comparative Analysis Report*.

[7] Quality Compass® 2017 is used in accordance with a Data License Agreement with the NCQA.

Access to Care

HEDIS access to care measures relate to whether enrollees are able to access primary care providers at least annually, whether children are able to access appropriate well-care services, and whether pregnant women are able to access adequate prenatal care. These measures reflect the accessibility and timeliness of care provided.

NOTE: Last year, when reporting 2016 RY rates, CHPW experienced data reporting and collection issues that significantly impacted its individual as well as statewide rates on a number of measures, particularly those related to child and adolescent access and maternal care. CHPW remedied the situation; as a result, this year's reported statewide rates for these measures are more aligned with statewide averages reported in prior years.

Statewide rates for all access measures improved at the state level between 2016 and 2017 RY, except for adult access to primary care, which declined slightly yet significantly for all age groups (given the large population size). Child and adolescent access measures shifted up substantially, reflecting CHPW's correction of its data collection and reporting issue. Despite improvements, performance on a number of access measures, including adult access to primary care, well-care visits for children 3–6 and adolescents 12–21, and the maternal health measures, are all below the 40th percentile of performance nationwide. Table 9 on the next page displays the statewide results of these measures for the last four reporting years.

Table 9: Access to Care HEDIS Measures, 2014–2017 RY

	2014 State Rate	2015 State Rate	2016 State Rate	2017 State Rate	2017 National Quintile*
Adults' Access to Preventive/Ambulatory Health Services					
20–44 years	NR	77.9	71.8	71.1	
45–64 years	NR	84.6	80.4	79.9	
Children and Adolescents' Access to Primary Care Practitioners					
12–24 months	97.3	97.5	92.7	96.7	
25 months–6 years	87.5	88.8	81.9	86.4	
7–11 years	91.2	91.9	87.5	91.2	
12–19 years	90.8	91.2	87.5	90.8	
Well-Care Visits					
0–15 months	64.0	56.8	60.3	66.3	
3–6 years	65.1	66.6	66.7	67.9	
12–21 years	42.7	42.6	43.3	45.8	
Maternal Health					
Timeliness of Prenatal Care	NR	73.7	68.2	77.9	
Frequency of Prenatal Care (>81% of recommended visits)	NR	43.8	40.3	49.4	
Postpartum Care	NR	51.6	52.2	58.8	

* Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.

NR: Not reported during the 2014 reporting year

 Below the 20th Percentile

 20th to 39th Percentile

 40th to 59th Percentile

 60th to 79th Percentile

 At or above the 80th Percentile

Preventive Care

Preventive care measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. These measures reflect MCO access and quality.

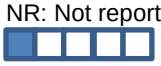
Performance on many preventive care measures improved or remained steady between 2016 and 2017 RY. The state performed at or above the 60th percentile of Medicaid plans nationwide on children's combination 10 (receipt of all recommended childhood vaccines) and adult BMI percentile assessment. However, rates for children's BMI percentile assessment, nutrition and physical activity counseling, and women's health screenings remain below the 40th percentile of national performance. Table 10 displays results for preventive care measures.

Table 10: Preventive Care HEDIS Measures, 2014–2017 RY

	2014 State Rate	2015 State Rate	2016 State Rate	2017 State Rate	2017 National Quintile*
Weight Assessment and Counseling					
Children's BMI Percentile Assessment	39.7	36.7	45.8	58.0	
Children's Nutrition Counseling	47.6	51.1	57.4	58.7	
Children's Physical Activity Counseling	43.1	45.1	53.5	53.2	
Adult BMI Percentile Assessment	NR	82.2	85.0	90.2	
Immunizations					
Children's Combination 2	70.7	70.9	71.4	70.5	
Children's Combination 10	39.4	41.6	40.8	36.9	
Adolescents' Combination 1	67.0	73.7	74.2	76.6	
HPV Vaccination	NR	NR	NR	22.3	
Women's Health Screenings					
Breast Cancer Screening	NR	54.4	52.3	53.5	
Cervical Cancer Screening	NR	50.4	52.8	55.8	
Chlamydia Screening	NR	51.2	54.8	54.4	

* Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.

NR: Not reported during the 2014 reporting year

 Below the 20th Percentile

 20th to 39th Percentile

 40th to 59th Percentile

 60th to 79th Percentile

 At or above the 80th Percentile

Chronic Care Management

Chronic care management measures relate to whether enrollees with chronic conditions are able to receive adequate outpatient management services to prevent worsening of chronic conditions and more costly inpatient services. These measures reflect access and quality.

Statewide performance on most chronic care management measures either improved slightly or remained steady in 2017 RY, and overall performance was strong. Additional scrutiny may be necessary on the antidepressant medication management measures, which both fell statewide in 2017 RY.

Table 11: Chronic Care Management HEDIS Measures, 2014–2017 RY

	2014 State Rate	2015 State Rate	2016 State Rate	2017 State Rate	2017 National Quintile*
Diabetes Care					
HbA1c Testing	88.1	90.4	88.3	89.6	
Eye Examinations	49.6	54.8	55.5	59.1	
Medical Attention for Diabetic Nephropathy	79.9	83.4	88.9	90.1	
Blood Pressure Control (<140/90)	59.7	63.7	63.0	66.0	
HbA1c Control (<8.0%)	45.7	46.3	39.0	49.6	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NR	85.9	85.6	85.0	
Diabetes Monitoring for People with Diabetes and Schizophrenia	NR	68.6	70.3	69.7	
Other Chronic Care Management					
Controlling High Blood Pressure (<140/90)	NR	53.6	53.5	56.0	
Antidepressant Medication Management (Acute Phase)	NR	51.7	54.2	50.8	
Antidepressant Medication Management (Continuation Phase)	NR	37.0	39.4	35.4	
Medication Management for People with Asthma: 75% Compliance (Ages 5–11)	NR	21.8	22.1	23.4	
Medication Management for People with Asthma: 75% Compliance (Ages 12–18)	NR	21.3	23.2	25.7	
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)	NR	37.7	38.7	43.1	
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase)	NR	39.1	48.2	53.5	

* Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.

NR: Not reported during the 2014 reporting year

Below the 20th Percentile

20th to 39th Percentile

40th to 59th Percentile

60th to 79th Percentile

At or above the 80th Percentile

Appropriateness of Care

Appropriateness of care measures relate to whether enrollees receive non-medically-indicated care. These measures reflect MCO quality.

Apple Health MCOs performed well on measures relating to appropriateness of care in 2017 RY. Each of the measures in Table 12 relates to the percentage of individuals who did not receive inappropriate services (meaning higher scores indicate better performance). Uniformly high performance on these measures indicates that Apple Health enrollees are not receiving potentially expensive unnecessary interventions.

Table 12: Appropriateness of Care HEDIS Measures, 2014–2017 RY

	2014 State Rate	2015 State Rate	2016 State Rate	2017 State Rate	2017 National Quintile*
Imaging for Low Back Pain	NR	77.7	76.3	74.3	
Antibiotics for Acute Bronchitis (Adults)	NR	29.3	30.3	36.1	
Antibiotics for Upper Respiratory Tract Infections (Children)	NR	92.6	93.5	93.7	

* Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.

NR: Not reported during the 2014 reporting year

 Below the 20th Percentile

 20th to 39th Percentile

 40th to 59th Percentile

 60th to 79th Percentile

 At or above the 80th Percentile

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The measures included in the CAHPS surveys enable inclusion of patient- or enrollee-reported experience, an important performance area that cannot be derived from medical record data alone. In the spring of 2017, Apple Health MCOs conducted the CAHPS 5.0H Child Medicaid with Chronic Conditions survey.

Data Collection and Validation

Each MCO individually contracted with a certified CAHPS vendor to administer the CAHPS 5.0 Child Medicaid with Chronic Conditions survey to its enrollees. Parent/caregiver respondents were surveyed in English or Spanish. All MCOs used a pre-approved enhanced mixed-mode protocol based on NCQA HEDIS guidelines. The four-wave mixed-mode protocol consisted of an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing and second reminder postcard to non-respondents, and finally a phone follow-up to non-respondents with a valid telephone number. A random sample of 26,461 cases was drawn of households from across the five participating MCOs. Data were gathered from 6,432 respondents; responses were analyzed and reported to HCA in August 2017.

Summary of CAHPS Performance Measure Results

The following results present the Apple Health MCO average rating as compared to national benchmarks, derived from the NCQA Quality Compass. For comparative plan performance on the CAHPS survey results, readers may refer to the *2017 Enrollee Quality Report*.

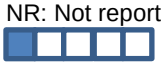
Table 13 compares 2017 RY performance with 2015 RY performance, the last time the child population was surveyed. Although results for four domains were at or above the 80th percentile of national performance, results for another four domains were in the lowest 20th percentile of national performance. These included Getting Care Quickly and Getting Needed Care, which may reflect low rates of access as indicated by HEDIS performance measure data. In 2016, when MCOs conducted the CAHPs 5.0 Adult Medicaid Survey, Getting Needed Care and Getting Care Quickly also ranked poorly (below the lowest 20th and 40th national percentiles, respectively).

Table 13: CAHPS Ratings Results, 2015–2017 RY

	2015 Rating	2016 Rating	2017 National Quintile*
Rating of Overall Health Care (Scored 9 or 10 out of 10)	63.0	64.6	
Rating of Personal Doctor (Scored 9 or 10 out of 10)	73.6	73.3	
Rating of Specialist Seen Most Often (Scored 9 or 10 out of 10)	72.0	71.0	
Rating of Plan (Scored 9 or 10 out of 10)	64.7	65.2	
Getting Needed Care	55.6	54.5	
Getting Care Quickly	66.6	67.8	
How Well Doctors Communicate	76.8	78.2	
Customer Service	66.5	64.9	

* Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.

NR: Not reported during the 2014 reporting year

 Below the 20th Percentile

 20th to 39th Percentile

 40th to 59th Percentile

 60th to 79th Percentile

 At or above the 80th Percentile

Recommendations

HEDIS measure results reflected low Apple Health performance on adult access to primary care, well-child visits for children 3–6 years, maternal health measures, children/adolescents' BMI percentile and nutrition/physical activity counseling measures, and women's health screenings.

- HCA needs to monitor rates of adult access to primary care, which have shown improvement but are still considerably lower than national rates. Specifically, HCA should seek root causes for low access rates for 20–44-year-olds in Apple Health Adult Coverage and Integrated Managed Care, which are much lower than rates for other members of the Medicaid population, and determine whether action is needed. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.
- Examine barriers to well-child visits for children ages 3–6, and determine whether statewide action is necessary. This measure did not show improvement in 2017 RY and is still below the national 50th percentile. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.
- To sustain improvements demonstrated by plans in 2017 RY, HCA should continue to monitor and emphasize maternal health measures, weight assessment and counseling for children/adolescents measures, women's health screenings, and antidepressant medication management. While performance on many of these measures improved from 2016 RY to 2017 RY, rates are all considerably below national averages, and plans should strive for continued improvement. To bring statewide performance in line with national standards, HCA should consider setting statewide performance benchmark goals for MCOs.

MCOs performed below the 20th percentile nationwide for four out of eight reported CAHPS survey questions. Given the interconnectedness of the variables impacting these scores, improvement efforts directed toward one or two process measures are likely to positively impact CAHPS results as a whole.

- HCA needs to encourage MCOs to increase focus on improving two easily definable CAHPS measures, Getting Needed Care and Getting Care Quickly, in an effort to improve CAHPS survey results globally.

Review of Previous-Year EQR Recommendations

Required external quality review activities include a review of the applicable state organization's responses to previously issued EQR recommendations. Table 14 displays Qualis Health's 2016 recommendations and suggested opportunities for improvement and HCA's responses.

Qualis Health has determined that HCA is taking comprehensive steps to address the issues outlined below. In 2017 CY, in response to plans' low HEDIS performance rates, HCA issued letters to all MCOs, requiring them to submit detailed quality improvement work plans for 2017. In their plans, MCOs were required to provide detailed descriptions of quality improvement efforts, including methods for assessing barriers to adult access to primary care and to prenatal care, and steps for implementing interventions aimed at eliminating barriers and improving access. Plans were also tasked with improving CAHPS measures, specifically those related to Getting Needed Care and Getting Care Quickly.

HCA also required plans to participate in a joint collaborative workgroup in 2017 CY to promote and increase the number of well-child visits.

Table 14: Review of HCA Responses to 2016 EQR Recommendations

Prior-Year Recommendations	HCA Response
Quality Strategy MCOs and BHOs would benefit from the guidance of an overarching State quality strategy (as required by federal regulation) that clearly defines statewide managed care program goals and targets for improvement. The State has not yet completed or released this joint quality strategy plan.	
The State needs to complete and distribute the State quality strategy to MCOs and BHOs, and hold BHOs and MCOs accountable for implementing their own quality strategy to align with the State's.	CMS is currently reviewing the HCA Quality Strategy submitted in 2017 [CY]. HCA requires the MCOs to have a Quality Assessment and Performance Improvement (QAPI) program description, an annual Quality Improvement work plan, and an annual evaluation of each MCO QAPI program. All these documents will be reviewed in 2018 as part of HCA's ongoing compliance monitoring. Managed care contracts specify content and QI-related activities the plans must conduct.
Integration With the progression of fully integrated managed care, collaboration among service networks is important in ensuring continued quality care.	
As the State continues to integrate the delivery of mental and physical healthcare services, the State needs to foster communication and collaboration between state agencies, MCOs, and BHOs to create transparency, ensure procedures are communicated, and minimize significant quality gaps. Best practices, when identified, should be shared broadly to ease IMC implementation across the state.	HCA has held regular meetings that include both MCOs and BHOs in the North Central region for the Integrated Managed Care program that begins January 1, 2018. Weekly-to-biweekly meetings are being held for the purpose of knowledge transfer. Topics include the details of contracting for specialized services, as well as programs based in the community. Prior to January 1, 2018, IMC implementation, the MCOs and BHOs meet several times to ensure open communication about policies

Prior-Year Recommendations	HCA Response
	for mental health and substance use disorder care delivery. As one example, a meeting with plenary speakers and breakout sessions was held. A second meeting is planned prior to North Central IMC implementation.
Performance Measures HEDIS measure results indicated that the MCO performance challenges were most prominent in adult access to primary care, child and adolescent access to primary care, well-child visits, maternal health, body mass index (BMI) assessments, and women's health screenings.	
HCA needs to continue to require that MCOs conduct PIPs when measure performance falls below HCA-designated standards. Additionally, HCA should consider requiring MCOs to conduct thorough root cause analyses and/or PIPs for performance measures that drop by more than 10 percentage points between reporting years.	• HCA continues to require MCOs to conduct formal performance improvement projects when individual MCO performance in the three well-child visit rates and childhood immunizations do not meet HCA performance standards. Additionally, all plans participate in a joint collaborative workgroup to improve well-child visit rates statewide. This group meets twice a month. • HCA requires MCOs to conduct a root-cause analysis and performance improvement plan for measures that drop by 10 percentage points or more from previous performance. • HCA implemented value-based purchasing initiatives in 2017 managed care contracts targeted at improving MCO performance in key performance measures.
In 2016 RY, HEDIS rates of adult access to primary care dropped for all MCOs, rates of child and adolescent access to primary care dropped for every age group at the state level, and all MCOs underperformed compared to national averages for timeliness and frequency of prenatal care. CAHPS scores for Getting Needed Care were also in the lowest quintile nationally.	
HCA needs to ensure the MCOs are closely monitoring and responding to barriers to adult and child members receiving primary care. Administrative data should be reviewed at least quarterly. To identify excessively low access rates and take steps to determine and remove barriers, the data should be appropriately disaggregated at local and regional levels consistent with local provider networks.	In 2016, HCA required MCOs to perform the following: • a barrier assessment of adult access to primary care and implementation of interventions to address barriers and improve performance • a barrier assessment to receiving prenatal care (both timeliness and frequency) and implementation of interventions to address barriers and improve performance • monitor performance at least quarterly through review of administrative or other data
HCA needs to require MCOs to identify barriers relating to receipt of prenatal care (both	See response above.

Prior-Year Recommendations	HCA Response
timeliness and frequency) to determine if statewide action is necessary, including potentially requiring MCOs to complete a statewide PIP on maternal health.	
HCA needs to require CHPW to complete a PIP on child and adolescent access to care.	In 2016, HCA required CHPW to conduct a performance improvement project on child and adolescent access to primary care. CHPW reported to HCA about several enrollee incentive and educational programs to encourage enrollees to and their parents to seek primary care.
MCOs performed in the lowest quintile nationwide for six out of eight reported CAHPS survey questions. Given the interconnectedness of the variables impacting these scores, improvement efforts directed toward one or two process measures are likely to positively impact CAHPS results as a whole.	
HCA needs to encourage MCOs to increase focus on improving two easily measurable CAHPS measures, Getting Needed Care and Getting Care Quickly, in an effort to improve CAHPS survey results globally.	In 2016, HCA required each MCO to implement a plan to improve CAHPS survey responses in Getting Needed Care and Getting Care Quickly.
Data Collection For the 2016 reporting year, HCA provided the MCOs with auditor-approved supplemental data, which were used in determining performance rates for administrative and hybrid measures. For hybrid measures, supplemental data provided by the State reduced the number of necessary chart reviews for MCOs, as MCOs were not required to review charts for individuals who, per HCA's supplemental data, had already received the service.	
HCA needs to continue to provide supplemental quality data to MCOs to reduce the burden of chart reviews and improve the integrity of statewide performance data.	HCA will continue to send supplemental data to the plans related to well-child visit and immunization rates to reduce MCO chart review burden and to improve the integrity of statewide performance data.
Compliance In this year's review, MCOs' scores demonstrated overall slight improvement, notably with enrollee rights and practice guidelines standards. Compliance with coordination and continuity of care, coverage and authorization, and grievance system standards continue to be areas of weakness.	
HCA needs to consider education or training efforts to address coordination and continuity of care, and transitional care with MCOs. These areas have been historically problematic, and though MCOs have shown improvement, additional efforts may be needed to ensure adequate care for enrollees.	The coordination and continuity of care section of HCA managed care contracts has undergone changes every year. Education and training efforts will occur with the MCOs to align with contractual changes.
Performance Improvement Projects MCOs did not receive timely feedback related to their contractually required performance improvement projects in 2016.	
HCA needs to provide MCOs with timely feedback on the design and implementation of each performance improvement project so that	HCA corrected this issue in 2017 so that MCOs received timely feedback on 2016 contractually required performance improvement projects. To

Prior-Year Recommendations	HCA Response
MCOs have the opportunity to address issues potentially impacting improvement to processes, healthcare outcomes, and enrollee satisfaction.	improve MCO project documentation, HCA developed a "PIP Tips" document to help MCOs with CMS-required documentation. Performance improvement projects were also the topic of one of the Medicaid Quality Forums attended by HCA, Qualis Health, and MCO Quality Improvement and HEDIS managers. HCA is considering approving MCO performance improvement project topics in advance of MCO project implementation in hopes of improving the process.

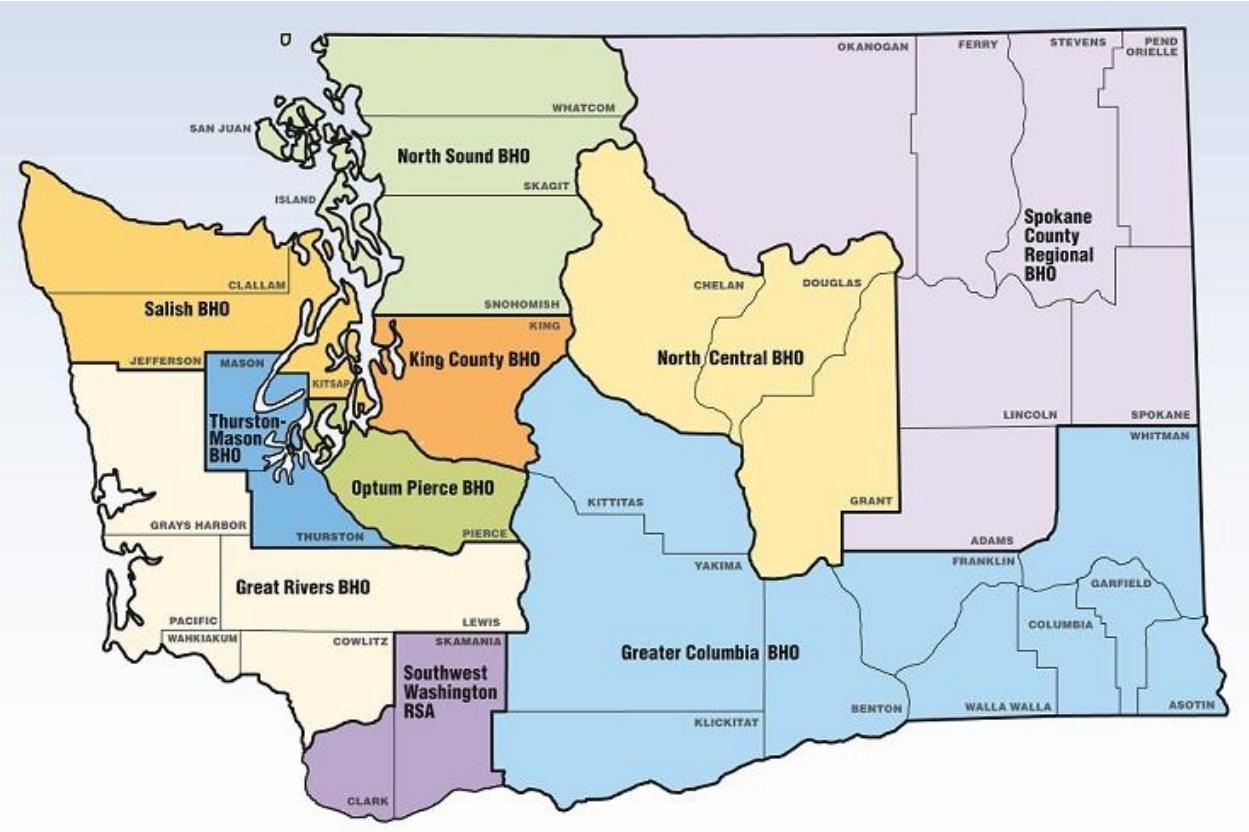
Behavioral Healthcare Provided by Behavioral Health Organizations

Introduction

As discussed in the Executive Summary of this report, Washington State is moving forward to integrate behavioral healthcare benefits into the Apple Health managed care program to provide clients with access to both physical and behavioral healthcare services through a single managed care plan. Although the integration is scheduled to be completed no later than 2020, the legislation allows regional county authorities to elect to move forward with the integrated managed care transition on an earlier timeline, if desired. A few regions have begun this transition, in which behavioral healthcare services purchased and administered by regional BHOs have been transferred to Apple Health MCOs through the IMC contracts administered by the HCA. North Central Behavioral Health Organization (NCBHO) chose to begin the process of moving forward as an integration "mid-adopter," beginning the transition in 2017 with the intention of fully transferring the administration of behavioral healthcare services in its region to MCOs by December 31, 2017.

Figure 2, below, shows the BHOs and their service areas.

Figure 2: Behavioral Health Organization Service Areas



Source: Washington State Division of Behavioral Health and Recovery

Compliance Review

The compliance portion of Qualis Health's external quality review of BHOs assesses overall performance, identifies strengths, and notes opportunities for improvement or recommendations requiring corrective action plans (CAPs) in areas where BHOs did not clearly or comprehensively meet federal and/or State requirements.

Methodology

Qualis Health evaluated the BHOs' performance on each element of the protocol by reviewing and performing desk audits on documentation submitted by the BHOs, conducting telephone interviews with the BHOs' contracted provider agencies; and conducting on-site interviews with the BHO staff.
The procedures for conducting the review included the following:

- performing desk audits on documentation submitted by each BHO
- conducting telephone interviews with two of each BHO's contracted mental health agencies and two of its substance use disorder (SUD) treatment providers
- reviewing up to ten each of grievances, appeals, and notices of action; State fair hearing cases; and cases of suspected fraud, waste, and abuse
- conducting on-site interviews with BHO staff on standards related to availability of services, coordination of care, and quality assessment and performance improvement; and performance improvement projects

Scoring

For the compliance section of the review, Qualis Health applied the three-point scoring metric using the following criteria, adapted from CMS guidelines:

Fully Met means all documentation listed under a regulatory provision, or component thereof, is present and BHO staff provided responses to reviewers that were consistent with each other's responses and with the documentation.

Partially Met means all documentation listed under a regulatory provision, or component thereof, is present, but BHO staff were unable to consistently articulate evidence of compliance, or BHO staff could describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.

Not Met means no documentation is present and BHO staff had little to no knowledge of processes or issues that comply with regulatory provisions, or no documentation is present and BHO staff had little to no knowledge of processes or issues that comply with key components of a multi-component provision, regardless of compliance determinations for remaining, non-key components of the provision.

Scoring Key

Fully Met (pass) ●	Partially Met (pass) ◉	Not Met ○

Summary of Compliance Results

Table 15: Results of BHO Compliance Review

	Availability of Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Provider Selection	Subcontractual Relationships and Delegation	Practice Guidelines	QAPI	Health Information Systems
Great Rivers (GRBHO)	◉	◉	●	●	●	●	●	●
Greater Columbia (GCBHO)	◉	◉	◉	◉	◉	◉	◉	◉
King County (KCBHO)	◉	◉	●	◉	◉	◉	◉	◉
North Sound (NSBHO)	◉	◉	◉	◉	●	●	◉	◉
Optum Pierce (OPBHO)	◉	◉	◉	◉	●	◉	◉	◉
Salish (SBHO)	◉	●	●	◉	●	●	◉	◉
Spokane (SCRBHO)	◉	◉	●	◉	◉	●	◉	◉
Thurston-Mason (TMBHO)	◉	◉	◉	◉	●	◉	◉	◉

Availability of Services

Table 16: Availability of Services Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues
Delivery Network/Network Adequacy Standards	438.206 (b)(1), 438.68	KCBHO,NSBHO, TMBHO, SBHO
Second Opinion	438.206 (b)(3)	KCBHO, TMBHO
Out-of-network Services	438.206 (b)(4)	KCBHO, SCRBHO, SBHO
Payment of Out-of-network Services	438.206 (b)(5)	
Provider Credentials	438.206 (b)(6), 438.214	KCBHO, NSBHO, TMBHO, GCBHO, GRBHO, SBHO
Timely Access	438.206 (c)(1)	OPBHO,NSBHO
Access and Cultural Considerations	438.206 (c)(2–3)	OPBHO, NSBHO, TMBHO, SCRBHO, GCBHO

Strengths: Access

- Most of the BHOs regularly monitor network sufficiency by measuring and reviewing:
  - the penetration rate of enrollees in both SUD treatment and mental health services
  - service utilization patterns, including provider caseloads
  - the geographic location of providers and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by enrollees

- Many BHOs have a strong, data-driven process for monitoring the timeliness of access to care across provider networks, which includes monitoring access compliance standards by auditing clinical records, reviewing grievance logs, and conducting enrollee surveys.

- All BHOs maintain an appropriate network of BHAs supported by written agreements.

- With the addition of SUD treatment services, all of the BHOs had to increase their provider networks. OPBHO increased its network capacity from 12 to 23 providers, including adding four additional evaluation and treatment (E&T) facilities and four additional residential treatment facilities (RTFs). Because of the increase in BHAs, the BHO hired two additional provider relations representatives in order to appropriately review and maintain the expanded provider network contracts and agreements, as well as the monthly and year-end deliverables.

- Several of the BHOs' contracted BHAs have systems in place, including mobile medical vans and visiting medical staff, to provide care to enrollees who have both mental health and medical needs.

- With the most diverse populated county, KCBHO has a mix of culturally diverse agencies that primarily provide services to enrollees of Hispanic, Asian, and African-American descent.

- GRBHO used its geo mapping and the results of an informal gap analysis conducted by its chief integration officer to focus its expansion processes into Grays Harbor and Lewis Counties.

Strengths: Timeliness

- Because all of the BHOs experienced an increase in enrollment since the implementation of the Patient Protection and Affordable Care Act, several of the BHOs supported their provider agencies in initiating same-day walk-in intakes and assessments in order to meet the increase in enrollment and service requests.

- Most BHOs actively monitor their provider networks to ensure there is timely access to the full range of Medicaid-covered services across their respective regions and to ensure that their providers perform in accordance with contract obligations.

- SBHO's BHA contracts and its policy on access to services include a requirement to provide timely access to care and services. In 2016, SBHO averaged 3.9 days between the request for mental health services and the first intake for the requested services; this was the shortest average timeframe among BHOs statewide.

Strengths: Quality

- Most BHOs have robust policies and procedures to address enrollees with limited English proficiency and diverse cultural and ethnic backgrounds and to ensure services are provided in a culturally competent manner for all enrollees.

- SBHO provided a cultural diversity training in December 2016, and the curriculum included the following:
    - awareness of the lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) community
    - gender, gender identity, and gender dysphoria
    - difference between sexual orientation and gender identity
    - risk factors and health disparities that exist for the members of the transgender community
    - how to create inclusive and culturally competent services

Recommendation (Access, Timeliness, Quality)

Many of the BHOs are not ensuring that out-of-network providers are appropriately credentialed and that the referring BHA requesting out-of-network services is verifying and retaining documentation evidencing that the out-of-network provider has the credentials necessary to provide the services and that the provider is not debarred/excluded from receiving federal funds. This information should be provided to the BHO prior to the BHO's authorization of the out-of-network services.

- DBHR needs to include in its BHO contracts a requirement that BHOs develop policies and procedures for verifying that out-of-network providers are appropriately credentialed and that the BHA requesting out-of-network services is verifying and retaining documentation evidencing that the out-of-network provider has the credentials necessary to provide the services and that the provider is not debarred/excluded from receiving federal funds.

Coordination and Continuity of Care

Table 17: Coordination of Care Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues
Primary Care and Coordination of Healthcare Services	438.208 (b)(1–5)	OPBHO, KCBHO, SCRBHO, GCBHO, TMBHO, GRBHO
Enrollee Privacy and HIPAA Compliance	438.208 (b)(6) 45 CFR 160.310, 160.316	NSBHO, TMBHO, GRBHO
Confidentiality of Records	42 U.S.C. 290dd–2	TMBHO
Confidentiality of Alcohol and Drug Abuse Patient Records—Access and Restrictions	2.12 (a–c), 2.16 (a), 2.19, 2.22 (a–c), 2.23	NSBHO
Confidentiality of Alcohol and Drug Abuse Patient Records—Audit and Evaluation	2.53	TMBHO
Distribution of Enrollee Information	431.300 (a–c), 431.301, 431.302, 431.307 (a)(1)	OPBHO, NSBHO
Additional Services for Enrollees with Special Healthcare Needs	438.208 (c)(2)	OPBHO, NSBHO, TMBHO, SCRBHO, GCBHO
Treatment/Service Plans	438.208 (c)(3)	KCBHO, TMBHO, SCRBHO,
Direct Access to Specialists	438.208 (c)(4)	KCBHO

Strengths: Access

- Most of the BHOs have a method for identifying enrollees with special healthcare needs, which includes requiring the BHAs to obtain and document the following information for individuals receiving outpatient services:
  - the name of any current primary medical care provider
  - any current physical health concerns
  - current medications and any related concerns
  - history of any substance use/abuse and treatment, including tobacco use
  - any disabilities or special needs

- KCBHO has a mechanism in place to monitor and manage service utilization by ensuring providers:
  - have a comprehensive utilization management process that identifies patterns of service utilization by all clients, and strategies to ensure that the right services are provided at the right time in the right place
  - review the agency-specific outpatient service utilization reports provided by KCBHO to identify service utilization patterns for all mental health outpatient benefits
  - develop and implement protocols for the utilization management of their clients who are frequently served by other costly systems, such as residential or inpatient psychiatric care

- KCBHO tracks enrollees who have had three or more authorized psychiatric hospitalizations or multiple residential SUD treatment admissions in the preceding 12 months and works with providers to provide case management for these enrollees.

Strengths: Quality

- Interviews with BHAs indicated that they are knowledgeable about the requirements of 42 CFR and the BHOs' policies on confidentiality.

- Several of the BHOs' BHAs indicated that they have hired additional staff, including nurse practitioners, registered nurses (RNs), and licensed practical nurses (LPNs), to assist in identifying enrollees with special healthcare needs.

- Most BHOs have several mechanisms in place to ensure the confidentiality of protected health information (PHI) is maintained, including:
  - incorporating the requirements for compliance with applicable State and federal laws regarding healthcare information into all BHA contracts
  - monitoring network providers for compliance with applicable privacy and confidentiality requirements by performing annual on-site audits and conducting case-by-case record reviews as needed
  - monitoring complaints and grievances related to clients' rights to privacy, confidentiality, disclosure of information, and access to records
  - conducting administrative audits and reviews to monitor the BHAs' compliance with the clinical record retention requirements

- Several BHOs' electronic devices, including cell phones, are encrypted and can only be accessed using multiple passwords.

- Most of the BHOs require the BHAs to develop comprehensive information security and privacy policies and procedures to ensure data security and the protection and confidentiality of client records.

- The majority of BHOs require their staff and the staff of the BHAs to attend annual trainings on HIPAA and the requirements of 42 CFR Part 2.

- Several BHOs have privacy officers who are responsible for the oversight and monitoring of all client information and protected health information (PHI).

- NSBHO care coordinators meet weekly to discuss all current cases in order to keep one another informed and to discuss enrollee outcomes. Monthly, the team meets with the BHO's medical director to discuss all cases and the course of treatment.

- TMBHO's care managers are required to use lock boxes when transporting clinical records. When the reviews are completed, the records are appropriately destroyed. To maintain compliance with current confidentiality regulations, the BHO is shifting to performing all clinical chart reviews at the agencies on site.

- GRBHO's Utilization Management (UM) Team identifies persons with special healthcare needs (such as those in eating disorder treatment or detoxification services) and assigns care managers to work with these populations.

- TMBHO includes in its record review monitoring tool the criteria that 1) documentation exists indicating that each individual is informed of federal confidentiality requirements and 2) the individual receives a copy of the individual notice required under 42 CFR Part 2.

- NSBHO receives a weekly report from Volunteers of America (VOA) on NSBHO enrollees who are under the age of 21 and who have been admitted to an inpatient mental health facility, which allows the BHO to monitor their stay and address any barriers to discharge.

- When documents containing PHI are transported to and from SBHO or its BHAs, the BHO ensures confidentiality is maintained by requiring that:
  - the approval of a supervisor is obtained
  - only the minimum necessary amount of PHI is transported
  - PHI (including in portable media devices) is never left unattended, including inside a vehicle
  - all PHI is transported in a dedicated, locked container within a locked vehicle, preferably out of sight, such as in the trunk
  - BHA staff maintain a log of files or documents that are being transported from the BHA site

- Last year, SCRBHO stated it had 85 PHI violations, which included faxing errors and unencrypted emails. As a result, the BHO enhanced its BHAs' contracts to include further protection of PHI, and is providing additional training for its own staff and BHA staff on proper protection of PHI.

- OPBHO's case management staff meets monthly to review, coordinate care, case manage, and monitor enrollees with high-risk and special healthcare needs. Additionally, at this month-end meeting, the case managers, medical director, and quality staff review utilization reports to identify over- or underutilization of services.

- KCBHO tracks enrollees who have had three or more authorized psychiatric hospitalizations or multiple residential SUD treatment admissions in the preceding 12 months and works with providers to provide case management for these enrollees.

- Results from GCBHO's clinical record review of BHA treatment plans indicated that 95 percent of the treatment plans met the required nine elements, which include reviewing for enrollee participation, enrollee voice, and whether the treatment plan incorporates any special healthcare needs identified in the assessment.

- GRBHO has several mechanisms in place to ensure its framework for maintaining confidentiality is appropriate:
  - In the event of a breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from any GRBHO data system, the contractor must comply with all requirements of the HIPAA Security and Privacy rules and breach notification rules.
  - The BHO completes a risk assessment and evaluation of its quality program to determine areas for quality improvement, as well as an annual review to evaluate performance.
  - GRBHO requires all contracted providers to maintain an incident reporting structure that includes reporting breaches and incidents involving patient privacy.

Recommendations (Access, Timeliness, Quality)

All of the BHOs require the BHAs to assess and coordinate care and services by:

- asking about other systems or providers the individual may also be receiving services from or has received services from in the recent past
- attempting to obtain releases of information in order to coordinate care
- asking the enrollee if they need a primary care physician, providing a referral, and helping them obtain an appointment
- tracking and coordinating care with an assigned primary care provider through the treatment plan and progress notes

However, the results from Qualis Health's mental health clinical record reviews indicated a lack of documentation demonstrating care coordination, with the majority of BHAs' results reflecting poor to very poor care coordination.

- The BHOs need to continue their efforts to train, educate, and monitor the BHAs on coordination of care and services to ensure enrollees are receiving appropriate and medically necessary services and that documentation of these services is present in the progress notes.

Many BHOs stated they were not monitoring out-of-network providers for coordination of care and services; instead, the BHOs were relying on the BHO in whose region the BHA was located to monitor the BHA and submit results of its review to all BHOs that have contracts with the BHA. Many of the contracts for out-of-network providers have been in effect for over a year and were not subject to any pre-contractual monitoring or other monitoring since the contracts have been in place. Even though the BHOs had made agreements with other BHOs to share monitoring results for providers who are out of network, the BHOs contracting with the out-of-network providers are ultimately responsible for ensuring that the care and services provided are appropriate and meet all State contract, WAC, and CFR requirements.

- To ensure BHAs are meeting all WAC, State contract, and CFR requirements and that the care furnished to enrollees is appropriate, the State needs to ensure that BHOs are monitoring out-of-network providers in cases when the BHO has not received a monitoring report from the BHO in whose region the provider is located.

Many of the BHOs lacked documented policies and procedures to audit BHAs' accessibility considerations with regard to providing physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities, stating instead that the State licensing agency was responsible for assessing the BHAs' compliance with these requirements. During Qualis Health's on-site reviews, reviewers discovered that several of the mental health and SUD treatment agencies lacked appropriate physical access and reasonable accommodations, despite being licensed by the State.

- The BHOs are ultimately responsible for ensuring their contracted BHAs maintain accessible facilities, including providing physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. The BHOs need to conduct thorough assessments of all contracted providers at the time of initial contracting and re-contracting to ensure adequate access is provided.

Coverage and Authorization of Services

Table 18: Coverage and Authorization of Services Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues
Coverage	438.210 (a)	TMBHO
Authorization of Services	438.210 (b)	TMBHO, GCBHO
Notice and Timeliness of Adverse Benefit Determination	438.210 (c), 438.404	
Timeframe for Decisions, Standard and Expedited	438.210 (d)(1–2)	TMBHO
Compensation for Utilization Management Activities	438.210 (e)	
Emergency and Post-Stabilization Services	438.114	OPBHO, NSBHO

Strengths: Access

- All BHOs have policies and procedures stating they do not provide incentives to deny, limit, or discontinue medically necessary services.

- Many BHOs monitor the inappropriate use of crisis services during annual clinical chart reviews and through review of utilization reports.

- The majority of BHOs made refinements to their authorization processes and trained the BHAs on the new authorization request requirements, including the narrative of symptoms, number of hours required for each level of care, and timeliness of requests.

- GCBHO monitors the administration of crisis services through a variety of methods, including making test calls and checking telephone directories to ensure crisis phone numbers are included, monitoring access, conducting emergent concurrent reviews, reviewing the interfacing of crisis services with community support and hospital certification services, and reviewing and analyzing MIS data.

Strength: Timeliness

- Most BHOs monitor compliance with the authorization process and timeframes through:
  - annual review of provider and subcontractor administrative/sub-delegated agreements
  - annual provider chart reviews
  - monthly review of grievance tracking reports

  .

Strengths: Quality

- All BHOs require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be determined by a professional who meets or exceeds the requirements of a chemical dependency professional (CDP) or mental health professional (MHP) with the appropriate clinical expertise to make that decision.

- All BHOs' case managers are either licensed MHPs or licensed CDPs. Several case managers are dually licensed.

- GRBHO uses the PreManage system for producing daily reports to track individuals presenting to their local emergency department (ED) for mental health and/or SUD treatment visits. When an individual has been cited in a report as presenting to the ED with a mental health or SUD diagnosis rather than a medical diagnosis, the BHO's utilization management coordinator notifies the BHA where the client is receiving ED services for the purpose of immediate follow-up by the client's BHA case manager.

- SCRBHO's utilization management plan outlines the utilization review process to be compliant with regulatory and contractual requirements. The plan includes conducting annual program monitoring to audit for evidence of medical necessity and compliance with access to care standards, and monitoring to determine that behavioral healthcare benefits are not arbitrarily denied or reduced based solely upon the individual's diagnosis, type of behavioral health illness, or condition.

- OPBHO uses these mechanisms to monitor the inter-rater reliability of clinical staff:
  - intensive mentoring of every care manager during his/her first six months of employment
  - routine auditing of samples of completed inpatient and outpatient authorizations to ensure that care managers consistently comply with access to care standards
  - weekly case consultations with OPBHO's medical director

- OPBHO's care managers review the utilization reports to identify enrollees who have had crisis service encounters during the previous month to explore the reasons for the encounters and implement case management services if needed.

- Review of OPBHO's year-end evaluation and utilization and tracking logs indicated a high rate of compliance with the State standards for authorization decisions.

Recommendations (Access, Timeliness, Quality)

Many of the BHOs lack a mechanism to track and monitor requests for standard and expedited service authorizations.

- The BHOs need to develop and implement a process for tracking and monitoring requests for standard and expedited service authorizations.

Several BHOs lack a policy and procedure that describes a formal process for conducting inter-rater reliability monitoring to ensure there is consistent application of review criteria pertaining to the initial and continuing authorization of services.

- DBHR needs to ensure that all BHOs have a policy and procedure that describes a formal process for conducting inter-rater reliability monitoring to ensure there is consistent application of review criteria pertaining to the initial and continuing authorization of services.

Provider Selection

Table 19: Provider Selection Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues
Credentialing and Re-credentialing	438.214 (a),(b),(e)	SBHO, OPBHO, KCBHO, NSBHO, TMBHO, SCRBHO, GCBHO
Nondiscrimination of Providers	438.214 (c), 438.12	
Excluded Providers	438.214 (d)	OPBHO, KCBHO, TMBHO, SCRBHO

Strengths: Quality

- Several BHOs have policies on credentialing indicating that network providers are responsible for ensuring any entity subcontracted for behavioral healthcare delivery is qualified to perform services per the contract between the network provider and BHOs.

- Most of the BHOs have a policy on subcontractual relationships and delegation indicating the BHO does not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification, solely based on that license or certification.

- GRBHO has several methods of monitoring the BHAs' credentialing processes and policies. GRBHO requires the BHAs to perform a self-evaluation of their own credentialing files and submit a CAP for substandard results. The BHO then follows up with its own review by selecting a sampling of credentialing files that were previously reviewed by the BHA.

Recommendations (Access, Timeliness, Quality)

Many of the BHOs are not ensuring that the BHAs are conducting, for all staff, a Washington State Patrol background check and excluded provider check before hire, as well as monthly excluded provider checks.

- DBHR needs to make sure that all BHOs have implemented a process for ensuring that the BHAs are consistently conducting, for all staff, a Washington State Patrol background check and excluded provider check before hire, as well as monthly excluded provider checks.

Many of the BHOs are not consistently monitoring and verifying their contracted BHAs' credentialing and re-credentialing processes.

- The State needs to enforce the BHOs' completion of CAPs related to ensuring the BHOs are all monitoring and verifying their contracted BHAs' credentialing and re-credentialing processes.

Subcontractual Relationships and Delegation

Table 20: Subcontractual Relationships and Delegation Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues
Subcontractual Relationships and Delegation	438.230 (a–c)	TMBHO, SCRBHO, GCBHO

Strength: Access

- Most BHOs conduct a comprehensive annual performance evaluation of each of the contracted provider agencies. Review areas include policies/procedures, credentialing files, financial reports, compliance programs, quality improvement (QI) plans and activities, grievance and crisis logs, staff training and, when applicable, subcontractor agreements and business associate agreements.

Strengths: Quality

- If a continuous clinical or non-clinical quality monitor does not meet a performance goal, OPBHO conducts an analysis of barriers and opportunities for improvement and implements actions to improve performance and meet the goal by an established date. Once the analysis of barriers and opportunities for improvement is completed, the QA/PI manager presents a plan of corrective action to the QA/PI Committee. Corrective action may be as formal as a long-term performance improvement project (PIP) or may consist of operational or procedural changes.

- KCBHO monitors its BHAs' delegated services and delegates and assigns CAPs when appropriate. KCBHO provided evidence that it follows through on the CAPs it assigns to its BHAs.

- NSBHO's policy on delegation outlines a thorough process for ensuring specific functions are addressed through delegation or through direct performance.

- TMBHO's policy on subcontractual relationships and delegation ensures that prior to any delegation of responsibility or authority to a subcontractor, the BHO will implement a formal delegation plan, consistent with the requirements of 42 CFR 438.230 and the "Subcontract" section of the PIHP, to evaluate the subcontractor's ability to perform delegated activities.

- SCRBHO has several methods for monitoring and evaluating its contracted BHAs to ensure the BHAs are in compliance with the requirements in their delegation or contract agreements. Methods include reviewing the monthly BHA contract compliance reports, the Ombuds reports, the grievance logs, the results of the desktop reviews of the BHAs' policies and procedures, and the results of the BHO's credentialing, fiscal, clinical, and administrative monitoring.

Recommendation (Access, Timeliness, Quality)

Several BHOs stated that while they require the BHAs to apply the same CFR criteria to any services the BHAs delegate to other entities, the BHOs are not monitoring their BHAs' delegation agreements with their subcontractors.

- DBHR needs to ensure that all BHOs are monitoring their BHAs' delegation agreements with subcontractors to ensure the delegates are following the same CFR criteria required of the BHAs.

Practice Guidelines

Table 21: Practice Guidelines Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues
Adoption of Practice Guidelines	438.236 (a–b)	SBHO, OPBHO, TMBHO
Dissemination of Guidelines	438.236 (c)	OPBHO, KCBHO
Application of Guidelines	438.236 (d)	OPBHO

Strength: Access

- Most BHOs post their practice guidelines on the BHO website for access by both providers and enrollees.

Strengths: Quality

- NSBHO has distributed its practice guidelines to it BHAs and has provided them with the specific core elements used during the clinical chart review audits. Interviews with the provider agencies substantiated that the BHO has communicated and worked with the agencies on the use of practice guidelines in the treatment of enrollees.

- SBHO consults with its BHAs' clinical directors to identify which elements to monitor within each adopted practice guideline, which relate to schizophrenia and bipolar disorder. To ensure that those elements are included in the services provided to each enrollee with a diagnosis of schizophrenia or bipolar disorder, the BHO reviews at least yearly a sample of charts for adherence to the appropriate guideline.

- During coverage determinations, SBHO's Utilization Management Team reviews the provisional treatment plan to determine coverage of the medically necessary services. If the individual has a diagnosis of major depressive disorder, post-traumatic stress disorder (PTSD), or opiate use disorder, the authorization coordinator will review the provisional treatment plan to ensure that it follows the practice guidelines for that diagnosis, as appropriate.

- GRBHO's Care Management Team tracks the care of enrollees who are high utilizers to ensure their treatment follows the practice guidelines, as appropriate. The care managers coordinate with the providers to ensure that the enrollee is receiving evidence-based care reflective of best practices.

- KCBHO has been meeting with its BHAs to discuss the development of a co-occurring disorder (COD) treatment guideline to meet the needs of its enrollees who have a COD diagnosis.

- TMBHO's BHAs are required to develop and implement policies and procedures that support the BHO's clinical practice guidelines. When a clinician determines the clinical practice guidelines are not desirable for a particular enrollee, the clinical rationale and justification for not following the clinical practice guidelines are to be documented in the enrollee's medical record.

- In order to incorporate additional input from its BHAs into the selection and development of practice guidelines, SCRBHO created a practice guideline task group that included representatives from the BHAs. In order to implement the practice guidelines across SCRBHO's provider network, the practice guideline task group designed a "train the trainers" presentation

that was used to train agency staff. The task group provided the training to agency representatives, who then began providing ongoing training to their respective staff.

Recommendation (Access, Timeliness, Quality)

Although all BHOs have practice guidelines, many of the BHOs have had the same practice guidelines in place for several years without knowing whether the practice guidelines are still meeting the needs of their enrollees and functioning to improve enrollee outcomes.

- The State needs to make sure the BHOs are choosing practice guidelines based on valid and reliable clinical data in order to meet the needs of their enrollees. The BHOs then need to include in their QAPI program how the practice guidelines are incorporated into the administration and monitoring of services.

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Quality Assessment and Performance Improvement

Table 22: Quality Assessment and Performance Improvement Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues
General Rules	438.330 (a)	OPBHO, SCRBHO, GCBHO
Basic Elements	438.330 (b)(1–4)	KCBHO, GCBHO
Performance Measurement	438.330 (c)	
Performance Improvement Projects	438.330 (d)(1–3)	NSBHO
Program Review by the State	438.330 (e)	SBHO, NSBHO, TMBHO, GCBHO

Strength: Access

- When GRBHO identifies an issue with under- or overutilization of services, the BHO contacts the enrollee's BHA or other service provider to inform them that the individual is not receiving the level of care that was requested or recommended at the time of authorization, and provides case consultations on how to best meet the individual's identified needs.

Strength: Timeliness

- GCBHO has taken corrective action when it has identified quality of care issues. When data indicated that the BHAs were outside the acceptable time range for sending authorization requests for services to the BHO, the BHO implemented a performance improvement project and worked with the BHAs to meet the BHO's required timeframe for submitting authorization requests after the initial intake.

Strengths: Quality

- SBHO performs clinical record chart reviews, reviews the QRT satisfaction survey results, performs encounter data validation, reviews access data, and reviews crisis services to assess the quality and appropriateness of care furnished to enrollees.

- GRBHO's 2016–2017 Quality Management Program Evaluation includes the BHO's accomplishments, its progress in meeting identified objectives and goals, and thorough descriptions and results of its quality management (QM) work plan indicators. The BHO's quality management staff, Quality Management Committee, executive teams, advisory board, and governing board review and comment on this report.

- GCBHO has a quality management program plan that outlines the BHO's quality management framework. The plan describes how the BHO will assess the quality and appropriateness of care furnished to enrollees. The plan also describes the BHO's leadership and responsibilities, the roles and responsibilities of the BHO's staff, goals and objectives of the quality management program, the BHO's performance measurements, and how the BHO will evaluate its quality management program.

- OPBHO has a very active QA/PI Committee, which meets regularly to discuss quality assessment and process improvement using data collected through several venues. The BHO's QA/PI Committee minutes indicate that the committee monitors, evaluates, and makes management decisions for several review activities, including clinical record and administrative reviews, satisfaction surveys, grievances and appeals, and access data.

- TMBHO's Quality Review Team (QRT) administers consumer satisfaction surveys, which are reviewed by leadership and shared with the BHO's care managers and quality staff. The results of the surveys are presented to the advisory board and governing board.

Recommendations (Access, Timeliness, Quality)

Several BHOs lack both policies and procedures for identifying, monitoring, and detecting underutilization and overutilization of services as well as processes for taking corrective action to address underutilization and overutilization.

- DBHR needs to ensure that all BHOs have and follow policies and procedures for identifying, monitoring, and detecting underutilization and overutilization of services.

Although the State completed a draft of the State's quality strategy plan and submitted the plan to CMS, CMS has not yet approved the plan.

- Once the State receives CMS's approval for the quality strategy plan and distributes the final plan to the BHOs, DBHR will need to ensure the BHOs comply with the quality strategy plan.

Several BHOs did not complete an annual evaluation of the impact and effectiveness of their QAPI program, including accomplishments, progress toward meeting identified objectives and goals, and the results of QM work plan indicators.

- DBHR has included this requirement in an amendment to its BHO contracts but will need to ensure that all BHOs follow through by completing an annual evaluation of the impact and effectiveness of their QAPI program, including accomplishments, progress toward meeting identified objectives and goals, and the results of QM work plan indicators.

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Health Information Systems

Table 23: Health Information Systems Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues
General Rule, Utilization, Claims, Grievances and Appeals, and Disenrollments	438.242 (a)	GCBHO
Basic Elements and Enrollee Encounter Data	438.242 (b),(c)	SBHO, KCBHO, SCRBHO, GCBHO

Strength: Access

- KCBHO monitors the reports produced by its IT department to review access to care standards, analyze services by diagnosis, review inpatient and outpatient length of stay, study frequency of opioid treatment services and the service utilization of high-intensity programs, and conduct studies on over- and underutilization of services.

Strengths: Quality

- OPBHO has a robust system for collecting and analyzing data across the entire spectrum of healthcare services the BHO provides. Information is shared and discussed at various committee-level meetings at the BHO, including the Executive Committee, Governing Board, and QA/PI Committee meetings, and the month-end BHO/providers group meeting.

- TMBHO implemented Avatar approximately one year ago, and all of its BHAs are using the system. The BHO supported its BHAs in this change by holding regular meetings and by providing technical assistance in both group and one-on-one settings. The BHO has created a help desk for its BHAs to address Avatar-related challenges

Recommendation (Access, Timeliness, Quality)

Several BHOs lack a policy and procedure to ensure their BHAs are checking their data for quality and integrity before submitting them to the BHO. The policy should include:

  - the requirement for providers to submit written attestations of data accuracy
  - a form letter for providers to complete attesting to data accuracy
  - a system for the form letters to be transmitted electronically to the BHO

- DBHR needs to make sure all BHOs have a policy and procedure to ensure BHAs are checking their data for quality and integrity before submitting them to the BHO.

Performance Improvement Project Validation

Performance improvement projects (PIPs) are designed to assess and improve the processes and outcomes of the healthcare system. They represent a focused effort to address a particular problem identified by an organization. As prepaid inpatient health plans (PIHPs), Behavioral Health Organizations (BHOs) are required to have an ongoing program of PIPs that focus on clinical, non-clinical, and substance use disorder (SUD)-focused areas that involve:

- measurement of performance using objective quality indicators
- implementation of systems interventions to achieve improvement in quality
- evaluation of the effectiveness of the interventions
- planning and initiation of activities for increasing or sustaining improvement

Methodology

Qualis Health evaluates the BHOs' PIPs to determine whether they are designed, conducted, and reported in a methodologically sound manner. The PIPs must be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time that is expected to have a favorable effect on health outcomes and enrollee satisfaction. In evaluating PIPs, Qualis Health determines whether:

- the study topic was appropriately selected
- the study question is clear, simple, and answerable
- the study population is appropriate and clearly defined
- the study indicator is clearly defined and is adequate to answer the study question
- the PIP's sampling methods are appropriate and valid
- the procedures the BHO used to collect the data to be analyzed for the PIP measurement(s) are valid
- the BHO's plan for analyzing and interpreting PIP results is accurate
- the BHO's strategy for achieving real, sustained improvement(s) is appropriate
- it is likely that the results of the PIP are accurate and that improvement is "real"
- improvement is sustained over time

Scoring

Qualis Health assigns a score of "Met," "Partially Met," or "Not Met" to each of the 10 evaluation components that are applicable to the performance improvement project being evaluated. Components may be "Not Applicable" if the performance improvement project is at an early stage of implementation. Components determined to be "Not Applicable" are not reviewed and are not included in the final scoring. Scoring is based on the answers BHOs provide in the completion of a response form, which address questions listed under each evaluation component, following a review of written documentation and in-person interviews. Opportunities for improvement, technical assistance, and recommendations requiring a corrective action plan (CAP) are provided for each standard where appropriate.

Following PIP evaluations, BHOs are offered technical assistance to aid them in improving their PIP study design, methodology, and outcomes. BHOs may resubmit their PIPs up to two weeks following the initial evaluation. PIPs are assigned a final score following the final submission.

Full description of Qualis Health's PIP evaluation methodology is included in Appendix D.

Summary of PIP Validation Results

In 2017, each BHO was required to complete a clinical PIP and a non-clinical PIP (one of which was required to focus on children), as well as a substance use disorder-focused PIP. Clinical PIPs topics utilize outcome indicators to measure changes in behavioral health status or functional status, such as prevention and care of acute and chronic conditions for high-risk, high-volume, or high-need enrollees. Non-clinical PIPs focus on member satisfaction or process of care areas and may address coordination or continuity of care, access to care, and availability of services, as well as enrollee appeals, grievances, and satisfaction.

Qualis Health's review of the BHOs' PIPs revealed many areas of strength as well as some opportunities for improvement. Themes within the BHOs' chosen topics included timely access, care coordination, increasing enrollee engagement in services, and improved identification of enrollee level of care. Many PIPs were still in the initial phases of study, primarily the SUD-focused PIPs, for which sufficient data were not yet available to conduct thorough analysis of the study topics. In those cases, Qualis Health was unable to assess for success related to real or sustained improvement. Table B-8 indicates the BHOs' PIP topics and validation results and is followed by summaries describing each of the BHO's PIPs.

Table 24: Summary of BHO PIP Validation Results

BHO	Study Topic		Validation Result
Great Rivers	Clinical PIP	Improved Outcomes for Children and Youth with Intensive Behavioral Health Needs	Fully Met
	Non-clinical/ Children's PIP	Children's Evidence-Based Practices Service Reporting	Fully Met
	SUD PIP	Grievance Process for Behavioral Health Agencies Providing Substance Use Disorder Services	Fully Met
Greater Columbia	Clinical/Children's PIP	Promoting Medication Adherence in Youth	N/A
	Non-clinical PIP	Increasing Timeliness of Provider-Submitted Authorization Requests through Identification of Systemic Barriers	Fully Met
	SUD PIP	Increasing Engagement in Recovery by Identifying Reasons for Premature Exit from Detox Programs	N/A
King County	Clinical PIP	Effectiveness of the Transitional Support Program	Partially Met
	Non-clinical/ Children's PIP	Improved Coordination with Primary Care for Children and Youth	Partially Met
	SUD PIP	SUD Residential Treatment Length of Stay	Partially Met
North Central	Clinical PIP	Crisis Resolution Through Follow-Up Services	Partially Met

	Non-clinical/ Children's PIP	Service Intensity and Frequency for Children and Adolescents	Partially Met
	SUD PIP	Timely Access to SUD Treatment Services	Partially Met
North Sound	Clinical/Children's PIP	EPSDT and the Effects of Care Coordination on Level of Care	Fully Met
	Non-clinical PIP	The Impact of the Open Access Service Delivery Model on Behavioral Health Treatment Initiation	Fully Met
	SUD PIP	SUD Golden Thread	Partially Met
Optum Pierce	Clinical/Children's PIP	Increasing the Number of People Who Remain in the WISe Program Through Their Initial Authorization Period	Partially Met
	Non-clinical PIP	Satisfaction in 24-Hour Facilities in Pierce County	Not Met
	SUD PIP	The Use of the GAIN-SS in a Clinical Referral	Partially Met
Salish	Clinical PIP	Tobacco Use Cessation	Fully Met
	Non-clinical/ Children's PIP	Increasing Child and Family Team Meetings among High-Risk, High-Cost, and High-Need Children Served by the Mental Health System	Fully Met
	SUD PIP	Improving Implementation of the Grievance System among SUD Treatment Providers	Fully Met
Spokane	Clinical PIP	Eating Disorder Services	Fully Met
	Non-clinical/ Children's PIP	Youth Crisis Line Awareness	Fully Met
	SUD PIP	SUD Treatment Continuity of Care	Fully Met
Thurston-Mason	Clinical/Children's PIP	High-fidelity Wraparound/WISe	Fully Met
	Non-clinical PIP	Increasing Co-occurring Mental Health and Substance Use Disorder Service Participation for Adult Enrollees	Partially Met
	SUD PIP	SUD Residential Treatment Access	Partially Met

Greater Rivers (GRBHO)

Clinical: Improved Outcomes for Children and Youth with Intensive Behavioral Health Needs (Fully Met)
GRBHO selected this PIP study topic in order to improve outcomes for children and youth with intensive behavioral health needs. These youth are involved with more systems, utilize more services, and are at higher risk for severely negative outcomes than the majority of child and adolescent enrollees. The PIP's primary focus is improving Child and Adolescent Needs and Strengths (CANS) assessment scores over time, specifically the 2s and 3s in five key domains: Behavioral/Emotional Needs, Functioning, Risk Factors, Youth Strengths, and Caregiver/Family Needs and Strengths, to ultimately improve overall outcomes in service delivery. The BHO considered many factors in the selection of these domains, including input from stakeholders, review of results from existing statewide WISe "dashboard" reports, and the clinical judgment of GRBHO staff experienced in the provision and evaluation of wraparound services. The WISe Quality Management Plan outlines a protocol for transition planning, which includes improvements in CANS scores that will then prompt planning by the youth's Child and Family Team for transition to a less intensive level of care. At the time of the EQR, the first re-measurement period had just been completed.

Non-clinical/Children's: Children's Evidence-Based Practices Service Reporting (Fully Met)
For its non-clinical PIP, GRBHO selected a topic based on data that revealed low reporting rates of evidence-based practices (EBPs). All BHOs and BHAs are required to submit EBPs when submitting encounter information for a given service using the EBP codes listed in the Service Encounter Reporting Instructions (SERI). Only a very small percentage of all children and youth served across GRBHO's network had been reported as having received an EBP over the first nine months of BHO operations. Initial discussion of this data at a meeting of the Great Rivers Quality Management Committee suggested that underreporting could be affecting performance; moreover, confusion about what reportable EBP services are and how such encounters should be submitted may have contributed to less-than-optimal results over this time period. GRBHO then undertook a more structured root cause analysis to identify additional contributors to these low rates. As a result and through its collaboration with the BHAs, the BHO was able to identify and address barriers and employ solutions that have shown a steady increase in the use and reporting of evidence-based practices.

SUD: Grievance Process for Behavioral Health Agencies Providing Substance Use Disorder Treatment Services (Fully Met)
GRBHO selected this SUD PIP as a means to increase the number of reported grievances submitted to the BHO by the BHAs. Although the grievance process is outlined in the Washington State Medicaid benefits booklet, it is new for many of the SUD treatment agencies. GRBHO recognized this gap and saw the need for improvement to ensure individual grievances are identified, reviewed, and responded to within the grievance system. Thus, the BHO developed training focused on grievance systems. This training outlined clear processes to investigate, resolve, and follow up on grievances within specified time periods and demonstrated how to document grievance information for analysis and utilization in quality improvement. Although this PIP is still in the infancy stages of implementation, GRBHO has made great strides to effect change, including providing training, testing BHA knowledge around grievance processes and policies, following up with BHAs, and monitoring grievance reporting (which includes ensuring that all grievances are properly documented and resolved) on an ongoing basis.

Greater Columbia (GCBHO)

Clinical/Children's: Promoting Medication Adherence in Youth (Not Applicable)
GCBHO selected this PIP study topic in order to increase medication compliance among Medicaid-enrolled youth. The BHO presented this topic during the 2016 EQR, but at that time a root cause analysis had not been conducted. Between the 2016 and 2017 reviews, there was an unexpected change in GCBHO Quality Management staff. As a result, this PIP remains in its initial stages, although the BHO has conducted further research to understand the reasons why youth do not comply with their medication prescriptions. Through this research, GCBHO identified some top causes for youth non-compliance with medication prescriptions and incorporated those reasons into a survey to determine if the same reasons were the causes for non-compliance within its own region. GCBHO administered the survey to Wraparound with Intensive Services (WISe)-enrolled youth and families in July 2017 as part of its root cause analysis. GCBHO decided to focus on youth enrolled in WISe because these youth have the highest utilization of the most intensive services and have generally not been successful in traditional outpatient mental health services. The results revealed that youth and families enrolled in WISe did not understand the importance of medication adherence. Additionally, it was discovered that many of these youth had missed dosages as a result of forgetting to take the medication. Since GCBHO has been able to drill down and understand the barriers to medication adherence, an intervention(s) and a study question can be developed.

Non-clinical: Increasing Timeliness of Provider-Submitted Authorization Requests through Identification of Systemic Barriers (Fully Met)
For its non-clinical PIP, GCBHO selected a topic based on authorization data from April 2015 through April 2016, which showed that delays in authorizations had been on the rise and that numerous BHAs were failing to meet contractual expectations for timeliness. The volume of requests for services at a given BHA showed no correlation with the average length of time it took the BHA to submit an authorization request. GCBHO measured data from 14 mental health agencies, including the number of authorization requests submitted by each agency and the average length of time between receiving the request for service and submitting the authorization request. After meeting with various key stakeholders to discuss these issues, GCBHO sought to implement a new authorization request policy and monitor its effectiveness. The PIP clearly shows that the implementation of a five-day authorization policy had a direct correlation with improved timeliness of authorization request submissions. The PIP was initiated in 2015 and has had two full re-measurement periods showing sustained improvement. Therefore, the BHO should retire this PIP and pursue a new non-clinical PIP topic. Whatever avenue GCBHO chooses, the PIP should be formulated so that the question can be answered simply and measurement can be conducted over shorter periods of time and changed as needed in order to create a successful end result.

SUD: Increasing Engagement in Recovery by Identifying Reasons for Premature Exit from Detox Programs (Not Applicable)
GCBHO selected this SUD PIP as a means to develop strategies for increasing engagement in detox facilities prior to discharge, with the end goal of reducing recidivism rates. This topic was presented during the 2016 EQR, but at that time GCBHO had not conducted research to identify the root causes of detox recidivism rates. As previously stated, between the 2016 and 2017 reviews, there was an unexpected change in GCBHO Quality Management staff. Since this change, the BHO has been able to develop a questionnaire to determine reasons for readmission to Lourdes Desert Hope Detox facility. At the time of the EQR, the BHO had collected 45 surveys and identified two prominent reasons for detox readmissions. GCBHO plans to collect more surveys to substantiate its findings. The BHO will then create an intervention to improve engagement in detox programs in order to decrease recidivism rates. Once the

intervention is identified, the BHO will be able to address the challenges and formulate a PIP study question.

King County (KCBHO)

Clinical: Effectiveness of the Transitional Support Program (Partially Met)
The purpose of this PIP is to reduce the rate of psychiatric hospital readmissions and length of stay to ultimately improve utilization and promote good clinical care by increasing focus on efficient and effective discharge planning and strong connections and engagement in community-based outpatient services. This clinical PIP is a continuation of the PIP that was in place in 2016 and had previously shown statistically significant improvement with both study indicators (the number of psychiatric hospitalization admissions and the length of stay for those hospitalizations) from the baseline measurement to the re-measurement period, one year prior to and one year post-enrollment in the Transitional Support Program (TSP). Although KCBHO previously completed a rendition of this PIP, it identified barriers and challenges with implementing the Transitional Support Program in two specific hospitals. As a result, the BHO recognized the need to continue its evaluation activities and quality improvement efforts to increase TSP penetration rates and lower psychiatric readmissions at these facilities. KCBHO identified these two hospitals as also having the highest re-hospitalization rates within the provider network. High numbers of potentially preventable events can indicate deficiencies in quality of care. The BHO should implement its new strategy at these facilities and then retire the PIP in its current format. As KCBHO monitors these interventions, it is important to pay close attention to the organizational change process and the degree to which it is affecting the specific intervention. During implementation, the BHO and key stakeholders should make several checks to ensure that the hospitals are successfully integrating the changes. Further, once the re-measurement is complete, if rates remain suboptimal, the BHO should continue its efforts internally.

Non-clinical/Children's: Improved Coordination with Primary Care for Children and Youth (Partially Met)
KCBHO is continuing its non-clinical PIP focused on improving coordination with primary care providers for Medicaid-enrolled children and adolescents. This PIP is in its fourth year, as KCBHO previously sought to conduct this PIP utilizing data from the five Apple Health managed care organizations (MCOs); however, the BHO experienced difficulty obtaining data from all of the MCOs. Because of KCBHO's difficulty in obtaining data, this PIP remained in a very early stage for several years. Nonetheless, the BHO is now focusing its efforts on working with one MCO (Molina) to ensure that care for their dually enrolled enrollees is coordinated, with an aim to make sure these enrollees receive the right care at the right time, while avoiding unnecessary duplication of services. KCBHO has followed through on last year's recommendation to fully formulate and begin the PIP. With baseline measurement and re-measurement periods redefined, KCBHO should be able to progress further with collecting, reporting, and analyzing the data for youth dually enrolled in the BHO and Molina Healthcare.

SUD: SUD Residential Treatment Length of Stay (Partially Met)
KCBHO selected this PIP in early 2017 as a means to minimize readmissions as well as reduce and/or prevent the number of stay extensions. With the integration of mental health and SUD treatment services in April 2016, KCBHO became responsible for the authorization and utilization management of residential SUD treatment services. This PIP is still in the early stages of development and implementation as the BHO does not have the relevant data to determine whether a problem truly exists with the current authorization process as it relates to SUD residential treatment lengths of stay. Once the data are obtained, the BHO should consider homing in on a particular focus area, such as discharge planning and post-discharge linkages for continuity of care. This will also aid the BHO in developing its intervention.

North Central (NCBHO)

Clinical: Crisis Resolution through Follow-Up Services (Partially Met)
NCBHO implemented this PIP as a result of a previous PIP focused on the use of a standardized discharge policy and procedure to increase the provision of follow-up services to enrollees who received crisis services. The policy required progress notes to include an indication of whether or not follow-up should be completed, as assessed by the clinician at that time. Results indicated the policy and procedure did result in increased numbers of individuals receiving follow-up when indicated; however the quality of the follow-up contacts and their impact was not reviewed during the previous PIP. Therefore, NCBHO selected this PIP after a review of initial data indicated Medicaid enrollees accessed recurrent crisis services at a higher rate than non-Medicaid enrollees. The results were indicative of an increased need for clinical coordination within NCBHO's provider network to ensure enrollees accessing crisis services were adequately assisted. The BHO further asserted that efforts could be made to ensure Medicaid enrollees were aware of available services and were assisted in enrolling in those services, both preventatively and upon conclusion of a crisis episode for ongoing support. The idea of focusing this PIP on improved crisis episode follow-up as a means to decrease the number of enrollees who have recurrent crisis episodes has merit, as those who seek crisis services are a high-risk and, generally, high-need population. If the BHO were continuing operations into 2018, it would be encouraged to thoroughly review the data being tabulated and revise the data analysis plan to include a statistical calculation that identifies whether one or more variables had an effect on the outcome of the implemented intervention.

Non-clinical/Children's: Service Intensity and Frequency for Children and Adolescents (Partially Met)
For this PIP, NCBHO examined data on service hours provided relative to an enrollee's current level of care. When it was in operation, the BHO utilized a level of care system, with each level associated with an expected average number of service hours per month. The BHO's review results revealed that levels 1, 2, and 3 had approximately the same average hours of service per month, although service hour expectations vary greatly across the different levels of care. The BHO reported that service hour results indicated a pattern of significant underserving of children and adolescents receiving care at levels 2 and 3. Providing services at an intensity and frequency appropriate to the enrollee's needs, as measured by average number of service hours per month, can benefit the enrollees in areas of treatment success and prevention of future or further deterioration. Thus, the BHO chose to focus on training as a means to increase the number of monthly service hours received by these enrollees. At the time of the EQR, the BHO had not completed the PIP and had just begun the data analysis step.

SUD: Timely Access to SUD Services (Partially Met)
NCBHO selected this PIP topic through discussion with a variety of stakeholders and through a review of national and local data related to the substance use disorder treatment needs of enrollees. Members of the BHO's Quality Review Team (QRT) expressed dissatisfaction with enrollee wait times for assessments and described how those wait times affected court cases, child protective cases, and other legal involvements. Initial data showed that only 45.59 percent of assessments were completed within 10 days. Further, the average wait time for a completed SUD assessment was 24 days within NCBHO's network. The BHO determined that by focusing on the completion of timely assessments, it would improve overall treatment completion, satisfaction, and effectiveness rates. NCBHO completed this PIP and indicated a statistically significant improvement from the baseline measurement period to the third re-measurement period.

North Sound (NSBHO)

Clinical/Children's: **EPSDT and the Effects of Care Coordination on Level of Care (Fully Met)**
NSBHO's clinical PIP is still in the initial stages of implementation. The BHO began this PIP after determining that qualifying Early and Periodic Screening, Diagnosis and Treatment (EPSDT) referrals were either not being documented at the BHA level or not being transmitted to the BHO. Subsequent reviews found a continuing disconnect in the reporting of EPSDT referrals and the use of care coordination processes to enhance communication with the medical providers and the overall service delivery to enrollees. The PIP's primary focus is improving care coordination with the use of the EPSDT and, as a result, lowering enrollees' overall level of care placement. Care coordination helps to bridge the gaps among multiple systems that serve children and families. In order for the care coordination tasks to be efficacious, there must be effective communication and participation among all of the involved providers. While the BHO is monitoring the progress of its implemented interventions, it would benefit from ensuring care coordination processes are streamlined to reduce duplication of efforts and ensure smooth transitions between levels of care.

Non-clinical: The Impact of the Open Access Service Delivery Model on Behavioral Health Treatment Initiation (Fully Met)
NSBHO selected this PIP after an analysis of timely access to intake assessments. At the onset, enrollees were receiving an assessment within seven days of a request for service only 20 percent of the time. Through its collaboration with MTM Consulting, the BHO was able to identify and address barriers to implementing the open access model with the BHAs across its region. The phasing in of open access began in November 2015, with the last BHA implementation expected to occur in the fall of 2017. NSBHO has made great strides in implementing the open access model at several BHAs within its service delivery network. Thus far, the BHO has shown statically significant improvement in the percentage of enrollees receiving an intake assessment within seven days of the request for service.

SUD: SUD Golden Thread (Partially Met)
NSBHO is still in the infancy stages of pursuing its selected SUD PIP topic related to the "golden thread," which resulted from the outcomes of a utilization review the BHO conducted at the SUD treatment BHAs. NSBHO has not fully completed the study question selection process and first needs to complete an analysis of enrollee needs, care, and services. Further, the BHO needs to examine its data to ensure the topic is consistent with the demographic and epidemiologic information of its current enrollees. Additionally, before fully implementing this PIP, the BHO needs to ensure baseline data indicate that an issue truly exists. Then, NSBHO should review its data to better home in on the problem/barriers the BHO seeks to address. Moreover, while undertaking this PIP, NSBHO needs to ensure a correlation is made between the data and how they relate to overall enrollee care. Hence, it is important to obtain the enrollee's perspective and input through focus groups, surveys, etc. If a survey is developed, it can aid in determining the direction of this performance improvement project. Similarly, the BHO should think about how the intervention will have a measurable impact on its enrollees. When considering study indicators, NSBHO must demonstrate how the measures capture change in health status, functional status, or enrollee satisfaction.

Optum Pierce (OPBHO)

Clinical/Children's: Increasing the Number of People Who Remain in the WISe Program through Their Initial Authorization Period (Partially Met)
OPBHO selected this PIP after an analysis of WISe data, which indicated a significant number of enrollees were leaving the WISe program prior to the expiration of their initial 180-day authorization.

Thus, the BHO chose to focus on engagement as a means to increase the number of youth who remain in the WISe program up to or beyond their initial 180-day authorization. However, no data were available identifying that engagement was lacking in the program prior to the intervention. Because engagement is a mandatory component of WISe, the intervention outlined for this PIP topic should be redefined. To better understand why enrollees are leaving the program before the end of their initial 180-authorization and whether engagement is truly a problem, OPBHO needs to conduct a root cause analysis. The BHO also needs to determine what the average length of stay is before continuing with this PIP, as it may be appropriate in some cases for enrollees to discharge before the end of their authorized length of stay. OPBHO's study topic could potentially yield system improvement as well as improvement in overall enrollee care; however, the BHO has not clearly identified the problems that exist or the intervention it seeks to implement.

Non-clinical: Satisfaction in 24-Hour Facilities in Pierce County (Not Met)
OPBHO selected the study topic for this PIP after analyzing the results of a satisfaction survey administered in June 2016 and conducting research regarding inpatient satisfaction. The results of the survey indicated that areas of opportunity for most providers appeared in the category of therapeutic services. Thus, this PIP focuses on enrollee satisfaction with therapeutic services provided in OPBHO's four evaluation and treatment centers (E&Ts). The BHO has laid the foundation for a PIP that has the potential to affect a significant portion of enrollees and also has the potential to significantly impact enrollee satisfaction within the four E&T facilities located within the BHO's network. However, OPBHO plans to conduct further research by re-administering its satisfaction surveys to enrollees at the four E&Ts and then measuring the change in satisfaction with therapeutic services by comparing the results with those gathered in June 2016. This PIP has not been fully developed, as the data collection needed to demonstrate that an issue truly exists has not been completed. This PIP can only be initiated once thorough data collection and analysis has been completed.

SUD: The Use of the GAIN-SS in a Clinical Referral (Partially Met)
OPBHO identified this PIP topic during the 2016 EQR but has not progressed in defining the study question or implementing a specific intervention. The topic of examining the incongruity of clinicians' diagnoses and GAIN-SS scores has the potential to impact healthcare integration within the BHO. Thus, for the purpose of this PIP, OPBHO seeks to focus on the process of behavioral health clinicians using the GAIN-SS tool and effectively making referrals within each system of care in Pierce County. The BHO expects that as a result, cross-system clinical referrals will improve and individuals in the community will receive the appropriate level of care at the appropriate time. OPBHO should consider first concentrating on the mental health system, as data are already easily available. Once data are consistently available for SUD treatment services, OPBHO can decide if pursuing another phase of the PIP is feasible. This PIP has not progressed since the last EQR. The BHO should address the service gaps between what is possible and what is actually being provided and move forward. OPBHO needs to document progress with this PIP or lack thereof. If progress has not been made with the initial intervention, then the original intervention should be revised and attempted again. If the BHO has discovered that an issue does not exist regarding referrals with the use of the GAIN-SS tool, then it should retire the PIP and pursue a new study topic.

Salish (SBHO)

Clinical: Tobacco Use Cessation (Fully Met)
SBHO initiated this PIP in August 2014. The intention of the PIP is to improve the BHO's ability to apply tobacco cessation and prevention interventions among its enrollees. This is a three-phase PIP aimed at improving tobacco use cessation among Medicaid enrollees. Phase I was improving assessment of

tobacco use and recording of that information in the electronic medical record (EMR). Phase II is the broadening of the tobacco cessation intervention to include additional steps consistent with the Public Health Service clinical practice guidelines. The third and final phase of the PIP will be the measurement of tobacco use outcomes before and after the interventions, with the goal of decreasing tobacco use among enrollees in the study population. The first phase of this PIP was completed in February 2016. The PIP demonstrated sustained improvement through its baseline and two re-measurement periods. The intervention for phase two was initiated in March 2016, so SBHO was able to complete the first re-measurement period on March 31, 2017. The BHO began measuring its intervention for the second phase in April 2017.

Non-clinical/Children's: Increasing Child and Family Team Meetings among High-Risk, High-Cost, and High-Need Children Served by the Mental Health System (Fully Met)
SBHO completed the first phase of this PIP in December 2016, which focused on improving the identification of intensive needs for children and youth and demonstrated sustained improvement over time. As a result of the outcomes obtained from the first phase, the BHO decided to expand the scope of the PIP to a second phase, focused on improving the frequency of child and family team (CFT) meetings for children who are identified as high risk, high need, and high cost based on either meeting criteria for SBHO's CIS Program or WISe eligibility. At the time of the EQR, SBHO reported that BHAs were not providing monthly meetings for this high-need, high-risk, and high-cost population. Thus, the aim of this PIP is to provide training to relevant clinical staff to increase the frequency of CFT meetings. The training addresses issues identified in barrier analyses conducted with the providers and surveys of clients and their families.

SUD: Improving Implementation of the Grievance System among SUD Treatment Providers (Fully Met)
SBHO's selection of this SUD PIP topic was the result of its review of preliminary data indicating low numbers of reported grievances among its BHAs. The low numbers suggest the possibility that all types of grievances may not be included in the formalized system, or that awareness and use of the formal grievance process could be improved. Thus, the aim of this PIP is to improve the implementation of the grievance system among SUD treatment providers, specifically by improving staff knowledge and awareness and then measuring the rate of grievances reported per 1,000 clients for whom an authorization decision was made. As this PIP moves forward and the BHO works to finalize its study question or questions, all elements of the PIP study design should be taken into consideration to ensure all aspects of the PIP are realistic and obtainable. During the EQR on-site review, reviewers recommended that SBHO change the data source of the denominator for one of the indicators due to the State's phase-out of the authorization process. Reviewers also suggested that SBHO run some preliminary data to determine whether changing the denominator made sense before changing course. This would allow for time to gather more information and decide the best course of action. The performance improvement project manager looked at the data and planned to follow the on-site recommendations. Thus, the baseline data will be retroactively calculated. As a result of this change, the language regarding the denominator in the first study question will also need to be replaced with the new denominator language before proceeding to the other steps of this PIP.

Spokane (SCRBHO)

Clinical: Eating Disorder Services (Fully Met)
SCRBHO selected this PIP study topic after three eating disorder diagnoses became covered Medicaid diagnoses under Washington State's Access to Care standards. These standards outline the minimum criteria to be clinically eligible to receive behavioral health services from a BHO system of care. Eating

disorder diagnoses that currently meet the access to care standards for BHO-funded services for Medicaid enrollees include anorexia nervosa restricting type (F50.01), anorexia nervosa binge-eating/purging type (F50.02), and bulimia nervosa (F50.2). SCRBHO is embarking on new territory as it relates to diagnosing and treating Medicaid enrollees who have one of the covered eating disorder diagnoses. The BHO formed a partnership with the Emily Program, a Spokane eating disorder treatment center that currently only accepts privately insured individuals. Through this partnership, SCRBHO provider clinicians will receive training and continuous clinical consultation and support to better serve those enrollees with an eating disorder diagnosis. SCRBHO is also in the initial phases of developing a code to be captured in Raintree for BHAs to report DSM-5 diagnoses as well as the severity level. This will allow for the BHO to track enrollee progress and more effectively monitor the utilization of services for each severity level. This is a new clinical PIP for the BHO; thus it is still in the infancy stages.

Non-clinical/Children's: Youth Crisis Line Awareness (Fully Met)
SCRBHO selected this PIP topic after completing an analysis of data regarding the percentage of Medicaid-eligible children ages 0–17 who had received mental health services within the BHO's region during 2015, evaluation of the region's suicide rates (as they were much higher than those of Washington State overall), and research related to suicide rates, help line mediums, and mental health service utilization. SCRBHO reported that the suicide rates in its region are much higher than those of Washington State as a whole. In 2015, the Spokane County Medical Examiner Annual Report identified suicide as the leading cause of death for youth 10–19 years old. Some adolescents will not seek help because of the stigma attached to mental health disorders. Although this cultural stigma exists, seeking help could be positively influenced by fellow peers and school staff. Adolescents who are most in need of help are less likely to seek help from family and friends. Thus, providing awareness and making crisis services readily available through several mediums are integral in prevention efforts. SCRBHO is seeking to provide awareness on the national Crisis Text Line 741-741 and other mental health hotlines for teens as a mechanism to help adolescents overcome barriers that may prevent them from initiating mental health services. The baseline and two re-measurement periods have not been completed yet as this PIP is still in its nascent stage.

SUD: SUD Treatment Continuity of Care (Fully Met)
SCRBHO is seeking to ensure coordination of care and discharge planning to allow for a seamless transition from inpatient to outpatient services and vice versa. As part of its continuity of care plan, the BHO is seeking to improve engagement and retention and reduce recidivism. Thus, this PIP focuses on the provision of concurrent open episodes for both outpatient and inpatient residential substance use disorder treatment providers by supporting coordination and discharge planning between the outpatient and inpatient treatment providers. Further, the BHO is allowing for overlapping authorizations (inpatient authorization and outpatient authorization) and training the providers to ensure they understand the process in order to prevent the providers from working independently of one another with regard to the enrollee's treatment. SCRBHO intends to measure improvement by the increase in the number of enrollees who complete residential treatment and successfully transition (entering intensive outpatient or outpatient and staying at that level of care for 30 days or longer) from clinically managed high-intensity residential services to intensive outpatient or outpatient treatment. SCRBHO has conducted a baseline measurement and a re-measurement for its SUD PIP. Initially, the BHO did not achieve the results it anticipated and was unable to show statistical significance. Consequently, the BHO is taking the necessary steps and conducting a failure mode analysis. Some challenges and barriers have been identified, and the BHO is leading workgroups to identify the root causes of these barriers.

Thurston-Mason (TMBHO)

Clinical/Children's: High-fidelity Wraparound (Fully Met)
TMBHO initiated this clinical/children's PIP in 2011, when the BHO's intention for the PIP was to assess whether the implementation of wraparound services could significantly improve clinical outcomes related to the behavior and functioning of the youth enrolled in the program as measured by the Strengths and Difficulties Questionnaire (SDQ), Total Difficulties Scale, and CANS scores. TMBHO has shown sustained improvement through repeated measurements over comparable periods of time. Further, the BHO has shown a great deal of work and effort regarding WISe and the full implementation of this program. TMBHO has drafted a well-assembled report describing its methodology, findings, and conclusion. The report clearly outlines the changes in performance and how these changes are attributed to the interventions. Given the BHO has demonstrated its accomplishments and shown sustained improvement over several years, it is recommended that this PIP be retired and a new study question be formulated with a new intervention.

Non-clinical: Increasing Co-occurring Mental Health and Substance Use Disorder Service Participation for Adult Enrollees (Partially Met)
TMBHO has noted that there is a disparity within its network between the number of individuals who meet the criteria for having both a mental health diagnosis and a substance use disorder diagnosis and those who have actually received co-occurring services or standalone services for both of their diagnoses. Thus, the BHO is seeking to increase availability of co-occurring mental health and substance use disorder treatment services for adult enrollees who meet the criteria for medical necessity for both mental health and substance use disorder services. Although the BHO has not fully formulated the study question for this PIP, it has identified the PIP's goal as increasing enrollee participation in co-occurring mental health and SUD treatment services for Medicaid adults who meet medical necessity standards for both a mental health and a substance use disorder diagnosis. This PIP topic has the potential to create meaningful change for a group of high-need, at-risk adult enrollees.

SUD: SUD Residential Treatment Access (Partially Met)
TMBHO has decided to focus on increasing accessibility and timeliness of SUD residential treatment services for enrollees who have an overall American Society of Addiction Medicine (ASAM) level of care of 3.1, 3.3, or 3.5. The BHO has preliminary data that show a variance between the number of enrollees referred for residential treatment and those who were actually admitted. However, TMBHO has reported difficulty in gathering data to fully understand SUD treatment utilization as a whole along with barriers to treatment access. Although TMBHO has begun to formulate the study question for this PIP, the BHO has not analyzed enough accurate and available data to define the specific issue. Thus, the BHO is not in a position to fully articulate the study question. Overall, TMBHO needs to collect and analyze data related to accessing residential treatment services, then decide what the issues are and choose an intervention to address one of them.

Strengths

- Over the course of 2017, DBHR has improved its PIP review and approval process by implementing tracking mechanisms that outline the BHOs' PIP approval dates to help ensure BHOs implement interventions for their PIPs only after the approval process has taken place.
- DBHR continues its communication and collaboration with the EQR team to make certain that clear, concise, and consistent feedback is provided to the BHOs regarding study topic submissions.
- The majority of PIPs that had reached the point of data analysis received overall scores of fully met, with high confidence in reported results.
- Most BHOs were able to use qualitative and quantitative data to inform assessments of their projects' effectiveness and, if needed, implement modifications to improve outcomes.
- Several BHOs were able to identify and assess change ideas that might help solve complex quality issues in behavioral healthcare.
- PIPs demonstrated an overall commitment to improving the processes and outcomes of behavioral healthcare for all enrollees.
- Most BHOs were receptive and responsive to feedback and technical assistance regarding the formulation and implementation of PIPs.

Recommendations

This is the second year DBHR has required BHOs to have a pre-approved and implemented third PIP focusing on SUD treatment services. Many BHOs still face challenges regarding collecting SUD data and identifying potential topics based on that data. Without complete and accurate data, the BHOs found it difficult to fully understand the needs of enrollees related to substance use disorder treatment and what gaps might exist in the SUD program, outside of contract requirements. The formulation of a PIP needs to include the collection and analysis of internal and external data related to the study topic. Without this data, the BHOs are unable to analyze the data and identify a study topic.

- DBHR needs to continually develop procedures to ensure the BHOs are able to receive reliable historical SUD treatment service data.

Some BHOs did not involve enrollee/stakeholder input at the onset of the selection of the PIP study topic.

- DBHR needs to ensure that input from enrollees, family members, peers, and/or advocates are considered during the selection of the BHOs' PIPs.

Some BHOs struggled with choosing new PIP topics.

- DBHR needs to ensure that when selecting a PIP study topic, the BHOs:
    - ensure there are data that can be collected and analyzed to support the focus of the PIP as an area that truly needs improvement
    - do not attempt to create a PIP around a program or process that does not show evidence of needing improvement. PIPs are meant to improve the care and treatment of enrollees in areas that are in need of advancement, not highlight programs or processes that are successful.
    - fully and clearly define the intended intervention(s)

A few BHOs' PIPs were in place for extended measurement periods with only minimal explanation or

updates to the PIP submission.

- DBHR needs to ensure that the BHOs' PIP measurement periods are clearly stated and appropriate in length.
- Data need to be reviewed at least on a quarterly basis to ensure the PIP is moving in a successful direction.
- Any changes in the study periods need to be clearly documented with thorough and valid explanations of deviations from the initial plan.

Several of the BHOs have staff who are unfamiliar or unsure of the PIP process. Many of these staff need continued technical assistance with understanding the CMS protocol for conducting performance improvement projects.

- DBHR and the EQRO need to continue to provide technical assistance to the BHOs and their staff on the CMS protocol and PIP study design.
- DBHR and the EQRO need to continue to provide technical support to ensure BHOs understand how to utilize core improvement concepts and tools when implementing PIPs.

Information Systems Capabilities Assessment (ISCA)

Qualis Health's subsidiary, Outlook Associates, conducted an ISCA for DBHR and its contracted BHOs as part of the 2017 EQR. These assessments examined the State and BHO information systems and data processing and reporting procedures to determine the extent to which they support the production of valid and reliable State performance measures and the capacity to manage care of BHO enrollees. This included examination of the data exchanges among the BHA, BHO, and State information systems to identify potential issues and challenges.

Methodology

The ISCA procedures were based on the CMS protocol for this activity, and adapted for the BHOs with DBHR's approval. The resulting questionnaire was divided into seven scored review areas similar to those used for the last ISCA conducted in 2015.

Each BHO selected two BHAs to complete a provider survey tool and meet with the review team for a brief on-site interview and a security walkthrough of each facility. The purpose of the agency visits was to validate the information provided by the BHO. For BHAs selected to participate in the BHO reviews and for the State review, the primary tool was modified appropriately. Reviewers utilized three survey tools during the reviews. One was developed for the BHOs, one for the BHAs, and one for DBHR. In addition to the survey tool, reviewers designed an on-site walkthrough tool, which focused on physical and data security. For each BHO ISCA review area, Outlook Associates used the information collected in the ISCA data collection tool, responses to interview questions, and information gleaned from the security walkthroughs to rate the BHO's performance in the seven review areas. Scores are based on fully meeting, partially meeting, or not meeting standards. The security walkthrough was not performed at DBHR, although the ISCA survey the agency completed included a section addressing DBHR's physical security.

The ISCA review process consists of four phases:

Phase 1: Standard information about DBHR's or the BHO's information systems is collected. DBHR completed the ISCA data collection tool before the on-site review, which mirrored the process with the BHOs. The BHOs and two of their BHAs also completed the ISCA data collection tool before the on-site review.

Phase 2: The completed ISCA data collection tools and accompanying documents are reviewed. Submitted ISCA tools are thoroughly reviewed. Wherever an answer seems incomplete or indicates an inadequate process, it is marked for follow-up. If the desktop review indicates that further accompanying documents are needed, those documents are requested.

Phase 3: On-site visits and walkthroughs with DBHR or the BHO and two selected BHAs are conducted. Claims/encounter walkthroughs and data center security walkthroughs are conducted. In-depth interviews with knowledgeable BHO and BHA staff are conducted. After the interviews and walkthroughs are completed, additional documents are requested if needed. As mentioned previously, the on-site visit was conducted at DBHR, but the walkthrough content was addressed through the survey.

Phase 4: Analysis of the findings from DBHR's or the BHO's information system on-site review commences. In this phase, the material and findings from the first three phases are reviewed in cooperation with DBHR or the BHO and selected BHAs to close out any open review questions. The BHO-specific or DBHR ISCA report is then finalized.

Each of the items in the review areas were evaluated against industry standards for health data information systems, especially Medicaid Management Information Systems. Table D-1 describes those standards.

Table 25: ISCA Scoring Standards

Citation	Issuing Body	Description of Standard
45 CFR 160	Health & Human Services (HHS)	Federal regulations for general administrative requirements pertaining to security and privacy.
45 CFR 164	Health & Human Services (HHS)	HHS Standards for Security and Privacy Part 164 covers security and privacy of individually identifiable health information.
ISO/IEEE 29119	International Standards Organization/Institute of Electrical and Electronics Engineers	Contains five standards that define an internationally agreed upon set of standards to support software testing.
NIST	National Institute of Standards and Technology	NIST Special Publications 800 series provides a catalog of security controls for all U.S. federal information systems except those related to national security. NIST standards have been incorporated into CMS security controls such as the Minimum Acceptable Risk Standards catalog of security and privacy controls.
ANSI ASC X 12	American National Standards Institute, the Accredited Standards Committee	Uniform standards for inter-industry electronic exchange of business transactions, namely electronic data interchange.
ISO/IEC 27000:2016, 27001:2013, and 27002:2013	International Organization for Standardization/International Electrotechnical Commission	Series of international standards providing best practice recommendations on information security management.
42 CFR 438	Health & Human Services (HHS), Centers for Medicare and Medicaid Services	Federal regulations for Medical Assistance Programs, Managed Care. Subpart F pertains to Grievance and Appeals Systems.

The table below presents the scoring key for the ISCA standards.

Scoring Key

Fully Met (pass) ●	Partially Met (pass) ◉	Not Met ○

Summary of Results

Results of the ISCA review activities are presented in two sections:

- The first results summary presents an evaluation of the DBHR and other state-level systems that collect data from the BHOs.
- The second results summary consists of an evaluation of the entire behavioral health data network as a whole, summarizing the findings resulting from each of the BHO reviews as well as statewide analysis and trends.

DBHR ISCA Results

Table 26 displays a summary of the scores resulting from DBHR's ISCA review. Detailed discussion of each section and its elements follows.

Table 26: ISCA Scores by Section

ISCA Section	Description	ISCA Result
Overall ISCA Score	This is the overall score for DBHR's ISCA.	◉ Partially Met (pass)
A. Information Systems	This section assesses DBHR's management of the information systems.	● Fully Met (pass)
B. IT Infrastructure	This section assesses DBHR's network infrastructure.	◉ Partially Met (pass)
C. Information Security	This section assesses the security of DBHR's information systems.	◉ Partially Met (pass)
D. Encounter Data Management	This section assesses DBHR's ability to capture and report accurate encounter data.	◉ Partially Met (pass)
E. Eligibility Data Management	This section assesses DBHR's ability to capture and report accurate Medicaid eligibility data.	● Fully Met (pass)
F. Provider Data Management	This section assesses DBHR's ability to maintain accurate provider information.	● Fully Met (pass)
G. Performance Measures and Reporting	This section assesses the DBHR's performance measure and reporting processes.	◉ Partially Met (pass)

ISCA Section Details

Each ISCA subsection features a score corresponding to the "Met," "Partially Met," and "Not Met" scoring system. For each subsection, if a recommendation requiring a corrective action plan (CAP) has been issued, the subsection will receive a score of Not Met or Partially Met, depending on the severity, and the section will also receive that corresponding score. If a subsection receives recommendations for an opportunity for improvement, the subsection will receive a score of Partially Met or Fully Met, and the section will also receive that corresponding score, unless another subsection received a score of Not Met. If no recommendations are noted within a subsection, the subsection receives a score of Fully Met. If all subsections receive a score of Fully Met, the section also receives a score of Fully Met.

Score	Description
○ Not Met (fail)	Recommendation Requiring CAP(s) issued
◉ Partially Met (pass)	Recommendation for Opportunity for Improvement(s) issued
● Fully Met (pass)	No Recommendations issued

Section A: Information Systems

This section assesses management of the information systems, specifically examining the capacity for collecting, storing, analyzing, and reporting client demographic and treatment data.

Characteristics of well-managed systems include:

- data structure that supports complex queries that can be changed easily
- secure access via authentication with permission levels
- written policies and procedures that support industry standard and best practice IT management
- reasonable system response times
- complete and consistent testing procedures
- clear version control procedures
- ability to make changes to systems with minimal disruption to users
- adequate training and user documentation
- open communication with end users of information system changes and issues

DBHR demonstrates compliance in all of these areas.

DBHR utilizes two major systems to collect data from the BHOs and for reporting: the Behavioral Health Data System (BHDS) and ProviderOne. BHDS is the primary data repository for reporting behavioral healthcare activity and monitoring the BHOs. DBHR began using the system in April 2016. The BHOs submit their native data directly to BHDS via secure file transfers. Encounter and eligibility data are received from ProviderOne, the primary source for encounter data.

ProviderOne is owned by the Washington State Health Care Authority (HCA) and supported and maintained by Client Network Services, Inc.(CNSI). The BHOs submit their encounter data directly to ProviderOne via HIPAA standard electronic data interchange (EDI).

The BHOs are able to report issues with BHDS via a dedicated mailbox, or they can telephone for more immediate assistance. DBHR uses Microsoft's Team Foundation Server (TFS) for version control of its releases. Help desk services are available for ProviderOne issues using the Open Source Ticket Request System (OTRS) for version control in conjunction with a document management system.

Enhancements and modifications to ProviderOne are uploaded every eight weeks. The State's Change Review Board, with representatives from DSHS, HCA, and DBHR, review the change requests and establish priority, using written criteria intended to guide the hierarchy and prioritize decision-making. HCA follows a standard SDLC (systems development life cycle) methodology to implement changes. Changes to ProviderOne are communicated to DBHR and then to the BHOs. The State Joint Management Team coordinates systems changes and enhancements for the systems owned by different divisions within DSHS.

DBHR monitors the quality and completeness of the BHOs' submitted data through multiple mechanisms. DBHR provides the BHOs with data quality and completeness reports biweekly. ProviderOne returns encounter transaction results reports weekly. Annual encounter data validation (EDV) audits are conducted annually by the State's EQRO. DBHR also contractually requires the BHOs to perform EDV with their BHAs.

Strengths

- DBHR has a complete set of management policies meeting industry standards.
- DBHR monitors the quality and completeness of the BHOs' data through several different processes. It requires the BHOs to monitor their BHAs in a similar fashion.
- The governance team for ProviderOne consists of representatives from all stakeholders.
- ProviderOne change control processes meet industry standards, and the State's Change Control Board meets regularly.
- BHDS maintains development, test, and production environments.
- All major databases are available 24 hours a day, 7 days a week.
- DBHR convenes monthly data group meetings with the BHOs to discuss issues with the collection and submission of data.
- DBHR reviews and updates the Service Encounter Reporting Instructions (SERI) every six months at a minimum. A dedicated workgroup, which meets bimonthly, reviews the changes. The workgroup comprises a well-rounded mix of clinical and coding staff from DBHR and the BHOs.
- All BHOs are submitting their encounters to ProviderOne electronically via HIPAA standard transactions.

Weakness

- In April 2016, DBHR replaced the Target system with BHDS and ProviderOne for SUD treatment agencies. The SUD treatment agencies have experienced difficulty adjusting to the new data exchange procedures, causing underreporting of the SUD data statewide.

Table 27: Results for Section A: Information Systems

Sub-Area	Issues	Recommendation	Score	Standard
IS Management Policies	None	None	●	45 CFR §§160, 164; BHO Contract Section 10.10.1
Reconciliation and Balancing	None	None	●	BHO Contract
Training	None	None	●	45 CFR §164.312
Testing Procedures	None	None	●	ISO/IEEE 29119
System Changes and Version Control	None	None	●	NIST SP 800-28
EDI	None	None	●	45 CFR §164.312; ANSI ASC X12
Total Score			●	

Meets Criteria

Section B: IT Infrastructure

This section assesses DBHR'S network infrastructure and the ability to maintain its equipment and telecommunications capacity to support end users' needs.

Characteristics of a well-managed IT environment include:

- adequate maintenance staff or maintenance contracts to ensure timely replacement of computer equipment and/or software.
- adequate staff or contracts that ensure timely responses to emergent and critical system failures.
- redundancy within the data center hardware that minimizes the length of system outages, loss of data, and disruption of end user service.
- business continuity and disaster recovery (BC/DR) plans that are maintained and tested regularly.

DBHR demonstrates compliance in most of these areas.

DBHR systems are run on the State Government Network (SGN) managed by Washington Technology Services and located in the State Data Center (SDC) in Olympia. Data backups occur daily, weekly, and monthly. The backup data are stored at the SDC. DBHR local devices and wide area network (WAN) are supported by DSHS IT (Enterprise Technology Group). ProviderOne is housed in a data center in Ashburn, VA. A disaster recovery (DR) warm site is housed in Denver. The DR system is synchronized with the production system. ProviderOne is hosted and managed by CNSI through a contract with HCA. Both BHDS and ProviderOne are available 24 hours a day, 7 days a week.

Strengths

- System backups for both BHDS and ProviderOne are completed daily, weekly, and monthly.
- CNSI provides a warm backup site for ProviderOne in Denver.
- Both BHDS and ProviderOne apply industry standard redundancy techniques to prevent loss of data and disruption to services. Redundancy techniques are applied at the host, network, and storage levels.
- DBHR's disaster recovery plan is reviewed and tested annually. It is updated at least annually and more frequently if needed.

Weakness

- There is no disaster recovery site for BHDS.

Table 28: Results for Section B: IT Infrastructure

Sub-Area	Issues	Recommendation	Score	Standard
Redundancy	None	None	●	45 CFR §164.308; NIST SP 800-34
Data Center/Server Room	None	None	●	45 CFR §164.308; OSI/ISO Network Management Model (FCAPS)
Backup	An off-site disaster recovery location is maintained for ProviderOne but not	Work with the SDC to establish a disaster recovery site for BHDS	◉	45 CFR §164.308; NIST SP 800-34; BHO Contract

	for BHDS			
Network Availability	None	None	●	ISO Network Management Model (FCAPS)
Total Score			◉	

Recommendation

Best practice guidelines recommend that all data centers and business-critical applications have off-site disaster recovery capabilities that will meet the organization's needs. An off-site disaster recovery location is maintained for ProviderOne, but not for BHDS. A prolonged outage at the SDC would have a detrimental effect on day-to-day operations at DBHR.

- DBHR needs to continue to work with the SDC to establish an off-site disaster recovery location for BHDS in the event of a catastrophic outage.

Section C: Information Security

This section assesses the security of DBHR's information systems that use data submitted by the BHOs and the safeguards in place to proactively avoid malicious access to facilities and/or data systems, intrusions, and breaches of protected health information (PHI) and personally identifiable information (PII). State and agency-level security policies were reviewed.

Characteristics of good security management include:

- physical security safeguards at all facilities
- policies and procedures that adhere to national healthcare security standards, include specific references and guidelines for mobile devices, and are routinely reviewed and updated
- procedure to remove access to appropriate systems when an employee or contractor leaves, which includes an expedited path in case of emergency
- dedicated security administration staff, adequate to support the agency and its internal and external users
- policies and procedures that adhere to HIPAA Security and Privacy standards, including the reporting and remediation of security and privacy breaches

DBHR demonstrates compliance in most of these areas.

Information security is taken very seriously within the State. The behavioral health information systems must meet a variety of federal, State, and agency-level security regulatory requirements. ProviderOne must adhere to all of the CMS-mandated security regulations for a Medicaid Management Information System (MMIS). Additionally, State regulations require every agency to designate a security officer. Each unit within DSHS staffs a security officer as well.

Active Directory is used to manage access to the local network; there are individual logons required for each of the applications. A separate, secure email application is used for sending any emails with PHI.

The last comprehensive penetration test of the DSHS network was performed in November 2012. The test identified several issues, which resulted in a corrective action plan. DSHS continues to work on these issues, but has lacked funding to proceed at a faster pace.

CNSI is contractually required to perform routine penetration testing on ProviderOne. A full security design review of ProviderOne is underway. DBHR has instituted a process to remove access from terminated staff and contractors to the DSHS network and its applications.

Strengths

- DSHS has a current and thorough set of security policies and procedures.
- DBHR requires staff to complete annual security and privacy training, and has a designated security officer within the agency.
- Physical security safeguards are in place at DBHR's office site. The State Data Center and the CNSI main data center have procedures and policies in place that support industry standard physical security safeguards.
- All laptops and mobile devices are encrypted.

- The BHOs have a three-way data sharing agreement with the HCA and DSHS Research and Data Analysis (RDA) division that describes in detail the processes of terminating staff and contractors and outlines the responsibilities of the end users in utilizing the data.
- Access to BHDS is restricted to authorized staff and specified contractors. External entities can access the BHDS only via SFT. No external entity can directly access BHDS.
- DSHS security staff use Tripwire to perform monthly vulnerability scans on DSHS devices.
- The Medicaid State Security Plan is reviewed and updated annually. At the time of the EQR, there were no outstanding security corrective action plans to be addressed.

Weaknesses

- DSHS has not completed a comprehensive penetration test since 2012.
- DSHS continues to work on issues discovered during the last penetration test. These include obtaining tools to routinely scan applications for vulnerabilities, which is required by the State Office of the Chief Information Officer (OCIO) in published standards.

Table 29: Results for Section C: Information Security

Sub-Area	Issues	Recommendation	Score	Standard
Physical Security	None	None	●	45 CFR §164.310; NIST SP 800-66; BHO Contract Section 3.4.4
Security Policies	None	None	●	45 CFR §§164.308,164.312; NIST SP 800-39; BHO Contract Section 3.4.4
Security Testing	Penetration testing on DSHS applications is out of date, and issues identified in the last test remain unaddressed	Continue working on issues found in 2012 penetration test. Initiate penetration testing at a regular interval	◉	NIST SP 800-53, 115
Access Removal Policies			●	45 CFR §§164.308,164.312; ISO/IEC 27000:2016–27002; BHO Contract Section 3.4.4
Mobile Device Security and Policies			●	45 CFR §§164.308,164.312; NIST SP 800-124
Total Score			◉	

Recommendations

The last penetration test on DSHS applications was completed in 2012. Issues identified during that test are still not resolved. Penetration testing should be completed at least annually, per NIST standards.

- DSHS needs to complete work on the corrective action plan created as a result of findings identified in the last penetration test in 2012.
- DSHS needs to re-institute routine penetration testing on the DSHS network.

Section D: Encounter Data Management

This section assesses the State's ability to capture and report accurate encounter data.

Characteristics of good encounter data management include:

- documented procedures on encounter data submission, which include timeframes and validation check
- automated edit and validity checks of key fields
- production of error reports and procedures to correct those errors
- periodic audits to validate the encounter data
- regular meetings with agency staff to ensure all data are captured accurately and in a timely manner
- reconciliation procedures that compare BHO data to provider data

DBHR demonstrates compliance in most of the above areas.

All of the BHOs submit their encounter data directly to ProviderOne. ProviderOne performs a series of pre-adjudication file-level edits and adjudication edits that reflect industry standards. Data format and validity checks are performed on standard coded fields found in the 837 transaction set. The BHOs receive a report of transactions and errors in return.

An extract of accepted encounters is sent weekly to each BHO to compare to its own systems. Each BHO also receives a weekly copy of the Encounter Transaction Results Report (ETRR). Internal and external EDV audits are conducted annually.

Procedures for submitting data to BHDS and ProviderOne are well documented. DBHR publishes the SERI, which contains all data reporting requirements for the BHOs. HCA publishes the Washington Apple Health Encounter Data Reporting Guide, which describes the encounter data reporting process and the required reporting elements.

DBHR also hosts monthly data group meetings with BHO representatives to discuss data issues and ProviderOne enhancements.

Strengths

- All of the BHOs submit their encounters to ProviderOne electronically as HIPAA-compliant transactions (837I and 837P).
- BHOs are contractually bound to conduct their own EDV reviews with each of their contracted BHAs.
- ProviderOne has a robust set of data edits to ensure that standard codes, such as for diagnosis and procedure, are valid.
- State-level operational staff do not change Medicaid encounter information. All errors are returned to the BHOs for correction.

Weaknesses

- There are minimal data quality edits in place for encounter data in order to maximize the amount of data collected. Some of the edits produce warning messages instead of rejecting the

encounters. Data quality in the behavioral health encounters could be improved if more edits were applied.

- Detox and residential services are underreported. SUD treatment agencies struggled with the change in reporting requirements after they integrated with the BHO networks in April 2016. A few agencies have not yet reported their data for 2016.
- Timeliness edits were waived during special processing periods in order for some of the BHOs to obtain encounters from their SUD treatment agencies.

Table 30: Results for Section D: Encounter Data Management

Sub-Area	Issues	Recommendation	Score	Standard
Data Validation	None	None	⦿	42 CFR §438.242; 45 CFR §164.312
Error Handling	ProviderOne has minimal data quality edits in place for encounter data in order to maximize the amount of data collected	Implement processes to create edits in ProviderOne to reject incorrectly submitted encounters	⦿	45 CFR §164.312
Auditing	None	None	●	42 CFR §438.608 45 CFR §164.312
Total Score			⦿	

Recommendation

ProviderOne has minimal data quality edits in place for encounter data in order to maximize the amount of data collected. Some of the edits produce warning messages instead of rejecting the encounters.

- DBHR needs coordinate with HCA to implement processes for creating edits in ProviderOne to reject encounters that are submitted incorrectly to the State.

Section E: Eligibility Data Management

This section assesses DBHR's ability to capture and report accurate Medicaid eligibility data.

Characteristics of good management of eligibility data include:

- uploading of monthly eligibility data from the State with reconciliation processes in place
- uploading and applying eligibility data changes from the State in between monthly files
- managing internal eligibility files to eliminate duplicate member records
- running reports to identify changes in eligibility that effect service data

DBHR demonstrates compliance in all of the above areas.

ProviderOne is the primary authority for eligibility data. ProviderOne pulls the eligibility data from the Automated Client Eligibility System (ACES) owned by DSHS/Economic Services Administration (ESA). ACES is the system of record for Medicaid eligibility information. Neither ProviderOne nor BHDS modifies eligibility data. Eligibility information in ProviderOne is updated daily. ProviderOne generates eligibility files for the BHOs and provides them with a monthly audit file and weekly update files in 834 format. Medicaid-eligible enrollees are assigned to BHOs based upon residential ZIP code.

The majority of agencies query ProviderOne online to verify eligibility when a client appears for services. When gaps in eligibility occur, providers try to avoid gaps in client services by using other funds until Medicaid funds become available, or by referring those clients to other agencies.

Strengths

- ProviderOne receives eligibility updates daily from ACES. That information is distributed to the BHOs via standard HIPAA-compliant transactions in weekly update files and monthly rosters.
- BHAs use ProviderOne to verify eligibility when a client appears for services, minimizing the risk of serving non-Medicaid-eligible clients.
- ProviderOne manages eligibility and has an established process for merging records and linking Medicaid IDs in the rare occasions in which duplicate records exist.

Table 31: Results for Section E: Eligibility Data Management

Sub-Area	Issues	Recommendation	Score	Standard
Eligibility Updates and Verification Process	None	None	●	42 CFR §§438.242, 438.608; BHO Contract
Duplicate Management	None	None	●	42 CFR §§438.242, 438.608
Eligibility Loss Management	None	None	●	42 CFR §§438.242, 438.608
Total Score			●	

Meets Criteria

Section F: Provider Data Management

This section assesses DBHR's ability to maintain accurate and timely provider information.

Characteristics of good provider data management practices include:

- establishing a communication process to update and maintain provider credentials, licenses, and skill sets
- supporting information systems that integrate provider information with member and service data
- developing and maintaining policies and procedures that support timely exchange of provider information
- using provider data to edit encounter data to ensure that qualified providers are performing services they are qualified to perform

DBHR demonstrates compliance in most of the above areas.

The Agency Licensing and Certification System (ALCS) is the DBHR system that contains provider data. This system stores information about each BHA site and the services it performs. The DBHR licensing team maintains the Medicaid provider directory of licensed behavioral health providers.

ProviderOne contains limited provider data for the purpose of adjudicating the encounters submitted by the BHOs. BHAs enroll the billing and rendering provider IDs prior to submitting any encounters to ProviderOne.

Currently, BHAs submit and maintain NPIs (National Provider IDs) at the site level. The BHOs are required to obtain and monitor provider credentials, including licensing and certification information, as well as findings about the agencies or any of their employees.

Strength

- BHOs are contractually required to credential providers within their network and monitor their status.

Table 32: Results for Section F: Provider Data Management

Sub-Area	Issues	Recommendation	Score	Standard
Provider Directory Management	None	None	●	42 CFR §§438.242, 438.608; BHO Contract
Payment Reconciliation	None	None	●	42 CFR §§438.242, 438.608
Total Score			●	

Meets Criteria

Section G: Performance Measures and Reporting

This section assesses DBHR's performance measure and reporting processes.

Characteristics of good reporting practices include:

- use of encounter data, member data, and service data from an integrated database as the primary source for performance measurements
- policies and procedures that describe how the organization maintains data quality and integrity
- staff dedicated and trained in all tools to develop queries and tools for reporting
- support for continuing education of staff responsible for reporting metrics
- use of data for program and finance decision making
- use of analytics software and other industry standard reporting tools

DBHR demonstrates compliance in most of these areas.

Decision Support and Evaluation (DSE) is the end user reporting unit within DBHR. It is responsible for all reports used and distributed by DBHR. This includes block grant application data and reporting, data and reports for rate setting, and other reports to support monitoring and compliance functions. Its primary sources of data are BHDS and ProviderOne. The unit has its own copy of BHDS, which is refreshed nightly.

The BHOs are contractually obligated to track two performance measures: Psychiatric Hospital Readmission Rates and Mental Health Treatment Penetration.

Strengths

- DSE is a unit within DBHR that is charged with analyzing the data and providing reports to meet their needs.
- DSE runs biweekly reports for each of the BHOs that monitor data quality, timeliness, and completeness. These reports are also discussed at the monthly BHO data group meetings.
- DBHR requires BHOs to track two performance measures, which are well-defined and documented within the BHO contracts.
- All of the BHOs have grievance systems in place.

Weaknesses

- DBHR has not set any benchmarks or targets for the BHOs' required performance measures.
- DBHR generates and monitors other measures, but is not sharing the data with the BHOs. However, it shares the measures, in aggregate, with the public via its website.

Table 33: Results for Section G: Performance Measures and Reporting

Sub-Area	Issues	Recommendation	Score	Standard
Performance Measure Processes	The BHOs do not have access to the performance measure data that DBHR or RDA compiles. DBHR also has not set benchmarks or required targets for the measures	Share the performance data with each of the BHOs and set benchmarks and targets for the measures	◉	42 CFR §438.242; BHO Contract
Validation of Performance Metrics	None	None	●	BHO Contract
Documentation of Metrics	None	None	●	N/A
Appeals and Grievances	None	None	●	BHO Contract Section 7
Total Score			◉	

Recommendations

DBHR requires the BHOs to monitor two performance measures but has not set performance goals or targets, which could be used to improve client outcomes.

- DBHR needs to set benchmarks for each of the required performance measures and measure the BHOs' outcomes.
- DBHR needs to share the performance measure data it collects with each of the BHOs.

BHO ISCA Results

Table 34: Results of BHO ISCA Review

BHO	Information Systems	IT Infrastructure	Information Security	Encounter Data Management	Eligibility Data Management	Provider Data Management	Performance Measures and Reporting
Great Rivers	●	◉	◉	●	●	●	●
Greater Columbia	●	◉	◉	●	●	●	●
King County	◉	◉	◉	◉	●	●	●
North Central	●	◉	◉	●	●	●	●
North Sound	◉	◉	◉	◉	●	●	◉
Optum Pierce	●	◉	○	●	●	●	●
Salish	◉	◉	◉	◉	●	●	●
Spokane	●	●	◉	◉	●	●	●
Thurston-Mason	◉	●	●	◉	○	◉	◉

Overall, the BHOs performed very well on the ISCA. The IT Infrastructure and Information Security sections were the weakest areas of performance. Only two of the nine BHOs fully met the criteria for IT Infrastructure, with widespread issues concerning back-up policies and procedures at provider sites. Similarly, only one of the nine BHOs fully met the Information Security criteria, owing frequently to physical security and weaknesses around policies and procedures, especially at the provider level.

SUD treatment providers continue to struggle to submit their data to the BHOs. This has forced the State to loosen the timely filing edits on several occasions in order to transmit the data into ProviderOne. The SUD data is critical to rate setting and needs to be included, but lifting the edits for even a small amount of time presents downstream ramifications. Many of the BHOs went above and beyond to accommodate the SUD treatment providers for data submission, such as by adapting old systems and allowing direct data entry into their own information systems.

Section A: Information Systems

This section assesses the BHO's management of the information systems, specifically examining the BHO's capacity for collecting, storing, analyzing, and reporting client treatment data.

Characteristics of well-managed systems include:

- data structure that supports complex queries that can be changed easily
- secure access via authentication with permission levels
- written policies and procedures that support industry standard and best practice IT management
- reasonable system response times
- complete and consistent testing procedures
- clear version control procedures
- ability to make changes to systems with minimal disruption to users
- adequate training and user documentation

Contractually, the BHOs are required to maintain a health information system that complies with federal regulations; they must either provide an information system for their BHAs or require their BHAs to maintain their own health information system that facilitates the capture and submission of the required client data.

Most of the BHOs comply with these terms. One BHO received a score of partially met for this area because its policies and procedures did not include a last review date and the reviewers could not discern when the policies had last been reviewed and updated. Reconciliation of data and payment was particularly challenging for two of the BHOs' provider agencies.

TMBHO's agencies were unable to match their data with the BHO's and had requested more information. At the time of the review, one of SBHO's SUD treatment agencies had not yet submitted any of its data to the BHO, which had prevented the BHO from completing a reconciliation process with its agencies.

Strengths

- All of the BHOs have written IS policies and procedures that follow industry standards.
- All of the BHOs utilize industry standard testing procedures when implementing changes from the Service Encounter Reporting Instructions (SERI).
- All of the BHOs hold monthly meetings with the BHAs to discuss IT issues and challenges.
- All of the BHOs use sound version control procedures for promotion of system changes.
- OPBHO typically responds to authorization requests in one hour or less.

Opportunity for Improvement

SBHO has not performed a reconciliation of its data because one SUD treatment agency has not yet submitted any encounter data to the BHO.

- DBHR should assist SBHO with obtaining encounter data from the agency.

Section B: IT Infrastructure

This section assesses the BHO's network infrastructure and the BHO's ability to maintain its equipment and telecommunications capacity to support end users' needs.

Characteristics of a well-managed IT environment include:

- Adequate maintenance staff or maintenance contracts to ensure timely replacement of computer equipment and/or software
- Adequate staff or contracts that ensure timely responses to emergent and critical system failures
- Redundancy within the data center hardware that minimizes the length of system outages, loss of data, and disruption of end user service.
- Business continuity and disaster recovery (BC/DR) plans that are maintained and tested regularly.

Each BHO must have a primary and backup system to capture the data requested by the State, as well as the ability to exchange data with the State. BHOs are also required to have a written BC/DR plan that ensures timely reinstitution of their primary data system. The BHOs are responsible for ensuring that their BHAs have a BC/DR plan in place.

All of the BHOs have network infrastructure and telecommunications capacity to support their business needs. Most of them contract for data center services and follow industry best practice backup procedures, although one BHO had not been testing its backups monthly.

The State, the BHOs, and the BHAs are all required to have documented BC/DR plans. However, five of the BHOs received a partially met score in this sub-category; while all BHOs had BC/DR plans in place, many of the BHAs did not.

Strengths

- All of the BHOs have excellent policies in place related to infrastructure. GCBHO has developed an exceptional set of policies and procedures.
- All of the BHOs perform backups regularly and adhere to industry standards.
- All of the BHOs have written disaster recovery plans in place.

Recommendation

Many of the BHAs did not have documented business continuity and disaster recovery (BC/DR) plans in place.

- DBHR needs to work with and monitor the BHOs to ensure that all of the BHOs and their contracted BHAs have written BC/DR plans. The BHOs should collect the BC/DR plans from the agencies and ensure that the plans are updated and tested annually.

Section C: Information Security

This section assesses the security of the BHO's information systems and the safeguards in place to proactively avoid malicious access to facilities and/or data systems, intrusions, and breaches of protected health information (PHI) and personally identifiable information (PII).

Characteristics of good security management include:

- physical security safeguards at all facilities
- policies and procedures that adhere to national healthcare security standards, include specific references and guidelines for mobile devices, and are routinely reviewed and updated
- procedure to remove access to appropriate systems when an employee or contractor leaves, which includes an expedited path in case of emergency
- dedicated security administration staff, adequate to support the agency and its internal and external users
- policies and procedures that adhere to HIPAA Security and Privacy standards, including the reporting and remediation of security and privacy breaches

The BHOs must maintain adequate physical security for all of their facilities and adhere to HIPAA security and privacy standards for the protection of client data in any format. Thus far, none of the BHOs have needed to execute HIPAA breach procedures.

While all of the BHOs have security policies in place, some anomalies were discovered during the review. This was the weakest area of performance for the BHOs. Most of the problems were easily and quickly remedied, and many were minor in nature. However, the consequences of a small lapse in security could result in serious breaches of PHI/PII. It is important that all of the issues identified during the ISCA process be corrected as soon as possible.

Four of the BHOs had physical security issues at the time of the on-site review. Reviewers discovered many of these issues at the BHA facilities visited. The most common issue was the protection of client PHI in the reception area, which could easily be resolved by use of privacy screens on the computers. Two of the BHOs did not restrict public access to their reception area. Additionally, security policies for four of the BHOs' BHAs were either incomplete or inadequate. Reviewers recommended that these BHOs work with their agencies to ensure that the policies are updated, completed, and meet the security standards for Medicaid agencies.

Strengths

- Most of the BHOs have good physical security safeguards in their office areas.
- All of the BHOs have security policies in place that adhere to industry standards.
- All of the BHOs follow best practice guidelines in protecting client data. They have established procedures for authorizing access to their network and applications.
- Most of the BHOs have procedures in place to remove access authorization to systems when staff or contractors leave, including expedited processes for unanticipated, immediate dismissals.
- NSBHO hired an external contractor to conduct a HIPAA risk assessment and identify weaknesses in policies and procedures. The BHO has extended the contractor's work to perform a similar assessment at each of its BHAs.

Opportunity for Improvement

All BHAs reviewed for the ISCA did not have security policies and procedures in place.

- DBHR should work with the BHOs to ensure that all of the contracted BHAs have security policies and procedures in place, including one addressing procedures in the event of a HIPAA breach.

Recommendation

Several BHOs received recommendations for corrective action plans to address issues of privacy and security.

- DBHR needs to work with the BHOs to ensure that all of the corrective action plans from the 2017 ISCA related to security and privacy are completed as soon as possible. The specific recommendations included:
  - GCBHO needs to verify that all agencies have security and privacy policies on site.
  - KCBHO needs to modify its policy to disable inactive accounts after 60 days.
  - OPBHO needs to ensure that locks and all security elements are in working condition at all times to maximize the security of its office.
  - One of SCRBHO's BHAs interviewed allows more than three incorrect logon attempts before access lockout. The BHO needs to work with all BHAs to ensure security policies and procedures match national IT standards and 45 CFR 164.312 requirements.

Section D: Encounter Data Management

This section assesses the BHO's ability to capture and report accurate encounter data.

Characteristics of good encounter data management include:

- documented procedures on encounter data submission, which include timeframes and validation check
- automated edit and validity checks of key fields
- production of error reports and procedures to correct those errors
- periodic audits to validate the encounter data
- regular meetings with agency staff to ensure all data are captured accurately and in a timely manner
- reconciliation procedures that compare BHO data to provider data

The BHOs are required to collect and submit service data to ProviderOne within 30 days of the close of the month and correct their encounter errors within 30 days of receiving notification of the errors. The State supplies guidelines for data submission in the form of the SERI from DBHR and the Health Encounter Data Reporting Guide published by HCA. The BHOs are required to conduct encounter data validation reviews of their BHAs and ensure that all of their agencies submit their encounter data in a timely manner and ensure the data are accurate.

All of the BHOs monitor the service data received from their BHAs and submit their data to ProviderOne in a timely manner. Many of the SUD treatment BHAs are still struggling to submit their data. The BHOs have been working with these BHAs since April 2016 on data submission and many have created workaround solutions, including assistance with manual data entry.

Strengths

- All of the BHOs perform encounter data validation reviews of their BHAs at least annually.
- All of the BHOs monitor the BHAs' service data submissions, including the timeliness of the submissions.
- The BHOs return encounter processing errors to the agencies for correction.
- OPBHO performs random service validations with its clients to confirm that they received the services reported by the provider.

Opportunities for Improvement

SUD treatment providers continue to struggle to submit encounter data in a timely manner despite the BHOs' assistance.

- DBHR should work with the BHOs to emphasize the urgency and importance of upgrading systems to meet the encounter submission requirements. BHOs may consider incentives, penalties, and intensive technical assistance for providers not meeting the submission requirements.
- DBHR should monitor the SUD encounter data closely and work with the BHOs to ensure all the data are submitted. This may include working with ProviderOne to periodically lift the one-year edit for a special run in order to allow older data to be uploaded.

Section E: Eligibility Data Management

This section assesses the BHO's ability to capture and report accurate Medicaid eligibility data.

Characteristics of good management of eligibility data include:

- uploading of monthly eligibility data from the State with reconciliation processes in place
- uploading and applying eligibility data changes from the State in between monthly files
- managing internal eligibility files to eliminate duplicate member records
- running reports to identify changes in eligibility that effect service data

BHOs are required to maintain enrollee eligibility data, which they accomplish through automated uploads of monthly eligibility files from ProviderOne and weekly updates to keep the files current. At the time of the review, TMBHO was the only BHO not processing the eligibility files from ProviderOne. Instead, the BHO relies on eligibility information provided by the BHAs and from financial data received from the State.

Strengths

- All BHOs require their BHAs to verify eligibility at initial contact and monthly thereafter. Most of the provider agencies reviewed for the ISCA also check eligibility at every client contact.
- All BHOs except TMBHO process the eligibility files provided by the State via ProviderOne.
- All BHOs identify duplicate client records in the systems and have processes in place to merge the duplicates into one record without losing any of the associated encounter data.
- Three of the BHOs manage retroactive eligibility changes and apply those changes to encounter data.

Opportunity for Improvement

TMBHO does not use the ProviderOne monthly eligibility files to maintain current enrollee eligibility status.

- DBHR should monitor TMBHO's progress on automating the eligibility update process and encourage the BHO to use the monthly and weekly update files from ProviderOne.

Section F: Provider Data Management

This section assesses the BHO's ability to maintain accurate and timely provider information.

Characteristics of good provider data management practices include:

- establishing a communication process to update and maintain provider credentials, licenses, and skill sets
- supporting information systems that integrate provider information with member and service data
- developing and maintaining policies and procedures that support timely exchange of provider information
- using provider data to edit encounter data to ensure that qualified providers are performing services they are qualified to perform

Overall, the BHOs maintain accurate and current provider information. TMBHO is not using provider data to ensure that services have been delivered by appropriate staff. However, most BHOs have instituted an edit check during encounter processing to ensure that the service was performed at a licensed facility by a professional with the proper credentials.

Several BHOs reported challenges in keeping the provider information up to date and are working to improve the currency of provider data.

Strengths

- Most BHOs are monitoring credentialing data to ensure it is up to date.
- Most BHOs support an online provider directory that is available to the public.
- GRBHO reviews the provider credentialing information monthly to monitor for changes to credentials that may affect previously adjudicated encounters. In these cases the BHO initiates a process to re-submit the encounter.

Section G: Performance Measures and Reporting

This section assesses the BHO's performance measure and reporting processes.

Characteristics of good reporting practices include:

- use of encounter data, member data, and service data from an integrated database as the primary source for performance measurements
- policies and procedures that describe how the organization maintains data quality and integrity
- staff dedicated and trained in all tools to develop queries and tools for reporting
- support for continuing education of staff responsible for reporting metrics
- use of data for program and finance decision making
- use of analytics software and other industry standard reporting tools

BHOs are required to track two core performance measures. All BHOs are all complying with this requirement. Additionally, all of the BHOs have information systems and reporting tools to support ad hoc and routine reporting, as well as dedicated trained staff to meet their reporting needs.

To better utilize reporting to improve operations and care, the BHOs should consider developing results-based outcome measures to improve client care. This would assist them in moving into a data-driven decision-making environment that is essential in managed care.

Strengths

- Six of the BHOs provided samples of reports used to monitor utilization and other aspects of their operations.
- OPBHO is beginning to incorporate the use of a geographic information system (GIS) into identifying underserved areas in its region.
- NSBHO and SBHO verify reports before issuing them to their stakeholders.

Opportunity for Improvement

BHOs could enhance the effectiveness of their reporting capabilities by tracking results-based outcome measures.

- DBHR should work with the BHOs to develop a set of outcome metrics that are focused on improving the health of enrollees and developing population-based treatment protocols.

Encounter Data Validation

Encounter data validation (EDV) is a process used to validate encounter data submitted by Behavioral Health Organizations (BHOs) to the State. Encounter data are electronic records of the services provided to Medicaid enrollees by behavioral health agencies (BHAs) under contract with a BHO. Encounter data are used by BHOs and the State to assess and improve the quality of care and to monitor program integrity. Additionally, the State uses encounter data to determine capitation rates paid to the BHOs.

Methodology

Prior to performing the data validation for encounters, Qualis Health reviewed the State's standards for collecting, processing, and submitting encounter data to develop an understanding of State encounter data processes and standards. Documentation reviewed included:

- the Service Encounter Reporting Instructions (SERI) in effect for the date range of encounters reviewed
- the Behavioral Health Data System for BHOs
- the Health Care Authority Encounter Data Reporting Guide for Managed Care Organizations, Qualified Health Home Lead Entities, Behavioral Health Organizations
- the 837 Encounter Data Companion Guide ANSI ASC X12N (Version 5010) Professional and Institutional, State of Washington

Qualis Health performed three activities supporting a complete encounter data validation for the BHOs: a review of the procedures and results of each BHO's internal EDV required under the BHO's contract with the State; State-level validation of all encounter data received by the State from each BHO during the review period; and an independent validation of State encounter data matched against provider-level clinical record documentation to confirm the findings of each BHO's internal EDV.

Validating BHO EDV Procedures

Qualis Health performed independent validation of the procedures used by the BHOs to perform encounter data validation. The EDV requirements included in the BHOs' contract with DBHR were the standards for validation.

Qualis Health obtained and reviewed each BHO's encounter data validation report submitted to DBHR as a contract deliverable for calendar year 2016. The BHOs' encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates, and fields selected for validation were reviewed for conformance with DBHR contract requirements. The BHOs' encounter and/or enrollee sampling procedures were reviewed to ensure conformance with accepted statistical methods for random selection.

Each BHO submitted a copy of the data system (spreadsheet, database, or other application) used to conduct encounter data validation, along with any supporting documentation, policies, procedures, or user guides, to Qualis Health for review. Qualis Health's analytics staff then evaluated the data system to determine whether its functionality was adequate for the intended program.

Additionally, each BHO submitted documentation of its data analysis methods, from which summary statistics of the encounter data validation results were drawn. The data analysis methods were then reviewed by Qualis Health analytics staff to determine validity.

Qualis Health Encounter Data Validation

Qualis Health's encounter data validation process consists of electronic data checks—state-level validation of all encounter data received by the State from each BHO during the review period, and a clinical record review—independent validation of State encounter data matched against provider-level clinical record documentation to confirm the findings of each BHO's internal EDV.

Electronic Data Checks

Qualis Health analyzed encounter data submitted by each BHO to the State to determine the general magnitude of missing encounter data, types of potentially missing encounter data, overall data quality issues, and any issues with the processes the BHO has in compiling encounter data and submitting the data files to the State. Specific tasks included:

- a review of standard edit checks performed by the State on encounter data received by the BHO and how Washington's Medicaid Management Information System (MMIS) treats data that fail an edit check
- a basic integrity check on the encounter data files to determine whether expected data exist, whether the encounter data element values fit within expectations, and whether the data are of sufficient quality to proceed with more complex analysis
- application of consistency checks, including verification that critical fields contain values in the correct format and that the values are consistent across fields
- inspection of data fields for general validity
- analysis and interpretation of data on submitted fields, the volume and consistency of encounter data and utilization rates, in aggregate and by time dimensions, including service date and encounter processing data, provider type, service type, and diagnostic codes

On-site Clinical Record Review

Qualis Health performed clinical record reviews on site at BHAs under contract with each BHO. The process included the following:

- selecting a statistically valid sample of encounters from the file provided by the State
- loading data from the encounter sample into an auditing tool (MS Access database) to record the scores for each encounter data field
- providing the BHO with a list of the enrollees whose clinical charts were selected for review for coordination with contracted provider agencies pursuant to the on-site review

Qualis Health staff reviewed encounter documentation included in the clinical record to validate data submitted to the State and to confirm the findings of the analysis of State-level data.

Upon completion of the clinical record reviews, Qualis Health calculated error rates for each encounter field. The error rates were then compared to error rates reported by each BHO to DBHR for encounters for which dates of service fell within the same time period.

Sampling Methodology

With the integration of mental health and substance use disorder (SUD) treatment services, Qualis Health revised the sampling methodology in order to ensure an appropriate representation of encounters in the sampled data.

For each BHO, Qualis Health received two data files from the State: one with patient demographics and another with encounter-level data. Qualis Health first processed the raw data, then validated that all data contained sufficient information to be included in a sample (most encounters, for example, should contain

a first name, last name, and birthdate). Qualis Health then verified that the data were appropriate to the agency size and type. For example:

- The volume of encounter data should be in an amount proportional to agency size; i.e., large agencies should have a larger number of encounters than smaller agencies.
- Procedure codes and modifiers should be consistent with an agency's primary business function; i.e., methadone clinics should submit encounters for services expected to be provided at a methadone clinic.
- All expected services should be reflected in the data; i.e., if withdrawal services are typically provided at a particular type of agency, procedure codes reflecting those services should appear in the overall dataset.

Once Qualis Health verified the completeness of the data, the required number of agencies were selected, including two mental health agencies and four SUD treatment agencies.
Using the SERI, the procedure codes and modifiers were mapped to seven service modalities:

1. Mental Health
2. Substance Use: Assessment Services
3. Substance Use: Outpatient Case Management
4. Substance Use: Opiate Substitution
5. Substance Use: Outpatient Treatment
6. Substance Use: Residential Services
7. Substance Use: Withdrawal Management

The mental health and substance use encounters were separated; then, using J.R. Chromy's method of sequential random sampling, one sample was pulled for each group, with roughly 35 to 50 patients per unique BHA/agency pair (RUID) combination. Once the sample patients were selected, the patients and the service modalities were merged with the encounter data. Upon this merge, reviewers verified that the samples contained the required number of encounters (at least 411 encounters for mental health and at least 411 for SUD, for more than 822 encounters in total for the BHO) and that all service modalities for SUD treatment services in a given BHO's data were represented.
The substance use sample *must* contain encounters from each of the six substance use modalities listed above in proportion to overall volume of these modalities in each of the selected BHO/agency combinations. For example, if an agency only performs services in the withdrawal management modality, the sample will only contain sample patients from that agency who have received services in this modality. Likewise, for agencies providing services representing all six substance use modalities, the sample will contain encounters for services the agency has provided from all six modalities.

Scoring Criteria

Qualis Health used CMS's three-point scoring system in evaluating the BHOs. The three-point scale allows for credit when a requirement is partially met and the level of performance is determined to be acceptable. The three-point scoring system includes the following levels:

● Fully Met

◉ Partially Met

○ Not Met

Summary of EDV Review

The results of the BHOs' EDV reviews are presented below.

Table 35: Results of Review of BHO EDV Procedures—Mental Health

EDV Standard	Description	Great Rivers	Greater Columbia	King County	North Central	North Sound	Optum Pierce	Salish	Spokane	Thurston-Mason
Sampling procedure	Sampling was conducted using an appropriate random selection process and was of adequate size.	●	◉	◉	●	●	●	●	●	○
Review tools	Review and analysis tools are appropriate for the task and used correctly.	●	◉	●	◉	●	◉	●	●	●
Methodology and analytic procedures	The analytical and scoring methodologies are sound, and all encounter data elements requiring review are examined.	◉	◉	○	●	◉	●	●	●	○

Table 36: Results of Review of BHO EDV Procedures—SUD

EDV Standard	Description	Great Rivers	Greater Columbia	King County	North Central	North Sound	Optum Pierce	Salish	Spokane	Thurston-Mason
Sampling procedure	Sampling was conducted using an appropriate random selection process and was of adequate size.	●	◉	◉	●	●	●	●	●	○
Review tools	Review and analysis tools are appropriate for the task and used correctly.	●	◉	●	◉	●	◉	●	●	●
Methodology and analytic procedures	The analytical and scoring methodologies are sound, and all encounter data elements requiring review are examined.	◉	◉	○	●	◉	●	●	●	○

Table 37: Results of Qualis Health EDV—Mental Health

EDV Standard	Description	Great Rivers	Greater Columbia	King County	North Central	North Sound	Optum Pierce	Salish	Spokane	Thurston-Mason
Electronic Data Checks	Full review of encounter data submitted to the State indicates no (or minimal) logic problems or out-of-range values.	●	◉	●	●	●	●	●	●	●
On-site Clinical Record Review	State encounter data are substantiated through audit of patient charts at individual provider locations. Audited fields include demographics (name, date of birth, ethnicity, and language) and encounters (procedure codes, provider type, duration of service, service date, and service location).	○	○	○	○	○	○	○	○	○

Table 38: Results of Qualis Health EDV—SUD

EDV Standard	Description	Great Rivers	Greater Columbia	King County	North Central	North Sound	Optum Pierce	Salish	Spokane	Thurston-Mason
Electronic Data Checks	Full review of encounter data submitted to the State indicates no (or minimal) logic problems or out-of-range values.	●	●	●	●	●	●	●	●	●
On-site Clinical Record Review	State encounter data are substantiated through audit of patient charts at individual provider locations. Audited fields include demographics (name, date of birth, ethnicity, and language) and encounters (procedure codes, provider type, duration of service, service date, and service location).	○	○	○	○	○	○	○	○	○

BHO EDV Procedures

Results of the review of the BHOs' EDV report summaries submitted to the State indicated numerous issues, including the following:

- Several of the BHOs' summary reports lacked all of the information required by the State contract, such as adequate descriptions of the methodology, sampling procedures, data analysis results, and summary of findings and corrective action plans that would determine whether or not items met criteria for adequacy.
- Several of the BHOs' encounter data fields did not include all the required elements.
- Several BHOs used their internal data for comparison with the provider data rather than using data downloaded from ProviderOne.
- Many BHOs reported that although encounter data had been accepted by ProviderOne, there had been issues using it. The State confirmed that ProviderOne accepts all encounters and stated that the ProviderOne system does not reject encounters with incorrect information.

Overall, the BHOs described protocols that would be appropriate and adequate for validating BHAs' encounter data. The sampling procedures appeared to result in random oversamples; however, only six of the nine BHOs met criteria for this area; two partially met criteria, and one did not meet criteria. The primary reason for the partially met scores was lack of documentation explaining the sampling procedure. The data entry tools developed by the BHOs that submitted them appeared to be appropriate for the reviews, with the exception of a few BHOs whose tools were missing contract-required elements.

BHO Sampling Procedures

- Two of the BHOs submitted inadequate documentation describing the sampling procedure and methodology.
- Seven BHOs compared their own data to the clinical records. One BHO used the State data from ProviderOne. One BHO did not document a clear source of comparison data within its State deliverable.

Data Entry Tools

- Four of the nine BHOs used an MS Access database to record and document the results of the encounter reviews.
- Three BHOs used Excel spreadsheets.
- One BHO used a combination of paper and an MS Access database, using the paper tool on site and later completing data entry with the tool.
- One BHO did not clearly indicate the type of tool it utilized.
- Four BHOs did not provide their tool for review.

Methodology

- Seven of the nine BHOs adequately described their EDV methodology. One BHO did not provide error rates for each element reviewed.

Qualis Health's Electronic Data Checks

Qualis Health analyzed the required demographic data elements BHOs submitted to the State and found the following regarding mental health electronic data:

- All nine BHOs did not achieve 100 percent for Social Security Number and sexual orientation.
- Six did not achieve 100 percent for ethnicity/race.
- Five did not achieve 100 percent for first name, last name, and gender.
- Four did not achieve 100 percent for language and date of birth.
- Three did not achieve 100 percent for units of service and provider type.
- Two did not achieve 100 percent for procedure code.

Additionally, reviewers found the following regarding SUD electronic data:

- All nine BHOs did not achieve 100 percent for Social Security Number and sexual orientation.
- Seven did not achieve 100 percent for provider type.
- Five did not achieve 100 percent for ethnicity.
- Four did not achieve 100 percent for first name, last name, and date of birth.
- Two did not achieve 100 percent for language and units of service.
- For two data elements, preferred language and sexual orientation, the response "unknown, patient refused" was unusually high for many BHOs.

On-site Clinical Record Review

For each of the BHOs, Qualis Health reviewed demographic and encounter data for at least 411 mental health encounters and at least 411 SUD encounters within approximately 100 unique client clinical records for mental health services and 100 unique client clinical records for SUD treatment services. The demographic data included the enrollee's last name, first name, Social Security Number, date of birth, race/ethnicity, Hispanic origin, gender, language, and sexual orientation. Results for demographic validations varied between BHOs. All BHOs did not review demographic data through their EDV process, as it is not required in the BHOs' contract for EDV with the State. The BHOs typically reached the 95

percent match rate for mental health on first name, last name, and date of birth. Three BHOs did not meet the match rate for gender for mental health encounters. The most common elements that did not reach 95 percent for mental health were race/ethnicity, Hispanic origin, preferred language, Social Security Number, and sexual orientation.

For SUD demographic match rates, one BHO did not meet the 95 percent match rate for first and last name. Two BHOs did not meet the match rate for gender and date of birth. Seven BHOs did not meet the match rate for Social Security Number. Eight BHOs did not meet the match rate for Hispanic origin and sexual orientation. All nine BHOs did not meet the match rate for ethnicity/race and preferred language.

For each of the encounters, the following data fields were reviewed: procedure code, service date, service duration, service location, agency, provider type, and service code agrees with treatment described. For mental health, the fields for service code agrees with treatment described, procedure code, service duration, and provider type received the highest rate of mismatches within the Qualis Health review, with all nine of the BHOs not meeting the 95 percent standard. Three BHOs did not meet the 95 percent standard in date of service. Six BHOs did not meet the 95 percent standard for location or procedure code, with one BHO receiving a no match for almost 100 percent for location. Four BHOs did not meet the standard for provider type, and five BHOs did not meet the standard for service duration, but only two BHOs did not meet the 95 percent standard for author identified. For SUD encounters, all nine BHOs did not meet the 95 percent match rate for all encounter data elements.

Qualis Health's on-site demographic and encounter review yielded large variation compared to the BHOs' reviews. The most common elements that resulted in high variation were location, service code agrees with treatment described, and service duration. Other areas that resulted in high variation were BHO specific. One discrepancy could be a result of Qualis Health using the State data, whereas all but two BHOs used their own data. Qualis Health also did not review the same encounters as the BHO, which could account for some of the differences in results.

Reviewers identified a variety of issues related to encounters within the clinical on-site review. Examples of errors included:

Coding Errors

- Improper durations were submitted for the code used.
- Codes were submitted that did not meet SERI, WAC, or contract requirements.
- Improper codes were submitted for an individual in a 24/7 facility.
- Incorrect codes were submitted for the services provided.
- Encounters were submitted for services that were rendered by a community member.
- Only one location code was submitted for all services provided.
- Multiple services that are not allowed to be submitted together (example: high-intensity codes with individual modality codes) were submitted in the same encounter.
- Location was not documented on the progress note.
- Codes were submitted without a modifier or with the incorrect modifier.
- Only one E&M code was submitted for the majority of E&M services.
- Code H0020 was submitted for the day that a dosed medication was to be taken, instead of on the day it was administered.
- Progress notes did not contain location or procedure codes.
- Individual codes were submitted for group services.

Documentation Concerns

- Encounters were submitted without clinical documentation, supporting documentation, and/or evidence of medical necessity.
- Encounters were submitted without the required elements.
- The same documentation was submitted for multiple different services.
- SUD group documentation lacked evidence of SUD treatment.
- The location code included in the encounter did not match the code included in the clinical note.
- Location codes were incorrect.
- Documentation did not support the duration submitted.
- Documentation was completed by the client and not the clinician.

Provider Type Errors

- The provider type submitted did not reflect the provider type for the staff that provided the service.
- Codes were submitted for a provider type not allowable per the SERI (example: provider type 5 submitted as 96372).
- Credentials were not signed on progress notes.

Duration Errors

- Units for were submitted for codes that should be submitted in minutes.
- Multiple units were submitted for codes that allow only a unit of one.
- Services were bundled incorrectly.
- Durations were input automatically instead of submitted as the actual time it took to complete the service.
- Excessive durations were submitted for reported services.

Submission of Services Ineligible for Submission to the State

- Services were submitted prior to the completion of an intake assessment.
- Duplicate encounters were submitted for the same service.
- Submitted services overlapped for part of the duration.
- SUD residential treatment services were submitted when no service was documented and/or rendered.
- Services were submitted without supporting documentation.
- Encounters were submitted for no-shows, or otherwise when no service occurred.
- Encounters were submitted for internal or staffing consultations.
- Encounters were submitted daily, while writing only one progress note a week.
- Encounters were submitted for administrative tasks: listening to and leaving voicemails, reading and sending e-mails, texting, faxing, writing letters, calling in prescriptions, rescheduling appointments, making reminder calls, supervision/staffing, updating demographics, entering information into the EMR, completing release of information (ROI) documents
- SUD educational groups were facilitated by people not employed by the BHA, and documentation did not indicate co-facilitation with BHA staff.
- Encounters were submitted for social events, with no therapeutic intervention documented, including watching movies, embroidery, coloring, working on computer skills, transportation, Halloween parties, eating lunch.
- Additional non-encounterable activities submitted included reviewing a chart without the client present, verifying attendance, attending court, grocery and other shopping, attending housing

meetings, discussing how to budget, attending yoga group, observing the client sleeping, listening to music, reading the newspaper, providing social interaction, completing DVR paperwork.

Opportunities for Improvement

Because there is no standardized format for the BHOs to submit their yearly EDV reports to DBHR, many of the reports were missing crucial information, such as adequate descriptions of the methodology, sampling procedures, data analysis results, and summary of findings that would determine whether or not items met criteria for adequacy.

- DBHR should work with the BHOs to create a standardized template for the EDV contract deliverable to ensure that all BHOs are consistent in reporting the same information.

DBHR does not have a process in place to identify and monitor encounters for accuracy, timeliness, and truthfulness and, when issues arise, to report and resolve the issues with the BHOs.

- DBHR should develop a process for monitoring encounters for accuracy, timeliness, and truthfulness and actively work with the BHOs when issues are identified.

Most of the BHOs perform EDV using their own internal data from clinical encounters for comparison with provider data rather than using data downloaded from ProviderOne.

- DBHR should consider requiring the BHOs to use the State's data rather than the BHOs' internal data to ensure that data transmissions are submitting accurate encounter information from the BHO to ProviderOne.

Recommendations

In reviewing the EDV deliverables the BHOs submitted to the State, it was noted that the BHOs' data collection and analytical procedures for validating encounter data were not standardized.

- In order to improve the reliability of encounter data submitted to the State, DBHR needs to continue to work with the BHOs to standardize data collection and analytical procedures for encounter data validation.

Qualis Health discovered encounters in which services were bundled incorrectly as well as other numerous errors. These errors further suggest that the BHOs and providers need information or further training about how to correctly code encounters prior to submission to the State. Additionally, many of the BHOs and providers were unfamiliar with the terms of EDV in the State contracts and with the specifics of the SERI.

- DBHR needs to provide guidance to the BHOs on how to bundle services correctly, review the numerous errors in encounter submission that were found in the clinical chart review, and revise the SERI to further clarify proper coding for clinicians. DBHR also needs to ensure the BHOs know and understand the content of the State contract, SERI, and standards for documentation. DBHR may consider providing further training on the contract, SERI, and documentation to the BHOs and/or the BHAs, in particular, the SUD treatment BHAs.

BHOs report different internal protocols for handling encounter errors. The BHOs have not received any identified protocol from the State for how to address identified encounter errors.

- DBHR needs to create expectations or protocols for BHOs on how to address errors identified in encounters.

Golden Thread Focus Study

For the 2017 EQR focus study, Qualis Health examined the degree to which substance use disorder (SUD) treatment providers' clinical records demonstrated adherence to the "golden thread," a series of clear, consistent care linkages between an individual's needs, diagnosis, and treatment. In evaluating provider records, reviewers asked the following questions:

- Does the individual's assessment contain sufficient documentation to support the diagnosis, and does it include all of the individual's needs?
- Are the documented needs reflected in specific goals in the treatment plan/individual service plan (ISP)? Does the ISP address the individual's diagnosis and all of the identified needs in the assessment?
- Do the progress notes address the individual's treatment plan goals and the needs identified in the assessment?

To answer these questions, Qualis Health reviewed between 18 and 31 patient charts randomly selected from each BHO's EDV sample. Reviewers specifically evaluated documentation in three areas: assessments and re-assessments, individual service planning, and progress notes. Each section (assessments/re-assessments, ISPs, and progress notes) contained several subsections that were reviewed and scored. The results of this review are discussed in the following section.

Summary of Results

Assessments

In reviewing clinical chart assessments, Qualis Health analyzed five different areas, evaluating how well the chart documentation adhered to the criteria presented in Table 39.

Table 39: Results for Review of Assessments in Clinical Charts

Criterion	Percentage of Charts Meeting Standard								
	GCBHO	GRBHO	KCBHO	NCBHO	NSBHO	OPBHO	SBHO	SCRBHO	TMBHO
1. Evidence of medical necessity based on the presence of a DSM 5 substance-related diagnosis	94.7%	94.4%	90.3%	100.0%	100.0%	100.0%	95.7%	100.0%	90.0%
2. Sufficient information within assessment to justify the diagnosis	100.0%	75.0%	67.7%	84.0%	67.0%	94.4%	95.7%	93.3%	73.3%
3. Recommendation(s) based on ASAM criteria	94.7%	72.2%	80.6%	84.0%	89.0%	94.4%	95.7%	100.0%	73.3%
4. Clear presentation of the individual's concerns in the assessment	73.7%	47.2%	51.6%	68.0%	44.0%	88.9%	73.9%	46.7%	40.0%
5. Client voice present throughout the assessment	89.5%	63.9%	48.4%	76.0%	56.0%	72.2%	69.6%	53.3%	40.0%

Individual Service Plans

In reviewing individual service plans, Qualis Health analyzed eight different areas, evaluating how well the chart documentation adhered to the following criteria presented in Table 40.

Table 40: Results for Review of Individual Service Plans in Clinical Charts

Criterion	Percentage of Charts Meeting Standard								
	GCBHO	GRBHO	KCBHO	NCBHO	NSBHO	OPBHO	SBHO	SCRBHO	TMBHO
1. All concerns in assessment addressed in the treatment plan	57.9%	2.8%	25.8%	8.0%	33.0%	88.9%	13.6%	46.7%	43.3%
2. Treatment plan is individualized	84.2%	63.9%	80.6%	60.0%	81.0%	83.3%	60.95	100.0%	80.0%
3.1. Treatment plan includes all substance use needing treatment, including tobacco	5.3%	0.0%	32.3%	8.0%	30.0%	72.2%	0.0%	40.0%	40.0%
3.2 Treatment plan includes the individual's bio-psychosocial problems	52.6%	16.7%	54.8%	8.0%	59.0%	72.2%	0.0%	46.7%	63.3%
3.3 Treatment plan includes treatment goals	84.2%	86.1%	80.6%	92.0%	74.0%	88.9%	73.9%	100.0%	86.7%
3.4 Treatment plan includes estimated dates or conditions for completion of each treatment goal	84.2%	77.8%	45.2%	64.0%	56.0%	72.2%	60.9%	70.0%	60.0%
3.5. Treatment plan includes potential approaches to resolve identified problems	57.9%	14.3%	25.8%	32.0%	33.0%	72.2%	9.1%	30.0%	60.0%
4. Goals and/or objectives are measureable	10.5%	19.4%	3.2%	0.0%	22.0%	44.4%	0.0%	0.0%	3.3%
5. Interventions are aligned with the problems identified in the assessment	57.9%	16.7%	35.5%	16.0%	52.0%	83.3%	18.2%	20.0%	53.3%
6. If the individual treatment plan includes assignment of work to an individual, the assignment has therapeutic value	78.9%	66.7%	35.5%	36.0%	56.0%	72.3%	45.5%	96.7%	73.3%
7. The plan was updated to address applicable changes in identified needs, or as requested by the individual, at least once a month for the first three months and at least quarterly thereafter	72.2%	42.9%	9.7%	45.8%	59.0%	77.8%	9.5%	55.2%	23.1%
8. The plan was updated to identify achievement of goals and/or objectives	52.6%	30.6%	9.7%	40.0%	41.0%	77.8%	17.4%	53.3%	40.0%

Progress Notes

For the final portion of the Golden Thread review, Qualis Health examined whether or not the progress notes indicated that the services provided were connected to the interventions, objectives, and goals identified in the individual service plan resulting from the needs and concerns identified in the assessment or reassessment process. This review area included seven criteria, presented in Table 41.

Table 41: Results for Review of Progress Notes in Clinical Charts

Criterion	Percentage of Charts Meeting Standard								
	GCBHO	GRBHO	KCBHO	NCBHO	NSBHO	OPBHO	SBHO	SCRBHO	TMBHO
1. Progress notes were written in a timely manner in accordance with WAC 388-877B-0350	89.5%	27.8%	77.4%	76.0%	67.0%	N/A	82.6%	60.0%	86.7%
2. Documentation clearly states the focus of each session	63.2%	61.1%	54.8%	56.0%	30.0%	72.2%	69.6%	30.0%	33.3%
3. Documentation clearly states the interventions described in the service plan	47.4%	13.9%	9.7%	40.0%	74.0%	61.1%	0.0%	3.3%	26.7%
4. Documentation describes the individual's response to the intervention	42.1%	11.1%	25.8%	16.0%	37.0%	55.6%	8.7%	33.3%	33.3%
5. Interventions address the goals and objectives in the service plan	52.6%	36.1%	32.3%	52.0%	70.0%	77.8%	9.1%	43.3%	60.0%
6. Documentation indicates progress, or lack thereof, toward meeting the goals and objectives in the service plan	57.9%	8.3%	19.4%	20.0%	78.0%	61.1%	13.6%	36.7%	33.3%
7. Services provided align with the individual's assigned level of care	63.2%	83.3%	51.6%	68.0%	67.0%	83.3%	59.1%	86.7%	53.3%

Concluding Notes

During the clinical record review, reviewers noted a number of issues common among BHAs that may have contributed to lower scores on the assessments. These included the following examples:

- Clinical records did not include assessments.
- Clinical records did not contain an updated assessment when warranted.
- Assessments lacked WAC-required elements.
- Assessments consisted of a check-box format, without narrative to explain why boxes were checked or not.
- Assessments did not identify all of the client's concerns or needs.
- Assessments did not contain documentation that justified the diagnosis.
- Clinical records did not contain ISPs.
- The ISP was completed before the assessment was completed.
- Services were provided before ISPs were created.
- ISP was not completed and/or reviewed within WAC timelines.
- The ISP was not individualized.
- ISPs did not contain documentation that they were completed jointly with the client.
- Goals in the ISP were not clearly linked to what was identified in the assessment.
- Goals and/or objectives in the ISP were not measurable.
- Interventions were not outlined in the ISP.
- ISP did not include the frequency, duration, and scope/amount of services to be provided.
- ISPs did not contain progress notes.
- Documentation did not include evidence of clinical interventions.
- Documentation of services provided did not address items in the ISP or needs identified in the assessment.
- Documentation did not always meet WAC timeliness requirements.
- Progress notes were written by a chemical dependency professional trainee but not co-signed by a chemical dependency professional.
- Group progress notes lacked documentation indicating the purpose of the group and each individual's progress toward the goals outlined in the ISP.
- Group documentation was written almost exclusively by the client.
- Clinical records did not contain evidence that individuals were receiving the required amount of services per week according to their level of care.

NCBHO Transition Implementation Status

As discussed previously, North Central Behavioral Health Organization (NCBHO) chose to begin the process of moving forward as an integration "mid-adopter," beginning the transition in 2017 with the intention of fully transferring the administration of behavioral healthcare services in its region to MCOs by December 31, 2017. For its 2017 EQR, DBHR requested that Qualis Health assess the BHO's readiness and status in the transition. The following describes the results of this assessment.

Since the 2016 EQR, NCBHO experienced many successes and challenges with regard to its programs and the services provided by its BHAs. The BHAs will continue to experience many of these challenges after the BHO ceases operations. Examples include the following:

- The BHO expanded its WISe program into Grant County in 2016. The County limited the program to 40 children, although the BHO perceived the number of children needing care to be much higher. The BHO stated the providers in the county have been unable to meet the demand for WISe services, citing lack of clinicians and staff.
- The BHO lacked an adequate number of inpatient beds at evaluation and treatment (E&T) facilities in Grant County, which forced the region to over-rely on beds at Eastern State Hospital.

At the time of the EQR, the BHO submitted its mid-adopter close-out activities summary. Qualis Health reviewed the summary with the BHO to ascertain its status in completing the activities. Throughout the year, knowledge transfer meetings occurred with the BHO, the MCOs, the regional behavioral health administrative service organization (BH-ASO), and HCA. The following content describes NCBHO's transition status as of September 29, 2017.

Personnel

- NCBHO's governing board and the BHO's administrator conducted a review of the post-transition staffing needs and projects that would need to be taken into consideration.
- The Douglas County Human Resources department and legal advisor assisted in ensuring appropriate handling of employee termination. Employees were initially notified of NCBHO's intention to close in September 2016.
- Final performance evaluations were in process and were due to be completed by December 1, 2017.
- The BHO had not yet issued formal notification of retention guidelines with signed agreements for eligible employees.
- The BHO planned to issue formal notifications of employee terminations by December 1, 2017. Two employees were to remain employed by the County for a few months after December 31 to complete data transfers and handle financial arrangements.

Office Space/Inventory

- The day before the on-site review, the BHO held a discussion with DBHR regarding return of State property and materials. The BHO had coordinated with State Archives regarding proper archiving of records requiring retention, and with Douglas County IT regarding archival or disposal of electronic and digital files.
- Douglas County assisted the BHO with lease termination, utilities contracting, liquidation of surplus inventory, and vacating office space.
- The BHO submitted notification of contract termination to leasing agents and utilities contractors September 29, 2017.
- Inventory of NCBHO and Douglas County office property occurred in early August 2017.

- The BHO planned to identify property for return or liquidation in late December 2017.
- Liquidation and return of property was scheduled to occur in January 2018.

Financial

- The BHO's fiscal and contracts manager and Douglas County's financial staff were retained to maintain oversight of contractual requirements through the BHO's termination of operations. Additional payment activities were scheduled to occur into early 2018.
- A discussion between the BHO and DBHR regarding financial expectations following contract termination had yet to be scheduled.
- The governing board was in the process of reviewing calculation of projected costs beyond the transition.
- The BHO expected to receive and review final revenue and expense reports from providers by January 31, 2018.
- The BHO was on target to submit revenue and expense reports to the State by November 15, 2017, February 15, 2018, and May 15, 2018.
- Payment for December services on cost-reimbursement was scheduled to occur by January 31, 2018.
- The BHO's financial audit with Washington State Auditor was scheduled to be complete before termination of operations. DBHR's final financial review of NCBHO was scheduled to occur in March 2018.
- Payments on invoices for mental health inpatient and substance use disorder residential treatment that were authorized prior to December 31, 2017, were planned to continue through 2018.

Contracts and Service Agreements

- All NCBHO network oversight contracts were scheduled to expire or terminate on or before December 31, 2017. Notices of non-renewal to network providers included a summary of final close-out expectations.
- The BHO submitted a list of all contracts and agreements with termination dates and was on schedule to complete the terminations.

Clinical Services Activities

- The BHO's provider network was continuing to provide clinical services for enrollees throughout the transition. The BHO expected that all of its providers would maintain similar service contracts with the MCOs and the BH-ASO with little to no interruption in clinical service for enrollees.
- The BHO intended to prepare census and enrollment information in early December 2017 for continuing care management for CLIP, mental health inpatient services, SUD out-of-network residential treatment, and all special programming for Medicaid and non-Medicaid contracted services.

Enrollee Notification

- The BHO stated that the notification to enrollees regarding the regional transfer of service delivery to the MCO/BH-ASO network was to be issued by HCA and the North Central Accountable Community of Health. At the time of the review, the Consumer Engagement Workgroup of the IMC Advisory Board was in the process of developing the communications. NCBHO assisted in the development of the materials.

- NCBHO updated its website to include information on the transfer of service delivery, as well as contact information for all contracted MCOs, the BH-ASO, the third-party administrator, the HCA, and behavioral health agencies.

Authorizations and Census/Enrollment

- NCBHO was scheduled to meet with Behavioral Healthcare Options in October 2017 to review the termination of its contract and outline steps for the transfer of information. At the time of the review, NCBHO was setting dates for receiving final submissions of authorization requests and decisions, copies of notice of adverse benefit determination letters, and final open authorization information.

Crisis Hotline

- NCBHO contracted with Behavioral Health Response Worldwide for regional crisis hotline services. Longstanding phone numbers for Grant and Chelan and Douglas counties had been routed to the service 24/7. This contract was scheduled to terminate on December 31, 2017, with formal notification to be provided at least 60 days prior. The BHO expected that Beacon Health, as the BH-ASO, will assist providers in continued contracting and transition with regard to the crisis hotline.

WISe Oversight

- The BHO stated that WISe oversight would continue and would be the responsibility of the MCO in which each WISe participant is enrolled. The BHO provided information to the MCOs regarding oversight, including use of the Behavioral Health Assessment System (BHAS) and all Plan, Do, Study, Act (PDSA) projects/results. The BHO intended to provide a current enrollment census near the end of December with all additional special programming enrollment information.

Mental Health Inpatient

- Because the BHO delegated care management and discharge transition activities to hospital liaisons employed by the BHAs contracted for crisis services, NCBHO intended to provide copies of hospital agreements and BHO transfer agreements relative to these services to the MCOs and the BH-ASO by November 2017.

Designated Mental Health Professionals (DMHPs) (Designated Crisis Responders)

- At the time of the review, NCBHO was reviewing the County's designation process with the incoming MCOs and BH-ASO to coordinate continuing designation of DMHPs. The BHO stated it would assist entities in connecting with County representatives to complete designation of existing DMHPs into the new system prior to December 31, 2017, to avoid interruptions in services.
- The BHO notified existing court representatives of the upcoming transition and made efforts to connect MCO and BH-ASO representatives with local court representatives for coordination of ongoing court processes and payments.

Peer Bridgers

- The BHO had scheduled discussions with the BH-ASO regarding its contracts and services with Pathways for peer bridger services.

Less Restrictive Alternative (LRA) Monitoring

- The BHO had provided information to the MCOs and BH-ASO on LRA monitoring for adults and youth provided by Catholic Family and Child Services and Grant Integrated Services.

Jail Services

- The BHO had contracts with Catholic Family and Child Services and Grant Integrated Services for jail transition services. This service was provided as a bridge to outpatient services upon release. The BHO intended to provide the enrollment census for this program to the BH-ASO at the time of transition.

Medicaid Personal Care (MPC)

- NCBHO intended to notify referral sources of changes to oversight and the approval process by November 1, 2017. At the time of the EQR, the BHO did not have information regarding who would maintain responsibility for this process after the transition. Records of MPC approvals and denials were to be available in 2018 for payment verification. NCBHO stated it was working with the MCOs and BH-ASO as appropriate to review existing procedures.

Children's Long-term Inpatient Program (CLIP)

- The BHO planned to coordinate the transfer of the CLIP Review Committee, care management activities, and provision of application assistance with the MCOs when the entity assigned with oversight of the program had been identified.

Substance Use Disorder Treatment—Out-of-network Residential

- NCBHO intended to request a final list of open authorizations for SUD residential treatment for coordination of continuing service and cost projection to share with the MCOs. Out-of-network SUD treatment providers were to receive a notice of non-renewal, with instructions or requests for close-out assistance. NCBHO reserve funding or a substance abuse treatment block grant were intended to finance all SUD residential treatment stays that were active on the date of the transition. Information on out-of-network contracting for SUD treatment services was to be provided to the MCOs and BH-ASO.

Tribal Agreements

- At the time of the review, decisions regarding NCBHO's tribal agreements were on hold. The BHO was continuing to hold discussions with DBHR regarding the requirements of these agreements. Any agreements made prior to December 31, 2017 were to be provided to the MCOs and BH-ASO.

Data Submission and Transfer Activities

- The BHO and all BHAs were expected to meet contractual obligations for data submission through December 31, 2017. The BHO delegated an information systems (IS) employee to finalize service data, ensure accuracy, and complete final NCBHO data submissions through early 2018., NCBHO planned to begin procedures to close the electronic health record system when all submissions were verified and complete.
- Qualis Health completed an assessment for the Healthier Washington Practice Transformation Support Hub to identify areas of concern for NCBHO providers. This assessment identified areas of technical assistance to prepare for the transition. NCBHO, Netsmart, Qualis Health, and the IMC Technology Workgroup will continue discussing the data transition with representatives from

the BHAs, MCOs, the BH-ASO, HCA, and the North Central ACH to prepare providers for a change in data submission processes.

- The BHO developed a specific timeline of data activities to review with providers and contractors. Primary target dates for selected activities included the following:
    - Qualis Health's technical assistance assessment results had been reviewed with providers.
    - The BHO had submitted its encounter data validation report.
    - The BHO planned to continue to identify ongoing data needs for payment verification through 2018.
    - The BHO intended to notify Great Rivers BHO of termination of NCBHO's Washington State Consortium membership 60 days prior to the transition.
    - BHAs' final monthly data submission was scheduled for January 10, 2018.
    - Receipt of the BHAs' final encounter data validations was scheduled for January 31, 2018.
    - The closure of myAvatar system access was tentatively scheduled for February 1, 2018.

Record Retention

- NCBHO was scheduled to meet with a representative of Washington State Archives to review requirements for record retention and develop a plan for identifying necessary records, as well as ensuring secure maintenance, secure transport, and storage of physical records. To complete financial activities after December 31, 2017, a set of records related to service provision and payments was to be maintained and available to the Douglas County designee to verify accuracy.
- The BHO was developing a plan with Douglas County IT/IS regarding archival or disposal of electronic and digital files, including staff email.
- The BHO was arranging for the destruction of its hard drive, server, and other hardware by January 31, 2018.

Audits and Monitoring Activities

- The BHO was in the process of completing reviews and audits as required through the expiration/termination of contracts and completion of transition activities.
- As NCBHO prepared to transfer services to the MCOs and BH-ASO, the BHO expressed concerns regarding ongoing monitoring of the BHAs and the handling of grievances and appeals.

Quality Management

- The BHO stated it would complete necessary quality management activities as described in the Quality Management Plan and/or as required by contract, including submission of deliverables where indicated, through 2018.

Committee, Board, and Other Transfer Activities

- The BHO expected that many of its committees, including the governing board, advisory board, Family Youth and System Partner Round Table (FYSPRT) Committee, CLIP Committee, Compliance Committee, and Quality Review Team (QRT), might transition into the MCO/BH-ASO system.
- The BHO's advisory board members indicated an intention to remain on the board as the network transitioned.
- The BHO employed a FYSPRT coordinator. The coordinator's responsibilities were to be transferred to the entity providing ongoing oversight.

- The BHO planned to provide its Compliance Committee membership information to all MCOs and the BH-ASO as recommendation of the members' continued participation with any compliance committees maintained beyond the transition.

NCBHO was very thorough and comprehensive and showed great leadership throughout this transition process.

Review of Previous-Year EQR Recommendations

Required external quality review activities include a review of the applicable state organization's responses to previously issued EQR recommendations. The table below displays Qualis Health's 2016 recommendations to DBHR and the State's responses to those recommendations.

Table 42: Review of DBHR Responses to 2016 EQR Recommendations

Prior-Year Recommendation	DBHR Response	EQRO Response
Enrollee Rights and Protections		
DBHR needs to ensure the BHOs are performing annual administrative on-site reviews of their contracted BHAs to make certain the BHAs are in compliance with standards regarding enrollee rights.	The current contract does require that the BHOs and their providers comply with any applicable federal and State laws that pertain to Enrollee Rights and Protections (PIHP section 11). Current contract also requires BHOs to review their subcontractors at least once per contracting period and that reviews must be included in the BHOs' ongoing quality management program (PIHP section 10.9). DBHR will coordinate with HCA to advocate that additional language be added to the subcontractor review section 10.9 of the PIHP contract amendment for July 2018 that requires BHOs to review Enrollee Rights and Protections on a more frequent basis.	Response accepted.
DBHR needs to make sure the BHOs have a process in place to collect and track the use of interpreter services in order to analyze unmet enrollee needs.	The current contract does require that the BHOs and their subcontractors maintain a log of all enrollee requests for interpreter services or translated written material (PIHP section 11.7.1.2.6). Current contract also requires that the BHOs evaluate the needs of their population in order to ensure an adequate network that provides all State-plan services (including interpreter services and requests for written information in translated languages) to meet the	Response accepted.

	clinical needs of the population (PIHP section 10.9.3.3). BHOs submit an annual Culturally and Linguistically Appropriate Services (CLAS) report to DBHR for review, which requires the BHO to collect and maintain accurate and reliable data to ensure the BHO is meeting the cultural and linguistic needs of the population (PIHP section 11.9.2.8). DBHR plans to add this item to its contract monitoring matrix as a priority when reviewing the annual CLAS reports.	
DBHR needs to ensure that all BHOs obtain and make readily available current information on the names, specialties, credentials, locations, telephone numbers of, and all non-English languages spoken by mental health professionals in the BHO's service area.	Additional language was added to the July 2017 contract amendment addressing this requirement (PIHP section 11.3.6).	Response accepted.
DBHR needs to ensure that all BHOs are informing and documenting in the enrollee's chart that the enrollee was given information on both medical and mental health advance directives as well as how and where to file complaints concerning non-compliance with advance directives.	The current contract requires the BHOs to maintain written policies and procedures for advance directives that meet current federal and State requirements (PIHP section 11.6). Per contract, the BHO and its subcontractors are required to provide written information to enrollees regarding medical and mental health advance directives in accordance with RCW 71.32. By contract, this includes information regarding how to file a grievance concerning non-compliance with a mental health advance directive with the Washington State Department of Health. DBHR will provide technical assistance and guidance to the BHO quality leads to ensure that BHOs are requiring documentation in the chart and monitoring their providers for this requirement.	Response accepted.
DBHR needs to clarify its expectation for the BHOs to monitor the use of seclusion	DBHR requests additional technical assistance from Qualis Health regarding this requirement,	Response accepted, pending technical assistance from the EQRO and subsequent

and restraint and behavioral de-escalation processes through annual administrative reviews, annual provider chart reviews, grievance reporting, Ombuds reports, enrollee satisfaction surveys and quarterly Provider Performance Reports. The BHOs need to require all BHAs to have policies and procedures in place on the use of seclusion and restraint.	particularly around the requirement for outpatient providers. Pending technical assistance, DBHR plans to provide a guidance document to the BHOs and any follow-up technical assistance at the bi-monthly BHO Quality Leads meetings.	action by DBHR.
Certifications and Program Integrity		
DBHR needs to ensure BHOs continually educate and maintain effective lines of communication with their staff and the staff at the BHAs on what should be reported to the BHO regarding suspected cases of fraud, waste or abuse as well as any other compliance issues that may be identified. Additionally, DBHR must make certain all suspected reports of fraud, waste and abuse are recorded in a formal log to be reviewed by the BHO's compliance committee and incorporated into the committee's meeting agenda as a standing agenda item.	Additional language was added to the July 2017 contract amendment addressing these requirements (PIHP section 8.3).	Response accepted.
DBHR needs to ensure that all BHOs are performing annual risk assessments and sharing the results with the BHO's executive team, governing board and appropriate committees. The leadership discussions need to include developing action plans to regularly monitor risks and vulnerable areas, and seek interventions where appropriate to mitigate risks. Additionally, DBHR needs to ensure the BHOs include the results of the annual	Additional language was added to the July 2017 contract amendment requiring BHOs to submit an annual program evaluation, which includes an annual risk assessment that is shared with the BHO executive team, governing board, and appropriate committees (PIHP section 9.2).	Response accepted.

risk assessment in the annual BHO program evaluation.		
DBHR needs to ensure the BHOs update their formal compliance programs to contain current BHO contract language, WAC language, and the seven elements: implementing policies and procedures, designating a compliance officer, conducting effective training and education, developing effective lines of communication, conducting internal monitoring and auditing, enforcing standards through well publicized guidelines, responding promptly to detected problems, and undertaking corrective action.	Additional language was added to the July 2017 contract amendment addressing these requirements (PIHP section 8.3).	Response accepted.
DBHR needs to make certain the BHOs annually monitor their BHAs to ensure each has an effective compliance program in order to provide guidance, enforce internal controls, and mitigate risks related to healthcare compliance.	Additional language was added to the July 2017 contract amendment requiring BHOs to have a clear process on monitoring (PIHP section 8.3.7). DBHR will coordinate with HCA to advocate that additional language be added to the subcontractor review section 10.9 of the PIHP contract amendment for July 2018 that requires BHOs to more closely review provider compliance programs.	Response accepted.
DBHR needs to require BHOs to have a formal chartered compliance committee, and make certain the committee meets monthly or at least on a quarterly basis. The committee should maintain committee meeting minutes that document the BHO's focus on developing and managing an organization-wide compliance program.	Additional language was added to the July 2017 contract amendment requiring a formal compliance program and committee (PIHP section 8.3).	Response accepted.
DBHR needs to confirm all BHOs have	The current contract requires the BHOs to report	Response accepted.

policies and procedures in place that include the intention of the BHOs and BHAs to report to DSHS within ten business days any excluded individuals and entities discovered in the screening process.	to DSHS any excluded individuals and entities discovered in the screening within ten business days (PIHP 8.8.2). DBHR will provide additional guidance in the bi-monthly BHO Quality Leads meetings regarding this requirement.	
DBHR needs to make certain BHOs have policies and procedures on retaining for six years all records disclosing the extent of services the provider furnishes to enrollees, including but not limited to records pertaining to credentialing and recredentialing; incident reporting; requests for services; authorizations; clinical records; complaints; grievances; appeals; referrals for fraud, waste and abuse; and outcomes of fraud, waste and abuse. The policy needs to include mechanisms for ensuring BHO and BHA compliance with the policy.	The six-year record retention requirement is a contract requirement of the General Terms and Conditions contract (section 18). In the fall of 2016, DBHR reviewed the BHOs' policies and procedures for grievances and appeals. Record retention for grievances and appeals was incorporated into that review. In early 2017, DBHR provided guidance and technical assistance to the BHO quality leads regarding changes in record retention due to a CFR amendment effective July 2017. .	Response accepted.
DBHR needs to make sure BHOs have updated administrative monitoring tools to include monitoring their BHAs for disclosure of ownership or controlling interest in the organization with five percent or more interest.	The current contract requires the BHOs to comply with ownership and control oversight requirements. DBHR will coordinate with HCA to advocate that additional and more specific language be added to the subcontractor review section 10.9 of the PIHP contract amendment for July 2018 to enhance what is already in contract.	Response accepted.
DBHR needs to ensure that all BHOs develop policies and procedures to monitor their vendors, providers and subcontractors for civil money penalties and assessments.	DBHR requests technical assistance from Qualis Health regarding this requirement. Current contract states that civil money penalties may be imposed on the BHO (PIHP section 8.8.3.2). Pending technical assistance, DBHR will coordinate with HCA to advocate for additional language in the July 2018 contract amendment.	Response accepted pending technical assistance from the EQRO and subsequent action by DBHR.

Grievance System		
DBHR needs to continue to work with the BHOs to develop and implement reliable procedures for capturing all grievances in order to analyze and integrate the information to improve the care and services provided to enrollees and to generate reports for making informed management decisions.	In the fall of 2016, DBHR reviewed all BHO policies and procedures related to the grievance system for compliance. In the fall of 2016, DBHR significantly updated the requirements for the quarterly grievance data reports submitted by the BHOs to expand data elements and incorporate quality improvement. Since 2016, ongoing technical assistance is provided to the quality leads on a bi-monthly basis via a grievance system learning collaborative.	Response accepted.
DBHR needs to ensure that all BHOs are informing enrollees that interpreter services are provided at no cost to the enrollee.	In the fall of 2016, DBHR reviewed all BHO-generated enrollee notices to ensure that enrollees were being informed that interpreter services were provided at no cost.	Response accepted.
DBHR needs to work with all BHOs to require and monitor their contracted BHAs to ensure the BHAs have policies and procedures in place for proper recordkeeping of grievances and appeals.	In the fall of 2016, DBHR reviewed all BHO policies and procedures related to the grievance and appeal system for compliance, which included record retention and recordkeeping. In 2017, technical assistance was provided to the BHO quality leads regarding new federal regulations and contract requirements related to record keeping and retention.	Response accepted.
Performance Improvement Project Validation		
DBHR needs to develop procedures to ensure the BHOs are able to receive reliable SUD treatment service data.	Per contract, BHOs are responsible for developing and implementing data collection systems that work for their region, to ensure that they are receiving accurate and reliable data from their subcontracted providers. Per contract, DBHR has provided and developed procedures on how the BHOs are to submit data (PIHP section 13.1). Additional technical guidance and procedures are provided via the Service Encounter Reporting Instructions (SERI), Data Dictionary, and	Response accepted.

	Encounter Data Reporting Guide. DBHR has provided ongoing technical assistance to the BHOs in the monthly data and SERI workgroups. DBHR has provided data completeness, quality, and error reports on an ongoing basis to assist BHOs in improving data integrity and identifying problem areas.	
DBHR needs to clearly communicate to the BHOs that State performance measures and contract requirements are separate obligations and cannot be used as PIP study topics.	DBHR partnered with Qualis Health in April 2017 to provide technical assistance and training regarding PIP study topics during the Quality Forum. This issue was clarified during this training. DBHR continues to partner with Qualis Health to provide ongoing technical assistance to the BHOs regarding PIP study topic selection and approval. Technical assistance is provided on an as-needed basis, or during the bi-monthly BHO Quality Leads meetings.	Response accepted.
DBHR needs to ensure that when selecting a PIP study topic, the BHOs: • ensure there are data to support the focus of the PIP as an area that truly needs improvement • do not attempt to create a PIP around a program or process that does not show evidence of needing improvement. PIPs are meant to improve the care and treatment of enrollees in areas that are in need of advancement, not highlight programs or processes that are successful. • fully and clearly define the intended intervention(s)	DBHR partnered with Qualis Health in April 2017 to provide technical assistance and training regarding PIP study topics during the Quality Forum. DBHR continues to partner with Qualis Health to provide ongoing technical assistance to the BHOs regarding PIP study topic selection and approval.	Response accepted.
DBHR needs to ensure that the BHOs' PIP measurement periods are clearly	Since 2016, DBHR has partnered with Qualis Health to review all PIP study topic proposals. A	Response accepted.

stated and appropriate in length. Data need to be reviewed at least on a quarterly basis to ensure the PIP is moving in a successful direction. Any changes in the study periods need to be clearly documented with thorough and valid explanations of deviations from the initial plan.	study topic approval form has been developed to ensure all key elements are vetted and approved.	
DBHR and the EQRO need to continue to provide technical assistance to the BHOs and their staff on the CMS protocol and PIP study design.	DBHR continues to partner with Qualis Health to provide ongoing technical assistance to the BHOs regarding PIP study topic selection and approval. Technical assistance is provided on an as-needed basis, during Quality Forums, or during the bi-monthly BHO Quality Leads meetings.	Response accepted.
Encounter Data Validation		
In order to improve the reliability of encounter data submitted to the State, DBHR needs to work with the BHOs to standardize data collection and analytical procedures for encounter data validation.	DBHR hosts a monthly data workgroup composed of both BHO and DBHR staff that addresses data integrity issues and concerns on an ongoing basis. DBHR provides the BHOs with an error report after data submittal. DBHR also provides BHOs with data quality and data completeness reports on a routine basis. DBHR contracted with Qualis Health for the past two years to conduct an annual EDV review of the BHOs and to provide technical assistance. By contract, the BHOs are to complete their own EDV report using the standards outlined in the contract (PIHP section 9.7) and submit this report to DBHR for review.	Response accepted.
DBHR needs to provide guidance to the BHOs on how to bundle services correctly, review the numerous errors in encounter submission that were found in the clinical chart review, and revise the SERI to further clarify proper coding for clinicians. DBHR also needs to ensure the	In an effort to improve quality of documentation, DBHR implemented a statewide intervention by providing trainings in the form of a webinar, as well as providing multiple workshops at state conferences to address standards of documentation. DBHR has hosted a monthly workgroup with the BHOs to address SERI	DBHR should continue to provide guidance and trainings on encounterable services, documentation requirements and standards, SERI requirements, and contract requirements. DBHR should also implement a process in which to hold BHOs and providers accountable for errors that are not corrected.

BHOs know and understand the content of the State contract, SERI, and standards for documentation. DBHR may consider providing further training on the contract, SERI, and documentation to the BHOs and/or the BHAs.	questions and formulate mutually agreed-upon updates. DBHR requests more clarification regarding concerns related to bundling, as there are relatively few State plan services that are bundled. Pending clarification, DBHR would be willing to bring additional guidance to the BHOs via the monthly SERI workgroup.	
DBHR needs to have processes in place in which ProviderOne create edits to reject encounters that are submitted incorrectly to the State.	HCA oversees ProviderOne, and this is outside of DBHR's authority. HCA provides BHOs with a weekly Encounter Transaction Results Report (ETRR) that identifies what encounters were accepted. If the fields are required per HIPAA 837 standards, the file or encounter will be rejected during file validation. If the fields are needed for adjudication and the encounter file was accepted and loaded into the system, then adjudicative edits would reject the encounter. DBHR, in collaboration with the Decision Support and Evaluation Team, will coordinate with HCA to determine what additional error edits and checks can be implemented with ProviderOne.	Qualis Health acknowledges DBHR's response to creating edits within the ProviderOne system and that this process occurs under a contract with HCA. Qualis Health recommends that if the cost to the State to implement automated edit checks within the ProviderOne system is too great, that DBHR staff manually review the data for discrepancies, errors, and values out of a normal range. Furthermore, DBHR should conduct utilization review of the data and provide feedback and follow-up with the BHOs.
DBHR needs to create expectations or protocols for BHOs on how to address errors identified in encounters.	Per contract, BHOs must submit encounters 30 days after the end of the service month. BHOs must correct all errors within 30 calendar days of when an error report is produced. DBHR will continue to partner with Qualis Health and HCA to further develop ongoing strategies and protocols to address data errors.	Qualis Health acknowledges contract language indicating that BHOs are required to correct data within 30 days of an error report; however, the EQRO recommends that DBHR create a process that is enacted when the errors are continuous and/or are not corrected. Per the DBHR ISCA review, ProviderOne does not create edits or error reports for encounter data.
DBHR needs to have a process in place in which ProviderOne flags encounters that are excessive in duration.	DBHR does not have authority over ProviderOne. However, DBHR, in collaboration with the Decision Support and Evaluation team, will coordinate with HCA to advocate that this additional edit check be implemented.	Qualis Health acknowledges the challenges inherent in ProviderOne being a contract under HCA; however, DBHR should review data on a regular basis and provide BHOs with direction regarding the issues identified in

		those reviews if ProviderOne does not have automated reports built into the system.
DBHR needs to create regular WISe trainings offered throughout the state to ensure all WISe services are able to be captured.	In the spring of 2018, DBHR is releasing an RFP to expand and enhance the WISe training and coaching framework. This RFP will broaden the work under the WISe Workforce Collaborative; the contract to the successful bidder will start July 2018. As of January 2018, DBHR hired a new staff position, a WISe system coach, to assist with coaching support and technical assistance for WISe agency staff statewide. The WISe system coach will focus on system challenges during statewide implementation and program maintenance. Monthly coaching will occur in person and virtually.	Qualis Health accepts this response with the recommendation that a follow-up review or process be in place to ensure that the trainings and coaching are effective and implemented as required.

Appendix

Appendix A: MCO Profiles

Amerigroup Washington (AMG)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	63.8%	▼
Adults' access (45-64 yrs)	75.8%	
Adults' access (total)	68.2%	
Children's access (12-24 mos)	95.4%	
Children's access (25 mos-6 yrs)	82.7%	▲
Children's access (7-11 yrs)	85.9%	
Children's access (12-19 yrs)	86.2%	

Maternal health visits

Timeliness of prenatal care	81.0%	▲
Frequency of prenatal care	49.8%	
Postpartum care	62.3%	

Well-child visits

0-15 months, 6+ visits	72.0%	
3-6 yrs, annual visit	65.3%	
12-21 yrs, semi-annual visit	48.8%	

Preventive Care

Women's health screenings

Breast cancer screening	48.0%	
Cervical cancer screening	53.6%	
Chlamydia screening	57.0%	

Weight assessment and counseling

Children's BMI percentile assessment	59.7%	▲
Children's nutritional counseling	58.8%	
Children's physical activity counseling	56.3%	
Adult BMI percentile assessment	91.4%	▲

Children's immunizations

Combo 2	72.9%	
Combo 10	39.6%	

Adolescents' immunizations

Combo 1	66.0%	
HPV	18.1%	

Chronic Care Management

Diabetes care

HbA1c testing	90.1%	
Eye examinations	54.2%	
Medical attention for nephropathy	88.9%	
HbA1c control	54.6%	▲
Poor HbA1c control *	33.8%	▼
Bood pressure control	63.7%	
Screening - schizophrenia/bipolar	84.3%	
Monitoring - schizophrenia/bipolar	56.8%	

Other chronic care management

Asthma med. 5-11 yrs - 75% compliance	17.1%	
Asthma med. 12-18 yrs - 75% compliance	22.1%	
COPD medication - bronchodialator	82.9%	
Antidepressant medication - acute	50.7%	▼
Antidepressant medication - continuation	36.9%	▼
ADHD medication follow-up - initial	37.1%	
ADHD medication follow-up - continuing	50.0%	
Medication adherence - schizophrenia	58.3%	
Controlling high blood pressure	55.1%	

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	94.0%	
Antibiotics for acute bronchitis (adults)	40.0%	▲
Testing for children with pharyngitis	74.8%	
Imaging for low back pain	75.5%	

▼▲Plan score increased or decreased significantly from the prior year

* Lower rate is better performance

Amerigroup Washington (AMG), continued

Performance Measure Strengths & Opportunities

Strengths	Opportunities for Improvement
• Above state rate on well-child visits for children ages 0 to 15 months	• Below national rate for all adults access measures
• Above state rate on HbA1c control	• Below national rate for all maternal health measures
	• Below state rate for breast cancer screening

Consumer Experience (Child CAHPS)

Measure	Score	Quintile
Rating of personal doctor	71.8%	
Rating of specialist	72.7%	
Rating of overall healthcare	63.2%	
Rating of health plan	62.9%	
Getting needed care	81.5%	
Getting care quickly	87.7%	
Customer service	85.5%	

- Below the 20th Percentile
- 20th to 39th Percentile
- 40th to 59th Percentile
- 60th to 79th Percentile
- At or above the 80th Percentile

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance System	94.0%
Program Integrity Requirements	100.0%	Performance Improvement Projects	74.0%
Coordination and Continuity of Care	80.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Coordination	100.0%	QA/PI Program	100.0%
Coverage and Authorization	93.0%	Sub-contractual Relationships and Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Information Systems	100.0%
Enrollee Rights	98.0%	Healthy Options - Health Homes	82.0%

In 2016 in Washington, Amerigroup served 149,314 Medicaid enrollees.

Coordinated Care Washington (CCW)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	65.7%	
Adults' access (45-64 yrs)	76.5%	
Adults' access (total)	69.6%	

Maternal health visits

Timeliness of prenatal care	76.3%	
Frequency of prenatal care	49.6%	▲
Postpartum care	60.4%	

Children's access (12-24 mos)	96.9%	
Children's access (25 mos-6 yrs)	86.2%	
Children's access (7-11 yrs)	92.0%	▼
Children's access (12-19 yrs)	90.0%	

Well-child visits

0-15 months, 6+ visits	58.2%	▼
3-6 yrs, annual visit	70.9%	
12-21 yrs, semi-annual visit	44.5%	

Preventive Care

Women's health screenings

Breast cancer screening	53.1%	▲
Cervical cancer screening	52.8%	
Chlamydia screening	55.0%	

Weight assessment and counseling

Children's BMI percentile assessment	48.1%	▲
Children's nutritional counseling	63.2%	▲
Children's physical activity counseling	54.6%	
Adult BMI percentile assessment	90.1%	

Children's immunizations

Combo 2	76.0%	
Combo 10	45.0%	

Adolescents' immunizations

Combo 1	81.7%	
HPV	32.7%	

Chronic Care Management

Diabetes care

HbA1c testing	91.5%	
Eye examinations	66.6%	
Medical attention for nephropathy	91.0%	
HbA1c control	45.7%	
Poor HbA1c control *	43.4%	▼
Bood pressure control	58.5%	
Screening - schizophrenia/bipolar	84.6%	
Monitoring - schizophrenia/bipolar	69.2%	

Other chronic care management

Asthma med. 5-11 yrs - 75% compliance	21.6%	
Asthma med. 12-18 yrs - 75% compliance	21.0%	
COPD medication - bronchodialator	84.1%	
Antidepressant medication - acute	49.6%	
Antidepressant medication - continuation	33.5%	▼
ADHD medication follow-up - initial	41.8%	
ADHD medication follow-up - continuing	53.1%	
Medication adherence - schizophrenia	60.1%	
Controlling high blood pressure	53.1%	

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	93.0%	
Antibiotics for acute bronchitis (adults)	39.1%	
Testing for children with pharyngitis	62.0%	▲
Imaging for low back pain	75.7%	

▼▲Plan score increased or decreased significantly from the prior year

* Lower rate is better performance

Coordinated Care Washington (CCW), continued

Performance Measure Strengths & Opportunities

Strengths	Opportunities for Improvement
• Strong performance on childhood immunizations	• Below national rate for all maternal health measures • Below national rate for all adult access measures

Consumer Experience (Child CAHPS)

Measure	Score	Quintile	Measure	Score	Quintile
Rating of personal doctor	73.1%		Getting needed care	80.4%	
Rating of specialist	68.1%		Getting care quickly	88.0%	
Rating of overall healthcare	62.5%		Customer service	89.5%	
Rating of health plan	68.3%				

Below the 20th Percentile
20th to 39th Percentile
40th to 59th Percentile
60th to 79th Percentile
At or above the 80th Percentile

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance System	94.0%
Program Integrity Requirements	100.0%	Performance Improvement Projects	52.0%
Coordination and Continuity of Care	93.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Coordination	100.0%	QA/PI Program	93.0%
Coverage and Authorization	90.0%	Sub-contractual Relationships and Delegatior	100.0%
Enrollment and Disenrollment	100.0%	Healthy Information Systems	100.0%
Enrollee Rights	95.0%	Healthy Options - Health Homes	88.0%

In 2016 in Washington, Coordinated Care Washington (CCW) served 207,342 Medicaid enrollees.

Community Health Plan of Washington (CHPW)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	71.1%	
Adults' access (45-64 yrs)	81.1%	
Adults' access (total)	74.8%	▼

Children's access (12-24 mos)	96.2%	▲
Children's access (25 mos-6 yrs)	85.0%	▲
Children's access (7-11 yrs)	90.8%	▲
Children's access (12-19 yrs)	89.8%	▲

Maternal health visits

Timeliness of prenatal care	76.6%	▲
Frequency of prenatal care	45.3%	▲
Postpartum care	60.3%	▲

Well-child visits

0-15 months, 6+ visits	70.1%	▲
3-6 yrs, annual visit	69.6%	
12-21 yrs, semi-annual visit	44.3%	

Preventive Care

Women's health screenings

Breast cancer screening	58.4%	▲
Cervical cancer screening	58.0%	
Chlamydia screening	53.0%	

Weight assessment and counseling

Children's BMI percentile assessment	70.3%	▲
Children's nutritional counseling	67.9%	▲
Children's physical activity counseling	63.7%	
Adult BMI percentile assessment	88.1%	

Children's immunizations

Combo 2	70.6%
Combo 10	37.0%

Adolescents' immunizations

Combo 1	78.4%
HPV	24.8%

Chronic Care Management

Diabetes care

HbA1c testing	90.5%	
Eye examinations	63.5%	
Medical attention for nephropathy	87.4%	
HbA1c control	51.8%	▲
Poor HbA1c control *	37.2%	▼
Bood pressure control	73.7%	▲
Screening - schizophrenia/bipolar	86.2%	
Monitoring - schizophrenia/bipolar	73.5%	

Other chronic care management

Asthma med. 5-11 yrs - 75% compliance	23.8%	
Asthma med. 12-18 yrs - 75% compliance	25.2%	
COPD medication - bronchodialator	83.6%	
Antidepressant medication - acute	49.1%	▼
Antidepressant medication - continuation	33.2%	▼
ADHD medication follow-up - initial	42.3%	▲
ADHD medication follow-up - continuing	50.8%	
Medication adherence - schizophrenia	64.0%	
Controlling high blood pressure	65.1%	

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	94.6%	▲
Antibiotics for acute bronchitis (adults)	38.2%	
Testing for children with pharyngitis	75.4%	▲
Imaging for low back pain	71.6%	▼

▼▲Plan score increased or decreased significantly from the prior year

* Lower rate is better performance

Community Health Plan of Washington (CHPW), continued

Performance Measure Strengths & Opportunities

Strengths	Opportunities for Improvement
• Above state rate for controlling high blood pressure	• Below national rate for all maternal health measures • Below national rate for all adult access measures

Consumer Experience (Child CAHPS)

Measure	Score	Quintile	Measure	Score	Quintile
Rating of personal doctor	72.6%		Getting needed care	76.4%	
Rating of specialist	71.6%		Getting care quickly	81.6%	
Rating of overall healthcare	59.3%		Customer service	87.5%	
Rating of health plan	64.0%				

Below the 20th Percentile
20th to 39th Percentile
40th to 59th Percentile
60th to 79th Percentile
At or above the 80th Percentile

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance System	81.0%
Program Integrity Requirements	100.0%	Performance Improvement Projects	73.0%
Coordination and Continuity of Care	87.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Coordination	100.0%	QA/PI Program	100.0%
Coverage and Authorization	80.0%	Sub-contractual Relationships and Delegation	83.0%
Enrollment and Disenrollment	100.0%	Health Information Systems	100.0%
Enrollee Rights	100.0%	Healthy Options - Health Homes	70.0%

In 2016, Community Health Plan of Washington (CHPW) served 297,725 Medicaid enrollees.

Molina Healthcare of Washington (MHW)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	77.2%	▼
Adults' access (45-64 yrs)	83.5%	▼
Adults' access (total)	79.2%	▼
Children's access (12-24 mos)	97.1%	
Children's access (25 mos-6 yrs)	87.5%	▼
Children's access (7-11 yrs)	92.2%	▼
Children's access (12-19 yrs)	92.3%	

Maternal health visits

Timeliness of prenatal care	79.1%
Frequency of prenatal care	52.1%
Postpartum care	56.4%

Well-child visits

0-15 months, 6+ visits	65.6%
3-6 yrs, annual visit	67.2%
12-21 yrs, semi-annual visit	45.9%

Preventive Care

Women's health screenings

Breast cancer screening	56.1%
Cervical cancer screening	58.7%
Chlamydia screening	54.4%

Weight assessment and counseling

Children's BMI percentile assessment	56.3%
Children's nutritional counseling	54.8%
Children's physical activity counseling	49.7%
Adult BMI percentile assessment	92.6%

Children's immunizations

Combo 2	68.2%
Combo 10	33.3%

Adolescents' immunizations

Combo 1	78.2%
HPV	19.7%

Chronic Care Management

Diabetes care

HbA1c testing	88.7%	
Eye examinations	57.2%	
Medical attention for nephropathy	91.8%	
HbA1c control	50.3%	
Poor HbA1c control *	37.3%	▼
Bood pressure control	66.7%	
Screening - schizophrenia/bipolar	84.1%	
Monitoring - schizophrenia/bipolar	73.4%	

Other chronic care management

Asthma med. 5-11 yrs - 75% compliance	22.1%	
Asthma med. 12-18 yrs - 75% compliance	26.1%	
COPD medication - bronchodialator	84.6%	
Antidepressant medication - acute	50.7%	
Antidepressant medication - continuation	34.5%	▼
ADHD medication follow-up - initial	44.1%	
ADHD medication follow-up - continuing	54.0%	
Medication adherence - schizophrenia	62.3%	▼
Controlling high blood pressure	56.9%	

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	93.8%	
Antibiotics for acute bronchitis (adults)	34.4%	▲
Testing for children with pharyngitis	75.0%	▲
Imaging for low back pain	75.8%	▼

▼▲Plan score increased or decreased significantly from the prior year

* Lower rate is better performance

Molina Healthcare of Washington (MHW), continued

Performance Measure Strengths & Opportunities

Strengths	Opportunities for Improvement
• Above state rate for most age groups for both child and adult access measures	• Below national rate for all maternal health measures • Below national rate for all adult access measures

Consumer Experience (Child CAHPS)

Measure	Score	Quintile
Rating of personal doctor	74.1%	
Rating of specialist	73.0%	
Rating of overall healthcare	66.7%	
Rating of health plan	66.8%	
Getting needed care	83.7%	
Getting care quickly	86.5%	
Customer service	89.4%	

Below the 20th Percentile
20th to 39th Percentile
40th to 59th Percentile
60th to 79th Percentile
At or above the 80th Percentile

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance System	94.0%
Program Integrity Requirements	100.0%	Performance Improvement Projects	70.0%
Coordination and Continuity of Care	97.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Coordination	100.0%	QA/PI Program	100.0%
Coverage and Authorization	90.0%	Sub-contractual Relationships and Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Information Systems	100.0%
Enrollee Rights	93.0%	Healthy Options - Health Homes	91.0%

In 2016 in Washington, Molina Healthcare of Washington (MHW) served 697,392 Medicaid enrollees.

United Healthcare Community Plan (UHC)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	67.0%	▼
Adults' access (45-64 yrs)	78.1%	▼
Adults' access (total)	71.2%	▼

Maternal health visits

Timeliness of prenatal care	74.7%	
Frequency of prenatal care	45.3%	▲
Postpartum care	61.3%	

Children's access (12-24 mos)	96.2%	
Children's access (25 mos-6 yrs)	85.8%	▼
Children's access (7-11 yrs)	90.3%	▼
Children's access (12-19 yrs)	89.9%	▼

Well-child visits

0-15 months, 6+ visits	69.0%	
3-6 yrs, annual visit	66.1%	
12-21 yrs, semi-annual visit	47.7%	

Preventive Care

Women's health screenings

Breast cancer screening	48.7%	▲
Cervical cancer screening	50.1%	
Chlamydia screening	54.5%	

Weight assessment and counseling

Children's BMI percentile assessment	50.6%	▲
Children's nutritional counseling	55.7%	
Children's physical activity counseling	47.0%	
Adult BMI percentile assessment	86.7%	

Children's immunizations

Combo 2	71.1%
Combo 10	38.7%

Adolescents' immunizations

Combo 1	67.9%
HPV	20.0%

Chronic Care Management

Diabetes care

HbA1c testing	88.3%
Eye examinations	54.5%
Medical attention for nephropathy	90.0%
HbA1c control	45.3%
Poor HbA1c control *	44.5%
Bood pressure control	62.5%
Screening - schizophrenia/bipolar	86.4%
Monitoring - schizophrenia/bipolar	66.9%

Other chronic care management

Asthma med. 5-11 yrs - 75% compliance	36.4%
Asthma med. 12-18 yrs - 75% compliance	33.6%
COPD medication - bronchodialator	82.2%
Antidepressant medication - acute	54.5%
Antidepressant medication - continuation	40.8%
ADHD medication follow-up - initial	42.6%
ADHD medication follow-up - continuing	56.8%
Medication adherence - schizophrenia	61.9%
Controlling high blood pressure	46.2%

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	92.8%	
Antibiotics for acute bronchitis (adults)	33.0%	
Testing for children with pharyngitis	78.9%	▲
Imaging for low back pain	72.0%	

▼▲Plan score increased or decreased significantly from the prior year

* Lower rate is better performance

United Healthcare Community Plan (UHC), continued

Performance Measure Strengths & Opportunities

Strengths	Opportunities for Improvement
• Higher than state rate on all adult and child access measures	• Below national rate for all adults access measures • Below national rate for all maternal health measures • Below state rate for breast cancer and cervical cancer screening measures

Consumer Experience (Child CAHPS)

Measure	Score	Quintile	Measure	Score	Quintile
Rating of personal doctor	74.9%		Getting needed care	83.8%	
Rating of specialist	69.2%		Getting care quickly	88.8%	
Rating of overall healthcare	69.6%		Customer service	88.4%	
Rating of health plan	65.2%				

- Below the 20th Percentile
- 20th to 39th Percentile
- 40th to 59th Percentile
- 60th to 79th Percentile
- At or above the 80th Percentile

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance System	96.0%
Program Integrity Requirements	100.0%	Performance Improvement Projects	67.0%
Coordination and Continuity of Care	100.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Coordination	100.0%	QA/PI Program	100.0%
Coverage and Authorization	93.0%	Sub-contractual Relationships and Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Information Systems	100.0%
Enrollee Rights	98.0%	Healthy Options - Health Homes	85.0%

In 2016 in Washington, UnitedHealthcare Community Plan (UHC) served 224,973 Medicaid enrollees.

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Appendix B: BHO Profiles

Great Rivers Behavioral Health Organization (GRBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Availability of Services	⦿	**Subcontractual Relationships**	●
Coordination and Continuity of Care	⦿	**Practice Guidelines**	●
Coverage and Authorization of Services	●	**Health Information Systems**	●
Provider Selection	●	**QAPI Program**	●

Strengths	**Recommendations**
GRBHO has developed and uses data reports to monitor the timeliness of routine outpatient access. GRBHO's Utilization Management (UM) Team identifies persons with special healthcare needs (such as those in eating disorder treatment or detoxification services) and assigns care managers to work with these populations. GRBHO is redesigning its crisis services program to include a mobile crisis outreach team, which will provide crisis services to individuals in the community to prevent over-utilization of the emergency department.	Although GRBHO stated that it requires out-of-network providers to be subject to the same credentialing process and requirements as in-network providers, the BHO lacks documentation and a policy to ensure this process is in place. GRBHO needs to include a process for how it will ensure that out-of-network providers are appropriately credentialed in its credentialing policy, or develop a new policy to document this process. GRBHO conducts regular monitoring for mental health care coordination. The last review indicated that documentation of care coordination existed in clinical charts only 45 percent of the time. GRBHO needs to continue to work with its BHAs to ensure clinical records contain appropriate documentation of care coordination.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
Improved Outcomes for Children and Youth with Intensive Behavioral Health Needs	●	GRBHO followed a thorough process in developing and selecting the study topic for this PIP. The main focus is improving CANS assessment scores over time, specifically the 2s and 3s in five key domains, and, as a result, improving overall outcomes in service delivery.	N/A
Non-clinical PIP			
Children's Evidence-Based Practices Service Reporting	●	GRBHO has made great strides in implementing this PIP. Through its collaboration with the BHAs, the BHO was able to identify and address barriers and employ solutions that will hopefully steadily increase the use and reporting of evidence-based practices.	N/A
SUD PIP			
Grievance Process for Behavioral Health Agencies Providing Substance Use Disorder Treatment Services	●	Although this PIP is still in the infancy stages of implementation, the BHO has made great strides to effect change, including training, testing of BHA knowledge around grievance processes and policies, continual follow-up with BHAs, and ongoing monitoring of grievance reporting (which includes ensuring that all grievances are properly documented and resolved).	N/A

Great Rivers Behavioral Health Organization (GRBHO)

Encounter Data Validation (EDV)

Standard	MH	SUD	Standard	MH	SUD	Standard	MH	SUD
Sampling Procedure	●	●	Review Tools	●	●	Methodology and Analytic Procedures	◉	◉
Electronic Data Checks	●	●	On-site Clinical Record Review	○	○			

Comparison of Qualis Health and BHO EDV Results

Field	Qualis Health % Match	BHO % Match	Field	Qualis Health % Match	BHO % Match
Demographic Data					
Last Name	90%	0%	Hispanic Origin	79%	84%
First Name	90%	0%	Preferred Language	3%	93%
Gender	83%	96%	SSN	79%	95%
Date of Birth	90%	95%	Sexual Orientation	62%	89%
Ethnicity/Race	79%	88%			
Encounter Data					
Procedure Code	71%	51%	Service Duration	73%	89%
Date of Service	91%	92%	Provider Type	71%	83%
Service Location	76%	81%	Clinical Note Matches Procedure Code	59%	85%

Strengths	Recommendations
The BHO adopted a stratified, random sampling method based on agency and age group, and provided a more detailed description of the sampling process than in previous reviews. The BHO's report deliverable provided conclusions, limitations, and opportunities for improvement for each mental health and SUD treatment agency.	GRBHO needs to work with its network on documentation standards to ensure that clinical interventions are being well documented, which will enable GRBHO to match the correct code to the service. GRBHO needs to train providers on documentation requirements, SERI requirements, and WAC requirements for documentation and timeliness.

Information Systems Capabilities Assessment (ISCA)

Section	Score	Section	Score
Information Systems	●	Eligibility Data Management	●
IT Infrastructure	◉	Provider Data Management	●
Information Security	◉	Performance Measures and Reporting	●
Encounter Data Management	●		

Previous-Year Corrective Action Plans

Section	Number of CAPs	Number Resolved
Enrollee Rights and Protections	1	1

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Greater Columbia Behavioral Health Organization (GCBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Availability of Services	⦿	**Subcontractual Relationships**	⦿
Coordination and Continuity of Care	⦿	**Practice Guidelines**	⦿
Coverage and Authorization of Services	⦿	**Health Information Systems**	⦿
Provider Selection	⦿	**QAPI Program**	⦿

Strengths	**Recommendations**
The BHO uses a survey tool to gather information from its BHAs to identity gaps and needs in enrollee services. GCBHO indicated that it has encouraged its SUD treatment BHAs to adopt an open access model, which has enabled the BHAs to meet the State Medicaid standards for timely access to care and services. GCBHO has a specific policy and procedure that details how to engage the enrollee in participating in the development of his/her treatment plan.	The BHO needs to begin analyzing the BHAs' utilization data to identify over- and underutilization of services of its enrollees, as well as perform an in-depth review of all performance and encounter data. The BHO needs to use this information when making informed management decisions. The BHO needs to develop and implement a policy and procedure that describes how and when the authorization staff will conduct inter-rater reliability monitoring. The policy should also include what steps the BHO will take if results indicate an inconsistency among reviewers regarding the application of review criteria.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
Promoting Medication Adherence in Youth	N/A	GCBHO has identified two top reasons for non-adherence to medications for youth. Thus, an intervention(s) can now be chosen to increase medication compliance, and a fully formulated study question can be written.	The BHO should consider framing the PIP around a specific barrier or issue and implementing an intervention to mitigate the problem. For example: "Will providing X intervention reduce Y barrier for Z population by Q%?"
Non-clinical PIP			
Increasing Timeliness of Provider-Submitted Authorization Requests Through Identification of Systemic Barriers	●	GCBHO has conducted a well-thought-out and successful non-clinical PIP. The PIP clearly shows that the implementation of the five-day authorization policy had a direct correlation with improved authorization timeliness requests.	The PIP was initiated in 2015 and has had two full re-measurement periods showing sustained improvement. Therefore, the BHO should retire this PIP and pursue a new non-clinical PIP topic.
SUD PIP			
Increasing Engagement in Recovery by Identifying Reasons for Premature Exit from Detox Programs	N/A	GCBHO has chosen its SUD topic based on research and analysis of enrollee needs. This PIP is consistent with the health risks and demographics of the BHO's enrollees.	GCBHO is still working to create its study question. When formulating the study question, GCBHO should remember to frame the PIP around a specific barrier or issue and implement an intervention to mitigate the problem.

Greater Columbia Behavioral Health Organization (GCBHO)

Encounter Data Validation (EDV)

Standard	MH	SUD	Standard	MH	SUD	Standard	MH	SUD
Sampling Procedure	◉	◉	Review Tools	◉	◉	Methodology and Analytic Procedures	◉	◉
Electronic Data Checks	◉	●	On-site Clinical Record Review	○	○			

Comparison of Qualis Health and BHO EDV Results

Field	Qualis Health % Match	BHO % Match	Field	Qualis Health % Match	BHO % Match
Demographic Data					
Last Name	100%	0%	Hispanic Origin	69%	84%
First Name	100%	0%	Preferred Language	2%	93%
Gender	100%	96%	SSN	79%	95%
Date of Birth	99%	95%	Sexual Orientation	64%	89%
Ethnicity/Race	65%	88%			
Encounter Data					
Procedure Code	72%	51%	Service Duration	48%	89%
Date of Service	81%	92%	Provider Type	72%	83%
Service Location	49%	81%	Clinical Note Matches Procedure Code	52%	85%

Strengths	Recommendations
The BHO's report deliverable provided conclusions, limitations, and opportunities for improvement for each mental health and SUD treatment agency.	GCBHO should report encounter and demographic match rates separately so it can clearly articulate trends in the data and show the differences in mental health and SUD performance. GCBHO needs to train providers on documentation requirements, SERI requirements, and WAC requirements for documentation and timeliness.

Information Systems Capabilities Assessment (ISCA)

Section	Score	Section	Score
Information Systems	●	Eligibility Data Management	●
IT Infrastructure	◉	Provider Data Management	●
Information Security	◉	Performance Measures and Reporting	●
Encounter Data Management	●		

Previous-Year Corrective Action Plans

Section	Number of CAPs	Number Resolved
Enrollee Rights and Protections	3	2
Grievance System	6	4
Certifications and Program Integrity	8	5

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

King County Behavioral Health Organization (KCBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Availability of Services	⦿	**Subcontractual Relationships**	⦿
Coordination and Continuity of Care	⦿	**Practice Guidelines**	⦿
Coverage and Authorization of Services	●	**Health Information Systems**	⦿
Provider Selection	⦿	**QAPI Program**	⦿

Strengths	Recommendations
KCBHO stated it has a mix of culturally diverse agencies that primarily provide services to enrollees of Hispanic, Asian, and African-American descent. KCBHO tracks enrollees who have had three or more authorized psychiatric hospitalizations or multiple residential SUD treatment admissions in the preceding 12 months and works with providers to provide case management for these enrollees.	KCBHO noted it does not have a system for tracking requests for out-of-network services. KCBHO needs to implement a procedure to track requests for out-of-network services and use this information for network planning. The results of the on-site EQR of the care coordination records indicated that some BHAs are not using or completing treatment plans and that many treatment plans that were in place did not include enrollee voice and participation. KCBHO needs to ensure that all BHAs have treatment plans in place and that the treatment plans include documentation that the plans were developed with the enrollee's participation and in consultation with any specialists caring for the enrollee.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
Effectiveness of the Transitional Support Program	⦿	KCBHO previously completed a rendition of this PIP but identified barriers and challenges with implementing the Transitional Support Program in two specific hospitals. As a result, the BHO recognized the need to continue its evaluation activities and quality improvement efforts to increase TSP penetration rates and lower psychiatric readmissions at these facilities.	The BHO should implement its new strategy at these facilities and then retire the PIP in its current format. As KCBHO monitors these interventions, it is important to pay close attention to the organizational change process and the degree to which it is affecting the specific intervention.
Non-clinical/Children's PIP			
Improved Coordination with Primary Care for Children and Youth	⦿	KCBHO has followed through on last year's recommendation to fully formulate and begin the PIP. With baseline measurement and re-measurement periods redefined, KCBHO should be able to progress further with collecting, reporting, and analyzing the data for youth dually enrolled in the BHO and Molina Healthcare Apple Health.	KCBHO needs to provide current and relevant data on enrollee demographics and epidemiology. This should include overall standardized local, state, or national data linked to the study population.
SUD PIP			
SUD Residential Treatment Length of Stay	⦿	Enrollees who access SUD residential treatment have a high severity of drug use, and some are at high risk for death due to overdose. KCBHO is seeking to understand how lengths of stay impact treatment outcomes and what factors may affect optimal lengths of stay.	In its current format, the study question is not answerable, as the BHO has not defined specific metrics for X and Y. The BHO should narrow its focus so the study question is concise and easily answerable.

King County Behavioral Health Organization (KCBHO)

Encounter Data Validation (EDV)								
Standard	**MH**	**SUD**	**Standard**	**MH**	**SUD**	**Standard**	**MH**	**SUD**
Sampling Procedure	◉	◉	**Review Tools**	●	●	**Methodology and Analytic Procedures**	○	○
Electronic Data Checks	●	●	**On-site Clinical Record Review**	○	○			

Comparison of Qualis Health and BHO EDV Results					
Field	**Qualis Health % Match**	**BHO % Match**	**Field**	**Qualis Health % Match**	**BHO % Match**
Demographic Data					
Last Name	98%	NR	**Hispanic Origin**	83%	NR
First Name	100%	NR	**Preferred Language**	4%	NR
Gender	98%	NR	**SSN**	78%	NR
Date of Birth	98%	NR	**Sexual Orientation**	59%	NR
Ethnicity/Race	84%	NR			
Encounter Data					
Procedure Code	64%	NR	**Service Duration**	60%	NR
Date of Service	83%	NR	**Provider Type**	64%	NR
Service Location	74%	NR	**Clinical Note Matches Procedure Code**	51%	NR

Strengths	Recommendations
KCBHO stratified its samples by agency size and client type and pulled clients proportionally based on the number of clients at each agency. This approach appears to have provided an unbiased and representative sample.	KCBHO did not submit a copy of its review tool in its State deliverable, which is a contract requirement and would facilitate a more effective review of the tool. KCBHO needs to submit a copy of its review tool in its DBHR deliverable. KCBHO needs to train providers on documentation requirements, SERI requirements, and WAC requirements for documentation and timeliness.

Information Systems Capabilities Assessment (ISCA)			
Section	**Score**	**Section**	**Score**
Information Systems	◉	**Eligibility Data Management**	●
IT Infrastructure	◉	**Provider Data Management**	●
Information Security	◉	**Performance Measures and Reporting**	●
Encounter Data Management	◉		

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Grievance System	3	3
Certifications and Program Integrity	13	7
PIP Validation	3	3

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

North Central Behavioral Health Organization (NCBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Availability of Services	N/A	**Subcontractual Relationships**	N/A
Coordination and Continuity of Care	N/A	**Practice Guidelines**	N/A
Coverage and Authorization of Services	N/A	**Health Information Systems**	N/A
Provider Selection	N/A	**QAPI Program**	N/A

Strengths	**Opportunities for Improvement**
NCBHO ensured its BHAs were offering services 24 hours a day, 7 days a week, as well as when medically necessary. NCBHO indicated it had hired a trainer to facilitate a cultural competency training class for its BHAs in November 2017. NCBHO had a process in place to evaluate the impact and effectiveness of its QAPI program and encouraged its BHAs to continue this practice during and after the transition.	Results of Qualis Health's care coordination review indicated that the BHAs need further training and education on providing and documenting adequate care coordination. Of 20 charts reviewed, two demonstrated fair coordination of care, 12 demonstrated poor coordination, and 6 demonstrated very poor coordination. During 2017, one of the BHO's agencies experienced a breach of confidentiality. The BHO worked with the agency to help resolve the situation. The BHO stated that after the transition, the BHAs would need further training on what constitutes a breach of confidentiality.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Opportunities for Improvement**
Crisis Resolution Through Follow-up Services	⦿	The idea of focusing this PIP on improved crisis episode follow-up as a means to decrease the number of enrollees who have recurrent crisis episodes has merit, as those enrollees seeking crisis services are generally considered a high-risk and high-need population.	If the BHO were continuing operations into 2018, it would be encouraged to thoroughly review the type of data that is being tabulated and revise the data analysis plan to include a statistical calculation that would identify whether one or more variables had an effect on the outcome of the intervention.
Non-clinical PIP			
Service Intensity and Frequency for Children and Adolescents	⦿	The PIP addresses a high-risk, high-need population. Youth involved in child welfare systems experience mental illness at a higher rate than the overall youth population, resulting in a sum of nearly half of those involved in the system.	The BHO needed to state the confidence level used to assess statistical significance.
SUD PIP			
Timely Access to SUD Treatment Services	⦿	The choice of this study topic reflects an effort to ensure that high-risk individuals receive timely completed assessments to improve overall treatment completion, satisfaction, and effectiveness rates.	NCBHO did not submit an analysis of identified statistical significance in the differences between initial and repeat measurements. NCBHO only outlined the statistical significance in the difference from baseline to the final re-measurement. Even if statistical significance is not achieved between each measurement period, the analysis should still occur and the results displayed accordingly.

North Central Behavioral Health Organization (NCBHO)

Encounter Data Validation (EDV)								
Standard	**MH**	**SUD**	**Standard**	**MH**	**SUD**	**Standard**	**MH**	**SUD**
Sampling Procedure	●	●	**Review Tools**	◉	◉	**Methodology and Analytic Procedures**	●	●
Electronic Data Checks	●	●	**On-site Clinical Record Review**	○	○			

Comparison of Qualis Health and BHO EDV Results									
Field	**QH % Match MH**	**BHO %Match MH**	**QH %Match SUD**	**BHO %Match SUD**	**Field**	**QH %Match MH**	**BHO % Match MH**	**QH %Match SUD**	**BHO %Match SUD**
Demographic Data									
Last Name	99%	0%	100%	0%	**Hispanic Origin**	87%	84%	82%	84%
First Name	100%	0%	100%	0%	**Preferred Language**	9%	93%	5%	93%
Gender	99%	96%	98%	96%	**SSN**	84%	95%	81%	81%
Date of Birth	98%	95%	98%	95%	**Sexual Orientation**	88%	89%	84%	82%
Ethnicity/Race	92%	88%	94%	88%					
Encounter Data									
Procedure Code	90%	51%	82%	51%	**Service Duration**	93%	89%	52%	89%
Date of Service	100%	92%	88%	92%	**Provider Type**	90%	83%	82%	83%
Service Location	98%	81%	86%	81%	**Clinical Note Matches Procedure Code**	72%	85%	43%	85%

Strengths	Opportunities for Improvement
The BHO's presentation of results was clear and detailed, which enabled it to identify performance trends. The BHO identified low performers and issued corrective action swiftly.	NCBHO did not submit a copy of its audit tool in its deliverable for the State as required, preventing the EQR from thoroughly reviewing the tool.

Information Systems Capabilities Assessment (ISCA)			
Section	**Score**	**Section**	**Score**
Information Systems	●	**Eligibility Data Management**	●
IT Infrastructure	◉	**Provider Data Management**	●
Information Security	◉	**Performance Measures and Reporting**	●
Encounter Data Management	●		

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Enrollee Rights and Protections	2	2
Certifications and Program Integrity	9	8

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

North Sound Behavioral Health Organization (NSBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Availability of Services	⦿	**Subcontractual Relationships**	●
Coordination and Continuity of Care	⦿	**Practice Guidelines**	●
Coverage and Authorization of Services	●	**Health Information Systems**	⦿
Provider Selection	⦿	**QAPI Program**	⦿

Strengths	**Recommendations**
As part of its annual strategic planning process, NSBHO conducts a geographical service area needs assessment by reviewing and analyzing utilization data, provider staffing and enrollee ratios, and input from enrollees and clinical provider network staff regarding accessibility and timeliness of services. The BHO care coordinators meet weekly to discuss all current cases in order to keep one another informed and to discuss enrollee outcomes. Monthly, the team meets with the BHO's medical director to discuss all cases and the course of treatment.	The BHO needs to monitor its BHAs in order to ensure their hours of operation for Medicaid enrollees are no less than the hours offered for commercial enrollees. NSBHO needs to monitor its BHAs for providing adequate physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. The BHO needs to ensure all clinical records involving care coordination contain the appropriate release of information documents.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
EPSTD and the Effects of Care Coordination on Level of Care	●	NSBHO's clinical PIP is still in the initial stages of implementation. The main focus is improving care coordination with the use of the EPSDT screening and, as a result, decreasing enrollees' overall level of care placement.	While the BHO is monitoring the progress of the implemented interventions, it would benefit from ensuring care coordination processes are streamlined to reduce duplication of efforts and promote smooth transitions between levels of care.
Non-clinical PIP			
The Impact of the Open Access Service Delivery Model on Behavioral Health Treatment Initiation	●	NSBHO has made great strides in implementing the open access model at several BHAs within the BHO's service delivery network. Through its collaboration with MTM Consulting, the BHO was able to identify and address barriers to employing this model at the provider agencies across the region.	N/A
SUD PIP			
SUD Golden Thread	⦿	This topic is novel and has merit, especially as it centers on helping enrollees progress through treatment while focusing on clinical outcomes.	Before implementing this PIP fully, the BHO needs to ensure baseline data indicate that an issue truly exists. Then, NSBHO should review its data to better home in on the problem/barriers the BHO seeks to address. Moreover, while undertaking this PIP, NSBHO needs to ensure a correlation is made between the data and how they relate to overall enrollee care.

North Sound Behavioral Health Organization (NSBHO)

Encounter Data Validation (EDV)

Standard	MH	SUD	Standard	MH	SUD	Standard	MH	SUD
Sampling Procedure	●	●	Review Tools	●	●	Methodology and Analytic Procedures	◉	◉
Electronic Data Checks	●	●	On-site Clinical Record Review	○	○			

Comparison of Qualis Health and BHO EDV Results

Field	Qualis Health % Match	BHO % Match	Field	Qualis Health % Match	BHO % Match
Demographics Data					
Last Name	99%	100%	Hispanic Origin	57%	NR
First Name	100%	99%	Preferred Language	11%	66%
Gender	94%	NR	SSN	66%	78%
Date of Birth	97%	100%	Sexual Orientation	46%	NR
Ethnicity/Race	83%	83%			
Encounter Data					
Procedure Code	76%	88%	Service Duration	67%	91%
Date of Service	79%	96%	Provider Type	76%	91%
Service Location	53%	83%	Clinical Note Matches Procedure Code	50%	79%

Strengths	Recommendations
Based on a recommendation from the 2016 EQR, NSBHO included a brief description of the staff involved in its EDV process in its report deliverable submitted to the State. NSBHO's EDV process is highly organized and streamlined, and all EDV audit information is housed in one safe and secure location.	Although NSBHO reviewed all of the data elements required by DBHR and clearly listed the accuracy rates for each data element, it combined the results for mental health and SUD. NSBHO should report mental health and SUD results separately so that any clear trends can be identified. Additionally, presenting results by agency may help to identify additional areas for improvement. NSBHO needs to train providers on documentation requirements, SERI requirements, and WAC requirements for documentation and timeliness.

Information Systems Capabilities Assessment (ISCA) Follow-up

Section	Score	Section	Score
Information Systems	◉	Eligibility Data Management	●
IT Infrastructure	◉	Provider Data Management	●
Information Security	◉	Performance Measures and Reporting	◉
Encounter Data Management	◉		

Previous-Year Corrective Action Plans

Section	Number of CAPs	Number Resolved
Enrollee Rights and Protections	4	2
Grievance System	1	1
Certifications and Program Integrity	7	5
PIP Validation	4	4

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Optum Pierce Behavioral Health Organization (OPBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Availability of Services	⦿	**Subcontractual Relationships**	●
Coordination and Continuity of Care	⦿	**Practice Guidelines**	⦿
Coverage and Authorization of Services	⦿	**Health Information Systems**	⦿
Provider Selection	⦿	**QAPI Program**	⦿

Strengths	**Recommendations**
Many of the BHAs in the OPBHO network offer open access for same-day appointments. Many of the agencies have also modified their schedules to include weekend hours and evening appointments. During the summer, when service requests often increase, many agencies extend their hours of operation. OPBHO's case management staff meets monthly to review, coordinate care, case manage, and monitor enrollees with high-risk and special healthcare needs. Additionally, at this month-end meeting, the case managers, medical director, and quality staff review utilization reports to identify over- or underutilization of services.	Qualis Health reviewed 14 clinical records for coordination of care and services. Of the 14 charts, one demonstrated good care coordination, five demonstrated fair care coordination, seven showed poor care coordination, and one chart indicated very poor coordination. OPBHO needs to ensure the BHAs are following up on the BHO's recommendations regarding care coordination. Clinical records need to include clear evidence that care coordination occurred. The BHO needs to consistently apply its policy and assign CAPs for all contracted providers and vendors when performance standards fall below either the contracted benchmarks or the individual BHA's/vendor's own benchmarks.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
Increasing the Number of People Who Remain in the WISe Program Through Their Initial Authorization Period Adherence in Youth	⦿	OPBHO reviewed data indicating that a number of youth were discharging from WISe services before the end of their authorization period. Thus, the BHO chose to focus on engagement as a means to increase the number of youth who remain in the WISe program up to or beyond their initial 180-day authorization.	Because engagement is a mandatory component of WISe, the intervention outlined for this PIP topic should be redefined.
Non-clinical PIP			
Satisfaction in 24-Hour Facilities in Pierce County	○	The BHO has laid the foundation for a PIP that has the potential to affect a significant portion of enrollees and also has the potential to significantly impact enrollee satisfaction within the four E&T facilities located within the BHO's network.	OPBHO needs to make sure to include the specific intervention to be implemented at each E&T facility in the study question.
SUD PIP			
The Use of the GAIN-SS in a Clinical Referral	⦿	OPBHO identified this PIP topic during the previous EQRO review, but has not progressed in defining the study question or implementing a specific intervention.	OPBHO needs to document progress with this PIP or lack thereof. If progress has not been made with the initial intervention, then the original intervention should be revised and attempted again. If the BHO has discovered that an issue does not exist regarding referrals with the use of the GAIN-SS tool, then it should retire the PIP and pursue a new study topic.

Optum Pierce Behavioral Health Organization (OPBHO)

Encounter Data Validation (EDV)

Standard	MH	SUD	Standard	MH	SUD	Standard	MH	SUD
Sampling Procedure	●	●	Review Tools	◉	◉	Methodology and Analytic Procedures	●	●
Electronic Data Checks	●	●	On-site Clinical Record Review	○	○			

Comparison of Qualis Health and BHO EDV Results

Field	Qualis Health % Match	BHO % Match	Field	Qualis Health % Match	BHO % Match
Demographics Data					
Last Name	97%	NR	Hispanic Origin	92%	84%
First Name	98%	NR	Preferred Language	13%	93%
Gender	95%	96%	SSN	95%	95%
Date of Birth	98%	95%	Sexual Orientation	85%	89%
Ethnicity/Race	87%	88%			
Encounter Data					
Procedure Code	53%	51%	Service Duration	67%	89%
Date of Service	80%	92%	Provider Type	53%	83%
Service Location	37%	81%	Clinical Note Matches Procedure Code	56%	85%

Strengths	Recommendations
OPBHO stratified its samples within agencies by size, client type, and authorization group, as well as pulled patients proportionally based on the number of clients at each agency. This approach appears to have provided an unbiased and representative sample. Based on an opportunity for improvement from the 2016 review, OPBHO included the sample sizes by agency in the main report as requested.	OPBHO needs to clearly state how agencies were selected for inclusion in its sample, including why certain agencies were not selected. Because the process of agency selection could introduce bias, it is necessary to demonstrate that selection was random. OPBHO needs to train providers on documentation requirements, SERI requirements, and WAC requirements for documentation and timeliness.

Information Systems Capabilities Assessment (ISCA) Follow-up

Section	Score	Section	Score
Information Systems	●	Eligibility Data Management	●
IT Infrastructure	◉	Provider Data Management	●
Information Security	○	Performance Measures and Reporting	●
Encounter Data Management	●		

Previous-Year Corrective Action Plans

Section	Number of CAPs	Number Resolved
Grievance System	1	1
Certifications and Program Integrity	3	1
PIP Validation	1	1

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Salish Behavioral Health Organization (SBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Availability of Services	⦿	**Subcontractual Relationships**	●
Coordination and Continuity of Care	●	**Practice Guidelines**	●
Coverage and Authorization of Services	●	**Health Information Systems**	⦿
Provider Selection	⦿	**QAPI Program**	⦿

Strengths	**Recommendations**
Through utilization monitoring, SBHO identified an opiate treatment services gap in its network. After issuing an RFP, the BHO began contracting with the successful bidder to provide an opiate treatment program. SBHO indicated its SUD treatment BHAs adopted an open access model, which enables them to meet the State Medicaid standards for timely access to care and services. SBHO is currently in the process of adopting guidelines for treating PTSD for adults, PTSD for children, and substance use disorders.	SBHO has had the same two practice guidelines in place since 2005. Although the BHO states that the guidelines are still relevant and represent the needs of its enrollees, the BHO did not submit clinical data to back up these claims. The BHO needs to justify its continued use of these two practice guidelines by reviewing its clinical data to ensure they are still relevant. In order to ensure it is not contracting with a provider excluded from participation in federal healthcare programs, the BHO needs to ensure that all of its BHAs conduct a Washington State Patrol background check.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
Tobacco Use Cessation	●	SBHO initiated this PIP in August of 2014 and completed its first re-measurement for the second phase of the PIP in March 2017. The first phase of the PIP was proven to be successful. SBHO is continuing with the second phase while also measuring change outcomes relative to the first and second phases of the PIP.	N/A
Non-clinical PIP			
Increasing Child and Family Team Meetings among High-Risk, High-Cost, and High-Need Children Served by the Mental Health System	●	SBHO selected this study topic through a detailed process that combined input from a variety of stakeholders, a comprehensive data analysis, enrollee surveys, discussions regarding the feasibility of potential PIP topics, and a barrier analysis.	N/A
SUD PIP			
Improving Implementation of the Grievance System among SUD Treatment Providers	●	SBHO is in the early stages of formulating its SUD PIP. The BHO has selected an SUD topic based on data that show there is a clear issue regarding the lack of grievances filed by SUD treatment enrollees.	As this PIP moves forward and the BHO works to finalize its study question or questions, all elements of the PIP study design should be taken into consideration to ensure all aspects of the PIP are realistic and obtainable.

Salish Behavioral Health Organization (SBHO)

Encounter Data Validation (EDV)								
Standard	**MH**	**SUD**	**Standard**	**MH**	**SUD**	**Standard**	**MH**	**SUD**
Sampling Procedure	●	●	**Review Tools**	●	●	**Methodology and Analytic Procedures**	●	●
Electronic Data Checks	●	●	**On-site Clinical Record Review**	○	○			

Comparison of Qualis Health and BHO EDV Results									
Field	**QH % Match MH**	**BHO %Match MH**	**QH %Match SUD**	**BHO %Match SUD**	**Field**	**QH %Match MH**	**BHO % Match MH**	**QH %Match SUD**	**BHO %Match SUD**
Demographic Data									
Last Name	100%	NR	98%	NR	**Hispanic Origin**	100%	NR	90%	NR
First Name	100%	NR	98%	NR	**Preferred Language**	3%	NR	3%	NR
Gender	100%	NR	95%	NR	**SSN**	77%	NR	91%	NR
Date of Birth	98%	NR	13%	NR	**Sexual Orientation**	95%	NR	66%	NR
Ethnicity/Race	90%	NR	90%	NR					
Encounter Data									
Procedure Code	87%	NR	57%	NR	**Service Duration**	70%	NR	34%	NR
Date of Service	100%	NR	84%	NR	**Provider Type**	87%	NR	57%	NR
Service Location	96%	NR	85%	NR	**Clinical Note Matches Procedure Code**	57%	NR	34%	NR

Strengths	**Opportunities for Improvement**
SBHO's documentation of methodology was clear and complete. The BHO reported clear results, with sufficiently detailed analysis to identify focused areas for improvement.	SBHO needs to work with its network on documentation standards to ensure that clinical interventions are being well documented, which will enable SBHO to match the correct code to the service. The BHO needs to train providers on documentation requirements, SERI requirements, and WAC requirements for documentation and timeliness.

Information Systems Capabilities Assessment (ISCA)			
Section	**Score**	**Section**	**Score**
Information Systems	◉	**Eligibility Data Management**	●
IT Infrastructure	◉	**Provider Data Management**	●
Information Security	◉	**Performance Measures and Reporting**	●
Encounter Data Management	◉		

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Certifications and Program Integrity	13	13

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Spokane County Regional Behavioral Health Organization (SCRBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Availability of Services	⦿	**Subcontractual Relationships**	⦿
Coordination and Continuity of Care	⦿	**Practice Guidelines**	●
Coverage and Authorization of Services	●	**Health Information Systems**	⦿
Provider Selection	⦿	**QAPI Program**	⦿

Strengths	**Recommendations**
After SCRBHO became aware that the State would no longer finance interpreter services for BHAs providing only SUD treatment services, the BHO stated it would reimburse the BHAs for interpreter services until it was able to build this cost into its BHA contracts. The BHO provided a thorough description of how it assists its BHAs with coordinating care with the local hospitals, evaluation and treatment centers, Eastern State Hospital, and the peer bridger program. Quarterly, the BHO reviews over- and underutilization of services variances and then meets with agency leadership to identify factors and make necessary adjustments.	The BHO revised its policy on individual service/treatment plans to include the enrollee's voice and participation in the development of the treatment plan. However, results from the submitted examples of SUD treatment provider record reviews indicated treatment plans did not include enrollee signatures, indicating the enrollee had provided input and agreed with the treatment plan. SCRBHO needs to continue to work with its BHAs to ensure treatment plans include enrollee participation, as evidenced by the enrollee's signature. SCRBHO stated that while it requires the BHAs to apply the same CFR criteria to any services the BHAs delegate to other entities, the BHO does not monitor its BHAs' delegated agreements with other entities. SCRBHO needs to monitor its BHAs' delegated agreements with other entities to ensure the delegated entities are following the same CFR criteria required of the BHAs.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
Eating Disorder Services	●	This PIP addresses a high-risk, high-need population. The BHO hopes to increase the identification and assessment of eating disorders and provide subsequent treatment services, improving the overall health, functional status, and satisfaction of these enrollees while helping to decrease costly inpatient treatment and/or loss of life.	N/A
Non-clinical PIP			
Youth Crisis Line Awareness	●	SCRBHO has made great strides with this new children's PIP. It is evident the BHO has worked extensively to ensure appropriate resources are delivered to the schools involved in this PIP.	N/A
SUD PIP			
SUD Treatment Continuity of Care	●	Overall, this topic is novel and has merit, particularly with the focus on increasing service intensity and care coordination while an enrollee waits for a residential placement.	N/A

Spokane County Regional Behavioral Health Organization (SCRBHO)

Encounter Data Validation (EDV)								
Standard	**MH**	**SUD**	**Standard**	**MH**	**SUD**	**Standard**	**MH**	**SUD**
Sampling Procedure	●	●	**Review Tools**	●	●	**Methodology and Analytic Procedures**	●	●
Electronic Data Checks	●	●	**On-site Clinical Record Review**	○	○			

Comparison of Qualis Health and BHO EDV Results									
Field	**QH % Match MH**	**BHO %Match MH**	**QH %Match SUD**	**BHO %Match SUD**	**Field**	**QH %Match MH**	**BHO % Match MH**	**QH %Match SUD**	**BHO %Match SUD**
Demographic Data									
Last Name	99%	NR	97%	NR	**Hispanic Origin**	69%	NR	71%	NR
First Name	99%	NR	100%	NR	**Preferred Language**	3%	NR	3%	NR
Gender	99%	NR	98%	NR	**SSN**	94%	NR	91%	NR
Date of Birth	100%	NR	100%	NR	**Sexual Orientation**	57%	NR	63%	NR
Ethnicity/Race	78%	NR	74%	NR					
Encounter Data									
Procedure Code	89%	NR	46%	NR	**Service Duration**	72%	NR	51%	NR
Date of Service	98%	NR	74%	NR	**Provider Type**	89%	NR	46%	NR
Service Location	96%	NR	26%	NR	**Clinical Note Matches Procedure Code**	58%	NR	38%	NR

Strengths	**Opportunities for Improvement**
SCRBHO clearly disclosed the total number of client charts selected to demonstrate that the minimum number of client charts was met. SCRBHO's tool is well constructed, clearly defined, and robust. The tool, while complex, allows auditors to clearly track and monitor services for the entire BHO.	SCRBHO needs to work with its network on documentation standards to ensure that clinical interventions are being well documented, which will enable SCRBHO to match the correct code to the service. SCRBHO needs to train providers on documentation requirements, SERI requirements, and WAC requirements for documentation and timeliness.

Information Systems Capabilities Assessment (ISCA)			
Section	**Score**	**Section**	**Score**
Information Systems	●	**Eligibility Data Management**	●
IT Infrastructure	●	**Provider Data Management**	●
Information Security	◉	**Performance Measures and Reporting**	●
Encounter Data Management	◉		

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Enrollee Rights and Protections	3	3
Grievance System	1	1
Certifications and Program Integrity	5	4

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Thurston-Mason Behavioral Health Organization (TMBHO)

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	⦿	**Subcontractual Relationships**	●
Coordination and Continuity of Care	⦿	**Practice Guidelines**	⦿
Coverage and Authorization of Services	⦿	**Health Information Systems**	⦿
Provider Selection	⦿	**QAPI Program**	⦿

Strengths	Recommendations
TMBHO has created an "open network" in order to encourage out-of-network providers to join the BHO as contracted BHAs. The BHO has recently obtained BHA contracts with providers in Kitsap, Peninsula, and Cascade counties. TMBHO's care managers are assigned to specific BHAs and are required to meet regularly with the BHAs to discuss care coordination and resource management, and to provide clinical oversight. The BHO is cross training its case managers to authorize for both mental health and SUD treatment services, with a CDP overseeing the SUD treatment authorizations.	TMBHO needs to track and monitor second opinions in order to ensure that its BHAs are offering second opinions within a reasonable timeframe. TMBHO needs to ensure the BHAs are adhering to its policies and procedures on care coordination and are following up on the BHO's recommendations regarding documentation of care coordination. Clinical records need to include clear evidence that care coordination occurred. The BHO needs to continue to educate and monitor its BHAs on the importance of identifying and documenting special healthcare needs within the treatment plan.

Performance Improvement Projects

Clinical PIP	Score	Strengths	Recommendations
Hi-fidelity Wraparound/WISe	●	TMBHO has drafted a well-assembled report describing its methodology, findings, and conclusion. The report clearly outlines the changes in performance and how these changes are attributed to the interventions.	Given the BHO has demonstrated its accomplishments and shown sustained improvement over several years, it is recommended that this PIP be retired.
Non-clinical PIP			
Increasing Co-occurring Mental Health and Substance Use Disorder Service Participation for Adult Enrollees	⦿	This PIP topic has the potential to create meaningful change for a group of high-need, at-risk adult enrollees.	The BHO should consider the following while collecting additional data: What are the barriers to enrollees receiving co-occurring services? How can these barriers be removed?
SUD PIP			
SUD Residential Treatment Access	⦿	The study topic was chosen through a review of data collection and analysis and input from enrollees. A review of TARGET data for fiscal year 2015 showed that only 66 percent of Medicaid enrollees within Thurston and Mason counties were able to access SUD treatment services within 14 days of their request for service. Improving access to residential treatment services addresses a high-risk, high-need population.	TMBHO needs to collect and analyze data related to accessing residential treatment services, then decide what the issues are and choose an intervention to address one of them. TMBHO needs to include enrollees, family members, peers, and/or advocates in its PIP selection process.

Thurston-Mason Behavioral Health Organization (TMBHO)

Encounter Data Validation (EDV)

Standard	MH	SUD	Standard	MH	SUD	Standard	MH	SUD
Sampling Procedure	○	○	Review Tools	●	●	Methodology and Analytic Procedures	○	○
Electronic Data Checks	●	●	On-site Clinical Record Review	○	○			

Comparison of Qualis Health and BHO EDV Results

Field	Qualis Health % Match	BHO % Match	Field	Qualis Health % Match	BHO % Match
Demographic Data					
Last Name	98%	NR	Hispanic Origin	81%	NR
First Name	99%	NR	Preferred Language	4%	NR
Gender	89%	NR	SSN	87%	NR
Date of Birth	99%	NR	Sexual Orientation	78%	NR
Ethnicity/Race	90%	NR			
Encounter Data					
Procedure Code	72%	NR	Service Duration	64%	NR
Date of Service	88%	NR	Provider Type	72%	NR
Service Location	63%	NR	Clinical Note Matches Procedure Code	58%	NR

Strengths	Recommendations
N/A	TMBHO did not document its sampling procedure in the DBHR deliverable, or meet the contractually required minimum number of encounters and client charts in its sample. TMBHO needs to document its sampling procedure in the DBHR deliverable. TMBHO needs to ensure it samples the contractually required minimum number of encounters and client charts. TMBHO needs to train providers on documentation requirements, SERI requirements, and WAC requirements for documentation and timeliness.

Information Systems Capabilities Assessment (ISCA) Follow-up

Section	Score	Section	Score
Information Systems	◉	Eligibility Data Management	○
IT Infrastructure	●	Provider Data Management	◉
Information Security	●	Performance Measures and Reporting	◉
Encounter Data Management	◉		

Previous-Year Corrective Action Plans

Section	Number of CAPs	Number Resolved
Enrollee Rights and Protections	6	2
Grievance System	1	1
Certifications and Program Integrity	12	6

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Appendix C: Acronyms

ACES	Automated Client Eligibility System
AHAC	Apple Health Adult Coverage
AHFC	Apple Health Foster Care
AHRQ	Agency for Healthcare Research and Quality
AMG	Amerigroup Washington, Inc.
ASAM	American Society of Addiction Medicine
ASO	Administrative Services Organization
BHA	Behavioral Health Agency
BHDS	Behavioral Health Data System
BHO	Behavioral Health Organization
BHSO	Behavioral Health Services Only
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CANS	Child and Adolescent Needs and Strengths
CAP	Corrective Action Plan
CCW	Coordinated Care of Washington
CDP	Chemical Dependency Professional
CHIP	Children's Health Insurance Program
CHPW	Community Health Plan of Washington
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DBHR	Division of Behavioral Health and Recovery
DSHS	Department of Social and Health Services
EDI	Electronic Data Interchange
EDV	Encounter Data Validation
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
GCBHO	Greater Columbia Behavioral Health Organization
GRBHO	Great Rivers Behavioral Health Organization
HCA	Health Care Authority
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Healthcare Insurance Portability and Accountability Act
IMC	Integrated Managed Care
ISCA	Information Systems Capabilities Assessment
KCBHO	King County Behavioral Health Organization
MCO	Managed Care Organization
MHP	Mental Health Professional
MHW	Molina Healthcare of Washington
NCBHO	North Central Behavioral Health Organization
NCQA	National Committee for Quality Assurance
NSBHO	North Sound Behavioral Health Organization
OPBHO	Optum Pierce Behavioral Health Organization
PAHP	Prepaid Ambulatory Health Plans
PCP	Primary Care Provider

PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QM	Quality Management
QRT	Quality Review Team
RDA	Research and Data Analysis
RY	Reporting Year
SBHO	Salish Behavioral Health Organization
SCRBHO	Spokane County Regional Behavioral Health Organization
SDC	State Data Center
SERI	Service Encounter Reporting Instructions
SFTP	Secure File Transfer Protocol
SUD	Substance Use Disorder
TMBHO	Thurston-Mason Behavioral Health Organization
UHC	United Healthcare Community Plan
UM	Utilization Management
WAC	Washington Administrative Code
WISe	Wraparound with Intensive Services

Appendix D: PIP Review Procedures

HCA PIP Review Procedure

As part of its overall compliance review of Apple Health MCOs, HCA conducts a review of performance improvement projects (PIPs). (Qualis Health conducts its own review of PIPs for the Behavioral Health Organizations [BHOs], which follows.) HCA's review process and scoring methods for evaluating PIPs are outlined below.

Part A: Assessing the Study Methodology

1: Review the Selected Study Topic(s)
a) Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?
b) Is the PIP consistent with the demographics and epidemiology of the enrollees?
c) Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?
d) Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc)?
e) Did the PIP, over time, include all enrolled populations (i.e., special healthcare needs)?

2: Review the Study Question(s)
a) Was/were the study question(s) stated clearly in writing?

3: Review Selected Study Indicator(s)
a) Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?
b) Did the indicators track performance over a specified period of time?
c) Are the number of indicators adequate to answer the study question, appropriate for the level of complexity of applicable medical practice guidelines, and appropriate to the availability of resources to collect necessary data?

4: Review the Identified Study Population
a) Were the enrollees to whom the study question and indicators are relevant clearly defined?
b) If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?

5: Review Sampling Methods
a) Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
b) Were valid sampling techniques employed that protected against bias (specifying the type of sampling or census used)?
c) Did the sample contain a sufficient number of enrollees?

6: Review Data Collection Procedures
a) Did the study design clearly specify the data to be collected?
b) Did the study design clearly specify the sources of the data?

c) Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?
d) Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?
e) Did the study design prospectively specify a data analysis plan?
f) Were qualified staff and personnel used to collect the data?

7: Assess Improvement Strategies

a) Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes?
b) Are the interventions sufficient to be expected to improve processes or outcomes?
c) Are the interventions culturally and linguistically appropriate?

8: Review Data Analysis and Interpretation of Study Results

a) Was an analysis of the findings performed according to the data analysis plan?
b) Were numerical PIP results and findings accurately and clearly presented?
c) Did the analysis identify initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?
d) Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?

9: Assess Whether Improvement is "Real" Improvement

a) Was the same methodology as the baseline measurement used when measurement was repeated?
b) Was there any documented, quantitative improvement in processes or outcomes of care?
c) Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?
d) Is there any statistical evidence that any observed performance improvement is true improvement?

10: Assess Sustained Improvement

a) Was sustained improvement demonstrated through repeated measurements over comparable time periods?

Part B: Verifying Study Findings (optional)

Were the initial study findings verified upon repeat measurement?

Part C: Evaluate Overall Validity and Reliability of Study Results

Indicate one of the following regarding the results of the MCO's PIP.

- High confidence in reported results
- Confidence in reported results
- Low confidence in reported results
- Reported results not credible
- Enough time has not elapsed to assess meaningful change

PIP Scoring

TEAMonitor scored the MCOs' PIPs as Met, Partially Met or Not Met according to how well they performed against a checklist of elements designed to measure success in meeting the standards specified by CMS. The elements associated with the respective scores follow.

To achieve a score of Met, the PIP must demonstrate all of the following 12 elements:

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

To achieve a score of Partially Met, the PIP must demonstrate all of the following 7 elements:

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

To receive a score of Not Met, the PIP must fail to demonstrate any 1 of the following elements:

- A problem or need for enrollees not reflected in the topic of the PIP
- Study questions not stated in writing
- Relevant quantitative or qualitative measurable indicators not documented
- A sampling method not documented or determined prior to data collection
- Study design and data analysis plan not proactively defined
- Numerical results, e.g., numerator and denominator data, not reported
- Consistent measurement methods not used over time without rationale provided in the case of change in measurement methods

Qualis Health PIP Review Procedure

Qualis Health evaluates the BHOs' PIPs to determine whether they are designed, conducted and reported in a methodologically sound manner. The PIPs must be designed to achieve, through ongoing measurements and intervention in clinical and non-clinical areas, significant improvement sustained over time that is expected to have a favorable effect on health outcomes and enrollee satisfaction.

Qualis Health evaluates PIP design and implementation based on documents provided by the BHO and information received through BHO staff interviews using the ten-step process outlined in "EQR Protocol 3: Validating Performance Improvement Projects, Version 2.0" developed by the Centers for Medicare & Medicaid Services (CMS). The ten steps are outlined below.

Step 1: Review the Selected Study Topic(s)

1.1) Was the study topic chosen through a comprehensive process that involved data collection and analysis of enrollee needs, care and services?
1.2) Is the PIP consistent with enrollee demographics and health risks?
1.3) Was input from enrollees, family members, peers and/or advocates considered during the selection of the PIP?
1.4) Does the PIP address a broad spectrum of key aspects of enrollee care and services (e.g., access, timeliness, preventative, chronic, acute, coordination of care, inpatient, high need, high risk, etc.)?

Step 2: Review the Study Question(s)

2.1) Is the study question clear, concise and answerable?
2.2) Does the study question set the framework for goals, data collection, analysis and interpretation?
2.3) Does the study question include the intervention, the study population (denominator), what is being measured (numerator), a metric (percentage or average) and a desired outcome?

Step 3: Review the Identified Study Populations

3.1) Is the specific enrollee population clearly defined?
3.2) If there is an inclusion or exclusion criterion, is it clearly defined?
3.3) Is the study population reflective of the entire Medicaid enrollee population to which the study indicator applies? Or is a sample used?
3.4) Did data collection approaches ensure that all required information was captured for all enrollees to whom the study question applied?

Step 4: Review Selected Study Indicator(s)

4.1) Is there a clear description of the study indicator(s)? Are the numerator and denominator clearly defined?
4.2) Is there an explanation of how the indicators are appropriate and adequate to answer the study question? Does it describe how the indicator objectively measures change to impact the enrollee?
4.3) Is there a clear and realistic plan that includes where and how the data on the indicator is collected? Are all the elements of the data collection plan in place and viable? Are there mitigation strategies in case sufficient data is not able to be collected?

4.4) Are the baseline and first and second re-measurement periods unambiguously stated and appropriate in length?

Step 5: Review Sampling Methods

5.1) Is the method for defining and calculating the sample size clearly stated? Is the true and estimated frequency of the event considered and specified? Is the confidence level plainly stated? Is the acceptable margin of error given?
5.2) Is the sampling technique specified? Is it specified whether the sample is a probability or non-probability sample?
5.3) Are valid sampling techniques employed to protect against bias?
5.4) Does the sample contain a sufficient number of enrollees?

Step 6: Review Data Collection Procedures

6.1) Does the study design clearly specify the data to be collected?
6.2) Does the study design clearly specify the sources of data?
6.3) Is there a description of the data collection methods used that includes the types of data collected, an explanation of how the methods elicit valid and reliable data, the intervals at which the data will be collected and, if HEDIS or other formal methodology is used, a description of the process?
6.4) Is there a description of the instruments used for data collection? Did the description include a narrative regarding how the instrument provided consistent and accurate data collection over the time periods studied? Was any additional documentation that was requested provided and appropriate?
6.5) Does the study say who will be collecting the data? Are the individuals collecting the data qualified to collect the data, and, if so, are their qualifications included?
6.6) Is there a description of how inter-rater reliability is ensured?

Step 7: Review Data Analysis and Interpretation of Study Results

7.1) Is there a clear description of the data analysis plan that includes the type of statistical analysis used and the confidence level (e.g., chi-square test with significance level set at $p<.05$)? Was analysis performed according to plan? (This includes having a sufficient amount data to analyze for the analysis to be meaningful.)
7.2) Are numerical PIP results and findings accurately and clearly presented?
7.3) Is the data analysis methodology appropriate to the study question and data types?
7.4) Did the analysis identify statistical significance of any differences between the initial and repeat measurements? Was the analysis performed correctly?
7.5) Did the analysis identify threats to internal or external validity?
7.6) Does the analysis include an interpretation of the PIP's success, statistically significant or otherwise? Is there a description of any follow-up activities as a result?

Step 8: Assess Improvement Strategies

8.1) Were steps taken to identify improvement opportunities during the PIP process (e.g., root cause analysis, data analysis and other quality improvement [QI] activities)?
8.2) Were interventions taken to address causes/barriers identified through analysis and QI activities?
8.3) Are the interventions sufficient that an improvement in the processes or outcomes could be expected?
8.4) Are the interventions culturally and linguistically appropriate?

Step 9: Assess Whether Improvement is "Real" Improvement

9.1) Was the same methodology used for data collection at baseline and repeat measurements?
9.2) Is there a description of the data analysis regarding improvements in process or outcomes of care?
9.3) Is there an evaluation demonstrating that improvement appears to be the result of the intervention? Or an analysis related to why there was not improvement?
9.4) Is there any statistical evidence that any observed improvement is true improvement? Was statistical analysis performed thoroughly and accurately?

Step 10: Assess Sustained Improvement

10.1) Was sustained improvement demonstrated through repeated measurements over comparable periods of time? If improvement was not sustained, was there an explanation? Is there a plan for next steps?

PIP Scoring

Qualis Health assigns a score of "Fully Met," "Partially Met" or "Not Met" to each of the 10 evaluation components applicable to the performance improvement project being evaluated. Components may be "Not Applicable" if the performance improvement project is at an early stage of implementation. Components determined to be "Not Applicable" are not reviewed and are not included in the final scoring. Scoring is based on the answers to the questions listed under each evaluation component as determined by Qualis Health reviewers, following a review of written documentation and in-person interviews.

Fully Met means 100 percent of the required documentation under a protocol step, or component thereof, is present.
Partially Met means at least 50 percent, but not all, of the required documentation under a protocol step, or component thereof, is present.
Not Met means less than 50 percent of the required documentation under a protocol step, or component thereof, is present.
Once Qualis Health assigns a final score to the performance improvement project, an assessment is made to determine the validity and reliability of the reported results for projects that have progressed to at least a first re-measurement of the study indicator. For performance improvement projects that have not progressed to at least a first re-measurement period, the assessment will conclude that "Not enough time has elapsed to assess meaningful change." Because determining potential issues with the validity and reliability of the study design is sometimes a judgment call, Qualis Health reports one of the following levels of confidence in the study findings based on a global assessment of study design, development and implementation:

- High confidence in reported results
- Moderate confidence in reported results
- Low confidence in reported results
- Not enough time has elapsed to assess meaningful change

"High confidence in reported results" means the study results are based on high-quality study design and data collection and analysis procedures. The study results are clearly valid and reliable.

"Moderate confidence in reported results" means the study design and data collection and analysis procedures are not of sufficient quality to warrant a higher level of confidence. Study weaknesses (e.g., threats to internal or external validity, barriers to implementation, questionable study methodology) are identified that may impact the validity and reliability of reported results.

"Low confidence in reported results" means the study design and/or data collection and analysis procedures are unlikely to result in valid and reliable study results.

"Not enough time has elapsed to assess meaningful change" means a performance improvement project has not progressed to at least the first re-measurement of the study indicator.

Appendix E: Regulatory and Contractual Requirements

The following is a list of the access, quality, and timeliness elements cited in the Code of Federal Regulations (CFR) that MCOs and BHOs were required to meet in 2017. These standards, along with State contractual requirements specific to physical or mental healthcare, serve as the basis for the MCO and BHO compliance reviews. The numbers that follow each description denote the corresponding Apple Health Managed Care contract requirement.

438.206 Availability of Services

438.206(b)(1)(i-v) Delivery network, 6.1 and 6.2
438.207(b)(1)(2) Assurances of adequate capacity and services, 6.1 and 6.2
438.206(b)(2) Direct access to a women's health specialist, 10.8
438.206(b)(3) Provides for a second opinion, 16.2.3
438.206(b)(4) Services out of network, 6.1.3
438.206(b)(5) Out of network payment, 6.1.3

438.206(c) Furnishing of Services

438.206(c)(1)(i) through (vi) Timely access, 6.5, 6.7 and 9.5.12
438.206(c)(2) Cultural considerations,10.2

438.608 Program Integrity Requirements (Fraud and Abuse)

438.608(a)(b) Program integrity requirements, 12.6
455.104 Disclosure of ownership and control, 12.3
455.23 Provider Payment Suspension, 12.7

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- Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b) Excluded Individuals and Entities, 12.9 and 12.10.10
- Reporting, 12.10

447.46 Timely Claims Payment by MCOs

447.46 Timely claims payment, 9.11

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- Coordination of benefits, 16.11

438.208 Primary Care and Coordination

438.208(b) Primary care and coordination of healthcare services, 14.2.1 and 14.3.9

438.208(c) Additional Services for Enrollees with Special Healthcare Needs

438.208(c)(1) Identification, 14.2
438.208(c)(2) Assessment, 14.3 and 14.12
438.208(c)(3) Treatment plans, 14.3 and 14.12
438.208(c)(4) Direct access to specialists, 14.12
438.240(b)(4) Care Coordination Oversight, 14.10

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- Continuity of Care, 14.1
- Transitional Care, 14.5

- Coordination between the contractor and external entities, 14.4
- Skilled nursing facility coordination, 14.6
- Coordination of care for children in foster care and the fostering well-being program, 14.7
- Care coordination with Behavioral Health Organizations (BHOs), 14.8
- Screening tools, 14.11

438.210 Coverage and Authorization of Services

438.210(b)(1)(2)(3) Authorization of services, 11.1 and 11.3
438.210(c) Notice of adverse action, 11.5.1.2
438.210(d) Timeframe for decisions (1) (2), 11.4.1.3, 11.4.1.5 and 11.5.1.2.2
438.210(e) Compensation for utilization management decisions, 11.1.11

438.114 Emergency and Post-stabilization Services

438.114 Emergency and post-stabilization services, (a)(b)(c)(d) and (e), 16.5.5 and 16.5.6

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- Outpatient mental health, 16.8.13
- Second opinion for children prescribed mental health medications, 16.8.14
- Smoking Cessation, 16,8.26
- Emergency Contraceptives, 16.8.16.1.7.1
- Long Acting Reversible Contraceptives, 16.8.16.1.7.1

438.226 Enrollment and Disenrollment

438.226 and 438.56(b)(1)-(3) Disenrollment requested by the MCO, PIHP, 4.11
438.56(d) Procedures for disenrollment, 4.6

438.100 Enrollee Rights

438.100(a) General rule, 9.10, 10.1.1
438.100(b) Specific rights, 10.1
438.10(c)(3) Language-non-English, 3.3.2.1
438.10(c)(4) and (5) Language-oral interpretation, 3.3.1.1
438.10(d)(1)(i) Format, easily understood, 3.3.2.1
438.10(d)(1)(ii) and (2) Format, alternative formats, 3.2.3 and 7.6.8
438.10(f) (2-6) General information, 3.2 and 6.17
438.10(g) Specific information, 9.4.13 and 9.5.9
438.100(b)(2)(iii) Specific rights, 10.1
438.100(b)(2)(iv) and (v) Specific rights, 10.1 and 10.3
438.100(b)(3) Specific rights, 5.20.2.2
438.100(d) Compliance with other federal and state laws, 2.4
438.106 Liability for payment, 2.13

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- Customer Service, Subsection 6.6

438.228 Grievance Systems

438.228 Grievance systems, 3.2.7.19, 13.1 and 13.5.3
438.402(a) General requirements, 1.3, 1.13, 1.14, and 1.64
438.402(b)(1) Filing requirements – Authority to file, 13.3.1
438.402(b)(2) Filing requirements – Timing, 13.3.3 and 13.5.2.1
438.402(b)(3) Filing requirements – Procedures, 13.2.1, 13.31 and 13.3.5

438.404(a) Notice of action – Language and format, 11.3.7.2.1
438.404(b) Notice of action – Content of notice, 11.5
438.404(c) Notice of action – Timing of notice, 11.4 and 13.3.4
438.406(a) Handling of grievances and appeals – General requirements, 13.1
438.406(b) Handling of grievances and appeals – Special requirements for appeals, 13.4
438.408(a) Resolution and notification: Grievances and appeals – Basic rule, 11.4.5 and 13.3.10
438.408(b) and (c) Resolution and notification: Grievances and appeals – specific timeframes and extension of timeframes, 13.2.10 and 13.4.3
438.408(d) and (e) Resolution and notification: Grievances and appeals – Format of notice and content of notice of appeal resolution, 13.3.11
438.410 Expedited resolution of appeals, 13.4.5
438.414 Information about the grievance system to providers and subcontractors, 9.4.13
438.416 Recordkeeping and reporting requirements, 13.10
438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending, 13.3.4, 13.5.2.2 and 13.8
438.424 Effectuation of reversed appeal resolutions, 13.9

438.240 Performance Improvement Projects (PIP)

438.240(b)(1) Basic elements of MCO and PIHP quality assessment and performance improvement programs, and 438.240(d) Performance improvement projects., 7.2
438.240(e)(1)(ii) MCO conducted and documented results for each required PIP, 7.2 – 7.2.4

438.236 Practice Guidelines

438.236(a)(b) Adoption of practice guidelines, 7.9
438.236(c) Dissemination of practice guidelines, 7.9.2.6
438.236(d) Application of practice guidelines, 7.9.2.7

438.214 Provider Selection (Credentialing)

438.214(a) General Rules and 438.214(b) Credentialing and re-credentialing requirements, 9.3.2 and 9.13
438.214(c) Nondiscrimination & provider discrimination prohibited, 9.3
438.214(d) Excluded providers, 12.12.3
438.214(e) Provider selection-State requirements, 9.13.13, 12.3 and 12.4

438.240 Quality Assessment and Performance Improvement Program

438.240(a)(1) Quality assessment and performance improvement program – General rule, 7.1
438.240(b)(2) and (c), and 438.204(c) Performance measurement, 7.3
438.240(b)(3) Basic elements of MCO and PIHP quality assessment and performance improvement – detect both over and underutilization of services, 7.1.1.2.4.3
438.240(b)(4) Basic elements of MCO and PIHP quality assessment and performance improvement – assess care furnished to enrollees with special health care needs, 7.1.1.2.3 and 14.10.1
438.240(e) Basic elements of MCO and PIHP quality assessment and performance improvement – evaluating the program, 7.1.1.2.4 and 7.3.9

438.230 Subcontractual Relationships and Delegation

438.230(a) General rule (b) Specific conditions (1) evaluation of subcontractor prior to delegation, 7.1.3 and 9.6.1.6
438.230 (b)(2) Written agreement with subcontractors, 9.4
438.230 (b)(3) Monitoring of performance of subcontractors, 9.4.2

438.230 (b)(4) Corrective action of subcontractors, 9.4.15

438.242 Health Information Systems

438.242 Health information systems – General rule, 7.11
438.242 (b)(1)(2) Basic elements, 7.11
438.242 (b)(3) Basic elements, 7.11

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- Health Care Authority Encounter Data Reporting Guide (Administrative), Apple Health Contract Exhibit C 2.1.3
- Administrative, Apple Health Contract Exhibit C Section 3
- Administrative, Apple Health Contract 9.4.2 as related to Exhibit C
- Administrative, Apple Health Contract Exhibit C 2.1.7
- Health Action Plan (HAP), Apple Health Contract Exhibit C, 5.1, 5.3, 5.5 and 5.5.7
- Comprehensive Care Management, Apple Health Contract Exhibit C, 5.6
- Care Coordination and Health Promotion, Apple Health Contract Exhibit C 5.7
- Transitional Care, Apple Health Contract Exhibit C 5.8
- Individual and Family Support, Apple Health Contract Exhibit C 5.9
- Referral to Community and Social Support Services, Apple Health Contract Exhibit C C5.10

Appendix F: *2017 Enrollee Quality Report*

As a component of its external quality review work for HCA, Qualis Health produced the *2017 Enrollee Quality Report,* designed to provide Apple Health applicants and enrollees with simple, straightforward comparative health plan performance information that may assist them in selecting a plan that best meets their needs.

Data sources for this report include the Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measure sets. The rating method is in alignment with the star rating systems used by other states and reflects the data sources available for the Apple Health population in Washington. For more information on the methodology used to derive this report's star rating system, see the complete *2017 Enrollee Quality Report Methodology.*

2017 Washington Apple Health Plan Report Card

This report card shows how Washington Apple Health plans compare to each other in key performance areas. You can use this report card to help guide your selection of a plan that works best for you.

KEY: Performance compared to all Apple Health plans — ABOVE AVERAGE ★★★ AVERAGE ★★☆ BELOW AVERAGE ★☆☆

Performance Areas	Amerigroup Washington	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	UnitedHealthcare Community Plan
Getting Care	★☆☆	★★☆	★☆☆	★★★	★★☆
Keeping Kids Healthy	★☆☆	★★☆	★★☆	★★☆	★☆☆
Keeping Women and Mothers Healthy	★★☆	★★☆	★★☆	★★☆	★☆☆
Preventing and Managing Illness	★★☆	★☆☆	★★☆	★☆☆	★★☆
Satisfaction with Care	★★☆	★★☆	★☆☆	★★☆	★★☆
Satisfaction with Plan	★☆☆	★★☆	★★☆	★★☆	★★☆

These ratings were based on information collected from health plans and surveys of health plan members in 2016 and 2017. The information was reviewed for accuracy by independent auditors. Health plan performance scores were not adjusted for differences in their member populations or service regions.

Performance Area Definitions

Getting Care
- Members have access to a doctor
- Members report they get the care they need, when they need it

Keeping Kids Healthy
- Children in the plan get regular checkups
- Children get important immunizations
- Children get the appropriate level of care when they are sick

Keeping Women and Mothers Healthy
- Women get important health screenings
- New and expecting mothers get the care they need

Preventing and Managing Illness
- The plan helps its members keep long-lasting illness under control, such as asthma, high blood pressure or diabetes
- The plan helps prevent illnesses with screenings and appropriate care

Satisfaction with Care
- Members report high ratings for:
  - Doctors
  - Specialists
  - Overall healthcare

Satisfaction with Plan
- Members report high ratings for:
  - The plan's customer service
  - The plan overall