King County Regional Support Network

External Quality Review Report

Division of Behavioral Health and Recovery

January 2016

Qualis Health prepared this report under contract with the Washington State Department of Social and Health Services Division of Behavioral Health and Recovery (Contract No. 1534-28375).

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 managed mental healthcare services. Our work supports the Washington State Health Care Authority (HCA) and Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery.

This report has been produced in support of the DSHS Division of Behavioral Health and Recovery, documenting the results of external review of the state's Regional Support Networks (RSNs).Our review was conducted by Ricci Rimpau, RN, BS, CPHQ, CHC, Operations Manager; Lisa Warren, Quality Program Specialist; Crystal Didier, M.Ed, Clinical Quality Specialist; Sharon Poch, MSW, Clinical Quality Specialist; and Joe Galvan, Project Coordinator.

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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

Table of Contents

Introduction

This report presents the 2015 results of the external quality review of King County RSN, a mental health Regional Support Network (RSN) serving Washington Medicaid recipients.

In 2014, the Washington State Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) contracted with 11 RSNs throughout the State of Washington to provide comprehensive and culturally appropriate mental health services for adults, children and their families. DBHR currently contracts with the RSNs to deliver mental health services for Medicaid enrollees through managed care. The RSNs administer services by contracting with provider groups, including community mental health programs and private nonprofit agencies, to provide mental health treatment. The RSNs are accountable for ensuring that mental health services are delivered in a manner that complies with legal, contractual and regulatory standards for effective care.

King County RSN (KCRSN) administers public mental health funds for Medicaid participants enrolled in managed care plans in King County. KCRSN is managed by the county's Mental Health, Chemical Abuse and Dependency Services division of the Department of Community and Human Services and serves enrollees through contracts with 16 licensed community mental health centers.

The Balanced Budget Act (BBA) of 1997 requires State Medicaid agencies that contract with managed care plans to conduct and report on specific external quality review (EQR) activities. As the external quality review organization (EQRO) for DBHR, Qualis Health has prepared this report to satisfy the Federal EQR requirements.

In this report, Qualis Health presents the results of the EQR to evaluate access, timeliness and quality of care for Medicaid enrollees delivered by health plans and their providers. The report also addresses the extent to which the RSN addressed the previous year's EQR recommendations (see Appendix A).

EQR activities

EQR Federal regulations under 42 CFR §438.358 specify the mandatory and optional activities that the EQR must address in a manner consistent with protocols of the Centers for Medicare & Medicaid Services (CMS). This report is based on information collected from the RSN based on the CMS EQR protocols:

- **Compliance monitoring** through document review, clinical record reviews, on-site interviews at the RSN and telephonic interviews with provider agencies to determine whether the RSN met regulatory and contractual standards governing managed care
- **Encounter data validation** conducted through data analysis and clinical record review
- **Validation of performance improvement projects (PIPs)** to determine whether the RSN met standards for conducting these required studies
- **Validation of performance measures** including an Information Systems Capabilities Assessment (ISCA)

Together, these activities answer the following questions:

1. Does the RSN meet CMS regulatory requirements?

2. Does the RSN meet the requirements of its contract with the State and the Washington State administrative codes?
3. Does the RSN monitor and oversee contracted providers in their performance of any delegated activities to ensure regulatory and contractual compliance?
4. Does the RSN conduct the two required PIPs, and are they valid?
5. Does the RSN produce accurate and complete encounter data?
6. Does the RSN's information technology infrastructure support the production and reporting of valid and reliable performance measures?

Executive Summary

In fulfillment of Federal requirements under 42 CFR §438.350, the Washington State Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) contracts with Qualis Health to perform an annual external quality review (EQR) of the access, timeliness and quality of managed mental health services provided by Regional Support Networks (RSNs) to Medicaid enrollees.

In 2014, DBHR contracted with 11 RSNs throughout the State of Washington to provide comprehensive and culturally appropriate mental health services for adults, children and their families.
This report summarizes the 2015 review of King County Regional Support Network (KCRSN).

Qualis Health's EQR consisted of assessing and identifying strengths, opportunities for improvement and recommendations requiring corrective action plans to meet the RSN's compliance with State and Federal requirements for quality measures. These measures include quality assessment and performance improvement, validating encounter data submitted to the State, completing an information system capability assessment and validating the RSN's performance improvement projects.

The results are summarized below. For a complete, numbered list of all recommendations requiring Corrective Action Plans (CAPs), refer to Appendix B.

Scoring Icon Key			
● Fully Met (pass)	● Partially Met (pass)	● Not Met (fail)	● N/A (not applicable)

Compliance Review Results

This review assesses the RSN's overall performance, identifies strengths and notes opportunities for improvement and recommendations requiring Corrective Action Plans (CAPS) in areas where the RSN did not clearly or comprehensively meet Federal and/or State requirements. The accompanying recommendations offer guidance on how the RSN may achieve full compliance with State contractual and Federal CFR guidelines. The results are summarized below in table A-1. Please refer to the Compliance Review section of this report for complete results.

Table A-1: Summary Results of Compliance Monitoring Review, By Section

CMS EQR Protocol	CFR Citation	Results
Section 1. Availability of Services	438.206	● Partially Met (pass)
Section 2. Coordination and Continuity of Care	438.208	● Fully Met (pass)
Section 3. Coverage and Authorization of Services	438.210	● Fully Met (pass)

Section 4. Provider Selection	438.214	Partially Met (pass)
Section 5. Subcontractual Relationships and Delegation	438.230	Fully Met (pass)
Section 6. Practice Guidelines	438.236	Partially Met (pass)
Section 7. Quality Assessment and Performance Improvement Program	438.240	Fully Met (pass)
Section 8. Health Information Systems	438.242	Partially Met (pass)

Performance Improvement Project (PIP) Validation Results

As a mandatory EQR activity, Qualis Health evaluated the RSN's performance improvement projects (PIPs) to determine whether the projects are designed, conducted and reported in a methodologically sound manner. The projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. The results for the RSN's clinical and non-clinical PIPs are found in the following Table A-2. Further discussion can be found in the Performance Improvement Project section of this report.

Table A-2: Performance Improvement Project Validation Results

	Results	Validity and Reliability
Clinical PIP: Effectiveness of the Transitional Support Program	Not Met (fail)	Low confidence in reported results
Non-Clinical PIP: Improved Care Coordination with Managed Care Organizations (MCOs) for Children and Youth	Partially Met (pass)	Not enough time has elapsed to assess meaningful change

Information System Capability Assessment (ISCA) Results

The RSN's information systems and data processing and reporting procedures were examined to determine the extent to which they supported the production of valid and reliable State performance measures and the capacity to manage care of RSN enrollees.

The ISCA procedures were based on the CMS protocol for this activity, as adapted for the Washington RSNs with DBHR's approval. For each of the seven ISCA review areas, the following methods were used to rate the RSN's performance:

- Information collected in the ISCA data collection tool
- Responses to interview questions
- Results of the claims/encounter analysis walkthroughs and security walkthroughs

The organization was then ranked as fully meeting, partially meeting or not meeting standards. Although not rated, the RSN's meaningful use of EHR systems for informational purposes was evaluated.

The results are summarized below in Table A-3. Please refer to the ISCA section of this report for complete results.

Table A-3: ISCA Review Results

ISCA Section	Description	ISCA Result
A. Information Systems	This section assesses the RSN's information systems for collecting, storing, analyzing and reporting medical, member, practitioner and vendor data.	Fully Met (pass)
B. Hardware Systems	This section assesses the RSN's hardware systems and network infrastructure.	Fully Met (pass)
C. Information Security	This section assesses the security of the RSN's information systems.	Fully Met (pass)
D. Medical Services Data	This section assesses the RSN's ability to capture and report accurate medical services data.	Fully Met (pass)
E. Enrollment Data	This section assesses the RSN's ability to capture and report accurate Medicaid enrollment data.	Fully Met (pass)
F. Practitioner Data	This section assesses the RSN's ability to capture and report accurate practitioner information.	Fully Met (pass)
G. Vendor Data	This section assesses the quality and completeness of the vendor data captured by the RSN.	Fully Met (pass)
H. Meaningful Use of EHR	This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not scored.	N/A

Encounter Data Validation (EDV) Results

EDV is a process used to validate encounter data submitted by RSNs to the State. Encounter data are electronic records of the services provided to Medicaid enrollees by providers under contract with an RSN. Encounter data is used by the RSNs 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 RSNs.

Qualis Health performed independent validation of the procedures used by the RSN to perform its own encounter data validation. The EDV requirements included in the RSN's contract with DBHR were used as the standard for validation. Qualis Health obtained and reviewed each RSN's encounter data validation report submitted to DBHR as a contract deliverable for calendar year 2014. The RSN's 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 RSN's encounter and/or enrollee sampling procedures were reviewed to ensure conformance with accepted statistical methods for random selection. Table A-4 shows the results of the review of the RSN's Encounter Data Validation processes. Please refer to the EDV section of this report for complete results.

Table A-4: Results of External Review of the RSN's Encounter Data Validation Procedures

EDV Standard	Description	EDV Result
Sampling Procedure	Sampling was conducted using an appropriate random selection process and was of adequate size.	Fully Met (pass)
Review Tools	Review and analysis tools are appropriate for the task and used correctly.	Partially Met (pass)
Methodology and Analytic Procedures	The analytical and scoring methodologies are sound and all encounter data elements requiring review are examined.	Fully Met (pass)

Qualis Health conducted its own validation to assess the RSN's capacity to produce accurate and complete encounter data, including a review of the most recent Information System Capabilities Assessment (ISCA). The encounter data submitted by the RSNs to the State was analyzed 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 RSNs have in compiling encounter data and submitting the data files to the State. Clinical record review of encounter data was performed to validate data sent to the State and confirm the findings of the analysis of the State-level data.

Table A-5 summarizes results of Qualis Health's EDV. Please refer to the EDV section of this report for complete results.

Table A-5: Results of Qualis Health Encounter Data Validation

EDV Standard	Description	EDV Result
Electronic Data Checks	Full review of encounter data submitted to the state indicates no (or minimal) logic problems or out-of-range values.	Fully Met (pass)
Onsite Clinical Record Review	State encounter data are substantiated in 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). A passing score is that 95% of the encounter data fields in the clinical records match.	Not Met (fail)

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Compliance with Regulatory and Contractual Standards

The 2015 compliance review addresses the RSN's compliance with Federal Medicaid managed care regulations and applicable elements of the contract between the RSN and the State. The applicable CFR sections and results for the 2015 compliance reviews are listed in Table B-1, below.

The CMS protocols for conducting the compliance review are available here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Each section of the compliance review protocol contains elements corresponding to relevant sections of 42 CFR §438, DBHR's contract with the RSNs, the Washington Administrative Code and other State regulations where applicable. Qualis Health evaluated the RSN's performance on each element of the protocol by

- Reviewing and performing desk audits on documentation submitted by the RSN
- Performing onsite record reviews/chart audits at the RSN's contracted provider agencies
- Conducting telephonic interviews with the RSN's contracted provider agencies
- Conducting onsite interviews with the RSN staff

Compliance Scoring

Qualis Health uses CMS's three-point scoring system in evaluating compliance. 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** means all documentation listed under a regulatory provision, or component thereof, is present and RSN staff provides responses to reviewers that are consistent with each other and with the documentation.

- **Partially Met** means all documentation listed under a regulatory provision, or component thereof, is present, but RSN staff is unable to consistently articulate evidence of compliance, or RSN staff can 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 RSN staff have little to no knowledge of processes or issues that comply with regulatory provisions, or no documentation is present and RSN staff have 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 Icon Key			
Fully Met (pass)	Partially Met (pass)	Not Met (fail)	N/A (not applicable)

Summary of Compliance Review Results

Table B-1: Summary Results of Compliance Monitoring Review, By Section

CMS EQR Protocol	CFR Citation	Results
Section 1. Availability of Services	438.206	Partially Met (pass)
Section 2. Coordination and Continuity of Care	438.208	Fully Met (pass)
Section 3. Coverage and Authorization of Services	438.210	Fully Met (pass)
Section 4. Provider Selection	438.214	Partially Met (pass)
Section 5. Subcontractual Relationships and Delegation	438.230	Fully Met (pass)
Section 6. Practice Guidelines	438.236	Partially Met (pass)
Section 7. Quality Assessment and Performance Improvement Program	438.240	Fully Met (pass)
Section 8. Health Information Systems	438.242	Partially Met (pass)

This review assesses the RSN's overall performance, identifies strengths, and notes opportunities for improvement and recommendations requiring corrective action plans (CAPS) in areas where the RSN did not clearly or comprehensively meet Federal and/or State requirements. The accompanying recommendations offer guidance on how the RSN may achieve full compliance with State contractual and Federal CFR guidelines.

Strengths

- KCRSN annually reviews its specialist mix and geographic distribution of practitioners to ensure there are adequate services to meet its network population.
- KCRSN offers, at various times of the year, open enrollment for provider agencies to apply for admission into the network.
- KCRSN requires all out-of-network providers to complete and sign a single case service agreement, which requires the provider to submit license(s)/credentials and attest to a background check, and assures the provider is not on the excluded provider list.
- In 2014, KCRSN had a total of 9,703 requests for services. Of the requests, 81% received services within 14 days of the request, with the median number of days between the request and the intake being one day and the average number of days being 10.
- KCRSN has several methods to monitor timely access to care, including performing an annual administrative review with chart audits, routinely reviewing enrollee grievances and appeals, and reviewing data reports.

- KCRSN's policies pertaining to cultural competency are comprehensive and well written. They specify that services are "age appropriate, culturally relevant and linguistically competent."
- KCRSN network providers are required to communicate with the consumer's primary care provider (PCP) to coordinate physical and mental healthcare needs, or attempt to link enrollees to a PCP for medical care.
- KCRSN monitors network providers through onsite clinical record reviews to ensure that documentation of coordination of activities is evident in the enrollee's clinical records and that communication occurs within the scope of the consent and release(s) given by the enrollee.
- KCRSN conducted its annual onsite contract compliance reviews in 2014 for 19 King County Mental Health Plan (KCMHP) Outpatient Benefit-contracted mental health providers. Results from the record review on documentation of client voice incorporated into the treatment strategies or intervention averaged 42%. Eleven contractors needed corrected plans. Corrected action plans included
    - Providing specific training (or retraining) for staff regarding incorporating client voice into treatment plans
    - Planning for ongoing supervisory review of treatment plans at regular intervals
    - Instituting a process to look at client voice as part of quality assurance review
- KCRSN ensures that services are provided in an amount, duration and scope sufficient to achieve adequate care through several mechanisms, including the work of its Hospital and Residential Services Utilization Management Work Group. The work group develops effective strategies to address under- or overutilization of resources and makes recommendations to management for system quality improvements.
- KCRSN has a well-written policy that describes how newly hired staff are trained on making authorization decisions**.**
- KCRSN has several robust policies and procedures for crisis response, evaluation and treatment, and stabilization services. The RSN does not require authorization for these services, and the policies state that these services are available at no cost to the enrollee.
- KCRSN maintains a matrix of all delegated functions and effective mechanisms to monitor the performance of those functions.
- KCRSN has a robust process in place to evaluate prospective contractors for their ability to perform delegated functions.
- KCRSN reviews for adherence to practice guidelines during its annual record reviews at the provider agencies.
- Low adherence to the practice guidelines is brought to the attention the provider agencies, and technical training is offered.
- KCRSN's quality management program is designed to assure effective and efficient management of the publicly funded mental health system in King County. The program outlines comprehensive, systematic approaches to ensure that care is timely, accessible, appropriate and effective for consumers, and cost-effective for the system.
- KCRSN's Quality Improvement Committee (QIC) meets bi-monthly and is composed of management, the Quality Review Team (QRT) and other lead staff from the county.
- KCRSN reviews inpatient reports for inappropriate stays, analyzes encounter and claims data for frequency of services, audits clinical records for appropriateness of care, and tracks and analyzes enrollee complaints and grievances as mechanisms for monitoring for over- and underutilization.
- KCRSN provides a yearly summary of results for its annual clinical record and administrative reviews, which are analyzed by its quality management committee for making informed management decisions.

Summary of Corrective Action Plans (CAPs) and Opportunities for Improvement, By Section

Section 1: Availability of Services

Recommendation Requiring CAP
Although KCRSN monitors the provider agencies' policies and procedures for enrollees to receive second opinions, the RSN lacks a mechanism for monitoring requests for second opinions.

- KCRSN needs to implement a process for monitoring requests for second opinions.

Section 2: Coordination of Care

N/A

Section 3: Coverage and Authorization of Services

Opportunity for Improvement
KCRSN has a policy titled "Client Services 3B Review Inter-Rater Reliability," which describes the procedure for validating inter-rater reliability. The policy does not state the date it was created, approved, reviewed or updated.

- KCRSN should complete a review of all policies and procedures to ensure that creation dates, approval dates and the dates of the most recent reviews and updates are included on the documents.

Section 4: Provider Selection

Opportunity for Improvement
Although KCRSN's policy and procedure states that all RSN employees, contractors and subcontractors are to be screened to determine whether they have been listed by a Federal agency as debarred, excluded or otherwise ineligible for Federal program participation, it does not include members of the governing board.

- KCRSN should include the screening of its governing board members in its policy and procedure.

Section 5: Subcontractual Relationships and Delegation

N/A

Section 6: Practice Guidelines

Recommendation Requiring CAP
Although KCRSN has documentation that shows utilization management decisions and other decisions are based on the outcomes of practice guidelines, the RSN lacks policies and procedures regarding the adoption of practice guidelines, dissemination of the guidelines, decisions for utilization management, enrollee education, coverage of services and other areas.

- KCRSN needs to develop and implement policies and procedures that address the adoption of practice guidelines, the dissemination of the practice guidelines and how utilization management, enrollee education, coverage of services and other areas are based on and are consistent with the guidelines.

Section 7: Quality Assessment and Performance Improvement Program

N/A

Section 8: Health Information Systems

Opportunities for Improvement

Results from KCRSN's annual review of encounter data from its provider agencies showed:

- The system's overall rate of compliance with data timeliness requirements was 58%, a decrease of 16% when compared with findings from the 2013 site visits and of 13% compared with the 2012 compliance rate.
- The system's overall rate of compliance with data completeness requirements was 53%, a decrease of 12% when compared with findings from the 2013 site visits and of 22% compared with the 2012 compliance rate. Among the 17 contractors who received ratings for data completeness in both 2013 and 2014, ten earned the same rating, two improved, and five received a lower rating.

Although KCRSN has no definitive reason for this downward trend, it did note that a number of agencies are going through transitions to electronic health records (EHRs) for the first time or are between EHRs, which may have contributed to these issues. Agencies also reported there were several staff changes in key data/IT positions, which led to the need for further technical assistance in understanding and addressing the data requirements.

- KCRSN should continue to seek to determine the reasons for the decreases in scores over the last three years and then provide technical assistance as needed to reverse this trend.

Section 1: Availability of Services

Table B-2: Summary of Compliance Review for Availability of Services

Protocol Section	CFR	Result
Availability of Services		
1. Delivery Network	438.206 (b)(1)	Fully Met (pass)
2. Second Opinion	438.206 (b)(3)	Partially Met (pass)
3. Out-of-network	438.206 (b)(4)	Fully Met (pass)
4. Coordination of Out-of-network	438.206 (b)(5)	Fully Met (pass)
5. Out-of-network Provider Credentials	438.206 (b)(6)	Fully Met (pass)

6. Furnishing of Services and Timely Access	438.206 I(1)	Fully Met (pass)
7. Furnishing of Services and Cultural Considerations	438.206 I(2)	Fully Met (pass)
Overall Result for Section 1.		Partially Met (pass)

Delivery Network

FEDERAL REGULATION SOURCE(S)
§438.206 (b)(1): Availability of Services – Delivery Network

The State must ensure, through its contracts, that each MCO, and each PIHP and PAHP consistent with the scope of the PIHP's or PAHP's contracted services, meets the following requirements:

(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO, PIHP and PAHP must consider the following:

(I) The anticipated Medicaid enrollment

(ii) The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific Medicaid populations represented in the particular MCO, PIHP and PAHP

(iii) The numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services

(iv) The numbers of network providers who are not accepting new Medicaid patients

(v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0230
RSN Agreement Section(s) 4.4; 4.9

SCORING CRITERIA

- The RSN maintains and monitors a network of appropriate providers that is supported by written agreements.
- The RSN's provider network is sufficient to provide adequate access to all services covered under the contract.
- In establishing and maintaining the network, the RSN considers:
  - o The anticipated Medicaid enrollment
  - o The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific Medicaid populations represented in the RSN.
  - o The numbers and types (training, experience and specialization) of providers required to furnish the contracted Medicaid services
  - o The numbers of network providers who are not accepting new Medicaid patients
  - o Geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and

whether the location provides physical access for Medicaid enrollees with disabilities
- The RSN has formal procedures in place to monitor its provider network to ensure adequacy.

Reviewer Determination

● Fully Met (pass)

Strengths

- KCRSN maintains written agreements with contracted providers and has robust processes in place to monitor provider contract compliance and performance.
- KCRSN monitors service capacity within its provider network by assessing Medicaid enrollment, service penetration rates, and by monitoring provider staffing, availability of specialists, use of clinical services and supports, numbers of people served, service hours and provision of outreach services.
- KCRSN annually reviews its specialist mix and geographic distribution of practitioners to ensure there are adequate services to meet its network population.
- KCRSN offers, at various times of the year, open enrollment for provider agencies to apply for admission into the network.

Second Opinion

FEDERAL REGULATION SOURCE(S)
§438.206 (b)(3): Availability of Services – Delivery Network
3) Provides for a second opinion from a qualified healthcare professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0355
RSN Agreement Section(s) 9.10

SCORING CRITERIA

- The RSN provides for a second opinion from a qualified healthcare professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
- The RSN maintains policies and procedures related to second opinions that meet the standards.
- The RSN provides literature or other materials available to enrollees to provide information about an enrollee's right to a second opinion.
- RSN staff is knowledgeable about State and Federal requirements, as well as internal policies and procedures.
- The RSN has an effective process in place to monitor compliance with standards.

Reviewer Determination

Partially Met (pass)

Strength

- KCRSN has included in its client rights policy a provision that the provider agency shall provide assistance for the client to obtain a second opinion from another mental health professional within the agency and that the second opinion shall occur within 30 days of the request at no cost to the enrollee. Any requests for second opinions from a different mental health agency are forwarded to KCRSN for approval.

Recommendation Requiring CAP

Although KCRSN monitors the provider agencies' policies and procedures for enrollees to receive second opinions, the RSN lacks a mechanism for monitoring requests for second opinions.

- KCRSN needs to implement a process for monitoring requests for second opinions.

Out-of-Network

FEDERAL REGULATION SOURCE(S)
§438.206 (b)(4): Availability of Services – Delivery Network

4) If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP or PAHP must cover these services adequately and in a timely manner out of network for the enrollee, for as long as the MCO, PIHP or PAHP is unable to provide them.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

RSN Agreement Section(s) 4.3;13.3

SCORING CRITERIA

- The RSN provides documentation of services that are covered adequately and in a timely manner for out-of-network enrollees when the network is unable to provide necessary services covered under the contract.
- The RSN provides up-to-date existing agreements and/or contracts with out-of-network providers.
- The RSN has a process to track out-of-network encounters and reviews this information for network planning.

Reviewer Determination

Fully Met (pass)

Strength

- KCRSN routinely analyzes the frequency of requests for out-of-network services and uses that information when analyzing service gaps.

Coordination of Out-of-Network

FEDERAL REGULATION SOURCE(S)
§438.206 (b)(5): Availability of Services – Delivery Network
(5) Requires out-of-network providers to coordinate with the MCO or PIHP with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
RSN Agreement Section(s) 13.3

SCORING CRITERIA
- The RSN has a documented process of how out-of-network providers are paid.
- The RSN has a documented policy and process that requires out-of-network providers to coordinate with the RSN with respect to payment.
- The RSN ensures and has a documented policy and process that cost to the enrollee is not greater than it would be if the out-of-network services were furnished within the network.
- The RSN has a process on the action taken if the enrollee receives a bill for out-of-network services.

Reviewer Determination

● Fully Met (pass)

Strength
- KCRSN's policy on out-of-network providers includes coordination with respect to payment and specifies that the cost to the enrollee for out-of-network services will be no greater than it would be if the services were furnished within the network.

Out-of-Network Provider Credentials

FEDERAL REGULATION SOURCE(S)
§438.206 (b)(6): Availability of Services – Out-of-network Provider Credentials
6) Demonstrates that out-of-area providers are credentialed as required by §438.214.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0284
RSN Agreement Section(s) 8.6

SCORING CRITERIA
- The RSN has a process to ensure that out-of-network providers are credentialed.

Reviewer Determination

Fully Met (pass)

Strength

- KCRSN requires all out-of-network providers to complete and sign a single case service agreement, which requires the provider to submit license(s)/credentials and attest to a background check, and assures the provider is not on the excluded provider list.

Furnishing of Services and Timely Access

FEDERAL REGULATION SOURCE(S)
§438.206 (c)(1): Availability of Services – Furnishing of Services and Timely Access
The State must ensure that each MCO, PIHP and PAHP contract complies with the requirements of this paragraph.

1) Timely Access. Each MCO, PIHP and PAHP must do the following:
   i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.
   ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
   iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.
   iv) Establish mechanisms to ensure compliance by providers.
   v) Monitor providers regularly to determine compliance.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
RSN Agreement Section(s) 4.8

SCORING CRITERIA

- The RSN has documented policy and procedure for timely access.
- The RSN ensures its providers meet State standards for timely access to care and services, taking into account the urgency of the need for services.
- The RSN ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
- The RSN has established mechanisms to ensure services included in the contract are available 24 hours a day, 7 days a week, when medically necessary.
- The RSN takes corrective action and has documentation of such corrective action if providers fail to comply with access standards.
- The RSN has a documented policy and process to track and provide documentation of monitoring inappropriate use of emergency rooms by Medicaid enrollees.

Reviewer Determination

Fully Met (pass)

Strengths

- In 2014, KCRSN had a total of 9,703 requests for services. Of the requests, 81% received services within 14 days of the request, with the median number of days between the request and the intake being one day and the average number of days being 10.
- KCRSN has several methods to monitor timely access to care, including performing an annual administrative review with chart audits, routinely reviewing enrollee grievances and appeals, and reviewing data reports.

Furnishing of Services and Cultural Considerations

FEDERAL REGULATION SOURCE(S) **§438.206 Availability of services (c)(2): Furnishing of Services and Cultural Considerations** Each MCO, PIHP and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0200 RSN Agreement Section(s) 1.16; 4.4.2.
SCORING CRITERIA • The RSN has a documented policy and procedure related to the delivery of services in a culturally competent manner for all enrollees. This includes enrollees with limited English proficiency and diverse cultural and ethnic backgrounds. • The RSN monitors and documents through tracking of the use of services delivered to those with limited English proficiency and diverse cultural and ethnic backgrounds. • The RSN maintains documentation of any cultural competency training(s).
Reviewer Determination ● Fully Met (pass)

Strengths

- KCRSN's policies pertaining to cultural competency are comprehensive and well written. They specify that services are "age appropriate, culturally relevant and linguistically competent."
- KCRSN maintains several programs and contracts to provide services for enrollees from diverse cultural and ethnic backgrounds.

Section 2: Coordination and Continuity of Care

Table B-3: Summary of Compliance Review for Coordination and Continuity of Care

Protocol Section	CFR	Result

Coordination and Continuity of Care		
Primary Care and Coordination of Healthcare Services	438.208 (b)	Fully Met (pass)
Additional Services for Enrollees with Special Healthcare Needs	438.208 I(1)(2)	Fully Met (pass)
Treatment Plans	438.208I(3)	Fully Met (pass)
Direct Access to Specialists	438.208 I(4)	Fully Met (pass)
Overall Result for Section 2.		Fully Met (pass)

Primary Care and Coordination of Services

FEDERAL REGULATION SOURCE(S)
§438.208 (b): Coordination and Continuity of Care – Primary Care and Coordination of Healthcare Services for all RSN and Enrollees

(b) Primary care and coordination of healthcare services for all MCO, PIHP and PAHP enrollees. Each MCO, PIHP and PAHP must implement procedures to deliver primary care to and coordinate healthcare service for all MCO, PIHP and PAHP enrollees. These procedures must meet State requirements and must do the following:

(1) Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the enrollee.

(2) Coordinate the services the MCO, PIHP or PAHP furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP or PAHP.

(3) Share with other MCOs, PIHPs and PAHPs serving the enrollee with special healthcare needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

(4) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR, parts 160 and 164, subparts A and E, to the extent that they are applicable.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

RSN Agreement Section(s) 10.3.1

SCORING CRITERIA

- The RSN has a policy and procedure to deliver care to, and coordinate healthcare services, for all enrollees.
- The RSN ensures that each enrollee has access to a primary healthcare provider.
- The RSN ensures providers coordinate with the RSN and with other health plans regarding the services it delivers.

The RSN has a process in place to monitor care coordination.

The RSN ensures that the enrollee's privacy is protected in the process of coordinating care.

Reviewer Determination

● Fully Met (pass)

Strengths

- KCRSN network providers are required to communicate with the consumer's primary care provider (PCP) to coordinate physical and mental healthcare needs, or attempt to link enrollees to a PCP for medical care.
- KCRSN monitors network providers through onsite clinical record reviews to ensure that documentation of coordination of activities is evident in the enrollee's clinical records and that communication occurs within the scope of the consent and release(s) given by the enrollee.

Additional Services for Enrollees with Special Healthcare Needs

FEDERAL REGULATION SOURCE(S)
§438.208 (c)(1),(2): Coordination and Continuity of Care – Additional Services for Enrollees with Special Health Care Needs

(1) Identification. The State must implement mechanisms to identify persons with special healthcare needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms—

(i) Must be specified in the State's quality improvement strategy in §438.202; and

(ii) May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs and PAHPs.

(2) Assessment. Each MCO, PIHP and PAHP must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph [c][1] of this section) and identified to the MCO, PIHP and PAHP by the State as having special healthcare needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate healthcare professionals.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0420
RSN Agreement Section(s) 13.3.16

SCORING CRITERIA

- The RSN has a documented mechanism for identifying persons with special healthcare needs.
- The RSN has a policy and procedure to assess each enrollee in order to identify any ongoing special conditions of the enrollee that require a special course of treatment or regular care monitoring.
- The RSN ensures enrollees with special healthcare needs are assessed by an appropriate mental health professional (MHP).
- The RSN has a process in place to monitor compliance with this requirement.

Reviewer Determination

● Fully Met (pass)

Meets Criteria

Treatment Plans

FEDERAL REGULATION SOURCE(S)
§438.208 (c)(3): Coordination and Continuity of Care – Treatment Plans

(3) Treatment plans. If the State requires MCOs, PIHPs and PAHPs to produce a treatment plan for enrollees with special healthcare needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be—

(i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;

(ii) Approved by the MCO, PIHP or PAHP in a timely manner, if this approval is required by the MCO, PIHP or PAHP; and

(iii) In accord with any applicable State quality assurance and utilization review standards.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0425
RSN Agreement Section(s) 8.8.2.1.4; 10.2

SCORING CRITERIA

- The RSN ensures that treatment plans for enrollees with special healthcare needs are developed with the enrollee's participation, and in consultation with any specialists caring for the enrollee.
- The enrollee's treatment plan incorporates the enrollee's special healthcare needs.
- The RSN has a method to monitor treatment plans for enrollees with specialized needs.
- The RSN has a method to follow through on findings from monitoring the treatment plans.

Reviewer Determination

● Fully Met (pass)

Strength

- KCRSN conducted its annual onsite contract compliance reviews in 2014 for 19 King County Mental Health Plan (KCMHP) Outpatient Benefit-contracted mental health providers. Results from the record review on documentation of client voice incorporated into the treatment strategies or intervention averaged 42%. Eleven contractors needed corrective plans. Corrective action plans included
    - Providing specific training (or retraining) for staff regarding incorporating client voice into treatment plans
    - Planning for ongoing supervisory review of treatment plans at regular intervals
    - Instituting a process to look at client voice as part of quality assurance review

Direct Access

FEDERAL REGULATION SOURCE(S) **§438.208 (c)(4): Coordination and Continuity of Care – Direct Access to Specialists** (4) For enrollees with special healthcare needs determined through an assessment by appropriate healthcare professionals (consistent with §438.208 [c][2]) to need a course of treatment or regular care monitoring, each MCO, PIHP and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.
STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0430 RSN Agreement Section(s) 8.8.2.1.4; 13.3.16
SCORING CRITERIA • The RSN has policies and procedures regarding direct access to specialists for enrollees with special healthcare needs. • The RSN must allow the enrollee direct access to a specialist as appropriate for the enrollee's condition and identified needs. • The RSN monitors the availability of direct access to specialists.
Reviewer Determination ● Fully Met (pass)

Meets Criteria

Section 3: Coverage and Authorization of Services

Table B-4: Summary of Compliance Review for Authorization of Services

Protocol Section	CFR	Result
Coverage and Authorization of Services		
Basic Rule	438.210 (a)	● Fully Met (pass)
Coverage and Authorization of Services	438.210 (b)	● Partially Met (pass)
Notice of Adverse Action	438.210 (c)	● Fully Met (pass)
Timeframe for Decisions: (1) Standard Procedures (2) Expedited Authorizations	438.210 (d)	● Fully Met (pass)

Compensation for Utilization of Services	438.210 l	Fully Met (pass)
Emergency and Post-Stabilization Services	438.210 438.114	Fully Met (pass)
Overall Result for Section 3.		Fully Met (pass)

Basic Rule

FEDERAL REGULATION SOURCE(S)
§438.210 (a): Coverage and Authorization of Services
(a) Coverage. Each contract with an MCO, PIHP or PAHP must do the following:

(1) Identify, define and specify the amount, duration and scope of each service that the MCO, PIHP or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in § 440.230.

(3) Provide that the MCO, PIHP or PAHP—

(i) Must ensure that the services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the beneficiary;

(iii) May place appropriate limits on a service—

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services” in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain or regain functional capacity.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0150
RSN Agreement Section(s) 1.35; 4.1; 4.2; 5.1; 13

SCORING CRITERIA

- The RSN ensures that services are provided in an amount, duration and scope sufficient to achieve the purpose for which they are provided.
- The RSN has a policy and procedure for not discriminating against difficult-to-serve enrollees.
- The RSN ensures difficult-to-serve enrollees are not discriminated against when provided services.
- The RSN applies the State's standard for "medical necessity" when making authorization decisions.

Reviewer Determination

● Fully Met (pass)

Strength

- KCRSN ensures that services are provided in an amount, duration and scope sufficient to achieve adequate care through several mechanisms, including the work of its Hospital and Residential Services Utilization Management Work Group. The work group develops effective strategies to address under- or overutilization of resources and makes recommendations to management for system quality improvements. The goals are to ensure that individual adult consumers have timely access to the most appropriate outpatient, residential and/or inpatient resources to support their recovery, and that homelessness, incarceration, excessive stays in more restrictive settings and unnecessary hospitalizations are avoided.

Authorization of Services

FEDERAL REGULATION SOURCE(S)
§438.210 (b): Coverage and Authorization of Services – Authorization of Services

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require—

(1) That the MCO, PIHP or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP or PAHP—

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) 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, be made by a healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0320
RSN Agreement Section(s) 5.2

SCORING CRITERIA

- The RSN has documented policies and procedures for the consistent application of review

criteria for the initial and continuing authorization of services.
- The RSN has a mechanism in place to ensure consistent application of review criteria.
- The RSN consults with the requesting provider when appropriate.
- The RSN has a process to ensure 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 is made by a mental health professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

Reviewer Determination

Partially Met (pass)

Strength

- KCRSN has a well-written policy that describes how newly hired staff are trained on making authorization decisions**.**

Opportunity for Improvement

KCRSN has a policy titled “Client Services 3B Review Inter-Rater Reliability,” which describes the procedure for validating inter-rater reliability. The policy does not state the date it was created, approved, reviewed or updated.

- KCRSN should complete a review of all policies and procedures to ensure that creation dates, approval dates and the dates of the most recent reviews and updates are included on the documents.

Notice of Adverse Action

FEDERAL REGULATION SOURCE(S)

§438.210 (c): Coverage and Authorization of Services – Notice of Adverse Action

(c) Each contract must provide for the MCO, PIHP or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP or PAHP to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

RSN Agreement Section(s) 6.3

SCORING CRITERIA

- The RSN has a documented policy and procedure to notify the requesting provider, and give the enrollee written notice of any decision by the RSN to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.
- The RSN ensures the notice meets the requirements of §438.404, except that the notice to the provider need not be in writing.

Reviewer Determination

● Fully Met (pass)

Meets Criteria

Timeframes for Decisions

FEDERAL REGULATION SOURCE(S)
§438.210 (d): Coverage and Authorization of Services – Timeframes for Decisions (1) Standard Procedures (2) Expedited Authorizations

(d) Timeframe for decisions. Each MCO, PIHP or PAHP contract must provide for the following decisions and notices:

(1) Standard authorization decisions. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee or the provider requests extension; or

(ii) The MCO, PIHP or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) Expedited authorization decisions.

(i) For cases in which a provider indicates, or the MCO, PIHP or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function, the MCO, PIHP or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service.

(ii) The MCO, PIHP or PAHP may extend the three working days' time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
RSN Agreement Section(s) 5.2

SCORING CRITERIA

- The RSN has a documented policy and procedure for coverage and authorization decisions, including expedited authorizations.
- The RSN has a process for tracking standard and expedited authorization decisions.
- The RSN has mechanisms in place to ensure compliance with authorization timeframes.

Reviewer Determination

● Fully Met (pass)

Meets Criteria

Compensation for Utilization of Services

FEDERAL REGULATION SOURCE(S)
§438.210 (e): Coverage and Authorization of Services – Compensation for Utilization of Services
(e) Each contract must provide that, consistent with §438.6(h) and § 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0330
RSN Agreement Section(s) 5.4

SCORING CRITERIA

- The RSN has a documented policy and procedure specifying that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee.
- The RSN has mechanisms in place to ensure providers and/or utilization management contractors do not provide staff with incentives to deny, limit or discontinue medically necessary services.

Reviewer Determination

● Fully Met (pass)

Strength

- The RSN's contracts and policies and procedures confirm that provider compensation is not structured to provide incentives for providers to deny, limit or discontinue medically necessary services to enrollees.

Emergency and Post-Stabilization Services

FEDERAL REGULATION SOURCE(S)

§438.210 Coverage and Authorization of Services–§438.114 Emergency and Post-stabilization Services

(a) Definitions. As used in this section—

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or

her unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are as follows:

(1) Furnished by a provider that is qualified to furnish these services under this title.

(2) Needed to evaluate or stabilize an emergency medical condition.

Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.

(b) Coverage and payment: General rule. The following entities are responsible for coverage and payment of emergency services and post-stabilization care services.

(1) The MCO, PIHP or PAHP.

(2) The PCCM that has a risk contract that covers these services.

(3) The State, in the case of a PCCM that has a fee-for-service contract.

(c) Coverage and payment: Emergency services—

(1) The entities identified in paragraph (b) of this section—

(i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP or PCCM; and

(ii) May not deny payment for treatment obtained under either of the following circumstances:

(A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2) and (3) of the definition of emergency medical condition in paragraph (a) of this section.

(B) A representative of the MCO, PIHP, PAHP or PCCM instructs the enrollee to seek emergency services.

(2) A PCCM must—

(i) Allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services; and

(ii) Pay for the services if the manager's contract is a risk contract that covers those services.

(d) Additional rules for emergency services.

(1) The entities specified in paragraph (b) of this section may not—

(i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and

(ii) Refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

(2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

(3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for—

(e) Coverage and payment: Post-stabilization care services. Post-stabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of this chapter. In applying those determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment provisions, reference to "M C organization" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section.

(f) Applicability to PIHPs and PAHPs. To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

RSN Agreement Section(s) 5.2

SCORING CRITERIA

- The RSN has written policies and procedures pertaining to crisis, stabilization and post-hospital follow-up services.
- The RSN pays for treatment of conditions defined in its policies as urgent or emergent conditions.
- The RSN tracks and monitors payment denials, to ensure that there is no denial for crisis services.
- The RSN tracks and monitors the use of crisis services for inappropriate or avoidable use related to access to routine care.

Reviewer Determination

● Fully Met (pass)

Strength

- KCRSN has several robust policies and procedures for crisis response, evaluation and treatment, and stabilization services. The RSN does not require authorization for these services, and the policies state that these services are available at no cost to the enrollee.

Section 4: Provider Selection

Table B-5: Summary of Compliance Review for Provider Selection

Protocol Section	CFR	Result
Provider Selection		
General Rules, Credentialing, Re-credentialing	438.214 (a)(b)	● Fully Met (pass)
Nondiscrimination	438.214 (c)	● Fully Met (pass)

Excluded Providers	438.214 (d)	Partially Met (pass)
Overall Result for Section 4.		Partially Met (pass)

General Rules and Credentialing and Re-credentialing Requirements

FEDERAL REGULATION SOURCE(S)

§438.214: (a) General Rules (b) Provider Selection

(a) General rules. The State must ensure, through its contracts, that each MCO, PIHP or PAHP implements written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the requirements of this section.

(b) Credentialing and re-credentialing requirements.

(1) Each State must establish a uniform credentialing and re-credentialing policy that each MCO, PIHP and PAHP must follow.

(2) Each MCO, PIHP and PAHP must follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the MCO, PIHP or PAHP.

(e) State requirements. Each MCO, PIHP and PAHP must comply with any additional requirements established by the State.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-028
RSN Agreement Section(s) 4.5; 8.6; 8.8.2.1.12

SCORING CRITERIA

- The RSN has a credentialing and re-credentialing policy and procedure for providers who have signed contracts or participation agreements.
- The RSN has a uniform documented process for credentialing.
- The RSN has a uniform documented process for re-credentialing.
- The RSN monitors the credentialing and re-credentialing process.
- The RSN ensures the provider agencies have in place credentialing and re-credentialing polices and processes.

Reviewer Determination

Fully Met (pass)

Strength

- KCRSN's annual renewal of all provider contracts includes completing a credentialing application and verifying that the agency meets licensing and exclusion requirements. Recredentialing also includes review of grievances, extraordinary occurrences, solvency and fiscal status.

Nondiscrimination

FEDERAL REGULATION SOURCE(S)

§438.214 (c): Provider Selection and Nondiscrimination

(c) Nondiscrimination. MCO, PIHP and PAHP provider selection policies and procedures, consistent with §438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

§438.12: Provider Selection and Nondiscrimination

(1) An MCO, PIHP and PAHP may not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO, PIHP or PAHP declines to include individuals or groups of providers in its network it must give the affected providers written notice of the reason for its decision.

(2) In all contracts with healthcare professionals, an MCO, PIHP and PAHP must comply with the requirements specified in §438.214.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-028
RSN Agreement Section(s) 4.5; 8.6; 8.8.2.1.12

SCORING CRITERIA

- The RSN has policies and procedures for the selection and retention of providers that do not discriminate against providers who serve high-risk enrollees or specialize in conditions that require costly treatment.
- The RSN has policies and procedures in place that do not discriminate for participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification.
- The RSN has a process to notify individuals or groups of providers when not chosen for participation in the network.

Reviewer Determination

● Fully Met (pass)

Meets Criteria

Excluded Providers

FEDERAL REGULATION SOURCE(S)

§438.214 (d): Excluded Providers

(d) Excluded providers. MCOs, PIHPs and PAHPs may not employ or contract with providers excluded

from participation in Federal healthcare programs under either section 1128 or section 1128A of the Act.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-028
RSN Agreement Section(s) 4.5; 8.6; 8.8.2.1.12

SCORING CRITERIA

- The RSN has a policy and procedure to ensure the RSN does not employ or contract with providers excluded from participation in Federal healthcare programs.
- The RSN can demonstrate the process and the documentation to determine whether individuals or organizations are excluded providers.

Reviewer Determination

Partially Met (pass)

Opportunity for Improvement
Although KCRSN's policy and procedure states that all RSN employees, contractors and subcontractors are to be screened to determine whether they have been listed by a Federal agency as debarred, excluded or otherwise ineligible for Federal program participation, it does not include members of the governing board.

- KCRSN should include the screening of its governing board members in its policy and procedure.

Section 5: Subcontractual Relationships and Delegation

Table B-6: Summary of Compliance Review for Subcontractual Relationships and Delegation

Protocol Section	CFR	Result
Subcontractual Relationships and Delegation		
Subcontractual Relationships and Delegation	438.230	Fully Met (pass)

General Rule

FEDERAL REGULATION SOURCE(S)

§438.230 Subcontractual Relationships and Delegation

(a) General rule. The State must ensure, through its contracts, that each MCO, PIHP and PAHP—

(1) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and

(2) Meets the conditions of paragraph (b) of this section.

(b) Specific conditions.

(1) Before any delegation, each MCO, PIHP and PAHP evaluates the prospective subcontractor's ability

to perform the activities to be delegated.

(2) There is a written agreement that—

(i) Specifies the activities and report responsibilities delegated to the subcontractor; and

(ii) Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

(3) The MCO, PIHP or PAHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations.

(4) If any MCO, PIHP or PAHP identifies deficiencies or areas for improvement, the MCO, PIHP or PAHP and the subcontractor take corrective action.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388--865-0284
RSN Agreement Section(s) 8—

SCORING CRITERIA

- The RSN has policies and procedures for oversight and accountability for any functions and responsibilities that it delegates to any subcontractor/provider.
- The RSN performs pre-delegation assessments of contracted providers before delegation is granted on the subcontractor's ability to perform the activities to be delegated.
- The RSN has written contracts/agreements that address the specifics of what activities have been delegated to the subcontractor/provider.
- The RSN includes in the delegation contract/agreement that the RSN is responsible to monitor and review the subcontractor's/provider's performance on an ongoing basis and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- The RSN initiates a corrective action if subcontractor/provider performance is inadequate.

Reviewer Determination

● Fully Met (pass)

Strengths

- KCRSN maintains a matrix of all delegated functions and effective mechanisms to monitor the performance of those functions.
- KCRSN has a robust process in place to evaluate prospective contractors for their ability to perform delegated functions.

Section 6: Practice Guidelines

Table B-7: Summary of Compliance Review for Practice Guidelines

Protocol Section	CFR	Result

Practice Guidelines		
Clinical Evidence and Adoption	438.236(a-b)	Partially Met (pass)
Dissemination	438.236 (c)	Partially Met (pass)
Application	438.236 (d)	Partially Met (pass)
Overall Result for Section 6.		Partially Met (pass)

Basic Rule

FEDERAL REGULATION SOURCE(S)

§438.236 (a),(b): Practice Guidelines – Basic Rule

(a) Basic rule. The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP, meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP, adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field.

(2) Consider the needs of the MCO, PIHP or PAHP's enrollees.

(3) Are adopted in consultation with contracting healthcare professionals.

(4) Are reviewed and updated periodically as appropriate.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

RSN Agreement Section(s) 7.7.3

SCORING CRITERIA

- The RSN has documented policies and procedures related to adoption of practice guidelines including consultation with contracting healthcare professionals.
- The RSN's guidelines are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field.
- The RSN has documentation of the needs of the enrollees and how the guidelines fit those needs.
- The RSN has documentation that the guidelines are reviewed and updated periodically as appropriate.
- The RSN has a documented policy and procedure of how affiliated providers are consulted as guidelines are adopted and re-evaluated.

Reviewer Determination

Partially Met (pass)

Strengths

- Practice guidelines are routinely reviewed and discussed by KCRSN's various committees.
- Results of the 2014 children's clinical review on the incorporation of children's guidelines in the treatment plans indicated only 53% of charts were in compliance. Corrective action plans included a revision of treatment plan and/or progress note prompts or EHR formats to better document conversations about treatment goals and periodic (quarterly) peer or quality assurance team reviews.

Recommendation Requiring CAP

Although KCRSN has documentation that shows utilization management decisions and other decisions are based on the outcomes of practice guidelines, the RSN lacks policies and procedures regarding the adoption of practice guidelines, dissemination of the guidelines, decisions for utilization management, enrollee education, coverage of services and other areas.

- KCRSN needs to develop and implement policies and procedures that address the adoption of practice guidelines, the dissemination of the practice guidelines and how utilization management, enrollee education, coverage of services and other areas are based on and are consistent with the guidelines.

Dissemination of Guidelines

FEDERAL REGULATION SOURCE(S) **§438.236 (c): Practice Guidelines** (c) Dissemination of guidelines. Each MCO, PIHP and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
STATE REGULATION / RSN AGREEMENT SOURCE(S) RSN Agreement Section(s) 7.7.3.4; 7.7.3.5
SCORING CRITERIA • The RSN has a policy and procedure on how to disseminate practice guidelines to all providers and, upon request, to enrollees and potential enrollees. • The RSN can demonstrate it has disseminated the practice guidelines to all providers and to enrollees upon request.
Reviewer Determination Partially Met (pass)

Strength

- KCRSN's practice guidelines are listed on the RSN's website.

Application of Guidelines

FEDERAL REGULATION SOURCE(S) **§438.236 (d): Practice Guidelines** (d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines.
STATE REGULATION / RSN AGREEMENT SOURCE(S) RSN Agreement Section(s) 7.7.3.4; 7.7.3.5
SCORING CRITERIA • The RSN has documented that policy and procedures as well as documented meeting minutes regarding decisions for utilization management, enrollee education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines. • The RSN had documentation of the interface between the QA/PI program and the practice guidelines adoption process.
Reviewer Determination ● Partially Met (pass)

Strengths

- KCRSN reviews for adherence to practice guidelines during its annual record reviews at the provider agencies.
- The information gained from the record reviews is analyzed, reviewed and discussed by the Quality Improvement Committee (QIC).
- Low adherence to the practice guidelines is brought to the attention the provider agencies, and technical training is offered.

Section 7: Quality Assessment and Performance Improvement Program

Table B-8: Summary of Compliance Review for QAPI General Rules and Basic Elements

Protocol Section	CFR	Result
Quality Assessment and Performance Improvement Program		
Rules, Evaluation, Measurement, Improvement, Program Review by State	438.240 (a)(b)1 (d)(e)	● Fully Met (pass)
Submit Performance Measurement Data	438.240 (b)(c)	● Fully Met (pass)
Mechanisms to Detect Over- and Underutilization of Services	438.240 (b)3	● Fully Met (pass)

Quality and Appropriateness of Care Furnished to Enrollees With Special Healthcare Needs	438.240 (b)4	Fully Met (pass)
Overall Result for Section 7.		Fully Met (pass)

General Rules

FEDERAL REGULATION SOURCE(S)

§438.240 (a),(b),(d),(e): Quality Assessment and Performance Improvement Program.

(a) General rules.

(1) The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(1) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(d) Performance improvement projects.

(1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of system interventions to achieve improvement in quality.

(iii) Evaluation of the effectiveness of the interventions.

(iv) Planning and initiation of activities for increasing or sustaining improvement.

(2) Each MCO and PIHP must report the status and results of each project to the State as requested, including those that incorporate the requirements of §438.240(a) (2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

(e) Program review by the State.

(1) The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program. The review must include—

(i) The MCO's and PIHP's performance on the standard measures on which it is required to report; and

(ii) The results of each MCO's and PIHP's performance improvement projects. (2) The State may require that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-0280; 388-865-0320
RSN Agreement Section(s) 7.9; 7.10

SCORING CRITERIA

- The RSN has an ongoing quality assessment and performance improvement program (QAPI) for the services it furnishes to its enrollees.
- The RSN has a QA and PI process to evaluate the QAPI program and provides for an annual report to DBHR.
- The RSN collects, analyzes and uses performance data to support its quality assessment and performance improvement program.
- The RSN has a Quality Management Committee that meets regularly, reviews results of performance data and reports to the governing board.
- The RSN has effective mechanisms to assess the quality and appropriateness of care furnished to enrollees.
- The RSN conducts one clinical performance improvement project and one non-clinical performance improvement project each year.
- The RSN ensures its compliance with the State Quality Strategy plan.

Reviewer Determination

● Fully Met (pass)

Strengths

- KCRSN's quality management program is designed to assure effective and efficient management of the publicly funded mental health system in King County. The program outlines comprehensive, systematic approaches to ensure that care is timely, accessible, appropriate and effective for consumers, and cost-effective for the system.
- The program incorporates quality planning, quality assurance and quality improvement. The program describes major functions, organizational relationships, responsibilities and decision-making processes.
- KCRSN's Quality Improvement Committee (QIC) meets bi-monthly and is composed of management, the Quality Review Team (QRT) and other lead staff from the county.

Basic Elements

FEDERAL REGULATION SOURCE(S)

§438.240 (b),(c): Quality Assessment and Performance Improvement Program

(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(2) Submit performance measurement data as described in paragraph (c) of this section.

(c) Performance measurement. Annually each MCO and PIHP must—

(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of §438.204(c) and §438.240(a)(2)(listed below);

(2) Submit to the State, data specified by the State, that enables the State to measure the MCO's or

PIHP's performance; or

(3) Perform a combination of the activities described in paragraphs I (1) and I (2) of this section.

(a) General rules.

§438.204I: For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with State and other relevant stakeholders.

§438.240(a)(2): CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs and PIHPs.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0280; 388-865-0320
RSN Agreement Section(s) 7.9; 7.10

SCORING CRITERIA

- The RSN collects, analyzes and uses performance data to support its quality assessment and performance improvement program.
- The RSN reports performance data to the State every year.

Reviewer Determination

● Fully Met (pass)

Meets Criteria

Mechanisms to Detect Under- and Overutilization of Services

FEDERAL REGULATION SOURCE(S)

§438.240 (b)(3): Quality Assessment and Performance Improvement Program

(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(3) Have in effect mechanisms to detect both underutilization and overutilization of services.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0280; 388-865-0320
RSN Agreement Section(s) 7.9; 7.10

SCORING CRITERIA

- The RSN has a documented policy and procedure regarding the detection of both underutilization and overutilization of services.
- The RSN has consistent criteria for identifying underutilization and overutilization.
- The RSN has processes for routine monitoring for underutilization and overutilization.
- The RSN has processes for taking corrective action to address underutilization and overutilization.

Reviewer Determination

● Fully Met (pass)

Strengths

- KCRSN has several policies and procedures for the detection of both underutilization and overutilization of services.
- KCRSN reviews inpatient reports for inappropriate stays, analyzes encounter and claims data for frequency of services, audits clinical records for appropriateness of care, and tracks and analyzes enrollee complaints and grievances as mechanisms for monitoring for over- and underutilization.

Mechanism to Assess the Quality and Appropriateness of Care

FEDERAL REGULATION SOURCE(S)

§438.240 (b)(4): Quality Assessment and Performance Improvement Program

(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0280; 388-865-0320
RSN Agreement Section(s) 7.9; 7.10

SCORING CRITERIA

- The RSN has a process in place to assess the quality and appropriateness of care furnished to enrollees.
- The RSN monitors and tracks the quality and appropriateness of care furnished to enrollees.
- The RSN has processes to take action when quality and appropriateness of care issues are identified.

Reviewer Determination

● Fully Met (pass)

Strength

- KCRSN, through its QIC, monitors the quality and appropriateness of care furnished to enrollees by reviewing routine management indicator reports, system report cards, grievance system reports, utilization management plans and other routine or ad hoc reports that may suggest a need for QI.
- The QIC is responsible for developing appropriate methods for implementing quality improvement projects, identifying data sources and elements, establishing work groups/plans, and assigning the resources needed for the improvement of care and services.

Section 8: Health Information Systems

Table B-9: Summary of Compliance Review for Health Information Systems, General Rules and Basic Elements

Protocol Section	CFR	Result
Heath Information Systems		
Collect, Analyze, Integrate and Report Data	438.242 (a)	Fully Met (pass)
Data Accuracy, Timeliness, Completeness	438.242 (b)	Partially Met (pass)
Overall Result for Section 8.		Partially Met (pass)

General Rule

FEDERAL REGULATION SOURCE(S)

§438.242 (a): Health Information Systems

(a) General rule. The State must ensure, through its contracts, that each MCO and PIHP maintains a health information system that collects, analyzes, integrates and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and dis-enrollments for other than loss of Medicaid eligibility.

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STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-0275

RSN Agreement Section(s) 11

SCORING CRITERIA

- The RSN has a health information system that collects, analyzes, integrates and reports data on utilization, dis-enrollments and requests to change providers, grievances and appeals.
- The RSN utilizes reports from health information data to make informed management decisions.
- The RSN analyzes the health information data to identify services needed for enrollees.

Reviewer Determination

Fully Met (pass)

Strengths

- KCRSN encourages small provider agencies to coordinate data services with larger agencies for the transfer of data to the RSN.

- KCRSN provides a yearly summary of results for its annual clinical record and administrative reviews, which are analyzed by its quality management committee for making informed management decisions.

Basic Elements

FEDERAL REGULATION SOURCE(S)

§438.242 (b): Health Information Systems

(b) Basic elements of a health information system. The State must require, at a minimum, that each MCO and PIHP comply with the following:

(1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.

(2) Ensure that data received from providers is accurate and complete by—

(i) Verifying the accuracy and timeliness of reported data;

(ii) Screening the data for completeness, logic and consistency; and

(iii) Collecting service information in standardized formats to the extent feasible and appropriate.

(2) Make all collected data available to the State and upon request to CMS, as required in this subpart.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-0275
RSN Agreement Section(s) 11

SCORING CRITERIA

- The RSN collects data on service encounters and on all provider and enrollee characteristics included in the Consumer Information System (CIS) Data Dictionary.
- The RSN ensures that data received from providers is accurate and complete by collecting data in standardized formats and reviewing the data for accuracy, timeliness, completeness, logic and consistency.
- The RSN makes all collected data available to the State and, upon request, to CMS.

Reviewer Determination

Partially Met (pass)

Opportunities for Improvement

Results from KCRSN's annual review of encounter data from its provider agencies showed:

- The system's overall rate of compliance with data timeliness requirements was 58%, a decrease of 16% when compared with findings from the 2013 site visits and of 13% compared with the 2012 compliance rate.
- The system's overall rate of compliance with data completeness requirements was 53%, a decrease of 12% when compared with findings from the 2013 site visits and of 22% compared

with the 2012 compliance rate. Among the 17 contractors who received ratings for data completeness in both 2013 and 2014, ten earned the same rating, two improved, and five received a lower rating.

Although KCRSN has no definitive reason for this downward trend, it did note that a number of agencies are going through transitions to electronic health records (EHRs) for the first time or are between EHRs, which may have contributed to these issues. Agencies also reported there were several staff changes in key data/IT positions, which led to the need for further technical assistance in understanding and addressing the data requirements.

- KCRSN should continue to seek to determine the reasons for the decreases in scores over the last three years and then provide technical assistance as needed to reverse this trend.

Performance Improvement Project (PIP) Validation

PIP Review Procedures

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), Regional Support Networks (RSNs) are required to have an ongoing program of PIPs that focus on clinical and non-clinical 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

As a mandatory EQR activity, Qualis Health evaluates the RSNs' 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, in clinical and non-clinical areas that are 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 RSN used to collect the data to be analyzed for the PIP measurement(s) are valid
- The RSN's plan for analyzing and interpreting PIP results is accurate
- The RSN'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

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

PIP Scoring

Qualis Health assessed the RSNs' PIPs using the current CMS EQR protocol available here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Qualis Health assigns a score of Met or Not Met to each element that is applicable to the PIP being evaluated. Elements may be Not Applicable if the PIP is at an early stage of design or implementation. If a PIP has advanced only to the first measurement of the study indicator (baseline), elements 1–6 are

reviewed. If a PIP has advanced to the first re-measurement, elements 1–9 are reviewed. Elements 1–10 are reviewed for PIPs that have advanced to repeated re-measurement.

If all reviewed elements are assigned a score of Met, the overall score is Met. If any reviewed element is assigned a score of Not Met the overall score is Not Met.

Table C-1: Performance Improvement Project Validation Scoring

Scoring Icon Key			
Fully Met (pass)	Partially Met (pass)	Not Met (fail)	N/A (not applicable)

PIP Validity and Reliability

Qualis Health assesses the overall validity and reliability of the reported results for all PIPs. Because determining potential issues with the validity and reliability of the PIP is sometimes a judgment call, Qualis Health reports a level of confidence in the study findings based on a global assessment of study design, development and implementation. Levels of confidence and their definitions are included in Table C-2.

Table C-2: Performance Improvement Project Validity and Reliability Confidence Levels

Confidence Level	Definition
High Confidence in Reported Results	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	The study design and data collection and analysis procedures are not sufficient 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 or reported results.
Low Confidence in Reported Results	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	The PIP has not advanced to at least the first re-measurement of the study indicator.

PIP Validation Results: Clinical PIP

Effectiveness of the Transitional Support Program

King County Regional Support Network (KCRSN) selected this PIP based on the need to improve enrollees' connection to outpatient behavioral health services and supports following involuntary hospitalization in an effort to reduce re-hospitalization. Per KCRSN, 150 inpatient beds within the community and 200 beds at Western State Hospital haven been eliminated over the past ten years

The study question addresses "whether individuals served by the TSP program (who are Medicaid enrolled prior to TSP discharge) reduce the (average) number of hospitalizations when comparing the year prior to first TSP service with the year following first TSP service." Bed reductions and recent State Supreme Court rulings that make psychiatric boarding illegal have made making an initial connection to appropriate behavioral and physical healthcare after involuntary psychiatric hospitalization a clear need.

The transitional support program (TSP) employs a multi-disciplinary team that includes 3.5 full-time employee (FTE) mental health professionals, 1.75 registered nurses, 3.3 peer-support specialists and a 0.5 prescriber. TSP staff works with hospital discharge staff and enrollees to create and implement a transition plan specifically tailored to the needs of the individual to optimally facilitate engagement and reduce the probability of recidivism. TSP team members meet with hospital staff and enrollees prior to discharge to begin planning and continue to work with enrollees as they transition into the community. The TSP team uses evidence-based approaches to engage clients in planning, decision-making and "to meet clients where they are." The program has the capacity to serve 95 individuals at a time and served a total of 399 individuals in its first year.

Dates of Study Period:
Baseline: Individuals were first seen by TSP from July 1, 2014, to June 30, 2015; their baseline data will be July 1, 2013–June 30, 2014.
Re-measurement: For hospitalizations that occur during the year following the first TSP service for the individuals first seen July 1, 2014–June 30, 2015, re-measurement period will be July 1, 2014–June 30, 2016.

Table C-3: Clinical PIP Validation Results

Study Design		Activity	Narrative	SCORE
Design	1	Appropriate study topic	KCRSN selected this study topic based on a detailed review of local data related to individuals who were being involuntarily detained. The need to improve enrollees' connections to outpatient behavior health services and supports following a psychiatric hospitalization in an effort to reduce the rate of recidivism was apparent.	Partially Met (pass)
	2	Clearly defined, answerable study question	Per KCRSN, "The study question is whether individuals served by the TSP program (who are Medicaid enrolled prior to TSP discharge) reduce the average number of hospitalizations when comparing year prior to first TSP	Not Met (fail)

			service with the year following first TSP service." The study question is not clear and does not establish a solid framework for evaluation of performance improvement.	
	3	Correctly identified study population	The study population is defined as adults, age 18 years or older, involuntarily detained at a non-evaluation and treatment (E&T) facility within King County who are not enrolled in outpatient mental health or substance abuse services, or are enrolled but not engaged in outpatient treatment as defined by having fewer than six outpatient service hours during the previous 60 days.	Fully Met (pass)
	4	Correctly identified study indicator	The indicator is the change in the number of hospitalizations for the study population from pre- to post-TSP enrollment.	Partially Met (pass)

Reviewer Comments:

The study topic regarding increasing outpatient behavioral health connections and reducing readmission rates to involuntarily detained enrollees is relevant and appropriate. The study population is clearly identified as enrollees over the age of 18 involuntarily detained in a non-E&T setting who were not previously enrolled in outpatient mental health or chemical dependency services or have engaged in fewer than six hours of outpatient treatment in the last 60 days.

Without comparison data of another type of intervention or implementation of specific changes in the intervention process, the study question is not the basis for a performance improvement project. Analyzing program outcome data is program evaluation, not performance improvement.

The study indicator is noted as the change in the number of hospitalizations for the study population from pre- to post-TSP enrollment. KCRSN does not specify what the numerator and the specific denominator will be to calculate this indicator.

Implementation	5	Valid sampling technique	There were no samples used in this PIP.	N/A
	6	Accurate/ complete data collection	Information regarding enrollee TSP enrollment, Medicaid enrollment, outpatient enrollment and hospitalizations is collected and maintained with the RSN's electronic MIS. Data elements are verified through several reports; Medicaid enrollment is verified through DBHR.	Fully Met (pass)

	7	Appropriate data analysis/ interpretation of study results	KCRSN did look at and address some barriers related to program implementation. There is an implication that data analysis occurred; however, no actual data was shared in the PIP report.	Partially Met (pass)
Reviewer Comments: KCRSN did not use sampling techniques for this PIP. All Medicaid-enrolled TSP participants who fit the study population criteria are included in the indicator. The plan to collect accurate and complete data is appropriate. KCRSN noted that there is a plan to use a t-test or non-parametric paired comparisons; however, no planned use of a statistical equation or threshold of statistical significance was articulated.				
Outcomes	8	Appropriate improvement strategies		N/A
	9	Real improvement achieved		N/A
	10	Sustained improvement achieved	.	N/A
Overall Score				Not Met (fail)
Reviewer Comments	**Strength(s):** A PIP based on the intent to decrease the re-hospitalization rates is not without merit. KCRSN has access to reliable data and the ability to create a well-designed PIP. **Recommendation Requiring CAP:** Because all of the data is readily available for aggregation and analysis, it is unclear what the full purpose of this PIP is. Setting up a monitoring system related to the already occurring intent of the TSP is not a PIP if it doesn't utilize any strategies that seek to implement changes to processes and/or interventions that will ultimately improve the indicator. • KCRSN needs to consider implementing specific interventions beyond the current TSP practices if the RSN seeks to use the program for a PIP. KCRSN needs to either rework this PIP so that the study topic, study question and intervention truly assess performance improvement and not program evaluation, or it needs to adopt a new PIP that will assess and improve a process and thereby an outcome of care. **Confidence Level:** Low Confidence in Reported Results			

Standard 1: Selected Study Topic Is Relevant and Prioritized

Table C-4: Validation of PIP Selected Study Topic

Criterion	Description	Result
1.1	The study topic was selected through data collection and analysis of comprehensive aspects of specific enrollee needs, care and services.	Partially Met (pass)
1.2	The PIP is consistent with the demographics and epidemiology of the enrollees.	Partially Met (pass)
1.3	The PIP considered input from enrollees with special healthcare needs.	Not Met (fail)
1.4	The PIP addresses a broad spectrum of key aspects of enrollee care and services.	Fully Met (pass)
1.5	The PIP, over time, included all enrolled populations.	Fully Met (pass)

Reviewer Comments:

The study topic was selected after a review of RSN data related to involuntary hospitalizations and readmission rates. KCRSN also looked at information regarding single bed certification numbers and E&T usage. There was no review of national or state data or any review of historical trends related to this issue.

KCRSN found that an average of 175 adults had been authorized for involuntary inpatient hospitalization with an average length of stay of 11 days. Involuntary admissions account for 70% of all psychiatric admissions, and the rate for readmission within 90 days is 15%. No time periods are noted for this data.

KCRSN reported that stakeholders were consulted but does not articulate in what capacity enrollees participated. Further, when stakeholder participation is referenced, it is related to the development of the TSP model not the creation of the PIP. Peer incorporation into the TSP model is a best practice, but it does not constitute enrollee input in the selection of the PIP.

The PIP addresses a clear need for services, noted by the loss of approximately 250 hospital beds at community and state hospitals and recent Revised Code of Washington (RCW) revisions. The TSP model addresses the link between inpatient hospitalization and the necessary community resources to assist an enrollee in avoiding another involuntary placement. TSP uses two evidence-based practices, the Coleman Care Transitions Intervention (CTI) and the Assess Plan Identify Coordinate (APIC) model. CTI is a four-week “coaching” program in which the enrollee learns skills of self-management related to managing their mental illness and avoiding re-hospitalization. APIC involves four phases: assess clinical, social and safety needs; plan for treatment and services needed to address the enrollee’s needs; identify the community programs responsible for post-discharge services, and coordinate the transition plan to ensure implementation and meaningful relationships, avoid gaps in care and prevent re-hospitalization.

TSP has the capacity to serve 95 enrollees at a time, and the PIP will include all those who meet the criteria of the study population.

Opportunities for Improvement:

A more thorough review of data related to the study topic is needed. When citing data, it is best practice to

note the time period that is being referenced. Without knowing the time period of the data examined it is not clear if this PIP is truly consistent with current demographics and epidemiology. In order for the study topic to have been selected through a thorough process of data collection and analysis of comprehensive aspects of enrollees needs, care and services, multiple lenses should be reviewed, e.g., RSN trends over time, state data, national data, journal articles.

No dates or timelines are noted in the description of the selection of the PIP. It is difficult to fully assess the relevancy or intensity of the need without clearly understood timeframes. A clear narrative regarding how and when decisions to implement the program were made might better illustrate the necessity of the service. More detailed information regarding stakeholder input, including enrollee involvement, would also assist in supporting the choice of the study topic.

Standard 2: Study Question Is Clearly Defined

Table C-5: Validation of PIP Study Question

Criterion	Description	Result
2.1	The study question(s) is clear, concise and answerable.	● Not Met (fail)
2.2	The study question identifies the focus of the PIP and sets the framework for data collection, analysis and interpretation.	● Not Met (fail)

Reviewer Comments:
The study question addresses "whether individuals served by the TSP program (who are Medicaid enrolled prior to TSP discharge) reduce the (average) number of hospitalizations when comparing the year prior to first TSP service with the year following first TSP service." Although this question is answerable, it is not the basis for a true PIP, but rather program evaluation. Essentially setting up a monitoring system of some facet of care is not a PIP unless there is a specific intervention focused on improving the indicator.

Opportunities for Improvement:
In order for this study to be a robust PIP, the intervention needs to be related to an identified problem, upon which various interventions, not just a program's services, can be tested and applied to create improvement. KCRSN needs to reconsider the nature of this PIP.

Standard 3: Study Population Is Clearly Defined, and, if a Sample Is Used, Appropriate Methodology Is Used

Table C-6: Validation of PIP Study Population

Criterion	Description	Result
3.1	The enrollee population to whom the study question and indicator is	

	relevant is clearly defined.	Fully Met (pass)
3.2	The data collection approach captures all enrollees to whom the study question applied.	Fully Met (pass)
3.3	Appropriate data sources and evaluation methods were used to identify the study population.	Fully Met (pass)

Reviewer Comments:
The study population is clearly defined as enrollees age 18 and older who have been involuntarily detained at a non-E&T hospital within King County if they are not enrolled in outpatient mental health or substance abuse treatment or they are enrolled but not engaged in outpatient treatment. “Not engaged” is defined as having fewer than six hours of outpatient service in the previous 60 days. Data is collected within the RSN’s MIS; enrollees in the program are authorized for services with a unique code. The group is matched against the statewide Medicaid eligibility files to determine if enrollees are Medicaid eligible prior to TSP discharge. Community hospital admissions and discharges for enrollees are captured by the MIS and state hospital discharges are obtained monthly from DBHR and integrated into the MIS.

Meets Criteria

Standard 4: Study Indicator Is Objective and Measureable

Table C-7: Validation of PIP Study Indicator

Criterion	Description	Result
4.1	The study uses objective, clearly defined, measurable indicators.	Partially Met (pass)
4.2	The indicators track performance over a specified period of time.	Partially Met (pass)
4.3	The number of indicators is adequate to answer the study question, appropriate for the level of complexity of applicable clinical practice guidelines, and appropriate to the availability of and resources to collect necessary data.	Fully Met (pass)

Reviewer Comments:
The study indicator is defined as the change in the number of hospitalizations for the study population from pre- to post-TSP enrollment, but no numerator or denominator is articulated.

KCRSN notes the study period as "Baseline—individuals first seen by TSP during 7/1/14 to 6/30/15—their baseline data will be their hospitalizations during the year prior to being seen, i.e.,7/1/13–6/30/15. Re-measurement will be for hospitalizations that occur during the year following first TSP service for the individuals first seen 7/1/14–6/30/15—as such the re-measurement period will be 7/1/14 to 6/30/16." These dates are presented in a convoluted manner, and the purpose of the overlap of the baseline and re-measurement periods is unclear.

Opportunities for Improvement:
KCRSN should clearly define the numerator and denominator of this study. The study period for the PIP need to be written in a clear manner, with a straightforward explanation regarding the rationale for the chosen measurement periods.

Standard 5: Sampling Method

Table C-8: Validation of PIP Sampling Methods

Criterion	Description	Result
5.1	The sampling technique considered and specified the true (or estimated) frequency of occurrence of the event, the confidence interval to be used and the acceptable margin of error.	● N/A
5.2	Valid sampling techniques were employed that protected against bias.	● N/A
5.3	The sample contained a sufficient number of enrollees.	● N/A
Reviewer Comments: There were no samples used in this study.		

Standard 6: Data Collection Procedure

Table C-9: Validation of PIP Data Collection Procedures

Criterion	Description	Result
6.1	The study design clearly specifies the data to be collected.	● Fully Met (pass)
6.2	The study design clearly specifies the sources of data.	● Fully Met (pass)
6.3	The study design specifies a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply.	● Fully Met (pass)

6.4	The instruments for data collection provide for consistent and accurate data collection over the time periods studied.	Fully Met (pass)
6.5	The study design prospectively specifies a data analysis plan.	Not Met (fail)
6.6	Qualified staff and personnel were used to collect the data.	Not Met (fail)

Reviewer Comments:
KCRSN reported that the data to be collected includes TSP program enrollment, Medicaid enrollment, outpatient enrollment (including engagement/encounters) and hospitalizations. Information regarding enrollee TSP enrollment, Medicaid enrollment, outpatient enrollment and hospitalizations is collected and maintained with the RSN's MIS. Medicaid eligibility is verified through monthly files provided by DBHR.

KCRSN validates TSP enrollment through monthly TSP caseload reports. Data timeliness and data completeness within the MIS is monitored monthly through internal management reports. Hospital data is reported in quarterly management reports and reviewed for any anomalies.

Opportunities for Improvement:
KCRSN does not establish a clearly defined data analysis plan; while there is a plan to use a t-test/non-parametric paired tested as the method of statistical analysis, no clear equation is noted, and there is no p-value for a potential null hypothesis to show a statistically significant reduction in re-hospitalizations.
KCRSN needs to develop a more fully planned study design that articulates the full plan for data analysis and statistical significance.

KCRSN did not describe the qualifications of the staff who collected and validated the data.
KCRSN needs to describe the qualifications of the individuals employed in the data collection process.

Standard 7: Data Analysis and Interpretation of Study Results

Table C-10: Validation of PIP Data Analysis and Interpretation

Criterion	Description	Result
7.1	An analysis of the findings was performed according to the data analysis plan.	N/A
7.2	Numerical PIP results and findings were accurately and clearly presented.	N/A
7.3	The data analysis methodology was appropriate to the study question and data types.	N/A
7.4	The analysis identified initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity.	N/A
7.5	The analysis of study data included an interpretation of the extent to which the PIP was successful, as well as follow-up activities.	N/A

Reviewer Comments:
The PIP has not progressed to this point and, therefore, these requirements could not be validated**.**

Standard 8: Appropriate Improvement Strategies

Table C-11: Validation of PIP Improvement Strategies

Criterion	Description	Result
8.1	A continuous cycle of measurement and performance analysis was conducted.	N/A
8.2	Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes.	Partially Met (pass)
8.3	The interventions are/were sufficient to be expected to improve processes or outcomes.	Partially Met (pass)
8.4	The interventions are/were culturally and linguistically appropriate.	Fully Met (pass)

Reviewer Comments:
The PIP has not progressed to the point at which a continuous cycle of measurement and performance analysis has been conducted. KCRSN has not reported any results.

KCRSN noted many aspects of the program that are intended to address common barriers of engaging in outpatient services for enrollees following discharge from the hospital. Through monitoring of the program processes it became apparent that the referral process was problematic. Originally, RSN staff extracted the involuntary treatment admissions list daily, reviewed the list for eligibility and forwarded the list to the TSP provider agency. This led to increased lag time, especially if there was a long weekend or holiday or if RSN staff were unavailable. The KCRSN IT department set up a secure weblink so that the TSP program lead could directly extract the involuntary admissions that met the eligibility criteria.
KCRSN also reported that early analyses of data showed that very few enrollees were utilizing the services of the 0.5 FTE prescriber and program and that the RSN could think about using that funding in other ways.

TSP includes the APIC and Coleman models, which were developed and used in culturally diverse settings. The program also has access to ethnic minority specialists and interpreters.

Opportunities for Improvement:
KCRSN did not report any data analysis of its preliminary findings, though some was alluded to in terms of lag time for referrals and utilization of the prescriber. If there is data available it should be reported in the PIP.

Standard 9: Assess Whether Improvement Is "Real" Improvement

Table C-12: Validation of PIP Improvement Assessment

Criterion	Description	Result
9.1	The same methodology as the baseline measurement was used when measurement was repeated.	● N/A
9.2	There was documented, quantitative improvement in processes or outcomes of care.	● N/A
9.3	The reported improvement in performance appears to be the result of the planned quality improvement intervention.	● N/A
9.4	There is statistical evidence that any observed performance improvement is true improvement.	● N/A
Reviewer Comments: The PIP has not progressed to the point where a continuous cycle of measurement and performance analysis has been conducted.		

Standard 10: The RSN Has Sustained the Documented Improvement

Table C-13: Validation of PIP Sustained Improvement

Criterion	Description	Result
10.1	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	● N/A
Reviewer Comments: The PIP has not progressed to the point where a continuous cycle of measurement and performance analysis has been conducted.		

PIP Validation Results: Non-Clinical PIP

Improved Care Coordination with Managed Care Organizations (MCOs) for Children and Youth
In an effort to meet contract expectation with managed care organization (MCO) contracts and to address T.R. vs. Dreyfus lawsuit settlement requirements, the King County RSN chose a performance improvement topic that addresses the needs of youth with mental health needs who have additional high psychiatrically related acute care utilization. KCRSN consulted with youth clinical directors of its provider agencies, as well as the Parent Partner Network group to gain insight into the issues and needs of youth related to their mental health. KCRSN also reviewed utilization for youth who were continuously enrolled in outpatient or long-term other RSN benefits as well as Molina's Apple Healthcare Medicaid plan between December 2014 and May 2015. There were 2,205 youth, age 18 or younger, who were dually enrolled, and a total of 443 emergency department (ED) visits made by 321 youth. One-quarter of the ED visits were for youth who had a primary or secondary psychiatric diagnosis with codes 290-310 or a medical disorder with a clear psychosomatic component, e.g., gastrointestinal distress or asthma. KCRSN noted that it was clear that youth who had ED visits were not getting their needs met on a more routine outpatient basis. ED use is costly to the healthcare system; if youth receive the types of services and supports they need on an outpatient basis, their symptoms could be better managed and a system

savings might occur. KCRSN chose this PIP because it identifies a high-risk group with continued high utilization and negative outcomes, and it dovetails with healthcare integration efforts that create new opportunities to identify a population, coordinate care and track outcomes.

The PIP focuses on implementation of care coordinator efforts that aim to reduce high psychiatrically related ED use. KCRSN is considering, but has not yet fully defined, the care coordination intervention that will be used. Wraparound or Children's Crisis Outreach Response System (CCORS) are two interventions that KCRSN believes have the appropriate level of cross-sector planning capacity.

The study question is "Does implementation of a care coordination process/intervention to reduce psychiatrically related ED use significantly reduce the number of children/youth who have psychiatrically related ED use for the population of Medicaid-enrolled children/youth (age ≤18 on December 1, 2014) who are continuously enrolled from December 2014 through May 2015 in both outpatient or long-term other RSN mental health services and Molina Apple Healthcare and who have had prior psychiatrically related ED use over the same six-month period?"

Dates of Study Period:

The baseline measurement: December 1, 2014–May 31, 2015
First re-measurement period: December 1, 2015–May 31, 2016

Table C-14: Clinical PIP Validation Results

Study Design		Activity	Narrative	SCORE
Design	1	Appropriate study topic	The focus of the study topic is the reduction in psychiatrically related ED use among youth through a coordinated care intervention.	● Fully Met (pass)
	2	Clearly defined, answerable study question	The KCRSN wrote the study question as "Does implementation of a care coordination process/intervention to reduce psychiatrically related ED use significantly reduce the number of children/youth who have psychiatrically related ED use for the population of Medicaid-enrolled children/youth (age <=18 on December 1, 2014) who are continuously enrolled from December 2014 through May 2015 in both outpatient or long-term other RSN mental health services and Molina Apple Healthcare and who have had prior psychiatrically	● Not Met (fail)

			related ED use over the same six-month period?"	
	3	Correctly identified study population	The study population for this PIP is defined as a sub-population of Medicaid-enrolled youth 18 years of age or younger who are continually enrolled in both RSN outpatient services and Molina's Apple Health plan from December 2014 to May 2015 who have had at least one "psychiatrically related" ED visit during that period. KCRSN noted that a second sub-population of youth having ED visits with a medical diagnosis having a psychosomatic component will be further defined at a later point.	● Not Met (fail)
	4	Correctly identified study indicator	The indicator is the change in the number of enrollees in the PIP subpopulation who experience psychiatrically related ED episodes.	● Not Met (fail)
Reviewer Comments: The ultimate goal of this PIP is to reduce the number of psychiatrically related ED visits for youth. However, all elements of this PIP are not fully formed. The intervention has not been clearly defined, nor has the secondary medical diagnosis. Without fully answering the questions, the required elements cannot be fully met.				
Implementation	5	Valid sampling technique	There are no samples to be used; the entire study subpopulation will be included.	● N/A
	6	Accurate/ complete data collection	Data will be collected from Medicaid eligibility files, RSN enrollment data and MCO-to-RSN data files. The full nature of the intervention is not yet known; therefore, a complete plan for data collection cannot be made or assessed.	● Not Met (fail)
	7	Appropriate data analysis/ interpretation of study results	The PIP has not progressed to this stage.	● N/A
Reviewer Comments: The KCRSN's plans for sampling and data collection and analysis appear well thought out and appropriate. In order to truly know if the proposed plans are fitting, the full scope of the project needs to be defined, including all aspects of the intervention and the psychosomatic diagnosis component.				

Outcomes	8	Appropriate improvement strategies	The PIP has not progressed to this stage.	● N/A
	9	Real improvement achieved	The PIP has not progressed to this point.	● N/A
	10	Sustained improvement achieved	The PIP has not progressed to this point.	● N/A
Overall Score				● Partially Met (pass)
Reviewer Comments	**Strengths:** KCRSN has the foundation for a PIP that fully meets all the Medicaid required elements. The intent to reduce psychiatrically related ED usage among youth continuously enrolled in both RSN outpatient behavioral health services and Molina Healthcare is clear and appropriate. **Recommendation Requiring CAP:** This PIP, in its current design, is not fully formulated. • KCRSN needs to fully formulate this PIP, which includes getting stakeholder input regarding the study topic, study population, intervention and the study question. The study question needs to be written in a clear, concise and measurable manner. The intervention needs to be stated clearly and needs to measure improvement. KCRSN needs to be mindful of the difference between performance improvement and performance evaluation, taking care that this study is a true PIP that introduces a novel intervention and does not solely monitor and evaluate a program's already existing intervention. **Confidence Level:** Not enough time has elapsed to assess meaningful change			

Standard 1: Selected Study Topic Is Relevant and Prioritized

Table C-15: Validation of PIP Selected Study Topic

Criterion	Description	Result
1.1	The study topic was selected through data collection and analysis of comprehensive aspects of specific enrollee needs, care and services.	● Fully Met (pass)
1.2	The PIP is consistent with the demographics and epidemiology of the enrollees.	● Fully Met (pass)

1.3	The PIP considered input from enrollees with special healthcare needs.	Fully Met (pass)
1.4	The PIP addresses a broad spectrum of key aspects of enrollee care and services.	Fully Met (pass)
1.5	The PIP, over time, included all enrolled populations.	Fully Met (pass)

Reviewer Comments:
The PIP was selected through information and data collected via discussion with youth clinical directors from provider agencies, the Parent Partner Network group and the review of the amount and nature of acute care utilization for shared RSN-primary care youth continuously enrolled in outpatient or long-term RSN services as well as Molina Healthcare's Apple Healthcare Medicaid plan. KCRSN noted that youth who had psychiatrically related ED visits were not getting their needs met on a routine outpatient basis.

KCRSN reviewed ED utilization for a period of six months, from December 2014 to May 2015, and found that of the 2,202 shared enrollee youth, there were 443 ED events from 321 youth. Of the 443 visits, 109 encounters from 87 youth had a primary or secondary psychiatric diagnosis. That is 25% of the subpopulation who had at least one psychiatrically related ED visit. It was noted that further root cause analysis is needed to better understand the factors thought to lead to medical diagnosis with a psychiatric component.

By discussing the development of the PIP topic with the Parent Partner Network group, KCRSN gained much insight into the mental health needs of enrollees in this PIP.

The PIP is intended to address a broad spectrum of key aspects of enrollee needs and services such as preventive care and care coordination, reduction in ED utilization, and youth with mental health needs.

The entire dually enrolled sub-population is included in the PIP.

Standard 2: Study Question Is Clearly Defined

Table C-16: Validation of PIP Study Question

Criterion	Description	Result
2.1	The study question(s) is clear, concise and answerable.	Partially Met (pass)
2.2	The study question identifies the focus of the PIP and sets the framework for data collection, analysis and interpretation.	Partially Met (pass)

Reviewer Comments:
KCRSN stated its study question as "Does implementation of a care coordination process/intervention to reduce psychiatrically related ED use significantly reduce the number of children/youth who have psychiatrically related ED use for the population of Medicaid-enrolled children/youth (age ≤18 on

December 1, 2014) who are continuously enrolled from December 2014 through May 2015 in both outpatient or long-term other RSN mental health services and Molina Apple Healthcare and who have had prior psychiatrically related ED use over the same six-month period?"

The study question sets the framework for the study topic and the study population; it does not define the intervention to be used. Without a clear intervention, the full framework for data collection, analysis and interpretation cannot be built.

Opportunities for Improvement:
The study question should be clear, simple and answerable. Additionally, KCRSN should state its question in a way that articulates the ability to determine whether the intervention has a measurable impact on the study population. KCRSN does not thoroughly articulate its planned intervention, making it unclear if the intervention's impact is capable of being measured.

Without a clearly defined plan for intervention, the full framework for data collection, analysis and interpretation has not been set.

In order to have a fully clear, concise and answerable study question that also has a clearly defined plan for data collection and analysis, KCRSN needs to fully design the study's intervention.

Standard 3: Study Population Is Clearly Defined, and, if a Sample is Used, Appropriate Methodology Is Used

Table C-17: Validation of PIP Study Population

Criterion	Description	Result
3.1	The enrollee population to whom the study question and indicator is relevant is clearly defined.	● Not Met (fail)
3.2	The data collection approach captures all enrollees to whom the study question applied.	● Not Met (fail)
3.3	Appropriate data sources and evaluation methods were used to identify the study population.	● Not Met (fail)

Reviewer Comments:
The study population is described as Medicaid-enrolled youth age 18 or younger, who are continuously enrolled in both RSN outpatient/other services and Molina's Apple Health (Medicaid) plan from December 2014 through May 2015 who have had at least one psychiatrically related ED visit during that period—where "psychiatrically related" is initially defined as having a primary or secondary psychiatric diagnosis (codes 290-319) for the ED visit. A second subpopulation of youth having ED visits with medical diagnoses having a psychosomatic component will be further defined at a later point.

Without a complete definition of the second subpopulation of youth with a psychosomatic diagnosis component, the enrollee population cannot be clearly defined.

The data for a portion of the study population that is defined is identified via monthly files that the RSN sends to Molina and monthly files that Molina sends to the RSN. The RSN-to-Molina files are extracts of Medicaid eligibility files for a given month. Those enrollees identified as having Molina as their managed care organization (MCO) are linked to RSN data, and enrollees with an outpatient or long-term "carve-out" or who have had psychiatric hospitalization, detention or crisis stabilization service during a given month, are selected. The linked file is sent to Molina monthly. Through the process of linking the RSN enrollment data to the Medicaid enrollment data, KCRSN is able to verify that the individuals are continuously enrolled in Molina during a given period. The Molina-to-RSN that is then returned on a monthly basis shows the ED and hospitalization usage for the dually enrolled individuals.

As there is no clearly defined secondary subpopulation or intervention, there can be no approach or source to collect data related to these pieces of the PIP.

Opportunities for Improvement:
KCRSN needs to fully define the secondary subpopulation and its intervention for the PIP. After all elements are defined, KCRSN needs to articulate its plan for data collection, data sources and evaluation methods used to identify the study population.

Standard 4: Study Indicator Is Objective and Measureable

Table C-18: Validation of PIP Study Indicator

Criterion	Description	Result
4.1	The study uses objective, clearly defined, measurable indicators.	Not Met (fail)
4.2	The indicators track performance over a specified period of time.	Partially Met (pass)
4.3	The number of indicators is adequate to answer the study question, appropriate for the level of complexity of applicable clinical practice guidelines, and appropriate to the availability of and resources to collect necessary data.	Partially Met (pass)

Reviewer Comments:
For this PIP, KCRSN plans to measure the change in the number of dually enrolled youth who experience psychiatrically related ED episodes. KCRSN has not specified the exact method of referral and tracking of the intervention. KCRSN also notes CCORS and Wraparound as possible interventions but does not define any criteria or method for choosing one intervention versus the other. Without all aspects of the intervention thoroughly defined, the indicator cannot be fully defined and measurable.

The baseline measurement will be December 1, 2014–May 31, 2015, and the first re-measurement period will be December 1, 2015–May 31, 2016.

Opportunities for Improvement:
KCRSN needs to completely outline all facets of this PIP, including the secondary diagnosis criteria and intervention, in order to have a clearly defined and measurable indicator.

Standard 5: Sampling Method

Table C-19: Validation of PIP Sampling Methods

Criterion	Description	Result
5.1	The sampling technique considered and specified the true (or estimated) frequency of occurrence of the event, the confidence interval to be used and the acceptable margin of error.	● N/A
5.2	Valid sampling techniques were employed that protected against bias.	● N/A
5.3	The sample contained a sufficient number of enrollees.	● N/A
Reviewer Comments: There were no samples in this study. The entire study population is included in the indicator.		

Standard 6: Data Collection Procedure

Table C-20: Validation of PIP Data Collection Procedures

Criterion	Description	Result
6.1	The study design clearly specifies the data to be collected.	● Not Met (fail)
6.2	The study design clearly specifies the sources of data.	● Not Met (fail)
6.3	The study design specifies a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply.	● Not Met (fail)
6.4	The instruments for data collection provide for consistent and accurate data collection over the time periods studied.	● Not Met (fail)
6.5	The study design prospectively specifies a data analysis plan.	● Partially Met (pass)
6.6	Qualified staff and personnel were used to collect the data.	● Not Met (fail)
Reviewer Comments: Data for the defined portions of the PIP data are collected from three sources: Medicaid eligibility files, RSN enrollment data, and MCO-to-RSN files. Medicaid eligibility data is received through DBHR. There is no explanation of the data source for RSN enrollment data. KCRSN gives a detailed and somewhat complicated explanation of the information transfer between the RSN and Molina. Because there are several key data pieces that are not specified, the study design cannot clearly define all the data to be		

collected.

KCRSN asserts that the data is reliable for this PIP because it is payment/claims data and payment/claims data is considered the "gold standard" for reliable and valid data. Regardless of whether this assertion is true, it is not an acceptable explanation for how the RSN assured that the data was aggregated in an accurate manner. Additionally, Molina's data is only one piece of data collection. KCRSN has not completely defined all of the data elements of the PIP; therefore, a systematic method for collecting valid and reliable data cannot be specified.

KCRSN's plan for analysis is to use McNemar's test for paired ratios to ascertain if there is a statistically significant change in the number of psychiatrically related ED visits among the PIP subpopulation between the baseline and re-measurement periods. A $p<.05$ probability level will be used as the threshold for statistical significance.

KCRSN does not specify which RSN staff members are responsible for its data nor is all the data to be collected fully defined; therefore, it is not possible to know if qualified staff will be used to collect the data.

Opportunities for Improvement:
KCRSN needs to clearly define and explain all the data to be collected for this PIP. KCRSN also needs to fully and clearly describe the data sources, including the RSN's data and those yet to be defined. KCRSN needs to thoroughly articulate its plan to ensure valid and reliable data is collected from all sources.

KCRSN needs to describe the qualification of its staff that is involved in the data collection and analysis of this PIP.

Standard 7: Data Analysis and Interpretation of Study Results

Table C-21: Validation of PIP Data Analysis and Interpretation

Criterion	Description	Result
7.1	An analysis of the findings was performed according to the data analysis plan.	● N/A
7.2	Numerical PIP results and findings were accurately and clearly presented.	● N/A
7.3	The data analysis methodology was appropriate to the study question and data types.	● N/A
7.4	The analysis identified initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity.	● N/A
7.5	The analysis of study data included an interpretation of the extent to which the PIP was successful, as well as follow-up activities.	● N/A
Reviewer Comments: The PIP has not progressed to this stage.		

Standard 8: Appropriate Improvement Strategies

Table C-22: Validation of PIP Improvement Strategies

Criterion	Description	Result
8.1	A continuous cycle of measurement and performance analysis was conducted.	● N/A
8.2	Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes.	● N/A
8.3	The interventions are/were sufficient to be expected to improve processes or outcomes.	● N/A
8.4	The interventions are/were culturally and linguistically appropriate.	● N/A
Reviewer Comments: The PIP has not progressed to this stage.		

Standard 9: Assess Whether Improvement Is "Real" Improvement

Table C-23: Validation of PIP Improvement Assessment

Criterion	Description	Result
9.1	The same methodology as the baseline measurement was used when measurement was repeated.	● N/A
9.2	There was documented, quantitative improvement in processes or outcomes of care.	● N/A
9.3	The reported improvement in performance appears to be the result of the planned quality improvement intervention.	● N/A
9.4	There is statistical evidence that any observed performance improvement is true improvement.	● N/A
Reviewer Comments: The PIP has not progressed to this point.		

Standard 10: The RSN Has Sustained the Documented Improvement

Table C-24: Validation of PIP Sustained Improvement

Criterion	Description	Result
10.1	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	● N/A
Reviewer Comments: The PIP has not progressed to this point.		

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Information Systems Capabilities Assessment (ISCA)

Qualis Health's subcontractor, Healthy People, examined KCRSN's information systems and data processing and reporting procedures to determine the extent to which they supported the production of valid and reliable State performance measures and the capacity to manage care of RSN enrollees.

ISCA Methodology

The ISCA procedures were based on the CMS protocol for this activity, as adapted for the Washington RSNs with DBHR's approval. For each ISCA review area, Healthy People used the information collected in the ISCA data collection tool, responses to interview questions, and results of the claims/encounter walkthroughs and security walkthroughs to rate the RSN's performance for seven review areas. Rankings are based on the following: fully meeting, partially meeting or not meeting standards. Although not rated, the RSN's meaningful use of EHR systems was also evaluated.

The ISCA review process consists of four phases:

Phase 1: Standard information about RSN's information systems is collected. The RSN and two of its delegated provider agencies complete the ISCA data collection tool before the onsite 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: Onsite visits and walkthroughs with the RSN and two delegated provider agencies are conducted. Claims/encounter walkthroughs and data center security walkthroughs are conducted. In-depth interviews with knowledgeable RSN staff and delegated provider agency staff are conducted. Additional documents are requested if needed, based upon interviews and walkthroughs completed at the RSN and at two delegated provider agencies.

Phase 4: Analysis of the findings from the RSN's information system onsite review commences. In this phase, the material and findings from the first three phases are reviewed and in cooperation with the RSN and selected delegate provider agencies to close out any open review questions. The RSN-specific ISCA evaluation report is then finalized.

The following sections discuss the specific criteria for assessing compliance for each of the eight ISCA review areas.

Section A: Information Systems

This section assesses the RSN's information systems for collecting, storing, analyzing and reporting medical data by member, practitioner and vendor. Information systems that facilitate valid and reliable performance measurement have the following characteristics:

- flexible data structures

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

To ensure accurate and complete performance measure calculation, appropriate practices in computer programming should include

- good documentation
- clear, continuous communication between the client and the programmers on client information needs
- a quality assurance process version control
- continuous professional development of programming staff

Section B: Hardware Systems

This section assesses the RSN's hardware systems and network infrastructure. Appropriate protocol for sustaining quality hardware systems include

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

Section C: Information Security

This section assesses the security of the RSN's information systems. Appropriate practices for securing data include

- Maintaining a well-run security management program that includes IT governance, risk assessment, policy development, policy dissemination and monitoring. Each of these activities should flow into the next to ensure that policies remain current and that important risks are addressed.
- Protecting computer systems and terminals from unauthorized access through use of a password system and security screens. Passwords should be changed frequently and reset whenever an employee terminates.
- Securing paper-based claims and encounters in locked storage facilities when not in use. Data transferred between systems/locations should be encrypted.
- Utilizing a comprehensive backup plan that includes scheduling, rotation, verification, retention and storage of backups to provide additional security in the event of a system crash or compromised integrity of the data. Managers responsible for processing claims and encounter data must be knowledgeable of their backup schedules and of retention of backups to ensure data integrity.

- Verifying integrity of backups periodically by performing a “restore” and comparing the results. Ideally, annual backups would be kept for seven years or more in an offsite climate-controlled facility.
- Ensuring databases and database updates include transaction management, commits and rollbacks. Transaction management is useful when making multiple changes in the database to ensure that all changes work without errors before finalizing the changes. A database commit is a command for committing a permanent change or update to the database. A rollback is a method for tracking changes before they have been physically committed to disk. This prevents corruption of the database during a sudden crash or some other unintentional intervention.
- Employing formal controls in the form of batch control sheets or assignment of a batch control number to ensure a full accounting of all claims received.

Section 11.2 of DBHR’s RSN contract presents requirements related to Business Continuity and Disaster Recovery (BC/DR). The contractor must certify annually that a BC/DR plan is in place for both the contractor and subcontractors. The certification must indicate that the plans are up to date and that the system and data backup and recovery procedures have been tested. The plan must address these criteria:

- a mission or scope statement
- an appointed IS disaster recovery staff
- provisions for backup of key personnel, identified emergency procedures and visibly listed emergency telephone numbers
- procedures for allowing effective communication with hardware and software vendors
- confirmation of updated system and operations documentation, as well as process for frequent backup of systems and data
- offsite storage of system and data backups, ability to recover data and systems from backup files, and designated recovery options that may include use of a hot or cold site
- evidence that disaster recovery tests or drills have been performed

Exhibit C of the RSN contract presents detailed requirements for data security, including

- data protection during electronic transport, including via email and the public Internet
- safeguarding access to data stored on hard media (hard disk drives, network server disks and optical discs), on paper or on portable devices or media, and access to data used interactively over the State Governmental Network
- segregation of DSHS data from non-DSHS data to ensure that all DSHS data can be identified for return or destruction, and to aid in determining whether DSHS data has or may have been compromised in the event of a security breach
- data disposition (return to DSHS or destruction) when the contracted work has been completed or when data is no longer needed
- notification of DSHS in the event of compromise or potential compromise of DSHS shared data
- sharing of DSHS data with subcontractors

Section D: Medical Services Data

This section assesses the RSN’s ability to capture and report accurate medical services data. To ensure the validity and timeliness of the encounter and claims data used in calculating performance measures, it is important to have documented standards, a formal quality assurance of input data sources and transactional systems, and readily available historical data.

Appropriate practices include

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

Section E: Enrollment Data

This section assesses the RSN's ability to capture and report accurate Medicaid enrollment data. Timely and accurate eligibility data are paramount in providing high-quality care and for monitoring services reported in utilization reports.

Appropriate enrollment data management practices include

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

Section F: Practitioner Data

This section assesses the RSN's ability to capture and report accurate practitioner information. RSNs need to ensure accuracy in capturing rendering practitioner type as well as practitioner service location. RSNs also need to be able to uniquely identify each of their practitioners. RSNs must also present accurate practitioner information within the RSN provider directory.

Section G: Vendor Data

This section assesses the quality and completeness of the vendor data captured by the RSN. The majority of each RSN's claims/encounter data is contracted provider agency data. RSNs must perform encounter data validation audits at least annually for each of their contracted provider agencies. RSNs must also evaluate the timeliness of the claims/encounter data submitted to their agency by their vendors.

Section H: Meaningful Use of Electronic Health Records (EHR)

This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not rated. This review section evaluates the following:

- any planning and/or development efforts the RSN has taken toward adopting and using a certified EHR system
- number of providers in the RSN network currently using EHRs
- whether any EHR technology in use by the RSN has been verified as certified by the appropriate Federal body
- any training, education or outreach the RSN has delivered to network providers on the meaningful use of certified EHR technology
- whether the RSN uses data from EHRs as part of its quality improvement program (i.e., to improve the quality of services delivered or to develop PIPs)
- strategies or policies the RSN has developed to encourage the adoption of EHR by providers

Scoring Criteria

For each ISCA review area, the information collected in the ISCA data collection tool, responses to interview questions and results of the claims/encounter walkthroughs, as well as security walkthroughs were used to rate the RSN's performance. The rating was applied to the review areas specified in this chapter below and ranked as fully meeting, partially meeting or not meeting standards. The RSN's meaningful use of Electronic Health Records (EHR) systems was reviewed but is not rated. The table below presents the scoring key for the ISCA standards.

Table D-1: Scoring Key for ISCA Standards

Scoring Icon Key			
● Fully Met (pass)	● Partially Met (pass)	● Not Met (fail)	● N/A (not applicable)

Summary of Results

Healthy People examined King County RSN's information systems and data processing and reporting procedures to determine the extent to which they supported the production of valid and reliable State performance measures and the capacity to manage care of RSN enrollees.

KCRSN *fully met* the Federal standards related to information systems capabilities. Table D-2 presents KCRSN's ratings for the eight separate ISCA review areas.

Table D-2: ISCA Scores by Section

ISCA Section	Description	ISCA Result

A. Information Systems	This section assesses the RSN's information systems for collecting, storing, analyzing and reporting medical, member, practitioner and vendor data.	Fully Met (pass)
B. Hardware Systems	This section assesses the RSN's hardware systems and network infrastructure.	Fully Met (pass)
C. Information Security	This section assesses the security of the RSN's information systems.	Fully Met (pass)
D. Medical Services Data	This section assesses the RSN's ability to capture and report accurate medical services data.	Fully Met (pass)
E. Enrollment Data	This section assesses the RSN's ability to capture and report accurate Medicaid enrollment data.	Fully Met (pass)
F. Practitioner Data	This section assesses the RSN's ability to capture and report accurate practitioner information.	Fully Met (pass)
G. Vendor Data	This section assesses the quality and completeness of the vendor data captured by the RSN.	Fully Met (pass)
H. Meaningful Use of EHR	This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not scored.	N/A

KCRSN and its contracted provider agencies use a custom encounter data processing system, Mental Health Chemical Abuse and Dependency Services Division Information System (MHCADSD-IS), using IBM Informix Dynamic Server. Encounter processing is fully automated with authorizations for all but the highest level of care. KCRSN's encounter data processing servers reside at a Sabey Corp. co-location facility in Seattle.

The detailed KCRSN ISCA review findings for each of the eight ISCA review areas will be presented in the following sections of this report.

ISCA Section A: Information Systems

Table D-3: Information Systems

Section	Description	Result

Section A	This section assesses the RSN's information systems for collecting, storing, analyzing and reporting medical, member, practitioner and vendor data.	● Fully Met (pass)

KCRSN and its contracted provider agencies use a custom encounter data processing system, Mental Health Chemical Abuse and Dependency Services Division Information System (MHCADSD-IS), using an IBM Informix Dynamic Server. Encounter processing is fully automated with authorizations for all but the highest level of care.

To ensure proper administration, maintenance and quality assurance for MHCADSD-IS, KCRSN employs six full-time, experienced, well-trained staff members. KCRSN staff is responsible for implementing encounter data changes in the MHCADSD-IS.

KCRSN uses Microsoft Team Foundation Server (TFS), a software configuration management tool, to manage software development changes. When code is revised, the KCRSN developer "checks out" the file, makes the modifications, and checks it back in. The check-in requires that comments be entered that describe the change. When an entire computer program is ready to be released into production, the entire set of source code that constitutes the release is marked. This allows KCRSN to track which files (and revision numbers) were used in each release.

MHCADSD-IS database servers use transaction logging to record database transactions. The server keeps a record of each change that it makes to the database during a transaction. In the event of a system failure, the database server automatically uses the records to reverse the changes and return the database to the pre-failure state.

Outpatient encounter data are submitted by provider agencies through the HIPAA 837P transactions. HIPAA-compliant software identifies all missing, incomplete or invalid data elements in 837P transactions, rejects invalid data segments, and reports them to the submitter in the 997 Functional Acknowledgment transactions. The software uses either HIPAA standards or external code sources identified by HIPAA to determine the validity of the submitted codes. In addition, a batch error report generated for each legacy service transaction batch that is created from 837P transactions identifies transactions that do not meet the format or code values described in the Provider Transaction section of the MHCADSD Data Dictionary.

Inpatient encounter data are submitted by provider agencies through an online application developed by KCRSN IS staff. The application notifies the user if any of the required fields are missing or invalid. Any flagged data has to be corrected in order to post to KCRSN's IS database. The application uses either IS established codes or external code sources to determine the validity of the submitted codes.

Twelve of KCRSN's 19 contracted provider agencies during 2014 used EHRs. Some of KCRSN's larger provider agencies provided data submission services to smaller agencies that did not have the requisite IT infrastructure.

KCRSN's provider agencies request authorization for outpatient and inpatient services through MHCADSD-IS. The system automatically approves or denies all cases rated "2b" and below, using edits and validity checks programmed into MHCADSD-IS. KCRSN's credentialed clinical care staff performs authorization decisions manually for all "3b" cases, using information submitted by the agencies and

DBHR's Access to Care Standards.

KCRSN's encounter data processing servers reside at a Sabey Corp. co-location facility in Seattle.

Meets Criteria

ISCA Section B: Hardware Systems

Table D-4: Hardware Systems

Section	Description	Result
Section B	This section assesses the RSN's hardware systems and network infrastructure.	● Fully Met (pass)

In 2014, KCRSN's Medicaid-related data resided on a Hewlett-Packard Linux server. King County's data center is located at a Sabey Corp. co-location facility in Seattle.

KCRSN had a Hewlett-Packard "Support Plus 24" support contract on its production HP Linux server for all of 2014. This contract covers hardware maintenance and operating system technical support and guarantees a four-hour response time for critical issues. The coverage is in force continuously, including weekends and holidays.

KCRSN connects to the Internet through the county's network. The county monitors and manages the security of the network environment. KCRSN uses the private Inter-Governmental Network to connect to DBHR's Consumer Information System (CIS) and other applications.

Meets Criteria

ISCA Section C: Information Security

Table D-5: Information Security

Section	Description	Result
Section C	This section assesses the security of the RSN's information systems.	● Fully Met (pass)

KCRSN has multiple policies and procedures related to information security. KCRSN and King County information security policies and procedures are all fully compliant.

During 2014, KCRSN data backups were handled in the following manner:

- Encrypted backup tapes were created every day.

- One day of the week there was a full backup; on the other six days backup occurred incrementally.
- On a daily basis the backup tapes were transported to a secure offsite tape storage facility.
- Incremental backup tapes were retained for three months; full backup tapes were retained for one year.

KCRSN contracts with the State of Washington to provide an alternate data center in Olympia. The alternate data center has a Hewlett-Packard Unix server that can be used in the case of an emergency. Also, the data that is stored on KCRSN's primary Linux server is stored on a redundant array of independent disks (RAID)-configured disk array so that if one of the hard drives fails there will be no loss of data.

The county maintains a disaster recovery plan, including a formal auditing and testing process to ensure that information systems can be maintained, resumed and/or recovered as intended.

Encryption requirements were included in the 2014 KCRSN administrative provider agency site visit tool.

Meets Criteria

ISCA Section D: Medical Services Data

Table D-6: Medical Services Data

Section	Description	Result
Section D	This section assesses the RSN's ability to capture and report accurate medical services data.	● Fully Met (pass)

KCRSN accepts encounter data from its provider agencies in electronic format. During processing, encounter data submissions run through an automated, rules-based edit system to screen the data, identify potential input errors, and ensure compliance with DBHR's Data Dictionary and Service Encounter Reporting Instructions (SERI). KCRSN performs further edits and validity checks of procedure and diagnosis code fields, eligibility, service authorization and detection of duplicate encounter claims. Screened encounter data submissions are converted into a HIPAA-compliant 837 format before transmission to DBHR via a secure shell connection once a month. KCRSN's regional administrator is responsible for ensuring that the RSN complies with State Medicaid reporting requirements.

KCRSN uses PowerBuilder, Informix 4GL, SQL Server Integration Services, and SQL Server Reporting to store and provide reports for all service and encounter data. Microsoft Access is also used.

Opportunity for Improvement

KCRSN captures only the intake evaluation diagnosis when processing encounter data.

- It is recommended that KCRSN capture more than the intake evaluation diagnosis. However, it is not out of compliance with DBHR requirements to only capture the intake evaluation diagnosis.

ISCA Section E: Enrollment Data

Table D-7: Enrollment Data

Section	Description	Result
Section E	This section assesses the RSN's ability to capture and report accurate Medicaid enrollment data.	● Fully Met (pass)
DBHR provides member enrollment data to KCRSN. KCRSN receives 834 and 820/821 enrollment data files from DBHR. KCRSN extracts DBHR Medicaid eligibility files and loads them into MHCADSD-IS once a week. KCRSN uses a monthly reconciliation process to verify the eligibility data provided by DBHR against data submitted by providers. KCRSN provider agencies use MHCADSD-IS and the ProviderOne web portal to verify eligibility.		

Meets Criteria

ISCA Section F: Practitioner Data

Table D-8: Practitioner Data

Section	Description	Result
Section F	This section assesses the RSN's ability to capture and report accurate practitioner information.	● Fully Met (pass)
KCRSN claims/encounter reporting is accurate regarding both rendering practitioner type and practitioner service location. KCRSN also has accurate practitioner information within the RSN provider directory. KCRSN maintains up-to-date provider profile information in an accessible repository that enables the RSN's member services staff to help Medicaid enrollees make informed decisions about access to providers that can meet their special care needs, such as non-English languages or clinical specialties. KCRSN's subcontracted provider agencies deliver current practitioner changes to KCRSN on a periodic basis.		

Meets Criteria

ISCA Section G: Vendor Data

Table D-9: Vendor Data

Section	Description	Result
Section G	This section assesses the quality and completeness of the vendor data captured by the RSN.	Fully Met (pass)
KCRSN's claims/encounter data is contracted provider agency data; KCRSN does not provide any direct client care. As reported in the KCRSN 2014 Encounter Data Validation report, a plan was implemented to provide follow-up technical assistance to provider agencies that did not meet the 95% match rate. The focus of the technical assistance was congruence between the KCRSN contract monitoring team scoring and provider agency staff scoring of the same encounters.		

Meets Criteria

ISCA Section H: Meaningful Use of Electronic Health Records (EHR)

Table D-10: Meaningful Use of EHR

Section	Description	Result
Section H	This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not rated.	Not Rated
This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not scored. KCRSN has a process for testing with provider data systems during provider agency EHR implementation. KCRSN is monitoring data for quality, completeness and accuracy throughout EHR implementation, including a post-implementation review. KCRSN also provides technical assistance to each of its contracted agencies for EHR implementation.		

Meets Criteria

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Encounter Data Validation (EDV)

Encounter data validation (EDV) is a process used to validate encounter data submitted by Regional Support Networks (RSNs) to Washington State (the State). Encounter data are electronic records of the services provided to Medicaid enrollees by providers under contract with an RSN. Encounter data are used by RSNs 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 RSNs.

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

- Service Encounter Reporting Instructions (SERI) in effect for the date range of encounters reviewed
- The Consumer Information System (CIS) Data Dictionary for RSNs
- Health Care Authority Encounter Data Reporting Guide for Managed Care Organizations, Qualified Health Home Lead Entities, Regional Support Networks
- The 837 Encounter Data Companion Guide ANSI ASC X12N (Version 5010) Professional and Institutional, State of Washington
- Prior year's EQR report(s) on validating encounter data

After reviewing the State's data processes and standards, Qualis Health reviewed the RSN's capacity to produce accurate and complete encounter data, including a review of the most recent Information System Capabilities Assessment (ISCA) performed by an external quality review organization (EQRO).

Following the standards review and ISCA, Qualis Health performed three additional activities supporting a complete encounter data validation. First, Qualis Health performed a validation of encounter data received by the state from the RSNs. Second, Qualis Health conducted a review of the procedures and results of each RSN's internal EDV required under each RSN's contract with the State. Finally, Qualis Health conducted an independent validation of State encounter data matched against provider-level clinical record documentation to confirm the findings of the RSN's internal EDV.

State-level Encounter Data Validation

Qualis Health analyzed encounter data submitted by the RSNs 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 RSNs have 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 RSNs 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 fit with 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
- Analyzing and interpreting 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

Validating RSN EDV Procedures

Qualis Health performed independent validation of the procedures used by the RSNs to perform encounter data validation. The EDV requirements included in the RSNs' contract with Division of Behavioral Health and Recovery (DBHR) were the standards for validation.

Qualis Health obtained and reviewed each RSN's encounter data validation report submitted to DBHR as a contract deliverable for calendar year 2014. The RSN's 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 RSN's encounter and/or enrollee sampling procedures were reviewed to ensure conformance with accepted statistical methods for random selection.

Each RSN 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 RSN 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.

Clinical Record Reviews

Qualis Health performed clinical record reviews onsite at provider agencies that had contracts with the RSNs. 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 a custom database to record the scores for each encounter data field
- Providing the RSN with a list of the enrollees whose clinical charts were selected for review for coordination with contracted provider agencies pursuant to the onsite 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 the RSN to DBHR for encounters for which dates of service fell within the same time period.

Scoring Criteria

Table E-1: Scoring Scheme for Encounter Data Validation Standards

Scoring Icon Key			
● Fully Met (pass)	● Partially Met (pass)	● Not Met (fail)	● N/A (not applicable)

King County RSN Encounter Data Validation

King County RSN contracts with 19 community mental health providers for Medicaid-funded services. The EDV process for King County was conducted between the dates of April 19, 2014, and August 21, 2014. A total of 4,680 encounters were reviewed, for an overall average of 246 encounters per community mental health agency (CMHA).

Table E-2: Scores and Ratings on RSN's Encounter Data Validation

EDV Standard	Description	EDV Result
Sampling Procedure	Sampling was conducted using an appropriate random selection process and was of adequate size.	● Fully Met (pass)
Review Tools	Review and analysis tools are appropriate for the task and used correctly.	● Partially Met (pass)
Methodology and Analytic Procedures	The analytical and scoring methodologies are sound and all encounter data elements requiring review are examined.	● Fully Met (pass)
Opportunities for Improvement Qualis Health recommends KCRSN compare the data in enrollee charts with data processed by ProviderOne. Doing so can help the RSN ensure that its encounter data are received and processed as expected, enabling the RSN to address any data errors in a timely manner. Qualis Health recommends entering EDV results directly into the Access database, rather than		

recording results on paper and later conducting data entry. This would save time and reduce the risk of data entry error.

Sampling Procedure

Qualis Health reviewed the sampling procedure and overall sample size to evaluate King County RSN's adherence to the contractually required sampling methodology.

The time frame covered for the study period was the 12 months prior to the site visit at a CMHA. Site visits were scheduled at 19 CMHAs from April 9, 2015, through August 21, 2015.

The standard for the study was to review the 12 most recent encounters. In some instances, one or two more encounters for one or more individuals were reviewed to reach the identified number of encounters to review for a provider. Also, the period of review may have been extended if the person was continuously served by the provider and had fewer than 20 services within 12 months. Services reviewed were those that occurred at least 30 days prior to the site visit to adjust for the time lag of reporting the encounter to the RSN and documenting the service in the clinical record.

The RSN used a random sample that was drawn from the King County Mental Health Plan (KCMHP) Information System (IS), which contains the demographic, authorization and service encounter data submitted by the CMHAs via batch transactions for all clients enrolled in KCMHP services. These data were compared to data in each CMHA's clinical case records.

Qualis Health recommends that KCRSN compare the data in enrollee charts with data processed by ProviderOne. Doing so can help the RSN ensure that its encounter data are received and processed as expected, enabling the RSN to address any data errors in a timely manner.

Review Tools

KCRSN conducted the reviews while on site at the agencies. KCRSN used a hybrid paper and electronic system to monitor and score EDV activities. Data sheets were generated for each client listing the service encounters (including the elements of the encounter—date, provider, type of service, service location, etc.) to be reviewed. The data sheets were used to review the documentation in the clinical records of those encounters, and to identify any encounters in the record for which encounter data had not been submitted. The onsite findings were recorded directly on those data sheets. After the review, results were manually entered from the paper sheets to the Access database. It is unclear whether there is any double-entry or similar control for data entry accuracy. Qualis Health recommends entering EDV results directly in the Access database, rather than recording the results twice, which could risk data entry errors.

Methodology and Analytic Procedures

The following criteria were used to score the records:

1) *Match*: Exact matches exist for all the minimum data elements in each randomly selected sample between the subcontractor's encounters and those in the clinical records.

2) *No Match*: Subcontractor's encounters do not match those in the clinical records.
a) *Erroneous*: Encounter is presented by an electronic record, but contains incorrect data or is missing

any of the minimum data elements.

b) *Missing*: Clinical record contains evidence of a service but is not represented by an electronic record.

c) *Unsubstantiated*: Encounter is submitted by subcontractor but cannot be verified in the electronic record.

The EDV review team consisted of five contract monitors. All EDV review team members receive annual training prior to the onsite reviews and participate in the development of review tools. They are also apprised of any updates to review requirements by the State.

The DBHR contract calls for the following minimum set of encounter data fields to be validated:

- Date of service
- Name of service provider
- Procedure code
- Minutes of service
- Service location
- Provider type
- Service code agrees with treatment described

Qualis Health Encounter Data Validation

Results are presented for each of the EDV activities performed, including electronic data checks of demographic and encounter data provided by DBHR, onsite reviews comparing electronic data to data included in the clinical record, and a comparison of Qualis Health's EDV findings to the internal findings reported by the RSN to DBHR for the same encounter date range.

Table E-3: Scores and Ratings on Qualis Health Encounter Data Validation

EDV Standard	Description	EDV Result
Electronic Data Checks	Full review of encounter data submitted to the state indicates no (or minimal) logic problems or out-of-range values.	Fully Met (pass)
Onsite Clinical Record Review	State encounter data are substantiated in 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). A passing score is that 95% of the encounter data fields in the clinical records match.	Not Met (fail)
Recommendation Requiring CAP Encounter data did not meet the 95% standard for compliance. • To ensure encounter data are substantiated and in compliance, the RSN needs to o Provide training on the Service Encounter Reporting Instructions (SERI): on coding, on		

what is included and excluded in each modality, and on the general encounter reporting instructions
- Provide training on what services can be encountered and what services cannot
- Provide training on who can provide services that are encountered
- Provide training on medical necessity to ensure that services provided and encountered are medically necessary and cannot be provided by some other means
- Provide training on standards of documentation
- Monitor encounters more closely to ensure that the encounters submitted are accurate and well documented

Electronic Data Checks

Qualis Health analysts reviewed all demographic details and encounters for King County RSN from ProviderOne for the October 2013 through September 2014 reporting period, comprising 38,760 patients and 1,018,162 encounters. Fields for each encounter were checked for completeness and to determine if the values were within expected ranges. Results of the electronic data checks are provided in Table E-4.

While nearly all demographic fields passed logic and consistency checks, Qualis Health observed the following results:

- KCRSN does not appear to be collecting language data, as virtually all individuals were missing language entries. This represents 99% of the missing language data for the state.
- Two reporting unit IDs (RUIDs) were unidentified (24 and 80), resulting in 2% of records being incomplete for King County RSN. There were no missing values for the missing RUIDs, so if those RUIDs are not errors then the agency ID field would be 100% complete.
- 4.6% of the encounters were identified as duplicates (all encounter fields identical except claim number). However, due to the size of King County, the RSN accounted for 16.0% of the duplicate entries statewide.
- All sexual orientation data were present, but 24.5% of the values were “Unknown, patient refused.” KCRSN is the top-performing RSN in terms of having specific answers to that question.

KCRSN’s demographic and encounter data error rates were minimal. Other than Social Security Number (an optional field), nearly all fields were 100% accurate when checked for logical consistency and completeness.

Table E-4: Results of Qualis Health’s Encounter Data Validation

Measure	State Standard	RSN Performance
Demographic Data		
RSN ID	100% complete, all values in range	100%
Consumer ID	100% complete	100%
First Name	100% complete	100%
Last Name	100% complete	100%
Date of Birth	Optional	100%
Gender	Optional	100%
Ethnicity/Race	100% complete, all values in range	100%

Language Preference	100% complete, all values in range	0.1%
Social Security Number	Optional	83.5%
Sexual Orientation	100% complete	100%
	Encounter Data	
RSN ID	100% complete, all values in range	100%
Consumer ID	100% complete, all values in range	100%
Agency ID	100% complete, all values in range	98.0%
Primary Diagnosis	100% complete	100%
Service Date	100% complete	100%
Service Location	100% complete, all values in range	100%
Provider Type	100% complete, all values in range	100%
Procedure Code	100% complete	100%
Claim Number	100% complete	100%
Minutes of Service	100% complete	100%

Clinical Record Review

Qualis Health reviewed 438 encounters submitted by KCRSN to ProviderOne with a service date between October 1, 2013, and September 30, 2014, as well as demographic records associated with the 139 individuals whose encounters were included in the sample. Reviewers compared data from database extracts provided by DBHR to data included in the clinical records. Qualis Health reviewed encounter data fields required for review in the RSN contract with DBHR, including

- Date of service
- Name of service provider
- Procedure code
- Service units/duration
- Service location
- Provider type
- Verification that the service code agrees with the treatment described in the encounter documentation

Qualis Health reviewed all demographics fields delineated in the CIS Consumer Demographics native transaction as described in the most current CIS Data Dictionary, including

- First name
- Last name
- Gender
- Date of birth
- Ethnicity/Race
- Hispanic origin
- Preferred language
- Social Security Number
- Sexual orientation

Site Visit Results

Results of the comparison of demographic data included in the clinical record to demographic data extracted from the DBHR CIS system are shown in Table E-5.

The match rates for two demographic fields were 100% and above 95% for two other fields. The fields where the scores were below the 95% match rates included Ethnicity, Hispanic Origin, Language, Social Security Number and Sexual Orientation. For Ethnicity, Hispanic Origin and Language, the majority of errors appeared to be the result of data entry, where the values included in the clinical records differed from the values submitted by the provider agency. Social Security Number was missing from both databases for about a quarter of the records, and Sexual Orientation was missing from the client chart in another quarter of cases.

Results of the comparison of encounter data included in the clinical record to encounter data extracted from the ProviderOne database are shown in Table E-6.
The highest rates of mismatch were seen for procedure codes and clinical note. Qualis Health reviewers found several issues contributing to the no-match rate. Some of the observed discrepancies are

- Discovery of activities entered as encounters that do not qualify as encounters
- Lack of clinical documentation for services
- Incorrect coding

The comparison of the encounter field match rates from the Qualis Health review with the match rates from the KCRSN internal EDV is shown in Table E-8. For several fields, the Qualis Health review was substantially below KCRSN's result. Variance in the results may be partially explained by the following:

- A difference in Qualis Health and KCRSN encounter review. Qualis Health encounter review not only included whether the encounter data points matched, but also whether the encounter met the service encounter reporting instructions (SERI) or Washington Administrative Code (WAC) requirements and whether the encounter was a service that could be encountered.
- A lack of training and knowledge of encounter review elements, encounter submissions and documentation standards.
- The different sample sets reviewed. Qualis Health did not review the same sample encounters as KCRSN.

Table E-5: Demographic Data Validation

Demographic Data (N = 139)				
Field	**Match**	**No Match – Erroneous**	**No Match – Missing**	**No Match – Unsubstantiated**
Last Name	100.00%	0.00%	0.00%	0.00%
First Name	97.84%	2.16%	0.00%	0.00%
Gender	97.84%	2.16%	0.00%	0.00%
Date of Birth	100.00%	0.00%	0.00%	0.00%
Ethnicity/Race	91.37%	8.63%	0.00%	0.00%
Hispanic Origin	89.21%	10.07%	0.00%	0.00%
Preferred Language	0.72%	0.00%	0.72%	0.72%

Social Security Number	76.98%	4.32%	9.35%	8.63%
Sexual Orientation	82.73%	16.55%	0.00%	0.00%

Table E-6: Encounter Data Validation

Encounter Data (N = 438)				
Field	**Match**	**No Match – Erroneous**	**No Match – Missing**	**No Match – Unsubstantiated**
Procedure Code	40.87%	53.20%	0.00%	5.94%
Date of Service	94.52%	0.91%	0.00%	4.57%
Service Location	89.73%	3.20%	0.00%	7.08%
Service Duration	83.11%	10.96%	0.00%	5.94%
Provider Agency	94.29%	0.23%	0.00%	5.48%
Provider Type	84.02%	10.96%	0.00%	5.02%
Clinical Note Matches Procedure Code	28.54%	71.46%	0.00%	0.00%

Table E-7: Comparison of Qualis Health and RSN Demographics Data Validation Results

Field	**Qualis Health Match**	**RSN Match**	**Variance**
Last Name	100.00%	--	
First Name	97.84%	--	
Gender	97.84%	--	
Date of Birth	100.00%	--	
Ethnicity/Race	91.37%	--	
Hispanic Origin	89.21%	--	
Preferred Language	0.72%	--	
Social Security Number	76.98%	--	
Sexual Orientation	82.73%	--	

Table E-8: Comparison of Qualis Health and RSN Encounter Data Validation Results

Field	**Qualis Health Match**	**RSN Match**	**Variance**
Procedure Code	40.87%	84.00%	-43.13%
Date of Service	94.52%	85.00%	9.52%
Service Location	89.73%	80.00%	9.73%
Service Duration	83.11%	83.00%	0.11%
Provider Agency	94.29%	84.00%	10.29%
Provider Type	84.02%	84.00%	0.02%
Clinical Note Matches Procedure Code	28.54%	--	

Discussion

The KCRSN EDV processes related to sampling appear adequate to meet the requirements of the RSN's contract with DBHR.

For several encounter fields, Qualis Health found a substantial level of disagreement between encounter data extracted from ProviderOne and data included in the clinical record. These discrepancies between the clinical records of providers and encounter data in ProviderOne are substantially higher than what KCRSN found through its internal EDV reviews. Discrepancies for the difference in KCRSN's internal review and Qualis Health's review could have multiple factors contributing. One factor that could potentially be accounted for is the different sample sets reviewed. Qualis Health did not review the same encounters as KCRSN. Another factor that could have potentially contributed to the variance is the process by which KCRSN conducts the encounter review compared to that of Qualis Health. Within Qualis Health's review, data elements may have matched the encounter; however, there were elements of the encounter that did not follow the State's SERI or WAC requirements, contained documentation that did not match the code that was submitted, or did not reflect a service that should have been submitted. Examples include the following:

- Encountering 99211 instead of 96372 for injections
- Encountering psychotherapy, but the documentation does not support psychotherapy
- Submitting requests for services with multiple issues, such as always submitting with provider type 8 regardless of the clinician's credentials, or with no corresponding progress note or documentation.
- Submitting encounters for attending the medication review with the client
- Submitting evaluation and management (E&M) codes with multiple units
- Location code not matching documentation
- Special population consultations being encountered as an assessment (H0031)
- Encountering non-encounterable services such as faxing, records requests, texting, sending and receiving emails, cancelling or rescheduling an appointment, fishing, playing board games, joining a bowling group, leaving a voicemail
- Encountering outpatient codes while the client is in jail
- Encountering co-occurring services without the HH modifier
- Submitting day support encounters without clinical documentation. Documentation of day support activities stated "socialized and lunch," "active/lunch," "stable without incident", and "participated without incident"
- Documentation of intakes not containing all encounter elements such as location, duration, procedure code and provider type
- Submitting H0046 for services over 9 minutes
- Submitting H0034, mediation training and support, instead of an E&M code
- Submitting H0004, behavioral counseling and therapy, for a treatment review when the client was not present
- Having no documentation of T1001 in the clinical record
- Submitting family therapy documentation that does not support family therapy
- Encountering outpatient services prior to intake

- Inappropriate bundling
- Encountering H0025, behavioral health prevention education service, without supporting documentation
- Documentation not containing enough information to determine an encounterable service
- Submitting an encounter when the service did not occur
- Submitting encounters that do not show medical necessity
- Encountering family therapy conducted via phone
- Submitting peer services with the incorrect provider type
- Location code not matching
- Submitting encounters for treatment of dementia and Alzheimer's disease without discussing how the client could benefit from treatment of their mental health

Recommendation Requiring CAP

Encounter data did not meet the 95% standard for compliance.

- To ensure encounter data are substantiated and in compliance, the RSN needs to
    - Provide training on the Service Encounter Reporting Instructions (SERI): on coding, on what is included and excluded in each modality and on the general encounter reporting instructions
    - Provide training on what services can be encountered and what services cannot
    - Provide training on who can provide services that are encountered
    - Provide training on medical necessity to ensure that services provided and encountered are medically necessary and cannot be provided by some other means
    - Provide training on standards of documentation
    - Monitor encounters more closely to ensure that the encounters submitted are accurate and well documented

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Appendix A: Previous Year Findings and Recommendations

CFR	Prior Year Findings, Recommendations, Opportunities	RSN Activity Since the Prior Year	Current Status
Information on grievance process and time frame—§438.100(b); §438.10(g)(1) and (3)	KCRSN has not updated its policies and procedures on grievances, appeals and fair hearings since the State made significant changes to the complaint and grievance system in 2013. KCRSN needs to update its policies and procedures, website and member brochure to reflect recent changes in grievance, appeal and State fair hearing processes.	KCRSN submitted revised policies and procedures to DBHR in 2015.	Resolved
Record keeping and reporting requirements—§438.416	KCRSN does not monitor and report all grievances in its network provider-level system and does not analyze the type, frequency, and resolution of grievances as part of its QA/PI process to ensure that trends and systematic issues are appropriately addressed. KCRSN needs to monitor and report all grievances in its network provider-level system, and analyze the type, frequency, and resolution of grievances as part of the RSN's QA/PI process to ensure that trends and systematic issues are appropriately addressed.	KCRSN is now collecting and monitoring grievances.	Resolved

Appendix B: All Recommendations Requiring Corrective Action Plans (CAPs)

Compliance with Regulatory and Contractual Standards

Section 1: Availability of Services

Recommendation Requiring CAP
Although KCRSN monitors the provider agencies' policies and procedures for enrollees to receive second opinions, the RSN lacks a mechanism for monitoring requests for second opinions.

1. KCRSN needs to implement a process for monitoring requests for second opinions.

Section 2: Coordination of Care

N/A

Section 3: Coverage and Authorization of Services

N/A

Section 4: Provider Selection

N/A

Section 5: Subcontractual Relationships and Delegation

N/A

Section 6: Practice Guidelines

Recommendation Requiring CAP
Although KCRSN has documentation that shows utilization management decisions and other decisions are based on the outcomes of practice guidelines, the RSN lacks policies and procedures regarding the adoption of practice guidelines, dissemination of the guidelines, decisions for utilization management, enrollee education, coverage of services and other areas.

2. KCRSN needs to develop and implement policies and procedures that address the adoption of practice guidelines, the dissemination of the practice guidelines and how utilization management, enrollee education, coverage of services and other areas are based on and are consistent with the guidelines.

Section 7: Quality Assessment and Performance Improvement Program

N/A

Section 8: Health Information Systems

N/A

Performance Improvement Project (PIP) Validation

Clinical PIP Validation:

Recommendation Requiring CAP
Because all of the data is readily available for aggregation and analysis, it is unclear what the full purpose of this PIP is. Setting up a monitoring system related to the already occurring intent of the TSP is not a PIP if it doesn't utilize any strategies that seek to implement changes to processes and/or interventions that will ultimately improve the indicator.

3. KCRSN needs to consider implementing specific interventions beyond the current TSP practices if the RSN seeks to use the program for a PIP. KCRSN needs to either rework this PIP so that the study topic, study question and intervention truly assess performance improvement and not program evaluation, or it needs to adopt a new PIP that will assess and improve a process and thereby an outcome of care.

Non-clinical PIP Validation:

Recommendation Requiring CAP
This PIP, in its current design, is not fully formulated.

4. KCRSN needs to fully formulate this PIP, which includes getting stakeholder input regarding the study topic, study population, intervention and the study question. The study question needs to be written in a clear, concise and measurable manner. The intervention needs to be stated clearly and needs to measure improvement. KCRSN needs to be mindful of the difference between performance improvement and performance evaluation, taking care that this study is a true PIP that introduces a novel intervention and does not solely monitor and evaluate a program's already existing intervention.

Information Systems Capabilities Assessment (ISCA)

There were no Recommendations Requiring CAP for the Information Systems Capabilities Assessment (ISCA).

Encounter Data Validation (EDV)

Recommendation Requiring CAP
Encounter data did not meet the 95% standard for compliance.

5. To ensure encounter data are substantiated and in compliance, the RSN needs to
    - Provide training on the Service Encounter Reporting Instructions (SERI): on coding, on what is included and excluded in each modality, and on the general encounter reporting instructions
    - Provide training on what services can be encountered and what services cannot
    - Provide training on who can provide services that are encountered

- Provide training on medical necessity to ensure that services provided and encountered are medically necessary and cannot be provided by some other means
- Provide training on standards of documentation
- Monitor encounters more closely to ensure that the encounters submitted are accurate and well documented

Appendix C: Acronyms

BC/DR	Business Continuity and Disaster Recovery
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CIS	Consumer Information System
CMHA	Community Mental Health Agency
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DBHR	Department of Social and Health Services, Division of Behavioral Health and Recovery
E&M	Evaluation and Management
EDI	Electronic Data Interchange
EDV	Encounter Data Validation
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
HCA	Health Care Authority
HCPCS	Healthcare Common Procedural Coding System
ISCA	Information System Capability Assessment
KCMHP	King County Mental Health Plan
MCO	Managed Care Organization
MHCADSD-IS	Mental Health Chemical Abuse and Dependency Services Division Information System
MMIS	Medicaid Management Information System
PAHP	Prepaid Ambulatory Health Plans
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QIC	Quality Improvement Committee
QRT	Quality Review Team
RAID	Redundant Array of Independent Disks
RSN	Regional Support Network
RUID	Reporting Unit ID
SERI	Service Encounter Reporting Instructions
TFS	Team Foundation Server
WAC	Washington Administrative Code