



Optum Pierce Regional Support Network
External Quality Review Report
Division of Behavioral Health and Recovery

January 2016



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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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Introduction

This report presents the 2015 results of the external quality review of Optum Pierce 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.

Optum Pierce RSN (OPRSN) coordinates mental health services for Medicaid participants enrolled in managed care plans in Pierce County. OPRSN does not provide any direct client services; however, it provides financial and administrative oversight for the direct client services that are provided to enrollees through a network of treatment providers in Pierce County. The RSN is operated by OptumHealth, a privately held subsidiary of UnitedHealth Group.

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, onsite 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 Optum Pierce Regional Support Network (OPRSN).

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	438.210	 Fully Met (pass)

Services		
Section 4. Provider Selection	438.214	● Fully Met (pass)
Section 5. Subcontractual Relationships and Delegation	438.230	● Fully Met (pass)
Section 6. Practice Guidelines	438.236	● Fully Met (pass)
Section 7. Quality Assessment and Performance Improvement Program	438.240	● Partially 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: Effects of the WISe Model on Caregiver Strain	● Not Met (fail)	Low Confidence in Reported Results
Non-Clinical PIP: Reduction of RTF Average Length of Stay	● N/A	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
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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	● Partially Met (pass)
Review Tools	Review and analysis tools are appropriate for the task and used correctly	● Not Met (fail)
Methodology and Analytic Procedures	The analytical and scoring methodologies are sound and all encounter data elements requiring review are examined	● Not Met (fail)

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 is 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 (WAC) 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	● Fully Met (pass)
Section 5. Subcontractual Relationships and Delegation	438.230	● Fully Met (pass)
Section 6. Practice Guidelines	438.236	● Fully Met (pass)
Section 7. Quality Assessment and Performance Improvement Program	438.240	● Partially 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

- OPRSN's provider agencies expressed, through interviews, that they have experienced at least a 50% increase in enrollment since the implementation of the Affordable Care Act. To help with this increase in enrollment and service requests, OPRSN's provider agencies have initiated same-day walk-in intakes and assessments.
- The RSN uses a monitoring tool and a set of questions to track second opinions and the processes used when seeking a second opinion.
- OPRSN out-of-network policy is concise and requires that all out-of-network requests go through the RSN for approval.
- OPRSN has a very robust process for ensuring providers are meeting State standards for timely access to care and services.

- The RSN's provider agencies are required to submit monthly reports, which include the number of client services delivered and data on access timeliness.
- OPRSN engages in a wide variety of community education and anti-stigma efforts to promote understanding of mental health issues and reduce the stigma associated with seeking mental health services.
- Annually, all OPRSN and contracted provider agencies' staff are required to have a minimum of one hour of training on cultural competency. The RSN offers in-depth training annually and provides the web-based Relias Training Program to all staff and provider agencies.
- OPRSN sponsors community conversations regarding cultural competency, whose participants include law enforcement, mental health, physical health and substance abuse providers, other health systems staff, lawyers and peers.
- OPRSN monitors and assesses cultural competency by reviewing grievances, hours of interpretation, parity by age/ethnicity, clinical records and translated documents.
- OPRSN monitors care coordination through onsite reviews to ensure that documentation of care coordination activities is evident in individuals' clinical records.
- OPRSN has several policies and procedures for identifying and monitoring enrollees with special healthcare needs and ensuring their needs are addressed appropriately and in a timely manner.
- OPRSN works regularly with its county partners such as the local jail and the juvenile department to promote integrated and coordinated care for individuals involved in multiple systems.
- OPRSN's care managers review level of care guidelines and access to care standards, and apply clinical practice guidelines and evidence-based practice guidelines for authorizing requests for services. Care managers are trained to screen for potential cases of fraud and abuse during these reviews and report such cases to the compliance officer or the United Health Group compliance office for further investigation.
- Providers enter requests for outpatient authorizations into the RSN's electronic database. OPRSN then reviews the authorizations to ensure that the services requested meet level of care criteria. If further information is needed, OPRSN consults with the requesting practitioner. All requests for inpatient services are discussed with the referring agent at the time of initial referral.
- OPRSN uses these mechanisms to monitor the inter-rater reliability of clinical staff:
 - intensive mentoring of every care manager during his/her first six months of employment
 - routinely auditing samples of completed inpatient and outpatient authorizations to ensure that care managers consistently comply with Access to Care Standards
 - weekly case consultations with OPRSN's medical director
- To ensure enrollees receive a notice of action when the RSN denies an authorization, the notice is sent via certified mail. If the notice is undeliverable, the RSN will inform and enlist the provider to notify the enrollee.
- OPRSN has a robust process in place pertaining to crisis, stabilization and post-hospital follow-up services.
- In addition to tracking crisis services, OPRSN's care managers review individuals who have had four or more crisis service encounters during the previous month to explore the reasons for the encounters and what routine and outpatient services have or have not been utilized.
- OPRSN's policy and procedure on fraud and abuse states that all contracted providers and RSN employees, directors, volunteers and subcontractors are screened to determine whether they have been listed as ineligible for Federal program participation.
- Interviews with provider agencies validated that the agencies are involved with the development of the practice guidelines, the guidelines are reviewed at the quality management meetings, and the agencies are consulted about the implementation of guidelines.

- The Quality Management Committee minutes indicate that the committee reviewed, discussed and made management decisions on several review activities including clinical record reviews, satisfaction surveys, and analysis of grievances and appeals, access data, authorizations and utilization data.
- To help ensure proper utilization of services, OPRSN monitors utilization reports and performs an annual review of community mental health agencies to determine whether services are provided in a clinically appropriate manner and at the intensity appropriate to each consumer's needs. If services are consistently provided at too high or too low intensity for consumers, it may result in an investigation. Results are reviewed by the Utilization Committee with recommendations going to the Quality Committee.
- Providers are required to submit demographic and interpreter data to the RSN as well as self-reported ethnicity, age, sexual identity, educational level, employment and disability status. OPRSN monitors this information monthly and uses it in reporting to the QA/PI Committee and other internal groups regarding disparities, penetration rates and other concerns.
- OPRSN's information systems generate several reports used to make informed management decisions and identify enrollees' needs. Reports are reviewed by the Utilization and Quality Management Committees. Final reports are reviewed by the RSN's governing board.

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

Section 1: *Availability of Services*

Recommendation Requiring CAP

OPRSN has a policy and process in place for credentialing its own network providers, but it does not have a policy and procedure in place to ensure that out-of-network providers are credentialed.

- OPRSN needs to have a process in place to ensure that if services are provided by an out-of-network provider, the provider meets the same credentialing requirements as in-network providers.

Opportunities for Improvement

OPRSN had few requests for second opinions during 2014, which might indicate enrollees need further education on how to request and obtain second opinions.

- OPRSN should consider providing additional training to the provider agencies' staff to ensure the staff is informing the enrollees of their rights to a second opinion and the process for obtaining a second opinion.

Although OPRSN has a Cultural Competency Committee and has provided trainings on cultural competency in previous years, the RSN stated that because of the planning for the transition to a BHO during 2014, the committee did not meet nor did the RSN provide live cultural competency training.

- To continue to meet the cultural competency needs of its enrollees, OPRSN should resume its Cultural Competency Committee meetings as well as its live cultural competency trainings.

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

N/A

Section 7: Quality Assessment and Performance Improvement Program**Opportunity for Improvement**

OPRSN is not in compliance with the State Quality Strategy plan as the State does not have a current plan.

- OPRSN will need to be in compliance with the State Quality Strategy Plan once the State has developed and implemented its plan.

Recommendation Requiring CAP

OPRSN's 2014 quality assessment and performance improvement (QA/PI) work plan summary is quite informative and summarizes both ongoing activities as well as short-term activities. Although the summary lists the results of the activities, the plan does not include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations for the coming year. Including these elements in the QA/PI plan was a recommendation in the 2012 EQRO report.

- OPRSN needs to expand its year-end program evaluation to include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances, service verification and recommendations for the coming year.

Section 8: Health Information Systems

N/A

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)	● Not Met (fail)
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
<p>STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0230 RSN Agreement Section(s) 4.4; 4.9</p>
<p>SCORING CRITERIA</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ The anticipated Medicaid enrollment ○ The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific Medicaid populations represented in the RSN. ○ The numbers and types (training, experience and specialization) of providers required to furnish the contracted Medicaid services ○ The numbers of network providers who are not accepting new Medicaid patients ○ 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.
<p>Reviewer Determination</p> <p>● Fully Met (pass)</p>

Strengths

- Per OPRSN's policy on network adequacy, the RSN's provider relations unit has primary responsibility for developing, managing and monitoring the adequacy of the provider network through the following monitoring activities:
 - analysis of current and projected enrollee and consumer needs
 - analysis of utilization of services
 - review of individual and family input through the quality review team, Ombuds and QA/PI Committee
 - review of grievance trends and analysis
 - review of annual consumer satisfaction survey trends and analysis
 - review of critical incidents involving access to services concerns
 - analysis of current and projected network capacity
 - analysis of geographic location of providers and Medicaid consumers
 - analysis and review of access data
- OPRSN's provider agencies expressed, through interviews, that they have experienced at least a 50% increase in enrollment since the implementation of the Affordable Care Act. To help with this increase in enrollment and service requests, OPRSN's provider agencies have initiated same-day walk-in intakes and assessments.

Second Opinion

<p>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.</p>
<p>STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0355 RSN Agreement Section(s) 9.10</p>
<p>SCORING CRITERIA</p> <ul style="list-style-type: none"> • 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.
<p>Reviewer Determination</p> <p>● Partially Met (pass)</p>

Strengths

- OPRSN has a well-written policy on enrollees obtaining second opinions both inside the network as well as outside the network.
- OPRSN requires all second opinions to be submitted to the RSN for approval.
- The RSN uses a monitoring tool and a set of questions to track second opinions and the processes used when seeking a second opinion.

Opportunity for Improvement

OPRSN had few requests for second opinions during 2014, which might indicate enrollees need further education on how to request and obtain second opinions.

- OPRSN should consider providing additional training to the provider agencies' staff to ensure the staff is informing the enrollees of their rights to a second opinion and the process for obtaining a second opinion.

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 documented process of how out-of-network providers are paid.
- The RSN has a process to track out-of-network encounters and reviews this information for network planning.

Reviewer Determination

- Fully Met (pass)

Strengths

- Interviews with two of OPRSN's providers indicated that the agencies very rarely have requests for services as the OPRSN provider network is very comprehensive. Both agencies indicated that in the past, each had requested services for adolescents with eating disorders.
- OPRSN out-of-network policy is concise and requires that all out-of-network requests go through the RSN for approval.

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

<ul style="list-style-type: none"> • 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.
<p>Reviewer Determination</p> <p>● Fully Met (pass)</p>

Strengths

- OPRSN's policy states that subcontracted and out-of-network mental health services are contracted and paid by the provider agency making the referral.
- OPRSN stated that to its knowledge, no enrollee has received a bill for out-of-network services.

Out-of-Network Provider Credentials

<p>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.</p>
<p>STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0284 RSN Agreement Section(s) 8.6</p>
<p>SCORING CRITERIA</p> <ul style="list-style-type: none"> • The RSN has a process to ensure that out-of-network providers are credentialed.
<p>Reviewer Determination</p> <p>● Not Met (fail)</p>

Recommendation Requiring CAP

OPRSN has a policy and process in place for credentialing its own network providers, but it does not have a policy and procedure in place to ensure that out-of-network providers are credentialed.

- OPRSN needs to have a process in place to ensure that if services are provided by an out-of-network provider, the provider meets the same credentialing requirements as in-network providers.

Furnishing of Services and Timely Access

FEDERAL REGULATION SOURCE(S)**§438.206 I(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

- OPRSN has a very robust process for ensuring providers are meeting State standards for timely access to care and services.
- The RSN's provider agencies are required to submit monthly reports, which include the number of client services delivered and data on access timeliness.
- OPRSN's quality review team does an annual client satisfaction survey. Overall results from the 2014 survey indicated a decrease in client satisfaction for access to services, which could be the result of the network's 50% increase in enrollees over the past two years. The RSN is working

with its providers to help implement mechanisms to recruit additional staff to meet the access and timeliness to services needs due to the huge increase in its network's population.

Furnishing of Services and Cultural Considerations

<p>FEDERAL REGULATION SOURCE(S) §438.206 Availability of services I(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.</p>
<p>STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0200 RSN Agreement Section(s) 1.16; 4.4.2.</p>
<p>SCORING CRITERIA</p> <ul style="list-style-type: none"> • 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).
<p>Reviewer Determination</p> <p>● Fully Met (pass)</p>

Strengths

- OPRSN engages in a wide variety of community education and anti-stigma efforts to promote understanding of mental health issues and reduce the stigma associated with seeking mental health services.
- Annually, all OPRSN and contracted provider agencies' staff are required to have a minimum of one hour of training on cultural competency. The RSN offers in-depth training annually and provides the web-based Relias Training Program to all staff and provider agencies.
- OPRSN sponsors community conversations regarding cultural competency, whose participants include law enforcement, mental health, physical health and substance abuse providers, other health systems staff, lawyers and peers.
- OPRSN monitors and assesses cultural competency by reviewing grievances, hours of interpretation, parity by age/ethnicity, clinical records and translated documents.

Opportunity for Improvement

Although OPRSN has a Cultural Competency Committee and has provided trainings on cultural competency in previous years, the RSN stated that because of the planning for the transition to a BHO during 2014, the committee did not meet nor did the RSN provide live cultural competency training.

- To continue to meet the cultural competency needs of its enrollees, OPRSN should resume its Cultural Competency Committee meetings as well as its live cultural competency trainings.

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 l(1)(2)	● Fully Met (pass)
Treatment Plans	438.208l(3)	● Fully Met (pass)
Direct Access to Specialists	438.208 l(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

- OPRSN monitors care coordination through onsite reviews to ensure that documentation of care coordination activities is evident in individuals' clinical records.
- The specific items reviewed in the clinical record include the following:
 - individual signed releases of information to the primary care provider (PCP) and other medical providers
 - a letter, completed Early and Periodic Screening, Diagnosis and Treatment (EPSDT) form, or other treatment notification form to the PCP
 - a current list of medications and conditions that might impact the individual's physical or mental level of function
 - if authorized, the documentation of the individual's communication with the PCP, including when communication took place, a general description of information shared and the method of communication
 - documentation of the individual's refusal to sign Release of Information forms, if applicable
 - documentation of coordination of care functions in the individual's Individual Service Plan (ISP), as needed

Additional Services for Enrollees with Special Healthcare Needs**FEDERAL REGULATION SOURCE(S)****§438.208 I(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)

Strength

- OPRSN has several policies and procedures for identifying and monitoring enrollees with special healthcare needs and ensuring their needs are addressed appropriately and in a timely manner.

Treatment Plans

FEDERAL REGULATION SOURCE(S)

§438.208 I(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)

Strengths

- OPRSN works regularly with the local jail, juvenile department and inpatient psychiatric departments to promote integrated and coordinated care for individuals involved in multiple systems.
- OPRSN ensures that community mental health agencies (CMHAs) are communicating with all systems involved in the treatment of the enrollee through clinical record and service reviews.
- OPRSN monitors treatment plans through annual and concurrent reviews of randomly selected records to ensure that treatment plans include the enrollees' voice and provide for coordination of any additional care services.
- OPRSN staff includes clinicians with child, geriatric and minority specialty credentials.
- The RSN uses the interpretation language line to communicate with non-English speakers and offers TDD for hearing-impaired callers.

Direct Access**FEDERAL REGULATION SOURCE(S)****§438.208 I(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)

Strengths

- OPRSN monitors for incorporation of specialist recommendations through its annual clinical record and service review processes.
- OPRSN's policy on providing direct access to specialists states that all authorization requests for specialists are covered when services are clinically necessary. In the event that the existing provider panel cannot meet an enrollee's mental healthcare need, OPRSN will help identify an appropriate provider outside the network.
- Interviews with the provider agencies indicated that requests for direct access to specialists are very rare but when requested are usually approved by the RSN.

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)	● Fully Met (pass)
Notice of Adverse Action	438.210 l	● 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)

Strengths

- In determining authorizations, OPRSN's care managers consider medical necessity, statewide Access to Care Standards, OPRSN level of care criteria, information on the provider's authorization request, consideration of less restrictive alternatives and utilization management information.
- OPRSN's care managers review level of care guidelines and access to care standards, and apply clinical practice guidelines and evidence-based practice guidelines for authorizing requests for authorization. Care managers are trained to screen for potential cases of fraud and abuse during these reviews and report such cases to the compliance officer.
- All OPRSN care managers are licensed mental health professionals. For children, outpatient authorization decisions are made only by child specialists.
- All child inpatient authorization approvals are made by the OPRSN medical director, who is a child psychiatrist. All inpatient denials for adults are made by the OPRSN medical director.
- Providers enter requests for outpatient authorizations into the RSN's electronic database. OPRSN then reviews the authorizations to ensure that the services requested meet level of care criteria. If further information is needed, OPRSN consults with the requesting practitioner. All requests for inpatient services are discussed with the referring agent at the time of initial referral.

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 REGU'ATION / 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

- Fully Met (pass)

Strength

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

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)

Strength

- To ensure enrollees receive a notice of action when the RSN denies an authorization, the notice is sent via certified mail. If the notice is undeliverable, the RSN will inform and enlist the provider to notify the enrollee.

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)

Strengths

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

- Provider agencies stated that the turnaround time for standard authorizations is well within the three-day timeline and that the turnaround time for requests for expedited decisions are within 24 hours.

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)

Strengths

- OPRSN's policy on fraud and abuse states that the RSN does not provide additional compensation or incentives to providers for reducing the volume of Medicaid services provided or of services funded by other Federal or State healthcare programs.
- The policy also states OPRSN does not contract with entities that provide physician incentive plans.

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

<p>(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, AHP or applicable State entity of the enrollee's screening and treatment within 10 'calendar days of presentation for emergency services.</p> <p>(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.</p> <p>(3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for—</p> <p>(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 “managed care organization” must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section.</p> <p>(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.</p>
<p>STATE REGULATION / RSN AGREEMENT SOURCE(S)</p> <p>RSN Agreement Section(s) 5.2</p>
<p>SCORING CRITERIA</p> <ul style="list-style-type: none"> • 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.
<p>Reviewer Determination</p> <p>● Fully Met (pass)</p>

Strengths

- OPRSN has a robust process in place pertaining to crisis, stabilization and post-hospital follow-up services.
- In addition to tracking crisis services, OPRSN’s care managers review individuals who have had four or more crisis service encounters during the previous month to explore the reasons for the encounters and what routine and outpatient services have or have not been utilized.

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)	● Fully Met (pass)
Overall Result for Section 4.		● Fully 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 policies and processes.

Reviewer Determination

- Fully Met (pass)

Strengths

- OPRSN has a well-written policy on credentialing and re-credentialing.
- OPRSN monitors provider credentials initially upon a provider joining the network and annually during the clinical and administrative onsite reviews. Providers also submit an updated Practitioner Report monthly that lists the credentials, license(s) and practice specialties of its clinical staff.

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)

Strengths

- OPRSN's policy on non-discrimination states that the RSN does not deny participation for particular community mental health agencies (CMHAs) who serve high-risk mental health enrollees/individuals or specialize in mental health conditions that require costly treatment.
- The policy also states:
 - All OPRSN staff are advised of this policy and are responsible for reading, understanding and adhering to this standard.
 - OPRSN has not and will not terminate a mental healthcare provider because she/he advocated on behalf of an enrollee; filed a complaint against OPRSN; appealed a decision of OPRSN; requested a review or challenged a termination decision.

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.
- The RSN ensures that the RSN does not knowingly have on staff or on the governing board a person with beneficial ownership of more than 5% of the RSN's equity.
- The RSN's provider contracts include the provision that providers not knowingly have a director, officer, partner or person with a beneficial ownership of more than 5% of the agency's equity.

Reviewer Determination

- Fully Met (pass)

Strengths

- OPRSN's policy and procedure on fraud and abuse states that all contracted providers and RSN employees, directors, volunteers and subcontractors are screened to determine whether they have been listed as ineligible for Federal program participation.

- OPRSN's QA/PI manager performs monthly exclusion checks on all employees and contractors.
- OPRSN's contracts prohibit the provider from knowingly having a director, officer, partner or person with a beneficial ownership of more than 5% of the RSN's equity.
- Providers may not hire, contract or consult with individuals or organizations that have been debarred, suspended or otherwise excluded by any Federal agency.

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

<p>FEDERAL REGULATION SOURCE(S)</p> <p>§438.230 Subcontractual Relationships and Delegation</p> <p>(a) General rule. The State must ensure, through its contracts, that each MCO, PIHP and PAHP—</p> <p>(1) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and</p> <p>(2) Meets the conditions of paragraph (b) of this section.</p> <p>(b) Specific conditions.</p> <p>(1) Before any delegation, each MCO, PIHP and PAHP evaluates the prospective subcontractor's ability to perform the activities to be delegated.</p> <p>(2) There is a written agreement that—</p> <p>(i) Specifies the activities and report responsibilities delegated to the subcontractor; and</p> <p>(ii) Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.</p> <p>(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.</p> <p>(4) If any MCO, PIHP or PAHP identifies deficiencies or areas for improvement, the MCO, PIHP or PAHP and the subcontractor take corrective action.</p>
<p>STATE REGULATION / RSN AGREEMENT SOURCE(S)</p> <p>WAC 388-865-0284</p>

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

- Interviews with OPRSN's provider agencies indicated that the providers are well aware of the activities the RSN had delegated to the agencies. The providers stated, and review of contracts confirmed, that the provider contracts specify the activities to be delegated, reporting responsibilities and sanctions for inadequate performance.
- OPRSN monitors the agencies' compliance with the delegated activities by performing annual administrative, financial and clinical reviews, and reviewing the agencies' grievance logs, deliverables and month-end reports.
- Results are given to OPRSN's various committees to review and make management decisions concerning any need for corrective action plans.

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)	● Fully Met (pass)
Dissemination	438.236 (c)	● Fully Met (pass)
Application	438.236 (d)	● Fully Met (pass)
Overall Result for Section 6.		● Fully 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

- Fully Met (pass)

Strength

- Two of OPRSN's practice guidelines are "Coordination between Outpatient and Inpatient Provider" and "Primary Care Integration." The guidelines are reviewed and updated annually.

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 <ul style="list-style-type: none"> • 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  Fully Met (pass)

Strength

- Interviews with provider agencies validated that the agencies are involved with the development of the practice guidelines, the guidelines are reviewed at the quality management meetings, and the agencies are consulted about the implementation of guidelines.

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 <ul style="list-style-type: none"> • 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  Fully Met (pass)

Strength

- OPRSN submitted Quality Management Committee minutes regarding decisions for utilization management, enrollee education, coverage of services and other areas to which the guidelines apply.

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)	● Partially 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.		● Partially 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

- Partially Met (pass)

Strengths

- OPRSN has a very active Quality Management Committee, which meets regularly to perform quality assessment and process improvement on data collected through several venues.
- The Quality Management Committee minutes indicate that the committee reviewed, discussed and made management decisions on several review activities including clinical record reviews, satisfaction surveys, and analysis of grievances and appeals, access data, authorizations and utilization data.

Opportunity for Improvement

OPRSN is not in compliance with the State Quality Strategy plan as the State does not have a current plan.

- OPRSN will need to be in compliance with the State Quality Strategy Plan once the State has developed and implemented its plan.

Recommendation Requiring CAP

OPRSN's 2014 quality assessment and performance improvement (QA/PI) work plan summary is quite informative and summarizes both ongoing activities as well as short-term activities. Although the summary lists the results of the activities, the plan does not include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations for the coming year. Including these elements in the QA/PI plan was a recommendation in the 2012 EQRO report.

- OPRSN needs to expand its year-end program evaluation to include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances, service verification and recommendations for the coming year.

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.

<p>STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0280; 388-865-0320 RSN Agreement Section(s) 7.9; 7.10</p>
<p>SCORING CRITERIA</p> <ul style="list-style-type: none"> • 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.
<p>Reviewer Determination</p> <p>● Fully Met (pass)</p>

Meets Criteria

Mechanisms to Detect Under- and Overutilization of Services

<p>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.</p>
<p>STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0280; 388-865-0320 RSN Agreement Section(s) 7.9; 7.10</p>
<p>SCORING CRITERIA</p> <ul style="list-style-type: none"> • 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.
<p>Reviewer Determination</p> <p>● Fully Met (pass)</p>

Strength

- To help ensure proper utilization of services, OPRSN monitors utilization reports and performs an annual review of community mental health agencies to determine whether services are provided in a clinically appropriate manner and at the intensity appropriate to each consumer's needs. If

services are consistently provided at too high or too low intensity for consumers, it may result in an investigation. Results are reviewed by the Utilization Committee with recommendations going to the Quality Committee.

Mechanism to Assess the Quality and Appropriateness of Care

<p>FEDERAL REGULATION SOURCE(S)</p> <p>§438.240 (b)(4): Quality Assessment and Performance Improvement Program</p> <p>(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:</p> <p>(4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs.</p>
<p>STATE REGULATION / RSN AGREEMENT SOURCE(S)</p> <p>WAC 388-865-0280; 388-865-0320</p> <p>RSN Agreement Section(s) 7.9; 7.10</p>
<p>SCORING CRITERIA</p> <ul style="list-style-type: none"> • 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.
<p>Reviewer Determination</p> <p>● Fully Met (pass)</p>

Strengths

- OPRSN has several mechanisms to assess the quality and appropriateness of care furnished to enrollees, including reviewing and analyzing grievances and appeals, satisfaction surveys, outpatient delivery service timelines and agencies' adherence to clinical guidelines.
- Providers are required to submit demographic and interpreter data to the RSN as well as self-reported ethnicity, age, sexual identity, educational level, employment and disability status. OPRSN monitors this information monthly and uses it in reporting to the QA/PI Committee and other internal groups regarding disparities, penetration rates and other concerns.
- OPRSN has a process in place to monitor corrective actions plans at least every three months. If the RSN sees no improvement at the agency level regarding corrective action plans, the issues are brought to the executive team meetings and advisory board meetings. If the RSN continues to see no improvements, the next steps may involve financial penalties and possible termination of the agency contract.

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

General Rule

<p>FEDERAL REGULATION SOURCE(S)</p> <p>§438.242 (a): Health Information Systems</p> <p>(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.</p>
<p>STATE REGULATION / RSN AGREEMENT SOURCE(S)</p> <p>WAC 388-865-0275</p> <p>RSN Agreement Section(s) 11</p>
<p>SCORING CRITERIA</p> <ul style="list-style-type: none"> • 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.
<p>Reviewer Determination</p> <p>● Fully Met (pass)</p>

Strength

- OPRSN's information systems generate several reports used to make informed management decisions and identify enrollees' needs. Reports are reviewed by the Utilization and Quality Management Committees. Final reports are reviewed by the RSN's governing board.

Basic Elements

<p>FEDERAL REGULATION SOURCE(S)</p> <p>§438.242 (b): Health Information Systems</p> <p>(b) Basic elements of a health information system. The State must require, at a minimum, that each MCO and PIHP comply with the following:</p> <p>(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.</p> <p>(2) Ensure that data received from providers is accurate and complete by—</p> <p>(i) Verifying the accuracy and timeliness of reported data;</p> <p>(ii) Screening the data for completeness, logic and consistency; and</p> <p>(iii) Collecting service information in standardized formats to the extent feasible and appropriate.</p> <p>(2) Make all collected data available to the State and upon request to CMS, as required in this subpart.</p>
<p>STATE REGULATION / RSN AGREEMENT SOURCE(S)</p> <p>WAC 388-865-0275</p> <p>RSN Agreement Section(s) 11</p>
<p>SCORING CRITERIA</p> <ul style="list-style-type: none"> • 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.
<p>Reviewer Determination</p> <p>● Fully Met (pass)</p>

Meets Criteria

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

Effects of the WISe Model on Caregiver Strain

Guardians of youth with severe mental disorders face multiple stressors as they seek assistance from professionals. They attempt to juggle appointments and mediate school, primary care, mental health and other system providers while maintaining a household and keeping a full-time job. Brannon, Helfinger and

Foster (2003) found that the type and intensity of stress experienced by families has a direct impact on their selection of mental health services, their input in service planning and their ability to live successfully in the community. Researchers call the stress experienced by many guardians of children and youth with severe emotional disorders “caregiver strain.” Brannon (2013) defines caregiver strain as a “normative response to additional caregiving demands associated with caring for a child with special needs.” In 1997, Brannon noted three distinct dimensions of caregiver strain: objective, subjective externalized and subjective internalized. Objective is characterized by observable demanding occurrences such as time constraints, negative mental and physical health, financial strain, and disruption of family life and relationships. Subjective externalized strain is noted by negative feelings such as anger, frustration, resentment and embarrassment experienced by the caregiver toward the youth. The third is subjective internalized, which is related to negative caregiver feelings such as worry, sadness and fatigue.

OPRSN noted that in July 2014 the RSN provided mental health services to 1,808 unduplicated children and youth. Of those, 31% were enrolled in high-intensity services. OPRSN care managers reviewed data and identified 49 youth who were receiving more than 20 hours of services within that month. At that time, a significant number of children, youth and their families were being flagged to be screened for referral for the highly intensive, evidence-based program known as Wraparound with Intensive Services (WISe). In OPRSN, WISe is provided via contract with Catholic Community Services (CCS).

OPRSN prioritized the topic of caregiver strain for numerous reasons. OPRSN received feedback from a survey on the strengths and needs of children’s mental health services in the RSN. High-intensity/high-needs children and youth are an identified target population of DBHR because of concerns raised by the T.R. vs. Dreyfus lawsuit. There was support for the topic among contractors and consumer organizations. OPRSN believed there was data readily available on enrollees. WISe services provide vital local alternatives to hospitalization and other out-of-home placement.

The study question is “Does implementation of the WISe model decrease caregiver strain as measured by average scores on the Caregiver Strain Questionnaire-Short Form Seven (CSQ-SF7) for caregivers of children and youth enrolled in the WISe program?”

Dates of Study Period:

- First measurement group: December 1, 2014–June 30, 2015
- Intervention: December 1, 2014–July 1, 2015
- Second measurement group: July 1, 2015–December 31, 2015
- Third measurement group: January 1, 2016–June 30, 2016

Table C-3: Clinical PIP Validation Results

Study Design	Activity	Narrative	SCORE
Design	1 Appropriate study topic	The study topic focuses on reducing the stress that can be experienced by caregivers of children and youth in high-intensity mental health services.	● Fully Met (pass)
	2 Clearly defined, answerable study	The study question is “Does implementation of the WISe model	● Not Met (fail)

	question	decrease caregiver strain as measured by average scores on the Caregiver Strain Questionnaire-Short Form Seven (CSQ-SF7) for caregivers of children and youth enrolled in the WISE program?"	
3	Correctly identified study population	The study population is defined as caregivers of children authorized for the WISE model in OPRSN.	● Fully Met (pass)
4	Correctly identified study indicator	The numerator is average total scores on the CGSQ-SF7 completed by caregivers in the study population, and the denominator is all caregivers of children authorized for WISE services in OPRSN who participated in the CGSQ-SF7 at day one of WISE enrollment and day 180 of care.	● Fully Met (pass)
Reviewer Comments:			
OPRSN has selected an appropriate topic of study regarding the reduction of caregiver strain for those with children in intensive mental health services. The study population has been clearly identified as caregivers of children who are authorized for the WISE program and are authorized for and enrolled in services in OPRSN. OPRSN has also correctly identified the indicator with a clear numerator and denominator. The study question, while clear, does not seem to be fully answerable given the limited nature of the PIP. Without comparison data of other interventions it cannot be asserted with certainty that the WISE model is the true reason for the reduction of caregiver strain vs. any other type of intervention applied to a caregiver.			
Implementation	5	Valid sampling technique	No sampling was conducted for this PIP. ● N/A
	6	Accurate/complete data collection	From December 1, 2014, to June 30, 2015, there have been 89 newly authorized WISE children and youth. Of that population only 22 caregivers have completed the initial survey and only five have completed both. The measurement group is too small to complete a meaningful analysis of the data collected. ● Not Met (fail)
	7	Appropriate data analysis/interpretation of study results	The study has not progressed to the point of analysis and interpretation of study results. ● N/A

Reviewer Comments:				
OPRSN did not use sampling techniques for this PIP; all caregivers of children authorized for the WISe program in the Optum Pierce RSN who participated in the CGSQ-SF7 at day one of WISe enrollment and 180 days of care are included in the study population. Only five caregivers completed the two necessary surveys. Five respondents is not a large enough response rate to know if the findings are truly indicative of the entire population.				
Outcomes	8	Appropriate improvement strategies	This study has not progressed to the stage of analysis and comparison for interpretation.	● N/A
	9	Real improvement achieved	This study has not progressed to the stage of analysis and comparison for interpretation.	● N/A
	10	Sustained improvement achieved	This study has not progressed to the stage of analysis and comparison for interpretation.	● N/A
Overall Score				● Not Met (fail)
Reviewer Comments	<p>Strengths: OPRSN's intentions of attempting to look at the reduction of caregiver strain are not without merit. OPRSN has done research and identified a study population that is appropriate.</p> <p>Recommendation Requiring CAP: The PIP needs to focus on an enrollee-related issue that can be measured and for which interventions can be implemented to create improvement. Setting up a simple monitoring system related to one aspect of care is not a performance improvement project if it doesn't seek to truly improve the indicator. The individuals receiving the intervention need to be related to the identified problem, upon which various interventions, not just the program's services, can be tested and applied to create improvement. OPRSN has set up a PIP that only evaluates the effectiveness of the WISe program in relation to caregiver strain. There is no measure of true improvement, just the implementation of WISe as it is required and the potential natural outcome of reduction in caregiver strain.</p> <p>OPRSN needs to explore issues related to access, timeliness and other measurable outcomes for which interventions can be applied after a baseline measurement is taken. These interventions should be in addition to a given program and should have the ability to be tested and applied to create improvement. OPRSN also needs to investigate strategies to improve the number of participants in the study, including when and how caregivers are asked to complete the CGSQ-SF7. OPRSN could also consider adding a third interval/after-care questionnaire in order to measure for sustained improvement vs. the impact that WISe or any intervention has at the point of highest crisis/need. OPRSN should consider whether this is a viable PIP and examine the possibility of ending this PIP early. OPRSN needs to look into working with its stakeholders to select a more robust study question/population that would yield more plentiful and relevant data.</p> <p>Confidence Level: Low Confidence in Reported Results</p>			

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.	● 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)
<p>Reviewer Comments:</p> <p>The study topic was selected through the collection of data and analysis of aspects of specific enrollee needs, care and services. The PIP is also consistent with the demographics and epidemiology of the enrollees. OPRSN noted that in July 2014 the RSN provided mental health services to 1,808 unduplicated children and youth. Of those, 31% were enrolled in high-intensity services. In that same month, RSN care managers reviewed data and identified 49 youth who were receiving more than 20 hours of services. At this time a significant number of children, adolescents and their families were being flagged to be screened for referral to the highly intensive, evidence-based wraparound program called WISE. OPRSN did an excellent job obtaining input from enrollees during the selection of this PIP. OPRSN created a survey about priority areas for potential PIP topics that was distributed to the Consumer and Family Advisory Committee as well as to the RSN-level Quality Assessment and Performance Improvement (QA/PI) Committee. The current performance improvement project has had and will continue to have input from a diverse group of individuals. The organizational structure of the Optum Pierce RSN includes an executive-level position for an individual in behavioral health recovery. The recovery and resiliency unit manager oversees two full-time staff, a family support specialist and a peer support specialist, whose responsibilities include involving individuals in services and involving their families in all aspects and levels of work throughout the Optum Pierce RSN. The Consumer and Family Advisory Committee is facilitated by the peer support specialist and is composed of consumer and family representatives, consumer organization representatives, an Ombuds and quality review team (QRT) members.</p> <p>Meets Criteria</p>		

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.	● Partially Met (pass)
<p>Reviewer Comments: The study question, “Does implementation of the WISe model decrease caregiver strain as measured by average scores on the Caregiver Strain Questionnaire-Short Form Seven (CSQ-SF7) for caregivers of children and youth enrolled in the WISe program?” is clear. However, in order to discover if implementation of the WISe model truly decreases caregiver stress, administering a survey only to WISe participants and only at two intervals does not necessarily answer the question. In the way this study is put together it would be unclear if the specific intervention was the true reason for the change in respondents’ scores or if any type of intervention would have similar results.</p> <p>Opportunities for Improvement: OPRSN needs to create a stronger PIP and/or study question in order to prove that the use of the WISe model itself is the true cause of the reduction in caregiver strain. If OPRSN chooses to continue looking at reducing caregiver strain, the RSN could consider comparing the caregivers exposed to WISe to caregivers with youth in other intensive/higher levels of care and administering the CSQ-SF7 as a standard part of intake and at the time of treatment plan review. OPRSN might also consider adding another re-measurement of caregivers, three to six months after services have ended, in order to measure for true sustainability of the intervention. OPRSN could also choose to end this PIP and pursue another clinical/children-focused PIP.</p>		

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.	● Not Met (fail)
3.3	Appropriate data sources and evaluation methods were used to identify the study population.	● Fully Met (pass)
<p>Reviewer Comments: The study population is clearly defined as caregivers of children and youth who are authorized for the WISe model in OPRSN. The data collection approach was not sufficient to achieve a meaningful response rate. Completion of the questionnaire is optional and is supposed to be completed at intake and at 180 days of service, but there are not many noted directions related to the administration of the initial or 180-</p>		

day questionnaire.

The data sources used to identify the study population were appropriate. ProviderOne and Avatar MSO were used to verify age, Medicaid eligibility within OPRSN and authorization for the WISE model.

Opportunities for Improvement:

OPRSN needs to find an effective way to ensure a sufficient number of respondents. OPRSN should consider changing the completion of the questionnaire from optional to a required part of program participation. This can be accomplished simply by making it part of the routine intake and follow-up process. The questionnaire could be incorporated into the intake paperwork and the 180-day paperwork or another similar interval where other mandatory paperwork is completed. Instead of having the Parent Partner read a brief orientation statement, it might also be helpful to facilitate a more interactive conversation when going over the questionnaire.

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.	● Fully Met (pass)
4.2	The indicators track performance over a specified period of time.	● Fully 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)
<p>Reviewer Comments:</p> <p>OPRSN defined its numerator clearly and objectively as the average of the total scores on the CGSQ-SF7 completed by the caregivers in the study population. The denominator is defined as all caregivers of children authorized for the WISE model in the Optum Pierce RSN who participated in the CGSQ-SF7 at day one of WISE enrollment and again at 180 days of care. OPRSN goes on to specify the caregivers as the primary adult caregiver(s) such as biological parent(s), foster parent(s), legal guardian(s), extended family and natural support(s) living under the same roof as the child authorized for the WISE model in the Optum Pierce RSN. Authorized children are defined as individuals 0 to 21 years of age with Medicaid benefits confirmed by ProviderOne at the time of referral and, thereafter, verified monthly.</p> <p>The indicator is set to be tracked in three measurement groups: the first is December 1, 2014–June 30, 2015; the second is July 1, 2015–December 31, 2015; and the third will be January 1, 2016–June 3, 2016.</p> <p>Meets Criteria</p>		

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; the entire study population is included in the indicator.		

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.	● Fully Met (pass)
6.6	Qualified staff and personnel were used to collect the data.	● Fully Met (pass)
Reviewer Comments: The data is collected by Parent Partners and data entry specialists. The Parent Partner asks the caregiver to complete the questionnaire and, once it is completed, submits it to the CCS office within 12 hours of completion. Within one week of receipt, the CCS data entry specialist transfers the data from paper to an Excel spreadsheet. Accuracy is verified by the specialist's direct supervisor or a second trained data entry specialist. The final sum from the Excel document for each caretaker, as calculated by the formula $CGSQ7=(\text{sum}(Q1:Q4)/4) + (\text{sum}(Q5:Q7)/3)$, is entered into Avatar by the CCS data entry specialist as a score for the purposes of tracking and reporting. On a quarterly basis, copies of all completed		

spreadsheets are securely e-mailed to the assigned information systems (IS) personnel for purposes of additional analysis. An aggregated outcome report is shared on a quarterly basis with the RSN-level QA/PI Committee, WISE program staff and involved family members. Individual progress graphs are sent by IS personnel to the WISE program staff to allow the direct feedback to be shared and discussed with each caregiver completing two or more surveys.

Parent Partners are qualified to work with caregivers to complete the CFSQ-SF7 as certified peer counselors (CPC), having had orientation to the survey form, WISE training led by trainers from Portland State University and directions from their supervisor. Data entry specialists have completed on-the-job training led by their supervisors and WISE training led by Portland State University trainers, and they have the experience of entering data daily in their job duties.

Meets Criteria

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.	● 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 point, and therefore these requirements could not be validated.		

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 this point, and therefore these requirements could not be validated.		

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 this point, and therefore these requirements could not be validated.		

PIP Validation Results: Non-Clinical PIP

Reduction of RTF Average Length of Stay

In August 2014 the Washington State Supreme Court ruled that psychiatric boarding was illegal. This created a statewide need for more evaluation and treatment (E&T) beds. DBHR requested that OPRSN open two additional 16-bed E&T facilities to meet the increased need for inpatient treatment beds in Pierce County and across Washington State. Expanding the number of E&T beds in the area would also

raise the demand for adult residential treatment facility (RTF) beds in OPRSN because individuals being released from the E&Ts could potentially need a lower level of care residential placement. As of December 2014, OPRSN had doubled the number of E&T beds to 64, but the RTF beds remained the same. This, coupled with challenges with long lengths of stay at local RTFs, resulted in fewer options for discharges to lower levels of care.

Between 2009 and 2015, OPRSN has worked to educate RTF residents, coached RTF staff and administrators, provided consultation from out-of-state experts, designated this topic as a regional performance measure, appointed specific RSN staff to focus on the project, used an intensive collaborative community discharge planning team, made early links to Home and Community Services and initialed a differential payment system with a lower residential rate to individuals with higher lengths of stay all in an effort to reduce average lengths of stay in RTFs. Between October 2009 and December 31, 2013, the average length of stay (ALOS) per individual consumer within the RSN went from 1,578.86 days to 983.69 days. In 2013, community mental health agencies "B" and "C" decreased average lengths of stay in their three facilities to 278.97 and 406.95 days, respectively. During the same time period, agency "A," the largest RTF, had an average length of stay of 1,640.35 days, which represents a 590-day drop since its first measure in October 2009. As of June 1, 2015, agencies B and C had maintained an average length of stay of fewer than 18 months or less for two years.

This PIP plans to focus on the addition of clear contract terms and revised level of care guidelines to better define the distinctions in levels of care between congregate care facilities and residential treatment facilities to reduce the average length of stay at an RTF to 18 months or less. At the time the PIP proposal was written the contract was not finalized. OPRSN reported that the PIP planning team was in the process of working with the executive team to recommend adding the following elements to the contract: a specific list of assessments to be completed at entry to care, screens and coordination of services for alcohol and chemical use, prior approval of a daily schedule of activities/care, a requirement of best practices peer-led groups such as Wellness Recovery Action Plan (WRAP) and Hearing Voices, and prior approval of a daily documentation template. The consent to treatment form must describe the RTF as an intensive program that expects individuals to participate in treatment seven days per week, and that will discharge individuals not in need of this intensity of service to a lower level of support in coordination and planning with the individual's treatment plan. The consent will also stipulate that an individual who needs medical care that is beyond the scope of the RTF license will be moved to an appropriate program. With notification to OPRSN, the RTF may place the individual on a non-billable administrative status for brief durations of medical hospitalizations. The non-billable administrative status will allow the contractor to leave the clinical record open while the individual is in this status. (Medical stays beyond 72 hours will require RSN approval.) The contract will require the RTF to record evidence of initial discharge planning within the first 72 hours of admission and follow-up discharge planning throughout the course of treatment. The contract will require the RTFs to provide evidence of an individual's participation in a minimum of 10 hours of treatment activities each week (groups, individual therapy, etc.). It will stipulate the creation of a drug-free environment as evidenced by policies and policy enforcement regarding active intoxication and possession of alcohol and/ or drugs on the premises. The policies will include "in the moment" safety assessments of actively intoxicated individuals as well as notice that this behavior could result in mandatory chemical dependency treatment and/or removal from residential treatment facility level of care.

The study question is "Will the addition of clear contract terms and revised level of care guidelines that better define the distinctions in level of care between congregate care facilities and residential treatment facilities decrease authorized RTF lengths of stay to an average of 18 months or less?"

Dates of Study Period:

First measurement group:	July 1, 2014–September 30, 2015
Intervention	October 1, 2015–March 31, 2016
Second measurement group	April 1, 2016–September 30, 2016
Third measurement group	October 1, 2016–March 2016

Table C-14: Clinical PIP Validation Results

Study Design	Activity	Narrative	SCORE
Design	1	Appropriate study topic	● Not Met (fail)
	2	Clearly defined, answerable study question	● Partially Met (pass)
	3	Correctly identified study population	● Fully Met (pass)

4 Correctly identified study indicator

Operational definition is defined by the following numerator and denominator:

● Fully Met (pass)

Equation 1:

- Numerator = Total bed days used for all authorized RTF consumers at community mental health agency A still open and/or discharged during the period of measurement
- Denominator = Total authorized RTF consumers at community mental health agency A served during the period of measurement

Equation 2:

- Numerator = Total bed days used for all authorized RTF consumers at community mental health agency A that are equal to or over 548 days and still open and/or discharged during the period of measurement
- Denominator = Total authorized RTF consumers at community mental health agency A served during the period of measurement

Equation 3:

- Numerator = Total bed days used for all authorized RTF consumers at community mental health agency A that are equal to 365 to 547 days and are still open and/or discharged during the period of measurement
- Denominator = Total authorized RTF consumers at community

mental health agency A served during the period of measurement

The indicators provide a direct response to the study question by showing the average length of stay of individuals at RTF A on a monthly basis. The indicators are used to describe the population of the RTF A in three categories:

- the average number of bed days of all residents
- the average number of bed days of residents with lengths of stay greater than or equal to 548
- the average number of bed days of residents with lengths of stay between 365 and 547

Reviewer Comments:

OPRSN has successfully decreased overall average length of stay in RTFs within the RSN. All three agencies shown have stayed below, met or made significant improvement toward the goal of having an average length of stay of 18 months or less. Focusing on one agency that dropped its length of stay by an average of 590 days since its first measure in October 2009 does not appear to be a good fit for a study topic.

The study question, while clear and measurable, is problematic in that it seeks to answer whether instituting contract terms and clear guidelines will lead to lowering RTF A's average length of stay. Trend lines show that length of stay is already on the decline, so it would be difficult to judge what is attributable to the root cause: these new elements or previous interventions continuing to work. Also, OPRSN submitted proposed contract language and guidelines with this PIP; depending on the wording of the contract and what becomes a requirement it is possible that success would be mandated, thereby making it challenging to understand the true reason for any change that might occur.

The study population and the study indicator are clearly identified.

Implementation	5	Valid sampling technique	There were no samples in this study. The entire population of agency A is included in the indicator.	● N/A
	6	Accurate/complete data collection	The study is still in its baseline measurement period and has not progressed to this stage.	● N/A
	7	Appropriate data analysis/	The study is still in its baseline measurement period and has	● N/A

	interpretation of study results	not progressed to this stage.	
Reviewer Comments: There are no samples in this study. The entire population of agency A is included in the indicator. The study is still in its baseline period and has not progressed to data collection or analysis.			
Outcomes	8	Appropriate improvement strategies	The study is still in its baseline measurement period and has not progressed to this stage. ● N/A
	9	Real improvement achieved	The study is still in its baseline measurement period and has not progressed to this stage. ● N/A
	10	Sustained improvement achieved	The study is still in its baseline measurement period and has not progressed to this stage. ● N/A
Overall Score			● N/A
Reviewer Comments	<p>Strength: OPRSN has done a significant amount of work to reduce the average length of stay in its RTFs.</p> <p>Recommendation: Because of its prior success related to this topic, the small scope of the current PIP and the nature of the elements of the study question, OPRSN needs to consider whether this PIP is worthy of continuation.</p> <p>Confidence Level: Not enough time has elapsed to assess meaningful change.</p>		

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.	● Partially Met (pass)
1.2	The PIP is consistent with the demographics and epidemiology of the enrollees.	● Not Met (fail)
1.3	The PIP considered input from enrollees with special healthcare needs.	● Partially 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.	● Not Met (fail)
<p>Reviewer Comments:</p> <p>OPRSN collected and analyzed data related to average length of stay of enrollees in RTFs. Data revealed that over time the average length of stay had decreased, showing that this PIP is not consistent with demographics and epidemiology of the RSN's enrollees in terms of relevancy. While some of the rationale for this PIP is based on a survey of Medicaid-enrolled residents at the RTFs that found that 52% would prefer to live in more independent housing and 22% would prefer to live with family, two factors need to be taken into consideration regarding this survey. First, the survey was conducted in 2010, five years ago. Second, while the primary objective is always to have client voice and choice in treatment, there is no mention of whether the clients surveyed were truly capable of living more independently or had the option to live with their families.</p> <p>The PIP does address key aspects of enrollee care and services; nonetheless, the PIP focuses on only one RTF and not all enrollees at all the RTFs.</p> <p>Opportunities for Improvement:</p> <p>OPRSN needs to evaluate whether continuing this PIP is appropriate. Despite the fact that RTF A has not yet met the goal of reducing its average length of stay to less than 18 months, there has already been marked progress among the four RTFs within OPRSN, including RTF A. It should be noted that RTF A started with the highest average and has had the largest decrease per the trend line included in the chart in the PIP self-evaluation that was submitted. OPRSN should conduct a statistical analysis of RTF A's decrease to determine if there has been significant improvement over time, instead of looking at 18 months as the threshold. OPRSN should reflect on whether it is realistic to focus an entire multi-year PIP on one agency that is showing improvement over time and consider other topics related to persistent mental health issues, e.g., inpatient hospitalizations, recidivism, use of peers and emergency room use. OPRSN also has the option of changing its PIP topic completely.</p>		

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)
<p>Reviewer Comments:</p> <p>The study question is "Will the addition of clear contract terms and revised level of care guidelines that better define the distinctions in level of care between congregate care facilities and residential treatment</p>		

facilities decrease authorized RTF lengths of stay to an average of 18 months or less?”

The question is clear, identifies the focus of the PIP and sets the framework for data collection. The question itself is dubious. It cannot fully be judged whether clear guidelines that better identify the difference between levels of care and proposed contract requirements are causing the change or why they are causing the change. If something in the contract mandates an 18-month length of stay, it will inevitably lower the average length of stay to the desired outcome. Further, average length of stay was already something that was a focus for this RSN and was showing consistent decrease over time. It would be difficult to assess the cause of any further decline in length of stay as being anything other than the previous intervention.

Opportunity for Improvement:

OPRSN should consider whether this study question and PIP are appropriate at this time.

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.	● 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)
<p>Reviewer Comments:</p> <p>The study population, though limited, is clearly defined as all consumers authorized for RTF services at community mental health agency A during the time period of the specified measurement. The data collection approach is conducted through OPRSN's Management Information System (MIS) and pulled into monthly reports that are reviewed at the QA/PI meetings on a monthly basis.</p> <p>Meets Criteria</p>		

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.	● Fully Met (pass)

4.2	The indicators track performance over a specified period of time.	● Fully 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)
<p>Reviewer Comments: OPRSN uses a total of three equations with numerators and denominators to define its study indicators.</p> <p>Equation 1:</p> <ul style="list-style-type: none"> • Numerator = Total bed days used for all authorized RTF consumers at community mental health agency A still open and/or discharged during the period of measurement • Denominator = Total authorized RTF consumers at community mental health agency A served during the period of measurement <p>Total bed days, numbers of authorized RTF consumers at community mental health agency A and the period of measurement are specific, clearly defined, measurable, attainable and realistic indicators. The data are collected in a timely manner and reported on a monthly basis.</p> <p>Equation 2:</p> <ul style="list-style-type: none"> • Numerator = Total bed days used for all authorized RTF consumers at community mental health agency A that are equal to or over 548 days and still open and/or discharged during the period of measurement • Denominator = Total authorized RTF consumers at community mental health agency A served during the period of measurement <p>Equation 3:</p> <ul style="list-style-type: none"> • Numerator = Total bed days used for all authorized RTF consumers at community mental health agency A that are equal to 365 to 547 and still open and/or discharged during the period of measurement • Denominator = Total authorized RTF consumers at community mental health agency A served during the period of measurement <p>The indicators are used to describe the population of the RTF A in three categories:</p> <ul style="list-style-type: none"> • the average number of bed days of all residents • the average number of bed days of residents with lengths of stay greater than or equal to 548 • the average number of bed days of residents with lengths of stay between 365 and 547 <p>These indicators are adequate to answer the study question.</p> <p>Meets Criteria</p>		

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 are 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.	● 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.	● Fully Met (pass)
Reviewer Comments: The study design specifies that the data is to be collected through OPRSN with a clearly defined numerator and denominator. The numerator = total bed days used for authorized RTF consumers at community mental health agency A still open and/or discharged during the period of measurement. The denominator = total authorized RTF consumers authorized at community mental health agency A served during the period of measurement. The data is submitted to OPRSN by the eighth day of each month. A Crystal Report pulls the data from the OPRSN MIS. The information feeds a report titled "RTF ALOS," which is incorporated into a monthly quality management report. OPRSN reports that the instruments have not changed since 2010. Instruments are validated for accuracy on an annual basis. OPRSN did not include any kind of prospective data analysis plan in section 6.5 of the PIP self-evaluation		

tool and therefore could not be passed.

The senior reporting analyst, who has a BA in business and over 24 years of experience working in areas in the IT field including reporting and database analysis, finance and logistics, oversees the data collection.

Opportunity for Improvement:

If OPRSN intends to continue with this PIP, a data analysis plan needs to be created that will show if there is statistically significant improvement toward the goal.

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 study is still in its baseline measurement period and 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 study is still in its baseline measurement period and 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 study is still in its baseline measurement period and has not progressed to this stage.		

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 study is still in its baseline measurement period and has not progressed to this stage.		

Information Systems Capabilities Assessment (ISCA)

Qualis Health's subcontractor, Healthy People, examined OptumHealth Pierce 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.

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 are 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 OPRSN'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.

OPRSN *fully met* the Federal standards related to information systems capabilities. Table D-2 presents OPRSN'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

OPRSN directly contracts with Netsmart to provide the same Netsmart Avatar EHR as used by the Washington State RSN-Netsmart Consortium (WSC). Netsmart Technologies, an application service provider (ASP) in Dublin, OH, also remotely hosts the EHR on behalf of OPRSN. Netsmart uses SAVVIS/CenturyLink Communications Corp.'s co-location facilities in Columbus, OH, to host its ASP environment.

The detailed OPRSN 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)
<p>OPRSN and its eight contracted provider agencies use Netsmart's Avatar product suite for encounter data processing. VPN client software and/or hardware appliances are used to authenticate and connect to the environment. Avatar's remotely hosted managed services organization (MSO) and practice management (PM) software applications use the InterSystem Cache database management system. OPRSN uses Crystal Reports, Microsoft SQL, Microsoft Access and Microsoft Excel for additional analysis and reporting of Medicaid data.</p> <p>NetSmart's Avatar product suite is secure, robust and scalable, giving programmers the flexibility to develop sophisticated data processing methods. Netsmart uses Apache Subversion for software configuration and source code (version control) management. Avatar Cache databases use write image journaling to record database transactions. In the event of a system failure, the journal can be replayed up to the point of failure to prevent data loss.</p> <p>In 2014, OPRSN had five team members processing and maintaining the Avatar MSO database. OPRSN actively participates in Netsmart MSO Avatar user group meetings and trainings, which provide information about the Avatar system as well as report changes and updates.</p> <p>Each provider agency either enters claims/encounter data directly into Avatar PM or submits batch information from its in-house EHR system to OPRSN. If a claim/encounter requires an authorization, a valid authorization must be present before it is sent to the RSN. Encounters are batched hourly and sent through an electronic data interchange (EDI) mapping process that screens the data to ensure that all data submission standards, except for verification of eligibility, are met before exporting to Avatar MSO. Claims/encounter data are converted into a HIPAA-compliant 837 format before transmitting to DBHR via a secure shell connection once a month.</p> <p>OPRSN-contracted provider agencies request authorization for outpatient services through Avatar PM, where all authorization data are housed. OPRSN's care management unit processes the authorizations.</p> <p>In 2014, OPRSN and its provider agencies that qualified as health homes had access to the State-developed Predictive Risk Intelligence System (PRISM). OPRSN is currently contracting with its remaining provider agencies that are not also health homes to grant their PRISM access. PRISM integrates information from medical, social service, behavioral health and long-term care payment and assessment data systems. PRISM provides an intuitive and accessible display of beneficiary health and demographic data from administrative data sources. It has proven to be an invaluable tool for providing timely, actionable information to improve care and reduce costs. It should be noted that multiple RSNs, including OPRSN, have indicated that PRISM only allows the RSNs to search the PRISM database one member at a time. The RSNs are interested in having the underlying PRISM database for their membership so that the RSNs can run queries and conduct RSN-wide data analysis on the PRISM data.</p>		

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)
<p>OPRSN and NetSmart maintain current premium-level hardware, software and network service contracts. OPRSN's and Netsmart's data center facilities and hardware systems are well designed and maintained. Netsmart actively monitors its data center facility to identify performance and quality issues.</p> <p>Netsmart replaces server hardware at least every five years. Netsmart's software and hardware designs include redundant array of independent disks (RAID) configuration, connection to a network attached storage (NAS) device, and dual network interface card (NIC) and switch configuration.</p>		

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)
<p>OPRSN has multiple policies and procedures related to information security, all of which are in compliance with UnitedHealth Group's information security requirements, including</p> <ul style="list-style-type: none"> • UnitedHealth Group – Policies – Information Security – 04_0 Physical Security Policy • UnitedHealth Group – Policies – Information Security – 08_0 Access Control Policy • UnitedHealth Group – Policies – Information Security – 03_0 Personnel Security Policy <p>UnitedHealth Group is OptumHealth's parent company. UnitedHealth Group requires that Netsmart, as OptumHealth's contractor, meet Statement on Auditing Standards (SAS) No. 70, Service Organizations standards. SAS 70 audit standards were developed by the American Institute of Certified Public Accountants. UnitedHealth Group requires that Netsmart meet SAS 70 audit standards for both its software and its facilities. UnitedHealth Group's Information Risk Management (IRM) department worked with Netsmart for a year to assist Netsmart with coming into compliance with the SAS 70 standards. In 2014, Netsmart was in compliance with SAS 70 audit standards for both its software and facilities.</p> <p>Netsmart performs daily incremental backups and weekly full backups. All backups performed by Netsmart are encrypted. Netsmart replicates backups to its Kansas City, KS, facility on a nightly basis. Netsmart performs regular restoration testing of backup data to ensure that data are readily available for</p>		

production.

Netsmart's current disaster recovery plan is regularly reviewed, audited and tested to ensure that information systems can be maintained, resumed and/or recovered as intended. Netsmart performs frequent tests to verify the transition from primary to secondary databases.

Netsmart maintains a warm site (backup site from which to operate in the event of a disaster) in Kansas City. Netsmart can switch to the backup site within a short period of time because of the recent implementation of virtual servers.

Netsmart's secure three-tiered application architecture makes it difficult for unauthorized users to gain access to data and other network resources. Netsmart performs regular network scanning for potential vulnerabilities that may result from poor or improper system configuration.

Netsmart's Avatar Cache is protected by a before-image and after-image journaling mechanism. If a system fails, the database structure applies the before-image journal, and all uncommitted transactions are rolled back from the after-image journal.

Netsmart contracts with an outside vendor to perform penetration testing of its network to ensure that proper security measures and safeguards are in place.

In 2014, one of OPRSN's provider agencies was not able to encrypt its system's backup data that contained OPRSN protected health information (PHI). OPRSN has given the provider agency a corrective action plan related to this deficiency.

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)
<p>OPRSN had eight contracted provider community mental health agencies in 2014. Each provider agency either enters claims/encounter data directly into Avatar PM or submits batch information from its in-house EHR system to OPRSN. During processing, encounter data submissions were run through an automated, rules-based edit system in Avatar to screen the data and identify potential input errors, such as validity checks of procedure and diagnosis code fields, as well as to ensure compliance with DBHR-CIS Data Dictionary and Service Encounter Reporting Instructions (SERI).</p> <p>OPRSN's formal procedures for rectifying encounter data submitted with one or more required fields missing, incomplete or invalid are adhered to and well documented. OPRSN uses multiple reports to identify encounter services that should be flagged for transmission to DBHR, and to identify errors. If an</p>		

error occurs, the provider agency is notified promptly via email to correct the error(s) within the Avatar system. Once the agency corrects the error(s), the batch is recreated in Avatar MSO and flagged for transmission to DBHR. As required by DBHR, OPRSN verifies and certifies batched encounter data for accuracy and completeness before transmitting the data to directories in DBHR-CIS.

Meets Criteria

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)
<p>DBHR provides member enrollment data to OPRSN. OPRSN receives 834 and 820/821 enrollment data files from DBHR. OPRSN imports the member enrollment data into an eligibility database. Provider agencies are required to check eligibility by accessing ProviderOne.</p> <p>OPRSN uses Crystal Reports to perform monthly reconciliation activities to verify the authorization status of each encounter service, provider credentials, member monthly eligibility files, member ID codes, and income source and program codes.</p> <p>NetSmart Avatar filters out encounters that do not meet the requirements of the authorization. If the pending authorization is denied, any denied services submitted to OPRSN are not submitted to DBHR via the 837 file submission. Only authorized services are sent to the State. Per State guidelines, authorizations must be approved or denied within 14 days unless an extension is requested, upon which request twelve additional days are granted.</p>		

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)
<p>OPRSN claims/encounter reporting is accurate regarding both rendering practitioner type and practitioner service location. OPRSN also has accurate practitioner information within the RSN provider directory. OPRSN maintains up-to-date provider profile information that enables the RSN's member</p>		

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.

OPRSN's subcontracted provider agencies deliver current practitioner rosters to the RSN 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)
OPRSN's claims/encounter data are contracted provider agency data; OPRSN does not provide any direct client care. In 2014, all of OPRSN's provider agencies met the encounter data validation 95% match rate requirement set by DBHR.		

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
OPRSN provides Netsmart Technology's myAvatar EHR software application to each contracted agency. Netsmart Technology's myAvatar is a Federally certified EHR software application. Currently, none of OPRSN's eight contracted provider agencies use myAvatar as a full EHR. Some of the eight provider agencies do not use myAvatar EHR to any extent. Other provider agencies use it only to enter the data elements they are required to submit to OPRSN for each encounter, instead of using it as a full EHR.		
OPRSN provides training, implementation planning and support to the contracted agencies on myAvatar EHR. OPRSN is also able to accept EDI data from any contracted provider agency that prefers to use its own EHR system. OPRSN is available to test EDI data import with its provider agencies whenever the need arises.		

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)

Optum Pierce RSN Encounter Data Validation

Optum Pierce RSN contracts with eight agencies providing Medicaid-funded services. Audits took place onsite at each agency in the months between June and August 2014. The OPRSN's EDV was based on a sample of 651 client records consisting of 673 service encounters between the dates of October 1, 2013, and April 30, 2014.

Table E-2: Scores and Ratings on OPRSN'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.	 Partially Met (pass)
Review Tools	Review and analysis tools are appropriate for the task and used correctly.	 Not Met (fail)
Methodology and Analytic Procedures	The analytical and scoring methodologies are sound and all encounter data elements requiring review are examined.	 Not Met (fail)
<p>Opportunity for Improvement OPRSN's EDV report only summarized the sampling methodology and did not provide overall results or discussion. The selection of clients was described, but not the selection of encounters for each of the selected clients. Results were provided in a spreadsheet "addendum" that was not easily interpreted.</p> <ul style="list-style-type: none"> The written EDV report should be more complete and cover all aspects of the validation. 		

Recommendation Requiring CAP

OPRSN's report does not include the information necessary to determine whether the EDV was adequate.

- OPRSN needs to provide a more comprehensive description of the review tool and review process.

Sampling Procedure

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

OPRSN sampled from Medicaid-funded encounters that occurred from October 2013 through April 2014 for its eight providers. An overall sample size of 673 encounters was selected, exceeding the contract minimum of 411 encounters. The encounters were drawn from 651 client charts, well exceeding the contract minimum of 100 unique client charts.

The data source for the sample was an extract from the RSN's encounter database. Qualis Health recommends that all RSNs use data received by the State, after loading it into ProviderOne, to ensure that encounter data are received and processed as expected and any errors can be promptly detected and corrected.

OPRSN used a proportional sampling procedure based on agency size, age group composition (including two age groups, one each for children and adults) and authorization type. After determining the minimum overall sample size to achieve a ± 4 -point margin of error (95% confidence level), stratum-specific proportions of the sample frame were used to calculate the desired sample size of encounters from each stratum. The population strata were defined by tabulating the encounters with dates of service between October 2013 and April 2014. Although a sample size of 580 was targeted for the RSN overall, a minimum sample size of 25 for each stratum resulted in the higher final size of 673 encounters.

OPRSN provided a reasonably detailed explanation of the sampling procedure; however, it was unclear whether the values given in the discussion were actual sample-related values or "example" values. The RSN should provide a table indicating the numbers and proportions of clients in the sample frame, by gender, and the number selected for the final sample, for each agency.

It was also unclear how encounters for each client were selected. The sampling methodology only discussed the selection of clients and provided no discussion of how encounters were selected for each selected client. To make the EDV process more efficient, the RSN could select a smaller number of clients and a multiple set of encounters for each client, allowing them to retrieve fewer client charts during the onsite reviews. Ideally, a sequence of encounters would be selected for each client to ensure that all encounters in the RSN (or State) database are present in the chart and that there are no duplicates.

Given the resulting mix of encounters selected across the agency and age group strata, OPRSN's sampling procedure appears to have been adequate for providing an unbiased and representative sample.

Review Tools

Reviews were conducted at the agencies in onsite reviews. The OPRSN report refers only to an addendum, with no discussion of review tools other than a presentation of a spreadsheet summary template of aggregated scores.

OPRSN needs to better describe the EDV review tool, including the process whereby scores are recorded and aggregated. For example, it is unclear whether encounter records were stored in an Access database and taken onsite for the review, or printed out in hard copy.

Methodology and Analytic Procedures

The methods used for onsite reviews were not described in the RSN's EDV report. The scoring framework was described; however, the scoring framework did not include a separate category for "unsubstantiated," indicating that an encounter entry was present in the RSN data extract but not in the client chart. The DBHR contract calls for separate reporting for "match," "no-match," and "unsubstantiated" data elements.

Validation results for OPRSN indicated that all match rates for six of the seven encounter data fields were above the contracted limit of 95%. The overall encounter match rate was reported as 99.8%.

OPRSN's description of the review tool, methodology and procedures are insufficient for assessing the accuracy and completeness of the RSN's EDV data.

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 is 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
 - 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 OPRSN from ProviderOne for the October 2013 through September 2014 reporting period, comprising 17,573 patients and 370,073 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.

OPRSN's demographic and encounter data error rates were minimal. Other than Social Security Number (an optional field), all demographic fields were 100% accurate when checked for logical consistency and completeness. A very small number of encounter records were missing provider type. It should be noted, however, that while acceptable values for sexual orientation were present, 40% of the values were "Unknown, patient refused," the highest percentage among all of the RSNs.

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	100%
Social Security Number	Optional	92.9%
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	100%
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	99.8%
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 OPRSN to ProviderOne with a service date between October 1, 2013, and September 30, 2014, as well as demographics 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 contract, 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
- 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 demographic fields were mixed. Low match rates were found for ethnicity, Hispanic origin and sexual orientation, and mostly indicated that the chart demographic field did not match the extracted field. Each of these demographic fields also had unsubstantiated rates higher than the DBHR-recommended 2%.

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, provider type and clinical note. These errors were primarily due to

- encountering codes that have been discontinued since July 2013
- encountering services that are not services that can be encountered
- submitting documentation that does not include a clinical intervention
- submitting documentation that does not support the code submitted
- encountering a submission that does not follow SERI or WAC requirements
- submitting a code as units when it should be submitted as minutes

The high match rates found by OPRSN's review of demographic fields was not observed in Qualis Health's review, as shown in Table E-7.

The comparison of the total match rate from the Qualis Health encounter review to the total match rate from the OPRSN internal EDV is shown in Table E-8. For most fields, the Qualis Health review was substantially below the RSNs result, which could be a result of the following:

- Differences in the data sources, as the Qualis Health review used selected State encounter records for validation whereas the OPRSN review used RSN records.
- Difference in Qualis Health and OPRSN encounter review. Qualis Health encounter review not only included whether the encounter data points matched, but also included whether the encounter met the SERI or WAC requirements and if the encounter was a service that could be encountered.
- Lack of training and knowledge of encounter review elements and encounter submissions.
- Different sample sets reviewed. Qualis Health did not review the same sample encounters as OPRSN.

Table E-5: Demographic Data Validation

Demographics Data (N = 139)				
Field	Match	No Match– Erroneous	No Match– Missing	No Match– Unsubstantiated
Last Name	97.84%	2.16%	0.00%	0.00%
First Name	100.00%	0.00%	0.00%	0.00%
Gender	98.56%	1.44%	0.00%	0.00%
Date of Birth	99.28%	0.72%	0.00%	0.00%
Ethnicity/Race	83.45%	12.95%	0.00%	3.60%
Hispanic Origin	82.73%	10.07%	0.00%	7.19%
Preferred Language	99.28%	0.72%	0.00%	0.00%
Social Security Number	94.96%	0.00%	0.72%	2.16%
Sexual Orientation	80.58%	12.95%	0.00%	6.47%

Table E-6: Encounter Data Validation

Encounter Data (N = 438)				
Field	Match	No Match– Erroneous	No Match– Missing	No Match – Unsubstantiated
Procedure Code	64.61%	32.65%	0.00%	2.74%
Date of Service	79.91%	18.95%	0.00%	1.14%
Service Location	73.97%	24.43%	0.00%	1.60%
Service Duration	74.20%	23.52%	0.00%	2.28%
Provider Agency	79.91%	18.95%	0.00%	1.14%
Provider Type	67.58%	27.40%	0.00%	2.51%
Clinical Note Matches Procedure Code	57.08%	42.92%	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	97.84%	100.0%	-2.16%
First Name	100.00%	100.0%	0.00%
Gender	98.56%	99.7%	-1.13%
Date of Birth	99.28%	99.9%	-0.57%
Ethnicity/Race	83.45%	98.5%	-15.01%
Hispanic Origin	82.73%	98.8%	-16.04%
Preferred Language	99.28%	99.7%	-0.41%
Social Security Number	94.96%	98.8%	-3.81%
Sexual Orientation	80.58%	98.6%	-18.04%

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

Field	Qualis Health Match	RSN Match	Variance
Procedure Code	64.61%	100.00%	-35.39%
Date of Service	79.91%	100.00%	-20.09%
Service Location	73.97%	100.00%	-26.03%
Service Duration	74.20%	100.00%	-25.80%
Provider Agency	79.91%	100.00%	-20.09%
Provider Type	67.58%	98.96%	-31.38%
Clinical Note Matches Procedure Code	57.08%	100.00%	-42.92%

Discussion

The OPRSN EDV processes related to sampling appear adequate to meet the requirements of the RSN's contract with DBHR; however, its report should include a more thorough discussion of the selection of encounter records and a table indicating the number of clients and encounters selected for each agency,

by age group. OPRSN needs to improve the technical description of its review tool and review methodology.

The encounter and demographics data received from the State were 100% complete, with the exception of Social Security Number, an optional data element, which was 92.9% complete, and provider type, which was 99.8% complete.

Qualis Health's review of demographic data indicated low accuracy, which contrasted with OPRSN's findings.

For all 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 OPRSN found through its internal EDV reviews.

Discrepancies for the difference in OPRSN's internal review and Qualis Health's review could have multiple factors contributing, one being the different sample sets reviewed. Qualis Health did not review the same encounters as OPRSN. Another factor that potentially could have contributed to the variance is the process by which OPRSN 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 Service Encounter Reporting Instructions (SERI) or WAC requirements, contained documentation did not match the code that was submitted, or did not reflect a service that should have been submitted. Examples include the following:

- Encountering codes H0001 and H0002 which have been discontinued since July 2013
- Documenting unencounterable services such as leaving a message, writing letters, researching a poet for a client's school assignment, transportation and standing in line,
- Services submitted for being the middle man between the client and the payee.
- Requests for service duration was auto-filled at 15 minutes regardless of the time it took at one provider.
- Request for Service provider type was incorrectly submitted
- Encountering Rehabilitation case management when a client is not in a 24/7 facility
- Credentials missing from progress note
- Submitting family therapy but documentation supports an individual service
- Encountering 90837 for services over 68 minutes
- Incorrect bundling
- Submitting peer services with the incorrect provider type
- Submitting peer services prior to intake
- Submitting H0023 with provider type 12. This is not allowable per the SERI
- Incorrect location codes
- Lack of clinical documentation
- Encountering rehabilitation case management for a community meeting group
- Documentation not supporting excessive duration of services
- Encounters submitted to the state without provider type and missing elements on the documentation
- Group documentation does not meet WAC 388-377A-0150

Opportunity for Improvement

OPRSN's EDV report only summarized the sampling methodology and did not provide overall results or discussion. The selection of clients was described, but not the selection of encounters for each of the selected clients. Results were provided in a spreadsheet "addendum" that was not easily interpreted.

- The written EDV report should be more complete and cover all aspects of the validation.

Recommendations Requiring CAP

OPRSN's report does not include the information necessary to determine whether the EDV is adequate.

- OPRSN needs to provide a more comprehensive description of the review tool and review process.

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
§438.240(a)(b)1(d)(e)	OPRSN should ensure that more than one staff person is trained on the grievance system.	The RSN addressed this issue.	Resolved.

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

Compliance with Regulatory and Contractual Standards

Section 1: Availability of Services

Recommendation Requiring CAP

OPRSN has a policy and process in place for credentialing its own network providers, but it does not have a policy and procedure in place to ensure that out-of-network providers are credentialed.

1. OPRSN needs to have a process in place to ensure that if services are provided by an out-of-network provider, the provider meets the same credentialing requirements as in-network providers.

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

N/A

Section 7: Quality Assessment and Performance Improvement Program

Recommendation Requiring CAP

OPRSN's 2014 quality assessment and performance improvement (QA/PI) work plan summary is quite informative and summarizes both ongoing activities as well as short-term activities. Although the summary lists the results of the activities, the plan does not include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations for the coming year. Including these elements in the QA/PI plan was a recommendation in the 2012 EQRO report.

2. OPRSN needs to expand its year-end program evaluation to include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances, service verification and recommendations for the coming year.

Section 8: Health Information Systems

N/A

Performance Improvement Project (PIP) Validation

Recommendation Requiring CAP

The PIP needs to focus on an enrollee-related issue that can be measured and for which interventions can be implemented to create improvement. Setting up a simple monitoring system related to one aspect of care is not a performance improvement project if it doesn't seek to truly improve the indicator. The individuals receiving the intervention need to be related to the identified problem, upon which various interventions, not just the program's services, can be tested and applied to create improvement. OPRSN has set up a PIP that only evaluates the effectiveness of the WISe program in relation to caregiver strain. There is no measure of true improvement, just the implementation of WISe as it is required and the potential natural outcome of reduction in caregiver strain.

3. OPRSN needs to explore issues related to access, timeliness and other measurable outcomes for which interventions can be applied after a baseline measurement is taken. These interventions should be in addition to a given program and should have the ability to be tested and applied to create improvement. OPRSN also needs to investigate strategies to improve the number of participants in the study, including when and how caregivers are asked to complete the CGSQ-SF7. OPRSN could also consider adding a third interval/after-care questionnaire in order to measure for sustained improvement vs. the impact that WISe or any intervention has at the point of highest crisis/need. OPRSN should consider whether this is a viable PIP and examine the possibility of ending this PIP early. OPRSN needs to look into working with its stakeholders to select a more robust study question/population that would yield more plentiful and relevant data.

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

OPRSN's report does not include the information necessary to determine whether the EDV is adequate.

4. OPRSN needs to provide a more comprehensive description of the review tool and review process.

Recommendation Requiring CAP

OPRSN's encounter data did not meet the 95% standard for compliance.

5. 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.

Appendix C: Acronyms

ALOS	Average Length of Stay
ASP	Application Service Provider
BC/DR	Business Continuity and Disaster Recovery
CAP	Corrective Action Plan
CCS	Catholic Community Services
CFR	Code of Federal Regulations
CMHA	Community Mental Health Association
CMS	Centers for Medicare & Medicaid Services
CPC	Certified Peer Counselors
CPT	Current Procedural Terminology
DBHR	Department of Social and Health Services, Division of Behavioral Health and Recovery
EDI	Electronic Data Interchange
EDV	Encounter Data Validation
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
E&T	Evaluation and Treatment
HCA	Health Care Authority
HCPCS	Healthcare Common Procedural Coding System
IRM	Information Risk Management
ISCA	Information System Capability Assessment
IS	Information Systems
MCO	Managed Care Organization
MIS	Management Information System
MSO	Managed Services Organization
MMIS	Medicaid Management Information System
NAS	Network Attached Storage Device
NIC	Network Interface Card
PAHP	Prepaid Ambulatory Health Plans
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PRISM	Predictive Risk Intelligence System
PM	Practice Management
QA/PI	Quality Assessment and Performance Improvement
QRT	Quality Review Team
RAID	Redundant Array of Independent Disks
RTF	Residential Treatment Facility
RSN	Regional Support Network
SERI	Service Encounter Reporting Instructions
WAC	Washington Administrative Code
WISe	Wraparound with Intensive Services
WRAP	Wellness Recovery Action Plan
WSC	Washington State RSN-Netsmart Consortium

