Thurston-Mason Regional Support Network

External Quality Review Report

Division of Behavioral Health and Recovery

October 2015

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

As Washington's Medicaid External Quality Review Organization (EQRO), Qualis Health provides external quality review and supports quality improvement for enrollees of Washington Apple Health managed care programs and the managed mental healthcare services. Our work supports the Washington State Health Care Authority (HCA) and Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery.

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

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

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Introduction

This report presents the 2015 results of the external quality review of Thurston-Mason Regional Support Network (TMRSN) serving Washington Medicaid recipients.

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.
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.

Thurston-Mason Regional Support Network administers public mental health funds for Medicaid participants enrolled in managed care plans. The RSN does not provide any direct client services; however, it provides funding and oversight for direct client services and assistance within available resources, and contracts with provider agencies. In the Thurston-Mason County(ies) region, there were 67,018 Medicaid beneficiaries in the 2014 fiscal year, and of those 6,901 were enrolled with the RSN.

The primary focus of these publicly funded services is to serve Title 19 Medicaid-eligible adults who have chronic and persistent mental illness, and children/youth with severe emotional disturbances. Individuals without Medicaid may receive acute care and crisis services based on the availability of funding, which is monitored by TMRSN. The services provided are a vital part of maintaining the community's overall health, safety and quality of life.

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 activities. As the external quality review organization (EQRO) for the Washington State Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (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 Thurston-Mason Regional Support Network (TMRSN).

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 Thurston-Mason RSN 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 Thurston-Mason 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	Partially Met (pass)
Section 3. Coverage and Authorization of Services	438.210	Partially Met (pass)
Section 4. Provider Selection	438.214	Fully Met (pass)

Section 5. Subcontractual Relationships and Delegation	438.230	Partially Met (pass)
Section 6. Practice Guidelines	438.236	Partially 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 Thurston-Mason 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 Thurston-Mason 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: **Implementation of High-fidelity Wraparound to Achieve Better Outcomes for Children and Youth**	Fully Met (pass)	High confidence in reported results
Non-Clinical PIP: **Improving TMRSN Utilization Management of Core Outpatient Services**	Fully Met (pass)	High confidence in reported results

Information System Capability Assessment (ISCA) Results

Thurston-Mason RSN 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 Thurston-Mason 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, Thurston-Mason 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.	Partially Met (pass)
D. Medical Services Data	This section assesses the RSN's ability to capture and report accurate medical services data.	Fully Met (pass)
E. Enrollment Data	This section assesses the RSN's ability to capture and report accurate Medicaid enrollment data.	Fully Met (pass)
F. Practitioner Data	This section assesses the RSN's ability to capture and report accurate practitioner information.	Fully Met (pass)
G. Vendor Data	This section assesses the quality and completeness of the vendor data captured by the RSN.	Fully Met (pass)
H. Meaningful Use of EHR	This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not scored.	N/A

Encounter Data Validation (EDV) Results

EDV is a process used to validate encounter data submitted by RSNs to the State. Encounter data are electronic records of the services provided to Medicaid enrollees by providers under contract with an RSN. Encounter data is used by the RSNs and the State to assess and improve the quality of care and to monitor program integrity. Additionally, the State uses encounter data to determine capitation rates paid to the RSNs.

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

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

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

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

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

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

EDV Standard	Description	EDV Result
Electronic Data Checks	Full review of encounter data submitted to the State indicates no (or minimal) logic problems or out-of-range values.	Fully Met (pass)
Onsite Clinical Record Review	State encounter data 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). The standard for passing is 95% of records for all encounter data fields match. TMRSN had <95% records matched for encounter data fields.	Not Met (fail)

Compliance with Regulatory and Contractual Standards

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

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

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

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

Compliance Scoring

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

Fully Met means all documentation listed under a regulatory provision, or component thereof, is present, and RSN staff provides responses to reviewers that are consistent with each other and with the documentation.

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

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

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

Summary of Compliance Review Results

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

CMS EQR Protocol	CFR Citation	Results
Section 1. Availability of Services	438.206	Partially Met (pass)
Section 2. Coordination and Continuity of Care	438.208	Partially Met (pass)
Section 3. Coverage and Authorization of Services	438.210	Partially Met (pass)
Section 4. Provider Selection	438.214	Fully Met (pass)
Section 5. Subcontractual Relationships and Delegation	438.230	Partially Met (pass)
Section 6. Practice Guidelines	438.236	Partially 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 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

- TMRSN has a thorough process in place for ensuring it maintains a delivery network capable of providing adequate services to its enrollees by maintaining written agreements with contracted providers and having processes in place to monitor provider contract compliance and performance.
- TMRSN allows enrollees to seek services at neighboring RSNs through an out-of-network service contract in the event an enrollee requires specialized treatment unavailable within the TMRSN network.
- TMRSN realized there was a significant issue with the level of care assignment for enrollees and determined they may not be receiving the correct level of services; for instance, a high-needs enrollee may be seen at a lower level of care and not necessarily receive the appropriate interventions. TMRSN began a formal performance improvement project (PIP) and is now using the LOCUS and CALOCUS to help improve level of care assignments.
- Out-of-network providers are held to the same credentialing standard as in-network providers, and TMRSN frequently uses providers from another RSN to avoid the use of single case agreements.

- TMRSN has strong data-driven processes for monitoring the timeliness of access to care across the provider network, and effective processes are in place to take corrective action when concerns relative to access to care are identified.
- Since the last review, TMRSN developed and implemented a procedure for inter-rater reliability testing to ensure consistent application of criteria for authorization decisions.
- TMRSN's clinical manager ensures staff who are making authorization decisions have the appropriate clinical experience and expertise to make decisions.
- Consistent application of TMRSN authorization criteria through periodic peer review, supervision and consultation is provided as needed.
- TMRSN reviews and monitors the network provider's credentialing process and verification of qualifications during the credentialing and re-credentialing process during periodic administrative, licensing or monitoring reviews as needed to ensure compliance with standards and policy.
- TMRSN reported that through its quality monitoring review, the RSN discovered the adult population may have not been receiving the level of healthcare that they require. TMRSN identified a need for Wraparound and diversion programs.

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

Section 1: Availability of Services

Recommendations Requiring CAP: N/A

Opportunity for Improvement
TMRSN reported its largest provider, which supports 90% of the enrollees, has experienced challenges in meeting the access to care timelines during the Medicaid expansion.

- TMRSN should continue to provide technical assistance and corrective action to this contracted provider in order to meet the access to care timelines.

Section 2: Coordination of Care

Recommendations Requiring CAP
TMRSN's largest contracted provider's conversion to an electronic medical record (EMR) system has caused up to an 18-month delay in accurate data transmission, and this has directly impacted the RSN's capability to effectively monitor care coordination.

- TMRSN needs to consider implementing other options in order to acquire data more accurately and in a more timely manner from its provider agencies, including imposing monetary sanctions when the agencies do not respond appropriately to CAPs.

TMRSN reported it had significant internal staffing challenges, causing leaders to fulfill dual roles and create gaps in information system staffing. This and the lack of accurate data from its largest contracted provider caused a gap in completing thorough utilization review during the review period. The RSN also stated that it has submitted numerous corrective action plans to its largest provider but without effective follow-through by the agency.

- In order to do thorough and timely utilization reviews and monitor care coordination, TMRSN needs to consider implementing other options in order to acquire data more accurately and in a more timely manner from its provider agencies, including imposing monetary sanctions when the agencies do not respond appropriately to CAPs.

TMRSN has a policy in place to identify any ongoing special conditions of enrollees who require a special course of treatment or regular care monitoring. However, at the time of review, TMRSN's challenges with under-staffing, resulting in staff members holding dual roles, caused the RSN to delay monitoring the agencies, which has directly impacted the capability of the RSN to implement strategies ensuring all contractors meet the standards.

- TMRSN needs to develop and implement new strategies in light of the RSN's staffing issues to ensure all contractors meet the standards for identifying ongoing special conditions of enrollees who require a special course of treatment or regular care monitoring.

Opportunities for Improvement: N/A

Section 3: Coverage and Authorization of Services

Recommendation Requiring CAP
TMRSN has mechanisms in place to ensure compliance with authorization timeframes; however, authorizations from its largest contracted provider are sometimes delayed up to six months.

- TMRSN needs to continue to provide technical assistance and hold this provider accountable to a corrective action plan in order to ensure compliance with timely submission of authorization requests.

Opportunity for Improvement:
TMRSN reported that because of lack of accurate data they were not able to assess and determine how many enrollees used crisis services for inappropriate or avoidable use related to access to routine care.

- TMRSN should continue to work with its provider agencies to collect timely and accurate date to track and monitor the use of crisis services for inappropriate or avoidable use related to access to routine care.

Section 4: Provider Selection

Recommendations Requiring CAP: N/A

Opportunity for Improvement
While TMRSN fully met this section, the RSN is encouraged to carefully monitor its provider contracts to ensure that provider agencies do not knowingly have a director, officer, partner or person with a beneficial ownership of more than 5% of the agency's equity.

- TMRSN is encouraged to carefully monitor and provide oversight as the region undergoes SUD integration

Section 5: Subcontractual Relationships and Delegation

Recommendation Requiring CAP: N/A

Opportunity for Improvement
TMRSN has dedicated significant time and its limited staffing resources to monitoring, coaching and providing technical assistance in order to ensure enrollee access because its largest provider agency serving 90% of its enrollees has not complied with the implementation of improvement plans for the corrective action the RSN has imposed.

- TMRSN should take advantage of remedial action in its contracts to enforce corrective actions.

Section 6: Practice Guidelines

Recommendations Requiring CAP
TMRSN reports it has discontinued the use of practice guidelines and is working to adopt the model developed by another RSN, which includes a diagnostic approach. At the time of this review, the RSN stated it was still in the planning stages for adopting diagnostic-based guidelines.

- TMRSN needs to finalize and implement its new process for adopting diagnostic guidelines and base the guidelines on valid and reliable clinical evidence or on the consensus of its healthcare professionals, as well as on the needs of its enrollees.

Although TMRSN has a policy which states that 10% of clinical records are reviewed for compliance with clinical practice guidelines, and the Quality Improvement Committee meets to review and analyze each report or concern identified relating to TMRSN clinical practice guidelines, this process has been put on hold as the RSN has discontinued its practice guidelines.

- When the RSN has adopted its new guidelines, it will need to follow its policy on ensuring guidelines are in place and clinicians are actually following and using the guidelines. Also, the RSN will need to document the interface between the guidelines and the Quality Assurance Performance Improvement program, to ensure decisions for utilization management, enrollee education, coverage of services and other areas are applied consistent with the guidelines.

Opportunities for Improvement: N/A

Section 7: Quality Assessment and Performance Improvement Program

Recommendations Requiring CAP: N/A

Opportunities for Improvement
At the time of the review, TMRSN had not completed its annual quality program evaluation, primarily because of the lack of adequate and accurate data from its largest provider.

- TMRSN needs to continue its efforts with this provider to obtain access to accurate data for assessing quality and appropriateness of care.
- The RSN needs to evaluate its quality program and submit its annual quality improvement evaluation to DBHR.

The RSN was unable to ensure its compliance with the State's quality strategy plan, as the State does not have a current quality strategy plan.

- When the State’s quality strategy plan is completed, the RSN will need to comply with the plan.

As previously stated, TMRSN reported it is constantly engaging its largest contracted provider in performance improvement plans and corrective action in order to support its Quality Assessment and Performance Improvement programs.

- The RSN should continue these efforts and ensure there is a formal corrective action plan in place and hold this provider accountable for quality improvement and submission of performance data.

Although TMRSN stated it has several methods for monitoring over- and underutilization (including analyzing encounter and claims data for frequency of services, tracking and analyzing enrollees' grievances, reviewing inpatient tracking reports for inappropriate stays and auditing clinical records), the RSN has stated these processes were put on hold for several reasons, including lack of staffing. The RSN has recently hired additional staff, which will allow the clinical manager to resume the procedures and processes for ensuring the quality of care provided to enrollees is appropriate.

- The RSN should resume its process for monitoring over- and underutilization of services.

To assess and ensure that the quality of care furnished to enrollees is appropriate, the RSN performs onsite record reviews focusing on the Golden Thread, provides clinician trainings, meets one on one for chart reviews and provides training on treatment planning. As stated previously, because of the lack of staffing, these processes were put on hold. The RSN has recently hired additional staff, which will allow the clinical manager to resume the procedures and processes for ensuring the quality of care provided to enrollees is appropriate.

- The RSN needs to resume its process for ensuring quality care is provided and appropriate for enrollees.

Section 8: Health Information Systems

Recommendations Requiring CAP: N/A

Opportunities for Improvement

TMRSN's lack of access to accurate data from their contracted providers has caused a delay in producing the 2014 annual quality management program evaluation.

- TMRSN needs to continue its efforts with its contracted providers to obtain access to accurate data for assessing quality and appropriateness of care and then evaluate its quality improvement program and submit the annual quality improvement evaluation to DBHR.

Several subcontracted providers reported during the telephone interviews that challenges exist with data extraction and delivery of data to the RSN computer systems.

- As previously stated, TMRSN should continue to work with its network providers to improve the process of collecting data in standardized formats and reviewing the data for accuracy, timeliness, completeness, logic and consistency.

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)	Fully Met (pass)
3. Out-of-network	438.206 (b)(4)	Fully Met (pass)
4. Coordination of Out-of-network	438.206 (b)(5)	Fully Met (pass)
5. Out-of-network Provider Credentials	438.206 (b)(6)	Fully Met (pass)
6. Furnishing of Services and Timely Access	438.206 (c)(1)	Partially Met (pass)
7. Furnishing of Services and Cultural Considerations	438.206 (c)(2)	Fully Met (pass)
Overall Result for Section 1.		Partially Met (pass)

Delivery Network

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

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

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

(I) The anticipated Medicaid enrollment

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

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

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

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

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

SCORING CRITERIA

- The RSN maintains and monitors a network of appropriate providers that is supported by written agreements.
- The RSN's provider network is sufficient to provide adequate access to all services covered under the contract.
- In establishing and maintaining the network, the RSN considers:
  - 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.

Reviewer Determination

● Fully Met (pass)

Strengths

TMRSN has a thorough process in place for ensuring it maintains a delivery network capable of providing adequate services to its enrollees by

- Maintaining written agreements with contracted providers and having processes in place to monitor provider contract compliance and performance
- Using data to regularly evaluate its network performance relative to access to care in terms of timeliness and the geographic location of contracted providers
- Creating utilization reports that break out the number of consumers served by age group, number of services and service hours, including utilization trends; number of consumers served with Medicaid and non-Medicaid funds; and number of consumers by provider and services received
- Evaluating access to services by reviewing enrollees' complaints and grievances; analyzing service penetration rates of enrollees by age, ethnicity and gender; reviewing service utilization; and conducting satisfaction surveys
- Utilizing its Managed Care Accessibility Report to break out enrollee services by zip code and the distance to providers within those zip codes

Second Opinion

FEDERAL REGULATION SOURCE(S)
§ 438.206 (b)(3): Availability of Services – Delivery Network

3) Provides for a second opinion from a qualified healthcare professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- TMRSN has a formal policy and procedure regarding enrollee access to a second opinion, and demonstrates that practices are in agreement with the policy and procedure.
- TMRSN reports very few requests for second opinions during the last year. However, the RSN has several contracted providers which, if needed, can provide second opinions for one another.
- TMRSN allows out-of-network second opinions if necessary through a service contract with another county and ensures no bill is sent for services.

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 out of network for the enrollee in an adequate and timely manner, 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 covered adequately and in a timely maner 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

- The RSN has revised the enrollee handbook to incorporate information on how to access healthcare which is outside of the network.
- TMRSN allows enrollees to seek services at neighboring RSNs through an out-of-network contract when the enrollee requires specialized treatment not available within the network.

Coordination of Out-of-Network

FEDERAL REGULATION SOURCE(S)
§ 438.206 (b)(5): Availability of Services – Delivery Network

(5) Requires out-of-network providers to coordinate with the MCO or PIHP with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- TMRSN's provider agencies are required to code and track out-of-network provider services.
- TMRSN has an effective process in place to ensure that enrollees are not liable for costs associated with medically necessary out-of-network care.

Out-of-Network Provider Credentials

FEDERAL REGULATION SOURCE(S)
§ 438.206 (b)(6): – Out-of-network Provider Credentials

6) Demonstrates that out-of-area providers are credentialed as required by § 438.214
STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0284 RSN Agreement Section(s) 8.6
SCORING CRITERIA • The RSN has a process to ensure that out-of-network providers are credentialed.
Reviewer Determination ● Fully Met (pass)

Strength

- TMRSN requires that out-of-network providers are held to the same credentialing standard as in-network providers and frequently uses providers from another RSN to avoid the use of single case agreements.

Furnishing of Services and Timely Access

FEDERAL REGULATION SOURCE(S) **§ 438.206 (c)(1): Availability of Services – Furnishing of Services and Timely Access** The State must ensure that each MCO, PIHP and PAHP contract complies with the requirements of this paragraph. 1) Timely Access. Each MCO, PIHP and PAHP must do the following: i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. iv) Establish mechanisms to ensure compliance by providers. v) Monitor providers regularly to determine compliance. vi) 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

Partially Met

Strengths

- TMRSN has a strong, data-driven process for monitoring the timeliness of access to care across its provider network and has processes in place to take corrective action in the event that concerns relative to access to care are identified.
- TMRSN provider contracts specify the hours of operation for which services are to be available to enrollees.

Opportunity for Improvement

TMRSN reported its largest provider, which supports 90% of the enrollees, has had challenges in meeting its access to care timelines during Medicaid expansion.

- TMRSN should continue to provide technical assistance and corrective action to its largest contracted provider so as to meet the access to care timelines.

Furnishing of Services and Cultural Considerations

FEDERAL REGULATION SOURCE(S)
§ 438.206Availability of services (c)(2): Furnishing of Services and Cultural Considerations
Each MCO, PIHP and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0200
RSN Agreement Section(s) 1.16; 4.4.2.

SCORING CRITERIA

- The RSN has a documented policy and procedure related to the delivery of services in a culturally competent manner for all enrollees. This includes enrollees with limited English proficiency and diverse cultural and ethnic backgrounds.
- The RSN monitors and documents through tracking of the use of services delivered to those with limited English proficiency and diverse cultural and ethnic backgrounds.
- The RSN maintains documentation of any cultural competency training(s).

Reviewer Determination

Fully Met (pass)

Meets Criteria

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)	Partially Met
Additional Services for Enrollees with Special Healthcare Needs	438.208 (c)(1)(2)	Partially Met (pass)
Treatment Plans	438.208(c)(3)	Fully Met (pass)
Direct Access to Specialists	438.208 (c)(4)	Fully Met (pass)
Overall Result for Section 2.		Partially 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 Health Care 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

Partially Met

Strength

- TMRSN has policies and procedures in place for the delivery of care and coordination of services for its enrollees and to ensure each enrollee has access to a primary healthcare provider.

Recommendations Requiring CAP

TMRSN's largest contracted provider's conversion to an electronic medical record (EMR) system has caused up to an 18-month delay in accurate data transmission, and this has directly impacted the RSN's capability to effectively monitor care coordination.

- TMRSN needs to consider implementing other options in order to acquire data more accurately and in a more timely manner from its provider agencies, including imposing monetary sanctions when the agencies do not respond appropriately to CAPs.

TMRSN reported it had significant internal staffing challenges causing leaders to fulfill dual roles and create gaps in information system staffing. This and the lack of accurate data from its largest contracted provider caused a gap in completing thorough utilization review during the review period. The RSN also stated that it has submitted numerous corrective action plans to its largest provider but without effective follow through by the agency.

- In order to do thorough and timely utilization reviews and monitor care coordination, TMRSN needs to consider implementing other options in order to acquire data more accurately and in a more timely manner from its provider agencies, including imposing monetary sanctions when the agencies do not respond appropriately to CAPs.

Additional Services for Enrollees with Special Healthcare Needs

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

Partially Met (pass)

Recommendation Requiring CAP
TMRSN has a policy in place to identify any ongoing special conditions of enrollees that require a special course of treatment or regular care monitoring. However, at the time of review, TMRSN's challenges with under-staffing, resulting in staff members holding dual roles, caused the RSN to delay monitoring the agencies, which has directly impacted the capability of the RSN to implement strategies ensuring all contractors meet the standards.

- TMRSN needs to revisit its strategies and develop and implement new strategies in light of the RSN's staffing issues to ensure all contractors meet the standards for identifying ongoing special conditions of enrollees who require a special course of treatment or regular care monitoring.

Treatment Plans

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

(3) Treatment plans. If the State requires MCOs, PIHPs and PAHPs to produce a treatment plan for

enrollees with special healthcare needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be—

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

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strength

- TMRSN's largest provider has added documentation to the treatment plans to capture whether the enrollee agrees or disagrees with the treatment plan.

Direct Access

FEDERAL REGULATION SOURCE(S)
§ 438.208 (c)(4): Coordination and Continuity of Care Direct Access to Specialists

(4) For enrollees with special healthcare needs determined through an assessment by appropriate healthcare professionals (consistent with § 438.208[c][2]) to need a course of treatment or regular care monitoring, each MCO, PIHP and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0430
RSN Agreement Section(s) 8.8.2.1.4; 13.3.16

SCORING CRITERIA

- The RSN has policies and procedures regarding direct access to specialists for enrollees with special healthcare needs.
- The RSN must allow the enrollee direct access to a specialist as appropriate for the enrollee's condition and identified needs.
- The RSN monitors the availability of direct access to specialist.

Reviewer Determination

Fully Met (pass)

Meets Criteria

Section 3: Coverage and Authorization of Services

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

Protocol Section	CFR	Result
Coverage and Authorization of Services		
Basic Rule	438.210 (a)	Fully Met(pass)
Coverage and Authorization of Services	438.210 (b)	Fully Met(pass)
Notice of Adverse Action	438.210 (c)	Fully Met(pass)
Timeframe for Decisions: (1) Standard Procedures (2) Expedited Authorizations	438.210 (d)	Partially Met(pass)
Compensation for Utilization of Services	438.210 (e)	Fully Met(pass)
Emergency and Post-Stabilization services	438.210 438.114	Partially Met(pass)
Overall Result for Section 3.		Partially Met(pass)

Basic Rule

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

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

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

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

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

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

(iii) May place appropriate limits on a service—

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

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

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

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

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

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

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

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

STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-0150
RSN Agreement Section(s) 1.35; 4.1; 4.2; 5.1; 13

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strength

- TMRSN realized there was a significant issue with the level of care assignment for enrollees and determined they may not be receiving the correct level of services. TMRSN began a formal performance improvement project (PIP) and is now using LOCUS and CALOCUS to help improve level of care assignments.

Authorization of Services

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

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

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

(2) That the MCO, PIHP or PAHP—

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

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

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

SCORING CRITERIA

- The RSN has documented policies and procedures for the consistent application of review criteria for the initial and continuing authorization of services.
- The RSN has a mechanism in place to ensure consistent application of review criteria.
- The RSN consults with the requesting provider when appropriate.
- The RSN has a process to ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested is made by a mental health professional that has appropriate clinical expertise in treating the enrollee's condition or disease.

Reviewer Determination

Fully Met (pass)

Strengths

- TMRSN has documented policies and procedures for the consistent application of review criteria.
- Since the last review, TMRSN developed and implemented a procedure for inter-rater reliability testing to ensure consistent application of criteria for authorization decisions.
- TMRSN's clinical manager ensures staff who are making authorization decisions have the appropriate clinical experience and expertise to make decisions.
- Consistent application of TMRSN authorization criteria through periodic peer review, supervision and consultation is provided as needed.

Notice of Adverse Action

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

STATE REGULATION / RSN AGREEMENT SOURCE(S)
RSN Agreement Section(s) 6.3

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Meets Criteria

Timeframes for Decisions

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

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

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

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

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

(2) Expedited authorization decisions.

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

(ii) The MCO, PIHP or PAHP may extend the three working days' time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIH, 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

Partially Met (pass)

Recommendation Requiring CAP
TMRSN has mechanisms in place to ensure compliance with authorization timeframes; however, authorizations from its largest contracted provider are sometimes delayed up to six months.

- TMRSN needs to continue to provide technical assistance and hold this provider accountable to a corrective action plan in order to ensure compliance with timely submission of authorization requests.

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

- TMRSN's policies and procedures confirm that provider compensation is not structured to provide incentives to deny, limit or discontinue medically necessary services to enrollees.
- TMRSN performs all outpatient service authorizations and states that it has no incentives in place to deny, limit or discontinue medically necessary services.

Emergency and Post-Stabilization Services

FEDERAL REGULATION SOURCE(S)

§438.210 Coverage and authorization of services–§438.114 Emergency and Post-Stabilization Services

(a) Definitions. As used in this section—

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

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

her unborn child) in serious jeopardy

(2) Serious impairment to bodily functions

(3) Serious dysfunction of any bodily organ or part

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

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

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

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

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

(1) The MCO, PIHP or PAHP

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

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

(c) Coverage and payment: Emergency services—

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

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

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

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

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

(2) A PCCM must—

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

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

(d) Additional rules for emergency services:

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

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

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

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

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

(e) Coverage and payment: Post-stabilization care services. Post-stabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of this chapter. In applying those determining when the enrollee is sufficiently stabilized for transfer or discharge, that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment. Provisions, reference to "M C organization," must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section. (f) Applicability to PIHPs and PAHPs. To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply.
STATE REGULATION / RSN AGREEMENT SOURCE(S) RSN Agreement Section(s) 5.2
SCORING CRITERIA • The RSN has written policies and procedures pertaining to crisis, stabilization and post-hospital follow-up services. • The RSN pays for treatment of conditions defined in its policies as urgent or emergent conditions. • The RSN tracks and monitors payment denials, to ensure that there is no denial for crisis services. • The RSN tracks and monitors the use of crisis services for inappropriate or avoidable use related to access to routine care.
Reviewer Determination ● Partially Met (pass)

Strength

- TMRSN has well-written policies and procedures pertaining to crisis, stabilization and post-hospital follow-up services.

Opportunity for Improvement

TMRSN reported that because of lack of accurate data they were not able to assess and determine how many enrollees used crisis services for inappropriate or avoidable use related to access to routine care.

- TMRSN should continue to work with its provider agencies to collect timely and accurate date to track and monitor the use of crisis services for inappropriate or avoidable use related to access to routine care.

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 polices and processes.

Reviewer Determination

Fully Met (pass)

Strength

- TMRSN's policy and procedure specifies the requirements for credentialing, re-credentialing and contracting with contractors and providers to deliver community mental health services.

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 Non-Discrimination

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Meets Criteria

Excluded Providers

FEDERAL REGULATION SOURCE(S)

§ 438.214 (d): Excluded Providers

(d) Excluded providers. MCOs, PIHPs and PAHPs may not employ or contract with providers excluded from participation in Federal healthcare programs under either section 1128 or section 1128A of the Act.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-028

RSN Agreement Section(s) 4.5; 8.6; 8.8.2.1.12

SCORING CRITERIA

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

Meets Criteria

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	● Partially Met (pass)

General Rule

FEDERAL REGULATION SOURCE(S)

§ 438.230: Subcontractual Relationships and Delegation

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

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

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

(b) Specific conditions.

(1) Before any delegation, each MCO, PIHP and PAHP evaluates the prospective subcontractor's ability to perform the activities to be delegated.

(2) There is a written agreement that—

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

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

inadequate.

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

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

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388--865-0284

RSN Agreement Section(s) 8

SCORING CRITERIA

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

Reviewer Determination

Partially Met (pass)

Strength

- The RSN reviews and monitors the network provider’s individual clinician credentialing processes and verifies clinicians’ qualifications during administrative reviews.

Opportunity for Improvement

TMRSN has dedicated significant time and its limited staffing resources to monitoring, coaching and providing technical assistance in order to ensure enrollee access because its largest provider agency serving 90% of their enrollees has not complied with the implementation of improvement plans for the corrective action the RSN has imposed.

- TMRSN should take advantage of remedial action in its contracts to enforce corrective actions.

Section 6: Practice Guidelines

Table B-6: Summary of Compliance Review for Practice Guidelines

Protocol Section	CFR	Result
Practice Guidelines		
Clinical Evidence and Adoption	438.236 (a-b)	Not Met (fail)
Dissemination	438.236 (c)	Fully Met (pass)
Application	438.236 (d)	Not Met (fail)
Overall Result for Section 6.		Partially Met (pass)

Basic Rule

FEDERAL REGULATION SOURCE(S)

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

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

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

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

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

(3) Are adopted in consultation with contracting healthcare professionals

(4) Are reviewed and updated periodically as appropriate

STATE REGULATION / RSN AGREEMENT SOURCE(S)
RSN Agreement Section(s) 7.7.3

SCORING CRITERIA

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

Reviewer Determination
Not Met (fail)

Opportunities for Improvement-N/A

Recommendation Requiring CAP
TMRSN reports that it has discontinued the use of practice guidelines and is working to adopt the model developed by another RSN, which includes the diagnostic approach. At the time of the review, the RSN stated it was still in the planning stages for adopting diagnostic-based guidelines.

- TMRSN needs to finalize and implement its new process for adopting diagnostic guidelines and base the guidelines on valid and reliable clinical evidence or on the consensus of its healthcare professionals, as well as on the needs of its enrollees.

Dissemination of Guidelines

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

Strength

- TMRSN has policies and procedures in place for the dissemination of practice 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 • The RSN has documented 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 ● Not Met (fail)

Recommendation Requiring CAP

Although TMRSN has a policy which states that 10% of clinical records are reviewed for compliance with clinical practice guidelines and the Quality Improvement Committee meets to review and analyze each report or concern identified relating to TMRSN clinical practice guidelines, this process has been discontinued as the RSN has discontinued its practice guidelines.

- When the RSN has adopted its new guidelines, it will need to follow its policy on ensuring guidelines are in place and clinicians are actually following and using the guidelines. Also, the RSN will need to document the interface between the guidelines and the Quality Assurance Performance Improvement program, to ensure decisions for utilization management, enrollee education, coverage of services and other areas are applied in a manner consistent with the guidelines.

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)	● Partially Met (pass)
Mechanisms to Detect Over- and Underutilization of Services	438.240 (b)3	● Partially Met (pass)

Quality and Appropriateness of Care Furnished to Enrollees With Special Healthcare Needs	438.240 (b)4	Partially 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)

Strength

- TMRSN has two robust performance improvement projects in place.

Opportunities for Improvement

The RSN was unable to ensure its compliance with the State's quality strategy plan, as the State does not have a current quality strategy plan.

- When the State's quality strategy plan is completed, the RSN will need to comply with the plan.

At the time of the review, TMRSN had not completed its annual quality program evaluation, primarily because of the lack of adequate and accurate data from its largest provider.

- TMRSN needs to continue its efforts with this provider to obtain access to accurate data for assessing quality and appropriateness of care.
- The RSN needs to evaluate its quality program and submit its annual quality improvement evaluation to DBHR.

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 (c) (1) and (c) (2) of this section.

(a) General rules.

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

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

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

SCORING CRITERIA

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

Reviewer Determination

Partially Met (pass)

Opportunity for Improvement
As previously stated, TMRSN reported it is constantly engaging its largest contracted provider in performance improvement plans and corrective action in order to support its quality assessment and performance improvement program.

- The RSN should continue these efforts and ensure there is a formal corrective action plan in place and hold this provider accountable for quality improvement and submission of performance data.

Mechanisms to Detect Under- and Overutilization of Services

FEDERAL REGULATION SOURCE(S)

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

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

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

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

SCORING CRITERIA

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

Reviewer Determination

Partially Met (pass)

Opportunity for Improvement
Although TMRSN stated it has several methods for monitoring over- and underutilization (including analyzing encounter and claims data for frequency of services, tracking and analyzing enrollees' grievances, reviewing inpatient tracking reports for inappropriate stays and auditing clinical records), the RSN has stated these processes were put on hold for several reasons, including lack of staffing. The RSN has recently hired additional staff, which will allow the clinical manager to resume the procedures and processes for ensuring the quality of care provided to enrollees is appropriate.

- The RSN should resume its process for monitoring over- and underutilization of services.

Mechanism to Assess the Quality and Appropriateness of Care

FEDERAL REGULATION SOURCE(S)

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

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

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

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

SCORING CRITERIA

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

Reviewer Determination

Partially Met (pass)

Opportunity for Improvement
To assess and ensure that the quality of care furnished to enrollees is appropriate, the RSN performs onsite record reviews focusing on the Golden Thread, provides clinician trainings, meets one-on-one for chart reviews and provides training on treatment planning. As stated previously, because of the lack of staffing, these processes were put on hold. The RSN has recently hired additional staffing which will allow the clinical manager to resume the procedures and processes for ensuring the quality of care provided to enrollees is appropriate.

- The RSN should resume its process for ensuring quality care is provided and is appropriate to its enrollees.

Section 8: Health Information Systems

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

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

General Rule

FEDERAL REGULATION SOURCE(S) **§ 438.242 (a): Health Information Systems** (a) General rule. The State must ensure, through its contracts, that each MCO and PIHP maintain 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. .
STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0275 RSN Agreement Section(s) 11
SCORING CRITERIA • The RSN has a health information system that collects, analyzes, integrates and reports data on utilization, dis-enrollments and requests to change providers, grievances and appeals.

- The RSN utilizes reports from health information data to make informed management decisions.
- The RSN analyzes the health information data to identify services needed for enrollees.

Reviewer Determination

Partially Met (pass)

Strengths

- TMRSN has the ability to produce scheduled and ad hoc reports as requested.

Opportunity for Improvement

TMRSN's lack of access to accurate data from its contracted providers has caused a delay in producing the 2014 annual quality management program evaluation.

- As stated previously, TMRSN needs to continue working with its contracted providers to obtain accurate data so it is able to accurately assess requests to change providers, analyze all data, then integrate and generate reports to make informed management decisions.

Basic Elements

FEDERAL REGULATION SOURCE(S)

§ 438.242 (b): Health Information Systems

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

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

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

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

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

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

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

STATE REGULATION / RSN AGREEMENT SOURCE(S)

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

SCORING CRITERIA

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

- The RSN makes all collected data available to the State and, upon request, to CMS.

Reviewer Determination

Partially Met (pass)

Opportunities for Improvement

Several subcontracted providers reported during the review that challenges exist with data extraction and delivery to the RSN computer systems.

- As previously stated, TMRSN should continue to work with its network providers to improve the process of collecting data in standardized formats and reviewing the data for accuracy, timeliness, completeness, logic and consistency.

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 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 of 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

Implementation of High-fidelity Wraparound to Achieve Better Outcomes for Children and Youth

TMRSN and community stakeholders selected the "Implementation of High-fidelity Wraparound" for its 2011–2016 clinical program improvement project (PIP). The topic was important to the community for a variety of reasons: the data demonstrated a need for the program, the program aligned with local and State priorities, and community stakeholders were highly invested in the wraparound philosophy and the adherent model. A study conducted by Washington State Department of Health's Infectious Disease & Reproductive Health Assessment Unit found that Thurston and Mason counties ranked third-highest amongst all Washington counties on the Adverse Childhood Events Scores (ACES) in the 2009 Behavioral Risk Factor Surveillance System (BRFSS) study. This indicated that Thurston-Mason children/youth far exceed the state's average for risk factors such as living with mentally ill/suicidal

individuals, problem drinkers/alcoholics, individuals who served time in the justice system, separated/divorced caregivers, and physically and verbally assaultive caregivers/adults. A key component of High-fidelity Wraparound is the inclusion of parent and youth peer-to-peer support partners in the Wraparound process, which is a priority for TRSN. TRSN also recognized that its improvement efforts must align with State initiatives relating to children's mental health redesign, which proposes coordinated care grounded in System of Care philosophies for children/youth with intensive mental health needs (the primary target population of RSNs). Also the State's model identifies Wraparound as one of the core practice elements, with Wraparound care coordination being the primary vehicle to accomplish this goal.

Table C-3: Clinical PIP Validation Results

Study Design		Activity	Narrative	SCORE
Design	1	Appropriate study topic	TMRSN implemented High-fidelity Wraparound as its clinical PIP to achieve better outcomes for children and youth.	Fully Met (pass)
	2	Clearly defined, answerable study question	Will the introduction of High-fidelity Wraparound supports in the Thurston-Mason community significantly improve(decrease) the mean scores for overall emotional and behavioral functioning of Medicaid-enrolled children/youth (ages 5–20) who receive supports through the Mason-Thurston Wraparound Initiatives as measured by the Informant-rated (parent) Strengths and Difficulties Questionnaire Total Difficulties Scale?	Fully Met (pass)
	3	Correctly identified study population	Medicaid-enrolled children/youth (ages 5–20 years) who reside in Thurston or Mason counties, have involvement in multiple child-serving systems, and who meet the inclusionary criteria.	Fully Met (pass)
	4	Correctly identified study indicator	Numerator: SDQ Total Difficulties mean score at intake (pre) for all Medicaid youth enrolled in MTWI during the specified measurement periods minus the Total Difficulties mean score for the same cohort at re-measurement ($M_1 - M_2$). Denominator: Standard t-ratio Indicator: The Strengths and Difficulties Questionnaire, an internationally validated tool, which measures change in emotional and behavioral functioning over time.	Fully Met (pass)

Reviewer Comments:
TMRSN chose an appropriate study topic regarding implementation of High-fidelity Wraparound to achieve better outcomes for children and youth.

The Study question is clearly defined and measurable with an intervention, desired direction, numerator and denominator. The RSN has a clearly defined study population of Medicaid-enrolled children/youth (ages 5–20 years) who reside in Thurston or Mason counties, have involvement in multiple child-serving systems, and who meet the inclusionary criteria. TMRSN correctly identified the study indicator with a clear and correct numerator and denominator. The RSN has met all standards for the design of the PIP.

Implementation	5	Valid sampling technique	No sampling was conducted.	N/A
	6	Accurate/ complete data collection	Data for this study is collected manually from results of the Strengths and Difficulties Questionnaire (SDQ) Total Difficulties Scale.	Fully Met (pass)
	7	Appropriate data analysis/ interpretation of study results	The intervention was implemented as planned with no changes to the study design and without any known threats to the internal/external validity. Medicaid-enrolled children/youth included in this study appear to have improved emotional and behavioral functioning as a result of this intervention.	Fully Met (pass)

Reviewer Comments:
TMRSN did not use sampling techniques for this PIP. The RSN has accurate and complete data collection through administrative data collection of the SDQ and a structured interview. Appropriate data analysis and interpretation of study results were used, based on the calculated indicators; the results of the intervention appear to be significant. TMRSN has met standards for the implementation of the PIP.

Outcomes	8	Appropriate improvement strategies	Community stakeholders selected implementation of High-fidelity Wraparound for this clinical PIP because it addresses current gaps/barriers in our system of care, it aligns with local and State priorities, the community has demonstrated “readiness” to implement an adherent Wraparound program, studies demonstrate a good return on investment, and it is research based.	Fully Met (pass)
	9	Real improvement achieved	All three study periods show an improvement from baseline to 6-month follow-up and, when combined, demonstrate a significant improvement. The	Fully Met (pass)

			difference in improvements from year to year have trended in the desired direction with 2014 stand-alone data reaching p<.01 significance for the first time.	
	10	Sustained improvement achieved	The Mason-Thurston Wraparound Initiative (MTWI) has demonstrated sustained improvement through the second re-measurement.	● Fully Met (pass)
Overall Score				● Fully Met (pass)
Reviewer Comments	**Strength(s):** TMRSN met all standards for this PIP. **Recommendation(s):** TMRSN should continue this PIP to incorporate the Child and Adolescent Needs and Strengths (CANS) data in comparison to the SDQ data, through enhancing the study question, adding new indicators and explaining how the comparison of the CANS and SDQ is appropriate. **Confidence Level:** High confidence in reported results			

Standard 1: Selected Study Topic Is Relevant and Prioritized

Table C-4: Validation of PIP Selected Study Topic

Criterion	Description	Result
1.1	The study topic was selected through data collection and analysis of comprehensive aspects of specific enrollee needs, care and services.	● Fully Met (pass)
1.2	The PIP is consistent with the demographics and epidemiology of the enrollees.	● Fully Met (pass)
1.3	The PIP considered input from enrollees with special healthcare needs.	● Fully Met (pass)
1.4	The PIP addresses a broad spectrum of key aspects of enrollee care and services.	● Fully Met (pass)
1.5	The PIP, over time, included all enrolled populations.	● Fully Met (pass)
Reviewer Comments: TMRSN met all criteria for the study topic. The study topic was selected through data collection and analysis, using a 2008 Mercer actuarial study of service data and demonstrated that Thurston-Mason Regional Support Network's outpatient service hours (excluding per diem and crisis) for the birth-to-age-20 population were 19.8% below Washington State's average. Additional TMRSN studies for 2009 and 2010 demonstrate the RSN has continued to under-serve this population (2009 was 84% of the state average and 2010 was 86% of the state average). Low utilization rates not only have a fiscal impact (decreased Medicaid capitation rates), but also raise serious clinical concerns about access to medically necessary services.		

The PIP is consistent with the demographics and epidemiology of the enrollees. Only Medicaid-enrolled children/youth will be included in the statistical analysis for this study. The High-fidelity Wraparound program was further expanded in 2013 with a new capacity of 66 overall slots, 62 designated for Medicaid enrollees only, and then again in 2014 for a new capacity of 80 total slots, with 76 designated for Medicaid enrollees only.

The PIP considered input from enrollees with special healthcare needs. The stakeholder collaborative determined that the data best supported targeting youth utilizing deep-end, multi-system services who were exhibiting behavioral challenges, significantly interrupting functioning across multiple domains (home, school, etc.), and/or were at high risk of being placed outside the home environment. A family peer/advocate took the lead in convening a diverse group of stakeholders to form the Wraparound Steering Committee (now known as the Mason-Thurston Wraparound Initiative Steering Committee).

The PIP addressed enrollee care and services over time; all enrollees have acute mental illness.

Opportunities for Improvement- N/A

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.	Fully Met (pass)
2.2	The study question identifies the focus of the PIP and sets the framework for data collection, analysis and interpretation.	Fully Met (pass)

Reviewer Comments: TMRSN met all criteria for the study question.

The study question is clear, concise and answerable: Will the introduction of High-fidelity Wraparound supports in the Thurston-Mason community significantly improve (decrease) the mean scores for overall emotional and behavioral functioning of Medicaid-enrolled children/youth (ages 5–20)? The control group is defined as Medicaid youth who receive supports through the Mason-Thurston Wraparound Initiatives, as measured by the Informant-rated (parent) Strengths and Difficulties Questionnaire Total Difficulties Scale.

Opportunities for Improvement: N/A

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

Table C-6: Validation of PIP Study Population

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

Reviewer Comments: TMRSN meets all criteria for the study population.

The RSN PIP enrollee population is clearly defined: Medicaid-enrolled children/youth (ages 5–20 years) who reside in Thurston or Mason counties and have involvement in multiple child-serving systems meeting the inclusionary criteria.

The data collection approach captures all enrollees to whom the study question applies: the entire population of Medicaid-enrolled youth (ages 5–20) who reside in Thurston and Mason counties, receive Wraparound services, and completed the SDQ at intake and follow-up.

TMRSN has appropriate data sources and evaluation methods used to identify the study population: the RSN used ProviderOne, their EMR, and the SDQ of those enrolled in CCS N=95.

Opportunities for Improvement: N/A

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)

Reviewers Comments: TMRSN met all criteria for the study indicator.

The study uses objective, clearly defined, measurable indicators: Numerator: SDQ Total Difficulties mean score at intake (pre) for all Medicaid youth enrolled in the Mason-Thurston Wraparound Initiative during the specified measurement periods minus the Total Difficulties mean score for the same cohort at re-measurement ($M_1 – M_2$). Denominator: Standard t-ratio. Indicator: The Strengths and Difficulties Questionnaire, an internationally validated tool, which measures change in emotional and behavioral functioning over time.

The RSN indicators track performance over a specified period of time: first measurement (July 1, 2011–December 31, 2012), re-measurement (January 1, 2013–December 31, 2013), and second re-measurement (January 1, 2014–December 31, 2014).

TMRSN's number of indicators is adequate to answer the study question. TMRSN, in consultation with the University of Washington Evidence-Based Practice Institute (UW-EBPI), the SDQ developer and community stakeholders, selected the Strengths and Difficulties Questionnaire (SDQ) Total Difficulties Scale as the indicator, because it is a valid and reliable metric for measuring emotional and behavioral functioning of the target population. The Total Difficulties Scale is derived from the sum scores of four subscales (emotional symptoms, conduct problems, hyperactivity/inattention and peer relationship problems) and therefore more broadly examines functioning and well-being than would be possible with most indicators.

Opportunities for Improvement: N/A

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
TMRSN did not use sampling techniques for this PIP.		

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: TMRSN met all criteria for the data collection procedures.

The study design clearly specifies the date to be collected. Data for this study is collected manually from results of the Strengths and Difficulties Questionnaire (SDQ) Total Difficulties Scale. The SDQ is administered through a structured interview process. All individuals conducting the interviews are trained by the University of Washington Evidence-Based Practice Institute.

The RSN's study design clearly specifies the sources of data: ProviderOne and completed SDQs.

The study design specifies a systematic method of collecting valid and reliable data: The completed SD Questionnaire and a structured interview (for intake and follow-up). Baseline data is collected within a four-week window: two weeks before until two weeks after the intake. Re-measurement data is also collected within a 4-week window: two weeks before until two weeks after the six-month date.

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. The instruments for data collection provide for consistent and accurate data collection over the time periods studied and include the following:

1. All SDQ interviews are performed face-to-face and completed within specified time frames.
2. Baseline data is collected within a four-week window: two weeks before to two weeks after the intake.
3. Re-measurement data is also collected within a four-week window: two weeks before to two weeks after the six-month date.
4. The UW-EBPI also conducts statistical analysis of the SDQ Total Difficulties scores for this PIP at the specified intervals.
5. The study design prospectively specifies a data analysis plan. The statistical analysis will assess whether the change in respondents' mean SDQ Total Difficulties score from baseline to re-measurement is statistically significant.
6. This study involves the comparisons of scores from the same cohort being measured at scheduled intervals, including intake, 6 months, 12 months and 18 months (or at conclusion of MTWI support if between 12 and 18 months).
7. Qualified staff and personnel were used to collect the data. All individuals conducting the interviews are trained by the University of Washington Evidence-Based Practice Institute (UW-EBPI).

Staffing for this project included a program coordinator, clinical director, supervisor/coach, team facilitators, and family partners (certified peer counselors). Because High-fidelity Wraparound is a complex process requiring a variety of skill sets, all personnel functioning in key roles were required to have substantial training and were required to participate in ongoing coaching, supervision and booster trainings.

Opportunities for Improvement: N/A

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.	Fully Met (pass)
7.2	Numerical PIP results and findings were accurately and clearly presented.	Fully Met (pass)
7.3	The data analysis methodology was appropriate to the study question and data types.	Fully Met (pass)
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.	Fully Met (pass)
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.	Fully Met (pass)

Reviewer Comments: TMRSN met all criteria in the data analysis and interpretation of study results standard.

The RSN analysis of the finding was performed according to the data analysis plan. The intervention was implemented as planned with no changes to the study design and without any known threats to the internal/external validity. Medicaid-enrolled children/youth included in this study appear to have improved emotional and behavioral functioning as a result of this intervention.

The PIP results and finding were accurately and clearly presented in the tables (6-month Numerator=95, Baseline Mean=23.56 Standard Deviation (SD)=7.10, 6 month Mean=21.09 SD=8.30, 12 month n-42, Baseline Mean=23.02 SD= 6.75, Mean=20.12 SD=8.34).

The RSN's 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. This PIP involves comparisons of the same cohort of children's/youth's Strengths and Difficulties (SDQ) Total Difficulties Scale mean scores being measured multiple times, before and after (6-month intervals) the Wraparound intervention was initiated. Using this methodology, the respondents function as their own control group, lowering the level of unexplained variance or error. An additional measure tracked was the number/percentage of youth who completed "treatment." In order to be counted as a successful completion, the family and Wraparound Team must agree that at least 70% of their identified goals have been met, a transition plan has been developed, and the family/team participate in a "celebration" process.

TMRSN's analysis of study data included an interpretation of the extent to which the PIP was successful, as well as follow-up activities: High-fidelity Wraparound is an intensive support model, which requires small caseloads of twelve cases per facilitator and typical service duration of 12–18 months. Therefore, the study sample (n) was relatively small. Considering this, TMRSN chose to combine the first 18-month data for the initial study and then analyze MTWI data annually, including data from the previous phases for the re-measurement studies. TMRSN was selected as an early adoption location for the implementation of Wraparound with Intensive Services (WISe) starting July 2014. A requirement for this program was the use of the Child and Adolescent Needs and Strengths (CANS) tool for WISe screening and then every three months for treatment and discharge planning. The 2015 PIP has integrated CANS data into the study.

Opportunities for Improvement: N/A

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.	Fully Met (pass)
8.2	Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes.	Fully Met (pass)
8.3	The interventions are/were sufficient to be expected to improve processes or outcomes.	Fully Met (pass)
8.4	The interventions are/were culturally and linguistically appropriate.	Fully Met (pass)

Reviewer Comments: TMRSN met all criteria for the improvement strategies standard.

A continuous cycle of measurement and performance analysis was conducted. Community stakeholders selected implementation of High-fidelity Wraparound for this clinical PIP because it addressed current gaps/barrier in TMRSN's system of care, it aligned with local and State priorities, the community has demonstrated “readiness” to implement an adherent Wraparound program, studies demonstrated good return on investment, and it is research based.

The RSN had reasonable interventions that were undertaken to address causes/barriers identified through data analysis and QI processes. The Thurston-Mason community ranks well above state averages in risk studies indicating the need for intensive mental health supports, yet utilization data demonstrates that TMRSN outpatient services/supports (especially for the highest-need children/youth) are not being provided at a commensurate level. Furthermore, peer support services targeting this population in Thurston-Mason have been virtually nonexistent. The primary limitation of this study was the small sample served annually, which required including individuals from Phase 1 in this year’s study to have a large enough “n” to detect significant effects.

The RSN’s interventions were sufficient to be expected to improve process or outcomes. Wraparound is an “intensive, individualized care planning and management process.” It is not a “treatment” per se; rather, it is a community-based planning process that shows promise in reducing the number of children placed in more restrictive settings (e.g., inpatient and residential treatment) because of improvements in emotional and behavioral functioning. Each child/youth and family that participates in Wraparound is assigned a Team Facilitator and a Family/Youth Partner (Washington Certified Peer Counselor) who supports the family throughout the wraparound process. Maintenance in less restrictive, community-based placement shows an improvement in behavior and reduced juvenile justice recidivism, increased school achievement and attendance.

TMRSN’s interventions are culturally and linguistically appropriate. These efforts include

- “Cultural identity” addressed throughout Wraparound process and on the Wrap Plan
- Hiring minority facilitators and family partners whenever possible
- Ongoing social marketing activities that target presentations to agencies that specialize in serving minority populations

- Allowing a wide variety of referral sources
- Providing translation services (interpreters) as needed
- Using the website translator; making translated versions of brochures and other written materials available to the community
- Monitoring referral sources
- Monitoring enrollment rates of minority populations

Twenty-five and one-tenth percent (25.1%) of the 95 children/youth included in this study identify themselves as a minority population. This penetration rate far exceeded the Thurston-Mason minority population distribution of 14.4%, which demonstrated good access to Wraparound services for non-white children/youth.

Opportunities for Improvement: N/A

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.	Fully Met (pass)
9.2	There was documented, quantitative improvement in processes or outcomes of care.	Fully Met (pass)
9.3	The reported improvement in performance appears to be the result of the planned quality improvement intervention.	Fully Met (pass)
9.4	There is statistical evidence that any observed performance improvement is true improvement.	Fully Met (pass)

Reviewer Comments: TMRSN met all criteria for assessing improvement standard.

The same methodology as the baseline measurement was used when measurement was repeated using a T test. The RSN documented quantitative improvement in processes or outcomes of care: 6-month N = 95, Baseline Mean=23.56 SD=7.10, 6-month Mean=21.09 SD=8.30, 12-month n-42, Baseline Mean=23.02 SD= 6.75, Mean=20.12 SD=8.34). TMRSN showed true improvement through the baseline to the second re-measurement.

Opportunities for Improvement: N/A

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.	Fully Met (pass)

Reviewer Comments: TMRSN meets the criteria for the sustained improvement standard.

The RSN's PIP improvement was demonstrated through repeated measurements over comparable time periods: 6-month N=95, Baseline Mean=23.56 SD=7.10, 6-month Mean= 21.09 SD=8.30, 12-month n-42, Baseline Mean=23.02 SD= 6.75, Mean=20.12 SD=8.34). The reduction from baseline percent to the second re-measurement was statistically significant.

Opportunities for Improvement: N/A

PIP Validation Results: Non-Clinical PIP

Improving TMRSN's Utilization Management of Core Outpatient Services
The study topic for the current non-clinical PIP is a method for improving TMRSN's utilization management of core outpatient services at the RSN's largest provider agency. Specifically, the study topic focuses on the number of hours of core outpatient mental health services provided for Medicaid enrolled adults at the agency during the first 90 days following intake. TMRSN's initial interest in the study topic resulted from the quality manager's observation during chart review audits that Medicaid adult clients were receiving fewer outpatient service hours than expected, particularly in the initial stages of treatment following intake. The quality manager also noted the presence of a large number of adult outpatient cases that had been open for many years, long past the time clinically needed to assist those clients in building the skills and support necessary to gain stability and better control of their symptoms.

As a result of the quality manager's observations, TMRSN's care managers began to research outpatient utilization monitoring tools. The quality manager also agreed to contact other RSNs to ask their experience in monitoring outpatient service utilization patterns. Through these conversations, TMRSN learned in early 2012 that other Washington RSNs were finding the Level of Care Utilization System (LOCUS) and the Children and Adolescent Level of Care Utilization System (CALOCUS) useful for monitoring utilization of outpatient services. They described the LOCUS and CALOCUS tools as effective for identifying patterns of over- or underutilization based on their care managers' reviews of medical necessity and clinically effective treatment. TMRSN requested and received information on the LOCUS and CALOCUS tools. The tools were developed by the American Association of Community Psychiatrists and the American Academy of Child and Adolescent Psychiatry.

TMRSN also requested outpatient utilization data from two western Washington RSNs to compare to its own outpatient utilization data. The data comparison indicated that TMRSN adult Medicaid enrollees were receiving fewer outpatient service hours per month than adults in the two other RSNs. TMRSN also learned that in the past, child Medicaid enrollees had also received fewer service hours per child compared to the other RSNs. However, since 2011 TMRSN has increased the number of intensive service programs available to enrollees who are children. TMRSN's number of service hours for children has increased as a result of those programs. TMRSN has not added comparable intensive service programs for its adult enrollees during that same time. TMRSN committed to further explore its utilization management of adult outpatient services and to explore with its enrollees and providers the opportunity to study the topic through a formal PIP.

Table C-14: Non-Clinical PIP Validation Results

Study Design		Activity	Narrative	SCORE
Design	1	Appropriate study topic	Improving TMRSN utilization management of core outpatient services	Fully Met (pass)
	2	Clearly defined, answerable study question	Does implementing the LOCUS significantly increase the average number of core outpatient service hours received in the first 90 days following intake by TMRSN adult Medicaid enrollees who receive core outpatient services and who are not terminated before 90 days from the date of intake?	Fully Met (pass)
	3	Correctly identified study population	TMRSN is studying adult Medicaid-eligible enrollees who receive core outpatient mental health services for at least 90 days following an intake from Behavioral Health Resources.	Fully Met (pass)
	4	Correctly identified study indicator	Denominator = The number of unique episodes of intakes followed by at least 90 days continued enrollment by TMRSN adult Medicaid enrollees, all within the measurement period. Dividing the numerator by the denominator will yield an average number (mean) of core outpatient service hours received within the first 90 days following intake by adult Medicaid enrollees who receive an intake and who maintain enrollment for at least 90 days from the date of intake.	Fully Met (pass)
Reviewer Comments: The RSN has met all standards for the design of the PIP. TMRSN chose an appropriate study topic regarding improving TMRSN utilization management of core outpatient services at its largest provider agency. The study question is clearly defined and measurable with an intervention, desired direction, numerator and denominator. The RSN has a clearly defined study population of adult Medicaid-eligible enrollees who receive core outpatient mental health services for at least 90 days following an intake. The RSN correctly identified the study indicator with a clear and correct numerator and denominator.				
Implementation	5	Valid sampling technique	No sampling was conducted.	N/A

	6	Accurate/ complete data collection	Hours of services for adult mental health Medicaid enrollees with a LOCUS over 90 days enrollment from intake.	Fully Met (pass)
	7	Appropriate data analysis/ interpretation of study results	TMRSN presented training for clinical personnel from all of its core service provider agencies in 2013. In January 2014, TMRSN required its outpatient service providers to complete a LOCUS score sheet for all authorization requests for Medicaid-funded core services. The first six months of 2014 were deemed "pilot project," providing time for clinical supervisors and clinicians to become more familiar with the LOCUS as they used it. TMRSN provided guidance to agency supervisors, responded to questions, shaped agency understanding of the LOCUS as a clinical utilization tool, and prepared for full implementation as of July 1, 2014.	Fully Met (pass)
Reviewer Comments: TMRSN used appropriate data for the re-measurement analysis and interpretation of study result**.** No sampling was conducted. The RSN has accurate and complete data collection through MIS, ProviderOne, chart review, LOCUS, SAC codes and hours of services.				
Outcomes	8	Appropriate improvement strategies	TMRSN and stakeholders are choosing the LOCUS to improve frequency of initial outpatient services after intake, reduce amount of time necessary to achieve initial treatment goals, and improve TMRSN's outpatient authorization and utilization practices.	N/A
	9	Real improvement achieved	The PIP did not progress to this point.	N/A
	10	Sustained improvement achieved	The PIP did not progress to this point.	N/A
Overall Score				Fully Met (pass)

Reviewer Comments	TMRSN meet all standards to which the PIP has progressed. **Recommendation(s):** TMRSN should continue this PIP, along with improving the data transfer from the agency to TMRSN to ensure all data is captured. **Confidence Level:** Not enough time has elapsed to assess meaningful change.

Standard 1: Selected Study Topic Is Relevant and Prioritized

Table C-15: Validation of PIP Selected Study Topic

Criterion	Description	Result
1.1	The study topic was selected through data collection and analysis of comprehensive aspects of specific enrollee needs, care and services.	Fully Met (pass)
1.2	The PIP is consistent with the demographics and epidemiology of the enrollees.	Fully Met (pass)
1.3	The PIP considered input from enrollees with special healthcare needs.	Fully Met (pass)
1.4	The PIP addresses a broad spectrum of key aspects of enrollee care and services.	Fully Met (pass)
1.5	The PIP, over time, included all enrolled populations.	Fully Met (pass)

Reviewer Comments: TMRSN met all criteria in the study topic standard.

The study topic was selected through data analysis of comprehensive aspects of enrollee needs. TMRSN's initial interest in the study topic resulted from the quality manager's observation during chart review audits that Medicaid adult clients were receiving fewer outpatient service hours than expected, particularly in the initial stages of treatment following intake. The quality manager also noted the presence of a large number of adult outpatient cases that have been open for many years, long past the time clinically needed to assist those clients in building the skills and support necessary to gain stability and better control of their symptoms.

The PIP is consistent with the demographics and epidemiology of the enrollees: A preliminary review of 2012 TMRSN data indicated that 3,190 adult Medicaid enrollees received outpatient services. Nearly twice as many Medicaid adults as children received outpatient services. First, the RSN's largest agency provides about 95 percent of the outpatient services for TMRSN's adult enrollees. Second, TMRSN served nearly twice as many adult enrollees as children with outpatient services in 2012.

The PIP considered input from enrollees with special healthcare needs. TMRSN then presented the trends to its advisory board and proposed the topic as appropriate for a PIP. The board, which includes enrollees and family members of enrollees, agreed and asked for feedback as the intervention unfolds and re-measurement data became available.

The PIP addresses a broad spectrum of key aspects of enrollee care and services. All enrollee are severely and persistently mentally ill adults.

Opportunities for Improvement: N/A

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.	Fully Met (pass)
2.2	The study question identifies the focus of the PIP and sets the framework for data collection, analysis and interpretation.	Fully Met (pass)

Reviewer Comments: TMRSN met all criteria for the study question standard.

The study question is clear, concise and answerable: Does implementing the LOCUS significantly increase the average number of core outpatient service hours received in the first 90 days following intake by TMRSN adult Medicaid enrollees who receive core outpatient services and who are not terminated before 90 days from the date of intake?

Opportunities for Improvement: N/A

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)

Reviewer Comments: TMRSN met all the criteria for the study population standard.

The enrollee population to whom the study question and indicator is relevant is clearly defined. TMRSN is studying adult Medicaid-eligible enrollees who receive core outpatient mental health services for at least 90 days following an intake from the RSN's largest provider.

The data collection approach captures all enrollees to whom the study question applied. TMRSN will exclude data for adult Medicaid enrollees who are not continuously Medicaid-eligible for 90 days following

intake. TMRSN will also exclude data for adult Medicaid enrollees who are not continuously enrolled as active clients for 90 days following intake.

Appropriate data sources and evaluation methods were used to identify the study population: ProviderOne and LOCUS.

Opportunity for Improvement: N/A

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)

Reviewer Comments: TMRSN met all the criteria for the study indicator standard.

The RSN uses objective, clearly defined, measurable indicators: Denominator = The number of unique episodes followed by at least 90 days continued enrollment by TMRSN adult Medicaid enrollees, all within the measurement period. Dividing the numerator by the denominator will yield an average number (mean) of core outpatient service hours received within the first 90 days following intake by adult Medicaid enrollees who receive an intake and who maintain enrollment for at least 90 days from the date of intake.

The indicators track performance over a specified period of time: January 1, 2012 to June 30, 2014. Now that the intervention has begun, TMRSN is monitoring the study indicator quarterly. This PIP reflects only the results of the first two quarters in the first re-measurement year.

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. TMRSN believes its single study indicator is appropriate and suitable for addressing the study question. The indicator reflects TMRSN's goal of increased service hours being available for the agency's adult clients following intake, and the intervention makes clear the range of expected service hours for each of the levels of care. The single indicator makes it clear that TMRSN expects the plan of care for adult clients to include appropriate frequency and intensity of services. The single indicator is also realistic given the difficulties with data quality experienced since TMRSN transitioned to an MCO database product and the agency transitioned to an electronic medical record.

Opportunities for Improvement: N/A

Standard 5: Sampling Method

Table C-19: Validation of PIP Sampling Methods

Criterion	Description	Result
6.1	The study design clearly specifies the data to be collected.	N/A
6.2	The study design clearly specifies the sources of data.	N/A
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.	N/A
6.4	The instruments for data collection provide for consistent and accurate data collection over the time periods studied.	N/A
6.5	The study design prospectively specifies a data analysis plan.	N/A
6.6	Qualified staff and personnel were used to collect the data.	N/A
Reviewer Comments: TMRSN did not use sampling methods.		

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.	Fully Met (pass)
6.6	Qualified staff and personnel were used to collect the data.	Fully Met (pass)

Reviewer Comments: TMRSN met all criteria in the data collection procedure standards.

The RSN PIP study design clearly specifies the data to be collected: the hours of services for adult mental health Medicaid with LOCUS over 90 days' enrollment from intake.

The study design clearly specifies the sources of data: MIS, ProviderOne, chart review, LOCUS and hours of services.

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. To get the denominator information for this PIP baseline, TMRSN first ran a report in its managed care organization (MCO) management information

system (MIS) to isolate all intake services (service activity codes [SACs] = 210, 211, 212, 491, 492, 493) reported in core outpatient services or the Access Center (project codes = 100, 105, 111) during first nine months of the baseline period (January 1, 2012–September 30, 2012). A column was inserted to calculate the number of days between the intake date and the status end date. All those who had a closed status within 90 days were filtered out and excluded from the report.

The instruments for data collection provide for consistent and accurate data collection over the time periods studied: MIS, chart review, EMR and SAC codes are used. The time period studied has been an issue that TMRSN is actively resolving with new EMR systems and transferring of data.

The study design prospectively specifies a data analysis plan. The study indicator produces a continuous variable, a numeric average. The comparison groups are independent. A t-test is used to analyze the difference between the mean scores of two distinct groups. TMRSN will use a two-tailed test for the t-test. TMRSN expects the intervention will increase the average number of hours of core outpatient services provided to adult Medicaid enrollees in the first 90 days following intake. The t-test will test the null hypothesis that the two sample groups have the same mean and that any differences are due to chance or sampling error. The P value is used to ask whether the difference between the mean of two groups is likely to be due to chance.

TMRSN has qualified staff and personnel used to collect the data; TMRSN's MIS coordinator confirmed inclusion and exclusion criteria for numerator and denominator data. The RSN's data support personnel collected the study data from TMRSN's MIS database.

Opportunities for Improvement: N/A

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.	Fully Met (pass)
7.2	Numerical PIP results and findings were accurately and clearly presented.	Fully Met (pass)
7.3	The data analysis methodology was appropriate to the study question and data types.	Fully Met (pass)
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.	Fully Met (pass)
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.	Fully Met (pass)

Reviewer Comments: TMRSN met all criteria for data analysis and interpretation of study results standard.

Analysis of the findings was performed according to the data analysis plan. TMRSN presented training for clinical personnel from all its core service provider agencies in 2013. In January 2014, TMRSN required its outpatient service providers to complete a LOCUS score sheet for all authorization requests for Medicaid-funded core services. The first six months of 2014 were deemed "pilot project," providing time for clinical

supervisors and clinicians to become more familiar with the LOCUS as they used it. TMRSN provided guidance to agency supervisors, responded to questions, shaped agency understanding of the LOCUS as a clinical utilization tool, and prepared for full implementation as of July 1, 2014. Numerical PIP results and findings were accurately and clearly presented: baseline, 6.069 hours N=341; first re-measurement, 5.3 hours N=274.

This first re-measurement was a six-month period to give the "pilot" measurement; the first real re-measurement had passed before the EQR Review. The data analysis methodology was appropriate to the study question and data types. The two-tailed P value equals 0.0515. By conventional criteria (P< 0.05), this difference in mean hours between the two groups would be considered to be not quite statistically significant. P is a value ranging from zero to one, and if the two groups really have the same mean, this establishes the probability of observing at least as large a difference between sample means, as was in fact observed.

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. Baseline data for this PIP was collected before both TMRSN and the agency changed their data systems during 2013. However, even after implementing MCO as its database product in 2013, TMRSN's Data Dictionary, containing definitions and codes for service activities, did not change significantly. TMRSN's processing of outpatient authorization requests, once received from the agency, also did not change significantly.

All adults meeting inclusion criteria for the denominator are included in the study. The study population does not include sampling, and there has been no special handling of adults included versus those not meeting inclusion criteria. All adult Medicaid clients at the agency, whether included in the study or not, received the LOCUS assessment at intake. Adult clients whose service hours are included in the study received services in the same settings and from the same clinicians as those adults whose service hours did not meet inclusion criteria. No adult service clinicians have been excluded. Finally, there was no pretesting and post testing that might influence the clinicians or clients to perform toward an expected standard.

The analysis of study data included an interpretation of the extent to which the PIP was successful, as well as follow-up activities. Data for the first six months of a 12-month re-measurement period do not demonstrate a measured increase in core outpatient service hours in the first 90 days following intake for Medicaid-enrolled adults. MIS personnel indicate their position that data are incomplete. In addition, it is not yet clear whether adding the missing data would constitute a measured increase in service hours counted in the numerator.

TMRSN will report a conclusion relative to the full first remeasurement period after July 1, 2015. TMRSN will continue to meet with the agency's adult clinical managers to report quarterly updates to the study indicator as the first re-measurement period progresses. TMRSN will also continue to consult with clinical managers regarding results of its Inter-rater Reliability measurements. TMRSN will continue to explore possibilities for expanding its network of Certified Mental Health Agencies that could provide core outpatient services to adults. TMRSN does not plan to modify the study indicator prior to the next review.

Opportunities for Improvement: N/A

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.	Fully Met (pass)
8.2	Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes.	Fully Met (pass)
8.3	The interventions are/were sufficient to be expected to improve processes or outcomes.	Fully Met (pass)
8.4	The interventions are/were culturally and linguistically appropriate.	Fully Met (pass)

Reviewer Comments: TMRSN met all criteria for improvement strategies standard.

The RSN conducted a root cause analysis using the analogy of the weed provided to RSNs by EQRO in 2013, in that symptoms of the problem are above the surface and the root system underlying causes below the surface: the weed is the lack of frequency of core outpatient services for adults following intake. Causes include the following:

- The State and RSNs have focused on measuring the time between referrals and intake and first face-to-face service. TMRSN has not monitored closely enough the frequency of services following the initial face to face.
- In response to reduced revenue, the agency has reduced clinician positions, including some who were providing core outpatient services.
- Caseloads increased dramatically for remaining clinicians, leading to fewer service hours per month for individual enrollees.
- The agency emphasized increased use of group services to increase total service hours for its enrollees.

TMRSN, the agency and stakeholders are choosing the LOCUS to improve frequency of initial outpatient services after intake, reduce the amount of time necessary to achieve initial treatment goals, and improve TMRSN's outpatient authorization and utilization practices. Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes. Continuing difficulties with data transmission and accuracy have led TMRSN managers to review the viability of the RSN's current MIS product.

Opportunities for Improvement: N/A

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
The PIP has not progressed to this point.		

Standard 10: The RSN Has Sustained the Documented Improvement

Table C-24: Validation of PIP Sustained Improvement

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

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Information Systems Capabilities Assessment (ISCA)

Qualis Health's subcontractor, Healthy People, examined TMRSN'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.

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 TMRSN's performance for seven review areas. Rankings are based on the following: fully meeting, partially meeting, or not meeting standards. Although not rated, TMRSN'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 were 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.
- Storing paper-based claims and encounters in locked storage facilities when not in use. Data transferred between systems/locations should be encrypted.
- Maintaining 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.
- Ensuring integrity by periodically verifying backups 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.

- Including with databases and database updates 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.
- Using 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 Thurston-Mason 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, and a 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 Thurston-Mason 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 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 determined as being 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 (e.g., 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, 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 rubric for the ISCA Standards.

Table D-1: Scoring Rubric for ISCA Standards

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

Summary of Results

TMRSN's information systems and data processing and reporting procedures were all reviewed 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.

TMRSN *fully met* the Federal standards related to information systems capabilities for five review areas and *partially met* the Federal standards related to information systems capabilities for two review areas. One review area was not scored. Table D-2 presents TMRSN's ratings for the eight separate ISCA review areas.

Table D-2: Ratings for the ISCA sections

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.	Partially 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.	Partially 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

During the review year (January–December 2014), TMRSN used the CMHC-MIS EHR, developed by Netsmart Technologies, for encounter data processing. Each contracted provider agency either entered claims/encounter data directly into CMHC-MIS or submitted batch information to TMRSN from its in-house EHR system.

The CMHC-MIS system resides on servers located in the Thurston County IT Data Center. TMRSN contracts with a data and information systems company to provide maintenance administration of the CMHC-MIS system as well as other information systems-related activities (e.g., data analysis, programming).

The detailed TMRSN ISCA review findings for each of the eight ISCA review areas are 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.	Partially Met (pass)

During the review year (January–December 2014), TMRSN used the CMHC-MIS EHR, version 4.2, developed by Netsmart Technologies, for encounter data processing. Each contracted provider agency either entered claims/encounter data directly into CMHC-MIS or submitted batch information to TMRSN from its in-house EHR system. The CMHC-MIS system is secure, robust and scalable, giving programmers the flexibility to develop sophisticated data processing methods.

TMRSN's contracted provider agencies request authorization for services through CMHC-MIS. Credentialed TMRSN care managers perform all authorization decisions manually using Access to Care Criteria Standards and other information submitted by the provider agency.

To ensure proper administration, maintenance and training for the CMHC-MIS system, TMRSN contracts with a private vendor, which employs several programmers trained in modifying these programs. Netsmart provides core technical and programming support for CMHC-MIS. TMRSN also employs a full-time IS coordinator to monitor JCS-contracted activities and to perform other IS-related duties. However, TMRSN does not have a formal process in place to monitor its outsourced IT services. TMRSN needs to develop a formal process for monitoring outsourced IT services.

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)

The TMRSN network consists of sub-contractor/provider access via software and hardware VPN connectivity through the Washington State Inter-Governmental Network (IGN) to a Cisco firewall and Cisco Switch to the UNIX and Windows servers. Washington State Department of Information Services monitors and manages the security of the IGN network environment.

RSN staff access is through the Public Health and Social Service Network to the Thurston County network to a Cisco firewall and Cisco Switch to the UNIX and Windows servers. Thurston County Central Services monitors and manages the security of the county's network environment.

The county actively monitors its data center facility to identify performance and quality issues.

Meets Criteria

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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.	Partially Met (pass)

The CMHC-MIS application server is located in a locked down, climate-controlled technical equipment room with fire suppression at Thurston County's IT Data Center. The equipment room is kept locked at all times and is accessed using a numeric keypad. This code is changed quarterly for security purposes. Authorization to the locked equipment room is limited to pre-approved Thurston County Central Services staff with appropriate background checks. Access to the IT Data Center by others requires that they are accompanied by a Central Services staff and information regarding who is visiting, when, and the reason for the visit is entered into a logbook.

The center performs daily backups seven days per week. Thurston County Central Services and TMRSN perform quarterly restoration testing of backup data to ensure the data are readily available for production.

TMRSN encrypts backup data using Unitrends' InCrypt (Integrated Encryption). Unitrends' InCrypt (Integrated Encryption) solution uses a coprocessor installed in Unitrends' Data Protection Units and Data Protection Vaults to encrypt all the data from a company's designated sources by using the Advanced Encryption Standard (AES) algorithm with a 256-bit key.

The Disaster Recovery site is Thurston County's Emergency Management site. The site has limited key card entry that is logged, with cameras inside and outside, as well as alarms. Additionally, the data center itself has more limited key card entry that is logged.

All of TMRSN's provider agencies are not encrypting their backup data. TMRSN needs to work with its provider agencies to establish encryption practices in accordance with the DBHR contract requirements. It is important to note that the TMRSN contracts with its provider agencies do include the required data encryption requirements and one contracted provider agency is currently out of compliance with its contract with TMRSN.

TMRSN uses an informal process to monitor IT services with its vendor. TMRSN needs to define and establish formal monitoring responsibilities and procedures.

TMRSN has multiple policies and procedures related to information security. All policies and procedures met the need requirements. The county's disaster recovery policy was not annually updated. Despite the policy and procedure also not being updated annually, there were no issues detected with TMRSN's data recovery and backup protocols.

Recommendations Requiring CAP

Backup data is not being encrypted by all of TMRSN's provider agencies.

- TMRSN needs to work with its provider agencies to establish encryption practices in accordance with the DBHR contract requirements.
- TMRSN needs the county(ies) to annually update the disaster recovery policies.
- TMRSN needs to develop a formal process for monitoring outsourced IT services.

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)

TMRSN's formal procedures for rectifying encounter data that are submitted with one or more required fields missing, incomplete or invalid are followed and well documented. During processing, encounter data submissions run through an automated, rules-based edit system in CMHC-MIS to screen the data, identify potential input errors and ensure compliance with the State's Data Dictionary and Service Encounter Reporting Instructions. TMRSN performs further edits and validity checks of procedure and diagnosis code fields, eligibility verification, service authorization and detection of duplicate encounter claims. Screened encounter data submissions are then converted into a HIPAA-compliant 837 format before being transmitted to DBHR via an IGN secure shell connection once a month. As required by DBHR, TMRSN verifies and certifies batched encounter data for accuracy and completeness before transmitting the data.

CMHC/MIS has several proprietary reporting or data extraction tools available for use, in addition to all standard reporting tools available with MS SQL, Crystal Reports and all MS Office products.

Per DBHR instructions, TMRSN submits outpatient service data to DBHR via 837P transaction files and inpatient service data to DBHR via 837I transaction files. DBHR's Service Encounter Reporting Instructions v.201411.2 mandates the following for reporting outpatient service diagnosis codes:

- All Intake Evaluation modality encounters that are complete and for which a diagnosis has been determined are reported with that diagnosis.
- Encounters that occur after a patient intake has been completed and authorized must use the approved/authorized diagnosis in the HI01-2 field for the 837P HIPAA transaction.
- DBHR will only use the HI01-2 field when looking at diagnosis. Other diagnosis codes do not need to be reported.

The capture of the intake evaluation diagnosis only is not compliant with best practice protocols. However, it is not out of compliance with DBHR requirements capture only the intake evaluation diagnosis.

Meets Criteria

Opportunity for Improvement:

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

ISCA Section E: Enrollment Data

Table D-7: Enrollment Data

Section	Description	Result
Section E	This section assesses the RSN's ability to capture and report accurate Medicaid enrollment data.	Fully Met (pass)

DBHR provides member enrollment data to TMRSN and the RSN receives "834" and "820/821" enrollment data files from DBHR.

TMRSN determines Medicaid eligibility for clients and claims by submitting 270 files to ProviderOne and importing/processing 271 files from ProviderOne. For new authorization requests, 270s are created twice per week for all new authorization requests for the start date of the authorization request. For claims, 270s are created and submitted once per week for the current invoicing month to ProviderOne, just before invoicing. Form 270s are also created and submitted for next month's invoicing. Additionally, once per quarter, TMRSN completes a reconciliation for the previous quarter, and creates and submits form 270s for claims in that invoicing month, to ensure that Medicaid eligibility is updated.

Medicaid eligibility verification takes place at several points. Providers verify Medicaid eligibility coverage when the client first arrives to do an intake; this also happens when the provider submits an authorization request. Medicaid eligibility verification happens weekly when a claim is submitted for a client for the current month (this could be later if the provider submits a late service), and for all clients when they have an "open-ended" Medicaid eligibility layer (i.e., no lapse date).

TMRSN does not cross-check forms 834s and 837s before submitting 837s to remove services for members who weren't Medicaid eligible at the time of the encounter, because this is not a State requirement. Instead, TMRSN follows the State DBHR's Service Encounter Reporting Instructions (SERI) v201411.2, on p. 4, which specifies all services that meet the following criteria should be reported to the State:

- State plan services provided to Medicaid-eligible individuals
- Non-covered/non-State plan services to Medicaid-eligible individuals (i.e., IMD facilities, State-Only, or Federal Block Grant)
- All services to non-Medicaid individuals who are funded in whole or part by the RSN

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)

TMRSN claims/encounter reporting is accurate regarding both rendering practitioner type and practitioner service location. TMRSN also has accurate practitioner information within the RSN provider directory. TMRSN maintains up-to-date provider profile information in an accessible repository that enables the RSN's member services staff to help Medicaid enrollees make informed decisions about access to providers that can meet their special care needs, such as translation into non-English languages or clinical specialties.

TMRSN'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)

TMRSN's claims/encounter data is contracted provider agency data and TMRSN does not provide any direct client care. All of TMRSN's provider agencies did not meet the acceptable standard of 95% match rate for encounter data validation in 2014. However, TMRSN's encounter data validation results for 2014 were much improved from 2013. TMRSN developed a corrective action plan to increase encounter data validation accuracy for 2015.

Strength

- TMRSN's encounter data validation results for 2014 were much improved from 2013. TMRSN developed a corrective action plan to increase encounter data validation accuracy for 2015.

Recommendation Requiring CAP

- TMRSN needs to continue to actively monitor and intervene regarding their provider agencies' encounter data validation results.

ISCA Section H: Meaningful Use of 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
Netsmart's CMHC-MIS product is in the process of becoming a certified EHR for Meaningful Use Stage 2. TMRSN is able to accept EDI batch data from its provider agencies choosing not to use Netsmart's CMHC-MIS product.		

Meets Criteria

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.

In performing the data validation for encounters, Qualis Health initially 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, complete encounter data, including a review of the most recent Information System Capabilities Assessment (ISCA) performed by an external quality review organization (EQRO).

Qualis Health then 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
- Conducting a basic integrity check on the encounter data files to determine whether expected data exists, 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

Following completion of the electronic data analysis, Qualis Health conducted a review of clinical record documentation to confirm the findings of the data analysis.

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 RSN's contract with the Division of Behavioral Health and Recovery (DBHR) were the standards for validation.

Each RSN's encounter data validation report that was submitted to DBHR as a contract deliverable for the calendar year 2014 was obtained and reviewed. Encounter data was reviewed for conformance with DBHR contract requirements, such as

- validation methodology for encounter data
- encounter and enrollee sample size(s)
- selected dates and fields

The RSNs' 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:

- Application of standard statistical techniques to identify a sample of encounters from the file provided by the State
- Assurance that the sample size was sufficient to estimate the error rate for the encounter data
- Loading data from the encounter sample into a custom database, to record the scores for each encounter data field
- Providing a list of the enrollees whose clinical charts were selected for review to each RSN 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 RSNs 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)

TMRSN Encounter Data Validation

The TMRSN contracts with six providers for Medicaid-funded services. The EDV process for TMRSN was conducted in December, 2014. However, TMRSN's report states there were known gaps in service data because of the implementation of a new electronic health record (EHR) for its largest provider, which occurred during that year.

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

EDV Standard	Description	EDV Result
Sampling Procedure	Sampling was conducted using an appropriate random selection process and was of adequate size.	● Fully Met (pass)
Review Tools	Review and analysis tools are appropriate for the task and used correctly.	● Fully Met (pass)
Methodology and Analytic Procedures	The analytical and scoring methodologies are sound and all encounter data elements requiring review are examined.	● Fully Met (pass)
Opportunity for Improvement TMRSN should consider locking the encounter data for its review instrument to protect data from being inadvertently changed or deleted. **Recommendation Requiring CAP:** N/A		

Sampling Procedure

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

For its EDV, TMRSN sampled from Medicaid-funded encounters for its six providers that occurred from October, 2013, through September, 2014. An overall sample size of 453 encounters from 113 client

charts was selected, exceeding the contract minimum of 411 encounters, drawn from at least 100 unique client charts.

The data source for the sample was the RSN's MIS, specifically the Integrated Service Note (ISN) database. This source contains only services that were submitted and accepted by the State's MMIS, ProviderOne. ISN encounters are stored separately and cannot be accessed or modified by provider agency staff. While the data source is described as including records accepted by ProviderOne, 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.

TMRSN used a stratified sampling procedure based on agency, project code and age group (including two age groups, for children and adults). Stratum-specific proportions of the final sample were used to estimate the desired sample size of encounters from each stratum, allowing for a 10% oversample to guarantee that the minimum number of encounters would be available for audit. Excel's RANDBETWEEN function was used to assign a random number to each encounter, then after resorting encounters by the random value, the first n encounters were extracted, with n equal to the sample size for that stratum. In order to capture encounters that were reportable based on the chart but were not submitted to the RSN, several (two to six) encounters (if present) occurring before or after the selected encounter were also extracted for analysis. This step allows reviewers to assess whether a service on the chart is missing from the RSN encounter database.

TMRSN's sampling procedure as described in its provided documentation was sufficient for selecting a reliable and representative sample.

Review Tools

TMRSN use a spreadsheet-based EDV tool. The data elements extracted from the RSN's MIS are recorded for each encounter and a validation section for each data element is available for the reviewers to record validation codes. A prompt is provided to remind reviewers of the scoring methodology, which includes four possible validation codes:

- A code of 1 indicates the chart data match the encounter submission.
- A code of 2 indicates that chart data are not present, but the encounter was submitted to the RSN.
- A code of 3 reveals that chart data differ from the encounter submission.
- A code of 4 means chart data indicate a service, but a service is not present in RSN encounter data.

One enhancement TMRSN should consider with its review tool is locking the data fields that hold the encounter records to protect them from being inadvertently changed.

Methodology and Analytic Procedures

Encounter records were loaded into the EDV tool and the contracting agencies were requested to make the selected charts available for onsite review. TMRSN's MIS coordinator and its quality manager reviewed each encounter together and recorded results after achieving agreement on the scoring of encounter data elements in order to ensure inter-observer agreement. Qualis Health reviewed the validation calculations in the tool and found them to be correct.

TMRSN's review tool, methodology and procedures are sufficient 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. TMRSN had <95% records matched for encounter data fields.	Not Met (fail)

Opportunity for Improvement

- TMRSN needs to utilize encounter data processed by the State rather than data maintained by the RSN when conducting EDV.

Recommendation Requiring CAP

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

- To ensure encounter data is substantiated and in compliance, the RSN needs to
  - Provide training on the Service Encounter Reporting Instructions: on coding, on what is included and excluded in each modality, and on the general encounter reporting instructions
  - 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 the RSN from ProviderOne for the October 2013 through September 2014 reporting period, comprising 5,360 patients and 86,422 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 given in Table E-4.

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

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

Measure	State Standard	RSN Performance
Demographic Data		
RSN ID	100% complete, all values in range	100%
Consumer ID	100% complete	100%
First Name	100% complete	100%
Last Name	100% complete	100%
Date of Birth	Optional	100%
Gender	Optional	100%
Ethnicity	100% complete, all values in range	100%
Language Preference	100% complete, all values in range	100%
Social Security Number	Optional	78.8%
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	100%
Procedure Code	100% complete	100%
Claim Number	100% complete	100%
Minutes of Service	100% complete	100%

Clinical Record Review

Qualis Health reviewed 476 encounters submitted by TMRSN 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. Reviewed encounter data fields required for review in the TMRSN contract with DBHR included

- 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 data element match rate ranged from a low of 63% for Sexual Orientation to a high of 100% for Date of Birth. The majority of match errors appeared to be the result of data entry errors, where the values included in the clinical record differed from the values submitted by the provider agency, except for Social Security Number and Sexual Orientation, where the majority of non-matches were due to missing values on the patient's chart.

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 match rate for the procedure code data element, at 47.69%, is significantly below the DBHR contract benchmark of 95%. Qualis Health reviewers found several issues contributing to the no-match rate. High erroneous non-match rates for Procedure Code and Clinical Note were observed. Some of the observed discrepancies are

- Discovery of activities entered as encounters that do not qualify as encounters, including internal communications, staff meetings, transportation and use of outpatient codes for individuals in jail
- Lack of clinical documentation for services
- Incorrect bundling of services
- Coding errors, especially for 99214, which cannot be used regardless of medical decision-making

The rates of no match due to the unsubstantiated encounter information for a number of fields exceeds the DBHR contract threshold of <2% (under 2% of the sample). The rate of unsubstantiated encounters was directly due to lack of documentation in the clinical record for that reported encounter.

TMRSN did not review demographics data as part of its internal EDV process, so Qualis Health was unable to perform a comparison, as shown in Table E-7.

The comparison of the total match rate from the Qualis Health review to the total match rate from the TMRSN internal EDV is shown in Table E-8. There is significant variance across the data elements for Procedure Code and Clinical Note. The variance may be partially due to the data sources involved, because TMRSN used RSN-level data when performing their internal EDV, while Qualis Health used State-level data.

Table E-5: Demographic Data Validation

Demographics Data (N = 139)				
Field	Match	No Match – Erroneous	No Match – Missing	No Match – Unsubstantiated
Last Name	98.56%	1.44%	0.00%	0.00%
First Name	99.28%	0.72%	0.00%	0.00%
Gender	99.28%	0.72%	0.00%	0.00%
Date of Birth	100.00%	0.00%	0.00%	0.00%
Ethnicity	96.40%	2.88%	0.00%	0.72%
Hispanic Origin	92.09%	6.47%	0.00%	1.44%
Preferred Language	98.56%	0.72%	0.00%	0.72%
Social Security Number	83.45%	3.60%	2.88%	10.07%
Sexual Orientation	62.59%	8.63%	0.72%	28.06%

Table E-6: Encounter Data Validation

Encounter Data (N = 476)				
Field	Match	No Match – Erroneous	No Match – Missing	No Match – Unsubstantiated
Procedure Code	47.69%	44.75%	0.00%	7.56%
Date of Service	93.28%	0.42%	0.00%	6.30%
Service Location	92.23%	0.21%	0.00%	7.56%
Service Duration	91.39%	1.89%	0.00%	6.72%
Provider Agency	93.49%	0.21%	0.00%	6.30%
Provider Type	92.65%	0.21%	0.00%	7.14%
Clinical Note Matches Procedure Code	46.85%	53.15%	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	98.56%	Did not report	Could not determine
First Name	99.28%	Did not report	Could not determine
Gender	99.28%	Did not report	Could not determine
Date of Birth	100.00%	Did not report	Could not determine
Ethnicity	96.40%	Did not report	Could not determine
Hispanic Origin	92.09%	Did not report	Could not determine
Preferred Language	98.56%	Did not report	Could not determine
Social Security Number	83.45%	Did not report	Could not determine
Sexual Orientation	62.59%	Did not report	Could not determine

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

Field	Qualis Health Match	RSN Match	Variance
Procedure Code	47.69%	91.39%	-43.70%
Date of Service	93.28%	96.25%	-2.97%
Service Location	92.23%	91.83%	0.39%
Service Duration	91.39%	94.48%	-3.09%

Provider Agency	93.49%	96.69%	-3.20%
Provider Type	92.65%	94.92%	-2.28%
Clinical Note Matches Procedure Code	46.85%	90.51%	-43.66%

Discussion

The TMRSN EDV processes related to sampling, data collection and analysis appear adequate to meet the requirements of its contract with DBHR. However, discrepancies between the clinical records of providers and encounter data in ProviderOne are substantially higher than what TMRSN found through its internal EDV reviews.

The encounter and demographics data received from DBHR were 100% complete, with the exception of Social Security Number, an optional data element, which was 78.8% complete.

Qualis Health found a substantial level of disagreement between encounter data extracted from ProviderOne and data included in the clinical record, with a match range of 47.69% for procedure code and 46.85% for Clinical Note. The match rate for all data elements was below the DBHR contract standard of 95%.

With regard to demographics, there was a substantial level of disagreement between the value included in the CIS database extract and the values in the clinical record for Social Security Number and Sexual Orientation. The match rates for these fields, along with the Hispanic Origin category, fell below the acceptable level of 95%.

Additionally, considerable variance was found when comparing the Qualis Health EDV clinical chart review results to the TMRSN internal EDV results reported to DBHR.

Opportunities for Improvement

- TMRSN should consider locking the encounter data for its review instrument, to protect data from being inadvertently changed or deleted.
- TMRSN needs to utilize encounter data processed by the State rather than data maintained by the RSN when conducting EDV.

Recommendation Requiring CAP

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

- To ensure encounter data is substantiated and in compliance, the RSN needs to
    - Provide training on the Service Encounter Reporting Instructions: on coding, on what is included and excluded in each modality and on the general encounter reporting instructions
    - 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	Current Status
Respect and Dignity—§438.100(b)(2)(ii)	At one provider clinic, the small size of the reception area does not permit adequate space for private communications. TMRSN stated that this small agency was in the process of moving to a larger agency. TMRSN needs to continue to assess agencies' and facilities' compliance with this standard, including reviewing the physical layout of reception areas and office space.	**Recommendation stands**
Information Requirements—§438.100(b); §438.10(b)–(d)	TMRSN needs to require its providers to keep a log of all requests for interpreter services to enable TMRSN to better analyze any unmet needs in the RSN's service counties.	**Resolved**
General Rule—§438.228	Although TMRSN can query its database as to when NOAs are sent to enrollees, TMRSN should consider developing a log, similar to its grievance log, to track when authorizations are requested, decisions are made, and NOAs are mailed to enrollees, to ensure adherence to timelines.	**Resolved**
Seclusion and Restraint—§438.100(b)(2)(v)	TMRSN needs to ensure that all providers have and follow policies and procedures on seclusion and restraint.	**Resolved**

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

Compliance with Regulatory and Contractual Standards

Section 1: Availability of Services

N/A

Section 2: Coordination of Care

Recommendation Requiring CAP

TMRSN's largest contracted provider's conversion to EMR has caused up to an 18-month delay in accurate data transmission and this has directly impacted the RSN's capability to effectively monitor care coordination.

1. TMRSN needs to consider implementing other options in order to acquire data more accurately and in a timelier manner from its provider agencies, including imposing monetary sanctions when the agencies do not respond appropriately to CAPs.

TMRSN reported it had significant internal staffing challenges, causing leaders to fulfill dual roles and create gaps in information system staffing. This and the lack of accurate data from its largest contracted provider caused a gap in completing thorough utilization review during the review period. The RSN also stated that it has submitted numerous corrective action plans to its largest provider but without effective follow-through by the agency.

2. In order to do thorough and timely utilization reviews and monitor care coordination, TMRSN needs to consider implementing other options in order to acquire data more accurately and in a more timely manner from its provider agencies, including imposing monetary sanctions when the agencies do not respond appropriately to CAPs.

TMRSN has a policy in place to identify any ongoing special conditions of enrollees that require a special course of treatment or regular care monitoring. However, at the time of review, TMRSN's challenges with understaffing, resulting in staff members holding dual roles, caused the RSN to delay monitoring the agencies, which has directly impacted the capability of the RSN to implement strategies ensuring all contractors meet the standards.

3. TMRSN needs to develop and implement new strategies in light of the RSN's staffing issues to ensure all contractors meet the standards for identifying ongoing special conditions of enrollees who require a special course of treatment or regular care monitoring.

Section 3: Coverage and Authorization of Services

Recommendations Requiring CAP

TMRSN has mechanisms in place to ensure compliance with authorization timeframes; however, authorizations from its largest contracted provider are sometimes delayed up to six months.

4. TMRSN needs to continue to provide technical assistance and hold this provider accountable to a corrective cation plan in order to ensure compliance with timely submission of authorization requests.

Section 4: Provider Selection

N/A

Section 5: Subcontractual Relationships and Delegation

N/A

Section 6: Practice Guidelines

Recommendations Requiring CAP

TMRSN reports it has discontinued the use of practice guidelines and is working to adopt the model developed by another RSN, which includes a diagnostic approach. At the time of this review, the RSN stated it was still in the planning stages for adopting diagnostic-based guidelines.

5. TMRSN needs to finalize and implement its new process for adopting diagnostic guidelines and base the guidelines on valid and reliable clinical evidence or on the consensus of its healthcare professionals, as well as on the needs of its enrollees.

Although TMRSN has a policy which states that 10% of clinical records are reviewed for compliance with clinical practice guidelines and the Quality Improvement Committee meets to review and analyze each report or concern identified relating to TMRSN clinical practice guidelines, this process has been put on hold as the RSN has discontinued its practice guidelines.

6. When the RSN has adopted its new guidelines, it will need to follow its policy on ensuring guidelines are in place and clinicians are actually following and using the guidelines. Also, the RSN will need to document the interface between the guidelines and the Quality Assurance Performance Improvement program, to ensure decisions for utilization management, enrollee education, coverage of services and other areas are applied in a manner consistent with the guidelines.

Section 7: Quality Assessment and Performance Improvement Program

N/A

Section 8: Health Information Systems

N/A

Performance Improvement Project (PIP) Validation

There were no Recommendations Requiring CAP for Performance Improvement Project Validation.

Information Systems Capabilities Assessment (ISCA)

Section C: Information Security

Recommendations Requiring CAP

Backup data is not being encrypted by all of TMRSN's provider agencies.

7. TMRSN needs to work with its provider agencies to establish encryption practices in accordance with the DBHR contract requirements.

TMRSN's counties do not annually update the disaster recovery policies

8. TMRSN needs the county(ies) to annually update the disaster recovery policies.

Section G: Vendor Data

Recommendation Requiring CAP

All of TMRSN's provider agencies did not meet the acceptable standard of 95% match rate for encounter data validation in 2014. However, TMRSN's encounter data validation results for 2014 were much improved from 2013. TMRSN developed a corrective action plan to increase encounter data validation accuracy for 2015.

9. TMRSN needs to continue to actively monitor and intervene regarding its provider agencies' encounter data validation results.

Encounter Data Validation (EDV)

Recommendation Requiring CAP

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

10. To ensure encounter data is substantiated and in compliance, the RSN needs to
    - Provide training on the Service Encounter Reporting Instructions: on coding, on what is included and excluded in each modality and on the general encounter reporting instructions
    - 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

ACES	Adverse Childhood Events Scores
BBA	Balanced Budget Act
BC/DR	Business Continuity and Disaster Recovery
BRFSS	Behavioral Risk Factor Surveillance System
CANS	Child and Adolescent Needs and Strengths
CALOCUS	Child and Adolescent Level of Care Utilization System
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CIS	Consumer Information System
CMHC	Community Mental Health Center
CMHC-MIS	Community Mental Health Center Management Information Systems
CMS	Centers for Medicare & Medicaid Services
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
EMR	Electronic Medical Record
EQR	External Quality Review
EQRO	External Quality Review Organization
HCA	Health Care Authority
HCPCS	Healthcare Common Procedural Coding System
HEDIS	Health Effectiveness Data and Information Set
ISCA	Information System Capability Assessment
IMD	Institution for Mental Disease
LEIE	List of Excluded Individuals/Entities
LOCUS	Level of Care Utilization System
MCO	Managed Care Organization
MHCM	Mental Health Care Program
MHP	Mental Health Professional
MMIS	Medicaid Management Information System
MTWI	Mason Thurston Wraparound Initiative
NAMI	National Alliance on Mental Illness
MSO	Management System Organization
MTWI	Mason Thurston Wraparound Initiative
NAS	Network Attached Storage
NIC	Network Interface Card
PAHP	Prepaid Ambulatory Health Plans
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
RAID	Redundant Array of Independent Disks
RSN	Regional Support Network

SAC	Service Activity Code
SAM	System for Award Management
SDQ	Strengths and Difficulties Questionnaire
SERI	Service Encounter Reporting Instructions
TMRSN	Thurston-Mason Regional Support Network
URAC	Utilization Review Accreditation Commission
UW-EBPI	University of Washington Evidence-Based Practice Institute
WISe	Wraparound with Intensive Services
WSC	Washington State Consortium