North Sound Mental Health Administration
Regional Support Network
External Quality Review Report
Division of Behavioral Health and Recovery
January 2016

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

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

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

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Introduction

This report presents the 2015 results of the external quality review of North Sound Mental Health Administration RSN, a mental health Regional Support Network (RSN) serving Washington Medicaid recipients.

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

North Sound Mental Health Administration RSN (NSMHA) administers services for public mental health enrollees in Island, San Juan, Skagit, Snohomish and Whatcom counties. The RSN does not provide any direct client services; however, it provides funding and oversight for direct client services and other assistance through contracts with provider agencies. NSMHA has approximately 250,000 Medicaid-eligible beneficiaries within its service area.

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

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

EQR activities

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

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

Together, these activities answer the following questions:

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

Executive Summary

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

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

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

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

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

Compliance Review Results

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

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

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

Section 3. Coverage and Authorization of Services	438.210	Partially Met (pass)
Section 4. Provider Selection	438.214	Partially Met (pass)
Section 5. Subcontractual Relationships and Delegation	438.230	Fully Met (pass)
Section 6. Practice Guidelines	438.236	Fully Met (pass)
Section 7. Quality Assessment and Performance Improvement Program	438.240	Partially Met (pass)
Section 8. Health Information Systems	438.242	Fully Met (pass)

Performance Improvement Project (PIP) Validation Results

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

Table A-2: Performance Improvement Project Validation Results

	Results	Validity and Reliability
Clinical PIP: WRAP + MAP: Integrating Care Coordination and Clinical Practice Models for Medicaid Children and Youth Enrolled in WISe – Year 2 (2015)	Not Met (fail) **Recommendation requiring CAP** It is not acceptable to solely submit another institution's data analysis report regardless of the situation with the RSN's data; NSMHA could have synthesized the data from the report and answered PIP questions. When selecting future	Low confidence in reported results

	PIPs, NMSHA needs to be thoughtful about the study topics and questions that are chosen. NSMHA must ensure that all aspects of the proposals are realistic from the onset of the projects. Minor changes are allowable and many times warranted, but need to be done after careful consideration and with input from stakeholders**.**	
Non-Clinical PIP: Improving the Quality of Care Coordination for High-Risk Transition-Age Youth	Partially Met (pass)	Moderate confidence in reported results

Information System Capability Assessment (ISCA) Results

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

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

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

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

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

Table A-3: ISCA Review Results

ISCA Section	Description	ISCA Result

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

Encounter Data Validation (EDV) Results

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

Qualis Health performed independent validation of the procedures used by the RSN to perform its own encounter data validation. The EDV requirements included in the RSN's contract with DBHR were used as the standard for validation. Qualis Health obtained and reviewed each RSN's encounter data validation report submitted to DBHR as a contract deliverable for calendar year 2014. The RSN's encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates and fields selected for validation were reviewed for conformance with DBHR contract requirements. The RSN's encounter and/or enrollee sampling procedures were reviewed to ensure conformance with accepted

statistical methods for random selection. Table A-4 shows the results of the review of the RSN's Encounter Data Validation processes. Please refer to the EDV section of this report for complete results.

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

EDV Standard	Description	EDV Result
Sampling Procedure	Sampling was conducted using an appropriate random selection process and was of adequate size.	Fully Met (pass)
Review Tools	Review and analysis tools are appropriate for the task and used correctly.	Fully Met (pass)
Methodology and Analytic Procedures	The analytical and scoring methodologies are sound and all encounter data elements requiring review are examined.	Not Met (fail)

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

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

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

EDV Standard	Description	EDV Result
Electronic Data Checks	Full review of encounter data submitted to the state indicates no (or minimal) logic problems or out-of-range values.	Fully Met (pass)
Onsite Clinical Record Review	State encounter data are substantiated in audit of patient charts at individual provider locations. Audited fields include demographics (name, date of birth, ethnicity and language) and encounters (procedure codes, provider type, duration of service, service date and service location). A passing score is that 95% of the encounter data fields in the clinical records match.	Not Met (fail)

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Compliance with Regulatory and Contractual Standards

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

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

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

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

Compliance Scoring

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

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

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

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

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

Summary of Compliance Review Results

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

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

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

Strengths

- NSMHA monitors service capacity within its provider network by assessing Medicaid enrollment, service penetration rates, specialist mix and geographic distribution of practitioners, and by monitoring provider staffing, availability of specialists, use of clinical services and supports, numbers of people served, service hours and provision of outreach services.
- As part of the annual strategic planning process, provider profiles are completed and reviewed as part of the geographic service area needs assessment. Aggregate utilization data and provider staffing models and ratios are analyzed, and input from enrollees, clinical provider network staff and other stakeholders is solicited.
- Interviews with providers indicated there has been a 30–40% increase in enrollees as a result of the Affordable Care Act, increasing the need to hire clinicians. The RSN has been working with the provider agencies on attracting new clinicians to the area by advertising broadly to graduate programs in other states, offering tuition reimbursements and increasing pay rates. The RSN has

also been discussing streamlining the fast-track process for CD certification with the community colleges.

- NSMHA captures the agreement rate between the first and second opinions. The agreement rate for 2014 was 55%, down from 71% in 2013 and more consistent with the historic rate of 56% seen in the preceding three years (2010–12).
- NSMHA performs a year-end review of out-of-network referrals. The purpose of the review is to ensure that the provision of medically necessary services by mental health providers outside the NSMHA-contracted Behavioral Health Agencies (BHA) meets NSMHA standards, as would be the expectation of a contracted provider.
- NSMHA assesses timely access to care and services through several methods, including performing annual clinical record reviews, reviewing enrollee complaints and grievances, and performing enrollee surveys.
- NSMHA has a robust policy 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.
- NSMHA network providers are required to communicate with the enrollee's PCP to coordinate physical and mental healthcare needs, or attempt to link enrollees to a PCP for medical care.
- The RSN uses an extensive provider utilization review tool, which includes elements regarding coordination of care. Data from provider agency utilization reviews is compiled into an annual report so that NSMHA can thoroughly monitor requirements.
- NSMHA uses specifically developed templates to provide notices. Notices are provided in easily understood languages and formats. Notices are available in alternative formats and in appropriate manners that take into consideration any special needs, such as visual impairment or limited reading proficiency.
- NSMHA compiles detailed reports to monitor authorization timeliness and denial of authorization requests. In 2014 there were 24,322 authorizations; the average time from request to authorization was 2.4 days. This is a slight improvement from 2013, in which the average time was 2.5.
- NSMHA maintains a committee that establishes policies and procedures, including a documentation protocol for what will be used by contractors to ensure documentation of referral information, information detailing the services provided and the outcome of the intervention.
- When choosing new provider agencies, NSMHA utilizes a request for qualifications process that includes participation in the scoring and decision-making by a variety of stakeholders within the regional support network as well as NSMHA staff.
- NSMHA conducts a comprehensive annual performance evaluation of each contracted provider. Review areas include policies/procedures, credentialing files, financial reports, compliance program, QI plan and activities, grievance and crisis logs, staff training and, when applicable, subcontractor agreements and business associate agreements.
- NSMHA has a broad array of diagnosis-oriented practice guidelines to address the needs of its enrollees. The practice guidelines were developed through a collaborative process that included input from providers, the NSMHA Advisory Board and the Board of Directors.
- NSMHA has taken the practice guidelines for Wraparound with Intensive Services (WISe) and written them at a fourth-grade level in an effort to better reach enrollees and their families.
- NSMHA's internal quality team meets weekly, and the Quality Management Oversight Committee (QMOC) meets monthly. QMOC comprises NSMHA and provider staff, enrollees, a tribal representative, advocates and elected officials or their representatives and provides oversight of all quality management activities conducted throughout the region.

- NSMHA has a thorough 2012–2014 Quality Management Work Plan. The document defines the quality program, explains the scope of services, discusses its accountability to DSHS and describes its quality management processes, including specific review and clinical audit activities. The document further discusses its administrative processes, enrollee/advocate involvement, provider expectations, delegation and delegated functions, recommendations, remedial action and sanctions, and the structure of the Quality Management Program.

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

Section 1: Availability of Services

Opportunity for Improvement

NSMHA contracts with Volunteers of America (VOA) to run a centralized access line to respond to all requests for mental health services in its five-county region. In 2014, VOA received 20,320 calls, which is a 25% increase in call volume from 2013. The increased call volume appears to have had an impact on the average wait time, which has increased from about 1 ½ minutes or less in 2013 to 2–3 minutes in 2014. NSMHA has recommended that VOA explore options for reducing the wait time.

- NSMHA should continue to work with VOA on reducing wait time on calls from enrollees requesting services and monitor the centralized access line to ensure the wait time does indeed decrease.

Recommendation Requiring CAP

Review of NSMHA's policies on out-of-network services and provider credentialing indicated that neither policy contained any language regarding the credentialing of out-of-network providers.

- NSMHA needs to include in one of its policies the process by which out-of-network providers are credentialed.

Section 2: Coordination of Care

Opportunities for Improvement

NSMHA's 2014 routine utilization report for its quality improvement committee states that results from the clinical record reviews indicated the clinical record contained documentation of coordination with the individual's current external healthcare provider(s) only 77.7% of the time, which is below the RSN's benchmark of 90%.

- NSMHA should continue working with its providers to improve the documentation of coordination of care with enrollees' current external healthcare providers.

Section 3: Coverage and Authorization of Services

Recommendation Requiring CAP

NSMHA does not have a process for training authorization staff on inter-rater reliability.

- NSMHA needs to implement a documented process to develop training for authorization staff to ensure that authorizations are done in a consistent and appropriate manner.

Section 4: Provider Selection

Opportunity for Improvement
The Business Ethics and Regulatory Compliance Program Plan does not indicate that OIG checks need to be completed monthly by NSMHA.

- NSMHA should ensure that the plan specifies that OIG checks are completed monthly.

Recommendations Requiring CAP
The Primary Source Verification Credentialing, Re-Credentialing, Appointment and Privileging of Contracted or Employed Staff policy and procedure has not been updated in over ten years.

- NSMHA needs to review and update this policy and procedure to more accurately reflect current practice.

The current policy states that the information validated includes education, licensure, training and experience, but did not include criminal history background checks.

- The policy needs to state how the RSN verifies Washington State background checks on each agency employee in contact with individuals receiving services.

Section 5: Subcontractual Relationships and Delegation

N/A

Section 6: Practice Guidelines

N/A

Section 7: Quality Assessment and Performance Improvement Program

Opportunity for Improvement
NSMHA is not in compliance with the State's Quality Strategy plan as the State does not have a current Quality Strategy plan.

- When the State has finalized its Quality Strategy plan, the RSN will need to be in compliance with the plan.

Recommendations Requiring CAP
NSMHA has numerous policies and procedures that need to be updated. Multiple policies contain repealed WACs, including several that were updated after the repeal dates. NSMHA's Quality Management of North Sound Mental Health Administration document (policy #5502.00) has not been updated since 2004 and contains out-of-date terminology, such as the Mental Health Division in reference to DBHR.

- NSMHA needs to update its policies and procedures to ensure they reflect current practices, references and terminology.

NSMHA has a policy and procedure on utilization review of outpatient services, but it is specific to outpatient services only and does not address underutilization or overutilization of programs.

- NSMHA needs to create a policy and procedure regarding the underutilization and overutilization of individual services and programs. The policy and procedure must address processes for consistent criteria to identify and monitor underutilization and overutilization. NSMHA needs to also have a process for taking corrective action to address underutilization and overutilization.

Section 8: Health Information Systems

N/A

Section 1: Availability of Services

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

Protocol Section	CFR	Result
Availability of Services		
1. Delivery Network	438.206 (b)(1)	Fully Met (pass)
2. Second Opinion	438.206 (b)(3)	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)	Not Met (fail)
6. Furnishing of Services and Timely Access	438.206 (c)(1)	Fully 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

- NSMHA monitors service capacity within its provider network by assessing Medicaid enrollment, service penetration rates, specialist mix and geographic distribution of practitioners, and by

monitoring provider staffing, availability of specialists, use of clinical services and supports, numbers of people served, service hours and provision of outreach services.

- As part of the annual strategic planning process, provider profiles are completed and reviewed as part of the geographic service area needs assessment. Aggregate utilization data and provider staffing models and ratios are analyzed, and input from enrollees, clinical provider network staff and other stakeholders is solicited.
- Interviews with providers indicated there has been a 30–40% increase in enrollees as a result of the Affordable Care Act, increasing the need to hire clinicians. The RSN has been working with the provider agencies on attracting new clinicians to the area by advertising broadly to graduate programs in other states, offering tuition reimbursements and increasing pay rates. The RSN has also been discussing streamlining the fast-track process for CD certification with the community colleges.

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

- NSMHA has a very robust and detailed second opinion policy and procedure outlining the steps for obtaining and processing second opinions.
- NSMHA's year-end 2014 second opinion report states that there were 21 requests for second opinions during 2014, with 11 requests pertaining to questions regarding the reasonableness or necessity of recommended interventions and/or medications. This type of request accounted for

52% of the total number of requests, with five other types/reasons accounting for the remaining 48%.

- NSMHA captures the agreement rate between the first and second opinions. The agreement rate for 2014 was 55%, down from 71% in 2013 and more consistent with the historic rate of 56% seen in the preceding three years (2010–12).

Out-of-Network

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

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

STATE REGULATION / RSN AGREEMENT SOURCE(S)
RSN Agreement Section(s) 4.3;13.3

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- NSMHA has an excellent policy and procedure on covering out-of-network services.
- NSMHA performs a year-end review of out-of-network referrals. The purpose of the review is to ensure that the provision of medically necessary services by mental health providers outside the NSMHA-contracted Behavioral Health Agencies (BHA) meets NSMHA standards, as would be the expectation of a contracted provider.
- Of the 11 requests for out-of-network services, four were for medication services and seven were for eating disorder treatment, dissociative identity disorder (DID) treatment, and provision of services by specialists for individuals identified as a member of a State-identified special population (e.g., ethnic minority and deaf/hard of hearing).

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)

Meets Criteria

Out-of-Network Provider Credentials

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

6) Demonstrates that out-of-area providers are credentialed as required by §438.214.

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

SCORING CRITERIA

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

Reviewer Determination

● Not Met (fail)

Recommendation Requiring CAP
Review of NSMHA's policies on out-of-network services and provider credentialing indicated that neither policy contained any language regarding the credentialing of out-of-network providers.

- NSMHA needs to include in one of its policies the process by which out-of-network providers are credentialed.

Furnishing of Services and Timely Access

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strength

- NSMHA assesses timely access to care and services through several methods, including performing annual clinical record reviews, reviewing enrollee complaints and grievances, and performing enrollee surveys.

Furnishing of Services and Cultural Considerations

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- NSMHA has a robust policy 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.
- NSMHA reviews its providers' policies and procedures periodically to ensure the promotion of cultural and linguistic competence throughout the mental health system of care at all levels. This includes a review of Individual Service Plans to assess whether the plans address age, gender, culture, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.
- Through the RSN's online program Relias, internal staff and contracted staff are able to access training classes on a number of cultural topics.

- NSMHA conducts periodic onsite contract reviews of providers, which include review of documentation for orientation and training on cultural competency. This includes reviews conducted by the NSMHA Quality Review Team. In addition, NSMHA conducts a cultural and linguistic competence review of provider staff that includes
    - Education level
    - Knowledge of culturally competent policies and/or plan
    - Participation in cultural competence training
    - Experience working with specific minority groups

Section 2: Coordination and Continuity of Care

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

Protocol Section	CFR	Result
Coordination and Continuity of Care		
Primary Care and Coordination of Healthcare Services	438.208 (b)	Fully Met (pass)
Additional Services for Enrollees with Special Healthcare Needs	438.208 (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 Healthcare Services for all RSN and Enrollees

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

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

furnished to the enrollee.

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

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

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

STATE REGULATION / RSN AGREEMENT SOURCE(S)

RSN Agreement Section(s) 10.3.1

SCORING CRITERIA

- The RSN has a policy and procedure to deliver care to, and coordinate healthcare services, for all enrollees.
- The RSN ensures that each enrollee has access to a primary healthcare provider.
- The RSN ensures providers coordinate with the RSN and with other health plans regarding the services it delivers.
- The RSN has a process in place to monitor care coordination.
- The RSN ensures that the enrollee's privacy is protected in the process of coordinating care.

Reviewer Determination
Select red/yellow/green icon

● Fully Met (pass)

Strengths

- NSMHA network providers are required to communicate with the consumer's PCP to coordinate physical and mental healthcare needs, or attempt to link enrollees to a PCP for medical care.
- NSMHA network providers' mental healthcare programs (MHCPs) are expected to communicate with the PCP when any of the following occurs:
  - Initiation of care and services
  - Initial prescription of psychotropic medications
  - Changes in prescribed medications that might impact healthcare
  - Changes in the enrollee's clinical condition that potentially impacts his/her overall medical care
- NSMHA monitors network providers through onsite clinical record reviews to ensure that documentation of coordination activities is evident in the enrollee's clinical records and that communication occurs within the scope of the consent and release(s) given by the enrollee.

Additional Services for Enrollees with Special Healthcare Needs

FEDERAL REGULATION SOURCE(S)

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

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

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

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

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

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

SCORING CRITERIA

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

Reviewer Determination

Partially Met (pass)

Strengths

- NSMHA has several policies and procedures in place regarding the identification and coordination of services for enrollees with special healthcare needs.
- The RSN uses an extensive provider utilization review tool, which includes elements regarding coordination of care. Data from provider agency utilization reviews is compiled into an annual report so that NSMHA can thoroughly monitor requirements.

Opportunity for Improvement

NSMHA's 2014 routine utilization report for its quality improvement committee states that results from the clinical record reviews indicated the clinical record contained documentation of coordination with the individual's current external healthcare provider(s) only 77.7% of the time, which is below the RSN's benchmark of 90%.

- NSMHA should continue working with its providers to improve the documentation of coordination of care with enrollees' current external healthcare providers.

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)

Strengths

- NSMHA monitors treatment plans during the annual administrative and clinical review.
- NSMHA's 2014 routine utilization report indicates that the treatment plans addressed age, cultural or disability issues identified by the individual or their parents or other legal representative 96% of the time.

Direct Access

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

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

Meets Criteria

Section 3: Coverage and Authorization of Services

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

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

Emergency and Post-Stabilization Services	438.210 438.114	Fully 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)

Strengths

- NSMHA has a detailed authorization and reauthorization policy and procedure for outpatient services. The RSN has adopted the Washington State Access to Care Standards and the medical necessity criteria and incorporated them into the policy and procedure.
- NSMHA has incorporated robust Access to Care Standards and medical necessity criteria into provider contracts.

Authorization of Services

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

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

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

(2) That the MCO, PIHP or PAHP—

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

(ii) Consult with the requesting provider when appropriate.

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

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

SCORING CRITERIA

- The RSN has documented policies and procedures for the consistent application of review criteria for the initial and continuing authorization of services.
- The RSN has a mechanism in place to ensure consistent application of review criteria.

- The RSN consults with the requesting provider when appropriate.
- The RSN has a process to ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested is made by a mental health professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

Reviewer Determination

Partially Met (pass)

Strengths

- NSMHA's authorization and reauthorization for ongoing outpatient services policy and procedure has well-documented review criteria for initial and continuing authorization of services.
- The authorization policy and procedure ensures that all decisions related to the amount, duration or scope of service that is less than requested is made by a mental health professional with appropriate clinical expertise in the enrollee's condition.

Recommendation Requiring CAP

NSMHA does not have a process for training authorization staff on inter-rater reliability.

- NSMHA needs to implement a documented process to develop training for authorization staff to ensure that authorizations are done in a consistent and appropriate manner.

Notice of Adverse Action

FEDERAL REGULATION SOURCE(S)

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

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

STATE REGULATION / RSN AGREEMENT SOURCE(S)

RSN Agreement Section(s) 6.3

SCORING CRITERIA

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

Reviewer Determination

Fully Met (pass)

Strength

- NSMHA uses specifically developed templates to provide notices. Notices are provided in easily understood languages and formats. Notices are available in alternative formats and in appropriate manners that take into consideration any special needs, such as visual impairment or limited reading proficiency.

Timeframes for Decisions

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

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

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

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

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

(2) Expedited authorization decisions.

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- NSMHA compiles detailed reports to monitor authorization timeliness and denial of authorization requests. In 2014 there were 24,322 authorizations; the average time from request to authorization was 2.4 days. This is a slight improvement from 2013, in which the average time was 2.5.
- NSMHA meets or exceeds compliance with all authorization timeframes.
- For both standard and expedited re/authorization decisions, NSMHA will automatically approve any request for extension made by an individual or provider. An extension may also be obtained if NSMHA justifies a need for additional information and how the extension is in the individual's best interest.

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)

Meets Criteria

Emergency and Post-Stabilization Services

FEDERAL REGULATION SOURCE(S)

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

(a) Definitions. As used in this section—

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

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

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

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

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

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

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

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

(1) The MCO, PIHP or PAHP.

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

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

(c) Coverage and payment: Emergency services—

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

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

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

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

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

(2) A PCCM must—

(i) Allow enrollees to obtain emergency services outside the primary care case management system

regardless of whether the case manager referred the enrollee to the provider that furnishes the services; and

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

(d) Additional rules for emergency services.

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

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

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

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

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

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

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

STATE REGULATION / RSN AGREEMENT SOURCE(S)

RSN Agreement Section(s) 5.2

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- NSMHA provides Integrated Crisis Response Services (ICRS) in accordance with WAC 388-877A-0200 and 388-877A-0240. Any individual who is currently located in the NSMHA service area, regardless of age, county of residence, enrollment status with another RSN, finding source and/or ability to pay is eligible for ICRS.

- NSMHA maintains a committee that establishes policies and procedures, including a documentation protocol for what will be used by contractors to ensure documentation of referral information, information detailing the services provided and the outcome of the intervention.
- Documentation provided confirmed NSMHA tracks and monitors the use of crisis services. A strengths, weaknesses, opportunities and threats (SWOT) analysis was conducted in December of 2014. Triage facility usage was noted to have increased at the RSN's three programs, although length of stay has decreased. There were minimal findings and recommendations from the analysis.

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

General Rules and Credentialing and Re-credentialing Requirements

FEDERAL REGULATION SOURCE(S)

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

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

(b) Credentialing and re-credentialing requirements.

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

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

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

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

SCORING CRITERIA

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

Reviewer Determination

Partially Met (pass)

Strengths

- NSMHA requires providers to maintain and enforce their own policies and procedures regarding credentialing and re-credentialing. At least once every two years NSMHA completes a 100% onsite review of provider personnel records.
- When choosing new provider agencies, NSMHA utilizes a request for qualifications process that includes participation in the scoring and decision-making by a variety of stakeholders within the regional support network as well as NSMHA staff.

Recommendations Requiring CAP

The Primary Source Verification Credentialing, Re-Credentialing, Appointment and Privileging of Contracted or Employed Staff policy and procedure has not been updated in over ten years.

- NSMHA needs to review and update this policy and procedure to more accurately reflect current practice.

The current policy states that the information validated includes education, licensure, training and experience, but did not include criminal history background checks.

- The policy needs to state how the RSN verifies Washington State background checks on each agency employee in contact with individuals receiving 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 Nondiscrimination

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Meets Criteria

Excluded Providers

FEDERAL REGULATION SOURCE(S)

§438.214 (d): Excluded Providers

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

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

SCORING CRITERIA

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

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

Reviewer Determination

● Fully Met (pass)

Strengths

- NSMHA develops and maintains policies to address relevant risk areas identified by the Office of the Inspector General (OIG). Per policy, confirmed members of the List of Excluded Individuals and Entities (LEIE) will be prevented from becoming employed, and appropriate disciplinary action will be taken against NSMHA employees who fail to comply with applicable laws, regulations and policies.
- Provider agencies are required to screen employees and contractors through the LEIE prior to hire, annually and as directed per contract.

Opportunity for Improvement

The Business Ethics and Regulatory Compliance Program Plan does not indicate that OIG checks need to be completed monthly by NSMHA.

- NSMHA should ensure that the plan specifies that OIG checks are completed monthly.

Section 5: Subcontractual Relationships and Delegation

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

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

General Rule

FEDERAL REGULATION SOURCE(S)

§438.230 Subcontractual Relationships and Delegation

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

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

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

(b) Specific conditions.

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

(2) There is a written agreement that—

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

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

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- NSMHA has a very well-written policy, procedure and plan on delegation of services. The delegation plan includes the following:
  - An evaluation of the contractor’s ability to perform delegated activities
  - A detailed description of the proposed subcontracting arrangements, including name, address and telephone number of the sub-contractor(s); specific contracted services; compensation arrangement and monitoring plan.
- NSMHA conducts a comprehensive annual performance evaluation of each contracted provider. Review areas include policies/procedures, credentialing files, financial reports, compliance program, QI plan and activities, grievance and crisis logs, staff training and, when applicable, subcontractor agreements and business associate agreements.

- As part of its monitoring tool, NSMHA uses a web-based portal to capture grievance information at both the RSN and provider level.

Section 6: Practice Guidelines

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

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

Basic Rule

FEDERAL REGULATION SOURCE(S)

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

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

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

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

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

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

(4) Are reviewed and updated periodically as appropriate.

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- NSMHA has a broad array of diagnosis-oriented practice guidelines to address the needs of its enrollees. The practice guidelines were developed through a collaborative process that included input from providers, the NSMHA Advisory Board and the Board of Directors.
- NSMHA bases practice guidelines on valid and reliable clinical evidence from numerous mental healthcare professional associations.

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)

Strengths

- NSMHA has taken the practice guidelines for Wraparound with Intensive Services (WISe) and written them at a fourth-grade level in an effort to better reach enrollees and their families.
- Information and discussion regarding new and potential practice guidelines takes place monthly at the RSN provider meetings.
- Practice guidelines are available on the NSMHA website with additional links to other sites such as the American Psychiatric Association (APA).

Application of Guidelines

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

Strength

- NSMHA ensures provider compliance through contractual requirements and the inclusion of a monitoring element on the annual utilization review tool used during annual administrative and clinical audits. NSMHA's 2014 routine utilization report indicates that 95.5% of providers' proposed/provided treatment was consistent with NSMHA's clinical practice 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)	Fully 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	Fully Met (pass)
Overall Result for Section 7.		Partially Met (pass)

General Rules

FEDERAL REGULATION SOURCE(S)

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

(a) General rules.

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

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

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

(d) Performance improvement projects.

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

(i) Measurement of performance using objective quality indicators.

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

(iii) Evaluation of the effectiveness of the interventions.

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

(2) Each MCO and PIHP must report the status and results of each project to the State as requested,

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

(e) Program review by the State.

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

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

(ii) The results of each MCO's and PIHP's performance improvement projects.

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

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

SCORING CRITERIA

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

Reviewer Determination

Partially Met (pass)

Strengths

- NSMHA's internal quality team meets weekly, and the Quality Management Oversight Committee (QMOC) meets monthly. QMOC comprises NSMHA and provider staff, enrollees, a tribal representative, advocates and elected officials or their representatives and provides oversight of all quality management activities conducted throughout the region.
- NSHMA is certified as a Coordinated Quality Improvement Program (CQIP) in accordance with the State of Washington Department of Health. CQIP is a voluntary program that provides protection of information and documents received and reviewed in the course of quality review investigation activities. The protected information and documents may not be subpoenaed or used in court proceedings as discovery evidence.

- The 2013–2016 Strategic Plan Dashboard contains four goals. The goals are to
    - Adapt the organizational structure of NSMHA to play a vital role in the regional implementation of Health Care Reform initiatives to improve care coordination between primary healthcare and behavioral health services.
    - Develop innovative strategies to ensure all eligible individuals have equal access to quality behavioral health services.
    - Lead the North Sound region in the development and promotion of peer support and enrollee involvement strategies.
    - Increase the capacity and skills of the public mental health workforce.

Opportunity for Improvement

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

- When the State has finalized its Quality Strategy plan, the RSN will need to be in compliance with the plan.

Recommendations Requiring CAP

NSMHA's Reports website page is out of date; many reports have not been updated for over five years.

- NSMHA needs to update its Reports page and/or remove outdated reports.

NSMHA has numerous policies and procedures that need to be updated. Multiple policies contain repealed WACs, including several that were updated after the repeal dates. NSMHA's Quality Management of North Sound Mental Health Administration document (policy #5502.00) has not been updated since 2004 and contains out-of-date terminology, such as the Mental Health Division in reference to DBHR.

- NSMHA needs to update its policies and procedures to ensure they reflect current practices, references and terminology.

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

● Fully Met (pass)

Strengths

- NSMHA has a thorough 2012–2014 Quality Management Work Plan. The document defines the quality program, explains the scope of services, discusses its accountability to DSHS and describes its quality management processes, including specific review and clinical audit activities. The document further discusses its administrative processes, enrollee/advocate involvement, provider expectations, delegation and delegated functions, recommendations, remedial action and sanctions, and the structure of the Quality Management Program.
- In January of 2015, NSMHA produced a regional performance measure report that reviewed three performance measures over four years. The measures were detention diversion, crisis bed utilization and co-occurring identification rates. NSMHA met its goals for detention diversion and co-occurring identification.

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)

Strength

- NSMHA maintains a monthly utilization management dashboard. The document contains detailed information related to the number of Medicaid-eligible enrollees and data on outpatient and inpatient utilization. This is a good foundation to begin identifying underutilization and overutilization of programs.

Recommendation Requiring CAP

NSMHA has a policy and procedure on utilization review of outpatient services, but it is specific to outpatient services only and does not address underutilization or overutilization of programs.

- NSMHA needs to create a policy and procedure regarding the underutilization and overutilization of individual services and programs. The policy and procedure must address processes for consistent criteria to identify and monitor underutilization and overutilization. NSMHA needs to also have a process for taking corrective action to address underutilization and overutilization.

Mechanism to Assess the Quality and Appropriateness of Care

FEDERAL REGULATION SOURCE(S)

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

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

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

STATE REGULATION / RSN AGREEMENT SOURCE(S)

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

SCORING CRITERIA

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

Reviewer Determination
Fully Met (pass)

Strengths

- NSMHA has several processes in place to review the quality of care furnished to enrollees. NSMHA conducts annual provider record reviews and reviews the appropriateness of level of care at the time of authorization and reauthorization. NSMHA assesses enrollee quality through complaints and grievances and enrollee surveys.
- Results of the monitoring and review processes are reviewed at monthly QMOC meetings, and recommendations for corrective action plans are discussed.

Section 8: Health Information Systems

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

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

General Rule

FEDERAL REGULATION SOURCE(S)
§438.242 (a): Health Information Systems (a) General rule. The State must ensure, through its contracts that each MCO and PIHP maintains a health information system that collects, analyzes, integrates and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and dis-enrollments for other than loss of Medicaid eligibility. .
STATE REGULATION / RSN AGREEMENT SOURCE(S) WAC 388-865-0275 RSN Agreement Section(s) 11
SCORING CRITERIA • The RSN has a health information system that collects, analyzes, integrates and reports data on

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

Reviewer Determination

● Fully Met (pass)

Meets Criteria

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

● Fully Met (pass)

Strength

- NSMHA uploads provider batch files daily and is able to provide feedback for correction rapidly.

Performance Improvement Project (PIP) Validation

PIP Review Procedures

Performance improvement projects (PIPs) are designed to assess and improve the processes and outcomes of the healthcare system. They represent a focused effort to address a particular problem identified by an organization. As Prepaid Inpatient Health Plans (PIHPs), Regional Support Networks (RSNs) are required to have an ongoing program of PIPs that focus on clinical and non-clinical areas that involve

- Measurement of performance using objective quality indicators
- Implementation of systems interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities for increasing or sustaining improvement

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

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

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

PIP Scoring

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

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

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

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

Table C-1: Performance Improvement Project Validation Scoring

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

PIP Validity and Reliability

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

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

Confidence Level	Definition
High Confidence in Reported Results	The study results are based on high-quality study design and data collection and analysis procedures. The study results are clearly valid and reliable.
Moderate Confidence in Reported Results	The study design and data collection and analysis procedures are not sufficient to warrant a higher level of confidence. Study weaknesses (e.g., threats to internal or external validity, barriers to implementation, questionable study methodology) are identified that may impact the validity and reliability or reported results.
Low Confidence in Reported Results	The study design and/or data collection and analysis procedures are unlikely to result in valid and reliable study results.
Not Enough Time Has Elapsed to Assess Meaningful Change	The PIP has not advanced to at least the first re-measurement of the study indicator.

PIP Validation Results: Clinical PIP

WRAP + MAP: Integrating Care Coordination and Clinical Practice Models for Medicaid Children and Youth Enrolled in WISe – Year 2 (2015)
The North Sound Mental Health Administration Regional Support Network (NSMHA) reported that because of data corruption it was not possible to submit a written 2015 Clinical PIP report. Instead, the

North Sound Mental Health Administration Fidelity Outcomes Report, prepared by the Wraparound Evaluation and Research Team at the University of Washington (UW), was submitted in its place.

At the same time as the UW report was submitted in lieu of the PIP report, NSMHA announced revisions to the PIP study topic and study question. NSMHA asserted that the only thing that could be effectively measured was fidelity to the Wraparound model, as the range in type and intensity of services varies across the state based on the needs of the individual and the realities of a large-scale public mental health system. Last year the study question was, "Does utilization of the Managing and Adapting Practices clinical decision and practice model significantly decrease the mean total difficulties score of the Strengths and Difficulties Questionnaire in Medicaid children and youth <21 enrolled in Wraparound with Intensive Services?" This year NSMHA decided there would be two study questions: "1) How has adherence to the Wraparound model and youth outcomes changed from 2008–2013 when similar data was collected for a previous evaluation project, and 2) How has adherence to the Wraparound model been impacted by the mid-2014 implementation of WISe and Managing and Adapting Practice (MAP)?"

Unfortunately, solely submitting a document written by an external party does not satisfy the requirements of an acceptable PIP report. Changing a study topic and a study question without a clearly documented process that includes stakeholder input and/or in-depth analysis is also inadequate. Without following the approved PIP format, the required Centers for Medicare & Medicaid Services (CMS) external quality review (EQR) protocol scoring elements cannot be adequately answered; consequently, it is not possible to pass this PIP on any standard.

Table C-3: Clinical PIP Validation Results

Study Design		Activity	Narrative	SCORE
Design	1	Appropriate study topic		● Not Met (fail)
	2	Clearly defined, answerable study question		● Not Met (fail)
	3	Correctly identified study population		● Not Met (fail)
	4	Correctly identified study indicator		● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not sufficiently addressed, and therefore no standards can be passed.				
Implementation	5	Valid sampling technique		● Not Met (fail)
	6	Accurate/ complete data collection		● Not Met (fail)

	7	Appropriate data analysis/ interpretation of study results	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not sufficiently addressed, and therefore no standards can be passed.			
Outcomes	8	Appropriate improvement strategies	● Not Met (fail)
	9	Real improvement achieved	● Not Met (fail)
	10	Sustained improvement achieved .	● Not Met (fail)
Overall Score			● Not Met (fail)
Reviewer Comments		**Recommendation requiring CAP** It is not acceptable to solely submit another institution's data analysis report regardless of the situation with the RSN's data; NSMHA could have synthesized the data from the report and answered PIP questions. When selecting future PIPs, NMSHA needs to be thoughtful about the study topics and questions that are chosen. NSMHA must ensure that all aspects of the proposals are realistic from the onset of the projects. Minor changes are allowable and many times warranted, but need to be done after careful consideration and with input from stakeholders**.** **Confidence Level:** Low confidence in reported results	

Standard 1: Selected Study Topic Is Relevant and Prioritized

Table C-4: Validation of PIP Selected Study Topic

Criterion	Description	Result
1.1	The study topic was selected through data collection and analysis of comprehensive aspects of specific enrollee needs, care and services.	● Not Met (fail)
1.2	The PIP is consistent with the demographics and epidemiology of the enrollees.	● Not Met (fail)

1.3	The PIP considered input from enrollees with special healthcare needs.	● Not Met (fail)
1.4	The PIP addresses a broad spectrum of key aspects of enrollee care and services.	● Not Met (fail)
1.5	The PIP, over time, included all enrolled populations.	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not addressed, and therefore no sections of this standard can be passed.		

Standard 2: Study Question Is Clearly Defined

Table C-5: Validation of PIP Study Question

Criterion	Description	Result
2.1	The study question(s) is clear, concise and answerable.	● Not Met (fail)
2.2	The study question identifies the focus of the PIP and sets the framework for data collection, analysis and interpretation.	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not sufficiently addressed, and therefore no sections of this standard can be passed.		

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.	● Not Met (fail)
3.2	The data collection approach captures all enrollees to whom the study question applied.	● Not Met (fail)
3.3	Appropriate data sources and evaluation methods were used to identify the study population.	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not sufficiently addressed, and therefore no sections of this standard can be passed.		

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.	● Not Met (fail)
4.2	The indicators track performance over a specified period of time.	● Not Met (fail)
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.	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not sufficiently addressed, and therefore no sections of this standard can be passed.		

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.	● Not Met (fail)
5.2	Valid sampling techniques were employed that protected against bias.	● Not Met (fail)
5.3	The sample contained a sufficient number of enrollees.	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not sufficiently addressed, and therefore no sections of this standard can be passed.		

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.	● Not Met (fail)
6.2	The study design clearly specifies the sources of data.	● Not Met (fail)
6.3	The study design specifies a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply.	● Not Met (fail)
6.4	The instruments for data collection provide for consistent and accurate data collection over the time periods studied.	● Not Met (fail)

6.5	The study design prospectively specifies a data analysis plan.	● Not Met (fail)
6.6	Qualified staff and personnel were used to collect the data.	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not sufficiently addressed, and therefore no sections of this standard can be passed.		

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.	● Not Met (fail)
7.2	Numerical PIP results and findings were accurately and clearly presented.	● Not Met (fail)
7.3	The data analysis methodology was appropriate to the study question and data types.	● Not Met (fail)
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.	● Not Met (fail)
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.	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not addressed, and therefore no sections of this standard can be passed.		

Standard 8: Appropriate Improvement Strategies

Table C-11: Validation of PIP Improvement Strategies

Criterion	Description	Result
8.1	A continuous cycle of measurement and performance analysis was conducted.	● Not Met (fail)
8.2	Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes.	● Not Met (fail)
8.3	The interventions are/were sufficient to be expected to improve processes or outcomes.	● Not Met (fail)
8.4	The interventions are/were culturally and linguistically appropriate.	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not addressed, and		

therefore no sections of this standard can be passed.

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.	● Not Met (fail)
9.2	There was documented, quantitative improvement in processes or outcomes of care.	● Not Met (fail)
9.3	The reported improvement in performance appears to be the result of the planned quality improvement intervention.	● Not Met (fail)
9.4	There is statistical evidence that any observed performance improvement is true improvement.	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not addressed, and therefore no sections of this standard can be passed.		

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.	● Not Met (fail)
Reviewer Comments: Without following the approved PIP format, required CMS scoring elements are not addressed, and therefore no sections of this standard can be passed.		

PIP Validation Results: Non-Clinical PIP

Improving the Quality of Care Coordination for High-Risk Transition-Age Youth

As a result of the 2009 class-action lawsuit T.R. vs. Dreyfus, an amendment was made to the contract between Regional Support Networks and the Division of Behavioral Health and Recovery, requiring that at least one PIP focus on children and families. NSMHA chose the topic of improving the quality of care coordination of high-risk transition-age youth (HRTAY) to address this new requirement, as well as to respond to a clear need within this specific enrollee population. NSMHA noted that life-stage transitions are inevitable, and as a person enters older adolescence and early adulthood there are increasing expectations to demonstrate self-reliance, independence and responsibility. This is a challenging time for most young people, but it can be especially difficult for Medicaid-eligible transition-age youth (TAY) with unmet behavioral health needs. NSMHA listed issues such as stigma, lack of natural supports, poverty, mental health crisis, substance abuse and disconnected services as all adversely affecting the transition into adulthood.

In 1982, Jane Knitzer wrote a report for the Children's Defense Fund that highlighted the fact that two out of three children and adolescents with serious mental health needs were not getting any services or help, and that adolescents in particular were unlikely to get mental healthcare when needed. The report found that in general, neither State nor Federal governments had demonstrated mental health or social service policy that reflected the needs of children, youth and families. In 2008, Knitzer wrote another report that acknowledged significant improvement in policy and practice in children's mental health. However, one area of deficit highlighted was services for TAY. Only seven states had consistent support and funding for young children through youth transitioning into adulthood.

NSMHA noted that the need to improve services for transition-age youth received clear and intentional focus in Washington State beginning in 2005 through a Federal Mental Health Transformation Grant. The grant ended in 2010 and many strategies were not sustained. Currently the state is the recipient of a Substance Abuse and Mental Health Services Administration (SAMHSA) System of Care (SOC) expansion grant, with the objective of expanding and sustaining SOC values and practice throughout the state. One outcome has been to develop strategies to improve employment outcomes for system-involved transition-age youth.

In January 2013, NSMHA began the process of brainstorming PIP topics related to children, youth and families. 2003–2013 historical data from the Consumer Information System (CIS) was reviewed and compared with that of a cohort in each year, comparing encounters for the same age ranges: 15–17, 18–23, 19–23, 20–23 and 22–13. From 2003 to 2009, for youth ages 15–17, an average of 33% of enrollees continued to receive services when they turned 18. By the age of 21, the same youth had only an 11% enrollment rate. In the 2010–2012 data, from a baseline of 100% enrollment between the ages of 15 and 17, the average enrollment dropped to only 20%, and by the time youth were ages 21–23 the average was 0%.

Through a variety of meetings that included a range of stakeholder input, NSMHA explored possible reasons for the drop in enrollment. After considering a variety of factors it was hypothesized that high-quality care coordination efforts specifically designed for the TAY population might be a common improvement effort to address these items.

NSMHA reported that clinical and paraprofessional staff is traditionally trained to think in terms of serving children and adults, meaning under 18 years of age and over 18 years of age. Providing appropriate services to TAY can be difficult. NSMHA cites a review of 2011 inpatient data that showed that TAY youth made up 73% of hospitalization episodes for children and youth 0–20 years old, and concluded it was

therefore imperative to undertake a focused TAY workforce development initiative in order to reduce risks, provide appropriate inventions and support smoother transitions into adulthood.

Through the use of a survey and in community and online events, NSMHA further focused the target population and study topic. In April of 2013 the Quality Management Oversight Committee (QMOC) convened as a workgroup for the PIP. QMOC comprises enrollees, advocates, providers and NSMHA staff. The topic of transition-age youth was well received. The PIP proposal was submitted to DBHR in May 2013 and was initially rejected in June 2013, cited for the need to focus on clinical outcomes. Once requirements for non-clinical vs. clinical PIPs was clarified, NSMHA was granted approval to continue with the study topic in July 2013. In July 2013, QMOC continued to meet, using all collected input, and developed the final target population, study topic and structure for interventions. The PIP received ultimate approval from QMOC on July 24, 2013.

The study question is: "Does implementing workforce development strategies and related practice guidelines (specific to delivering services to Transition-Age Youth and implemented by staff in provider agencies) improve the clinician perception of competency to provide quality coordinated care to High-Risk Transition-Age Youth (HRTAY) as measured by increase in the total mean score on the Transition Service Provider Competency Scale?"

Dates of Study Period:
Baseline: April 28, 2014–June 4, 2014
Intervention: May 12, 2014–July 18, 2014
First re-measurement: August 14, 2014–September 17, 2014
Second re-measurement: October 27, 2014–November 26, 2014

Table C-14: Clinical PIP Validation Results

Study Design		Activity	Narrative	SCORE
Design	1	Appropriate study topic	The study topic is focused on improving the quality of care coordination for high-risk transition-age youth by developing a comprehensive array of services and supports. NSMHA sought to study this topic by specifically exploring clinician confidence in providing services to high-risk transition-age youth. NSMHA conducted extensive research on services for transition-age youth, spanning decades, looking at national, state and local information.	Fully Met (pass)
	2	Clearly defined, answerable study question	"Does implementing workforce development strategies and related practice guidelines (specific	Partially Met (pass)

		to delivering services to Transition-Age Youth and implemented by staff in provider agencies) improve the clinician perception of competency to provide quality coordinated care to High-Risk Transition-Age Youth (HRTAY) as measured by increase in the total mean score on the Transition Service Provider Competency Scale?" NSMHA intended for there to be a second study question related to youth perception of quality of care, but it was abandoned because of lack of resources.	
3	Correctly identified study population	The study population was identified as providers with a master's degree or higher who oversee outpatient services to high-risk transitional-age youth, who have a caseload of five or greater and have had five or more appointments between January 1, 2014, and March 21, 2014. These providers must have a master's degree or PhD and have completed the required workforce development training work to be included in the study population. If the second study question had not been abandoned a second identified study population would have been eligible enrollees.	Partially Met (pass)
4	Correctly identified study indicator	The numerator was identified as the post-intervention change in the total mean score of the Transition Service Provider Competency Scale (TSPCS); M_2—M_1. The denominator was identified as the differences in variation and size (standard error of the means) between pre-intervention and post-intervention scores of the TSPCS. If the study question had not been discarded a second indicator	Partially Met (pass)

			would have been a measurement of youth perspective of whether the intervention increased youth participation in aspects of treatment planning.	
Reviewer Comments: NSMHA reported conducting an extraordinarily thorough process when choosing this study topic and identified subject matter that is, on the whole, appropriate. While the study question, study population and study indicator are clearly identified, it is not clear that this PIP truly meets the criteria of a valid PIP. While it can be known from the study question that there is a measureable impact on the defined study population, the service providers, it cannot be known if there was a direct impact to enrollees. An outcome to enrollees is the true purpose of the PIP. The portion of the study that was not pursued would have been a clearer measure of enrollee improvement.				
Implementation	5	Valid sampling technique	There were no samples in this study.	● N/A
	6	Accurate/ complete data collection	Providers emailed or faxed certificates of completion and completed scales to NSMHA . National Provider Identifier (NPI) numbers were required to be included so that the data could be supplemented with demographic and employment data from the NSMHA CIS in order to supplement the characteristics.	● Fully Met (pass)
	7	Appropriate data analysis/ interpretation of study results	NSMHA used a paired t-test, and then used a repeated measure analysis of variance (ANOVA) to analyze the results of the interventions. The null hypothesis will be rejected at an alpha level of $p \leq 0.05$.	● Fully Met (pass)
Reviewer Comments: Sampling techniques were not used for this PIP. NSMHA had a clear and detailed plan to ensure accurate and complete data collection. The plan for statistical analysis of the data is appropriate to interpret the results of the data.				
Outcomes	8	Appropriate improvement strategies	NSMHA administered a “barriers and boosters” questionnaire to participating providers at the two re-measurement assessments and aggregated the results. Issues were noted, but improvement strategies were not implemented.	● Partially Met (pass)
	9	Real improvement achieved	A paired t-test was run on providers to determine if there	● Fully Met (pass)

			was a statistically significant mean difference between pre-intervention and the first re-measurement. Completing the training resulted in a statistically significant increase of 7.7 score units in self-evaluation of competency (95% CI: 4.4 to 10.9, t[55] = 4.7, two-sided p < 0.05).	
	10	Sustained improvement achieved	A one-way repeated ANOVA was performed to assess if there were differences in mean TCPCS scores. The results showed there were statistically significant differences in the mean TSPCS score over six months (F[2, 102] = 18.23, two-sided p < 0.05).	● Fully Met (pass)
Overall Score				● Partially Met (pass)
Reviewer Comments	**Strength(s):** NSMHA has chosen a well-researched and thoroughly appraised study topic. The study question that was pursued was clear and answerable. Data collection and analysis was appropriate, and real and sustained improvement was achieved. **Recommendation(s):** When choosing future PIPs, both clinical and non-clinical, NSMHA should ensure that the PIPs include one or more measurable indicators related to enrollee outcomes such as changes in functional status, goal achievement and satisfaction. Changes in provider status, while somewhat useful, is not alone a strong-enough indicator of a change in an enrollee outcome. Appropriate improvement strategies need to be addressed in future PIPs. Collecting data on barriers and boosters can be useful, but it is not sufficient to only list the top-rated issues with no plans for change articulated. Interventions should address noted barriers and be clearly stated. **Confidence Level:** Moderate confidence in reported results			

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.	Partially Met (pass)

Reviewer Comments:

The process for determining the PIP study topic was quite thorough and included multiple steps. In January of 2013 NSMHA began the process of brainstorming PIP topics related to children, youth and families. Child and adult care coordinators were informally surveyed regarding topics and a theme related to soon-to-be-18-years-old enrollees who were transitioning from child to adult services became evident. In April of 2013 the Quality Management Oversight Committee convened as a workgroup for the PIP. QMOC comprises enrollees, advocates, providers and NSMHA staff. The work group reviewed and prioritized potential study topics. The topic of transition-age youth was well received. A logic model was developed and interventions were articulated. The proposal was submitted to DBHR in May 2013 and was initially rejected in June 2013, citing the need to focus on clinical outcomes. Once requirements for non-clinical vs. clinical PIPs was clarified, NSMHA was granted approval to continue with the study topic in July 2013. Also, between April and June 2013 NSMHA conducted seven “Have Your Say Cafes” in five counties, including three in Snohomish. An online event called “World Café” was also held to gain input on the focus of the PIP. In July 2013, QMOC continued to meet, using all collected input, and developed the target population, study topic and structure for interventions. The PIP received ultimate approval from QMOC on July 24, 2013.

NSMHA used a variety of data sources to determine that this PIP was consistent with demographics and epidemiology of enrollees. In 2007, a World Health Organization study of lifetime prevalence and age-of-onset distributions of mental disorders found that onset for 50% of adult mental health disorders occurs by age 14, and for 75% of adults by age 24.4. A review of NSMHA 2011 inpatient data showed that TAY made up 73% of the hospitalization episodes for enrollees ages 0–20. In 2012 DSHS produced a report on Washington’s youth. Included were 125,123 DSHS Medicaid clients served in 2008 between the ages of 12 and 17. The study noted that almost 30% of those clients had three or more Adverse Childhood Experiences (ACE). The study found that behavioral health problems were more likely as the number of ACEs increased. NSMHA examined 2003–2013 historical data from NSMHA’s CIS and compared encounters from one cohort in each year, comparing encounters from the same cohort across subsequent age ranges: 15–17, 18–23, 20–23 and 22–23. NSMHA found an average of 33% of youth ages 15–17 continued to received services at 18, but by age 21 the same youth had only an 11% enrollment rate. The 2010–2012 data showed that the average enrollment of 18-year-olds, with a baseline of 100% between ages15 and 17, was 20% and that between ages 21 and 23 the average was 0%.

NSMHA considered a great deal of input from enrollees when formulating this PIP. QMOC has enrollees and advocates as members, and it was noted that 18% of the Have Your Say Café attendees were youth and parents.

This PIP addresses aspects of enrollee mental healthcare and services specifically targeting the TAY population.

Opportunity for Improvement:
This PIP aims to address the needs of an enrolled population; however, the population actually studied is providers. When choosing PIPs for 2016, NSMHA should be careful to choose outcomes that measure change in enrollee status.

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:
The PIP study question is measurable and clearly stated as, “Does implementing workforce development strategies and related practice guidelines (specific to delivering services to Transition-Age Youth and implemented by staff in provider agencies) improve the clinician perception of competency to provide quality coordinated care to High-Risk Transition-Age youth (HRTAY) as measured by increase in the total mean score on the Transition Service Provider Competency Scale?”

The study question identifies the focus of the PIP as improving service delivery for HRTAY through the intervention of a clinician training and sets a framework for data collection and analysis through the administration of the Transition Service Provider Competency Scale at baseline and two re-measurement intervals. Analysis was done using a paired t-test, and then a repeated measure was used for ANOVA to analyze the results of the interventions. The null hypothesis will be rejected at an alpha level of $p \leq 0.05$.

Opportunity for Improvement:
While the study question is clear and answerable and there is a solid framework for data collection and analysis, the PIP does not clearly assess an aspect of enrollee improvement. For future PIPs, NSMHA needs to carefully consider study topics to ensure enrollee improvement is truly being measured.

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.	Partially Met (pass)
3.3	Appropriate data sources and evaluation methods were used to identify the study population.	Fully Met (pass)

Reviewer Comments:
NSMHA defined the study population as RSN providers who oversee outpatient services to Medicaid-eligible HRTAY enrollees in the region. High-risk transition-age youth were defined as 16–20-year-olds whose care criteria put them in a high-risk category. High risk was defined by youth having a Child and Adolescent Level of Care Utilization System or Level of Care Utilization System (CA/LOCUS) of three or four.

The study indicator used was the TSPCS. NSMHA chose this scale because it measures service provider perspective, supports systems of care core values by being culturally competent and youth guided, is recognized in the field of transitional-age youth, is designed and validated by Portland State University and is easily administered.

Medicaid status and RSN enrollment were verified from a data set transmitted by the State to NSMHA monthly. Demographic and eligibility tables were used in conjunction with the NSMHA demographic information to create a cross table that matched Medicaid and NSMHA patient ID numbers. If an enrollee was in the eligible table during the month, they were considered Medicaid eligible.
All completed scales and certificates of completion were emailed or faxed to NSMHA, then forwarded to an external consultant for data entry. Participant NPI numbers were used to link project data to the CIS database. The data was then supplemented with demographic and employment data from the CIS database.

Opportunity for Improvement:
It is unclear how CA/LOCUS scores are verified, other than as reported by the providers. A more systematic substantiation of CA/LOCUS scores of the clients on each provider's caseload would ensure that all eligible enrollees were being included in the PIP.

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:
The study used objective, clear, specific and measurable indicators. The numerator was defined as the post-intervention change in total mean score of the TSPCS, $M_2 - M_1$. The denominator was defined as the differences in variation and size (standard error of the means) between pre-intervention scores and post-intervention scores.

The indicator is tracked over time to include a baseline measurement prior to the intervention and two re-measurement periods to track improvement.

Meets Criteria

Standard 5: Sampling Method

Table C-19: Validation of PIP Sampling Methods

Criterion	Description	Result
5.1	The sampling technique considered and specified the true (or estimated) frequency of occurrence of the event, the confidence interval to be used and the acceptable margin of error.	● N/A
5.2	Valid sampling techniques were employed that protected against bias.	● N/A
5.3	The sample contained a sufficient number of enrollees.	● N/A

Reviewer Comments:
There were no samples in this PIP; the entire study population was included in the indicator.

Standard 6: Data Collection Procedure

Table C-20: Validation of PIP Data Collection Procedures

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

	study's indicators apply.	
6.4	The instruments for data collection provide for consistent and accurate data collection over the time periods studied.	● Fully Met (pass)
6.5	The study design prospectively specifies a data analysis plan.	● Fully Met (pass)
6.6	Qualified staff and personnel were used to collect the data.	● Fully Met (pass)

Reviewer Comments:
The study design specified that the data to be collected were the HRTAY provider responses and overall scores to the TSPCS at the three specified intervals. Providers faxed completed scales to NSMHA. NPI numbers were required to be included so that the data could be supplemented with demographic and employment data from the NSMHA CIS in order to supplement the characteristics.
For individual data points, a survey was considered complete if 80% of the questions were scored, no more than three missing items per 15-item survey. The total score was calculated from the total number of answered items. In the rare instances when the responses were not legible, two project members were required to independently agree on the item score prior to entry.

NSMHA used a paired t-test, and then used a repeated measure ANOVA to analyze the results of the interventions. The null hypothesis was to be rejected at an alpha level of $p \leq 0.05$.

An external research contractor was consulted for guidance on data collection and analysis planning. The project leads also consulted with the developers of the TSPCS to better understand potential barriers and opportunities for good data collection. The external consultant was also responsible for data entry. The consultant has extensive training in data collection as a research coordinator and project coordinator, and is a master's-level epidemiologist. Data were imported into Stata software to identify outlying data, and variable utilities were conducted where desired (e.g., calculating TSPCS average total score, deriving age of provider from current year minus reported year of birth to report mean provider age).

Meets Criteria

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.	Partially Met (pass)

Reviewer Comments:
The analysis of findings was performed according to NSMHA's plan and the results were clearly presented. Data analysis methodology was relevant to the study question and types of data.

Threats to internal validity were reported. Training and initial survey completions rated were good, but NSMHA did not anticipate such a large attrition rate. Numerous providers left their agencies, went on maternity leave, or were re-assigned to adult-only caseloads and were therefore not eligible to complete the study. Power calculations were done and suggested that these changes did not affect the ability to detect statistical significance in re-measurement.

The taking of multiple trainings was noted as a possible threat to external validity, as providers are required to take continuing education trainings as part of their licensure maintenance and agency requirements. It would not be possible to distinguish with certainty whether the intervention was the sole cause of any changes in confidence. In a post-hoc assessment of these trainings, three providers were noted to have taken similar Wraparound services trainings and that their mean scores did not differ significantly from the scores of those providers who did not take that type of training.

NSMHA achieved statistically significant improvement in provider perception of competence to provide quality coordinated care to HRTAY.

Opportunity for Improvement:
NSMHA reported that the fact that no direct measurement of enrollees was elicited had been a concern in previous PIP reviews, but that it was not feasible to collect such data. NSMHA viewed this non-clinical PIP as a workforce improvement project and therefore believed that a survey of providers was sufficient. Regardless of whether a PIP is clinical or non-clinical, ultimately its purpose is to impact change on Medicaid enrollees' care and lives. Workforce development itself is a valid step in improvement, but without any kind of enrollee measurement it is unclear that there was any direct effect on enrollees. NSMHA needs to think more broadly about ways to measure enrollee outcomes. Client surveys are an excellent tool, but they are not the only way to measure enrollee improvement for this PIP. Overall reduction in CA/LOCUS, goal achievement and measuring length of stay/continuation in services are just a few examples of tools that could be used in addition.

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.	Partially Met (pass)
8.3	The interventions are/were sufficient to be expected to improve processes or outcomes.	Partially Met (pass)
8.4	The interventions are/were culturally and linguistically appropriate.	Fully Met (pass)

Reviewer Comments:
A continuous cycle of measurement and performance analysis was conducted. A barriers and boosters questionnaire was administered at the two re-measurement intervals. The data was aggregated, lessons learned were noted, but no plans for improvement were implemented at any point in the PIP process.

The training modules of the intervention included core competencies in cultural and linguistic appropriateness.

Opportunities for Improvement:
NSMHA needs to work to not only collect data on barriers for future PIPs but use the information on an ongoing basis and make adjustments to the PIP process as needed to be sure interventions and outcomes are optimized.

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.	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:
The same methodology was used at baseline measurement and the two subsequent re-measurements. On the first re-measurement, a paired t-test was run to determine whether there was statistical significance between pre-intervention self-evaluation of competence in providing care coordination to HRTAY and post-intervention self-evaluation of competence. The analysis found that there was a statistically significant increase of 7.7 units in self-evaluation of competency (95% CI: 4.4 to 10.9, $t[55] = 4.7$, two-sided $p < 0.05$). For the second re-measurement a one-way repeated ANOVA was performed to assess if there were

differences in mean TSPCS scores of self-evaluation of competence in providing care coordination to HRTAY after the intervention. The results showed statistically significant differences in mean TSPCS scores over six months (F[2, 102] = 18.23, two-sided p < 0.05). The null hypothesis was therefore rejected.

Meets Criteria

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.	● Fully Met (pass)

Reviewer Comments:
NSMHA's PIP demonstrated sustained improvement through repeated measurements over time. In the first re-measurement the target goals of at least a 7.5 average score improvement in providers' self-evaluated competence was achieved and was maintained through the second re-measurement period.

Meets Criteria

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Information Systems Capabilities Assessment (ISCA)

Qualis Health's subcontractor, Healthy People, examined the information systems and data processing and reporting procedures for the North Sound Mental Health Administration Regional Support Network (NSMHA) to determine the extent to which they supported the production of valid and reliable State performance measures and the capacity to manage care of RSN enrollees.

ISCA Methodology

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

The ISCA review process consists of four phases:

Phase 1: Standard information about RSN's information systems is collected. The RSN and two of its delegated provider agencies complete the ISCA data collection tool before the onsite review.

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

Phase 3: Onsite visits and walkthroughs with the RSN and two delegated provider agencies are conducted. Claims/encounter walkthroughs and data center security walkthroughs are conducted. In-depth interviews with knowledgeable RSN staff and delegated provider agency staff are conducted. Additional documents are requested if needed, based upon interviews and walkthroughs completed at the RSN and at two delegated provider agencies.

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

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

Section A: Information Systems

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

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

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

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

Section B: Hardware Systems

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

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

Section C: Information Security

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

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

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

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

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

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

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

Section D: Medical Services Data

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

Appropriate practices include

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

Section E: Enrollment Data

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

Appropriate enrollment data management practices include

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

Section F: Practitioner Data

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

Section G: Vendor Data

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

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

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

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

Scoring Criteria

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

Table D-1: Scoring Key for ISCA Standards

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

Summary of Results

Healthy People examined North Sound Mental Health Administration System RSN's information systems and data processing and reporting procedures to determine the extent to which they supported the production of valid and reliable state performance measures and the capacity to manage care of RSN enrollees.

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

Table D-2: ISCA Scores by Section

ISCA Section	Description	ISCA Result

A. Information Systems	This section assesses the RSN's information systems for collecting, storing, analyzing and reporting medical, member, practitioner and vendor data.	Fully Met (pass)
B. Hardware Systems	This section assesses the RSN's hardware systems and network infrastructure.	Fully Met (pass)
C. Information Security	This section assesses the security of the RSN's information systems.	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

NSMHA uses an internally created NSMHA consumer information system (CIS) data processing system that uses a Microsoft SQL Server database system. The data processing system is well documented through a series of data flowcharts.

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

ISCA Section A: Information Systems

Table D-3: Information Systems

Section	Description	Result
Section A	This section assesses the RSN's information systems for collecting, storing, analyzing and reporting medical,	Fully Met (pass)

member, practitioner and vendor data.
NSMHA uses an internally created NSMHA CIS data processing system that uses a Microsoft SQL Server database system. The data processing system is well documented through a series of data flowcharts. To ensure proper administration, maintenance and quality assurance for NSMHA CIS, NSMHA employs three full-time, experienced, well-trained IT staff members. All programming work related to encounter data is performed in-house by NSMHA IT staff. NSMHA staff use Microsoft SQL Server, Access and Excel software for additional warehousing, analysis and reporting of Medicaid data. NSMHA uses Team Foundation Server for web-based reporting version control. Encounter data submitted to NSMHA CIS by provider agencies runs through an automated, rules-based edit system that screens the data, identifies potential input errors and ensures compliance with DBHR's data dictionary and encounter reporting requirements. NSMHA requires its provider agencies to submit encounter data within five days from the close of the service month and, if there are any errors, to correct them within ten days of receipt of an error report. Transactions that do not meet the initial edits are rejected by the NSMHA CIS and are not added to the database. Notification is sent back to the submitting agency. NSMHA verifies and certifies batched encounter data for accuracy and completeness before transmitting data to DBHR. Provider's authorization requests are exported to the NSMHA CIS database and are processed by NSMHA internal quality specialists. Decisions are sent back to the agencies though a similar process.

Meets Criteria

ISCA Section B: Hardware Systems

Table D-4: Hardware Systems

Section	Description	Result
Section B	This section assesses the RSN's hardware systems and network infrastructure.	● Fully Met (pass)
In 2014, NSMHA's Medicaid-related data resided on a Dell PowerEdge R720 server, located at NSMHA. The server is located behind an additional set of locked doors. Only authorized NSMHA staff is permitted to be in the server room. NSMHA has good server hardware redundancy. All SQL servers had multiple drive arrays in different redundant array of independent disks (RAID) configurations. NSMHA contracts with Dell for hardware and software tech support and assistance. The coverage is in force continuously, with next-business-day onsite service. NSMHA has a Microsoft Windows 2008-based network. Provider agencies have SFTP access to the NSMHA CIS for the purpose of uploading batch files and downloading error/acceptance reports and data extracts. Provider agencies also have access to a secure online interface for documenting and reporting		

client grievances.

Meets Criteria

ISCA Section C: Information Security

Table D-5: Information Security

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

NSMHA has multiple policies and procedures related to information security. NSRS information security policies and procedures are all fully compliant.

During 2014, multiple copies of the data warehouse were kept with full backups conducted each business night. The data processing database was backed up twice per day, once prior to nightly data processing and once after data processing. A full backup of the server was completed daily.

NSMHA has two sets of ten drives. Each set has two weeks' worth of backups that are rotated Monday through Friday. The drives that are used on Monday are not to be used again until the next Monday. The same rotation follows for other days of the week. Additionally, a weekly backup job is completed for drives that are sent off site. There is a set of five drives that are rotated off site. Internally, the backup drives are stored in fire-proof safes. The off-site backups are stored in a secure facility in Bellingham by a secure data storage vendor that picks up the backup drives from NSMHA once a week.

Disaster recovery is limited to file restorations. NSMHA plans to do full data restoration testing in the near future.

Hard drives on all laptops are encrypted and require multiple passwords/phrases to gain access. Smartphones are all hardware encrypted, pass coded and locked down to prevent users from installing software. Hard drives used for backups are also encrypted. CD/DVD burning is limited to staff of the NSMHA IS/IT department, and group policy prohibits access to USB drives attached to network computers.

Improvement could be made by working with all 13 contracted provider agencies to ensure that they are encrypting their data according to DBHR standards.

Opportunities for Improvement

During the review, it was noted that not all of the provider agencies are encrypting their data according to DBHR standards.

- NSMHA should work with all thirteen contracted provider agencies to ensure that they are encrypting their data according to DBHR standards. Full data restoration testing is recommended, despite the redundant full backups that are maintained.

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)

When provider agencies submit encounter data to NSMHA, various data checks are performed on the data elements in the submitted record. Encounter data submissions are run through an automated, rules-based edit system to screen the data, identify potential input errors and ensure compliance with DBHR's Data Dictionary and Service Encounter Reporting Instructions (SERI). NSMHA performs further edits and validity checks of procedure and diagnosis code fields, eligibility, service authorization and detection of duplicate encounter claims. The records that pass the data checks are successfully added to the NSMHA CIS. As a part of the process of adding the record to the NSMHA CIS, various data elements are also added to the record. These include the date and time the record was initially received, a flag to determine if the record needs to be submitted to DBHR and, should the record submitted be a modification to an existing record, the date and time of the modification. These elements are system-generated values and are automatically added. The records that are not successful in passing the various data checks are returned to the submitting agency with an explanation of what caused the error(s) so that the data can be corrected and resubmitted.

Per DBHR instructions, NSMHA 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* indicates the following for reporting outpatient service diagnosis codes:

- For all intake evaluation modality encounters that are complete and a diagnosis has been determined, report that diagnosis.
- For all encounters that occur after an intake has been completed and authorized, use the approved/authorized diagnosis in the HI01-2 field in the 837P HIPAA transaction.
- DBHR will only use the HI01-2 field when looking at a diagnosis. Other diagnosis codes do not need to be reported.

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

Meets Criteria

ISCA Section E: Enrollment Data

Table D-7: Enrollment Data

Section	Description	Result
Section E	This section assesses the RSN's ability to capture and report accurate Medicaid enrollment data.	● Fully Met (pass)
DBHR provides member enrollment data to NSMHA. NSMHA receives 834 and 820/821 enrollment data files from DBHR. These files are downloaded from the ProviderOne SFTP site and processed in the NSMHA CIS data system once a week. Medicaid eligibility verification takes place at multiple stages, including at time of access to services and, retrospectively, via data reports.		

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)
NSMHA claims/encounter reporting is accurate regarding both rendering practitioner type and practitioner service location. NSMHA also has accurate practitioner information within the RSN provider directory. NSMHA maintains up-to-date provider profile information in an accessible repository that enables the RSN's member services staff to help Medicaid enrollees make informed decisions about access to providers that can meet their special care needs, such as non-English languages or clinical specialties. NSMHA's subcontracted provider agencies deliver current practitioner changes to NSMHA 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)
NSMHA's claims/encounter data is contracted provider agency data; NSMHA does not provide any		

direct client care. NSMHA requires its providers to submit encounter data within five days from the close of the service month and, if there are any errors, to correct them within ten days of receipt of error report. Transactions that do not meet the initial edits are rejected by the NSMHA CIS and not added to the database. Notification is sent back to the submitting agency. NSMHA monitors all 13 provider agencies closely on these vendor data requirements.

Meets Criteria

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

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
NSMHA has a process for testing with provider data systems during provider agency EHR implementation. Testing of batch files is conducted. Once successful testing has been completed, the provider agency may again submit production batches. NSMHA also provides technical assistance to each of its contracted agencies for EHR implementation.		

Meets Criteria

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Encounter Data Validation (EDV)

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

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

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

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

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

State-level Encounter Data Validation

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

- A review of standard edit checks performed by the State on encounter data received by the RSNs and how Washington's Medicaid Management Information System (MMIS) treats data that fail an edit check

- A basic integrity check on the encounter data files to determine whether expected data exist, whether the encounter data fit with expectations and whether the data are of sufficient quality to proceed with more complex analysis
- Application of consistency checks, including verification that critical fields contain values in the correct format and that the values are consistent across fields
- Inspection of data fields for general validity
- Analyzing and interpreting data on submitted fields, the volume and consistency of encounter data and utilization rates, in aggregate and by time dimensions, including service date and encounter processing data, provider type, service type and diagnostic codes

Validating RSN EDV Procedures

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

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

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

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

Clinical Record Reviews

Qualis Health performed clinical record reviews onsite at provider agencies that had contracts with the RSNs. The process included the following:

- Selecting a statistically valid sample of encounters from the file provided by the State
- Loading data from the encounter sample into a custom database to record the scores for each encounter data field
- Providing the RSN with a list of the enrollees whose clinical charts were selected for review for coordination with contracted provider agencies pursuant to the onsite review

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

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

Scoring Criteria

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

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

North Sound RSN Encounter Data Validation

North Sound Mental Health Administration Regional Support Network (NSMHA) contracts with 11 providers for Medicaid-funded services. The EDV process for NSMHA was conducted during the first half of 2014 and covered the period of encounters occurring between October 2013 and May 2014. The NSMHA EDV was based on a sample of 212 client records comprising 970 encounters.

Table E-2: Scores and Ratings on NSMHA'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.	Not Met (fail)
Recommendation Requiring CAP North Sound RSN failed to review provider name and agreement of the clinical notation with procedure code. • NSMHA needs to review all required encounter data elements.		

Sampling Procedure

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

NSMHA sampled from Medicaid-funded encounters that occurred from October 2013 through May 2014 for its 11 providers. An overall sample size of 970 encounters was selected, exceeding the contract minimum of 822 encounters. The encounters were drawn from 212 client charts, exceeding the contract minimum of 200 unique client charts.

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

NSMHA used a proportional sampling procedure based on agency size and age group composition (including two age groups: for children, aged 20 and under, and adults, aged 21 and over). After determining the minimum overall sample size, stratum-specific proportions of the sample frame were used to calculate the desired sample size of encounters from each stratum. The targeted number of client charts was randomly drawn for each stratum, and up to five random encounters were selected for each chart.

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

Review Tools

Reviews were conducted at the agencies in onsite reviews. NSMHA used an access database tool to collect results for each reviewed encounter and chart. The tool prompts the reviewer through a series of screens and provides fields to record results. The tool also allows the user to create notes relating to specific findings.

Methodology and Analytic Procedures

The methods used for onsite reviews were not extensively described in NSMHA's EDV report. Not all of the encounter fields specified under the DBHR contract as "minimum data elements" appear to have been collected, as no results were reported for the name of the service provider or for whether the clinical note matched the procedure code. The DBHR contract calls for the following minimum set of encounter data fields to be validated:

- Date of service
- Name of service provider
- Procedure code

- Minutes of service
- Service location
- Provider type
- Service code agrees with treatment described

It was not clear how many reviewers participated in the work or what steps they took to assess or promote inter-rater reliability.

Validation results for NSMHA indicated that match rates for five of the seven minimum encounter data fields were above the contracted limit of 95%. The overall encounter match rate (percent of encounters with all fields matching) was not reported.

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

Qualis Health Encounter Data Validation

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

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

EDV Standard	Description	EDV Result
Electronic Data Checks	Full review of encounter data submitted to the state indicates no (or minimal) logic problems or out-of-range values.	Fully Met (pass)
Onsite Clinical Record Review	State encounter data are substantiated in audit of patient charts at individual provider locations. Audited fields include demographics (name, date of birth, ethnicity and language) and encounters (procedure codes, provider type, duration of service, service date and service location). A passing score is that 95% of the encounter data fields in the clinical records match.	Not Met (fail)
Recommendation Requiring CAP Encounter data did not meet the 95% standard for compliance. • To ensure encounter data are substantiated and in compliance, the RSN needs to o Provide training on the Service Encounter Reporting Instructions (SERI): on coding, on what is included and excluded in each modality, and on the general encounter reporting instructions o Provide training on what services can be encountered and what services cannot o Provide training on who can provide services that are encountered		

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

Opportunity for Improvement

NSMHA uses its own encounter data for validation purposes.

- NSMHA should use encounter data from ProviderOne instead of RSN encounter data when doing validation to identify inconsistencies between the chart and State-maintained data.

Electronic Data Checks

Qualis Health analysts reviewed all demographic details and encounters for NSMHA from ProviderOne for the October 2013 through September 2014 reporting period, comprising 22,759 patients and 531,463 encounters. Fields for each encounter were checked for completeness and to determine if the values were within expected ranges. Results of the electronic data checks are provided in Table E-4.

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

- The language field was technically complete, but 24.9% of the fields for this RSN were coded as "Unknown/patient refused," which seems disproportionately high compared to that observed for other RSNs.
- About 22% of the encounter records appear to be duplicates, with the exception of the claim number. NSMHA accounted for 39.7% of the duplicates statewide.
- All sexual orientation data were present, but 71.4% of the values were "Unknown, patient refused."

NSMHA'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/Race	100% complete, all values in range	100%
Language Preference	100% complete, all values in range	100%
Social Security Number	Optional	56.8%

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 491 encounters submitted by NSMHA to ProviderOne with a service date between October 1, 2013, and September 30, 2014, as well as demographic records associated with the 140 individuals whose encounters were included in the sample. Reviewers compared data from database extracts provided by DBHR to data included in the clinical records. Qualis Health reviewed encounter data fields required for review in the RSN contract with DBHR, including

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

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

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

Site Visit Results

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

The match rates for several demographic fields were low, including ethnicity, Hispanic origin, language, Social Security Number and sexual orientation. For ethnicity, Hispanic origin and language, the majority of errors appeared to be the result of data entry, where the values included in the clinical records differed from the values submitted by the provider agency. Social Security Number was missing from both databases for about a quarter of the records, and sexual orientation was missing from the client chart in another quarter of cases.

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

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

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. NSMHA did not validate all demographic fields. For ethnicity, the high match rate found by NSMHA's review of demographic fields was not observed in Qualis Health's review, as shown in Table E-7.

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

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

Table E-5: Demographic Data Validation

Demographic Data (N = 140)				
Field	**Match**	**No Match – Erroneous**	**No Match – Missing**	**No Match – Unsubstantiated**
Last Name	96.43%	3.57%	0.00%	0.00%

First Name	99.29%	0.71%	0.00%	0.00%
Gender	97.14%	2.14%	0.00%	0.71%
Date of Birth	99.29%	0.71%	0.00%	0.00%
Ethnicity/Race	82.86%	14.29%	0.00%	2.86%
Hispanic Origin	69.29%	26.43%	0.00%	4.29%
Preferred Language	50.71%	47.14%	0.00%	2.14%
Social Security Number	60.00%	0.71%	27.14%	1.43%
Sexual Orientation	64.29%	8.57%	0.00%	26.43%

Table E-6: Encounter Data Validation

Encounter Data (N = 491)				
Field	**Match**	**No Match – Erroneous**	**No Match – Missing**	**No Match – Unsubstantiated**
Procedure Code	62.53%	31.16%	1.63%	4.68%
Date of Service	93.28%	0.41%	1.63%	4.68%
Service Location	92.46%	1.22%	1.63%	4.68%
Service Duration	85.13%	7.74%	1.63%	5.50%
Provider Agency	93.28%	0.41%	1.63%	4.68%
Provider Type	92.87%	0.81%	1.63%	4.68%
Clinical Note Matches Procedure Code	58.86%	41.14%	0.00%	0.00%

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

Field	**Qualis Health Match**	**RSN Match**	**Variance**
Last Name	96.43%	100.00%	–3.57%
First Name	99.29%	100.00%	–0.71%
Gender	97.14%	N/A	N/A
Date of Birth	99.29%	100.00%	–0.71%
Ethnicity/Race	82.86%	95.80%	–12.94%
Hispanic Origin	69.29%	N/A	N/A
Preferred Language	50.71%	N/A	N/A
Social Security Number	60.00%	N/A	N/A
Sexual Orientation	64.29%	N/A	N/A

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

Field	**Qualis Health Match**	**RSN Match**	**Variance**
Procedure Code	64.15%	99.80%	–35.65%
Date of Service	94.91%	99.70%	–4.79%
Service Location	94.09%	98.80%	–4.71%

Service Duration	86.76%	99.00%	–12.24%
Provider Agency	94.91%	N/A	N/A
Provider Type	94.50%	100.00%	–5.50%
Clinical Note Matches Procedure Code	58.86%	N/A	N/A

Discussion

The NSMHA EDV processes related to sampling appear adequate to meet the requirements of the RSN's contract with DBHR. NSMHA needs to improve the technical description of its review tool and review methodology.

The encounter and demographic data received from the State were 100% complete, with the exception of Social Security Number, an optional data element, which was 56.8% complete.

Qualis Health's review of demographic data indicated low accuracy for a number of data elements. NSMHA did not review all demographic fields, but the major contrast between the two reviews was for ethnicity.

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

- Encountering psychotherapy for 60 minutes with documentation that states a voicemail was left for school counselor
- Encountering interactive complexity without supporting documentation
- Submitting 90837 for psychotherapy services over 68 minutes, which should be encountered as H0004
- Submitting 90791 for intakes provided by non-licensed MHPs
- Encountering wraparound services with documentation supporting non-wraparound services
- Encountering child and family team meetings that do not meet the SERI requirements of this service
- Submitting encounters that lack clinical interventions
- Submitting a location code that does not match the description in the documentation
- Encountering services that cannot be encountered such as faxing, leaving voicemail, taking client to get ice cream, transportation, taking client to the skate park, playing board games, teaching Othello and Scattergories, playing basketball, taking client to get food, writing letters, researching

games and tools to use with client, making phone calls to get a fax number, internal coordination between staff, staffing a client

- Encountering evaluation and management codes with psychotherapy add-ons that are not significant and separately identifiable within the documentation
- Submitting encounters that are incorrectly bundled
- Submitting encounters for engagement and outreach for a client who no-showed for an appointment, but without supporting documentation that the service occurred
- Encountering a service for coordinating care for a client's children
- Encountering services for being a go-between for the client and the client's payee
- Submitting a unit of 1 for 90791, when this code should be submitted using minutes
- Submitting an encounter with documentation that is illegible
- Encountering family psychotherapy when documentation supports a different service
- Encountering evaluation and management codes by time without the supporting documentation that greater than 50% was spent on counseling and coordination as defined by the CPT manual
- Submitting group encounters with documentation that does not contain all the WAC-required elements
- Submitting two services at the same time for the same individual: one medication evaluation and one psychotherapy service

Opportunity for Improvement

NSMHA uses its own encounter data for validation purposes.

- NSMHA should consider utilizing encounter data processed by the State rather than data maintained by the RSN when conducting EDV.

Recommendation Requiring CAP

North Sound RSN failed to review provider name and agreement of the clinical notation with procedure code.

- NSMHA needs to review all required encounter data elements.

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

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

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Appendix A: Previous Year Findings and Recommendations

CFR	Prior Year Findings, Recommendations, Opportunities	RSN Activity Since the Prior Year	Current Status
Information requirements—§438.100(b); §438.10(b)–(d)	NSMHA needs to develop and implement methods to monitor calls received by all contracted providers to ensure that enrollees are treated with respect and dignity and can obtain timely interpreter services.	NSMHA stated it has not developed or implemented methods to monitor calls.	**Resolved**
General information for all enrollees—§438.100(b); §438.10(f)(2)–(6)	NSMHA needs to develop and implement mechanisms to provide enrollees with the names, specialties, locations, telephone numbers of and non-English languages spoken by contracted practitioners in the service area.	NSMHA has developed and implemented mechanisms to provide enrollees with the names, specialties, locations, telephone numbers of and non-English languages spoken by contracted practitioners in the service area.	**Resolved**
RSN Contract 11.2.2: Testing of DR/BC Plan	One of RSN's provider agencies reported that it had not tested its BC/DR plan recently. NSMHA needs to update its data security policies and procedures in accordance with DBHR contract requirements and industry best practices.	NSMHA submitted a facility checklist and administrative audit checklist.	**Resolved**

RSN Contract Exhibit C: Data Security Requirements	NSMHA's data security policies and procedures are outdated and have not been reviewed recently. Many have not been updated since 2005. Best practices call for a review of policies and procedures at least every two years. NSMHA needs to update its data security policies and procedures in accordance with DBHR contract requirements and industry best practices.	NSMHA had agreed to complete this activity by May 2014 as part of its corrective action plan with DBHR. The RSN provided no update.	**Recommendation Stands**
RSN Contract Exhibit C: Data Security Requirements	Two of NSMHA's provider agencies reported that passwords used to connect to key software are not required to be changed and do not enforce a complexity component. NSMHA needs to revise its password security requirements to force changes and meet complexity standards, in accordance with DBHR contract requirements and industry best practices.	NSMHA submitted a facility checklist and administrative audit checklist, but these documents have not been updated to include password requirements. NSMHA provided no update on the status of providers' password security. The RSN had agreed to complete this activity complete by May 2014 as part of its corrective action plan with DBHR.	**Recommendation Stands**
RSN Contract Exhibit C: Data Security Requirements	NSMHA's data security policies and procedures are outdated and have not been reviewed recently. Many have not been updated since 2005. Best practices call for a review of policies and procedures at least every two years. NSMHA needs to update its data security policies and procedures in accordance with DBHR contract requirements and industry best practices.	NSMHA had agreed to complete this activity by May 2014 as part of its corrective action plan with DBHR. The RSN provided no update.	**Recommendation Stands**

RSN Contract Exhibit C: Data Security Requirements	NSMHA's provider agencies use various encryption strategies for laptop computers, hard drives, and other portable devices. Unencrypted laptop storage that relies on a manual process by users to properly identify protected health information and avoid storage on the device should be discouraged. NSMHA should review provider agencies' encryption strategies to ensure that they align with current industry standards and HIPAA requirements.	NSMHA submitted a facility checklist and administrative audit checklist, but these documents have not been updated to include encryption requirements. NSMHA provided no update on the status of providers' encryption practices.	**Recommendation Stands**

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

Compliance with Regulatory and Contractual Standards

Section 1: Availability of Services

Recommendation Requiring CAP
Review of NSMHA's policies on out-of-network services and provider credentialing indicated that neither policy contained any language regarding the credentialing of out-of-network providers.

1. NSMHA needs to include in one of its policies the process by which out-of-network providers are credentialed.

Section 2: Coordination of Care

N/A

Section 3: Coverage and Authorization of Services

Recommendation Requiring CAP
NSMHA does not have a process for training authorization staff on inter-rater reliability.

2. NSMHA needs to implement a documented process to develop training for authorization staff to ensure that authorizations are done in a consistent and appropriate manner.

Section 4: Provider Selection

Recommendations Requiring CAP
The Primary Source Verification Credentialing, Re-Credentialing, Appointment and Privileging of Contracted or Employed Staff policy and procedure has not been updated in over ten years.

3. NSMHA needs to review and update this policy and procedure to more accurately reflect current practice.

The current policy states that the information validated includes education, licensure, training and experience, but did not include criminal history background checks.

4. The policy needs to state how the RSN verifies Washington State background checks on each agency employee in contact with individuals receiving services.

Section 5: Subcontractual Relationships and Delegation

N/A

Section 6: Practice Guidelines

N/A

Section 7: Quality Assessment and Performance Improvement Program

Recommendations Requiring CAP

NSMHA's Reports website page is out of date; many reports have not been updated for over five years.

5. NSMHA needs to update its Reports page and/or remove outdated reports.

NSMHA has numerous policies and procedures that need to be updated. Multiple policies contain repealed WACs, including several that were updated after the repeal dates. NSMHA's Quality Management of North Sound Mental Health Administration document (policy #5502.00) has not been updated since 2004 and contains out-of-date terminology, such as the Mental Health Division in reference to DBHR.

6. NSMHA needs to update its policies and procedures to ensure they reflect current practices, references and terminology.

NSMHA has a policy and procedure on utilization review of outpatient services, but it is specific to outpatient services only and does not address underutilization or overutilization of programs.

7. NSMHA needs to create a policy and procedure regarding the underutilization and overutilization of individual services and programs. The policy and procedure must address processes for consistent criteria to identify and monitor underutilization and overutilization. NSMHA needs to also have a process for taking corrective action to address underutilization and overutilization.

Section 8: Health Information Systems

N/A

Performance Improvement Project (PIP) Validation

Recommendation requiring CAP

It is not acceptable to solely submit another institution's data analysis report regardless of the situation with the RSN's data; NSMHA could have synthesized the data from the report and answered PIP questions.

8. When selecting future PIPs, NMSHA needs to be thoughtful about the study topics and questions that are chosen. NSMHA must ensure that all aspects of the proposals are realistic from the onset of the projects. Minor changes are allowable and many times warranted, but need to be done after careful consideration and with input from stakeholders**.**

Information Systems Capabilities Assessment (ISCA)

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

Encounter Data Validation (EDV)

Recommendation Requiring CAP

North Sound RSN failed to review provider name and agreement of the clinical notation with procedure code.

9. NSMHA needs to review all required encounter data elements.

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

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

Appendix C: Acronyms

ACE	Adverse Child Experiences
ANOVA	Analysis of Variance
APA	American Psychiatric Association
BC/DR	Business Continuity and Disaster Recovery
BHA	Behavioral Health Agency
CALOCUS	Child and Adolescent Level of Care Utilization System
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CIS	Consumer Information System
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CQIP	Coordinated Quality Improvement Program
DBHR	Division of Behavioral Health and Recovery
EDI	Electronic Data Interchange
EDV	Encounter Data Validation
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
HCA	Health Care Authority
HCPCS	Healthcare Common Procedural Coding System
HRTAY	High-Risk Transition-Age Youth
ICRS	Integrated Crisis Response Services
ISCA	Information System Capability Assessment
LEIE	List of Excluded Individuals and Entities
LOCUS	Level of Care Utilization System
MCO	Managed Care Organization
MHCP	Mental Healthcare Programs
MMIS	Medicaid Management Information System
NPI	National Providers Identifier
OIG	Office of the Inspector General
PAHP	Prepaid Ambulatory Health Plans
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
QMOC	Quality Management Oversight Committee
QAPI	Quality Assessment and Performance Improvement
QMOC	Quality Management Oversight Committee
RAID	Redundant Array of Independent Disks
RSN	Regional Support Network
SAMHSA	Substance Abuse and Mental Health Services Administration
SERI	Service Encounter Reporting Instructions
SOC	System of Care
TAY	Transition-Age Youth
TSPCS	Transition Service Provider Competency Scale
WAC	Washington Administrative Code

WISe	Wraparound with Intensive Services