Timberlands 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 Timberlands RSN (TRSN), 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.

Timberlands RSN administers public mental health funds for Medicaid participants enrolled in managed care plans in Lewis, Pacific and Wahkiakum counties. TRSN does not provide any direct client services; however, it provides financial and administrative oversight for the direct client services that are provided to enrollees through contracts with three community health agencies in the three-county area. TRSN's governing board sets policy and has oversight responsibilities.

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 Timberlands Regional Support Network (TRSN).

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	● Fully Met (pass)
Section 2. Coordination and Continuity of Care	438.208	● Partially Met (pass)
Section 3. Coverage and Authorization of	438.210	● Partially Met (pass)

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

Performance Improvement Project (PIP) Validation Results

As a mandatory EQR activity, Qualis Health evaluated 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: Improving Identification and Clinical Outcomes for Children in Need of Intensive Home- and Community-Based Mental Health Services	Fully Met (pass)	High Confidence in Reported Results
Non-Clinical PIP: Improving Coordination of Care Outcomes for Individuals with Major or Severe Physical Health Co-Occurring Disorder	Fully Met (pass)	High 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 are used by the RSNs and the State to assess and improve the quality of care and to monitor program integrity. Additionally, the State uses encounter data to determine capitation rates paid to the RSNs.

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

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

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

Qualis Health conducted its own validation to assess the RSN's capacity to produce accurate and complete encounter data, including a review of the most recent Information System Capabilities

Assessment (ISCA). The encounter data submitted by the RSNs to the State were 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	Fully Met (pass)
Section 2. Coordination and Continuity of Care	438.208	Partially Met (pass)
Section 3. Coverage and Authorization of Services	438.210	Partially Met (pass)
Section 4. Provider Selection	438.214	Fully Met (pass)
Section 5. Subcontractual Relationships and Delegation	438.230	Partially Met (pass)
Section 6. Practice Guidelines	438.236	Partially Met (pass)
Section 7. Quality Assessment and Performance Improvement Program	438.240	Partially Met (pass)
Section 8. Health Information Systems	438.242	Partially Met (pass)

This review assesses the RSN's overall performance, identifies strengths, and notes opportunities for improvement and recommendations requiring 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

- TRSN evaluates access to services by reviewing enrollees' service utilization, complaints and grievances; analyzing service penetration rates for enrollees by age, ethnicity and gender; monitoring for losses or addition of practitioners; and conducting satisfaction surveys.
- TRSN's contracted provider, BHO, provides a geomap report for TRSN, which is very informative and assists the RSN in planning its provider network.
- TRSN had a 13% increase in enrollee services during 2014. TRSN responded to this increase by providing funding to increase clinician support.
- TRSN's contract with the community mental health agencies (CMHAs) require the CMHAs to maintain the ability to adjust the number, mix and geographic distribution of mental healthcare professionals (MHCPs) to meet access and distance standards as the enrollees' needs for mental health services shift within the service area.

- Timely access to second opinions, either within or outside of the network of contracted provider agencies, is monitored as part of the routine quarterly clinical record and service process conducted by the TRSN quality manager.
- TRSN's agencies are required, through the contracts and policies and procedures, to maintain sufficient capacity, including the number, mix and geographic distribution of MHCPs and office locations, to meet the needs of the anticipated number of enrollees in the service area. The agencies must also provide, at minimum, an age- and linguistically and culturally competent community mental health services intake evaluation by a mental health professional (MHP) within ten working days of an enrollee request.
- TRSN's intake assessment format includes a section for describing each enrollee's culture and relevant issues of concern. These are incorporated into treatment planning as appropriate for the individual enrollee. Continuing care requests also make note of any relevant cultural issues relevant to the enrollee's functioning and treatment needs.
- TRSN hosts, facilitates and participates in multiple monthly meetings that include a variety of ancillary service agencies, network provider agencies and special service agencies to provide discussion around care coordination and quality of care. TRSN encourages allied system communication through request for information forms, exchange of records and shared treatment goals. Communication is documented during clinical record and service reviews.
- TRSN conducted ongoing clinical record and service reviews throughout 2014. These reviews focused on clients at high risk and/or requiring complex care; clients with special needs arising from age, gender, cultural differences or physical condition; and clients with concerns relating to their care.
- As part of the review process, TRSN's clinical care manager reviews for the completion and implementation of consulting specialists' recommendations.
- TRSN's largest provider has dedicated jail liaison positions to facilitate communication between CMHC and the jail/juvenile detention system.
- TRSN works with the local jail, juvenile department and inpatient psychiatric department regularly to promote integrated and coordinated care for individuals involved in multiple systems.
- TRSN's clinical record and service reviews consider whether level of care (LOC) standards are appropriate to identified needs of the enrollees.
- TRSN's contracted entity, which is responsible for approving authorization decisions, is an URAC-approved entity. As a requirement of URAC (formerly known as the Utilization Review Accreditation Commission), the entity is required to perform inter-rater reviews to ensure consistent applicant reviews.
- TRSN's results of the annual reviews of the delegated entities were concise and addressed the expectations of the contracts.
- TRSN provides ongoing oversight and monitoring for core elements of each guideline, as appropriate, during clinical utilization reviews, and administrative and clinical audits.
- TRSN has a very robust quality management (QM) program that clearly defines the process the RSN uses to conduct its QM program.

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

Section 1: Availability of Services

N/A

Section 2: Coordination of Care

Recommendations Requiring CAP
TRSN monitors treatment plans and progress notes to ensure progress notes are linked to appropriate service goals. Clinical record and service reviews performed in 2014 indicated that just 35% of progress notes were linked to appropriate service plan goals. TRSN stated that this will be a focus for improvement for 2015.

- TRSN needs to continue its efforts to ensure services are provided to help the client attain the goals on their service plan and to ensure the link between the service/intervention provided and the goal/objective is clear.

Section 3: Coverage and Authorization of Services

Recommendation Requiring CAP
Level of care was appropriate 43% of the time in reviews that combined authorization and re-authorization requests. Analysis of this data indicated several issues, including errors such as scoring CA/LOCUS assessments and insufficient documentation of clinical reasoning for changing LOC.

- TRSN needs to continue to work with its provider agencies to ensure the scoring on CA/LOCUS assessments are accurate and also to ensure there is sufficient documentation of the clinical reasoning in the clinical record for changing the level of care.

Section 4: Provider Selection

N/A

Section 5: Subcontractual Relationships and Delegation

Opportunity for Improvement
TRSN's clinical record review tool used to monitor the provider agencies was updated and in draft format. The tool has not been finalized and distributed to the agencies.

- TRSN should finalize the tool and distribute the tool to its provider agencies.

Recommendation Requiring CAP
Review of the Quality Management Committee minutes during 2014 indicates that TRSN administration needs to address, with the contracted entity that provides after-hours crisis line services for enrollees, the

multiple concerns with the crisis line. Over the last year there appeared to be a trend of complaints in crisis line services from clients, CMHAs and community partners.

- TRSN needs to continue its work with its contracted entity to resolve the concerns with the crisis line staff and implement protocols for improved communication to ensure enrollees are receiving needed services.

Section 6: Practice Guidelines

Opportunity for Improvement

Two of TRSN's provider agencies stated during the EQR provider interview that they were unsure if the practice guideline for PTSD had been implemented.

- TRSN should consider improving communication with its provider agencies on the dissemination and implementation of practice guidelines.

Section 7: Quality Assessment and Performance Improvement Program

Opportunity for Improvement

TRSN is not in compliance with the State quality strategy plan as the State does not have a current plan.

- When the State implements its quality strategy plan, TRSN will need to be in compliance with the plan.

Recommendations Requiring CAP

TRSN had several policies and procedures that had not been reviewed and/or revised during the review year.

- TRSN needs to review and revise its policies and procedures to ensure compliance with its contract with DBHR and the State WACs. During resubmission of information, TRSN stated that it had instituted a new process and is now reviewing policies and procedures.

Section 8: Health Information Systems

Opportunity for Improvement

TRSN does not track requests to change providers.

- TRSN should consider developing a mechanism for tracking when enrollees request a change in providers.

Section 1: Availability of Services

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

Protocol Section	CFR	Result
Availability of Services		

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

- TRSN's policy on network planning states that the RSN monitors the following indicators to identify service needs:
  - service provision by ZIP code to determine accessibility throughout the region
  - hours of service by age group and by county to identify patterns of low utilization
  - amount of service by levels of care to monitor for over- and underutilization
  - service hours by modality and by county to monitor types of services provided
  - number of days from hospital discharge to community-based services
  - hospital recidivism
- TRSN evaluates access to services by reviewing enrollees' service utilization, complaints and grievances; analyzing service penetration rates for enrollees by age, ethnicity and gender; monitoring for losses or addition of practitioners; and conducting satisfaction surveys.
- TRSN's contracted provider, BHO, provides a geomap report for TRSN, which is very informative and assists the RSN in planning its provider network.
- TRSN had a 13% increase in enrollee services during 2014. TRSN responded to this increase by providing funding to increase clinician support.
- TRSN stated that 21% of its mental health services are provided to children and adolescents, 11% of services are provided to older adults and 68% of services are provided to adults. These proportions have remained steady over the last four years (+/–5%).

- TRSN's contract with the community mental health agencies (CMHAs) require the CMHAs to maintain the ability to adjust the number, mix and geographic distribution of mental healthcare professionals (MHCPs) to meet access and distance standards as the enrollees' needs for mental health services shift within the service area.
- In addition, CMHAs are required to notify TRSN of changes that result in a diminished capacity to provide services and submit a plan to provide for the provision of uninterrupted services.

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
- TRSN has several policies in place requiring the RSN to provide for a second opinion from a qualified healthcare professional within the network, or to arrange for the enrollee to obtain a second opinion outside the network at no cost to the enrollee.
- If an enrollee disagrees with the MHCP's recommendations or approach to providing covered services, the enrollee may direct a request for a second opinion to the MHCP or may contact the MHCP's supervisor and/or the RSN Ombuds for assistance.
- TRSN indicates that while the requests for second opinions are still rare, it has seen an increase in second opinions, which may indicate that providers are educating enrollees on this process during the intake assessment.

- The annual quality review team (QRT) surveys are utilized to capture whether enrollees understand their right to a second opinion and to determine whether there have been complaints about their rights to obtain a second opinion.
- In addition, timely access to second opinions, either within or outside of the network of contracted provider agencies, is monitored as part of the routine quarterly clinical record and service process conducted by the TRSN quality manager.

Out-of-Network

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- TRSN's contracted agencies are responsible for providing appropriate contracting and payment for out-of-network services as part of their full-risk contracts.
- Although TRSN maintains a consumer log that tracks out-of-network requests for services, the RSN states it rarely receives enrollee requests for out-of-network providers based on Medical necessity.

Coordination of Out-of-Network

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

(5) Requires out of network providers to coordinate with the MCO or PIHP with respect to payment

and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- TRSN's policy for out-of-network providers states that the provider shall not bill or accept payment from enrollees. Enrollees are educated via enrollee rights information that they are not to be billed for approved out-of-network services and may call TRSN or Ombuds if a bill is received.

Out-of-Network Provider Credentials

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Meets criteria

Furnishing of Services and Timely Access

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strengths

- TRSN's contracted provider agencies are informed of timely access requirements through the *Coverage and Authorization of Services Policy* and the requirements contained in the agencies' individual contracts with the RSN.

- TRSN's agencies are required, through the contracts and policies and procedures, to maintain sufficient capacity, including the number, mix and geographic distribution of MHCPs and office locations, to meet the needs of the anticipated number of enrollees in the service area. The agencies must also provide, at minimum, an age- and linguistically and culturally competent community mental health services intake evaluation by a mental health professional (MHP) within ten working days of an enrollee request.
- TRSN monitors providers' compliance with the policy by performing routine office visits, annual administrative reviews, chart reviews and quarterly monitoring of statistical data reports.

Furnishing of Services and Cultural Considerations

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

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

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

Reviewer Determination

● Fully Met (pass)

Strengths
- TRSN requires the contractor to provide or purchase age-, linguistically and culturally competent community mental health services for clients for whom services are medically necessary and clinically appropriate.
- TRSN requires CMHAs to maintain staffing to include a sufficient number of child and geriatric mental health specialists to allow enrollees of these subpopulations to be served by staff with those particular areas of expertise, or to have close supervision by a specialist.
- TRSN requires enrollees with a disability to be served by a disability specialist or by staff working with a disability consultant to ensure appropriate treatment planning.

- TRSN's intake assessment format includes a section for describing each enrollee's culture and relevant issues of concern. These are incorporated into treatment planning as appropriate for the individual enrollee. Continuing care requests also make note of any relevant cultural issues relevant to the enrollee's functioning and treatment needs.

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)	Partially 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

● Fully Met (pass)

Strengths

- TRSN has a well-written policy on care coordination. The policy states, “When an individual is enrolled for services, the CMHA must request information about allied systems/providers that are also currently providing services to the individual, or that have in the recent past. The CMHA shall request that the client complete and sign releases of information to and from these allied systems/providers so that coordination of care can be implemented.”
- TRSN has provided training on coordinated treatment planning with regard to comorbid and complex individuals as well as individuals with intellectual disabilities.
- TRSN hosts, facilitates and participates in multiple monthly meetings that include a variety of ancillary service agencies, network provider agencies and special service agencies to provide discussion around care coordination and quality of care. TRSN encourages allied system communication through request for information forms, exchange of records and shared treatment goals. Communication is documented during clinical record and service reviews.

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

- The requirement to assess for special needs is communicated through TRSN's policy and procedures and CMHA contracts.
- TRSN conducted ongoing clinical record and service reviews throughout 2014. These reviews focused on clients at high risk and/or requiring complex care; clients with special needs arising from age, gender, cultural differences or physical condition; and clients with concerns relating to their care.
- As part of the review process, TRSN's clinical care manager reviews for the completion and implementation of consulting specialists' recommendations.

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 ● Partially Met (pass)

Strengths

- TRSN ensures that CMHAs are communicating with all systems involved through clinical record and service reviews. TRSN states that corrective actions are taken when warranted.
- TRSN works with the local jail, juvenile department and inpatient psychiatric department regularly to promote integrated and coordinated care for individuals involved in multiple systems.
- TRSN regularly cross-references the jail roster with all new Medicaid enrollee admissions to the RSN.
- TRSN's largest provider has dedicated jail liaison positions to facilitate communication between CMHC and the jail/juvenile detention system.

Recommendation Requiring CAP

TRSN monitors treatment plans and progress notes to ensure progress notes are linked to appropriate service goals. Clinical record and service reviews performed in 2014 indicated that just 35% of progress notes were linked to appropriate service plan goals. TRSN stated that this will be a focus for improvement for 2015.

- TRSN needs to continue its efforts to ensure services are provided to help the client attain the goals on their service plan and to ensure the link between the service/intervention provided and the goal/objective is clear.

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)

Strengths

- TRSN's policy states, "Enrollees shall have direct access to a specialist as appropriate for the enrollee's condition and identified needs. The provider shall ensure that enrollees have information about this right, information on the role of a specialist in the mental health system, and information on how to access a specialist."
- The policy also states that recommendations from specialists shall be incorporated into the individual service plans with documentation that supports the implementation of the recommendations in the clinical record.
- The RSN monitors for incorporation of specialist recommendations through its quarterly clinical record and service review process.

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)	● Partially Met (pass)

Coverage and Authorization of Services	438.210 (b)	Fully Met (pass)
Notice of Adverse Action	438.210 (c)	Fully Met (pass)
Timeframe for Decisions: (1) Standard Procedures (2) Expedited Authorizations	438.210 (d)	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

● Partially Met (pass)

Strengths

- TRSN's clinical record and service reviews consider whether level of care (LOC) standards are appropriate to identified needs of the enrollees.

Recommendation Requiring CAP
Level of care was appropriate 43% of the time in reviews that combined authorization and re-authorization requests. Analysis of this data indicated several issues, including errors such as scoring CA/LOCUS assessments and insufficient documentation of clinical reasoning for changing LOC.

- TRSN needs to continue to work with its provider agencies to ensure the scoring on CA/LOCUS assessments are accurate and also to ensure there is sufficient documentation of the clinical reasoning in the clinical record for changing the level of care.

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

● Fully Met (pass)

Strengths

- TRSN's contracted entity, which is responsible for approving authorization decisions, is an URAC-approved entity. As a requirement of URAC (formerly known as the Utilization Review Accreditation Commission), the entity is required to perform inter-rater reviews to ensure consistent applicant reviews.
- TRSN noted that clinical record and service reviews were used to document the consistent application of initial and re-authorization criteria. Results indicated that criteria were consistently applied for authorization (85%) more often than for re-authorization (73%).

Notice of Adverse Action

FEDERAL REGULATION SOURCE(S)
§438.210 (c): Coverage and Authorization of Services – Notice of Adverse Action
(c) Each contract must provide for the MCO, PIHP or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP or PAHP to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider

need not be in writing.

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Meets Criteria

Timeframes for Decisions

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

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

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

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

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

(2) Expedited authorization decisions.

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Meets Criteria

Compensation for Utilization of Services

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

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)

Meets Criteria

Section 4: Provider Selection

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

Protocol Section	CFR	Result
Provider Selection		
General Rules, Credentialing, Re-credentialing	438.214 (a)(b)	● Fully Met (pass)
Nondiscrimination	438.214 (c)	● Fully Met (pass)
Excluded Providers	438.214 (d)	● Fully Met (pass)
Overall Result for Section 4.		● Fully Met (pass)

General Rules and Credentialing and Re-credentialing Requirements

FEDERAL REGULATION SOURCE(S)

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

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

(b) Credentialing and re-credentialing requirements.

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

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

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

STATE REGULATION / RSN AGREEMENT SOURCE(S)

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

SCORING CRITERIA

- The RSN has a credentialing and re-credentialing policy and procedure for providers who have signed contracts or participation agreements.

- The RSN has a uniform documented process for credentialing.
- The RSN has a uniform documented process for re-credentialing.
- The RSN monitors the credentialing and re-credentialing process.
- The RSN ensures the provider agencies have in place credentialing and re-credentialing polices and processes.

Reviewer Determination

● Fully Met (pass)

Strengths

- TRSN's policy on credentialing and re-credentialing is very concise and includes performing administrative chart reviews.
- TRSN delegates practitioner credentialing and re-credentialing to the contracted providers and requires providers to have policies in place for credentialing.

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

- TRSN’s contracts with providers specifically state that the contractor must run excluded provider checks on all staff and subcontractors. Subcontractors must submit attestations that they have run excluded provider checks on their staff.
- TRSN’s compliance officer runs monthly excluded provider checks on all provider agency staff.
- TRSN’s policy and procedures prohibit relationships with a director, officer or partner of the PIHP, a person with beneficial ownership of five percent or more of the PIHP’s equity, or a person with an consulting employment or other arrangement with the PIHP, for the provision of items and

services that are significant and material to the PIHP's obligations under its contract with the State.

Section 5: Subcontractual Relationships and Delegation

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

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

General Rule

FEDERAL REGULATION SOURCE(S)

§438.230 Subcontractual Relationships and Delegation

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

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

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

(b) Specific conditions.

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

(2) There is a written agreement that—

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

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

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

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

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

SCORING CRITERIA

- The RSN has policies and procedures for oversight and accountability for any functions and

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

Reviewer Determination

Partially Met (pass)

Strengths

- TRSN has a policy and procedure in place for oversight and accountability for any functions and responsibilities that it delegates to any subcontractor/provider.
- TRSN includes in its contracts with delegated entities the specifics of what activities have been delegated, the oversight required to monitor the activities, and the remedial actions that will result if the entities are not in compliance.
- TRSN's results of the annual reviews of the delegated entities were concise and addressed the expectations of the contracts.

Opportunity for Improvement

TRSN's clinical record review tool used to monitor the provider agencies was updated and in draft format. The tool has not been finalized and distributed to the agencies.

- TRSN should finalize the tool and distribute the tool to its provider agencies.

Recommendation Requiring CAP

Review of the Quality Management Committee minutes during 2014 indicates that TRSN administration needs to address, with the contracted entity that provides after-hours crisis line services for enrollees, the multiple concerns with the crisis line. Over the last year there appeared to be a trend of complaints in crisis line services from clients, CMHAs and community partners.

- TRSN needs to continue its work with its contracted entity to resolve the concerns with the crisis line staff and implement protocols for improved communication to ensure enrollees are receiving needed services.

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)	Partially Met (pass)
Application	438.236 (d)	Fully Met (pass)
Overall Result for Section 6.		Partially Met (pass)

Basic Rule

FEDERAL REGULATION SOURCE(S)

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

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

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

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

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

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

(4) Are reviewed and updated periodically as appropriate.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

RSN Agreement Section(s) 7.7.3

SCORING CRITERIA

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

Reviewer Determination

Fully Met (pass)

Strengths

- TRSN ensures that providers adopt practice guidelines based on the population served by the RSN. Two of TRSN's practice guidelines, for major depressive disorder and post-traumatic stress disorder, were adopted by the Quality Management Committee. Its membership includes clinical directors, the TRSN Ombuds, client and family advocates and the quality review coordinator.
- TRSN also considers best practice implementation guides distributed by DBHR.
- CMHA compliance with TRSN practice guidelines is ensured by inclusion of this requirement in the CMHA contracts.
- TRSN conducts regular reviews of provider agencies to ensure practice guidelines are being implemented and reviews the policies and procedures around the practice guidelines regarding how they are implemented.

Dissemination of Guidelines

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

Opportunity for Improvement

Two of TRSN's provider agencies stated during the EQR provider interview that they were unsure if the practice guideline for PTSD had been implemented.

- TRSN should consider improving communication with its provider agencies on the dissemination and implementation of practice guidelines.

Application of Guidelines

FEDERAL REGULATION SOURCE(S) **§438.236 (d): Practice Guidelines** (d) Application of guidelines. Decisions for utilization management, enrollee education,

coverage of services and other areas to which the guidelines apply are consistent with the guidelines.
STATE REGULATION / RSN AGREEMENT SOURCE(S) RSN Agreement Section(s) 7.7.3.4; 7.7.3.5
SCORING CRITERIA • The RSN has documented 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)

Strengths

- TRSN provides ongoing oversight and monitoring for core elements of each guideline, as appropriate, during clinical utilization reviews, and administrative and clinical audits.
- Evidence from these reviews shows that the data results of the use of practice guidelines are presented at the Quality Management Committee (QMC), where analysis is performed to identify gaps in service and/or need for improvement.

Section 7: Quality Assessment and Performance Improvement Program

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

Protocol Section	CFR	Result
Quality Assessment and Performance Improvement Program		
Rules, Evaluation, Measurement, Improvement, Program Review by State	438.240 (a)(b)1 (d)(e)	● Partially Met (pass)
Submit Performance Measurement Data	438.240 (b)(c)	● Fully Met (pass)
Mechanisms to Detect Over- and Underutilization of Services	438.240 (b)3	● Fully Met (pass)
Quality and Appropriateness of Care Furnished to Enrollees With Special Healthcare Needs	438.240 (b)4	● Partially Met (pass)

Overall Result for Section 7.	Partially Met (pass)

General Rules

FEDERAL REGULATION SOURCE(S)

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

(a) General rules.

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

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

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

(d) Performance improvement projects.

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

(i) Measurement of performance using objective quality indicators.

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

(iii) Evaluation of the effectiveness of the interventions.

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

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

(e) Program review by the State.

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

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

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

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

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

SCORING CRITERIA

- The RSN has an ongoing quality assessment and performance improvement program (QAPI) for the services it furnishes to its enrollees.
- The RSN has a QA and PI process to evaluate the QAPI program and provides for an annual report to DBHR.
- The RSN 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

- TRSN has a very robust quality management (QM) program that clearly defines the process the RSN uses to conduct its QM program.
- TRSN has a very active Quality Management Committee that meets quarterly to review and make recommendations on improving the care and services for its enrollees based on the results of performance data. The Quality Management Committee analyzes and improves utilization and improvement data through corrective action, quality initiatives or performance improvement projects.

Opportunity for Improvement

TRSN is not in compliance with the State quality strategy plan as the State does not have a current plan.

- When the State implements its quality strategy plan, TRSN will need to be in compliance with the plan.

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

- TRSN's care management program collects and analyzes data on multiple utilization and performance indicators to identify areas of concern that need to be addressed by Quality Management.
- TRSN's Quality Management Committee analyzes the results to provide improvement strategies through corrective action, quality initiatives or performance improvement projects.
- TRSN's performance measures include collecting and analyzing data around timelines for initial intakes, follow-up appointments, hospital readmissions, crisis services and outpatient utilization.

Mechanisms to Detect Under- and Overutilization of Services

FEDERAL REGULATION SOURCE(S)

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

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Fully Met (pass)

Strength

- TRSN has a policy and procedure in place for tracking utilization of services and has recently implemented LOCUS/CALOCUS to assist in determining whether the level of service meets the needs of the clients.

Mechanism to Assess the Quality and Appropriateness of Care

FEDERAL REGULATION SOURCE(S)

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

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

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

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

SCORING CRITERIA

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

Reviewer Determination

● Partially Met (pass)

Strengths

- TRSN has several methods in place to assess the quality and appropriateness of services. The RSN's well-written year-end care management and quality management evaluations for 2014

included these methods as well as an evaluation and analysis of the data collected through these methods. The evaluations offered improvement strategies for 2015.

- The 2014 TRSN Quality Management Plan defined ten objectives for the TRSN Quality Management Program. TRSN met or partially met all of its 2014 plan objectives.
- Continuing CA/LOCUS implementation with focus on improving utilization of services within the recommendations, improving Golden Thread documentation, improving discharge planning for inpatient and outpatient services, and improving treatment planning for transition-age youth were among the top objectives.

Recommendation Requiring CAP

TRSN had several policies and procedures that had not been reviewed and/or revised during the review year.

- TRSN needs to review and revise its policies and procedures to ensure compliance with its contract with DBHR and the State WACs. During resubmission of information, TRSN stated that it had instituted a new process and is now reviewing policies and procedures.

Section 8: Health Information Systems

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

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

General Rule

FEDERAL REGULATION SOURCE(S)

§438.242 (a): Health Information Systems

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

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STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-0275

RSN Agreement Section(s) 11
SCORING CRITERIA • The RSN has a health information system that collects, analyzes, integrates and reports data on utilization, dis-enrollments and requests to change providers, grievances and appeals. • The RSN utilizes reports from health information data to make informed management decisions. • The RSN analyzes the health information data to identify services needed for enrollees.
Reviewer Determination Partially Met (pass)

Strengths

- TRSN and its provider agencies use the same health information system, Avatar. This allows the RSN to receive data from all agencies in the same format and also allows all data to be integrated and reported.
- Each of TRSN's contracted agencies also uses the practice management (PM) application to collect client demographics, diagnoses, and enrollment and encounter information. This information is transmitted to the RSN hourly.
- Grievances and appeals are tracked via Excel and Access and can be linked to the data warehouse as a secondary source when writing Crystal Reports or using Access databases.
- TRSN's Quality Management Committee and clinical directors meetings review the collected data to determine best solutions to address identified needs.

Opportunity for Improvement

TRSN does not track requests to change providers.

- TRSN should consider developing a mechanism for tracking when enrollees request a change in providers.

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)

Meets Criteria

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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

Improving Identification and Clinical Outcomes for Children in Need of Intensive Home- and Community-Based Mental Health Services

TRSN has chosen the study topic of identifying and providing treatment to children and youth in need of intensive home- and community-based mental service. This process is crucial because of the prevalence, complexity, early onset and impact of mental health disorders on youth, families and communities. TRSN notes that per the Centers for Disease Control and Prevention, 13%–20% of children living in the United States experience a mental disorder in a given year and that a subset of that group experiences extreme or complex mental health issues. TRSN cites the research report from the National Research Council and Institute of Medicine "From Neurons to Neighborhood: The Science of Early Childhood Development," which "concluded that the course of development can be altered early in childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favor of more adaptive outcomes, and that model programs that deliver carefully designed interventions with well-defined goals can affect both parenting behavior and the developmental trajectories of children whose life course is threatened by socioeconomic disadvantage, family disruption or diagnosed disability. Early intervention, such as in-home services, can strengthen a family's ability to care for the child and avoid out-of-home placement." In 2012, because of concerns raised by a community partner regarding concerns that a youth was not receiving the necessary intensity of services to prevent decompensation, TRSN began to investigate the complex situation. TRSN researched Level of Care (LOC) assignment, at which time there were only two levels: Level 1, brief intervention, and Level 2, community support. After doing some research it became clear that there was a lack of differentiation between the utilization of the two services, making it difficult to determine if enrollees were being over- or underserved. Additionally, recent lawsuits in Washington State underscore the importance of identifying and treating this high-risk population. This project seeks to develop a way to consistently identify children and youth in need of intensive home- and community-based mental health services.

The study question is "Does implementation of the CALOCUS for all eligible children increase the percentage of eligible children identified as needing intensive home- and community-based services as measured by CALOCUS Level of Care (LOC) 4?"

Dates of Study Period:

Baseline:	January 1, 2012–December 31, 2012
Intervention:	May 1, 2013–July 15, 2013
First re-measurement:	August 1, 2013–July 31, 2014
Second re-measurement:	August 1, 2014–May 31, 2015

Table C-3: Clinical PIP Validation Results

Study Design		Activity	Narrative	SCORE
Design	1	Appropriate study topic	TRSN selected its study topic through research and evaluation of information and data related to the	● Fully Met (pass)

			mental health of children and youth in the United States, Washington State and the TRSN's community, noting the importance of identifying and treating those in need of intensive home- and community-based mental health services.	
	2	Clearly defined, answerable study question	Does implementation of the Child and Adolescent Level of Care Utilization System (CALOCUS) for all eligible children increase the percentage of eligible children identified as needing intensive home- and community-based services as measured by CALOCUS Level of Care (LOC) 4?	● Fully Met (pass)
	3	Correctly identified study population	The study population/denominator includes all Medicaid children ages 0–20 who are open and authorized for services in TRSN.	● Fully Met (pass)
	4	Correctly identified study indicator	The numerator includes eligible enrollees in the denominator assessed as needing a LOC 4 by CALOCUS.	● Fully Met (pass)
Reviewer Comments: TRSN chose a study topic related to the implementation of the CALOCUS to increase the percentage of children and youth identified as needing intensive home- and community-based services. The study question is clearly defined with a specific and measureable intervention: an identified goal of increasing the number of children and youth determined as needing LOC 4 for a clearly established study population of Medicaid-eligible children ages 0–20 authorized for services in TRSN. The TRSN distinctly defines the study indicator as all eligible enrollees in the denominator assessed as requiring a LOC 4 by CALOCUS.				
Implementation	5	Valid sampling technique	No sampling was conducted.	● N/A
	6	Accurate/ complete data collection	On a monthly basis, the TRSN IS administrator queries the MSO database through the use of Crystal Reports. The report identifies youth who are within the study population indicator. Another set of program instructions queries the MSO database for CALOCUS LOC 4 or higher assigned within a given reporting month. To ensure that all data has been	● Fully Met (pass)

			recorded at the MSO, all reports are pulled no earlier than the 11th of the subsequent month.	
	7	Appropriate data analysis/ interpretation of study results	TRSN uses a chi-square test with a probability level of <.05 for data analysis.	● Fully Met (pass)
Reviewer Comments: No sampling techniques were utilized for the PIP. TRSN has a sound plan to ensure accurate and complete data collection. TRSN is using appropriate statistical analysis of the data to interpret study results.				
Outcomes	8	Appropriate improvement strategies	Through root cause analysis, TRSN staff, QMC, and the advisory and governing boards agreed to the implementation of a new utilization of care system, selecting the CALOCUS as its assessment tool. The rationale for the implementation of the use of the tool is that due to the CALOCUS' dimensional ratings and strong inter-rater reliability, it will improve clinicians' ability to identify enrollees in need of intensive mental health services. TRSN provided trainings on the CALOCUS to providers, monitored assessments through performance reports and provided feedback at monthly clinical director meetings. TRSN also reviewed data with clinical directors and discussed clients who were clinically reasoned down from LOC 4. TRSN identified barriers, including authorization length being linked to authorization level, a belief that there were not enough resources to provide LOC 4 or that LOC 4 required 24-hour supervision. TRSN addressed these barriers and incorporated them into a monitoring and tracking plan. TRSN plans to conduct additional CALOCUS trainings	● Fully Met (pass)

			to educate staff on the identified barriers.	
	9	Real improvement achieved	All three study periods show statistically significant improvement from baseline/first measurement to re-measurement, first re-measurement to second-re-measurement and baseline/first measurement to second re-measurement, with *p* values of less than .0001, .0016 and .0001, respectively.	● Fully Met (pass)
	10	Sustained improvement achieved	TRSN has demonstrated sustained improvement through the second re-measurement.	● Fully Met (pass)
Overall Score				● Fully Met (pass)
Reviewer Comments	**Strength(s):** TRSN has selected a thoughtful and well-designed study topic. The study question is clear, as is the study population, the indicator and the intervention. Through baseline and two re-measurement periods, demonstrated sustained improvement has been achieved. **Recommendation(s):** TRSN should continue with the second phase of its study. **Confidence Level:** High confidence in reported results			

Standard 1: Selected Study Topic Is Relevant and Prioritized

Table C-4: Validation of PIP Selected Study Topic

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

1.4	The PIP addresses a broad spectrum of key aspects of enrollee care and services.	Fully Met (pass)
1.5	The PIP, over time, included all enrolled populations.	Fully Met (pass)

Reviewer Comments:
In 2012, because of concerns raised by a community partner that a youth was not receiving the necessary intensity of services to prevent decompensation, TRSN began to investigate the situation. TRSN researched LOC assignment, at which time there were only two levels: Level 1, brief intervention, and Level 2, community support. After doing some research it became clear that there was a lack of differentiation between the utilization of the two services, and it was difficult to determine if enrollees were being over- or underserved.
TRSN then researched provider agencies' process for determining the need for intensive home- and community-based services. It found the criteria was not consistent. Next, TRSN attempted to define intensive services and again found that interpretations varied.
TRSN noted a steady increase in the number of youth served while the number of youth services remained steady, supporting the idea that youth were being underserved. It was also observed that TRSN's children's community hospitalizations increased 53% between 2011 (17) and 2012 (26) and remained at a similar level in 2013 (27).
TRSN's Quality Committee discussed the need for a more effective utilization tool to determine appropriate level of service. Information on trends and requirements was discussed at Quality Management meetings, and with advisory and governing boards it was agreed that implementing the CALOCUS was necessary to address the issue of identifying and evaluating the service population.

Meets Criteria

Standard 2: Study Question Is Clearly Defined

Table C-5: Validation of PIP Study Question

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

Reviewer Comments:
The study question is clear: Does implementation of Child and Adolescent Level of Care Utilization System for all eligible children increase the percentage of eligible children identified as needing intensive home- and community-based services as measured by CALOCUS Level of Care 4?

The question identifies the focus of the PIP as children identified as needing home- and community-based services, and sets the framework for the intervention of the implementation of the CALOCUS, the basis for a numerator and denominator, and baseline and re-measurement periods.

Meets criteria

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

Table C-6: Validation of PIP Study Population

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

Reviewer Comments:
The enrollee population is clearly defined. The numerator includes eligible clients in the denominator assessed as a LOC 4 by CALOCUS.

Data collection is completed on a monthly basis by the TRSN IS administrator, who queries the MSO database through the use of Crystal Reports. The report identifies youth who are within the study population indicator. Another set of program instructions queries the MSO database for CALOCUS LOC 4 or higher assigned within a given reporting month. To ensure that all data has been recorded at the MSO, all reports are pulled no earlier than the 11th of the subsequent month.

Verification of Medicaid eligibility: To ensure integrity of ProviderOne 834 data, TRSN reviews the 834 data to verify that the ZIP codes in the files are within the TRSN enrollment area. If errors have been identified in the 834 files, the 834 database is updated before processing the denominator report.

Verification of enrollment status: Accuracy of enrollment status is verified at the community agency level when services are sought and for each routine service provided. Verification of enrollment status is completed prior to encounters being submitted to DBHR by the Avatar MSO software.

Verification of authorization: TRSN's MIS system filters out unqualified enrollees by excluding enrollees who do not have an outpatient authorization.

Meets Criteria

Standard 4: Study Indicator Is Objective and Measureable

Table C-7: Validation of PIP Study Indicator

Criterion	Description	Result
4.1	The study uses objective, clearly defined, measurable indicators.	● 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 PIP uses an unbiased, clearly defined and measurable indicator. The numerator is defined as eligible clients in the denominator assessed as a LOC 4 by CALOCUS. The denominator includes all Medicaid children ages 0–20 who are open and authorized for services. The time periods were specific as baseline: January 1, 2012–December 31, 2012; intervention: May 1, 2013–July 15, 2013; first re-measurement: August 1, 2013–July 31, 2014; and second re-measurement: August 1, 2014–May 31, 2015. The last re-measurement period ended early because statistically significant improvement and sustained improvement had been shown; TRSN opted to end early so it could begin the second phase of the study. There is only one indicator for the study, which is appropriate for the level of complexity and available resources necessary to collect data. **Meets Criteria**		

Standard 5: Sampling Method

Table C-8: Validation of PIP Sampling Methods

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

Meets Criteria

Standard 6: Data Collection Procedure

Table C-9: Validation of PIP Data Collection Procedures

Criterion	Description	Result
6.1	The study design clearly specifies the data to be collected.	● Fully Met (pass)
6.2	The study design clearly specifies the sources of data.	● Fully Met (pass)
6.3	The study design specifies a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply.	● Fully Met (pass)
6.4	The instruments for data collection provide for consistent and accurate data collection over the time periods studied.	● Fully Met (pass)
6.5	The study design prospectively specifies a data analysis plan.	● Fully Met (pass)
6.6	Qualified staff and personnel were used to collect the data.	● Fully Met (pass)

Reviewer Comments:
The study design clearly defines the data to be collected as children under 21 years old throughout the reporting period who have Medicaid as their primary funding, have an authorization date on or before the reporting month and an end date to the authorization on or after the end of the reporting month, and have a CALOCUS LOC of 4 or higher.

The source of data is the MSO database using Crystal Reports.

To ensure a systematic method of collecting a valid and reliable data set, the following procedures were completed for the below listed elements:
Medicaid eligibility: To ensure integrity of ProviderOne 834 data, TRSN reviews the 834 data to verify that the ZIP codes in the files are within the TRSN enrollment area. If errors have been identified in the 834 files, the 834 database is updated before processing the denominator report.

Enrollment status: Accuracy of enrollment status is verified at the community agency level when services are sought and for each routine service provided. Verification of enrollment status is completed prior to encounters being submitted to DBHR by the Avatar MSO software.

Authorization: TRSN's MIS system filters out unqualified enrollees by excluding enrollees who do not have an outpatient authorization.

CALOCUS: CALOCUS must be completed by a mental health professional (MHP) or, if completed by a non-MHP, must be reviewed and scored by an MHP. CALOCUS and CALOCUS scores are reviewed by CMHA supervisors prior to authorization submission and TRSN's care management contractor, BHO, after authorization submission for accuracy in assessment and scoring.

LOC assignment: TRSN's IS administrator will run a Crystal Report monthly to identify clients adjusted from LOC 4 to a lower level (TRSN allows clinicians to use clinical reasoning to adjust LOC assignments when necessary. Clinicians who would like a different LOC assigned indicate the LOC determined by CALOCUS, the LOC the clinician recommends, and their clinical reasoning for recommending a different LOC on the authorization request). TRSN's quality manager will complete quarterly clinical reviews of eligible charts to verify that LOC assignment is appropriate. Written chart-specific feedback will be provided to CMHA for verification.

Errors: Clinicians or clinical directors can edit for data entry error within seven days of scoring. If errors occur outside of seven days, a new CALOCUS is completed. Reports pull from the most recent CALOCUS assessment in the measurement period.

Data were analyzed using a chi-square test with a probability level of < .05.

TRSN's quality manager and IS administrator have been involved in the collection and maintenance of the data.

Meets Criteria

Standard 7: Data Analysis and Interpretation of Study Results

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

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

An analysis of the findings was performed according to plan. The data analysis methodology was appropriate to the study question and data types. A chi-square test was completed for each of the three study periods. All three study periods show statistically significant improvement from baseline/first measurement to re-measurement, first re-measurement to second-re-measurement, and baseline/first measurement to second re-measurement, with *p* values of less than .0001, .0016 and .0001, respectively.

This suggests that the difference in percentage of eligible clients identified as needing services being due to chance rather than the implementation of the CALOCUS is extremely unlikely.

Some identified factors that could have threatened internal and external validity include possible over-scoring due to CALOCUS rating instructions and Medicaid expansion during the second re-measurement period having increased demand for intake assessments. TRSN does not believe these factors had a significant effect on the outcome of the study. A retraining of providers was completed after a survey was sent out to learn what questions clinicians had. This retraining was successful and handouts were made available to those who were unable to attend.

Meets Criteria

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

Reviewer Comments:
TRSN conducted a continuous cycle of measurement and performance analysis. Through its monitoring efforts, TRSN was able to identify that children and youth were being assessed as LOC 4 or higher but authorized at a lower LOC because a clinician was requesting a lower LOC utilizing their clinical reasoning. Inappropriate reduction of LOC was due to clinicians' perceptions related to authorization length and availability of resources and client request/amenability. TRSN completed a follow-up training for providers targeting strategies to reduce instances of children and youth being assessed as LOC 4 or higher but inappropriately authorized for a lower level because of clinical reasoning. TRSN then analyzed the number of enrollees clinically reasoned down after the second training. Chi-square results indicated a statistically significant result when comparing the first and second measure: X_2 (1, N=14) = 28.226, ≤.0001. This suggests that the retraining was successful in impacting clinicians who assess enrollees who

need home- and community-based services by encouraging them to use clinical reasoning more accurately when considering recommending a lower LOC after they have identified a youth as LOC 4 or higher with the CALOCUS.

The CALOCUS is primarily completed by the clinician through a verbal interview, and interpreters are available and utilized to translate the tool when necessary.

Meets Criteria

Standard 9: Assess Whether Improvement Is "Real" Improvement

Table C-12: Validation of PIP Improvement Assessment

Criterion	Description	Result
9.1	The same methodology as the baseline measurement was used when measurement was repeated.	● Fully Met (pass)
9.2	There was documented, quantitative improvement in processes or outcomes of care.	● Fully Met (pass)
9.3	The reported improvement in performance appears to be the result of the planned quality improvement intervention.	● Fully Met (pass)
9.4	There is statistical evidence that any observed performance improvement is true improvement.	● Fully Met (pass)

Reviewer Comments:
The same methodology was used at baseline and both re-measurements. When comparing the baseline to the re-measurements and the two re-measurements to each other using a chi-square test, all test results indicate statistically significant improvement. The results suggest that the difference in percentage of eligible enrollees identified as needing community-based services being due to chance rather than the implementation of the CALOCUS is highly unlikely.

Meets Criteria

Standard 10: The RSN Has Sustained the Documented Improvement

Table C-13: Validation of PIP Sustained Improvement

Criterion	Description	Result
10.1	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	● Fully Met (pass)

Reviewer Comments:
TRSN's PIP has shown sustained improvement that was demonstrated through repeated measurement over comparable time periods. Fifty-five children and youth were identified as needing intensive home- and community-based services between August 1, 2013, and July 2014, and another 43 were classified between August 1, 2014, and May 31, 2015. The second re-measurement was stopped sooner than originally planned when it became clear that the goals of the PIP had been achieved so that TRSN could begin the second phase of its PIP. TRSN plans to continue use of the CALOCUS and work to improve the adequacy of LOC 4 services.

Meets Criteria

PIP Validation Results: Non-Clinical PIP

Improving Coordination of Care Outcomes for Individuals with Major or Severe Physical Health Co-Occurring Disorder

TRSN has continuously worked to address coordination of care among its enrollees, using the issue as its PIP topic from 2009 to 2013. Building on that, for this PIP, TRSN has specifically chosen to study coordination of care for the subpopulation of enrollees who have comorbid major or severe physical health issues and mental health disorders. TRSN notes that people with serious mental illness served by public mental health systems die, on average, 25 years earlier than the general population. Poor mental health is associated with an increased risk of diseases such as cardiovascular disease, cancer and diabetes, while good mental health is a known protective factor. According to the 2001–2003 National Comorbidity Survey Replication (NCS-R), a nationally representative epidemiological survey, more than 68% of adults with a mental disorder (diagnosed with a structured interview) reported having at least one general medical disorder, and 29% of those with a medical disorder had a comorbid mental health condition. TRSN reports that data analyzed between January 1, 2012, and January 31, 2014, indicate that 12% of its mental health enrollees were assessed as having a serious or severe level of functioning impact in the physical health domain of their intake or re-assessment. TRSN also noted that between July 15, 2013, and April 15, 2014, through the use of the Child and Adolescent Level of Care Utilization System (CALOCUS) and Level of Care Utilization System (LOCUS), 4% of enrollees were indicated as having major or severe co-occurring physical health issues. TRSN believes that the difference in percentages is most likely due to the stricter defined criteria of the CALOCUS/LOCUS and that using such a tool would be helpful in identifying the specific targeted population for its PIP.

Emerging care models are shifting focus beyond service delivery to the overall health of clients. Managed care takes a proactive approach to identifying health risk as opposed to just managing service delivery. To better manage health risks, TRSN seeks to expand its ability to identify risk factors at the client level through intelligent mining of health demographics as well as service encounter codes.

The study question is "Does re-training of the revised Coordination of Care with Medical Providers Protocol increase the percentage of eligible clients with major or severe physical health issues identified by CA/LOCUS clients who receive care that adheres to the Coordination of Care Protocol as indicated by monthly Coordination of Care service code use?"

Dates of Study Period:

Baseline:	August 1, 2013–June 30, 2014
Intervention:	July 1, 2014–July 31, 2014
First re-measurement:	August 1, 2014–May 31, 2015
Second re-measurement:	Not applicable

Table C-14: Clinical PIP Validation Results

Study Design		Activity	Narrative	SCORE
Design	1	Appropriate study topic	TRSN chose the study topic of coordination of care of clients who have comorbid major or severe physical health issues and mental health disorders after completing its 2009–2013 PIP focused on increasing coordination of care with primary care providers for the general TRSN population. TRSN, the Quality Management Committee (QMC) and area providers agreed that coordination for high-risk, high-needs populations should be prioritized.	● Fully Met (pass)
	2	Clearly defined, answerable study question	The study question is clearly defined, specific, measurable and answerable: "Does re-training of the revised Coordination of Care with Medical Providers Protocol increase the percentage of eligible clients with major or severe physical health issues identified by CALOCUS clients who receive care that adheres to the Coordination of Care Protocol as indicated by monthly Coordination of Care service code use?"	● Fully Met (pass)
	3	Correctly identified study population	The study population was defined to include all Medicaid clients who are open and authorized for services and have major or severe physical health issues identified by select physical health comorbidity criteria on the Child and	● Fully Met (pass)

			Adolescent Level of Care Utilization System (CALOCUS) or Level of Care Utilization System (LOCUS).	
	4	Correctly identified study indicator	The study has a clearly identified numerator and denominator. The numerator includes clients in the denominator who receive care that adheres to the Coordination of Care Protocol as indicated by monthly coordination of care service code use. The denominator includes eligible clients with identified major or severe physical health issues indicated by a CALOCUS physical health comorbidity score of major (4) or severe (5).	● Fully Met (pass)
Reviewer Comments: TRSN has selected an appropriate study topic: coordination of care for clients who have comorbid major or severe physical health issue and mental health disorder. The study question is clearly defined and answerable with an intervention and desired goal. The study indicator has been correctly identified with a clear numerator and denominator.				
Implementation	5	Valid sampling technique	There were no samples in this study. All enrollees who fit the criteria were included in the sample.	● N/A
	6	Accurate/ complete data collection	The IS administrator queries the managed services organization (MSO) database utilizing Crystal Reports. The query identifies enrollees who have Medicaid as their primary funding source, and have an authorization date on or before the reporting month and an end date of authorization on or after the end of the reporting month. Another query of the MSO database is run for coordination of care (COC) codes received within the reporting month and return a 0 for none or a 1 for one or more COC codes present in the reporting month. On a monthly basis, the results are imported into an Access database. To ensure all data	● Fully Met (pass)

			has been recorded at the MSO, reports are pulled after the 11th of the subsequent month.	
	7	Appropriate data analysis/ interpretation of study results	TRSN used a chi-square test with a probability level of ≤ .05.	Fully Met (pass)
Reviewer Comments: TRSN did not use sampling techniques for this PIP. Accurate and complete data collection was conducted by querying the MSO database on a monthly basis. TRSN used a chi-square test with a probability level of ≤ .05 to ensure that appropriate data analysis and interpretation of study results was completed.				
Outcomes	8	Appropriate improvement strategies	TRSN implemented several appropriate improvement strategies. TRSN conducted trainings using a PowerPoint presentation and comprehension test that was made available to all providers to be used to train any new staff. TRSN also conducted chart reviews specific to the COC protocol each quarter of 2014, and feedback was given to providers. A monthly report that identified all clients assessed as having major or severe co-occurring medical issues and which COCs were provided to them was also available to providers in order to assist in tracking adherence to the protocol.	Fully Met (pass)
	9	Real improvement achieved	The average number of COC codes did increase from 116 to 119 from baseline to first re-measurement and there was a decrease in hospital admissions and recidivism in 2014, though this cannot be causally linked to the intervention. However, chi-square test results that compare data from baseline to the first re-	Partially Met (pass)

			measurement period were X2 (1, N=8) = 3.021, ≤.0822; this does not quite indicate statistically significant improvement.	
	10	Sustained improvement achieved	This study has not progressed to this stage of analysis.	● N/A
Overall Score				● Fully Met (pass)
Reviewer Comments	**Strength(s):** TRSN has chosen a well-thought-out study topic with a clearly defined and answerable question. The study population is clear: all Medicaid clients who are open and authorized for services and have major or severe physical health issues identified by select physical health comorbidity criteria on the Child and Adolescent Level of Care Utilization System (CALOCUS) or Level of Care Utilization System (LOCUS). The study indicator is clearly identified. TRSN has conducted accurate and complete data collection. The use of a chi-square test is appropriate to analyze the data collected. Appropriate strategies were implemented in an effort to achieve improvement. **Recommendation(s):** As noted in the PIP, a root cause analysis should be conducted with the clinical directors in order to better understand why the COC protocol is not being used as intended and what further interventions can be implemented to assist in improving performance. **Confidence Level:** High 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.	● Fully Met (pass)

Reviewer Comments:
The study topic was selected after the completion of a former PIP that studied coordination of care with primary care physicians and improved coordination in its general population, and through data collection and analysis of specific enrollee needs, care and services. The PIP topic was discussed at QMC, with TRSN staff and with clinical directors. Advisory and governing boards were also consulted for feedback. Things considered when prioritizing this topic included Washington's focus on system integration, concerns over the growth of the elderly population and a shortage of physicians by 2020, and inadequate information related to care coordination. Also considered were the facts that the majority of Medicaid beneficiaries are relatively inexpensive while a small portion are responsible for a significant amount of total spending, data for the study was existing and available, and focusing on the highest-risk and highest-cost population had the potential to yield excellent benefits.

The study population included all Medicaid enrollees who are open and authorized for services in TRSN and have major or severe physical health issues identified by select physical health comorbidity criteria on the CALOCUS or LOCUS.

Meets Criteria

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:
TRSN's study question is clear, concise and answerable: "Does re-training of the revised Coordination of Care with Medical Providers Protocol increase the percentage of eligible clients with major or severe physical health issues identified by CALOCUS clients who receive care that adheres to the Coordination of Care Protocol as indicated by monthly Coordination of Care service code use?"

The question identifies the focus of the PIP as enrollees with major or severe physical health issues identified by the CALOCUS or LOCUS and sets the framework for data collection and analysis by selecting the intervention of re-training providers on the revised Coordination of Care Protocol. The data collected will be the use of the coordination of care service codes.

Meets Criteria

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

Table C-17: Validation of PIP Study Population

Criterion	Description	Result
3.1	The enrollee population to whom the study question and indicator is relevant is clearly defined.	● Fully Met (pass)
3.2	The data collection approach captures all enrollees to whom the study question applied.	● Fully Met (pass
3.3	Appropriate data sources and evaluation methods were used to identify the study population.	● Fully Met (pass
Reviewer Comments: The study population is clearly identified as all Medicaid clients who are open and authorized for services in TRSN and have major or severe health issues by select physical health comorbidity criteria on the CALOCUS or LOCUS. Data are collected from the number of enrollees who meet the study indicator criteria and adhere to the COC protocol by using the monthly coordination of care service code. **Meets Criteria**		

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 uses clearly defined, measurable indicators that are objective. The denominator includes eligible clients with identified major or severe health issues indicated by the CALOCUS or LOCUS physical health comorbidity score of major (4) or severe (5). The numerator includes clients in the denominator who		

receive care that adheres to the Coordination of Care Protocol as indicated by monthly coordination of care service code use. TRSN indicators track performance over a specified period of time: baseline, August 1, 2013–June 30, 2014; and first re-measurement, August 1, 2014–May 31, 2015. The number of indicators is adequate based on the study question. **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: TRSN did not use sampling techniques for this PIP.		

Standard 6: Data Collection Procedure

Table C-20: Validation of PIP Data Collection Procedures

Criterion	Description	Result
6.1	The study design clearly specifies the data to be collected.	Fully Met (pass)
6.2	The study design clearly specifies the sources of data.	Fully Met (pass)
6.3	The study design specifies a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply.	Fully Met (pass)
6.4	The instruments for data collection provide for consistent and accurate data collection over the time periods studied.	Fully Met (pass)
6.5	The study design prospectively specifies a data analysis plan.	Fully Met (pass)

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

Reviewer Comments:
The study design clearly specifies the data to be collected. Predictive Risk Intelligence System (PRISM) information necessary for the revised COC Protocol is faxed to TRSN. The TRSN quality manager tracks the dates for PRISM requests and responses for enrollees in an Access database. Data are verified by TRSN's IS administrator.

To track COC, three local encounter codes are used: 43000 Medical Collaborative Contact, 43005 Medical Collaboration Contact <10 Min, 43100 Medical Correspondence, 43000UA Brief Medical Collaborative Contact, and 43005UA Brief Medical Collaboration Contact <10 Min.

On a monthly basis, the TRSN IS administrator queries the MSO database through the use of Crystal Reports. The report identifies enrollees who have Medicaid as the primary funding source and have an authorization date on or before the reporting month and an end date to authorization on or after the end of the reporting month. Another set of program instructions queries the MSO database for COC codes received within the reporting month and return a 0 for none or a 1 for one or more COC codes present in the reporting month. All reports are pulled no earlier than the 11th of the subsequent month.

In order to ensure the data selected for the study is accurate and valid, the following procedures and processes are taken for the below listed elements:

Medicaid Eligibility: To ensure integrity of ProviderOne 834 data, TRSN reviews the 834 data to verify that the ZIP codes in the files are within the TRSN enrollment area. If errors have been identified in the 834 files, the 834 database is updated before processing the denominator report.

Enrollment status: Accuracy of enrollment status is verified at the community agency level when services are sought and for each routine service provided. Verification of enrollment status is completed prior to encounters being submitted to DBHR by the Avatar MSO software.

Authorization: TRSN's management information systems (MIS) system filters out unqualified enrollees by excluding enrollees who do not have an outpatient authorization.

CALOCUS: CALOCUS must be completed by a mental health professional (MHP), or, if completed by a non-MHP, the CALOCUS must be reviewed and scored by an MHP. CALOCUS and LOCUS scores are reviewed by community mental health association (CMHA) supervisors prior to authorization submission and TRSN's care management contractor, BHO, after authorization submission for accuracy in assessment and scoring.

Major or severe physical health issue: TRSN's MIS system filters out unqualified enrollees by excluding enrollees who do not have Major or Severe criteria selected on the current LOCUS or CALOCUS.

Coordination of care codes: TRSN completes annual encounter data validation to verify accuracy of data. TRSN's 2013 EDV indicated 89.3% accuracy of data. An analysis of EDV errors indicated no errors related to the coordination of care services. Ongoing service code monitoring and training are completed through monthly Information Systems Quality Control (ISQC) meetings, which are attended by at least one representative from each CMHA and the TRSN IS administrator.

Adherence to Coordination of Care Protocol: TRSN's quality manager (QM) will complete quarterly clinical reviews of eligible charts to verify a referral to a PCP was completed if needed, releases of information for medical providers are present and current, prescriber notes are communicated, PRISM data has been requested, and a physical health-related service goal is present in addition to coordination of care codes and related documentation (progress note or fax cover sheet). Written chart-specific feedback will be provided to CMHAs for verification.

Missing data: LOCUS and CALOCUS are not accepted without a comorbidity score. Clients without a current service plan will be excluded from the study.

TRSN specified a chi-square test with a probability level of ≤ .05 would be used for data analysis.

TRSN's quality manager, MA and IS administrator collected and tracked the study data.

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.	● Fully Met (pass)

Reviewer Comments:
TRSN's analysis of findings was performed according to the data analysis plan. Raw data from the first re-measurement period was compared with data from the baseline measurement period. For the baseline there were 59 enrollees in the study population, the numerator was 9, the denominator was 59 and the calculated indicator was .15. During the first re-measurement period there were a total of 94 eligible enrollees, the numerator was 8, the denominator was 94 and the calculated indicator was .085. Chi-square test results did not indicate statistically significant improvement, with a probability level of ≤.0822.

TRSN noted multiple threats to validity:

- THE CALOCUS and LOCUS directions indicate that clinicians who are not certain of which rating to assign should choose the higher rating; this could have resulted in possible over-scoring of enrollees into the major or serious criteria.
- Some provider staff appeared to have misunderstood a portion of the initial training, which resulted in some data being lost during the baseline measurement period. This may have resulted in a small reduction to the baseline denominator.
- Increasing medical attention and advertising for medical health homes and integrated services may have impacted results.
- Some enrollees' health may have improved after their initial assessment and required less coordination.
- The size of the study population was relatively small.
- Because of staffing issues, TRSN was unable to provide PRISM reports in a timely fashion.
- Not all provider staff had access to Avatar to enter coordination of care codes; therefore, some services were not being documented.
- There were slightly unequal measurement periods—11 months for baseline and 9 months for re-measurement.
- Medicaid expansion created increased demand for services during the measurement period and may have impacted clinicians' ability to provide coordination of care services.

TRSN does not plan to continue this PIP but does plan to continue efforts to increase coordination of care with this population and all enrollees.

Meets Criteria

Standard 8: Appropriate Improvement Strategies

Table C-22: Validation of PIP Improvement Strategies

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

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.	Partially Met (pass)
Reviewer Comments: The same methodology as the baseline measurement was used for the first re-measurement using a chi-square test. While results did not quite indicate statistically significant improvement, there were some qualitative indicators of improvement. COC did increase from 116 to 119 between the baseline and first re-measurement period. TRSN was able to identify 35 more enrollees with comorbid issues in the re-measurement period. Overall, TRSN providers are more aware of the revised COC Protocol. **Meet 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.	N/A
Reviewer Comments: The PIP has not progressed to this point. TRSN has chosen not to continue this PIP.		

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Information Systems Capabilities Assessment (ISCA)

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

ISCA Methodology

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

The ISCA review process consists of four phases:

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

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

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

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

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

Section A: Information Systems

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

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

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

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

Section B: Hardware Systems

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

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

Section C: Information Security

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

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

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

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

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

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

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

Section D: Medical Services Data

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

Appropriate practices include

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

Section E: Enrollment Data

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

Appropriate enrollment data management practices include

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

Section F: Practitioner Data

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

Section G: Vendor Data

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

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

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

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

Scoring Criteria

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

Table D-1: Scoring Key for ISCA Standards

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

Summary of Results

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

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

Table D-2: ISCA Scores by Section

ISCA Section	Description	ISCA Result

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

TRSN is a member of the Washington State RSN-Netsmart Consortium (WSC). The WSC comprises several counties formed under five RSNs and several licensed provider agencies that use a common managed care and practice management system, remotely hosted by Netsmart Technologies, an application service provider (ASP) in Dublin, OH. Netsmart uses SAVVIS/CenturyLink Communications Corporation's co-located facilities in Columbus, OH, to host its ASP environment. WSC holds one contract with Netsmart. The Netsmart contract is managed by TRSN.

WSC membership is structured in three tiers: (1) Administration, represented by the respective administrators with final authority for directing the WSC; (2) the "E-Team," with one or more technical representatives from each RSN as well as Netsmart, who advise the administrators on technical matters; and (3) the Executive Committee, represented by committees of the counties and/or groups of counties for voting and decision-making.

TRSN's systems administrator leads the WSC's E-Team. The team leader is elected annually to serve as the single point of contact for the following: coordinating with the Netsmart project manager on product

development matters, communicating all such correspondence to the E-Team members and chairing the team meetings.

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

ISCA Section A: Information Systems

Table D-3: Information Systems

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

TRSN and its three contracted provider agencies use Netsmart's Avatar product suite for encounter data processing. VPN client software and/or hardware appliances are used to authenticate and connect to the environment. Avatar's remotely hosted managed services organization (MSO) and practice management (PM) software applications use the InterSystem Cache database management system. TRSN uses Crystal Reports for additional analysis and reporting of Medicaid data.

NetSmart's Avatar product suite is secure, robust and scalable, giving programmers the flexibility to develop sophisticated data processing methods. Netsmart uses Apache Subversion for software configuration and source code (version control) management. Avatar Cache databases use write image journaling to record database transactions. In the event of a system failure, the journal can be replayed up to the point of failure to prevent data loss.

TRSN actively participates in WSC user group meetings and trainings, which provide information about the Avatar system as well as report changes and updates.

Each provider agency enters claims/encounter data directly into Avatar PM. If a claim/encounter requires an authorization, a valid authorization must be present before it is sent to the RSN. Encounters are batched hourly and sent through an electronic data interchange (EDI) mapping process that screens the data to ensure that all data submission standards, except for verification of eligibility, are met before exporting to Avatar MSO. Claims/encounter data are converted into a HIPAA-compliant 837 format before transmitting to DBHR via a secure shell connection once a month.

TRSN-contracted provider agencies request authorization for outpatient services through Avatar PM, where all authorization data are housed. TRSN delegates the outpatient and inpatient authorization to Behavioral Health Options (BHO).

In 2014, no TRSN provider agencies had RSN-provided access to the clinical information for the members being served. This is not an RSN-specific deficiency, but rather a global healthcare information data-sharing deficiency across the RSNs. The State-developed Predictive Risk Intelligence System (PRISM) should be available and accessible to all RSN provider agencies. PRISM integrates information

from medical, social service, behavioral health and long-term care payment and assessment data systems. PRISM provides an intuitive and accessible display of beneficiary health and demographic data from administrative data sources. It has proven to be an invaluable tool for providing timely, actionable information to improve care and reduce costs. Additionally, multiple RSNs, including TRSN, have indicated that PRISM only allows the RSNs to search the database one member at a time. The RSNs are interested in having the underlying PRISM database for their membership so that the RSNs can run queries and conduct RSN-wide data analysis on the PRISM data.

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)
TRSN and NetSmart maintain current premium-level hardware, software and network service contracts. TRSN's reporting data reside on a server located onsite. Computek, Inc. is contracted for server and network hardware maintenance. TRSN's and Netsmart's data center facilities and hardware systems are well designed and maintained. Netsmart actively monitors its data center facility to identify performance and quality issues. Netsmart replaces server hardware at least every five years. Netsmart's software and hardware designs include redundant array of independent disks (RAID) configuration, connection to a network attached storage (NAS) device, and dual network interface card (NIC) and switch configuration.		

Meets Criteria

ISCA Section C: Information Security

Table D-5: Information Security

Section	Description	Result
Section C	This section assesses the security of the RSN's information systems.	● Fully Met (pass)
TRSN has multiple policies and procedures related to information security. The TRSN information security policies and procedures are all fully compliant. TRSN conducts daily backups to removable, encrypted drives. Four drives are stored within a locked server cabinet at TRSN's offices. One drive is rotated to a safety deposit box on a regular basis for offsite storage.		

Netsmart performs daily incremental backups and weekly full backups. All backups performed by Netsmart are encrypted. Netsmart replicates backups to its Kansas City, KS, facility on a nightly basis. Netsmart performs regular restoration testing of backup data to ensure that data are readily available for production.

Netsmart's current disaster recovery plan is regularly reviewed, audited and tested to ensure that information systems can be maintained, resumed and/or recovered as intended. Netsmart and the WSC work together to perform monthly tests to verify the transition from primary to secondary databases. WSC conducts annual restoration testing with Netsmart.

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

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

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

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

TRSN delegates oversight of Netsmart-contracted services to the WSC, for which TRSN's IS administrator serves as the E-Team leader. Netsmart is audited yearly by WSC.

Meets Criteria

ISCA Section D: Medical Services Data

Table D-6: Medical Services Data

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

TRSN had three contracted provider community mental health agencies in 2014. Each provider agency entered claims/encounter data directly into Avatar PM. During processing, encounter data submissions were run through an automated, rules-based edit system in Avatar to screen the data and identify potential input errors, such as validity checks of procedure and diagnosis code fields, as well as to ensure compliance with DBHR-CIS Data Dictionary and Service Encounter Reporting Instructions (SERI).

TRSN's formal procedures for rectifying encounter data submitted with one or more required fields missing, incomplete or invalid are adhered to and well documented. TRSN has multiple Crystal Reports to identify encounter services that should be flagged for transmission to DBHR, and to identify errors. If an error occurs, the provider agency is notified promptly via email to correct the error(s) within the Avatar system. Once the agency corrects the error(s), the batch is recreated in Avatar MSO and flagged for transmission to DBHR. As required by DBHR, TRSN verifies and certifies batched encounter data for accuracy and completeness before transmitting the data to directories in DBHR-CIS.

Per DBHR instructions, TRSN 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 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. It is important to note that TRSN does collect multiple diagnoses from provider agencies in Avatar's diagnoses entry screen for clients.

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 TRSN. TRSN receives 834 and 820/821 enrollment data files from DBHR. TRSN uses a custom program to combine enrollment data with encounter services and then track and reconcile which services have been paid for by Medicaid, State funds or other sources. The RSN performs monthly reconciliation activities to verify the authorization status of each encounter service, provider credentials, member month eligibility files, member ID codes and income source and program codes. NetSmart Avatar filters out encounters that do not meet the requirements of the authorization. If the pended authorization is denied, any denied services submitted to TRSN are not submitted to DBHR via the 837 file submission. Only authorized services are sent to the State. Per State guidelines, authorizations must be approved or denied within 14 days unless an extension is requested. Twelve additional days are granted.		

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)
TRSN claims/encounter reporting is accurate regarding both rendering practitioner type and practitioner service location. TRSN also has accurate practitioner information within the RSN provider directory. TRSN maintains up-to-date provider profile information in Avatar 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. TRSN's subcontracted provider agencies deliver current practitioner rosters to TRSN 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)
TRSN's claims/encounter data is contracted provider agency data; TRSN does not provide any direct client care. All three provider agencies met the acceptable standard of a 95% match rate, with the exception of a single data element: "Service code agrees with treatment provided." Each of the three provider agencies submitted a corrective action plan to TRSN regarding this data element. Additionally, TRSN changed its provider agency instruction manual language regarding this data element to assist the provider agencies in better understanding the data element submission requirement.		

Meets Criteria

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

Table D-10: Meaningful Use of EHR

Section	Description	Result

Section H	This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not rated.	● Not Rated
TRSN provides the Netsmart Technology's myAvatar EHR software application to each contracted agency. Netsmart Technology's myAvatar is a Federally certified EHR software application. TRSN provides software, training, implementation planning and support to the contracted agencies.		

Meets Criteria

Encounter Data Validation (EDV)

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

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)

Timberlands RSN Encounter Data Validation

The Timberlands RSN contracts with three agencies providing Medicaid-funded services. The EDV process at TRSN was conducted in November and December of 2014. The TRSN EDV was based on a sample of 326 client records consisting of 412 service encounters between the dates of June 1, 2014, and September 30, 2014.

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

EDV Standard	Description	EDV Result
Sampling Procedure	Sampling was conducted using an appropriate random selection process and was of adequate size.	Partially Met (pass)
Review Tools	Review and analysis tools are appropriate for the task and used correctly.	Fully Met (pass)
Methodology and Analytic Procedures	The analytical and scoring methodologies are sound and all encounter data elements requiring review are examined.	Fully Met (pass)
Opportunities for Improvement TRSN could provide a more detailed explanation of the sampling procedure (including a description of the SQL procedures used).		

Sampling Procedure

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

Timberlands RSN sampled from Medicaid-funded encounters that occurred from October 2013 through September 2014 for its three providers. An overall sample size of 420 encounters was selected, exceeding the contract minimum of 411 encounters. The encounters were drawn from 286 client charts, exceeding the contract minimum of 100 unique client charts.

The data source for the sample was an extract from the State's encounter database. This aligns with Qualis Health's recommendation 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.

TRSN used a proportional sampling procedure based on agency size and age group composition (including two age groups, one each for children and adults). Stratum-specific proportions of the final sample were used to estimate the desired sample size of encounters from each stratum. The population strata were defined by tabulating the encounters with dates of service between June and September 2014, which aligned with the conclusion of the RSN's previous corrective action.

TRSN did not provide a detailed explanation of the sampling procedure, other than to note that the sample selected was based on the proportions of adults and children for each provider and was selected using an SQL query that returned a random selection. The RSN should provide a more detailed explanation of the sampling process (including a description of the SQL query).

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

Review Tools

Reviews were conducted at the RSN office by desk review. The randomly selected State records were extracted to an Access-based tool and sequentially compared to the RSN's practice management system- extracted records for validation. The comparison results in either a match or one of three types of mismatches including erroneous, missing or unsubstantiated, according to the contract guidelines.

According to the documentation provided describing TRSN's review tool, it appears to be adequate for conducting an accurate EDV.

Methodology and Analytic Procedures

State-derived encounter records were loaded into the EDV tool, and the electronic charts for contracting agencies were reviewed using the tool. TRSN's EDV auditing staff include an IS administrator, operations managers and a quality manager/clinical director, each of whom have had various trainings and certifications in EDV and healthcare compliance.

Validation results for TRSN indicated that match rates for six of the seven encounter data fields were above the contracted limit of 95%. The overall match rate was 72.6%, with the majority of non-matches indicating erroneous values submitted to the State for required encounter fields.

TRSN's review tool, methodology and procedures are sufficient for assessing the accuracy and completeness of the RSN's EDV data.

Qualis Health Encounter Data Validation

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

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

EDV Standard	Description	EDV Result
Electronic Data Checks	Full review of encounter data submitted to the State indicates no (or minimal) logic problems or out-of-range values.	Fully Met (pass)
Onsite Clinical Record Review	State encounter data 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)

Opportunity for Improvement

TRSN's EDV process relies on data maintained by its own facility.

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

Recommendation Requiring CAP

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

- To ensure encounter data 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

Electronic Data Checks

Qualis Health analysts reviewed all demographic details and encounters for the TRSN from ProviderOne for the October 2013 through September 2014 reporting period, comprising 3,302 patients and 52,534 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.

TRSN'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. It should be noted, however, that while acceptable values for sexual orientation were present, 79 percent of the values were "Unknown, patient refused," the highest percentage among all of the RSNs.

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

Measure	State Standard	RSN Performance
	Demographic Data	
RSN ID	100% complete, all values in range	100%
Consumer ID	100% complete	100%
First Name	100% complete	100%
Last Name	100% complete	100%
Date of Birth	Optional	100%
Gender	Optional	100%
Ethnicity/Race	100% complete, all values in range	100%
Language Preference	100% complete, all values in range	100%
Social Security Number	Optional	88.5%
Sexual Orientation	100% complete	100%
	Encounter Data	
RSN ID	100% complete, all values in range	100%
Consumer ID	100% complete, all values in range	100%
Agency ID	100% complete, all values in range	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 459 encounters submitted by TRSN to ProviderOne with a service date between October 1, 2013, and September 30, 2014, as well as demographic records associated with the 118

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 demographic fields were all very high, indicating very few errors. The few errors that were detected were for ethnicity, Hispanic origin and sexual orientation, and indicated that the chart demographic field did not match the extracted field. Two demographic records out of the 118 samples were unsubstantiated for all fields.

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

- Discovery of activities entered as encounters that do not qualify as encounters, including leaving voicemails, transportation and scheduling appointments.
- Lack of clinical documentation for services
- Incorrect bundling of services

TRSN did not conduct a demographic data validation, and therefore Qualis Health's demographic data validation results could not be compared. Demographic data validation is not required under the DBHR-RSN contracts.

The comparison of the total match rate from the Qualis Health encounter review to the total match rate from the TRSN internal EDV is shown in Table E-8. For most fields, the Qualis Health review was substantially below the RSN's result, particularly for the encounter fields described above. The exceptions were for the encounter fields described above.

- Variance may be partially explained by a difference in Qualis Health and TRSN encounter review. Qualis Health encounter review not only included whether the encounter data points matched, but also whether the encounter met the SERI or WAC requirements and whether the encounter was a service that could be encountered.
- Variance may be partially explained by a lack of training and knowledge of encounter review elements, encounter submissions and documentation standards.
- Variance may also be partially explained by the different sample sets reviewed. Qualis Health did not review the same sample encounters as TRSN.

Table E-5: Demographic Data Validation

Demographic Data (N = 118)				
Field	**Match**	**No Match – Erroneous**	**No Match – Missing**	**No Match – Unsubstantiated**
Last Name	98.31%	0.00%	0.00%	1.69%
First Name	98.31%	0.00%	0.00%	1.69%
Gender	98.31%	0.00%	0.00%	1.69%
Date of Birth	98.31%	0.00%	0.00%	1.69%
Ethnicity/Race	97.46%	0.85%	0.00%	1.69%
Hispanic Origin	97.46%	0.85%	0.00%	1.69%
Preferred Language	98.31%	0.00%	0.00%	1.69%
Social Security Number	95.76%	0.00%	0.00%	1.69%
Sexual Orientation	92.37%	5.93%	0.00%	1.69%

Table E-6: Encounter Data Validation

Encounter Data (N = 459)				
Field	**Match**	**No Match – Erroneous**	**No Match – Missing**	**No Match – Unsubstantiated**
Procedure Code	59.26%	38.13%	0.00%	2.61%
Date of Service	88.02%	9.37%	0.00%	2.61%
Service Location	88.02%	9.37%	0.00%	2.61%
Service Duration	83.22%	14.16%	0.00%	2.61%
Provider Agency	88.02%	9.37%	0.00%	2.61%
Provider Type	88.02%	9.37%	0.00%	2.61%
Clinical Note Matches Procedure Code	57.52%	42.48%	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	98.31%	--	--
First Name	98.31%	--	--
Gender	98.31%	--	--
Date of Birth	98.31%	--	--
Ethnicity/Race	97.46%	--	--
Hispanic Origin	97.46%	--	--
Preferred Language	98.31%	--	--
Social Security Number	95.76%	--	--
Sexual Orientation	92.37%	--	--

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

Field	Qualis Health Match	RSN Match	Variance
Procedure Code	59.26%	99.03%	–39.77%
Date of Service	88.02%	99.03%	–11.01%
Service Location	88.02%	95.15%	–7.13%
Service Duration	83.22%	98.50%	–15.28%
Provider Agency	88.02%	99.51%	–11.49%
Provider Type	88.02%	99.51%	–11.49%
Clinical Note Matches Procedure Code	57.52%	81.07%	–23.55%

Discussion

TRSN's EDV processes related to sampling, data collection and analysis appear adequate to meet the requirements of its contract with DBHR, although the RSN should improve the technical description of its sampling 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 88.5% complete.

Qualis Health's review of demographic data indicated high accuracy, except for sexual orientation, which showed a 92.4% match.

For all encounter fields, Qualis Health found a substantial level of disagreement between encounter data extracted from ProviderOne and data included in the clinical record, with a match range of only 59% for procedure code and 58% for clinical note. These discrepancies between the clinical records of providers and encounter data in ProviderOne are substantially higher than what TRSN found through its internal EDV reviews.

Additionally, considerable variance was found when comparing the Qualis Health EDV clinical chart review results to the TRSN internal EDV results reported to DBHR. Discrepancies for the difference in TRSN'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 TRSN. Another factor that potentially could have contributed to the variance is the process by which TRSN conducts the encounter review compared to that of Qualis Health. Within Qualis Health's review, data elements may have matched the encounter; however, there may have been elements of the encounter that did not follow the State's Service Encounter Reporting Instructions (SERI) or WAC requirements, contained documentation did not match the code that was submitted, or did not reflect a service that should have been submitted. Examples include the following:

- Encountering transportation or including transportation in the duration of the encounter
- Submitting codes that have been retired since July 2013
- Documenting services that lacked clinical interventions to support the service that occurred
- Submitting an encounter when there was no contact with an individual, or the individual no-showed or cancelled their appointment
- Submitting encounters for requests for service that were all 15 minutes and, when applicable, did not contain credentials of staff
- Encountering 99211 instead of 96372 for injections
- Submitting encounters for non-encounterable services such as scheduling or rescheduling an appointment, calling in a prescription, leaving a voicemail or message, reading or sending an email, faxing, calling when the phone was disconnected or not in service at the time, making reminder calls
- Bundling services incorrectly
- Documenting family psychotherapy that was not supported by the content of the documentation
- Submitting co-occurring services without the HH modifier
- Documenting an encounter that supports psychoeducation but was submitted as something else
- Encountering an add-on psychotherapy code with an E&M code, in which documentation of the two services are not "significant and separately identifiable"
- Documenting group services that do not contain all the elements specified in WAC 388-377A-1050
- Submitting codes other than rehabilitation case management when an individual is in jail
- Encountering rehabilitation case management when the individual is at home or school
- Documenting group services that are not encounterable services, such as social activities, natural parks and Mary Kay facial groups.
- Submitting H0033 oral medication administration, direct observation, when documentation supports H0034 medication training and support.

Opportunity for Improvement

TRSN's EDV process relies on data maintained by its own facility.

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

Recommendation Requiring CAP

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

- To ensure encounter data are substantiated and in compliance, the RSN needs to

- Provide training on the Service Encounter Reporting Instructions: on coding, on what is included and excluded in each modality and on the general encounter reporting instructions
- Provide training on 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
General requirements and filing requirements—§438.402(a)–(b)	TRSN was not aware that its contracted agencies were delegated the responsibility to resolve Level 1 grievances they receive from enrollees. TRSN needs to describe in its contracts or in delegation agreements the process for delegating grievances, monitoring the delegation process, and initiating and following up on any corrective action plans.	TRSN included this language in its contracts.	Resolved.
Seclusion and restraint—§438.100(b)(2)(v)	TRSN's oversight of providers related to seclusion and restraint is limited to ensuring that providers have policies that prohibit the use of seclusion and restraint. TRSN needs to develop more specific procedures for behavior de-escalation to ensure that providers can handle volatile situations appropriately.	TRSN has developed more specific procedures to ensure providers are able to handle volatile situations.	Resolved.
Children's PIP Validation	To fully meet the standard Interpretation of Results, TRSN needs to complete the first re-measurement, finish implementing the intervention, and discuss any changes made to the study design and whether the intervention was implemented as planned. The RSN should also describe any improvement in enrollee health, functional status or satisfaction; discuss whether the target goal was met; describe how the intervention influenced results; discuss lessons learned; draw a conclusion about the study results and describe next steps for the study.	TRSN has completed this stage.	Resolved.

Children's PIP Validation	To fully meet the standard Study Results, TRSN needs to complete the first re-measurement and present the raw data and the results of statistical analyses, as well as any other data analyses that may help to explain the study results.	TRSN has completed this stage.	Resolved.
Non-clinical PIP Validation	To fully meet the standard Study Results, TRSN needs to complete the baseline measurement, implement the selected intervention, and begin the first re-measurement. The RSN needs to present the raw data, results of statistical analysis and any other data analyses that may help to explain the study results.	TRSN has completed this stage.	Resolved.
Non-clinical PIP Validation	To fully meet the standard Interpretation of Results, TRSN needs to complete the baseline measurement, implement the intervention, complete the first re-measurement, and discuss any changes made to the study design and whether the intervention was implemented as planned. The RSN should also describe any improvement in enrollee health, functional status or satisfaction; discuss whether the target goal was met; describe how the intervention influenced results; discuss lessons learned; draw a conclusion about the results and describe next steps for the study.	TRSN has completed this stage.	Resolved.
Non-clinical PIP Validation	To fully meet the standard Improvement Strategies, TRSN needs to implement the intervention, report tracking and monitoring results, describe any identified barriers and how those barriers were addressed, and describe next steps.	TRSN has not yet completed this stage.	Further action is required.

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

Compliance with Regulatory and Contractual Standards

Section 1: Availability of Services

N/A

Section 2: Coordination of Care

Recommendation Requiring CAP
TRSN monitors treatment plans and progress notes to ensure progress notes are linked to appropriate service goals. Clinical record and service reviews performed in 2014 indicated that just 35% of progress notes were linked to appropriate service plan goals. TRSN stated that this will be a focus for improvement for 2015.

1. TRSN needs to continue its efforts to ensure services are provided to help the client attain the goals on their service plan and to ensure the link between the service/intervention provided and the goal/objective is clear.

Section 3: Coverage and Authorization of Services

Recommendation Requiring CAP
Level of care was appropriate 43% of the time in reviews that combined authorization and re-authorization requests. Analysis of this data indicated several issues, including errors such as scoring CA/LOCUS assessments and insufficient documentation of clinical reasoning for changing LOC.

2. TRSN needs to continue to work with its provider agencies to ensure the scoring on CA/LOCUS assessments are accurate and also to ensure there is sufficient documentation of the clinical reasoning in the clinical record for changing the level of care.

Section 4: Provider Selection
N/A

Section 5: Subcontractual Relationships and Delegation

Recommendation Requiring CAP
Review of the Quality Management Committee minutes during 2014 indicates that TRSN administration needs to address, with the contracted entity that provides after-hours crisis line services for enrollees, the multiple concerns with the crisis line. Over the last year there appeared to be a trend of complaints in crisis line services from clients, CMHAs and community partners.

3. TRSN needs to continue its work with its contracted entity to resolve the concerns with the crisis line staff and implement protocols for improved communication to ensure enrollees are receiving needed services.

Section 6:* *Practice Guidelines

N/A

Section 7:* *Quality Assessment and Performance Improvement Program

Recommendation Requiring CAP
TRSN had several policies and procedures that had not been reviewed and/or revised during the review year.

4. TRSN needs to review and revise its policies and procedures to ensure compliance with its contract with DBHR and the State WACs. During resubmission of information, TRSN stated that it had instituted a new process and is now reviewing policies and procedures.

Section 8:* *Health Information Systems

N/A

Performance Improvement Project (PIP) Validation

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

Information Systems Capabilities Assessment (ISCA)

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

Encounter Data Validation (EDV)

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

5. To ensure encounter data are substantiated and in compliance, the RSN needs to
    - Provide training on the Service Encounter Reporting Instructions: 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

ASP	Application Service Provider
BC/DR	Business Continuity and Disaster Recovery
CALOCUS	Child and Adolescent Level of Care Utilization System
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CIS	Consumer Information Systems
CMHA	Community Mental Health Agencies
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DBHR	Department of Social and Health Services, Division of Behavioral Health and Recovery
EDI	Electronic Data Interchange
EDV	Encounter Data Validation
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
HCA	Health Care Authority
HCPCS	Healthcare Common Procedural Coding System
ISCA	Information System Capability Assessment
LOC	Level of Care
MCO	Managed Care Organization
MHCP	Mental Healthcare Professional
MHP	Mental Health Professional
MSO	Managed Services Organization
MMIS	Medicaid Management Information System
NAS	Network Attached Storage
NIC	Network Interface Card
PAHP	Prepaid Ambulatory Health Plans
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Practice Management
PRISM	Predictive Risk Intelligence System
QAPI	Quality Assessment and Performance Improvement
QRT	Quality Review Team
RAID	Redundant Array of Independent Disks
RSN	Regional Support Network
WSC	Washington State RSN-Netsmart Consortium