

- 6.14.5. If the Contractor is unable to provide valid certifications or if HRSA finds discrepancies in the Revenue and Expenditure Report, HRSA may initiate remedial action. Remedial action may include recoupment from funds disbursed during the current or successive Agreement period. Recoupment shall occur within 90 days of the close of the State fiscal year or within 90 days of HRSA's receipt of the certification, whichever is later.
- 6.14.6. HRSA reserves the right to modify the form, content, instruction, and timetables for collection and reporting of financial data. HRSA agrees to involve the RSN in the decision process prior to implementing changes in format, and shall request the RSN to review and comment on format changes before they go into effect whenever possible.

7. CARE MANAGEMENT

- 7.1. Care Management – Care Management is a set of clinical management oversight functions that shall be performed by the Contractor. Care Management functions shall be not delegated to a network CMHA. These activities must be performed by a Mental Health Professional.
- 7.2. Access Standards: A request may be made through a telephone call, walk-in, or written request from an Enrollee or those defined as Family in this Agreement or in the receipt of a written EPSDT referral.
- 7.3. The Contractor must verify eligibility for Title XIX prior to the provision of non-crisis services to an Enrollee.
- 7.4. The Contractor must maintain documentation of all requests for service even if no service actually occurs.
- 7.5. The Contractor shall not refer a Healthy Options Enrollee to the Enrollee's Healthy Options managed care plan for mental health services if the Enrollee is determined to be eligible based on medical necessity and the Access to Care Standards.
- 7.6. Appointment Standards: The Contractor shall comply with appointment standards that are consistent with the following:
 - 7.6.1. The Contractor shall make available crisis mental health services on a 24-hour, 7 days per week basis and may be accessed without full completion of intake evaluations and/or other screening and assessment processes.
 - 7.6.1.1. Emergent mental health care must occur with two (2) hours of a request for mental health services from any source.
 - 7.6.1.2. Urgent care must occur with 24 hours of a request for mental health services from any source.
 - 7.6.2. A routine intake evaluation appointment must be available and offered to every Enrollee within ten (10) business days of the request unless both of the following conditions are met:
 - 7.6.2.1. An intake evaluation has been provided in the previous twelve (12) months that establishes medical necessity and
 - 7.6.2.2. The PIHP agrees to use the previous intake evaluation as the basis for authorization decisions.

7.6.3. The time period from request from mental health services to first Routine services appointment offered must not exceed 28 calendar days.

7.6.3.1. The Contractor must document the reason for any delays. This includes documentation when the consumer declines an intake appointment within the first ten (10) working days following a request or declines an Routine appointment offered within the 28 day timeframe.

7.6.4. The Contractor must monitor the frequency of Routine appointments that occur after 28 days for patterns and apply corrective action where needed.

7.7. Authorization General Requirements:

7.7.1. Level of Care Guidelines: The Contractor must establish policies for authorization that include the Access to Care Standards and written Level of Care Guidelines. The Contractor's Level of Care Guidelines must be provided to HRSA upon request. HRSA reserves the right to request changes to the Contractor's Level of Care guidelines.

7.7.2. The Contractor must use these policies for making decisions about scope, duration, intensity and continuation of services. The Level of Care Guidelines must include:

7.7.2.1. Criteria for authorization of Routine and Inpatient care at a community hospital.

7.7.2.2. The Access to Care Standards for initial authorizations.

7.7.2.3. Continuing stay and discharge criteria for Routine and Inpatient Care. Access to Care Standards may not be used as continuing stay and discharge criteria.

7.7.2.4. Requires any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be determined by a professional who meets or exceeds the requirements of a Mental Health Professional and has appropriate clinical expertise to make that decision. A decision to deny inpatient care can only be made by a psychiatrist, doctor level-clinical psychologist.

7.7.3. The Contractor or its formal designee shall provide a written Notice of Determination or Notice of Action (in accordance with 42 CFR§438.404), to the Enrollee or their legal representative within 14 days of the authorization decision. Formulating the Notice of Determination or Notice of Action cannot be delegated to a subcontracted network CMHA, however, the CMHA may deliver the notification.

7.7.4. If the Enrollee is in the legal custody of the State of Washington such as in state foster care of group home placement, the Contractor or formal designee must provide a copy of any Notice of Action or Notice of Determination to HRSA when either an intake is denied or services beyond the intake have not been authorized. This must be mailed at the same time it is provided to the Enrollee. In these cases the legal representative which must receive the notices is the Children's Administration Regional Office. Foster children are designated by a "D" on their Medicaid ID. There may be an additional indicator of "D", "F", or "R" designating the type of placement.

7.8. Authorization for Routine Services

- 7.8.1. The Contractor shall make a determination of eligibility for an initial authorization of Routine services based on Medical Necessity and the Access to Care Standards following the initiation of the intake evaluation.
- 7.8.2. A decision by the PIHP or formal designee whether to authorize initial Routine services must occur within 14 days of the date the intake evaluation was initiated, unless the Enrollee or the CMHA requests an extension from the PIHP.
 - 7.8.2.1. Authorization and provision of Routine Services may begin before the completion of the intake evaluation once medical necessity has been established.
- 7.8.3. An extension of up to 14 additional calendar days to make the authorization decision is possible upon request by the Enrollee or the CMHA or the Contractor justifies (to HRSA upon request) a need for additional information and how the extension is in the Enrollee's interest.
 - 7.8.3.1. The Contractor must have a written policy and procedure to ensure consistent application of extensions within the service area.
 - 7.8.3.2. The Contractor must monitor the use and pattern of extensions and apply corrective action where necessary.
- 7.8.4. The Contractor must designate at least one (1) Children's Care Manager that is a Children's Mental Health Specialist or is supervised by a Children's Mental Health Specialist who oversees the authorizations of Enrollees under 21.
- 7.8.5. The Contractor or formal designee must review requests for additional services to determine a re-authorization following the exhaustion of previously authorized services by the Enrollee. This must include:
 - 7.8.5.1. An evaluation of the effectiveness of services provided during the benefit period and recommendations for changes in methods or intensity of services being provided.
 - 7.8.5.2. A method for determining if an Enrollee has met discharge criteria.

7.9. Authorization for Inpatient Services

- 7.9.1. The Contractor must have appropriate clinical staff members available 24 hours a day, 7 days a week to respond to requests for certification of psychiatric inpatient care in community hospitals. A decision regarding certification of psychiatric inpatient care must be made within twelve (12) hours of the initial request.
- 7.9.2. Only a psychiatrist, doctor level-clinical psychologist may deny a request for psychiatric inpatient care.
 - 7.9.2.1. If the authorization is denied, a Notice of Action must be provided to the Enrollee or their legal representative.
- 7.9.3. The Contractor shall adhere to the requirements set forth in the *Community Psychiatric Inpatient Instructions and Requirements* available on HRSA Intranet or upon request.

- 7.9.4. If the Contractor denies payment of any portion of a psychiatric inpatient stay for consumer and the inpatient facility has a dispute, the Contractor shall follow the dispute process provided in the Community Inpatient Instructions.
- 7.9.5. The Contractor shall ensure that authorized community psychiatric inpatient services are continued through an Enrollee's discharge should a community hospital become insolvent, including any requirement for transfer.

7.10. Utilization Management Plan

- 7.10.1. The Utilization Plan may not be structured in such a way as to provide incentives to individuals or entities to deny, limit or discontinue medically necessary services.
- 7.10.2. The Contractor shall have a medical director (consultant or staff) who is qualified to provide guidance, leadership, oversight, utilization and quality assurance for the mental health programs. These following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the medical director to oversee:

7.10.2.1. Utilization reviews with the following components:

- Services requested in comparison to services identified as medically necessary.
- A review of which goals identified in the Individual Service Plan have been met, have been discontinued or have continued need.
- Patterns of denials.
- Response to Appeals and access to expedited Appeals.
- Use of Evidence-Based and other identified practice guidelines.
- Use of discharge planning guidelines.
- Community standards governing activities such as coordination of care among treating professionals.
- Coordination with Tribal and Recognized American Indian Organizations (RAIO) and other consumer serving agencies.

- 7.10.3. The ability to demonstrate upon request the process used to monitor the following including any monitoring outcomes and corrective actions:

- Consistent application of Medical Necessity criteria and Level of Care Guidelines including the use of Access to Care Standards for initial authorizations.
- Consistent application of review criteria for authorization decisions for continuing stay and discharge.
- Consultation with providers, when appropriate.
- That benefits are provided in accordance with the Contractor's Level of Care Guidelines

and are not arbitrarily denied or reduced (e.g. the amount, duration, or scope of a required service) based solely upon the diagnosis, type of mental illness, or the Enrollee's mental health condition.

- Over and under-utilization of services.

7.11. Practice Guidelines

7.11.1. Practice Guidelines are systematically developed statements designed to assist in decisions about appropriate mental health treatment. The guidelines are intended to assist practitioners in the prevention, diagnosis, treatment, and management of clinical conditions.

7.11.2. The Contractor shall adopt and implement a minimum of two (2) Practice Guidelines. The Practice Guidelines must:

- 7.11.2.1. Be based on valid and reliable clinical evidence or a generally accepted practice among the mental health professionals in the community.
- 7.11.2.2. Consider the needs of the Enrollees.
- 7.11.2.3. Be adopted in consultation with mental health professionals in the contracted network of CMHAs, when applicable.
- 7.11.2.4. Be disseminated to all affected providers and, upon request, to Enrollees.
- 7.11.2.5. Be chosen with regard to utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply.

7.12. Network Capacity – The Contractor shall maintain sufficient capacity, including the number, mix, and geographic distribution of Community Mental Health Agencies (CMHA), and Mental Health Care Providers (MHCPs) to meet the needs of the anticipated number of Enrollees in the service area.

7.12.1. At a minimum the Contractor shall:

- 7.12.1.1. Provide an intake evaluation by a MHP within ten (10) working days of an Enrollee request.
- 7.12.1.2. Provide or purchase age, linguistic and culturally competent community mental health services for Enrollees for whom services are medically necessary and clinically appropriate consistent with the Medicaid state plan and the Federal 1915 (b) Mental health Waiver.
- 7.12.1.3. Maintain the ability to adjust the number, mix, and geographic distribution of MHCPs to meet Access and Distance Standards as the population or Enrollees needing mental health services shift within the service area.
- 7.12.1.4. Maintain the ability to adjust reimbursement amounts for different specialties or for different practitioners in the same specialty to meet Access and Distance Standards as the needs of the Enrollees shift within the service area.

7.12.2. The Contractor shall require that contracted network CMHAs provide upon the Enrollee's request:

- 7.12.2.1. Identification of individual MHCPs who are not accepting new Enrollees.
- 7.12.2.2. CMHA licensure, certification and accreditation status.
- 7.12.2.3. Information that includes but is not limited to, education, licensure, registration, and Board certification and/or-certification of Mental Health Professionals and MHCPs.

7.13. Distance Standards

7.13.1. The Contractor shall ensure that when Enrollees must travel to service sites, the sites are accessible as follows:

- 7.13.1.1. In Rural Areas, a 30-minute drive from the primary residence of the Enrollee to the service site.
- 7.13.1.2. In Large Rural Geographic Areas, a 90-minute drive from the primary residence of the Enrollee to the service site.
- 7.13.1.3. In Urban Areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed 90-minutes each way.
- 7.13.1.4. Travel standards do not apply: a) when the Enrollee chooses to use service sites that require travel beyond the travel standards; b) to mental health clubhouses when the population is insufficient to support additional clubhouses within the geographic area c) to psychiatric inpatient services including E&T; d) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

7.14. Choice of MHCP

7.14.1. The Contractor shall offer each Enrollee a choice of participating MHCPs in accordance with WAC 388-865-0345. If the Enrollee does not make a choice, the Contractor ors designee must assign a MHCP no later than 14 working days following the request for mental health services. The Enrollee may change MHCPs during the first 90 days of enrollment and once during a twelve-month period for any reason. Any additional change of a MHCP requested by an Enrollee during a 12 month period may be approved at the Contractor's discretion, provided that justification for the change is documented.

7.14.2. For continuity of care the Contractor shall encourage the Subcontractor(s) to assign Enrollees to clinicians who are anticipated to provide services to the Enrollee throughout the authorization period.

7.15. Co-Occurring Disorder Screening and Assessment: The Contractor must maintain the implementation of the integrated, comprehensive screening and assessment process for chemical dependency and mental disorders as required by RCW 70.96C. Failure to maintain the Screening and Assessment process shall result in remedial actions up to and including financial penalties as described in Section 15, Remedial Actions, of this Agreement.

- 7.15.1. The Contractor must attempt to screen all individuals aged thirteen (13) and above through the use of HRSA provided Global Appraisal of Individual Needs – Short Screener (GAIN-SS) during:
- All new intakes.
 - The provision of each crisis episode of care including ITA investigations services, except when:
 - The service results in a referral for an intake assessment.
 - The service results in an involuntary detention under RCW 71.05, 71.34 or 70.96B.
 - The contact is by telephone only.
 - The professional conducting the crisis intervention or ITA investigation has information that the individual completed a GAIN-SS screening within the previous 12 months.
- 7.15.2. The GAIN-SS screening must be completed as self report by the individual and signed by that individual on HRSA-GAIN-SS form. If the individual refuses to complete the GAIN-SS screening or if the clinician determines the individual is unable to complete the screening for any reason this must be documented on HRSA-GAIN-SS form.
- 7.15.3. The results of the GAIN-SS screening, including refusals and unable-to-completes, must be reported to HRSA through the CIS system.
- 7.15.4. The Contractor must complete a co-occurring mental health and chemical dependency disorder assessment, consistent with training provided by HRSA and outlined in the SAMHSA Treatment Protocol 42, to determine a quadrant placement for the individual when the individual scores a two (2) or higher on either of the first two scales (ID Screen & ED Screen) and a two (2) or higher on the third (SD Screen).
- 7.15.4.1. The assessment is required during the next outpatient treatment planning review following the screening and as part of the initial evaluation at free-standing, non-hospital, evaluation and treatment facilities. The assessment is not required during crisis interventions or ITA investigations.

The quadrant placements are defined as:

- Less severe mental health disorder/less severe substance disorder.
- More severe mental health disorder/less severe substance disorder.
- Less severe mental health disorder/more severe substance disorder.
- More severe mental health disorder/more severe substance disorder.

7.15.5. The quadrant placement must be reported to HRSA through the CIS system.

8. QUALITY MANAGEMENT

- 8.1. The Contractor shall participate with HRSA in the implementation, update and evaluation of the Quality Strategy located on HRSA internet website.

- 8.2. The Contractor shall conduct an **annual review** of the CMHA's within the contracted network. All collected data including PIHP monitoring results, external quality review findings, agency audits, sub-contract monitoring activities, consumer Grievances and services verification shall be incorporated into this review. This review must be included in the PIHP's ongoing quality management program.
- 8.2.1. This review may be combined with a formal review of services performed pursuant to the State Mental Health Agreement between the Contractor and HRSA.
- 8.2.2. The annual review must at least address the following:
- 8.2.2.1. Timely access that meets the Access Standards of this Agreement.
 - 8.2.2.2. Consistent coordination efforts with primary medical care.
 - 8.2.2.3. Efforts to pursue and report third party revenue.
 - 8.2.2.4. Quality Improvement activities including Performance Improvement Projects.
 - 8.2.2.5. The Implementation of Practice Guidelines and the provider implementation of Practice Guidelines.
 - 8.2.2.6. The implementation of the GAIN-SS and the co-occurring assessment for quadrant placement of individuals.
 - 8.2.2.7. Efforts to create the expectation and support the delivery of mental health services that are driven by and incorporate the voice of the Enrollee and those they identify as family.
 - 8.2.2.8. The degree to which mental health services delivered are age, culturally and linguistically competent.
 - 8.2.2.9. Monitoring activities performed are in place to make sure that attempts are made to provide mental health services in the least restrictive environment.
 - 8.2.2.10. A review of services that are being provided that promote recovery and resiliency.
 - 8.2.2.11. Local efforts to provide services that are integrated and coordinated with other formal/informal service delivery systems.
- 8.2.3. The Contractor shall provide quality improvement feedback to CMHAs, the Advisory Board, and other interested parties. The Contractor shall maintain documentation of the activities and provide the documentation to HRSA upon request.
- 8.2.4. The Contractor shall invite Enrollees and Enrollees' families that are representative of the community being served, including all age groups, to participate in planning activities and in the implementation and evaluation of the public mental health system. The Contractor must be able to demonstrate how this requirement is implemented.
- 8.2.5. Performance Improvement Projects - The Contractor must identify where improvement is needed and continue or implement at least two (2) Performance Improvement Projects (PIP), at all times during the Agreement period. This must include at least one clinical and one non-clinical project. The PIPs can be a mix of PIPs identified by HRSA for statewide improvement and projects identified by the RSN for local improvements. The Contractor

shall evaluate the PIPs for increased or sustained improvement over time.

8.2.6. The Contractor shall participate with HRSA in review activities. Participation shall include at a minimum:

8.2.6.1. The submission of requested materials necessary for a HRSA initiated review within 30 days of the request.

8.2.6.2. The completion of site visit protocols provided by HRSA.

8.2.6.3. Assistance in scheduling interviews and agency visits required for the completion of the review.

8.2.7. The Contractor may establish measures designed to maintain quality of services, controls costs and is consistent with its responsibilities to Enrollees.

8.3. Performance Measures

8.3.1. Performance assessment, measurement, and monitoring are part of the overall QA/PI program of the Contractor. The overall goal is to incorporate quality assessment and performance improvement within the Mental Health Services Quality Strategy framework. To support this Quality Strategy and state and federal mandates, the Division plans to develop a series of performance measures over time.

Overall, there are two (2) sets of performance improvement measurements included in the Agreement: Core Performance Measures and Regional Performance Measures. The Core Performance Measures are established statewide and required of all Regional Support Network Contractors. For core performance indicators, the Division will calculate the baseline, define the measurement, establish the annual improvement target, and provide the quarterly and annual reports to the Contractor.

The Regional Performance Measures are to be developed, calculated, tracked and reported by the Contractor. The Contractor shall be responsible to collect and manage the data necessary to support the Regional Performance Measurement activities, including establishing the baseline, determining demonstrable improvement target, tracking change in performance over time, and reporting the annual findings to the Division.

The aim of the regional performance measurement is to allow the Contractor to develop a quantitative, regional understanding of the healthcare and service delivery system, to establish meaningful and relevant measures unique to its population and geographic service area, to maximize the collection of data at the local level, and to foster innovation and partnership between the Contractor and network providers.

8.3.1.1. Core Performance Measures – Specific to this Agreement period, the Division has established the Core Performance Measures and improvement targets using the following methodology.

8.3.1.1.1. Baseline and Targets: The Division shall calculate the baseline performance and establish the minimum standard and performance target for each performance measure and determine the annual improvement target for the Contractor.

- a) Contractor Baseline – A minimum of twelve (12) months of historical experience will be used to calculate the baseline performance for each RSN. The data for the baseline calculation will include at least a three (3)-month lag to ensure complete data reporting. The Division will use the baseline data to establish reasonable Minimum Standard and achievable Performance Target for each performance measure and the Annual Improvement Target for the Contractor.
- b) Minimum Standard – A minimum performance standard is the minimally expected level of performance specific to the measure. The Contractor shall be accountable for achieving the Minimum Standard by the end of the first twelve (12) months of this Agreement.
- c) Performance Target – An optimal level of performance is set for each measure. It is expected that the Contractor should continuously show improvement and strive to meet the Performance Target if the Minimum Standard has been met at the end of the first twelve (12) months. If the contractor has met or exceeded the Performance Target, the Contractor shall maintain the current level of performance, but not fall below the Performance Target.
- d) Contractor Annual Improvement Target - The Annual Improvement Target, as expressed in a percentage, is calculated to guide the Contractor to meet the Minimum Standard or to reach the Performance Target incrementally after having met the Minimum Standard. For Contractor's performance that has met the Minimum Standard, the annual improvement target will be calculated based on 20 percent (20%) incremental increase between the baseline or prior year experience and the performance target. The Contractor is expected to achieve the Contractor Annual Improvement Target by the end of each year of this Agreement.
- e) Annual Improvement Target – The Contractor Annual Improvement Target is calculated by adding the Contractor Annual Improvement Target to the Contractor's current performance. The Contractor is expected to achieve the Contractor Annual Target Goal at the end of each year of this Agreement.

8.3.1.2. Performance Measure Monitoring: The Division will calculate the Core Performance Measures and share with the Contractor on a quarterly basis. Measures will be calculated with a minimum of three (3) months lag after the end of each monitoring quarter to ensure complete data reporting.

8.3.1.3. Annual Performance Evaluation: The Division will calculate each Performance Measure annually. The annual calculation will include at least a three (3) month lag for service encounter reporting. Upon review of the annual performance results, the Division may request the Contractor to provide an explanation for Performance Measures that do not meet the annual Performance Targets. If an explanation is not received or determined to be inadequate, the Contractor shall be required to submit a corrective action plan to the Division. The corrective action plan shall be received by the Division within thirty (30) days after notification to Contractor.

8.3.1.4. Public Dissemination: The Contractor shall make the results of the core performance measure available to the public.

8.3.1.5. Core Performance Measures: (Please refer to Exhibit E for the improvement targets of the Core Performance Measures for the Contractor):

- a) A routine outpatient service must be offered to a Medicaid client within seven (7) days of discharge from a psychiatric inpatient hospital or Evaluation and Treatment (E&T) facility. This will be calculated as a percentage of discharges from community psychiatric inpatient hospitals and E&Ts with a routine outpatient service within seven (7) days, divided by the total number of discharges from community psychiatric inpatient hospitals and E&Ts.
- b) Time from a request for service to a routine service offered shall be within 28 days. This will be calculated as a percentage of Medicaid clients who received a routine service within 28 days of the service request, divided by the total number of Medicaid clients who requested, authorized and received routine services.
- c) Time from a service request to an intake service shall be within 14 days. This will be calculated as a percentage of Medicaid clients who received an intake service within 14 days of the service request, divided by the total number of Medicaid clients who requested services and received intake services.
- d) Consumer Periodics shall be submitted to the Division per requirements defined in Section 11, management Information System. A timeliness of submission measure will be calculated as a percentage of the number of Consumer Periodics that are successfully submitted within 60 days, divided by the total number of Consumer Periodics submitted in the reporting period.
- e) Outpatient encounters shall be submitted to the Division within 60 days of the close of the month in which the services were provided (i.e., service month). This will be calculated as a percentage of the number of outpatient encounters successfully submitted within 60 days after the services month, divided by the total number of outpatient encounters in the reporting period.

8.3.1.6. Regional Performance Measures: A minimum of three (3) Regional Performance Measures shall be developed, calculated, tracked, and reported by the Contractor.

The Regional Performance Measures chosen by the Contractor cannot be the same as the Core Performance Measures and/or currently calculated statewide and optional indicators from the Performance Improvement Project (PIP) by the Contractor. A Regional Performance Measure may not be deleted or modified, once the baseline and target have been established by the Contractor.

8.3.1.6.1. All Regional Performance Measures shall be chosen based on local relevance, clinical consensus, and research evidence and with input from the local Mental Health Advisory Board. The Contractor is encouraged to develop the Regional Performance Measures that reflect the following areas:

- Access and Availability
- Care Coordination and Continuity
- Effectiveness of Care
- Quality of Care
- Hope, Recovery, and Resiliency

- Empowerment and Shared Decision Making
- Self Direction
- Cultural Competency
- Health and Safety Measures
- Consumer Health Status and Functioning
- Community Integration and Peer Support
- Quality of Life and Outcomes
- Promising and Evidence-Based Practices
- Provider effectiveness and satisfaction
- Integrated Programs and Systems Integration

8.3.1.6.2. Identification and Review: The Contractor is required to provide the Regional Performance Measures to the Division for review by March 31, 2010. The description of each Regional Performance Measure chosen by the Contractor shall include the following:

- Name of the Regional Performance Measure;
- Proposed study population (or sub-populations) and time period measurement used for the measure;
- Operational definition of the measure, including descriptions of numerator and denominator;
- Proposed data source(s) and sample size if survey data or chart records will be utilized;
- Any exclusion criteria applied in the measure; and
- A brief description why the measure is chosen

8.3.1.6.3. Baseline Reporting: For Regional Performance Measures that have been reviewed by the Division, the Contractor shall calculate the baseline performance. It is expected that the Contractor shall complete and submit the performance baseline calculation to the Division by September 30, 2010.

8.3.1.6.4. Target Setting: The Contractor shall recommend to the Division an Annual Improvement Target for each Regional Performance Measure by October 31, 2010. All Annual Improvement Targets shall be mutually agreed upon by the Contractor and the Division by November 30, 2010. The agreed upon targets will be used as improvement measurements for year two (2) of the Agreement.

8.3.1.6.5. Reporting: The Contractor shall calculate and monitor the Regional Performance Measures against the established Improvement Targets throughout the year. The Contractor shall submit an annual report calculating all the Regional Performance Measures and their progress relating to the Improvement Targets. The Contractor is required to submit the annual report to the Division by January 15, 2012.

- 8.3.1.6.6. Evaluation: The Division will review the annual Regional Performance Measures report submitted by the Contractor. The Division may request the Contractor to provide an explanation for performance measures that do not meet the Annual Performance Targets. If the explanation is not received or determined to be inadequate, the Contractor shall be required to submit a corrective action plan to the Division.
- 8.3.1.6.7. Public Dissemination: The Contractor shall make the results of the Regional Performance Measures available to the public.

8.4. Quality Review Activities

- 8.4.1. The Department of Social and Health Services, Office of the State Auditor, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly-authorized representatives, may conduct announced and unannounced:
 - 8.4.1.1. Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement.
 - 8.4.1.2. Reviews regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement.
 - 8.4.1.3. Audits and inspections of financial records.
- 8.4.2. The Contractor shall notify HRSA when an entity other than HRSA performs any audit or review described above related to any activity contained in this Agreement.
- 8.4.3. The Contractor shall submit to an annual EQRO monitoring review and work with the EQRO Contractor set forth by DSHS to schedule a time for the monitoring review that works for both parties.
 - 8.4.3.1. The monitoring review process shall use standard methods and data collection tools and methods found in the CMS External Quality Review Protocols to assess the Contractor's compliance with regulatory requirements, adherence to quality outcomes, and timeliness of, and access to, services provided by the Contractor.
 - 8.4.3.2. In the event the Contractor or any of the Contractor's Subcontractors do not provide ready access to any information or facilities for the EQRO monitoring review during the scheduled time, the Contractor shall incur any costs for re-scheduling the EQRO Contractor to return and finish its review.
 - 8.4.3.3. DSHS shall provide a copy of the final EQRO monitoring review report to the Contractor, through print or electronic media and upon request to interested parties such as Enrollees, mental health advocacy groups, and members of the general public.
- 8.4.4. The Contractor shall, upon request provide evidence of how external quality review findings, agency audits, Contract monitoring activities and consumer Grievances are used to identify and correct problems and to improve care and services to Enrollees.