



---

# **The Oregon Health Plan's Managed Mental Health Care**

**Oregon Department of Human Services  
Addictions and Mental Health Division  
2008 External Quality Review Annual Report**

**July 2009**

**Contract #120923**

**Presented by  
Acumentra Health  
2020 SW Fourth Avenue, Suite 520  
Portland, Oregon 97201-4960  
Phone 503-279-0100  
Fax 503-279-0190**



# **The Oregon Health Plan's Managed Mental Health Care: 2008 External Quality Review Annual Report**

**MHO Compliance Review, PIP Validation, Performance  
Measure Validation, and Information Systems Capabilities  
Assessment**

**July 2009**

**Presented to the Oregon Department of Human Services,  
Addictions and Mental Health Division**

Acumentra Health prepared this report under contract with the Oregon Department of Human Services, Addictions and Mental Health Division (Contract No. 120923).

Director, State and Private Services.....	Michael Cooper, RN, MN
Account Manager .....	Jody Carson, RN, MSW, CPHQ
Project Manager–Monitoring.....	Laureen Oskochil, MPH
Project Manager–Monitoring.....	M. Kristin Price, PhD
Project Manager–Validation .....	Brett Asmann, MA
Project Coordinator .....	Ricci Rimpau, RN, BS, CPHQ
Project Coordinator .....	Priscilla Swanson, RN, CCM
Mental Health QI Specialist.....	Debra Brooks, LCSW
Mental Health QI Specialist.....	Jessica Morea Irvine, MS
Information Systems Analyst.....	Kim Shaw
Research Analyst .....	Clifton Hindmarsh, MS
Editor.....	Erica Steele Adams
Production Assistant.....	Angela Smith

## Table of Contents

Executive Summary .....	1
Introduction .....	11
OHP managed mental health care .....	11
AMH’s quality improvement activities .....	14
MHO Compliance Review.....	20
Section 1: Enrollee Rights .....	27
Section 2: Delivery Network .....	30
Section 3: Primary Care and Coordination of Services .....	32
Section 4: Coverage and Authorization of Services .....	35
Section 5: Provider Selection.....	37
Section 6: Contractual Relationships and Delegation .....	39
Section 7: Practice Guidelines .....	41
Section 8: Quality Assessment/Performance Improvement (QA/PI).....	43
Section 9: Grievance Systems.....	45
Section 10: Program Integrity .....	47
Performance Improvement Projects.....	49
Review procedures .....	49
Review results .....	51
PIP highlights and recommendations .....	60
Performance Measure Validation and ISCA Follow-Up.....	63
Review procedures .....	64
Performance measure completeness and accuracy .....	65
DMAP/AMH information systems .....	71
MHO information systems.....	75
Discussion and Recommendations .....	86
Appendix A. MHO Scores on PIP Validation .....	A-1
Appendix B. Criteria for ISCA Standards .....	B-1
Appendix C. Revision of Statewide Performance Measures.....	C-1

## Index of Tables and Figures

Table 1. Geographic coverage and OHP enrollment of Oregon MHOs - second quarter of 2008.....	13
Table 2. Opportunities for improvement and recommendations for MHO compliance. ....	24
Table 3. PIP rating and scoring system.....	51
Table 4. Plan-specific PIP topics by MHO.....	52
Table 5. Collaborative PIP topics by MHO.....	57
Table 6. Performance measure validation ratings, 2008.....	66
Table 7. Update of recommendations for improving statewide performance measures. ....	69
Table 8. Weighted average scores and ratings on ISCA sections, 2007. ....	72
Table 9. Opportunities for improvement and recommendations for MHOs: Data Processing Procedures and Personnel.....	76
Table 10. Opportunities for improvement and recommendations for MHOs: Data Acquisition Capabilities.....	77
Figure 1. Average scores of MHOs on compliance review sections.....	23
Figure 2. MHO compliance scores: Enrollee Rights. ....	27
Figure 3. MHO compliance scores: Delivery Network.....	30
Figure 4. MHO compliance scores: Primary Care and Coordination of Services...32	
Figure 5. MHO compliance scores: Coverage and Authorization of Services.....	35
Figure 6. MHO compliance scores: Provider Selection. ....	37
Figure 7. MHO compliance scores: Contractual Relationships and Delegation. ....	39
Figure 8. MHO compliance scores: Practice Guidelines.....	41
Figure 9. MHO compliance scores: Quality Assessment/Performance Improvement. ....	43
Figure 10. MHO compliance scores: Grievance Systems.....	45
Figure 11. MHO compliance scores: Program Integrity. ....	47
Figure 12. Overall scores for plan-specific PIPs scored on 80-point scale. ....	55

Figure 13. Overall scores for plan-specific PIPs scored on 100-point scale. ....	55
Figure 14. Average scores on plan-specific PIP validation standards.....	56
Figure 15. Average scores on collaborative PIP validation standards. ....	59
Figure 16. Average ISCA section scores for nine MHOs, 2005 and 2007.....	75
Figure 17. MHO compliance scores: Information Systems.....	78
Figure 18. MHO compliance scores: Staffing. ....	79
Figure 19. MHO compliance scores: Hardware Systems.....	80
Figure 20. MHO compliance scores: Security of Data Processing. ....	81
Figure 21. MHO compliance scores: Administrative Data. ....	82
Figure 22. MHO compliance scores: Enrollment System. ....	83
Figure 23. MHO compliance scores: Vendor Medicaid Data Integration.....	84
Figure 24. MHO compliance scores: Provider Compensation and Profiles.....	85

## Executive Summary

The Oregon Department of Human Services, Addictions and Mental Health Division (AMH) contracts with Acentra Health to perform external quality review (EQR) of the managed mental health services delivered to Oregon Health Plan (OHP) enrollees. Federal law requires an annual external review of the services provided to Medicaid enrollees through managed care.

AMH contracts with nine mental health organizations (MHOs) to deliver managed mental health care for OHP enrollees. The MHOs, in turn, contract with community mental health agencies, hospitals, and clinics to deliver treatment. The MHOs are responsible for ensuring that services are delivered in a manner that complies with regulatory and contractual obligations to provide effective care.

This annual report summarizes the results of Acentra Health's review in the three major EQR areas:

- assessment of the MHOs' compliance with regulatory and contractual provisions regarding access to and timeliness of care, MHO structure and operation, and quality measurement and improvement
- evaluation of the MHOs' performance improvement projects (PIPs)
- validation of the statewide performance measures that AMH uses to assess care provided by MHOs, including follow-ups to last year's Information Systems Capabilities Assessments (ISCAs) for AMH and for each MHO

## EQR results

The results of the 2008 EQR reflect progress made—and challenges encountered—by AMH and the MHOs in meeting the Medicaid managed care requirements of the Centers for Medicare & Medicaid Services (CMS).

All MHOs have made significant progress since the 2005 compliance review. The MHOs have improved their ability to manage care for their enrollees. As a group, they have made notable improvements in the following areas:

- Enrollee rights – All MHOs improved their informational materials for enrollees, including member handbooks, and policies and procedures that were incomplete or outdated in many areas.
- Coverage and Authorization – Several MHOs adopted level-of-care criteria and utilization management plans.

- Credentialing and recredentialing of providers – Overall, the MHOs improved their credentialing and recredentialing of providers.
- Delegation – All the MHOs implemented monitoring of functions delegated to subcontractors.
- Encounter data – Most MHOs have improved their abilities to obtain accurate, timely encounter data and to analyze the data. Several also validated providers' encounter data.

In response to Acumentra Health's recommendations in previous EQR reports, AMH has made strides in aligning the MHO contract with the federal regulations.

Previous EQR reports recommended that AMH work with the MHOs' quality improvement (QI) coordinators to strengthen the reporting of statewide performance measures or revise the current measures. AMH has worked with the QI coordinators to define new performance measures that are more useful in evaluating the MHOs' quality assessment and performance improvement processes. AMH plans to implement the new measures after they are approved by the MHO contractors.

In 2008, AMH continued implementing the Children's System Change Initiative (CSCI) and gathering data on clinical outcomes. The CSCI is designed to deliver mental healthcare services for children in the least restrictive environment by moving them, when appropriate, from psychiatric residential treatment facilities and state hospitals into community-based mental health services.

AMH continues to provide leadership to advance the integration of the mental health and medical managed care systems. AMH, in partnership with the Division of Medical Assistance Programs (DMAP), emphasizes the importance and value of delivering integrated mental and physical healthcare services to OHP enrollees. Both the CSCI and integrated health care were subjects of QI activities conducted by AMH and the MHOs.

AMH has addressed issues, mentioned in previous EQR reports, related to the transfer of non-encrypted encounter data on the state information system. The state's new Medicaid Management Information System (MMIS) has addressed these issues; however, with the implementation of the new MMIS, new concerns have been identified (see page 74).

## Compliance with contractual and regulatory standards

CMS has identified *access* to care and the *quality* and *timeliness* of care as the cornerstones of EQR analysis (42 CFR §438.320). Accordingly, this Executive Summary organizes the major EQR results under those three broad domains. More detailed results and recommendations are presented in each section of this report.

### Access to care

Good access to mental health care reflects ready availability of treatment centers and practitioners within and outside the MHO network, the ability to schedule timely appointments and to receive urgent and emergent care, and the provision of culturally appropriate services for all segments of the enrollee population.

Most of the Oregon MHOs provided good access for enrollees with urgent or emergent needs, while a few MHOs struggled to ensure routine access within required timeframes. A few MHOs lacked a comprehensive process for monitoring contracted providers' compliance with standards of timely access, while some MHOs did not have confidence in the access data that their providers submitted and were unable to obtain a true picture of member access.

Below are some examples of MHOs' efforts to improve access:

- One MHO's QI Committee developed an access "fidelity scale" to measure, monitor, and track access. This has improved the validity of the MHO's access data.
- Four MHOs had mobile crisis teams that can be dispatched into the community 24 hours a day, seven days per week.
- One MHO had a call center that enrollees can call when in crisis or for information and referral. Call center staff members also authorized inpatient services.
- One MHO stationed a clinician in two primary care clinics as part of its specialized geriatric services.
- In an effort to improve care coordination and access, one MHO co-located mental health providers in medical clinics in two counties.
- One MHO, through its collaborative PIP, had nurses co-located in two outpatient mental health clinics.
- Four MHOs implemented PIPs to address access. See Tables 4 and 5 for a description of each project.

Adult OHP enrollees responding to the 2008 Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey gave their MHOs high positive aggregate domain scores for their general satisfaction with the mental health treatment they received (79 percent) and for ready and convenient access to those services. Responders' satisfaction with access to services increased slightly from 71 percent in 2007 to 72 percent in 2008.

The Youth Services Survey for Families asks caregivers of children who receive Medicaid mental health services about their satisfaction with those services. Compared with the results of the 2007 survey, responders to the 2008 survey were less satisfied with their family's access to services (69 percent in 2008 compared with 72 percent in 2007).

### **Access to information**

The MHOs have significantly improved member access to information since the last compliance review. Most MHOs included links to their member handbooks and grievance forms on their websites, and some post their policies and procedures. FamilyCare makes "welcome" calls to new enrollees to offer assistance and verify that enrollees received their new member packet.

The MHOs have made progress in publishing information, letters, and forms in non-English languages and alternative formats. Two MHOs sent newsletters to all enrollees, and one of the MHOs published its newsletter in Spanish.

Six MHOs lacked certain information pertaining to emergency services in their member handbooks or needed to include clearer information about emergency services. Also, six MHOs did not inform enrollees that specific information about individual providers (for example, their specialties) is available upon request.

### **Quality of care**

Delivery of high-quality mental health care for OHP enrollees depends on the successful integration of administrative and service-based elements across the spectrum of MHO operations. Meeting standards in the following areas is essential for MHOs to establish accountable systems and to deliver high-quality care.

#### *Coordination of care*

The MHOs have demonstrated the ability to coordinate care for enrollees through implementation of the CSCI. Some MHOs hired utilization management staff who monitor services delivered to youth with special healthcare needs in their service area. Clinical records of children and youth with special healthcare needs reviewed by Acumentra Health demonstrated coordination of care with ancillary providers. The majority of MHOs audited charts of young enrollees with special healthcare

needs to assess the quality of care delivered to youth in the Intensive Services Array.

The records of adults with special healthcare needs did not consistently contain documentation of care coordination with primary care or ancillary service providers, even though medical or other system involvement was identified in the assessment.

Six MHOs aim to improve care coordination between physical and mental healthcare providers through their collaborative PIPs. Three MHOs' PIPs are focused on coordinating care between the MHO and medical managed care organizations (MCOs). One of the MHOs has an integrated plan with chemical dependency, mental health, and physical health service providers. This plan is coordinating care for methadone clients with mental health and medical issues. See Table 5 in the PIP section for a description of each MHO's project.

Most MHOs have implemented mechanisms to monitor the quality of care for enrollees with special healthcare needs. Six MHOs conduct clinical record reviews at their provider offices that address quality of care. The MHOs look for involvement in treatment planning, informed consent to treatment, care coordination with primary care providers, and allied service providers.

Below are some examples of MHOs' care coordination and monitoring efforts:

- One MHO required providers to present a "case" as part of its biennial monitoring site visit.
- One MHO implemented a level-of-care system that authorizes services based on level of need. The MHO then monitors the records to make sure enrollees with demonstrated service needs receive treatment that addresses their needs.
- One MHO is actively involved in community committees and advisory boards in its service area. The MHO coordinated care with allied agencies, such as Child Welfare, Oregon Youth Authority, Seniors and People with Disabilities, juvenile departments, and chemical dependency treatment providers, among others.
- One MHO coordinated care with seven fully capitated health plans delivering care in its service area in a project called the "mind-body connection."
- One MHO developed a collaborative care model with one fully capitated health plan (FCHP) that is designed to improve health care for those with serious mental illness and diabetes.

- One MHO was a member of a committee that examines “complex cases” with an FCHP to monitor treatment and outcomes for enrollees with challenging health needs.

### *Grievance systems*

All MHOs monitor grievances related to privacy, dignity, and respect. Grievances are reviewed by the MHOs’ quality assessment/performance improvement committees.

Adult OHP enrollees who responded to the 2008 MHSIP Adult Consumer Survey gave their MHOs high positive aggregate domain scores for their general satisfaction with the quality of the services provided. About 77 percent of responders in 2008 were satisfied with the quality of services, compared with 75 percent in 2007.

Compared with the results of the 2007 Youth Services Survey for Families, responders to the 2008 survey were slightly less satisfied with the appropriateness of providers’ treatments (65 percent in 2008 vs. 67 percent in 2007) and treatment outcomes (57 vs. 58 percent).

### **Timeliness of care**

Timely treatment is crucial for achieving good mental health outcomes for individual enrollees and for reducing the overall system cost of care by minimizing needs for future treatment. Similarly, timely response to enrollee grievances and timely compliance with notification requirements help ensure that the system meets enrollees’ needs for high-quality care.

### *Timeliness of information*

As a whole, the MHOs inform enrollees of their rights at 30 days after enrollment and annually thereafter. Three MHOs did not inform enrollees when a provider office closed or a practitioner left an agency in a timely manner.

All MHOs had policies regarding timeliness of authorization decisions. Three MHOs did not monitor the timeliness of authorization decisions. Three MHOs lacked mechanisms to consistently notify enrollees and providers of adverse actions.

Monitoring of timeliness of access is addressed above.

### **Performance improvement projects**

CMS requires MCOs serving Medicaid enrollees to conduct two PIPs each year with the goal of improving enrollees’ clinical outcomes and MCO administrative

processes related to providing services for enrollees. Validation of these projects through the annual EQR ensures that the projects are designed, conducted, and reported according to CMS standards.

AMH requires each MHO to conduct a mental/physical health collaborative PIP aimed at integrating healthcare services for OHP enrollees, in partnership with FCHPs and other MCOs overseen by DMAP. In 2008, seven MHOs conducted collaborative PIPs with MCO partners, and all nine MHOs conducted their own ongoing PIPs on separate topics.

AMH did not require the MHOs' collaborative PIPs to address all standards of the validation protocol in 2008. Although some PIPs earned better scores than others, the PIPs on average partially met the criteria for the standards they addressed.

Acumentra Health scored 10 additional plan-specific PIPs submitted by the MHOs. Some of the PIP topics were clinical and others nonclinical. Of these 10 PIPs, three received Fully Met scores, two received Substantially Met scores, and the remainder scored either Partially Met or Minimally Met.

The 2008 review found that many MHOs continue to experience difficulty with various elements of PIP development and implementation—e.g., engaging stakeholders (especially enrollees) in the topic selection process and adequately documenting their topic selection methods; collecting project outcome data consistently, regularly, and accurately; and ensuring fidelity to project models and methods following implementation.

## **Performance measure validation results**

AMH's statewide performance measures for MHOs reflect the goal of reducing inpatient hospitalization. The previous EQR studies noted deficiencies with regard to how AMH's quarterly utilization report explained the measure calculations and the limitations of the reported data. In addition, AMH lacked thorough internal documentation of the flow of data used in calculating the measures and of the steps taken to ensure accuracy and completeness.

The 2008 review clarified certain issues regarding the performance measures. However, as was true in 2007 and 2006, the measures comply only partially with CMS regulations. To date, AMH has not submitted formal revisions that address previous recommendations, including those regarding the quarterly report.

The 2007 ISCA review of DMAP and AMH information systems found that the state substantially met CMS data processing procedure standards to support the production of performance measures. However, the state only partially or minimally

met CMS data acquisition standards, particularly those related to ensuring the validity and timeliness of encounter and claims data and the production of performance measure reports.

The follow-up ISCA review in 2008 found that several AMH information system problems identified in the 2007 ISCA lingered in 2008. The annual report describes these issues in detail.

The 2007 ISCA reviews of MHOs found that most MHOs' information systems fully or substantially met CMS standards for data processing procedures and data acquisition capabilities. The MHOs' most notable shortcoming was in complying with standards related to administrative data. For example, during portions of 2007, several MHOs could not provide the state with accurate, complete, and timely claims and encounter data. Acumentra Health's follow-up reviews in 2008 revealed some progress in addressing the 2007 ISCA recommendations.

## **Recommendations for AMH and MHOs**

In the interest of strengthening continuous QI efforts, Acumentra Health offers several recommendations for AMH and the MHOs, highlighted below.

### ***For AMH:***

- Update AMH's Medicaid Managed Mental Health Care Quality Assessment and Improvement Strategy to reflect new priorities and contract requirements that AMH has established for MHOs since 2006.
- Continue to clarify terms of the managed care contract and provide other guidance for MHOs to support their compliance with regulatory standards.
- Encourage MHOs to incorporate evidence-based practices into their practice guidelines.
- Establish how MHOs should address adult members with special healthcare needs who have multiple conditions (e.g., co-occurring physical and/or substance abuse issues).
- Further define delegated functions and provide guidance to MHOs in monitoring their delegated activities.
- Clarify expectations for training of and develop resources for MHO compliance officers.
- Clarify expectations for MHOs' monitoring of providers' use of seclusion and restraint.

- Provide further guidance to MHOs implementing Declarations for Mental Health Treatment and advance medical directives.
- Clarify expectations for ensuring that MHO staff and management are not excluded from participating in federal healthcare programs.
- Clarify expectation about level of detail required for MHOs' provider/practitioner listings.
- Continue to provide in-depth PIP training for MHOs regarding best practices for data remeasurement, statistically valid analytic techniques, and appropriate methods for documenting the data collection process.
- Coordinate with DMAP to enable the MHOs and their collaborators in the mental/physical health integration PIPs to maintain a single PIP document and undergo a single annual project review with all partners present.
- Adopt the newly defined statewide performance measures following their approval by MHO contractors, operationalize the measures, and incorporate them into the Medicaid quality strategy.
- Address recommendations from previous reports. Acumentra Health continues to recommend that AMH
  - consider forming a QI committee to oversee MHO responsibilities and approve the annual work plan and the scope of work for the contract year
  - establish contractual requirements for MHOs to conduct regular audits to validate the encounter data submitted by providers

***For MHOs:***

- Develop more practice guidelines, incorporate evidence-based practices, and establish monitoring processes to ensure that authorization decisions are consistent with guidelines.
- Clearly define delegated activities and monitor all parties that perform those activities.
- Incorporate processes for preventing and detecting fraud and abuse into compliance plans, and provide training to compliance officers.
- Apply lessons learned from the CSCI to improve care coordination for adult members with multiple special healthcare needs.
- Monitor enrollees' treatment plans to ensure that they include all required documentation.

- Monitor providers' use of and policies on seclusion and restraint.
- Track access to second opinions performed within provider agencies.
- Apply the same credentialing processes to MHO staff that are required of providers, including assuring that staff and management are not excluded from participating in federal healthcare programs.
- For collaborative mental/physical health integration PIPs, develop baseline data, implement the planned interventions, remeasure the study indicators, and perform statistical testing to determine improvements.
- For other ongoing PIPs, pursue consistent remeasurement of study indicators, perform appropriate statistical tests to assess the degree of sustained improvement due to the PIP interventions, identify barriers to improvement, and modify the interventions accordingly.
- Identify and document lessons learned from PIPs, as required by the PIP validation protocol.
- Audit the encounter data submitted by provider agencies against providers' clinical records regularly to validate the accuracy and completeness of encounter data.

## Introduction

Acumentra Health, as AMH's external quality review organization (EQRO), presents this report to fulfill the requirements of 42 CFR §438.364. The report describes how Acumentra Health aggregated and analyzed data from AMH's EQR activities and drew conclusions as to OHP enrollees' access to mental health services and the timeliness and quality of services furnished by MHOs.

42 CFR §438.358 requires the EQR to use information from the following activities, conducted in accordance with CMS protocols:

- a review, conducted within the previous three years, of each MHO's compliance with standards for access to care, structure and operations, and quality measurement and improvement
- validation of PIPs required under 42 CFR §438.240(b)(1)
- validation of performance measures reported by managed care organizations or calculated by the state as required by 42 CFR §438.240(b)(2)

This report describes objectives, data collection and analysis methods, and conclusions drawn from the three activities.

Reports delivered to AMH during 2008 and 2009 assessed the strengths and weaknesses of each MHO's compliance efforts with respect to quality, timeliness, and access to care, and presented recommendations for improvement. The reports also assessed the strengths, weaknesses, and recommendations for improvement of each MHO's PIPs and information systems. AMH has begun follow-up reviews with each MHO to determine the required response to the EQR recommendations.

## OHP managed mental health care

AMH contracts with the following nine MHOs to deliver managed mental health services for OHP enrollees on a capitated basis:

- Accountable Behavioral Health Alliance (ABHA)
- Clackamas Mental Health Organization (CMHO)
- FamilyCare, Inc.
- Greater Oregon Behavioral Health, Inc. (GOBHI)
- Jefferson Behavioral Health (JBH)
- LaneCare

- Mid-Valley Behavioral Care Network (MVBCN)
- Multnomah Verity Integrated Behavioral Healthcare System (VIBHS)
- Washington County Health and Human Services (WCHHS)

The MHOs, in turn, contract with provider groups, including community mental health programs and other private nonprofit mental health agencies and hospitals, to deliver treatment services. The MHOs are responsible for ensuring that services are delivered in a manner that complies with legal, regulatory, and contractual regulatory obligations to provide effective care.

The nine MHOs provide statewide mental healthcare coverage for OHP enrollees. In the second quarter of 2008, the MHOs had about 390,878 enrollees total; 58.26 percent were children (ages 0 to 17) and 34.24 percent were between the ages of 18 and 64.<sup>1</sup> The total number of unique enrollees served during the second quarter of 2008 was 39,184; 38.36 percent were children, while 57.91 percent were adults ages 18 to 64. Table 1 presents the counties served by the MHOs, the number of unique members enrolled in each MHO, the percentage of the OHP enrollee population, the number of enrollees served, and the percentage of enrollees served by each MHO.

---

<sup>1</sup>

Oregon Health Plan Mental Health Utilization Quarterly Report. July 1, 2007 through June 30, 2008. January 2009. Available at: <http://www.oregon.gov/DHS/mentalhealth/data/utilization-reports/mho0707utilization0608quarterly.pdf>. Accessed July 8, 2009.

**Table 1. Geographic coverage and OHP enrollment of Oregon MHOs - second quarter of 2008.<sup>1</sup>**

MHO	Primary counties served	Unique members enrolled	Percent of enrollment	Unique members served	Members served as percent of enrollment
ABHA	Benton, Crook, Deschutes, Jefferson, Lincoln	27,841	7.1%	2,354	8.5%
CMHO	Clackamas, Gilliam, Hood River, Sherman*, Wasco	27,254	7.0%	2,441	9.0%
FamilyCare	Clackamas, Multnomah, Washington	11,290	2.9%	924	8.2%
GOBHI	Baker, Clatsop, Columbia, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler	32,332	8.3%	2,930	9.1%
JBH	Coos, Curry, Douglas*, Jackson, Josephine, Klamath	67,907	17.4%	6,152	9.1%
LaneCare	Lane	37,187	9.5%	5,604	15.1%
MVBCN	Linn, Marion, Polk, Tillamook, Yamhill	77,741	19.9%	7,342	9.4%
VIBHS	Multnomah	75,086	19.2%	8,301	11.1%
WCHHS	Washington	34,240	8.8%	3,136	9.2%
<b>Total</b>		<b>390,878</b>	<b>100%</b>	<b>39,184</b>	<b>10.0%</b>

<sup>1</sup>In the latter part of 2008, two counties transferred MHOs. These numbers do not reflect those changes in enrollment.

## **AMH's quality improvement activities**

### **Managed care quality strategy**

42 CFR §438.202 requires each state Medicaid agency contracting with MCOs (including both physical and mental health MCOs) to develop and implement a written strategy for assessing and improving the quality of managed care services. The strategy must comply with provisions established by the U.S. Department of Health and Human Services.

AMH's Medicaid Managed Mental Health Care Quality Assessment and Improvement Strategy describes AMH's plan for overseeing the MHOs that serve OHP enrollees. Adopted in August 2003 and last revised in 2006, the quality strategy incorporates elements of state and federal regulations and of the MHO contract. Data obtained from the oversight activities described in the strategy are analyzed and evaluated through EQR activities. Acumentra Health reviewed the strategy's compliance with federal standards as part of the 2006 EQR. AMH and DMAP are working to develop an integrated quality strategy for managed mental and physical health care.

### **Quarterly utilization report**

AMH's quarterly utilization report incorporates the four statewide performance measures for mental health care and presents data on mental health services provided to OHP enrollees. AMH issued only one quarterly report in 2008, covering data from April 1, 2007, to March 31, 2008. AMH issued another quarterly report in January 2009, covering data from July 1, 2007, to June 30, 2008.

### **Quality improvement annual work plans**

Each MHO submits its annual QI work plan to AMH for approval so that AMH can monitor the MHOs' QI activities and offer technical assistance. AMH has worked with the MHOs to incorporate the PIPs into their work plans and has worked with DMAP to establish more consistent contract language to facilitate QI collaboration between MHOs and medical MCOs. As of 2008, AMH designates these as quality assessment and performance improvement work plans, to encompass the full range of quality management activities.

### **CSCI implementation**

The goal of the CSCI, mandated by state lawmakers in 2003, is to serve children with serious emotional, behavioral, and mental disorders through least restrictive, culturally appropriate, evidence-based services and care coordination. A key goal

is to move children from psychiatric residential treatment and state hospitals into community-based services under managed care, when appropriate.

Key structural aspects of the CSCI include the involvement of children and families in service delivery and system operation, a uniform level-of-need determination process, child and family teams, coordinated service plans, community care coordination committees, children's system advisory committees, and a system-wide focus on outcomes and data dissemination.

In April 2008, AMH updated the status of CSCI implementation.<sup>2</sup> According to the AMH report, the first results strongly suggest that children are increasingly being served in outpatient settings through intensive community-based services (meaning they are at home and remaining in a regular school setting). AMH cited these specific results:

- Increasing numbers of children are receiving mental health services.
- Money earmarked for children's services is in fact being spent on children's services.
- Per parent/guardian responses to AMH's mental health consumer surveys, the initiation of mental health treatment has had a positive impact on school attendance, and is associated with a reduction in the chance of the child's being arrested or being suspended or expelled from school.
- The number of person-days of outpatient mental health service across all OHP-eligible children has increased markedly, with increases in all types of services.

AMH acknowledged that it may take more time and data to determine whether community-based services are serving children's needs adequately. The division is working with MHOs to develop a case level and outcome data collection process and plans to incorporate this requirement into the MHO contract.

As part of its review of AMH's administration of OHP mental health services in July 2007 (see page 18), CMS found that the CSCI has increased the efficiency of the system for delivering mental health services for children in Oregon. CMS commended AMH on the effective implementation of the CSCI and recommended that AMH consider submitting the program to CMS for consideration as a best practice for posting on the CMS website.

---

<sup>2</sup> Oregon Department of Human Services, Addictions and Mental Health Division. Trends in Services and Service Outcomes Before and After Implementation of the Children's System Change Initiative. April 2, 2008. Available online at: [www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/csci-trends-before-and-after-implementation-040208.pdf](http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/csci-trends-before-and-after-implementation-040208.pdf). Accessed June 1, 2009.

### **Consumer satisfaction surveys**

AMH conducts the annual Youth Services Survey for Families to ask the caregivers of children who receive state-funded mental health services about their satisfaction with those services. AMH has adapted the survey to collect data that can contribute to evaluating the progress of the CSCI. AMH also conducts annual surveys of adult OHP members' satisfaction with their mental health care, using a modified version of the Mental Health Statistics Improvement Program survey.

Acumentra Health conducted both surveys on behalf of AMH in 2008, mailing survey forms to about 12,000 adults and 11,900 parents and guardians. Response rates were 24 percent for the adult survey and 20 percent for the child survey. Final reports of the survey results were delivered to AMH in January 2009.

### **Evidence-based practice initiative**

Oregon lawmakers have mandated that increasing proportions of state funds be allocated for specific services that are based on evidence-based practices. By the 2009–2011 biennium, 75 percent of AMH funds to serve populations at risk of emergency psychiatric services and/or criminal or juvenile justice involvement must support evidence-based practices. AMH has established a policy and procedure for identifying, evaluating, approving, and listing relevant practices and programs on its public website. AMH has determined that MHOs may adopt evidence-based practices in lieu of the practice guidelines required by federal regulations.

The evidence-based practices targeted during CSCI implementation include wraparound services—informal supports and resources provided for children and their families to promote, maintain, or restore successful community living.

The Statewide Children's Wraparound Initiative, started in July 2008, seeks to build a community-based, coordinated system of services and supports for children with complex needs and their families.<sup>3</sup> The initiative's goals are to:

- “Provide services as early as possible so children can be successful at home, in school and in their communities.”
- “Make services available based on individual strengths and needs of the child and family.”
- “Maximize resources available to serve children across systems.”

The program deliverables include:

---

<sup>3</sup>See [www.wraparoundoregon.org/statewide-initiative.php](http://www.wraparoundoregon.org/statewide-initiative.php). Accessed July 8, 2009.

- analyzing state-level contracts, administrative rules, statutes, and federal regulations to identify changes needed to implement the system of care
- submitting a multi-biennial financing strategies document
- conducting a market assessment that includes data on prevalence, utilization, and unmet needs
- conducting an information system assessment

### **Mental and physical health integration**

DHS has adopted the following goal: “Improve health and reduce morbidity, mortality, and cost through greater coordination and integration of care provided by public and private behavioral health and physical health providers and community-based organizations.” A core team representing AMH, DMAP, and the Public Health Division is working with community partners to

- identify and address local, regulatory, and other barriers to integration
- provide assistance to identify and implement best practices
- explore state or federal resources available to assist with integration efforts

AMH has established contract requirements for each MHO to conduct a PIP aimed at integrating the delivery of mental and physical healthcare services for OHP enrollees. The MHOs are to collaborate in these projects with FCHPs, dental care organizations, and chemical dependency organizations overseen by DMAP. Several MHOs began their collaborative PIPs in 2007, and most of the remaining MHOs began their projects in 2008.

### **EQR activities**

Acumentra Health has conducted annual EQR reviews of OHP managed mental health care since 2005. The conclusions are intended to guide AMH in identifying system strengths and weaknesses and to facilitate continuous improvement of the care provided by MHOs. The EQR reports have identified many opportunities for improvement in MHO procedures during the transition to the relatively new regulatory environment for Medicaid managed care and during a change in the information systems for administering the mental healthcare system.

As part of the EQR contract, Acumentra Health also conducts PIP training for MHOs to help them comply more fully with PIP standards. Since the 2005 PIP validation reviews, Acumentra Health has conducted three training sessions for the

MHOs and two separate sessions for the MHOs and their partners in the mental/physical health collaborative PIPs.

### **CMS review**

In July 2007, CMS performed a focused review of AMH's administration of OHP mental health services to determine the program's compliance with federal statutory and regulatory requirements.<sup>4</sup> In addition to reviewing implementation of the CSCI, as noted above, the CMS review team focused on

- AMH's and MHOs' QI activities
- AMH oversight of MHOs
- mental health services delivered in adult foster homes and residential treatment facilities
- intensive treatment services (ITS)
- fraud and abuse
- grievances and appeals
- subcontracts
- EQRO activities

CMS found that AMH complied with federal requirements related to QI and EQRO activities, and that AMH appeared to have resolved issues related to the state's capacity to track ITS recipients. However, at the time of review, CMS found AMH out of compliance with federal requirements in other areas. Among other issues, CMS expressed concern about

- AMH's oversight of the MHOs to ensure that the MHOs were meeting contract requirements, monitoring subcontractor activities, and complying with federal regulations, especially regarding
  - fraud and abuse
  - the user-friendliness of the grievance and appeal system and AMH's oversight of the system to ensure protection of enrollee rights
  - MHO monitoring of subcontractors' compliance with regulatory and contractual requirements

---

<sup>4</sup> Centers for Medicare and Medicaid Services. Region 10 Final Report: Oregon Health Plan Review, Addictions and Mental Health (AMH) Division, 2007. February 2009.

- the adequacy of the state's policy and procedures for administering the OHP mental health program

CMS specified required corrective actions for which AMH must develop corrective action plans. CMS intends to perform a follow-up review within one year after issuing its final review report.

The CMS review team also found that AMH staffing, although dedicated, appeared insufficient to effectively administer and monitor a program responsible for the mental health needs of more than 350,000 Medicaid enrollees. CMS strongly recommended that the state appropriate funding for additional staff to resolve the issues identified in the report.

### **Response to EQR findings**

In response to the 2008 EQR findings, AMH required all MHOs to take some corrective actions within certain timeframes. AMH is following up with the MHOs during site visits to assure that they have completed their assigned actions. As of July 2009, AMH has conducted site reviews of three MHOs and found one to be in full compliance and two to be substantially compliant and working toward full compliance. AMH plans to complete reviews of the remaining six MHOs by the end of the year.

## MHO Compliance Review

During 2008 and early 2009, Acumentra Health reviewed the nine MHOs for compliance with regulatory and contractual standards governing the delivery of healthcare services through managed care. This review covered the MHOs' 2007 activities and documentation and sought to answer the following questions:

1. Does the MHO meet CMS regulatory requirements?
2. Does the MHO meet the contractual requirements of its agreement with AMH?
3. Does the MHO monitor and oversee contracted providers in their performance of any delegated activities to ensure regulatory and contractual compliance?

Detailed results of the MHO reviews appear in individual reports submitted to AMH during 2008 and 2009. High-level summary results appear below.

### Review procedures

Data collection procedures, adapted from CMS protocols, included these steps:

1. Each MHO received a written copy of all interview questions and documentation requirements in advance of onsite interviews.
2. The MHO mailed the requested documentation to Acumentra Health for review.
3. Acumentra Health staff visited the MHO and its contracted provider organizations to conduct onsite interviews.
4. Acumentra Health provided each MHO with an exit interview summarizing the results of the review.
5. Acumentra Health weighted the oral and written responses to each question and compiled results.

The scoring plan for each activity was adapted from CMS guidelines. The oral and written answers to the interview questions were scored by the degree to which they met contractual and regulatory criteria, and then weighted according to a system developed by Acumentra Health and approved by AMH.

Acumentra Health organized the compliance review into the 10 sections shown on the following page. Each section contains multiple review elements corresponding to relevant sections of 42 CFR §438. Acumentra Health also reviewed MHOs' adherence to state contract requirements.

## Compliance Review Sections

**Section 1: Enrollee Rights.** Assess the degree to which the MHO had written policies in place on enrollee rights, communicated annually with enrollees about those rights, and made that information available in accessible formats and language that enrollees could understand.

**Section 2: Delivery Network.** Evaluate the MHO's processes and efforts for tracking its care delivery network. Subsections include types of services, service availability, out-of-network services, and cultural competency.

**Section 3: Primary Care and Coordination of Services.** Assess the MHO's coordination of care for enrollees with special healthcare needs, as defined in the AMH contract.

**Section 4: Coverage and Authorization of Services.** Evaluate the MHO's policies and procedures for authorizing services in a timely manner and for covering emergency and post-stabilization services.

**Section 5: Provider Selection.** Assess policies and procedures for credentialing and recredentialing providers and agencies.

**Section 6: Subcontractual Relationships and Delegation.** Assess the MHO's management responsibilities in overseeing the performance of subcontracted and delegated entities.

**Section 7: Practice Guidelines.** Assess the MHO's practice guidelines to ensure that they are based on best practices, kept current, disseminated to providers, and available to enrollees upon request.

**Section 8: Quality Assessment and Performance Improvement (QA/PI).** Assess the MHO's provisions for implementing QA/PI programs, for tracking utilization of services, and for maintaining a health information system.

**Section 9: Grievance Systems.** Evaluate the MHO's policies and procedures regarding grievance and appeal processes and state fair hearings.

**Section 10: Program Integrity.** Assess whether the MHO has administrative and management arrangements or procedures, including a compliance plan, designed to guard against fraud and abuse.

Within each section, Acumentra Health used the MHO's written documentation and the answers to interview questions to score the MHOs' performance on each review element on a scale from 1 to 4. Acumentra Health combined the scores for the individual elements and used a predetermined weighting system to calculate a weighted average score for each section of the compliance review. Section scores were rated according to the following scale:

- 3.5 to 4.0 = Fully met
- 2.75 to 3.4 = Substantially met
- 1.75 to 2.74 = Partially met
- <1.75 = Not met

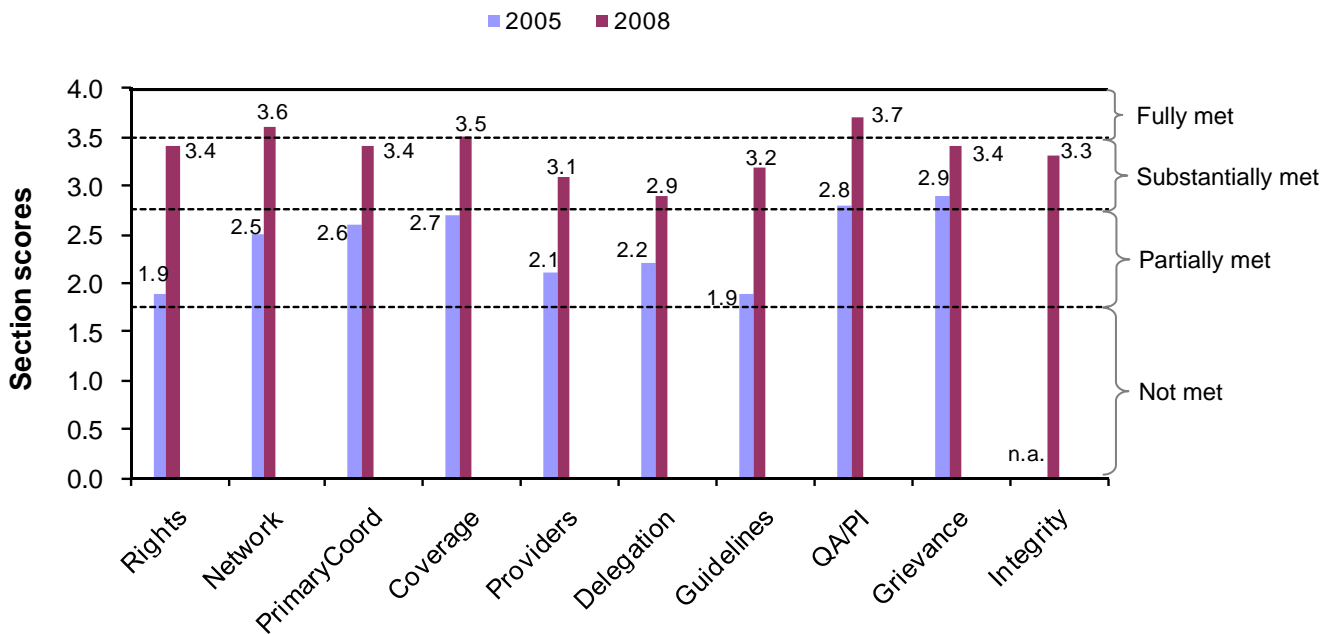
NOTE: The 2005 compliance review used a five-point scale that incorporated a "Minimally met" rating. As directed by AMH, Acumentra Health revised the scoring methodology for the 2008 compliance review. For purposes of comparison, the 2005 compliance scores shown in this report have been converted to the new four-point scale.

In addition, the federal Deficit Reduction Act of 2005 created new requirements for managed care plans regarding Program Integrity. Because these new criteria were not contained in the compliance protocol that Acumentra Health used to review the MHOs in 2005, no previous scores for Program Integrity exist with which to compare the 2008 scores.

In scoring each section, Acumentra Health assigned "findings" for areas in which the MHO did not comply with federal and/or state requirements. The reports listed recommendations to provide guidance on how to address any findings, and noted opportunities for improvement in areas where there were no findings but where the MHO had not clearly or comprehensively met the requirements.

## Review results

Figure 1 shows the scores on each compliance review section, averaged across the MHOs reviewed. As shown, the MHOs as a group fully complied with the contractual and regulatory standards reviewed in three review sections (Network, Coverage, and QA/PI) and substantially complied with standards in the remaining seven sections.



**Figure 1. Average scores of MHOs on compliance review sections.**

Compliance scores and opportunities for improvement varied widely among individual MHOs. Table 2 lists common opportunities for improvement and corresponding recommendations. The following pages discuss the MHOs’ overall strengths and opportunities for improvement in each review section. Please refer to the individual MHO reports for further detail.

**Table 2. Opportunities for improvement and recommendations for MHO compliance.**

Opportunity for improvement	Recommendation
<b><i>Enrollee Rights</i></b>	
<p>Six MHOs did not inform enrollees that information is available, upon request, which includes the names, gender, locations, telephone numbers of, and non-English languages spoken by, individual network practitioners within their networks.</p> <p>Two of these MHOs did not include any information about non-English languages spoken by their providers or their specialties in their member handbooks and/or provider listings.</p>	<p>MHOs need to inform enrollees that the following information is available upon request: the names, specialties, locations, telephone numbers of, and non-English languages spoken by providers in their service area, and whether providers are accepting new patients. This information should be included in an MHO’s provider listings.</p>
<p>Six of the MHOs’ member handbooks did not fully meet the criteria for explaining emergency services. Four of the handbooks did not explain post-stabilization services, and three did not clearly state that prior authorization is <u>not</u> required for emergency care.</p>	<p>In their member handbooks, MHOs need to clearly explain emergency services, including definitions of an emergency medical condition and post-stabilization services, and that prior authorization is not required.</p>
<p>Four MHOs did not educate staff about their advance medical and mental health directives policies during the review period, or provide community education about advance directives.</p>	<p>MHOs need to educate staff and providers about their policies on advance directives and provide community education on advance directives and mental health directives.</p>
<p>Five MHOs did not include review of contracted providers’ policies on and their use of seclusion and restraints in their credentialing and recredentialing processes.</p>	<p>MHOs need to incorporate a review of providers’ policies on and their use of seclusion and restraints into their credentialing and recredentialing.</p>
<b><i>Delivery Network</i></b>	
<p>Six MHOs did not monitor second opinions provided within agencies in their provider networks.</p>	<p>The MHOs should monitor and track the use of second opinions by their network providers.</p>
<p>A few MHOs lacked means to monitor contracted providers and ensure that the providers comply with standards for timely access for routine care.</p>	<p>The MHOs need to monitor all contracted providers’ availability through a standard process for assessing timely access to care.</p>
<p>Three MHOs did not receive reliable access data from their providers.</p>	<p>MHOs need to continue to work with providers to assure accuracy of access data.</p>
<b><i>Primary Care and Coordination of Services</i></b>	
<p>The treatment plans in the records reviewed of three MHOs did not contain documentation showing that enrollees participated in the</p>	<p>MHOs need to ensure that treatment plans for enrollees with special healthcare needs address the enrollee’s identified needs, reflect the</p>

development of their treatment plans, and some records did not contain treatment recommendations of other agencies.	recommendations of specialists or other providers, and reflect member involvement in the development of their treatment plans.
Six MHOs lacked mechanisms to monitor and measure the timeliness of direct access to specialists.	MHOs need to implement mechanisms to monitor and measure the timeliness of direct access to specialists to ensure that enrollees with identified special healthcare needs have direct access.
<b>Coverage and Authorization of Services</b>	
Three MHOs lacked a mechanism to provide timely written notification to the requesting enrollee/provider of an adverse action.	MHOs should inform enrollees and providers in writing of their service authorization denial decisions in a timely manner.
Two lacked formal policies and procedures to ensure consistent application of authorization review criteria.	MHOs need to have a mechanism in place to ensure consistent application of review criteria for authorization decisions.
Two MHO's authorization decisions were not consistently made by a healthcare professional with appropriate clinical expertise.	MHOs need to ensure that all authorization decisions are made by a healthcare professional with appropriate clinical expertise in treating the member's condition or disease.
Three MHOs lacked a mechanism for tracking standard and expedited authorizations.	MHOs need to set up a mechanism to track standard and expedited service authorizations.
<b>Provider Selection</b>	
Four MHOs did not fully meet the criteria for credentialing and recredentialing requirements because of incomplete policies and procedures and/or the lack of a monitoring process.	MHOs' credentialing and recredentialing policies and procedures need to include contracted providers and licensed staff, and implement a mechanism to ensure the ongoing monitoring of staff credentials.
Four MHOs did not ensure that their own staff and board members are not excluded from participating in federal healthcare programs.	MHOs need to expand their credentialing policies to apply the same standards to their contractors, staff, volunteers, and board members, to ensure that none have been excluded from participating in federal healthcare programs.
<b>Subcontractual Relationships and Delegation</b>	
Four MHOs did not monitor all provider types within their network.	MHOs need to identify performance standards for all delegated functions and develop and follow processes to monitor all delegated activities.
<b>Practice Guidelines</b>	
Four MHOs did not have a monitoring process to ensure that their treatment decisions are consistent with their practice guidelines.	MHOs need to ensure that their providers' decisions are consistent with their practice guidelines.
Two MHOs had no formally adopted guidelines during the review period.	MHOs should adopt clinical practice guidelines that are based on valid and reliable clinical evidence and based on the needs of enrollees.

---

***QA/PI General Rules and Basic Elements***

---

Three MHOs had incomplete access data from providers or were not confident in the accuracy of the data they received.

MHOs need to ensure that required access indicator data are valid.

Two MHOs did not validate provider encounter data to ensure accuracy.

MHOs need to validate providers' claims for accuracy.

---

***Grievance Systems***

---

Five MHOs lacked a process to adequately monitor and track the notification process for all notices of action.

MHOs need to implement a process to track and monitor the notification process for all notices of action, including delegated notices of action.

Three MHOs did not provide notices of action in the prevalent non-English languages of their areas. These and three other MHOs did not inform enrollees that their notices of action are available in alternative formats and/or non-English languages.

MHOs need to provide notices of action in the prevalent non-English language of their areas, and inform enrollees that notices of action are available in alternative formats and non-English languages.

Three MHOs do not have a formal process to monitor the timing of notices of action sent by providers or to address notices that occur outside the required time frames.

MHOs need to develop a process for monitoring the timing of notices and authorizations delegated to their contracted agencies.

MHOs need to monitor the timing of notices sent by providers and to implement a process to address notices that occur outside the required time frames.

---

***Program Integrity***

---

Four MHOs did not have formal compliance plans. Two others had plans, but they had not been formally approved and adopted by MHO management.

MHOs should develop and officially adopt comprehensive compliance plans that include administrative and management processes for preventing and detecting fraud and abuse, as well as language protecting whistleblowers.

Four MHOs did not provide their compliance officers with the necessary training in fraud and abuse prevention.

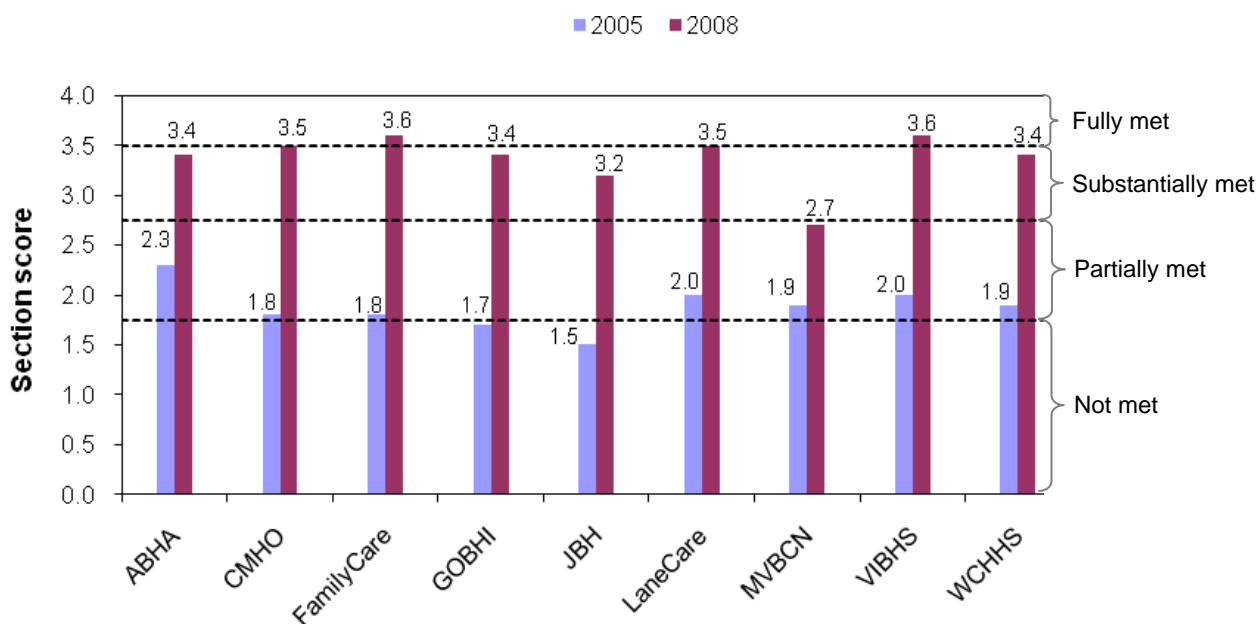
MHOs need to ensure that their compliance officers have the necessary training and education to guide the organizations' efforts to detect and prevent fraud and abuse.

---

## Section 1: Enrollee Rights

This section of the compliance protocol addresses the degree to which the MHO had written policies in place on enrollee rights, communicated annually with enrollees about those rights, and made that information available in accessible formats and language that enrollees could understand.

As shown in Figure 2, four MHOs fully met the standards in this area in 2008 and all others substantially or partially met the standards.



**Figure 2. MHO compliance scores: Enrollee Rights.**

The MHOs' improvement from 2005 was the greatest for this standard. In 2005, their member materials lacked several required elements on member rights. Since then, the MHOs have updated and further developed their policies and member materials. Overall, the MHOs' policies and procedures and member materials are well written and include most of the required elements. FamilyCare, VIBHS, and CMHO were particularly strong in this section overall.

Below are the major strengths for this section:

- Most MHOs' member handbooks were written in easy-to-understand language, and all MHOs made their handbooks available in alternative formats, including large print and Braille.

- All MHOs provided member handbooks in English and Spanish, and several MHOs issued their handbooks and other materials in additional languages, such as Russian and Vietnamese. VIBHS' member handbook and enrollee rights statements are available in 13 languages in addition to English.
- ABHA and JBH sent newsletters to all enrollees, and JBH published its newsletter in Spanish.
- Most MHOs included information on their grievance, appeal, and fair hearing processes in their member handbooks.
- Most MHOs included their privacy practices in their handbooks and some posted them on their websites.
- Most MHOs included links to their member handbooks and grievance forms on their websites, and some posted their policies and procedures.
- ABHA, GOBHI, LaneCare, and WCHHS conducted site reviews of contracted providers' offices to assess their privacy and confidentiality practices.
- Most MHOs informed members, through their member handbooks or other materials, that they have the right to be informed about all treatment options and alternatives.
- All MHOs monitored enrollee complaints and grievances related to enrollees' rights to privacy, dignity, and respect.
- Most of the MHOs included information about advance medical and mental health directives in their member handbooks.
- Several MHOs audited clinical records for the presence of Declarations for Mental Health Treatment during provider site visits.
- Representatives of ABHA, LaneCare, and MVBCN actively participated on their local hospital committees that review the hospitals' use of seclusion and restraint.
- Most MHOs included provisions regarding compliance with federal and state laws in their provider contracts, policies, and procedures, and most performed monitoring to ensure that the providers comply.

### **Opportunities for improvement**

During this review period, most MHOs did not inform enrollees that certain information about providers is available upon request (i.e., the names, gender,

locations, telephone numbers of, specialties of, and non-English languages spoken by, individual network providers within their networks).

Six MHOs lacked certain information pertaining to emergency services in their member handbooks or needed to include clearer information about emergency services. Four of the handbooks did not explain post-stabilization services, and three did not clearly state that prior authorization is not required for emergency care.

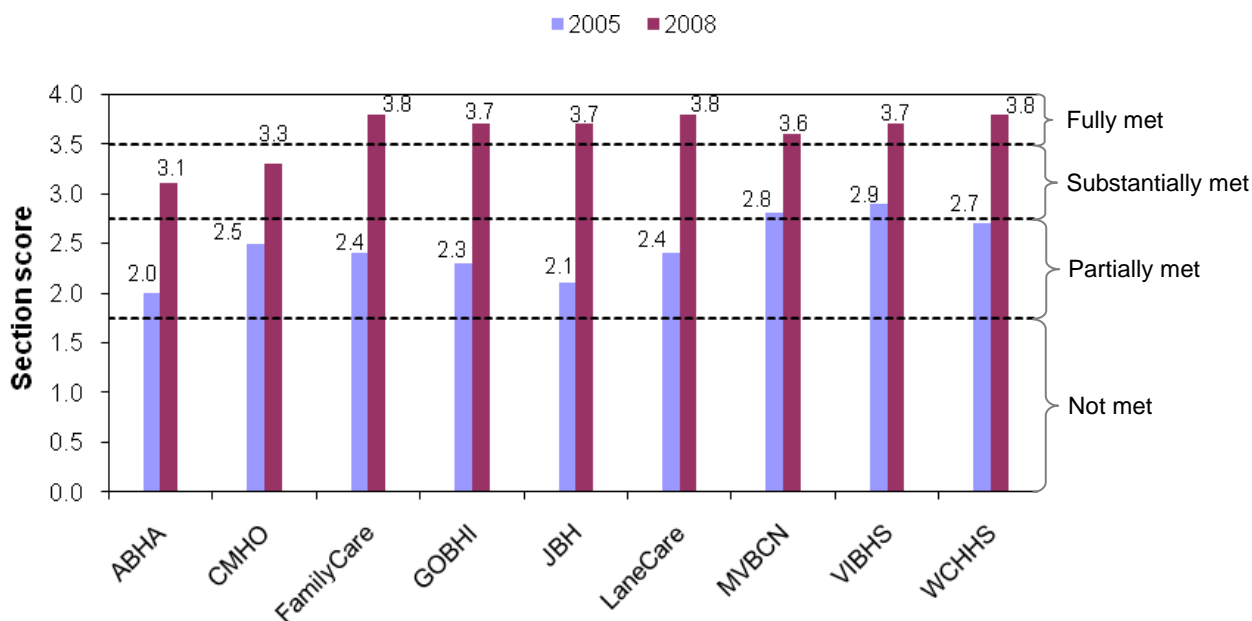
Five MHOs did not include review of contracted providers' policies on and use of seclusion and restraints in their credentialing and recredentialing processes.

A few MHOs did not educate their own staff about their advance medical and mental health directives policies during the review period, or provide community education about advance directives. Also, there appeared to be some confusion and incomplete implementation of advance directives and mental health directives.

## Section 2: Delivery Network

This section of the protocol is designed to evaluate the MHO's processes and efforts for monitoring the aspects of its care delivery network, including types of services, service availability, out-of-network services, and cultural competency.

The MHOs performed well on this section overall. Figure 3 shows that all MHOs either fully or substantially met the relevant standards in 2008.



**Figure 3. MHO compliance scores: Delivery Network.**

All MHOs have improved since 2005, when many lacked formal policies and procedures for providing second opinions and for the delivery of out-of-network services.

Overall, the MHOs maintain provider networks that provide adequate access for members and have the required policies and procedures. ABHA, LaneCare, and MVBCN monitored their networks through quality management indicator data, the number and types of grievances, and audited findings from site visits. LaneCare and MVBCN also used customer feedback, needs assessments, and capacity and gap reports to ensure that their provider networks were adequate. The capacity and gap analysis reports included enrollee population, and demographics, as well as provider population and providers' capacity.

LaneCare, MVBCN, WCHHS, and VIBHS identified potential providers through a competitive request-for-proposal qualification process that established the

applicants' ability to perform the requested services. This process was designed to ensure sufficient capacity to serve the MHO's Medicaid population.

All MHOs fully met the criteria for coordination of out-of-network providers.

Most MHOs fully met the criteria for cultural considerations. They participated in the state's efforts to deliver services in a culturally competent manner to all enrollees, including those with limited proficiency and diverse cultural and ethnic backgrounds. The MHOs had policies and procedures and members materials to support cultural competence.

### **Opportunities for improvement**

Most of the areas for improvement were related to monitoring provider networks.

In 2005, some MHOs lacked a comprehensive process for monitoring contracted providers' compliance with standards of timely access. Most MHOs now monitor providers to ensure that enrollees have timely access to routine and emergency care. A few of the MHOs lacked means to monitor contracted providers and ensure that the providers comply with standards for timely access for routine care.

Three MHOs did not receive reliable access data from their providers; therefore, they were unable to determine if the providers are fully meeting access standards. Those MHOs required corrective action from providers who did not submit accurate access data.

Six MHOs did not monitor second opinions provided by agencies in their provider networks.

### Section 3: Primary Care and Coordination of Services

This section of the protocol is designed to assess the MHO's coordination of care for enrollees with special healthcare needs, as defined in the AMH contract.

As shown in Figure 4, all the MHOs fully or substantially met the standards in 2008.



**Figure 4. MHO compliance scores: Primary Care and Coordination of Services.**

Most MHOs have improved from 2005, when several lacked good ongoing care coordination between contracted agencies and the primary care physicians (PCPs) or medical specialists.

Implementation of the CSCI has demonstrated the MHOs' ability to assure the quality of care for children with special healthcare needs. Most MHOs met the standards for coordinating care, and most actively identified children with special healthcare needs. Clinical records of children and youth with special healthcare needs reviewed by Acumentra Health demonstrated coordination of care with ancillary providers (this occurred less often with adult members; see opportunities for improvement below).

The records of members with special healthcare needs reviewed at ABHA, FamilyCare, and WCHHS demonstrated good care coordination and treatment

planning. The records reviewed at ABHA, CMHO, FamilyCare, GOBHI, and WCHHS included evidence of enrollee involvement in treatment planning during clinical record audits.

The majority of MHOs audited charts of young enrollees with special healthcare needs to assess the quality of care delivered to youth in the Intensive Services Array.

WCHHS and VIBHS used the Level of Care Utilization System to determine the service needs of adult enrollees, and VIBHS assessed youth with the Child and Adolescent Service Intensity Instrument.

ABHA adopted the Intensive Community Treatment Services and Supports Wraparound model to increase the availability and quality of individualized, intensive, and culturally competent home- and community-based services to serve children in the most natural environment possible. MVBCN contracted with a group that provides intensive wraparound services to children. MVBCN targeted several high-risk groups with special needs, including those with co-occurring mental health and chemical dependency disorders and high-need trauma survivors.

In two of MVBCN's counties, mental health providers were co-located in medical clinics in an effort to improve care coordination and access. VIBHS, through its collaborative PIP, had nurses co-located in two outpatient mental health clinics. WCHHS had a clinician stationed in two primary care clinics as part of its specialized geriatric services.

LaneCare is actively involved in committees and advisory boards in its service area. The MHOs coordinate care with allied agencies, such as Child Welfare, Oregon Youth Authority, Seniors and People with Disabilities, juvenile departments, and chemical dependency treatment providers, among others.

Most MHOs had policies and procedures to support and promote a culturally competent and diverse environment.

### **Opportunities for improvement**

MHOs have improved their care coordination for children since the inception of the CSCI. However, the records of adults with special healthcare needs did not consistently contain documentation of care coordination with primary care or ancillary service providers, even though medical or other system involvement was identified in the assessment.

In 2005, MHOs' treatment plans for members with special healthcare needs included few or no physical health issues. Most treatment plans now include at

least some physical health issues, and most records Acumentra Health reviewed in 2008 and 2009 reflected the involvement of enrollees and their families in the development of treatment plans. However, some did not contain the treatment recommendations of other agencies, and three MHOs' records did not contain evidence of the member's involvement in treatment planning.

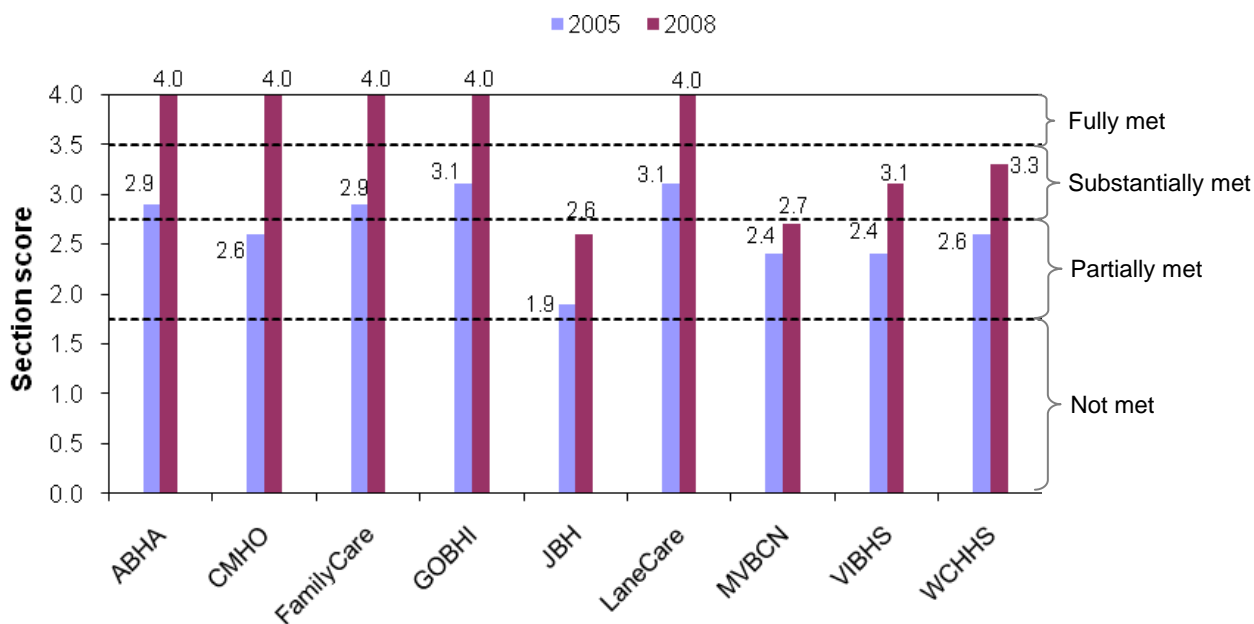
The MHOs should apply lessons learned from CSCI to their adult special healthcare needs population.

In 2005, some MHOs lacked formal mechanisms for providing direct access to specialists and to monitor the contracted agencies for providing that access. Six MHOs still lack a mechanism to monitor and measure the timeliness of direct access to specialists to ensure that their contracted providers meet the standards.

## Section 4: Coverage and Authorization of Services

This section of the protocol is designed to evaluate the MHO's policies and procedures for authorizing services in a timely manner and for covering emergency and post-stabilization services.

Figure 5 shows that five of the MHOs fully met the standards for this section in 2008.



**Figure 5. MHO compliance scores: Coverage and Authorization of Services.**

Overall, the MHOs' performance varied considerably in this section. ABHA, CMHO, FamilyCare, GOBHI, and LaneCare fully met all the criteria for this section.

Since 2005, the MHOs have developed or updated policies and procedures for making utilization management decisions. Now most MHOs have good utilization management plans, and some have adopted level-of-care criteria.

In 2005, most MHOs lacked methods to track or monitor the use of emergency room (ER) services. Now almost all MHOs track ER use and follow up with those members who use the ER to develop clinically appropriate alternatives.

LaneCare, MVBCN, VIBHS, and WCHHS can dispatch mobile crisis teams for members in need.

**Opportunities for improvement**

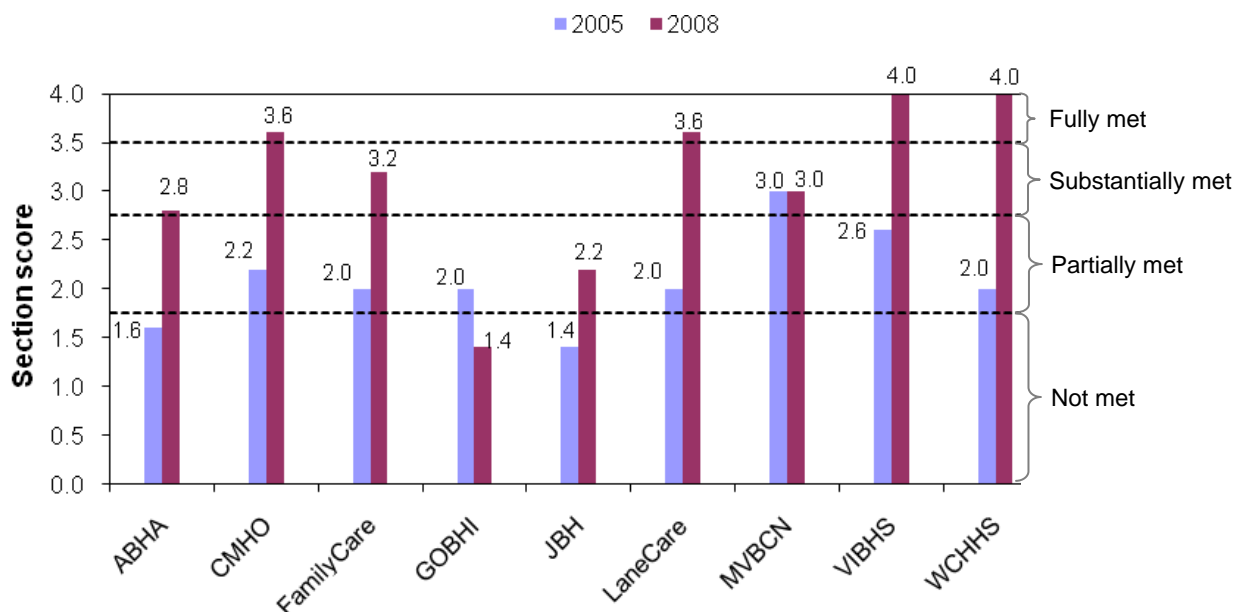
In 2005, many MHOs did not ensure that timely notices of action were sent to enrollees about decisions to deny or reduce services. Since then, the MHOs have put processes in place to ensure notices are sent within required timeframes. However, three MHOs still lack a mechanism to provide timely written notification to the requesting enrollee/provider of an adverse action.

- Three MHOs lacked a mechanism for tracking the timeliness of standard and expedited service authorizations.
- Two MHOs' authorization decisions were not consistently made by a healthcare professional with appropriate clinical expertise.

## Section 5: Provider Selection

This section of the protocol is designed to assess the MHO's policies and procedures for ensuring the appropriate mix of providers for the enrollee population and for credentialing and recredentialing providers and agencies.

Figure 6 shows that four of the MHOs fully met the relevant standards in 2008.



**Figure 6. MHO compliance scores: Provider Selection.**

In 2005, all of the MHOs needed to develop or improve their credentialing and recredentialing policies, procedures, and oversight. Most MHOs have improved greatly and now have

- thorough credentialing and recredentialing policies and they periodically recredential their contracted providers
- policies and procedures to ensure a nondiscriminatory process for selecting and compensating providers
- processes for determining whether practitioners are excluded from participating in federal healthcare programs

VIBHS and WCHHS achieved perfect scores for this section. CMHO, LaneCare, and VIBHS had comprehensive policies and procedures for their credentialing and recredentialing processes.

VIBHS checked the Office of Degree Authorization to ensure that degrees were issued from an accredited university.

CMHO and LaneCare had well-organized credentialing and recredentialing files that contained all the necessary components.

Five MHOs either credentialed providers or monitored credentialing practices by providers.

### **Opportunities for improvement**

While MHOs improved their credentialing and recredentialing of providers, four MHOs had incomplete policies and procedures and/or lacked a monitoring process.

Three MHOs did not apply the same credentialing procedures for their licensed staff members as they require of providers. Also, four MHOs did not monitor to ensure that their own staff and board members are not excluded from federal healthcare programs. MHOs need to apply the same credentialing processes to their staff that they apply to providers, including assuring that MHO staff and management are not excluded from participating in federal healthcare programs.

## Section 6: Contractual Relationships and Delegation

This section of the protocol addresses the MHO's management responsibilities related to overseeing activities that are delegated to subcontractors. Consistent monitoring of delegated functions may help to ensure more effective delivery of care to enrollees.

As shown in Figure 7, two MHOs fully met the criteria and four substantially met the criteria for this section.



**Figure 7. MHO compliance scores: Contractual Relationships and Delegation.**

In 2005, all the MHOs needed to revise or develop formal policies and procedures for addressing contracted and/or delegated responsibilities, and they did not consistently monitor all delegated activities. Several MHOs have since developed or improved their policies and procedures. FamilyCare and VIBHS fully met the all criteria for this section.

Several MHOs performed good oversight of delegated activities. GOBHI, LaneCare, MVBCN, and VIBHS oversaw their delegated activities through site reviews, auditing clinical records, and other means.

**Opportunities for improvement**

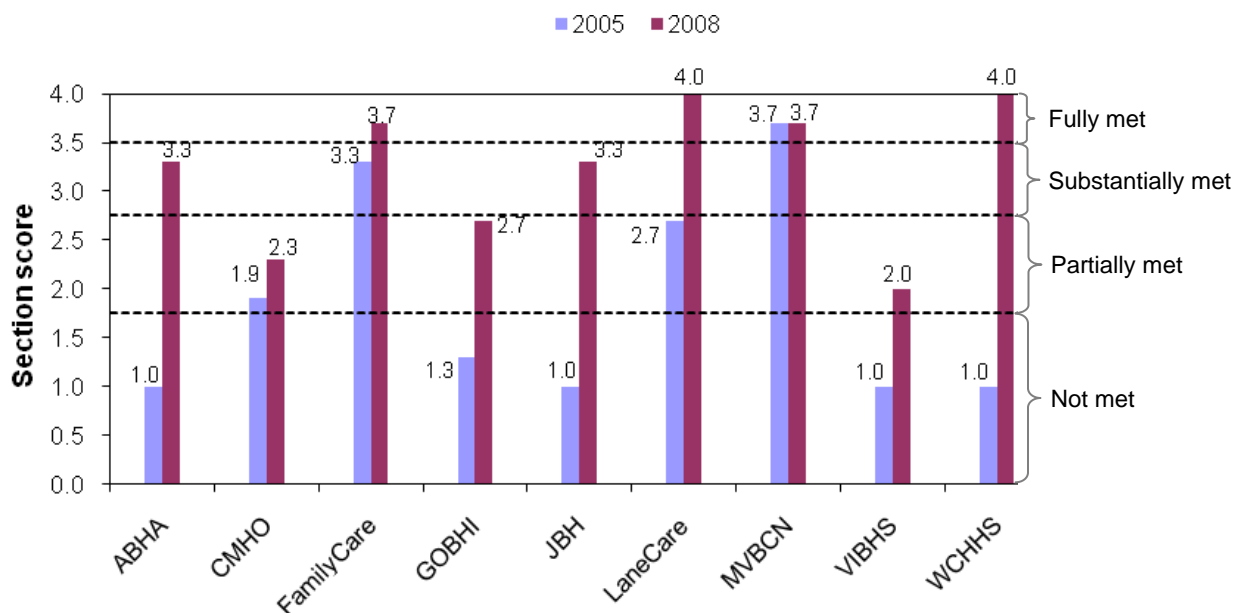
Four MHOs lacked a mechanism for monitoring all delegated activities and ensuring that they were conducted properly.

Two MHOs did not clearly define which activities they delegated. The MHOs should clearly define which activities are delegated, which are retained, and which are shared and develop mechanisms to monitor those that are delegated.

## Section 7: Practice Guidelines

This section of the protocol is designed to assess whether the MHO's practice guidelines are based on best practices, kept current, disseminated to providers, available to enrollees upon request, and used in utilization management.

Figure 8 shows that six MHOs either fully or substantially met the standards for this section in 2008.



**Figure 8. MHO compliance scores: Practice Guidelines.**

In 2005, most MHOs did not have formal practice guidelines, or their guidelines were outdated and not fully disseminated to providers. Most MHOs have since adopted guidelines or updated existing ones, and they disseminate their guidelines to providers.

Since 2005, several MHOs have improved greatly in this section, especially WCHHS, which fully met all the criteria for this section along with LaneCare. Most MHOs now have practice guidelines, which they periodically update, and most distribute their guidelines to providers by posting them on their websites and through other means, such as provider trainings.

LaneCare and WCHHS adopted guidelines based on evidence-based practices. WCHHS adopted evidence-based guidelines for specific diagnoses, which include associated evidence-based practices, and it reviews and updates the guidelines annually. WCHHS required its providers to document their interventions in the

enrollees' clinical records, and it reviewed for continuity between diagnoses and interventions during record audits.

ABHA adopted the Intensive Community Treatment Services and Supports Wraparound model as a practice guideline to increase the availability and quality of individualized, intensive, and culturally competent home- and community-based services to serve children in the most natural environment possible.

### **Opportunities for improvement**

During the review period, four MHOs still lacked a monitoring process to ensure that treatment decisions made by providers were consistent with their practice guidelines.

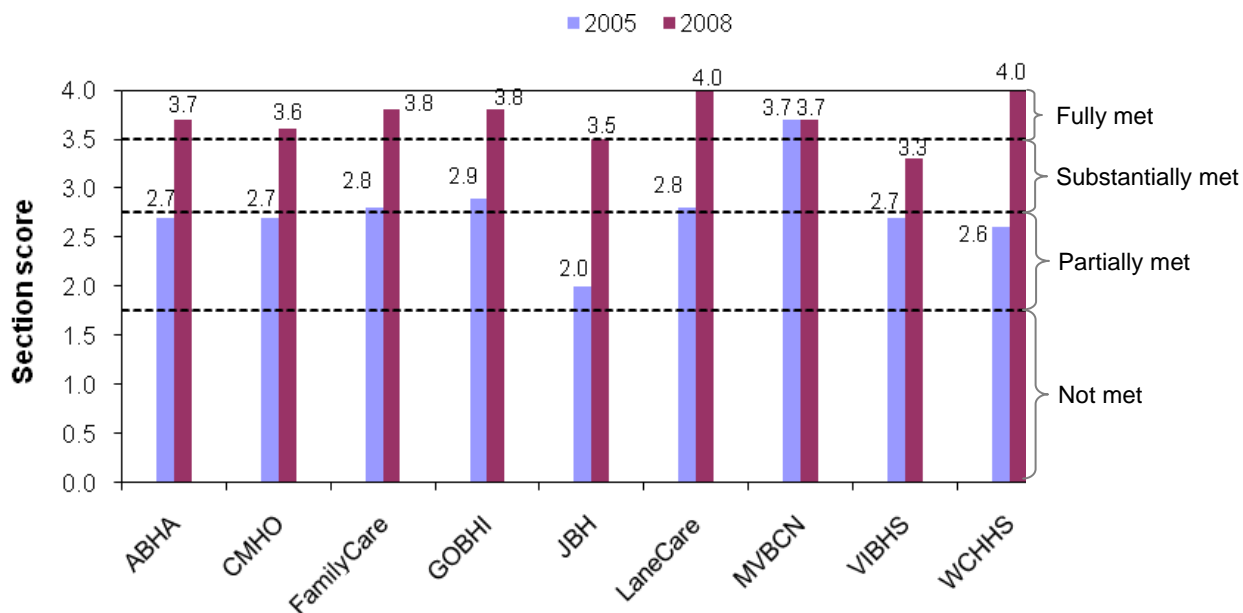
Two MHOs still had no formally adopted guidelines during the review period.

Some MHOs have implemented evidence-based practices within their networks that meet the requirements, but they did not consider them to be “practice guidelines.” The MHOs need to incorporate evidence-based practices into their practice guidelines.

## Section 8: Quality Assessment/Performance Improvement (QA/PI)

This section of the compliance protocol is designed to assess the MHO's provisions for implementing QA/PI programs, tracking service utilization, and maintaining a health information system.

Figure 9 shows that all of the MHOs fully or substantially met the standards.



**Figure 9. MHO compliance scores: Quality Assessment/Performance Improvement.**

In 2005, most MHOs needed to improve their analytical plans and define their use of available data in the PIPs, as well as in analyzing utilization patterns, quality of care, and special healthcare needs.

The MHOs have made many improvements in this area. LaneCare and WCHHS made substantial improvements from 2005 to fully meet all the criteria for this section.

Overall, the MHOs

- have good work plans
- regularly review over- and underutilization

- assess the quality and appropriateness of care furnished to enrollees with special healthcare needs through chart audits, data analysis, and other means

A major area for improvement in 2005 was incomplete/inaccurate encounter data from providers. Most MHOs have improved their encounter data collection procedures and are analyzing encounter data. Several MHOs used monthly claims and utilization, authorization, and demographic reports from their third-party administrator to identify concerns. Some MHOs also validated providers' encounter data for accuracy. GOBHI's QI Committee developed an access fidelity scale for providers to ensure consistency in calculating access data.

### **Opportunities for improvement**

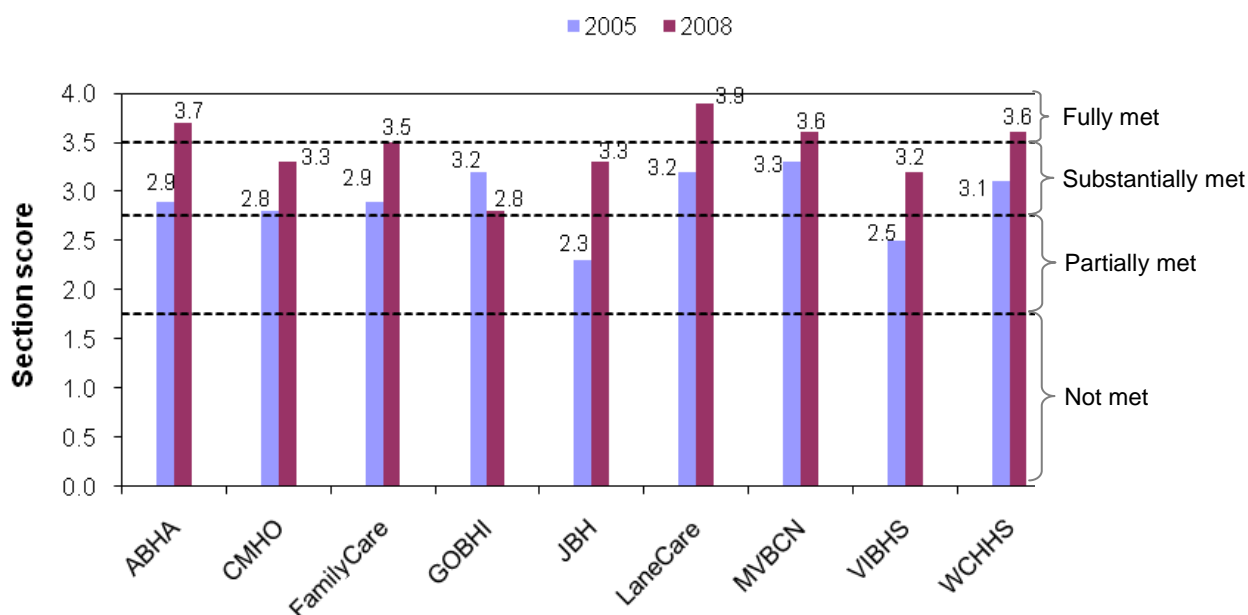
The MHOs need to continue their efforts to ensure complete and accurate encounter and access data.

- Three MHOs need to ensure that required access indicator data are valid.
- Two MHOs did not have consumer representation on their QI Committees, which is required by the MHO contract.
- Two MHOs did not have adequate mechanisms to assess the quality and appropriateness of care provided to their adult enrollees with special healthcare needs.
- Two MHOs did not validate providers' encounter data to ensure accuracy.

## Section 9: Grievance Systems

This section of the protocol is designed to evaluate the MHO's policies and procedures regarding grievance and appeal processes and state fair hearings and evaluate how the MHO monitors adherence to mandated timelines. Compliance in this area requires considerable oversight by the MHO and its contracted agencies to enforce, manage, and monitor enrollee rights and the provision of services.

Figure 10 shows that all the MHOs either fully or substantially met the standards.



**Figure 10. MHO compliance scores: Grievance Systems.**

In 2005, many MHOs lacked complete policies and procedures that addressed all enrollee rights and other criteria for this section. None of the MHOs had complete policies and procedures on providing notices of action, and in the majority of cases, the MHOs did not meet criteria for the content and/or timing of notices.

Overall, the MHOs have improved from 2005. Several MHOs now have comprehensive grievance and appeals policies and procedures and they monitor complaints, grievances, and appeals to identify trends in enrollee concerns. All but one MHO fully met the criteria for content of notice of action.

Strengths include:

- Most MHOs' member handbooks inform enrollees about their right to file grievances and appeals and about the state's fair hearing process.

- Four MHOs monitored complaints, grievances, and appeals monthly.
- Most notices of action were written in clear language.
- Most MHOs made their notices of action available in non-English languages.
- Four MHOs had well-written policies and procedures addressing the required timelines for notice of action, authorization decisions, and expedited authorization decisions.
- LaneCare and MVBCN tracked and trended grievances and appeals as part of their QA/PI programs. VIBHS tracked and trended grievances by year and domain.

### **Opportunities for improvement**

Six MHOs did not fully meet the requirements for notice of action language and format. The MHOs did not provide notices of action in the prevalent non-English languages of their areas and/or inform enrollees that the notices are available in alternative formats and/or non-English languages.

Several MHOs received recommendations related to the timing of notices of action. They need to develop a process for monitoring the timing of notices and authorizations delegated to their contracted agencies. The MHOs also need to ensure that their policies address all required elements, including exceptions to the advance notice requirements.

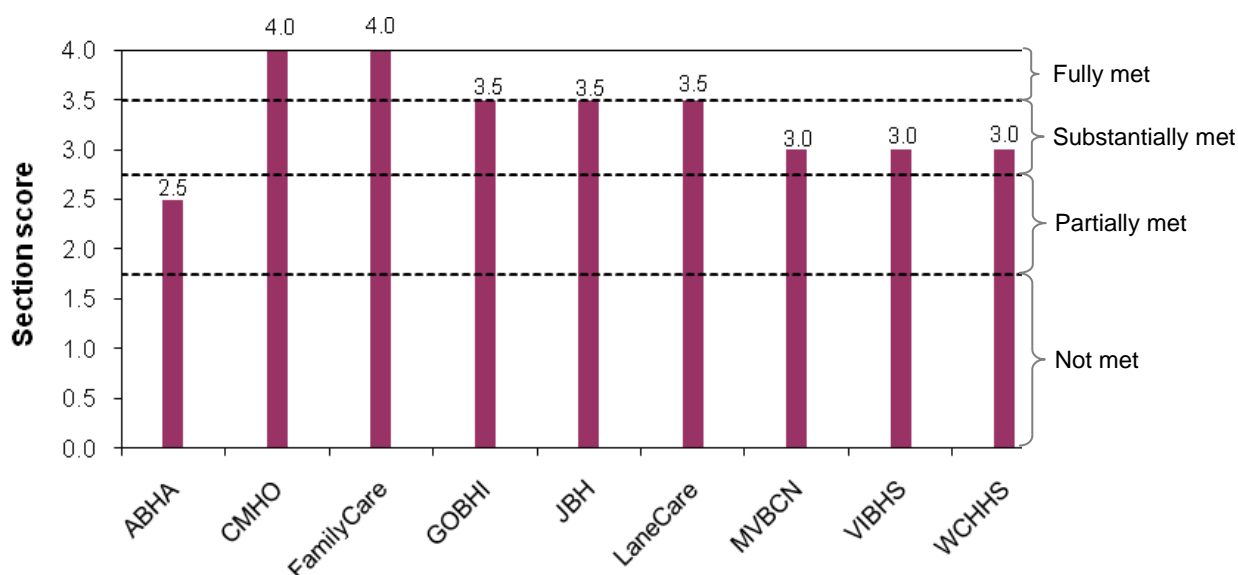
Five MHOs lacked a process to adequately monitor and track the notification process for all notices of action.

## Section 10: Program Integrity

This section of the compliance protocol is designed to assess the extent to which the MHO has in place administrative and management arrangements or procedures, including a compliance plan, designed to guard against fraud and abuse.

The 2005 federal Deficit Reduction Act created new requirements for managed care plans regarding program integrity. AMH added these new criteria to the compliance review in 2008 in the Program Integrity section. Because this is the first review period to include this section, there are no previous scores with which to compare 2008 scores.

Figure 11 shows that most MHOs fully or substantially met the standards.



**Figure 11. MHO compliance scores: Program Integrity.**

Most MHOs' administrative infrastructures and management arrangements and procedures are aligned to guard against fraud and abuse.

The MHOs stated their commitment to federal and state standards in their fraud and abuse policies. Some clearly stated in their compliance plans their commitment to preventing, detecting, and addressing fraud and abuse.

FamilyCare and CMHO fully met all the criteria for this section. FamilyCare, CMHO, and LaneCare adopted compliance plans that included the required criteria.

CMHO and FamilyCare have comprehensive compliance plans that go beyond the requirements of the Deficit Reduction and False Claims Acts to include compliance with applicable federal and state laws and MHO contract provisions. The plans clearly communicate the compliance officer's responsibility to spearhead the MHO's compliance efforts.

CMHO and FamilyCare trained compliance officers who provide fraud and abuse education to staff and providers.

### **Opportunities for improvement**

Four MHOs did not have formal compliance plans. Two other MHOs had plans, but they had not been formally approved and adopted by the MHOs' management.

Four MHOs did not provide their compliance officers with the necessary training in fraud and abuse prevention.

## Performance Improvement Projects

All MHOs that serve Medicaid enrollees must conduct two PIPs each year. The PIPs make it possible to assess and improve the processes and, optimally, the outcomes of care. To establish confidence in the reported improvements, a PIP must demonstrate that it results in real improvements in clinical care or enrollee service. PIPs are validated each year as part of the EQR process to ensure that they are designed, conducted, and reported in a methodologically sound way.

Detailed results of Acumentra Health's PIP evaluations for each Oregon MHO appear in individual reports submitted to AMH during 2008–2009. High-level summary results appear below.

In 2008, seven of the nine MHOs submitted mental/physical health collaborative PIPs in partnership with MCOs overseen by DMAP. AMH did not require the MHOs' PIPs to address all standards of the validation protocol. Although some PIPs earned better scores than others, the PIPs on average partially met the criteria for the standards they addressed. As directed by AMH, Acumentra Health did not assign overall scores for these PIPs.

Acumentra Health scored 10 additional non-collaborative PIPs submitted by the MHOs. Some of the PIP topics were clinical and others nonclinical. Of these 10 PIPs, three (two submitted by GOBHI and one by MVBCN) received Fully Met scores, and two (submitted by CMHO and VIBHS) received Substantially Met scores. The remaining PIPs were scored either Partially Met or Minimally Met, largely because of their incomplete status as first-year projects.

### Review procedures

Data collection tools and procedures, adapted from the CMS protocols, involved document review and onsite interviews from March 2008 through January 2009. Acumentra Health evaluated the information collected from each MHO according to the criteria specified in the document titled *Performance Improvement Project Validation*, adapted from the CMS protocol and approved by AMH.

Acumentra Health reviewed the PIPs for the following elements:

- a clear, concise statement of the topic being studied, the specific questions the study is designed to address, and the quantifiable indicators that will answer those questions
- a sampling methodology that yields a representative sample large enough for statistical comparisons (if needed)

- a written project plan with a study design, an analysis plan, and a summary of results
- an analysis plan that addresses project objectives, defines indicators clearly, specifies the population being studied, identifies data sources and the data collection procedure, and discusses analytical methodologies, statistical tests to be performed, and sampling procedures, if applicable
- validation of data at the point of data entry for accuracy and completeness
- when claims or encounter data are used for population-based analysis, assessment of data completeness
- validation rules created in the data entry database to determine whether data were missing or whether data fell within valid parameters
- in the case of data collection that involves a medical chart review, a check on inter-rater reliability
- a clear statement of the improvement strategies, their impact on the study question, and how that impact will be assessed and measured
- a summary of results that covers all data collection and analysis, explaining limitations inherent in the data and discussing whether the strategies resulted in improvements

PIP scoring involves rating the MHOs' performance on as many as 10 standards:

1. Selected study topic is relevant and prioritized
2. Study question is clearly defined
3. Study indicator is objective and measurable
4. Study population is clearly defined and, if a sample is used, appropriate methodology is used
5. Data collection process ensures valid and reliable data
6. Improvement strategy is designed to change performance based on the quality indicator
7. Data are analyzed and results interpreted according to generally accepted methods
8. Reported improvement represents actual change
9. MHO has documented additional or ongoing interventions or modifications
10. MHO has sustained the documented improvement

Each standard has a potential score of 100 points for full compliance. The total points earned for each standard are weighted and combined to determine the MHO's overall performance score for the specific PIP.

Typically, the overall PIP scoring is weighted 80 percent for demonstrable improvement in a project's first year (Standards 1–8) and 20 percent for sustained improvement in later years (Standards 9–10). Thus, for first-year PIPs, the highest achievable overall score is 80 points; for second-year or ongoing PIPs, the maximum PIP score is 100 if the MHO has completed multiple remeasurements, making it possible to assess sustained improvement. For PIPs rated on the 100-point scale, Acumentra Health also assesses the validity and reliability of PIP results. Table 3 shows the range of compliance ratings and associated scores.

**Table 3. PIP rating and scoring system.**

<b>Compliance rating</b>	<b>Description</b>	<b>Score on 100-pt scale</b>	<b>Score on 80-pt scale</b>
Fully met	Met or exceeded all criteria	80–100	70–80
Substantially met	Met essential criteria, had minor deficiencies	60–79	55–69
Partially met	Met essential criteria in most, but not all, areas	40–59	40–54
Minimally met	Marginally met criteria	20–39	25–39
Not met	Did not meet essential criteria	0–19	0–24

For the contractually required collaborative mental/physical health integration PIPs, AMH did not require MHOs to report activities pertaining to all review standards in the initial stage of PIP development. Therefore, Acumentra Health scored as many standards as each MHO submitted for review, but did not assign overall scores for these PIPs.

All MHOs except GOBHI and CMHO submitted a collaborative PIP for review in 2008. The MHOs usually, though not always, identified the collaborative PIP as a nonclinical project.

## Review results

Tables 4 and 5 summarize the plan-specific and collaborative PIPs reviewed for each MHO. Table A-1 in Appendix A reports all MHOs' scores by standard.

**Table 4. Plan-specific PIP topics by MHO.**

<b>MHO</b>	<b>PIP topic</b>	<b>Study focus</b>
ABHA	Implementation of Acceptance and Commitment Evidence-Based Practice Model of Care	This PIP seeks to reduce unnecessary hospitalization of enrollees with suicidal ideation. ABHA has adopted a system-wide recovery model of care (Acceptance and Commitment, or ACT) and has provided ACT training and support for all providers and their staffs.
CMHO	Increasing Percentage of Ambulatory Care Appointments Kept Within 7 Days of Psychiatric Hospital Discharge	CMHO implemented several interventions to increase the timeliness of post-discharge appointments. At remeasurement, CMHO reported having increased to 70 percent the proportion of members who received outpatient care within seven days, as well as improving other related processes.
FamilyCare	Community-Based Crisis Intervention	This PIP aims to reduce utilization of acute services for children and adolescents and thereby reduce inpatient costs. The MHO contracted with a community-based service provider to ensure that children and adolescent enrollees receive services at home, in school, and in the community.
GOBHI	Nonclinical PIP: Improving Data Integrity	This project seeks to improve the integrity of clinical records maintained by GOBHI's mental health service providers. Interventions have included a "Data Integrity Boot Camp" and requiring each provider to design and submit a data integrity action plan.

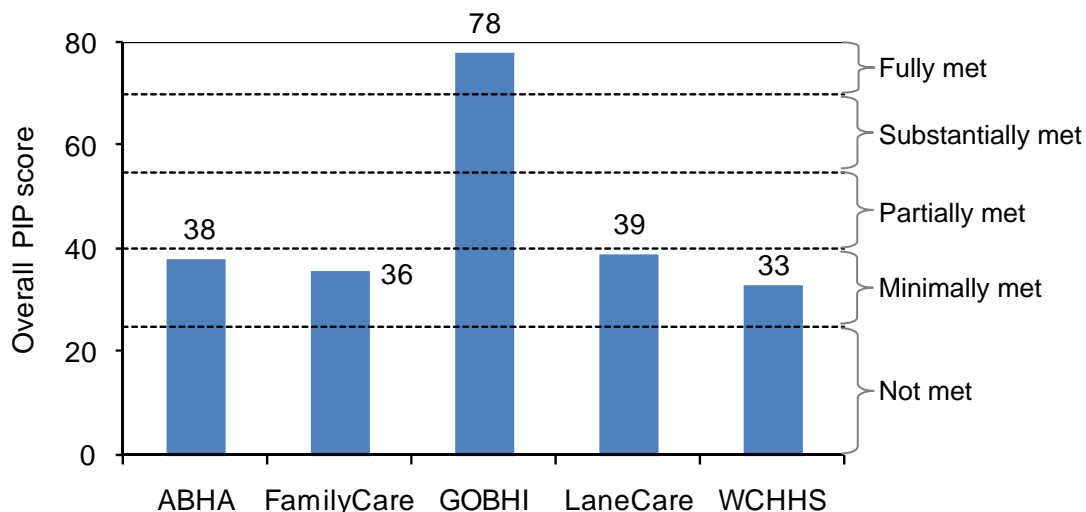
**Table 4. Plan-specific PIP topics by MHO (cont.)**

MHO	PIP topic	Study focus
GOBHI	Clinical PIP: Increasing Services for Children in Child Welfare Custody	The goal of this PIP is to serve a greater proportion of children in the state’s child welfare system, who are at high risk of developing mental health problems. GOBHI has sent targeted information to providers concerning their service penetration rates for this population, expecting that providers will create their own interventions that best suit the needs of their particular locations and service population.
JBH	Dual Diagnosis Treatment Assessment	JBH committed to improving integration and coordination of care for enrollees with dual mental health and substance abuse diagnoses. JBH adapted a fidelity scale for co-occurring disorders (CODs) to measure whether providers were assessing CODs and incorporating the assessments into enrollees’ treatment plans. JBH plans to discontinue this topic next year.
LaneCare	Reducing Hospital Utilization Through Coordination of Enrollee Care	This PIP aims to increase the coordination of enrollee care among staff of the Sacred Heart Hospital psychiatric unit (the Johnson Unit), LaneCare, and the MHO’s contracted outpatient providers, and to reduce enrollee psychiatric admissions and length of stay. LaneCare expects these measures to increase the quality of enrollee care by increasing the availability of beds in the Johnson Unit and reducing the hours an enrollee must wait in the emergency department for a bed in the psychiatric unit.

**Table 4. Plan-specific PIP topics by MHO (cont.).**

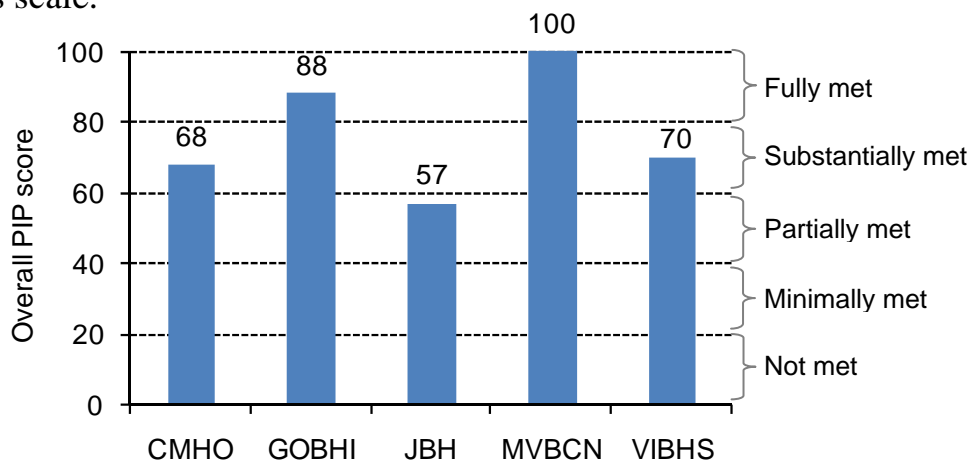
<b>MHO</b>	<b>PIP topic</b>	<b>Study focus</b>
MVBCN	Increasing Access to Intensive, Community-based Treatment Services for Children and Families	This PIP attempts to increase treatment for children in locations other than mental health clinics and other traditional settings. The intervention involves hiring and training new mental health care coordinators and conducting fidelity monitoring to ensure that providers consistently apply the wraparound model of care.
VIBHS	Initiation and Engagement	VIBHS reported that in 2006, 38 percent of all enrollee complaints were related to post-intake appointment access. This PIP tracks changes in the percentage of enrollees who move beyond the initial phase of treatment. Interventions include adding measures of initiation and engagement (I&E) to provider contracts, creating a plan for the MHO's QI staff to visit provider agencies, and tracking quarterly results of the I&E measures.
WCHHS	Improving Procedures for Authorization of Clinical Services	This PIP focuses on changing the process of authorizing clinical treatment for WCHHS's Medicaid population. The MHO seeks to determine whether delegating preauthorization to its contracted providers will improve the rate of appropriate service authorizations and save administrative costs for the MHO and for providers.

Figure 12 shows MHO scores on the plan-specific PIPs (some clinical, some nonclinical) that were rated on the 80-point scale in 2008. Because none of these projects had progressed to a second remeasurement, it was not possible to gauge sustained improvement. However, GOBHI’s nonclinical PIP received a Fully Met rating on this scale.



**Figure 12. Overall scores for plan-specific PIPs scored on 80-point scale.**

Figure 13 shows MHO scores on plan-specific PIPs that were rated on the 100-point scale. These studies had progressed to at least two remeasurements, making it possible to assess sustained improvement. MVBCN’s nonclinical PIP received a perfect score, and GOBHI’s clinical PIP also received a Fully Met rating on this scale.

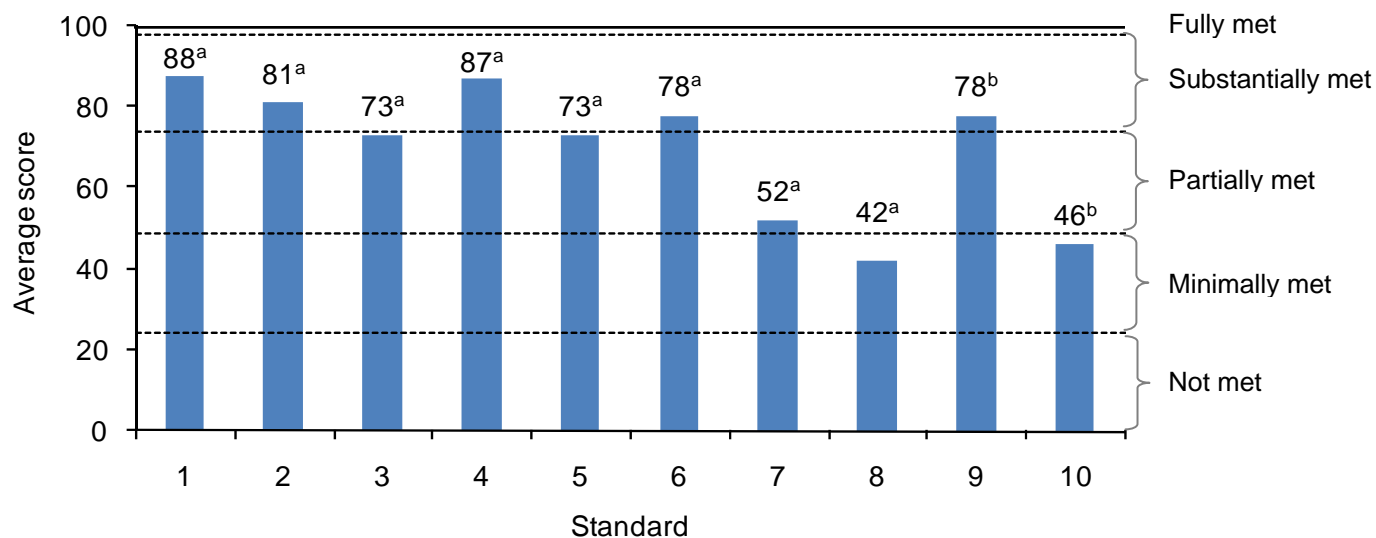


**Figure 13. Overall scores for plan-specific PIPs scored on 100-point scale.**

Figure 14 shows the scores by individual *validation standard* for plan-specific PIPs reviewed in 2008, averaged across MHOs. The standards are defined on page 50.

As a group, the MHOs substantially met the requirements for Standards 1, 2, 4, and 6, related to demonstrating the relevance and priority of the study topic, defining the study question, defining the study population, and describing the PIP intervention, respectively. The MHOs only partially met Standard 3, defining the study indicators, and Standard 5, describing the data collection and analysis plan. As some PIPs reviewed in 2008 were first-year projects, the scores on Standards 3 and 5 in part reflect difficulty in defining technical aspects of measurement and analysis in the initial stages of PIP development. The average scores on Standards 7 and 8 reflect the incomplete status of many PIPs this year.

Only four PIPs had progressed far enough to be scored on Standards 9 and 10. As a group, these MHOs substantially met Standard 9, related to documenting additional or ongoing interventions or modifications, but they performed less well on Standard 10, related to demonstrating sustained improvement.



<sup>a</sup> Average of 7 MHOs. <sup>b</sup> Average of 4 MHOs.

**Figure 14. Average scores on plan-specific PIP validation standards.**

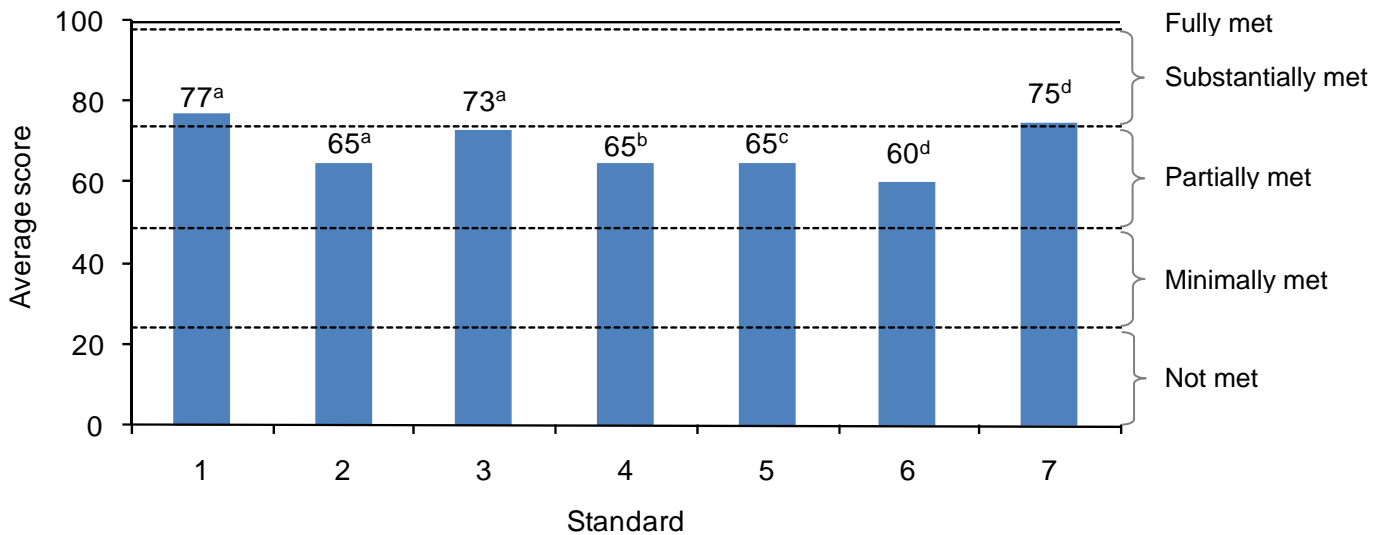
**Table 5. Collaborative PIP topics by MHO.**

MHO/Partners	PIP topic	Study focus
ABHA Central Oregon Independent Health Solutions Deschutes County Chemical Dependency Organization	Effects of Co-Occurring Substance Abuse and Mental Health Problems on Physical Health	The partners collaborated to increase coordination of chemical dependency, mental health, and chronic physical health care services for OHP enrollees in Deschutes County. The project seeks to increase this population’s use of primary care and mental health services by distributing letters informing enrollees about their PCPs, making appointments with PCPs, and available mental health services.
CMHO	None	CMHO did not participate in a mental/physical health collaborative PIP this year.
FamilyCare MHO FamilyCare MCO	Integrated Care Methadone Treatment Care Coordination	This PIP aims to increase coordination of care for enrollees receiving methadone treatment for opioid addiction. An onsite care coordinator works with enrollees to establish relationships with the enrollees’ PCPs, seeking to reduce inappropriate and/or avoidable emergency utilization and hospitalization.
GOBHI	None	GOBHI did not participate in a mental/physical health collaborative PIP this year.
JBH CareOregon Cascade Comprehensive Care 6 other health plans	Standardized Referral Process	This PIP seeks to improve the process by which PCPs refer Medicaid enrollees to mental health services. The partners have assessed baseline PCP satisfaction with the referral process, designed a standardized referral process based on this feedback, and prepared to implement the process.

**Table 5. Collaborative PIP topics by MHO (cont.).**

<b>MHO/Partners</b>	<b>PIP topic</b>	<b>Study focus</b>
LaneCare Lane Independent Physician Association Hayden Family Dentistry ODS	Improving Coordination of Mental, Physical, and Dental Healthcare	This PIP seeks to improve coordination of care through systematic healthcare referrals across mental, medical, and dental health plans. The partners expect that improved coordination of care across these systems will improve health outcomes for Lane County OHP enrollees.
MVBCN Marion-Polk Community Health Plan	Mental and Physical Health – Chronic Pain Consultation and Stabilization Service	The partners seek to improve treatment for enrollees with chronic pain and co-morbid addiction and mental health conditions. As their primary intervention, the partners opened a pain clinic in June 2008, aimed at shifting the focus of care from physician-centered services to self-care in the community.
VIBHS LifeWorks NW Cascadia Behavioral Healthcare System CareOregon Kaiser Permanente	Increasing Coordination and Integration of Medical and Mental Health Services	This PIP seeks to provide coordinated and integrated mental and primary health care for VIBHS enrollees, particularly those with serious and persistent mental illnesses (SPMI). VIBHS placed a registered nurse in selected mental health facilities that serve a large number of people with SPMI, to screen enrollees for physical health risks, determine which enrollees lack a PCP, and coordinate enrollee care.
WCHHS Tuality Health Alliance Providence Health Assurance	Improving Exchange of Clinical Documentation Between Mental Health and Primary Care Providers	This PIP focuses on integrating physical and mental health care by improving communication across systems through more consistent exchange of clinical documentation. At the time of the PIP evaluation, the partners had not designed an intervention.

AMH did not require the MHOs’ collaborative PIPs to address all standards of the validation protocol in 2008. Of the seven MHOs that submitted collaborative PIPs for review, all addressed the first three standards; five MHOs addressed the first four standards; three MHOs addressed the first five standards; and one MHO addressed Standards 1–7. Figure 15 shows the average scores by standard. (For definitions of the standards, see page 50).



<sup>a</sup> Average of 7 MHOs. <sup>b</sup> Average of 5 MHOs. <sup>c</sup> Average of 3 MHOs. <sup>d</sup> Represents 1 MHO.

**Figure 15. Average scores on collaborative PIP validation standards.**

## PIP highlights and recommendations

Two themes emerged from Acumentra Health's review of PIP best practices.

### **1. Among the most promising PIP interventions were those that involved giving additional support to provider agencies.**

#### A. Adding care coordinator(s) to staff

- FamilyCare: Hired an onsite care coordinator to work with methadone-assisted treatment participants to establish relationships between enrollees and their medical PCPs and mental health providers.
- LaneCare: Measured the coordination of care between its hospital psychiatric unit and outpatient follow-up treatment. Results of this study motivated the MHO to hire a care coordinator with the sole responsibility of coordinating care for psychiatrically hospitalized enrollees.
- MVBCN: Hired new mental healthcare coordinators to increase the availability and quality of intensive home and community-based services so that children can receive mental health treatment services in the least restrictive environments possible.
- VIBHS: Placed a registered nurse in selected mental health facilities that served large number of enrollees with SPMI to screen for health risks and coordinate enrollee care between physical and mental health care clinics.

#### B. Provider training

- ABHA: Adopted system-wide recovery model of care (Acceptance and Commitment, or ACT) for enrollees with suicidal ideation. Since June 2007, all ABHA providers and their staffs have received ACT training and continuing support, with the goal of reducing unnecessary hospitalization of enrollees with suicidal ideation.
- GOBHI: Sent targeted information to providers concerning their service penetration rates for children in state custody, and encouraged providers to create their own interventions that best suit the needs of their particular locations and enrollee population.
- VIBHS: Added measures of initiation and engagement to its outpatient provider contracts, reviewed these measures with providers quarterly, and developed provider improvement plans as indicated.

- C. Assuring confidence in implementing the intervention (e.g., checking medical charts for evidence that training is executed) and/or consistency in applying interventions (e.g., delivery of wraparound services)
- GOBHI: Required each provider group to submit a data integrity action plan with objective, measurable steps to improve data integrity, and required clinical supervisors to attend “Data Integrity Boot Camp” in 2007. GOBHI went back into the charts in 2008 to see whether the improvement was sustainable.
  - MVBCN: Conducted fidelity monitoring to ensure that providers consistently applied the wraparound model of care.

## **2. MHOs need to do the necessary initial preparation (barrier analysis, examination of system and system data) to achieve performance improvement.**

Successful PIPs have a common foundation. The CMS protocol, *Validating Performance Improvement Projects*, emphasizes that the most meaningful and long-lasting improvements in care come from a careful analysis of system challenges and barriers and from implementing interventions designed to meet those barriers. Several MHOs conducted analysis of their systems and barriers before designing an intervention strategy, enabling them to identify the most critical point at which to intervene to make lasting changes.

The Standardized Referral Process or Mind-Body Connection PIP (JBH and partners) presents a good example of proactive system analysis. The PIP partners conducted a thorough needs assessment before developing their intervention strategy, taking the necessary steps to identify existing barriers.

The assessment survey developed by JBH measured PCPs’ current satisfaction levels and identified barriers to the referral process. Armed with the survey responses, the partners developed an intervention strategy to address the PCPs’ needs directly. The measure the partners used to identify the system barriers (PCP satisfaction) became the primary study indicator. The intervention strategy was refined by input from all partners.

The following steps can guide MHOs in selecting PIP topics and intervention strategies that are likely to result in long-lasting and meaningful improvement.

1. In formulating the study topic:
  - a. Conduct analysis to identify system challenges and barriers to optimal performance.

- b. Consult with multiple stakeholders (e.g., enrollees and their families, agency directors, medical staff and directors, community members) to identify issues with widespread impact and obtain stakeholder buy-in.
    - c. Examine local data to confirm that the identified issue is relevant to the local healthcare system or population
  2. Develop data collection and verification procedures and an *a priori* data analysis plan. The MHO should document
    - a. critical data elements (e.g., specific service codes, presence/absence of test results)
    - b. whether data were collected manually, using a form, or electronically by query (attaching the form or query for review is a best practice)
    - c. staff training required
    - d. data verification procedures to ensure that data are accurate and reliable; e.g., comparing two different data sources (claims to chart, or state to plan-level data) or reviewing a sample for outliers and/or missing data
    - e. a precise statistical test (e.g., a chi-square test) and probability level (e.g.,  $p < .05$  or  $p < .10$ ) for each comparison
    - f. study time frames, specifying the beginning and end of three study periods: baseline, intervention, and remeasurement
  3. Design an intervention strategy to address the specific challenges and barriers identified through the system analysis. Supporting information may come from literature reviews, best-practice guidelines, and/or surveys of enrollees, practitioners, or other stakeholders.
  4. Pursue consistent remeasurement of the study indicators, perform appropriate statistical tests to assess the degree of sustained improvement due to the intervention(s), identify barriers to improvement, and modify the intervention(s) accordingly.

## Performance Measure Validation and ISCA Follow-Up

For review years 2006–2008, AMH defined statewide performance measures for MHOs, calculated the measures using data that the MHOs reported to DMAP, and reported the results in a quarterly utilization report. The four statewide performance measures are:

- acute hospital admissions per 1,000 members enrolled
- percentage of enrollees rehospitalized within 30 days of discharge from acute care
- percentage of enrollees rehospitalized within 180 days of discharge from acute care
- percentage of enrollees seen on an outpatient basis within 7 days of discharge from acute care

The first and fourth measures are similar to national measures produced for the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>).

Acumentra Health conducts an annual review of the performance measure process as part of EQR activities. During July 2008, Acumentra Health reassessed the completeness and accuracy of AMH's performance measures, seeking to answer these questions:

1. Are the performance measures based on complete data?
2. How valid are the performance measures? Do they measure what they are intended to measure?
3. How reliable are the performance measure data? Are the results reproducible?
4. Can AMH and the MHOs use the *OHP Mental Health Utilization Quarterly Report* to monitor their performance over time and to compare their performance with that of other health plans in Oregon and in other states?

In the onsite interview with Acumentra Health, AMH staff noted that the division was working with the MHOs to define new performance measures that will be more useful in evaluating the MHOs' quality assurance and performance improvement processes. By involving the MHOs in the revision of performance measures, AMH hopes to instill a sense of ownership that is likely to increase MHOs' investment in monitoring and improving their performance.

---

<sup>5</sup> HEDIS is a registered trademark of the National Committee for Quality Assurance.

A key feature of a valid performance measure is that it can be used to monitor the performance over time of health plans providing similar services, both within the state and nationally. AMH compares and communicates MHO performance through a utilization report, called the *OHP Mental Health Utilization Quarterly Report*. However, AMH did not publish this report quarterly.

The Information Systems Capabilities Assessment (ISCA), conducted in 2007, evaluated the extent to which the state's information systems for collecting, processing, and analyzing claims/encounter data support the production and reporting of valid and reliable performance measures.<sup>6</sup> Acumentra Health also conducted an ISCA for each MHO. During 2008, Acumentra Health conducted follow-up interviews with AMH and the MHOs to assess their response to previous ISCA recommendations.

## Review procedures

The performance measure validation process, adapted from the CMS protocol for this activity,<sup>7</sup> included the following steps.

1. Acumentra Health requested relevant documents from AMH and DMAP in advance of onsite interviews.
2. Acumentra Health used the documents supplied by AMH and DMAP to refine the questions to be asked at the onsite interviews.
3. Acumentra Health used the oral responses and written materials to assign compliance ratings for each performance measure.

The compliance ratings, also adapted from the CMS protocol, were:

**Fully compliant**—Measure was complete as reported, accurate, and could be interpreted easily by the casual reader.

**Substantially compliant**—Measure was complete as reported, accurate, and had only minor points in calculation that did not significantly hamper the ability of the reader to understand the reported rate.

**Partially compliant**—Measure either was complete as reported or was accurate, but not both, and had deficiencies in calculation that could hamper

---

<sup>6</sup> Acumentra Health. *AMH Performance Measure Validation 2007*. March 2007.

<sup>7</sup> U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Validating Performance Measures. Final Protocol, Version 1.0*. May 1, 2002.

the reader's ability to understand the reported rates.

**Not valid**—Measure either was incomplete as reported or was inaccurate.

**Not applicable**—Measure was not reported because no Medicaid enrollees qualified for the denominator.

Procedures for the 2007 state-level ISCA and MHO reviews were adapted from CMS protocol.<sup>8</sup> Acumentra Health scored compliance with federal standards for each individual element of the ISCA on a range from 1 to 5:

4.5 to 5.0 = Fully met	1.5 to 2.4 = Minimally met
3.5 to 4.4 = Substantially met	<1.5 = Not met
2.5 to 3.4 = Partially met	

After scoring the individual elements, Acumentra Health combined the scores and used a predetermined weighting system to calculate a weighted average score for each major section of the ISCA.

## Performance measure completeness and accuracy

This review sought to determine whether the data used to calculate each performance measure were complete and accurate and whether the calculation adhered to CMS specifications.

The 2006 review noted deficiencies related to how AMH's quarterly utilization report explained the calculation of the measures and the limitations of the reported data. In addition, AMH lacked thorough internal documentation of the production process, including the flow of data used in calculating the measures and the steps for ensuring accuracy and completeness. In 2007, the follow-up review found that AMH had improved many aspects of its analytic and reporting processes, but the performance measures still complied only partially with CMS requirements.

The 2008 onsite review yielded some verbal clarification with regard to the performance measures. However, AMH has submitted no formal revisions that address previous recommendations. Consequently, the measures remain only partially compliant in 2008, as in the previous two years. Table 6 summarizes the validation ratings.

---

<sup>8</sup>

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Appendix Z: Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans*. Final Protocol, Version 1.0. May 1, 2002.

**Table 6. Performance measure validation ratings, 2008.**

<b>Performance measure</b>	<b>Definition</b>	<b>Rating</b>
Acute hospital admissions/ 1,000 members	Number of admissions in time period/ (enrollees for time period/1000)	Partially compliant
Percent of eligibles readmitted to acute care within 30 days	Number of admissions for those discharged within previous 30 days during time period/ total discharges for the time period	Partially compliant
Percent of eligibles readmitted to acute care within 180 days	Number of admissions for those discharged within previous 180 days during time period/ total discharges for the time period	Partially compliant
Percent of eligibles seen within 7 days of discharge from acute care	Number of eligibles seen in outpatient setting within 7 days of discharge from acute care for the time period/ total discharges for the time period	Partially compliant

Acumentra Health reviewed the most recent *OHP Mental Health Utilization Quarterly Report*, dated October 2008, which presented performance measure data from April 1, 2007, through March 31, 2008. The lack of specificity regarding the measure calculations and the absence of narrative interpreting the results continue to limit the utility of this report for communicating MHO performance.

The following items summarize the strengths of the current system for producing mental health performance measures, opportunities for improving the system, and Acumentra Health's recommendations.

### **Strengths**

- The state has in place a formal, rigorous process to validate the completeness of encounter data submitted by MHOs, including the following steps.
  - After receiving and processing MHO encounter data, the Electronic Encounter Data Unit returns a report to the originator on the number of claims processed (including pended, duplicate, rejected, and unfound claims) and the total dollar value of claims.
  - The Actuarial Services Unit reports all accepted mental health claims for capitated services back to the MHOs quarterly for reconciliation, giving the MHO another opportunity to examine and verify the claims detail.

- AMH provides information on billed charges for encounters to the MHOs monthly, enabling the MHOs to identify large gaps in the data.
- The *OHP Mental Health Utilization Quarterly Report* partially defines all four measures with a numerator and denominator statement. An appendix lists the diagnosis and procedure codes used in calculating the measures.
- The report's executive summary defines the study population in terms of Medicaid eligibility, enrollment, receipt of mental health services, and admission for acute care.
- The executive summary identifies some limitations of the report, including
  - the absence of statistical significance testing of apparent differences among providers or across time periods
  - the 180-day interval between service delivery and when the service is contractually required to be billed
  - that the hospitalization data include transfers between facilities and readmissions within a 24-hour time frame (see second bullet under "Opportunities for improvement" below)

### **Opportunities for improvement**

- Several shortcomings of the AMH performance measures raise issues of comparability with similar widely accepted measures, such as HEDIS<sup>®</sup>.
  - Unlike similar measures, the AMH performance measure definitions do not include a continuous enrollment criterion for the study population. As a result, the AMH measures are not comparable with similar measures that use that criterion. AMH's quarterly utilization report does not address this.
  - The AMH performance measure definitions are imprecise about the circumstances in which enrollee transfers and readmissions may be counted as separate admissions (or episodes of care). The imprecise definition of an admission makes several of the performance measures difficult to interpret and compare with similar measures.
- Although AMH stated in the interview that it had developed a written process for quality control (defining staff responsibilities for analyzing data, creating reports, and writing program codes), AMH did not provide this document during the 2008 review.
- AMH lacks automated mental health-specific edits and audits to serve as logic checks for the encounter data received from DMAP—for example, to

ensure that diagnostic codes are assigned to appropriate age groups. AMH only checks for gross variations in the number of encounters submitted.

- AMH lacks a system for validating the encounter data submitted by MHOs and for resolving problems with accuracy and completeness.
- Although AMH has agreed to refine the quarterly report narrative to describe the study parameters and limitations more fully, AMH has not produced a report with the recommended revisions.

### **Recommendations**

- AMH's quarterly report should specify that the performance measures do not include a requirement for continuous enrollment in the study population, and thus are not directly comparable with similar measures.
- AMH needs to define hospital admissions and readmissions more precisely in terms of the circumstances in which a transfer or readmission may be counted as a separate admission for the same enrollee. AMH may wish to consult the HEDIS<sup>®</sup> technical specifications with regard to defining inclusion and exclusion criteria for counting admissions and discharges.
- AMH needs to develop and implement a formal process for applying mental health-specific edits and audits of encounter data received from DMAP.
- AMH needs to establish a system for validating MHO data submissions to ensure accuracy and completeness and for following up with MHOs to resolve problems. As an alternative, AMH could contract with an external auditor for an annual audit of MHO data submissions.
- For purposes of comparing performance among MHOs and with similar national measures or benchmarks, the quarterly report needs to explain the performance measure definitions and calculations more thoroughly to help readers assess the reported data. AMH should clearly define the numerators and denominators of the performance measures. The report's executive summary should define the study population and the data limitations, stating why AMH does not perform statistical analyses among providers and across time periods and/or where this information can be found.

Table 7 shows the 2008 status of recommendations presented in previous EQR reports for improving the accuracy and completeness of AMH's statewide performance measures.

**Table 7. Update of recommendations for improving statewide performance measures.**

2005 recommendation	2006 status	2007 status	2008 update
<p>Each measure should have a numerator and denominator statement that fully defines the population being measured, data sources used, and fields used to determine inclusion in the numerator and denominator.</p>	<p>The quarterly utilization report does not define numerators and denominators or explain the calculation of the measures. The report provides a list of diagnostic and procedure codes but does not specify which codes are used in calculating each measure.</p>	<p>The report lists a numerator and denominator for each measure, and it provides a list of codes used in calculating the measures. However, the report does not adequately define inclusions, exclusions, and data sources for each measure.</p>	<p>The report lists a numerator and denominator for each measure, but the descriptions are imprecise (e.g., unique enrolled per 1,000 members), and no formula is provided for the measures, such as:</p> $\frac{\text{Total admissions}}{\text{Unique enrollees} \div 1,000}$
<p>Analyze dually enrolled MHO members (those enrolled in both Medicaid and Medicare) separately or remove them from the total population.</p>	<p>Data in the report still include dually enrolled members. AMH has agreed to note this in future reports.</p>	<p>The executive summary notes that the report includes dual-eligible enrollees, but it defines such enrollees as those receiving mental health services and alcohol or drug treatment, rather than as those eligible for both Medicaid and Medicare.</p>	<p>AMH needs to note in its report whether the population includes enrollees dually enrolled in Medicare and Medicaid.</p>
<p>Remove ineligible enrollees (e.g., those who have died or been disenrolled) from the denominator of the readmission and outpatient care measures, or report an estimate of the potential impact—for example, the death rate.</p>	<p>Enrollment data may include deceased or disenrolled members. AMH has agreed to note this in future reports.</p>	<p>The report does not address this limitation of the data.</p>	<p>The report still does not address this limitation.</p>

**Table 7. Update of recommendations for improving statewide performance measures (cont.).**

<b>2005 recommendation</b>	<b>2006 status</b>	<b>2007 status</b>	<b>2008 update</b>
Document the entire process for producing performance measures—importing data, building tables, creating reports, archiving data, data sources, edit and validation routines, and parties responsible for each part of the process.	AMH has documented its in-house analytic plan but needs to develop written procedures describing the entire process of performance measure production.	AMH stated that it has a written process for quality control, defining staff responsibilities for analyzing data, creating reports, and writing program codes, but AMH did not provide this document for review.	AMH has not yet provided this document for review.
Incorporate a standard process for version control of programs used for generating reports. This would ensure that the correct version is in use and would enable AMH to revert quickly to a previous version.	AMH has documented its process for pulling data and which programs are used to analyze the data, but the documentation does not specify which versions of the programs are used.	No version control exists yet for SPSS and Access programs or for queries used to generate reports.	AMH uses a manual method of version control for SPSS and Access files.
Standardize the information contained in encounter data submissions from the MHOs. Monitor and enforce compliance with the standards.	AMH has not established standards for the number of diagnoses accepted or required in encounter data submissions from MHOs. Although this does not affect the validity of the performance measures, a requirement to include multiple diagnosis codes, if applicable, would provide more information on enrollees' conditions and enable a more comprehensive review of service utilization.	No change.	No change.

## DMAP/AMH information systems

For review years 2006–2008, DMAP used an encrypted system of web-based electronic mailboxes, similar to a virtual private network, to ensure HIPAA-compliant transfer of encounter and claims data. DMAP also used the Decision Support Surveillance and Utilization Review System (DSSURS), an Oracle database warehouse based in Atlanta, GA. DSSURS offers an enhanced query builder interface for extracting performance measure data and enables AMH analysts to extract data by entering Standard Query Language (SQL) code, as specified in the state’s MHO Utilization Process document.

In December 2008, DHS implemented a new Medicaid Management Information System (MMIS), replacing the legacy MMIS that was more than 30 years old. For the 2008 ISCA, Acumentra Health reviewed the legacy system. Under that system, MHOs and third-party billers submitted electronic encounter and claims data in the HIPAA-compliant ANSI X12 837 format to the MMIS server, located at the State Data Center (SDC) in Salem. Out-of-network and fee-for-service providers may send paper claims to the Electronic Data Management System in Salem; these claims are optically scanned, converted to the “837” format, and transferred to the MMIS through a Secure File Transfer Protocol (SFTP) connection. Encounter and claims data are validated daily by a UNIX translator and are sent by weekly batch to DSSURS through a dedicated T-1 line using SFTP.

AMH analysts use a proprietary query tool for access to DSSURS data and a documented standard procedure to extract data for the *OHP Mental Health Utilization Quarterly Report*. Because these data are continuously updated, analysts use a “snapshot” extract to generate reports. These snapshot files are saved on a secure shared drive at the SDC and are backed up along with network data. Tape backups of the network data are stored offsite at Iron Mountain facilities.

The 2007 ISCA revealed that the state substantially met the federal standards for data processing procedures and personnel to support the production of performance measures. However, the state only partially or minimally met the data acquisition standards related to ensuring the validity and timeliness of encounter and claims data and to producing performance measure reports.

Table 8 summarizes the 2007 ISCA section scores and ratings.

**Table 8. Weighted average scores and ratings on ISCA sections, 2007.**

<b>Review section</b>	<b>Score</b>	<b>Compliance rating</b>
<b>Data processing procedures and personnel</b>		
Data processing procedures and personnel	4.1	Substantially met
Staffing	4.3	Substantially met
Hardware systems	4.3	Substantially met
Security of data processing	4.3	Substantially met
<b>Data acquisition capabilities</b>		
Administrative data	3.4	Partially met
File consolidation	3.5	Substantially met
Performance measure repository structure	1.5	Minimally met
Report production	2.4	Minimally met

The 2007 ISCA also showed that AMH needed to ensure the validity and timeliness of the encounter and claims data used in calculating performance measures, by implementing best practices that 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
- periodic audits (internal and external) of randomly selected records to ensure data integrity and validity
- online capabilities for viewing and correcting pending claims and encounters to reduce processing lags
- five to seven years of historical data available online

For the 2008 ISCA follow-up, Acumentra Health reassessed issues associated with the legacy MMIS.

**2008 update:** AMH does not perform automated mental health-specific edits and audits of encounter data received from DMAP—for example, to ensure that diagnostic codes are assigned to appropriate age groups. As was the case in 2007, AMH only checks these data for gross variations in the number of encounters submitted. AMH uses a visual process to spot errors and may run cross-tabs of diagnostic codes and ages to check for problems.

AMH has no written policies and procedures for maintaining its performance measure data repository to streamline the association of data from different sources and periods for trend analysis, and to allow for quality-control checks or periodic audits of performance measure data.

The following items summarize the strengths of the state's information systems, opportunities for improvement, and Acumentra Health's recommendations.

### **Strengths**

- DHS implemented a new MMIS in December 2008, replacing the old MMIS that was more than 30 years old. Adequate hardware and software are in place to support the MMIS, including maintenance and timely replacement of equipment, disaster recovery procedures, adequate training for staff, and a secure computing environment.
- AMH saves “snapshots” of the data used to generate performance measure reports so that measures for previous reporting periods can be recreated.
- Once the MHOs have submitted encounter and claims data to the state, DMAP sends a report back to the MHOs noting the number of claims and dollar amounts. This system enables each MHO to verify that the state has received all data submitted by the MHO and to reconcile discrepancies.

### **Opportunities for improvement**

- The high-level documentation describing the flow of data from the mental health encounter to the performance measure report omits important details about data validation and processing and staff responsibilities.
- AMH has no written policies and procedures for maintaining its performance measure data repository—for example, to define how data snapshots occur.

### **Recommendations**

- DMAP needs to continue to improve its documentation to provide more specific details about the flow of data from the mental health encounter to the performance measure report.
- AMH needs to develop written policies and procedures for maintaining its performance measure data repository, including an explanation of how data snapshots occur.

**NOTE:** Although a thorough evaluation of the newly implemented MMIS is outside the scope of the 2008 ISCA follow-up, Acumentra Health has identified several potentially serious issues resulting from the state's transition to the new MMIS in December 2008.

1. Claims processing issues associated with the new MMIS left MHOs and providers unable to submit electronic claims or to verify OHP enrollee eligibility. The state needs to remedy these issues quickly or risk being unable to reconcile the weekly/monthly capitation with daily/monthly OHP enrollment. The state also risks being unable to collect valid data for generating performance measures and for supporting development of the MHOs' PIPs.
2. The new MMIS allows providers to use only DMAP's "legacy" numbers to identify the provider and the payer in billing for Medicaid reimbursement. HIPAA requires covered entities to use the approved National Provider Identifier numbers to identify providers on covered transactions that call for provider identifiers. Transactions that require the use of legacy identifiers to transmit provider information are noncompliant with HIPAA.

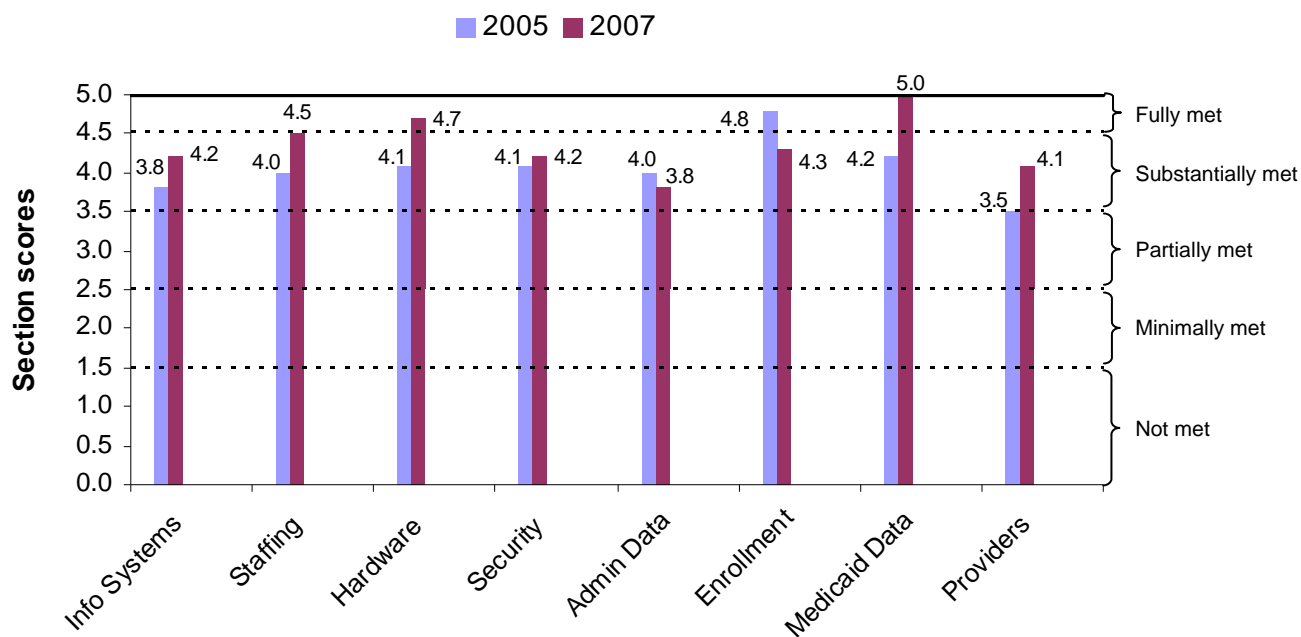
The 2009 ISCA will analyze these issues and the state's response in greater detail.

## MHO information systems

During review years 2006–2008, the state continued its transition to a new HIPAA-compliant system of data administration, converting to the use of nationally standardized codes and the “837” data format. By 2007, the MHOs generally had resolved their conversion issues internally or by contracting with Performance Health Technology (PH Tech) to administer their data systems.

In 2007, Acumentra Health conducted an ISCA for each MHO through electronic surveys, document review, and onsite interviews with the MHOs and their contracted provider agencies. As a group, the MHOs fully met the CMS standards for hardware systems and for integrating vendor Medicaid data, and they substantially met CMS standards in other areas.

Figure 16 shows the scores by individual section of the ISCA protocol in 2005 and 2007, averaged across the nine MHOs. As shown, the MHOs have improved their compliance with most standards since the baseline assessment in 2005. Appendix B defines the criteria for meeting ISCA standards.



**Figure 16. Average ISCA section scores for nine MHOs, 2005 and 2007.**

In 2008, Acumentra Health conducted follow-up interviews with the MHOs and evaluated documentation to determine the MHOs’ progress in addressing the 2007 ISCA recommendations. The following pages highlight strengths and opportunities for improvement for MHOs in each section of the ISCA review.

## Data Processing Procedures and Personnel

### Strengths

#### *Infrastructure*

- Eight of the nine MHOs or their third-party administrator (TPA) employed robust mid-range machines for processing data.

#### *Programming/Report development*

- Among MHOs that maintained in-house database systems, including commercial systems, each incorporated quality assurance processes for application development and software upgrades.

#### *Security*

- Most MHOs had processes in place to meet HIPAA standards for protecting enrollee, encounter, and claims data from unauthorized access. In a few cases, however, the MHOs used insecure, non-HIPAA-compliant methods to transport encounter data files or backup tapes.
- The majority of the MHOs' contracted providers submitted encounter data electronically in encrypted and/or password-protected files each month.
- All MHOs that maintained in-house database systems had good maintenance contracts in place for hardware and software to ensure timely support.

**Table 9. Opportunities for improvement and recommendations for MHOs:**

#### **Data Processing Procedures and Personnel.**

<b>Opportunity for improvement</b>	<b>2007 recommendation</b>	<b>2008 update</b>
The majority of MHOs do not incorporate version control for reports developed in-house for distribution to contracted providers.	MHOs need to have in place a version control process for all reports distributed to contracted providers.	Several MHOs have implemented a manual method of version control for developing and distributing reports.
One MHO had no standby database server. In the event of a failure, the MHO would have to rebuild the server, creating the potential for delays in reporting data to the state.	As part of disaster recovery preparation, the MHO needs to consider providing more comprehensive hardware redundancy of its production server.	No change.

## Data Acquisition Capabilities

### Strengths

#### *Enrollment*

- With each eligibility update from DMAP, eight of the nine MHOs or their TPA verified eligibility files before incorporating new data into the system or distributing the data to their contracted agencies.

#### *Encounter data*

- Most MHOs could track the history of enrollees with multiple enrollment dates and whether enrollees were dually enrolled in Medicare and Medicaid.
- All MHOs or their TPA had formal documentation for processing claims and encounter data.
- The majority of MHOs or their TPA had instituted multiple checkpoints for validation of encounter data.

#### *Auditing*

- The majority of MHOs or their TPA had a documented process for training claims and billing personnel, which included auditing the performance of new employees to ensure accuracy.

**Table 10. Opportunities for improvement and recommendations for MHOs:**

#### **Data Acquisition Capabilities.**

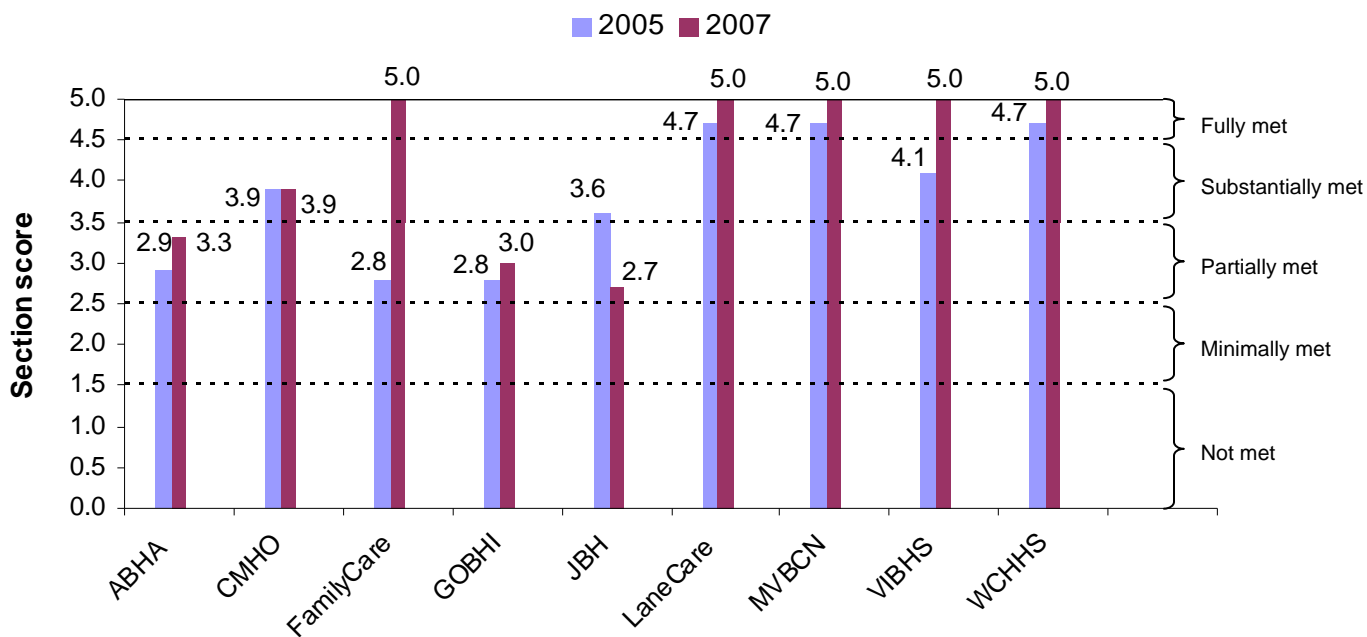
<b>Opportunity for improvement</b>	<b>2007 recommendation</b>	<b>2008 update</b>
Several MHOs had no formal controls in place to ensure that all Medicaid claims from hospitals were entered into the system when Medicare paid fully for mental health services.	MHOs need to have system controls in place to ensure proper accounting for all claims from hospitals.	No change.
Most MHOs exercise inadequate oversight of the contracted agencies' processes for claims and encounter data submission.	MHOs need to audit the encounter data submitted by providers against clinical records regularly to validate the data's accuracy and completeness. MHOs should consider contracting for annual independent audits to ensure adequate controls and checkpoints for integrity of encounter data.	Several MHOs have developed a process for auditing the encounter data submitted by providers against clinical records.

**Information Systems.** This section of the ISCA protocol focuses mainly on the software used to collect, store, and process encounter data. Desirable features of software include ease of use, scalability without degradation of performance with increased data volume, and integration with other software.

LaneCare, MVBCN, VIBHS, and WCHHS contracted with PH Tech as their TPA throughout the review period. The assessment found that PH Tech’s database management system was mature and robust, incorporating good documentation, an effective quality assurance process, and version control. PH Tech’s software packages, including a secure web-based application for updating eligibility status, were scalable and easily integrated with reporting packages. As a result, PH Tech’s client MHOs fully met the CMS requirements for information systems.

FamilyCare, which processed encounter/claims data in-house using commercial software, also fully met CMS requirements. CMHO’s in-house database system substantially met the requirements. By 2007, all MHOs could accept electronic submissions in the “837” format. However, ABHA and JBH were unable to submit accurate, complete encounter data to the state for portions of the review period.

**2008 update:** ABHA, JBH, LaneCare, MVBCN, VIBHS, and WCHHS outsource their claims processing, encounter data submission, and eligibility verification to PH Tech. PH Tech reported no major changes in its information systems in 2008. FamilyCare, GOHBI, and CMHO also reported no major changes.

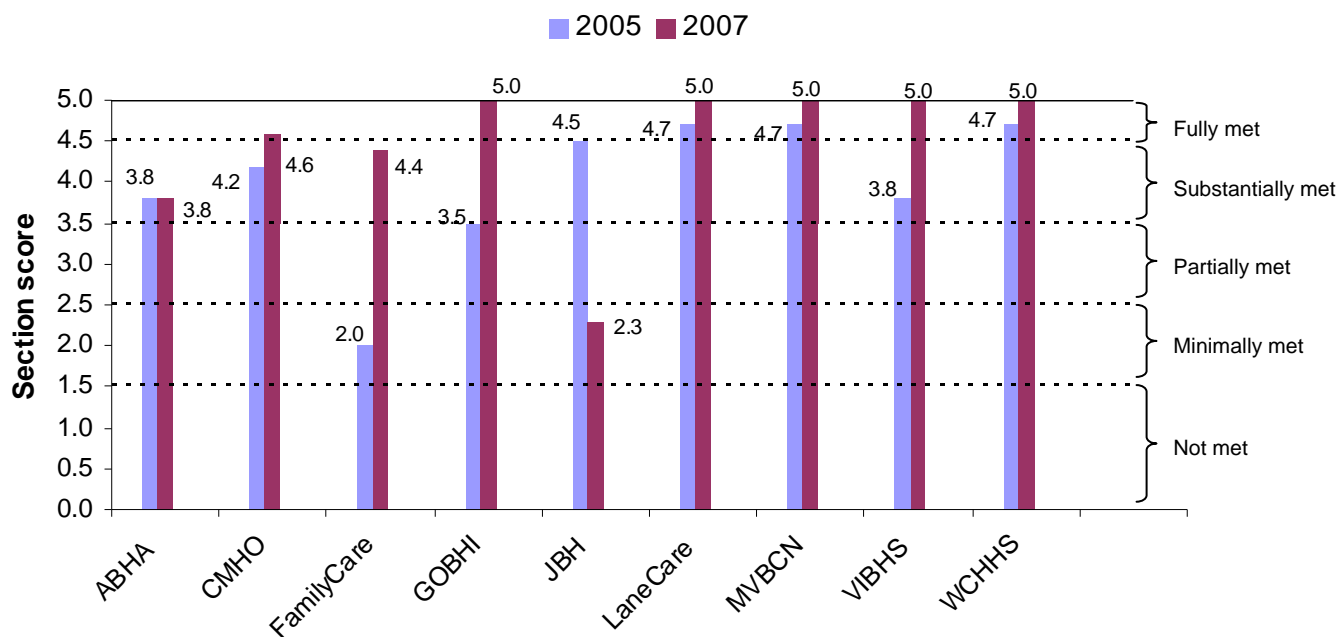


**Figure 17. MHO compliance scores: Information Systems.**

**Staffing.** This section of the protocol applies to the MHO or TPA staff assigned to process encounter and claims data. A “Fully met” score reflects adequate numbers of trained staff for processing accurate, complete, and timely encounter data; a comprehensive, documented training process for new hires and seasoned employees; established and monitored productivity goals for data processing; and low staff turnover.

In 2007, six of the MHOs fully met these criteria, and two others substantially met the criteria. PH Tech, on behalf of its clients, set weekly productivity goals for data accuracy and turnaround time, and provided comprehensive formal training for new hires and refresher training for experienced staff. However, during 2006, JBH had insufficient processing staff to ensure that complete claims and encounter data were reported in a timely manner.

**2008 update:** PH Tech continues to set and monitor productivity goals for data accuracy and turnaround time. JBH has developed a process to ensure reporting of complete claims and encounter data in a timely manner.

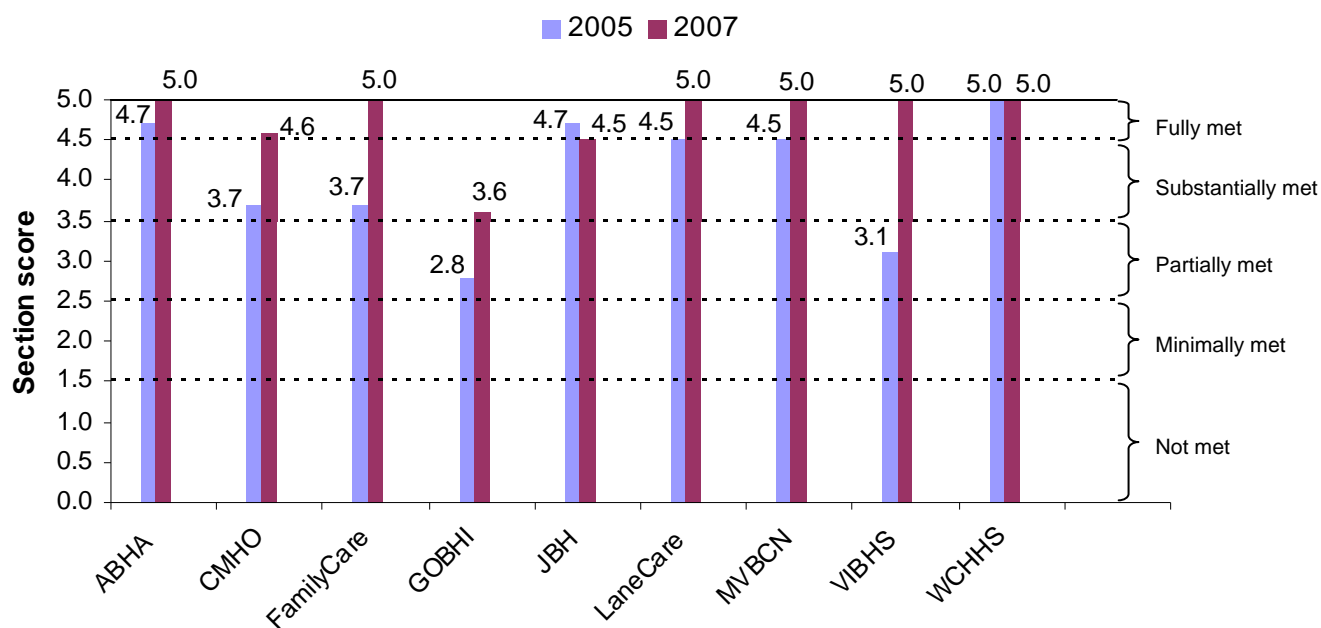


**Figure 18. MHO compliance scores: Staffing.**

**Hardware Systems.** Quality and maintenance of computer equipment and software are important in ensuring the integrity and timeliness of encounter data submitted to the state. Desirable features include robust server equipment; hardware redundancy in terms of data storage devices and other key components; premium hardware maintenance contracts; software maintenance contracts for commercial database systems; and a standby server as a backup to the main production server.

In 2007, all but one MHO fully met these criteria, typically employing robust servers to process and store data, with acceptable levels of redundancy, supported by good maintenance contracts. GOBHI substantially met the criteria but had no standby server for purposes of disaster recovery.

**2008 update:** GOBHI continues to lack comprehensive hardware redundancy for its single production server.

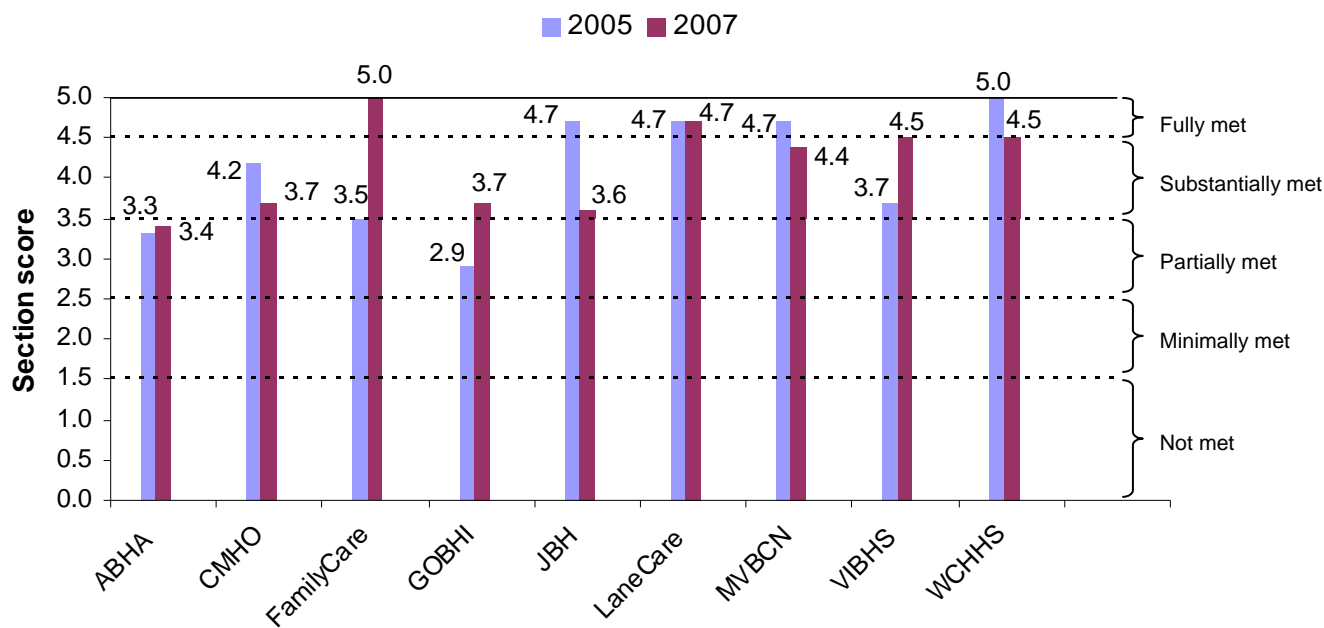


**Figure 19. MHO compliance scores: Hardware Systems.**

**Security of Data Processing.** Acumentra Health evaluated the physical security of each MHO’s data as well as the MHO’s backup systems and methods for protecting the database from corruption.

In 2007, FamilyCare, LaneCare, VIBHS, and WCHHS fully met the CMS criteria, and most other MHOs substantially met requirements. PH Tech, on behalf of its clients, provided good physical security, a documented security policy, good internal controls, and an effective batching procedure. However, at the time of the review, a PH Tech administrative staff person delivered backup tapes to a safe deposit box for storage, a potentially less secure procedure than using a specialized commercial storage facility. In several cases, the MHOs’ contracted providers transported unencrypted backup tapes between facilities or stored backup tapes in insecure locations, raising concerns related to HIPAA standards.

**2008 update:** PH Tech has contracted with a secure offsite storage facility to store backup tapes. Several MHOs are working with their contracted providers to ensure that backup tapes are encrypted and transported in compliance with HIPAA.



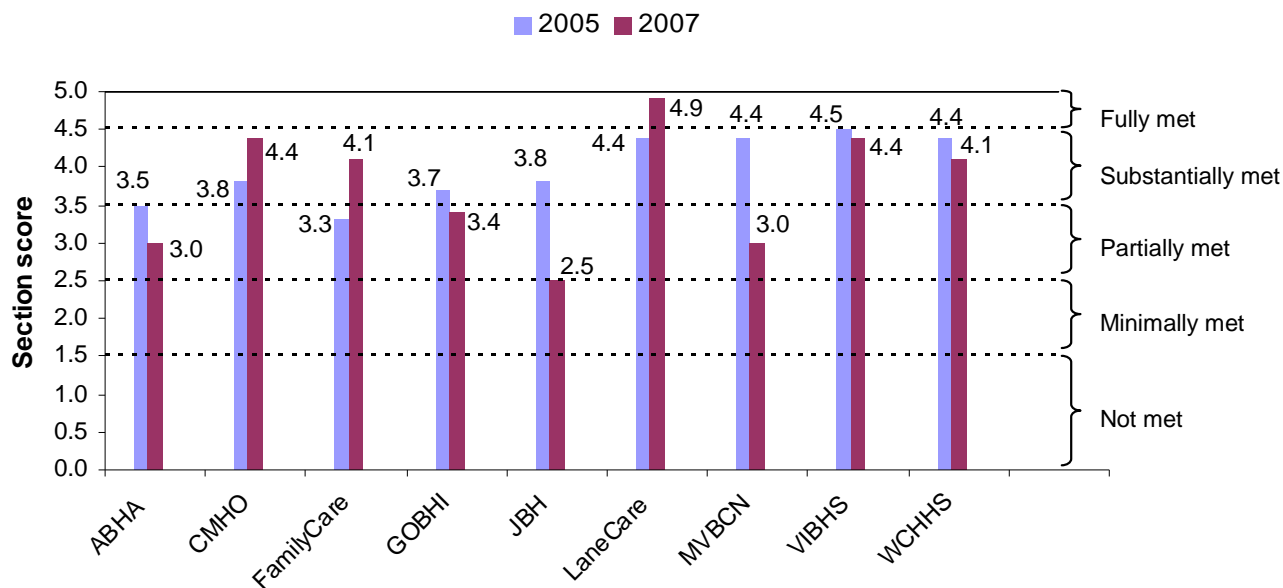
**Figure 20. MHO compliance scores: Security of Data Processing.**

**Administrative Data.** In addition to assessing each MHO’s ability to acquire and report accurate, complete, and timely claims and encounter data, Acumentra Health interviewed each MHO’s contracted provider agencies to evaluate their processes for validating data, the diagnosis and procedure codes captured by their billing systems, their handling of Medicaid and Medicare dual enrollees, the types of encounters forwarded to the MHO, and data submission methods.

In 2007, only LaneCare fully met the CMS requirements for this section. Other MHOs fell short because they lacked systematic processes for monitoring the data submitted by providers, and/or processes for auditing their own electronic billing systems. Often, certain providers did not submit encounter data when Medicare paid the full cost of care.

PH Tech performed automated edit and validity checks of procedure and diagnosis code fields, eligibility verification, and authorization. PH Tech also assigned a unique control number upon receipt of each claim or encounter. GOBHI audited each provider agency’s encounter data against clinical records every two years, and ABHA validated providers’ encounter data during routine onsite reviews.

**2008 update:** Several MHOs in addition to GOBHI and ABHA are developing policies and procedures for auditing their providers’ encounter data. FamilyCare is working with its provider agencies to ensure that they submit encounter data when Medicare pays the full cost of care. All other MHOs continue to lack a process to determine whether providers are submitting encounter data in this situation.

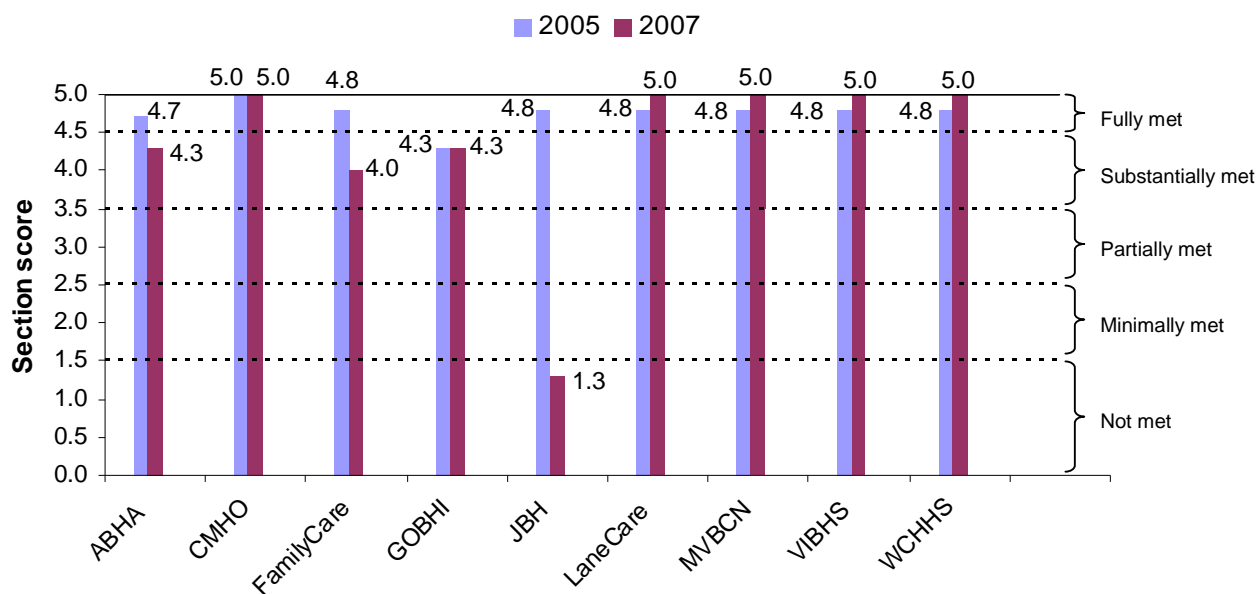


**Figure 21. MHO compliance scores: Administrative Data.**

**Enrollment System.** Timely and accurate eligibility data are essential for ensuring access to care for Medicaid enrollees. Eligibility information from DMAP is available for download on a weekly and monthly basis. Upon each download, the MHO should verify the file before incorporating it into the data warehouse or distributing it to contracted providers. This step helps to protect the database from potentially corrupted files.

In 2007, most MHOs fully or substantially met these criteria. With each eligibility update, the majority of MHOs or their TPA checked each record in the files before incorporating new data into the system. PH Tech provided easily accessible, up-to-date eligibility status for its MHO clients through a secure web-based application. PH Tech’s system could track the entire enrollment history for all enrollees for as long as PH Tech had provided services for the MHO. Most MHOs were able to track the history of enrollees with multiple enrollment dates and across insurance product lines.

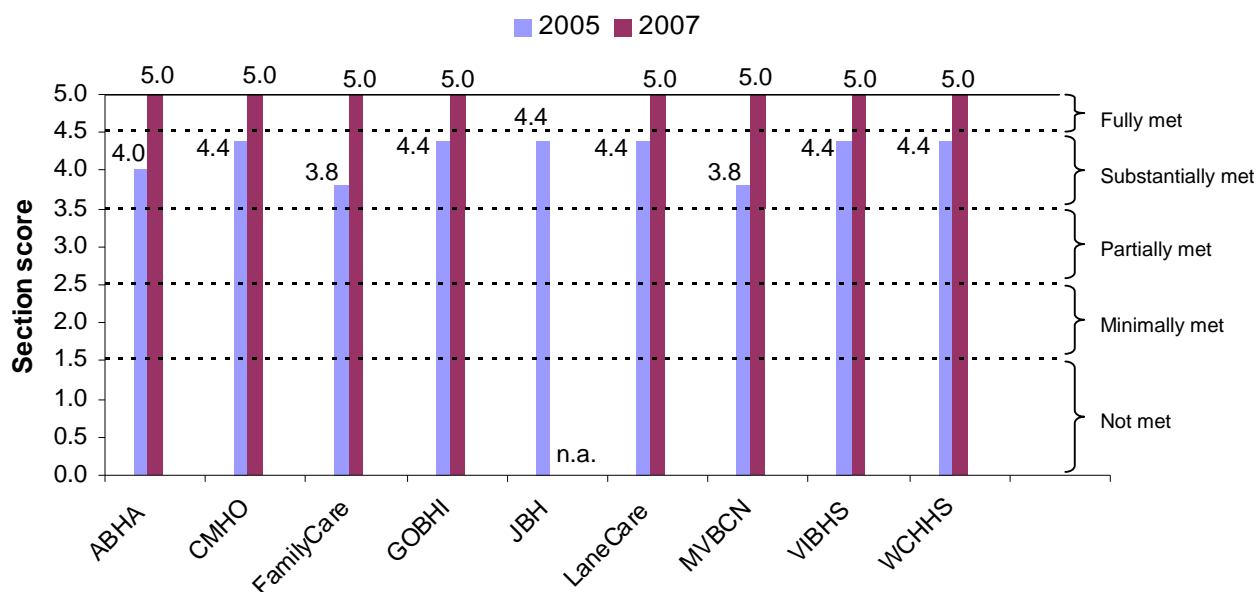
**2008 update:** The MHOs reported no significant changes in how they verify member eligibility.



**Figure 22. MHO compliance scores: Enrollment System.**

**Vendor Medicaid Data Integration.** The 2007 ISCA found that, where applicable, all MHOs collected member-level data from their contracted agencies and ensured that the data were compatible with the state’s data systems, fully complying with this standard. (Note: Acumentra Health defined vendors as TPAs that adjudicated claims, rather than as service providers.)

**2008 update:** Nearly all MHOs reported lag time and late reporting of encounter data to the state during 2008. MHOs attributed this to the state’s not having completed the National Provider Identifier (NPI) crosswalk in a timely manner, resulting in automatic claim/encounter denials and errors. However, the MHOs were able to submit all these claims and encounters after the state resolved this issue. The tardiness of the NPI crosswalk did not significantly affect the calculation of AMH’s performance measures.



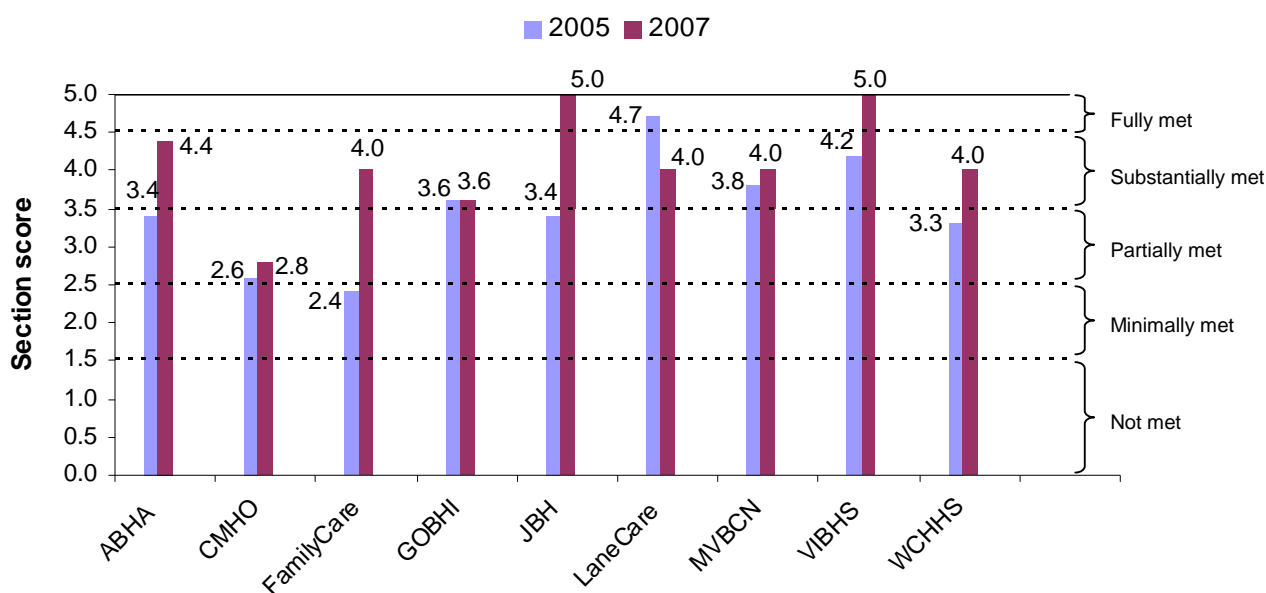
**Figure 23. MHO compliance scores: Vendor Medicaid Data Integration.**

**Provider Compensation and Profiles.** Acumentra Health evaluated each MHO’s provider compensation system to determine whether the compensation structure balanced contractual expectations, enrollees’ needs, and capitation rates set by AMH. Most MHOs had automated provider compensation on the basis of a rate list for each procedure code, per the provider’s credentials.

The review also assessed whether each MHO provided an accessible directory of qualified providers to help enrollees make informed choices. Ideally, each MHO should maintain a provider profile database with current information on clinicians’ gender, credentials, treatment specialties, languages spoken, and whether the provider’s office meets accessibility standards of the Americans with Disabilities Act (ADA). MHOs would benefit from making provider profiles available online for enrollees. If the MHO uses a central website for that purpose, the website should list current clinic locations or contact information for member counties.

In 2007, JBH and VIBHS fully met the criteria for this section, maintaining up-to-date databases of provider information that the MHO staff used to direct enrollees to appropriate providers. However, the majority of MHO directories, including those posted online, lacked some essential updated information, and some MHOs’ websites contained out-of-date contact information for providers.

**2008 update:** LaneCare and ABHA have updated their provider directories and member handbooks with information on provider profiles and ADA accessibility standards.



**Figure 24. MHO compliance scores: Provider Compensation and Profiles.**

## Discussion and Recommendations

The 2008 EQR results reflect progress made—and challenges encountered—by AMH and the MHOs in meeting Medicaid managed care requirements. This discussion highlights continuing system-wide opportunities for improvement, in addition to the MHO-specific recommendations presented in individual reports throughout the past year. With the goal of facilitating continuous improvement, Acumentra Health offers the following recommendations, building on those from previous EQRs.

### Managed care quality strategy

AMH's Medicaid Managed Mental Health Care Quality Assessment and Improvement Strategy represents the state's blueprint for improving managed mental health care for OHP enrollees. As such, the quality strategy needs to reflect AMH's year-to-year changes in contractual requirements and other directives for MHOs in response to EQR recommendations. However, AMH has not updated its quality strategy since 2006. As AMH works with DMAP to develop an integrated quality strategy for managed mental and physical health care, AMH needs to ensure that the strategy incorporates the intervening changes in AMH's priorities and requirements for MHOs.

### Compliance

The MHOs have made significant progress since the 2005 compliance review in developing or improving existing policies and procedures to meet standards. The MHOs conduct more oversight of providers and delegated parties, though some MHOs still need to be more thorough and consistent in their monitoring. They have improved their care coordination for children with special healthcare needs, and several MHOs have adopted level-of-care criteria and utilization management plans.

Most MHOs need further improvement in the following: defining and monitoring delegated activities, improving care coordination for adults, adopting additional evidence-based practice guidelines, and addressing fraud and abuse in compliance plans and training compliance officers.

AMH has made strides in aligning the MHO contract with the federal regulations. Further guidance in key areas will assist the MHOs in fully meeting standards (see list of recommendations below). AMH needs to provide further oversight of MHOs in certain areas. As cited in the CMS review, AMH's oversight of the MHOs needs

to ensure that they meet contract requirements, monitor subcontractor activities, and comply with federal regulations.

### **PIP validation**

The Oregon MHOs have undergone PIP validation each year since 2005 and have received technical training in PIP methods each year since 2006. These activities have improved the MHOs' understanding of the PIP process and documentation requirements. However, many MHOs continue to experience difficulty with PIP elements such as engaging stakeholders (especially enrollees) in the topic selection process and adequately documenting their topic selection methods; collecting project outcome data consistently, regularly, and accurately; and ensuring fidelity to project models and methods following implementation. In some cases, MHOs have collected data on inconsistent schedules, failed to perform statistically valid data comparisons, and/or presented their project results ineffectively, limiting the value and replicability of the PIPs.

Ongoing technical training can help the MHOs avoid these inconsistencies and problems. This annual report offers detailed recommendations (see pages 60–62) to guide MHOs in selecting PIP topics and intervention strategies that are likely to result in long-lasting and meaningful improvement.

In addition, the MHOs could benefit from a source of systematic information about other organizations' experiences in designing and documenting their PIPs, including best practices (e.g., for conducting and documenting literature searches, soliciting stakeholder input and assistance with PIP topic selection, and selecting and using appropriate data analysis tools).

As the MHOs and their collaborative partners pursue the mental/physical health integration PIPs, the partners have submitted separate project documentation for separate validation activities on behalf of AMH and DMAP. Not surprisingly, some inconsistencies have become evident in the separate PIP submissions. The state Medicaid agencies and all partners in the collaborative PIPs would benefit from standardized documentation and review of these projects.

### **Performance measure validation**

The 2008 review clarified certain issues arising from previous performance measure validation reviews. However, as was true in 2006 and 2007, AMH's four statewide performance measures comply only partially with CMS standards. AMH has submitted no formal revisions that address previous recommendations, including those regarding the quarterly report.

AMH has addressed a previous EQR recommendation by working with the MHOs' QI coordinators to define new performance measures that will be more useful in evaluating the MHOs' quality assessment and performance improvement processes. (See Appendix C.) AMH will review the new measures after they are approved by the MHO contractors to determine whether or not to adopt them. Any changes need to be incorporated into AMH's Medicaid quality strategy.

### **Recommendations for AMH and MHOs**

With the goal of facilitating continuous improvement, Acumentra Health offers the following recommendations, some of which build on recommendations of previous EQR reports.

#### ***For AMH:***

- Update the Medicaid Managed Mental Health Care Quality Assessment and Improvement Strategy to reflect new priorities and contract requirements that AMH has established for MHOs since 2006.

#### ***With regard to compliance:***

- Continue to clarify terms of the managed care contract and provide other guidance for MHOs to support their compliance with regulatory standards.
- Consider forming a QI committee within AMH that would guide AMH quality assessment and performance improvement activities and develop an annual work plan and the scope of work for the contract year.
- Encourage MHOs to incorporate evidence-based practices into their practice guidelines.
- Establish how MHOs should address adult members with special healthcare needs who have multiple conditions (e.g., co-occurring physical and/or substance abuse issues).
- Further define delegated functions and provide guidance to MHOs in monitoring their delegated activities.
- Clarify expectations for training of and develop resources for MHO compliance officers.
- Clarify expectations for MHOs' monitoring of providers' use of seclusion and restraint.
- Provide further guidance to MHOs implementing Declarations for Mental Health Treatment and advance medical directives.

- Clarify expectations for ensuring that MHO staff and management are not excluded from participating in federal healthcare programs.
- Clarify expectation about the level of detail required for MHOs' provider/practitioner listings (i.e., gender, ethnicity, non-English language capabilities, specialties, and office's ADA accessibility).

*With regard to PIPs:*

- Continue to provide in-depth training and information for MHOs regarding best practices for data remeasurement, statistically valid analytic techniques, and appropriate methods for documenting the data collection process.
- Consider supporting the development of a PIP knowledge base or similar repository to provide MHOs with a ready source of information about other organizations' experiences in designing and documenting their PIPs, including best practices. The repository could be located on a password-protected section of AMH's website.
- Coordinate with DMAP to enable the MHOs and their partners collaborating in mental/physical health integration PIPs to maintain a single PIP document and undergo a single annual project review with all partners present.

*With regard to performance measures and information systems:*

- Address the state-level ISCA recommendations listed on page 73.
- Adopt the newly defined statewide performance measures following their approval by MHO contractors, operationalize the measures, and incorporate them into the Medicaid quality strategy.
- Continue to work with MHOs to ensure the development of data systems that can capture and transmit high-quality encounter and claims data.
- In light of CMS concerns about the accuracy and completeness of Medicaid encounter data, establish contractual requirements for MHOs to conduct regular audits to validate the encounter data submitted by providers.

***For MHOs:***

*With regard to compliance:*

- The MHOs should do more to share best practices among themselves.
- Incorporate processes for preventing and detecting fraud and abuse into compliance plans, and provide training to compliance officers.

- Apply lessons learned from CSCI to improve care coordination for adult members with multiple special healthcare needs.
- Monitor enrollees' treatment plans to ensure that they include all required documentation.
- Incorporate evidence-based practices into practice guidelines.
- Monitor providers' use of and policies on seclusion and restraint.
- Track access to second opinions performed within provider agencies.
- Apply the same credentialing processes to MHO staff that are required of providers, including assuring that staff and management are not excluded from participating in federal healthcare programs.

*With regard to PIPs:*

- For collaborative mental/physical health integration PIPs, develop baseline data, implement the planned interventions, remeasure the study indicators, and perform statistical testing to determine improvements.
- For other ongoing PIPs, pursue consistent remeasurement of study indicators, perform appropriate statistical tests to assess the degree of sustained improvement due to the PIP interventions, identify barriers to improvement, and modify the interventions accordingly.
- Identify and document lessons learned from PIPs, as required by the PIP validation protocol. Discuss the reasons for deciding to change PIP topics before conducting data remeasurement.

*With regard to information systems:*

- Audit the encounter data submitted by provider agencies against providers' clinical records regularly to validate the accuracy and completeness of encounter data.

## Appendix A. MHO Scores on PIP Validation

Each MHO's performance improvement projects (PIPs) are validated each year through EQR to ensure that they are designed, conducted, and reported according to standards established by CMS.

Typically, each of the 10 performance standards in the validation review has a potential score of 100 points for full compliance. The total points earned for each standard are weighted and combined to determine the MHO's overall performance score for the PIP. The overall PIP scoring is weighted 80 percent for demonstrable improvement in a project's first year (Standards 1–8) and 20 percent for sustained improvement in later years (Standards 9–10). Thus, for first-year PIPs, the highest achievable overall score is 80 points; for second-year or ongoing PIPs, the maximum PIP score is 100 if the MHO has completed multiple remeasurements that make it possible to assess sustained improvement.

For the collaborative mental/physical health integration PIPs, AMH did not require the MHOs to report activities pertaining to all review standards initially. Therefore, Acumentra Health scored as many standards as each MHO submitted for review, but did not assign overall scores for these PIPs.

Table A-1 on the following page arrays the 2008 scores on all validation standards by MHO, for both collaborative and plan-specific PIPs.

**Table A-1. MHO PIP scores by validation standard, 2008.**

	ABHA	CMHO	Family Care	GOBHI	JBH	Lane Care	MVBCN	VIBHS	WCHHS
<b>Plan-specific PIPs</b>									
<b>Overall score</b>	<b>38*</b>	<b>68**</b>	<b>36*</b>	<b>***</b>	<b>57**</b>	<b>39*</b>	<b>100**</b>	<b>70**</b>	<b>33*</b>
Standard 1	35	95	60	See comments and scores on next page.	100	100	100	98	90
Standard 2	50	95	60		75	70	100	75	85
Standard 3	65	85	30		50	70	100	75	65
Standard 4	50	75	40		80	80	100	75	80
Standard 5	50	50	30		75	70	100	100	65
Standard 6	75	95	80		100	30	100	95	0
Standard 7	0	50	65		50	0	100	50	0
Standard 8	0	65	0		25	0	100	50	0
Standard 9	—	75	—		50	—	100	85	—
Standard 10	—	25	—		0	—	100	0	—
<b>Collaborative PIPs</b>									
Standard 1	50	*** See comments on next page.	65	*** See comments and scores on next page.	100	75	75	75	100
Standard 2	60		65		70	70	75	50	65
Standard 3	65		90		90	79	60	50	75
Standard 4	60		80		75	—	—	25	85
Standard 5	—		30		75	—	—	—	90
Standard 6	—		60		—	—	—	—	—
Standard 7	—		75		—	—	—	—	—
Standard 8	—		—		—	—	—	—	—

See footnotes on next page.

\*80-point rating scale:

70–80 = Fully met

55–69 = Substantially met

40–54 = Partially met

25–39 = Minimally met

0–24 = Not met

\*\*100-point rating scale:

80–100 = Fully met

60–79 = Substantially met

40–59 = Partially met

20–39 = Minimally met

0–19 = Not met

\*\*\* CMHO and GOBHI submitted no collaborative PIPs for 2008, but each submitted two plan-specific PIPs, one clinical and one nonclinical. Table A-1 shows the scores for CMHO's clinical PIP.

GOBHI's PIP scores were as follows:

	Clinical	Nonclinical
<b>Overall score</b>	<b>88**</b>	<b>78*</b>
Standard 1	100	100
Standard 2	100	100
Standard 3	90	100
Standard 4	100	95
Standard 5	100	90
Standard 6	100	100
Standard 7	100	100
Standard 8	85	100
Standard 9	60	—
Standard 10	50	—

## Appendix B. Criteria for ISCA Standards

### Data processing procedures and personnel

#### Information systems

A data storage and processing system that facilitates valid and reliable performance measurement would 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 encounter data

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to meet strict standards related to confidentiality of enrollees' records and standardization of codes. Per HIPAA regulations, encounter data must be in ANSI 4010 Version 837 format, commonly called the 837 Transaction Code Set, when transmitted electronically. This code set standardizes data content by specifying uniform definitions of the data elements and valid codes or values for each element. Agencies may use a clearinghouse or third-party administrator to convert their encounter and claims data to the new 837 format for processing.

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

- good documentation
- clear, continuous communication between the client and the programmers on client information needs (e.g., analysis needs, reports)
- a quality assurance process
- version control
- continuous professional development of programming staff

## Staffing

Best practices for sustaining quality in processing encounter data include

- adequate trained staff for processing and tracking errors in encounter data submission
- a comprehensive, documented formal training process for new hires and experienced professionals
- refresher courses for staff when updates occur and when new systems are implemented
- established and monitored productivity goals
- low staff turnover

## Hardware systems

Infrastructural support should include maintenance and timely replacement of computer equipment and software, disaster recovery procedures, adequate training of support staff, and a secure computing environment. Redundant storage minimizes the need to restore data following a crash. Optimal configuration for redundancy would incorporate both hardware and software clustering. Hardware redundancy also would apply to the stand-by server. In the event of a production server crash, time to recovery would be less than 15 minutes. These supports contribute to the integrity of the data and timely reporting of the performance measures.

## Security of data processing

Best practices for securing data would include mechanisms for protecting the system from unauthorized usage and accidental damage. Paper-based claims and encounters should be in locked storage facilities when not in use. The computer system and terminals should be protected from unauthorized access through use of a password system and security screens. Data transferred between systems should be encrypted. Passwords should be changed frequently and reset whenever an employee terminates. Health plans or providers should have access only to files containing data for their own members or practice.

Data security requires a comprehensive backup plan that includes, but is not limited to, 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, including the third-party administrator's, must be knowledgeable of their backup schedules and of retention of backups to ensure data integrity. This**

**information should be documented and easily accessible by managers and their staff.**

To ensure integrity of the data during backups, databases should not be accessible by users, and backups should be verified periodically by performing a “restore” and comparing the results. Annual backups would be kept for five years or more in an offsite climate-controlled facility.

For additional protection from corruption during database updates, databases should 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.

Formal controls in the form of batch control sheets or assignment of a batch control number should be used to ensure a full accounting for all claims received.

**Data acquisition capabilities****Administrative data**

Accurate and timely reporting of encounter data is crucial to an MHO’s success. The state uses the submitted encounter data to determine MHOs’ reimbursement rates, and MHOs use encounter data in compensating their providers and in monitoring the provision of services.

To ensure the validity and timeliness of encounter data for performance measures, the MHO needs documented standards, formal quality assurance of input data sources and transactional systems, readily available historical data, and a system for electronic submission of data. Best 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.
- online capabilities for viewing and correcting pending claims and encounters to reduce processing lags
- availability of five to seven years of historical data

### **Enrollment system (Medicaid eligibility)**

Timely and accurate eligibility data are paramount for providing high-quality care and for monitoring services reported in utilization reports. Access to up-to-date eligibility data should be easy and fast. Ideally, enrollment data should be updated daily or in real time. The system also should be capable of tracking an enrollee's entire history within the MHO, further enhancing the accuracy of the data.

### **Vendor Medicaid data integration**

An ideal vendor data integration system would

- be capable of converting data, including code sets, for compatibility with the state's data systems
- receive only member-level data, as opposed to aggregate data
- incorporate other data (e.g., dental care, primary care manager, history of care) to provide a more complete picture of a member's care
- ensure consistency in the data for required fields, including multiple diagnosis and procedures codes

### **Provider compensation and profiles**

An MHO designs its provider compensation structure to balance contractual expectations, the needs of enrolled populations, and capitation rates set by the state. To set appropriate capitation rates biannually, the state relies on accurate and timely encounter data.

A good payment structure is critical to ensure reasonable and timely compensation, which encourages an accessible, qualified community network of providers to continue to provide service to Medicaid enrollees.

An easily accessible list of qualified network providers in the form of a directory allows enrollees and staff to make informed choices. An ideal provider directory would list all available providers with their gender, credentials and specialties, languages spoken, whether they use sign language, whether they offer interpretive services, and whether the office is certified under the Americans with Disabilities Act (ADA).

## Appendix C. Revision of Statewide Performance Measures

### DRAFT

MHO Performance Measures  
QI Coordinators Work Group

#### 1. Percentage Rate of Served

- All ages will be counted (0 to 16; 24 to 65), however 65 and older and Transition Age Youth (16-24 years old) will be the focus group.

The rationale for specifying these two age groups is that they are historically underserved. The older adult age group (age 65 and over) represents 7.3% of the OHP enrollment, but receive only 3.6% of the total services per the FY 06-07 OHP Mental Health Utilization Report. This age group has been traditionally underserved in Oregon.

The transition age group (age 16-24) is not currently broken out in any of the age group categories for data tracking. This age group is at risk for being underserved in that the transition from the OHP youth service delivery system to the adult service delivery system is not well tracked. Many of the children's service utilization staff have indicated this group tends to "fall through the cracks" of the service delivery system and are anecdotally underserved. The rationale for this specific recommendation is to begin to collect data to determine if there is a need to formally identify this age group as an "at risk population."

#### 2. ICTS/ITS

- % of youth in ICTS per MHO (5 to through 19 if you were in before 18th bday)
- % of youth in ITS per MHO
- # per 1000 members per quarter in ICTS across MHOs
- # per 1000 members per quarter in ISA across MHOs
- Average length of stay based on the number of uninterrupted days in residential care
- Number of DHS children versus non-DHS children
- Percentage of youth and family who remained engaged in ICTS services 30 and 90 days post residential discharge

The overarching goal of the ICTS movement is to increase the ability of a child to receive services within their home community. Residential levels of care are only to be utilized when clinically necessary. Anecdotal information from residential facilities indicate that prior to the implementation of the ICTS system DHS children were staying in Psychiatric Residential Treatment facilities an average of 120 days longer than non-DHS children. Current reports from ICTS providers indicate ongoing struggles with transitioning DHS children out of restrictive levels of care due to placement issues. In the interest of ensuring that children within the DHS Child Welfare system have equitable access to the least restrictive levels of care and that institutional levels of care

are not over utilized, it will be important to monitor outcomes for both DHS and non-DHS children. This data can serve to inform us of our outcome successes and/or highlight potential areas for additional attention.

### 3. Peer Delivered Services

- Number of service provider organizations who are in the process of developing peer delivered services
- Number of service provider organizations who employ peers
- % of claims paid for by peer delivered services
- Goal: AMH has established and adopted criteria for peer certification
- Goal: MHOs have incorporated the criteria for peer certification into credentialing policies and procedures
- Goal: A set of acceptable encounter codes for peer delivered services has been approved by the MHO code group

### 4. Hospitalization

- # of adults admitted to the hospital per 1000 members per quarter
- # of hospital days per 1000 members per quarter
- % of clients who received a covered service within one calendar week following discharge from an acute inpatient psychiatric hospital
- Readmission rates within 30 and 180 days following discharge from an acute inpatient psychiatric hospital
- % of clients who received services during the first 30 and 90 days post discharge