



The Oregon Health Plan's Managed Mental Health Care

**Oregon Health Authority, Addictions and
Mental Health Division**

**2012 External Quality Review
Annual Report**

February 2013

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The Oregon Health Plan's Managed Mental Health Care: 2012 External Quality Review Annual Report

February 2013

**Presented to the Oregon Health Authority,
Addictions and Mental Health Division**

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EXECUTIVE SUMMARY

The Oregon Health Authority (OHA), Addictions and Mental Health Division (AMH) contracts with Acumentra 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.

Through July 2012, AMH contracted with 10 mental health organizations (MHOs) to deliver managed mental health care for OHP enrollees:

- 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)
- PacificSource Community Solutions (PacificSource)
- Washington County Health and Human Services (WCHHS)

The MHOs, in turn, contracted with individual practitioners, community mental health agencies, hospitals, and clinics to deliver treatment. The MHOs were responsible for ensuring the delivery of services in compliance with regulatory and contractual obligations to provide effective care.

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

- compliance with regulatory and contractual standards for access to care, structure and operations, 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 the MHOs, including an Information Systems Capabilities Assessment (ISCA) for AMH and for each MHO

EQR Results

Since 2005, Acumentra Health has conducted annual EQR reviews of Oregon’s contracted MHOs. The EQR reports have guided AMH in identifying system strengths and weaknesses with the goal of facilitating continuous improvement of the care enrollees receive. The accumulated data, based on consistent review criteria from year to year, provide a comprehensive picture of the MHOs’ services for OHP enrollees.

In August 2012, as part of Oregon’s health care transformation process, OHA began contracting with locally-governed coordinated care organizations (CCOs) to deliver physical and mental health services for OHP enrollees under managed care. The goal is for CCOs to use global budgets to improve the coordination of care and to focus on prevention, chronic illness management, and person-centered care. Currently, 15 CCOs—including components of some of the previous MHOs—are providing those services.

This 2012 annual report essentially represents a “close-out” report on the MHOs, reflecting progress and ongoing challenges in meeting the Medicaid managed care standards of the Centers for Medicare & Medicaid Services (CMS). The recommendations presented here can provide guidance to OHA and the CCOs as they move forward in serving members in the mental health system.

Compliance review

During 2012, Acumentra Health reviewed 5 of the 10 MHOs for compliance with 10 separate regulatory and contractual standards (other MHOs were reviewed for compliance in 2011). On average, the MHOs *fully met* four standards (Provider Selection, Quality Assessment/Performance Improvement Program, Grievance Systems, and Program Integrity) and *substantially met* the remaining standards.

Since the 2009 review, the MHOs have improved compliance with the Provider Selection and Program Integrity standards. For 5 of the 10 standards, however, the average compliance scores in 2012 were lower than the 2009 scores. In large part, this may be due to the high degree of uncertainty that MHOs faced in relation to health reform initiatives.

- Several MHOs had shifted their focus from regulatory and contractual compliance to developing and negotiating relationships with fully capitated health plans, with the objective of being included in the CCOs forming in their service areas.
- At the time of the compliance review, PacificSource, an integrated physical/mental health organization, had terminated its contract with an

MHO that had been managing the mental health benefit during the review period.

Below are some overall strengths and recommendations for the five MHOs reviewed in 2012.

Overall MHO strengths

- All MHOs have mechanisms in place to ensure that enrollee rights are in place, communicated to enrollees, and honored by the provider agencies.
- All MHOs' contracts, policies, and procedures include provisions regarding compliance with federal and state laws.

Recommendations for OHA and MHOs

- OHA should clarify to which state agency enrollees should direct complaints about MHO noncompliance with both medical and mental health advance directives.
- MHOs need to monitor mental health providers to ensure that
 - providers treat enrollees with respect, dignity, and privacy
 - providers comply with enrollees' right of access to their clinical records
 - clinical and authorization decisions are consistent with mental health practice guidelines
- MHOs need to develop and/or formalize processes to monitor mental health providers to ensure that enrollees have access to second opinions.
- MHOs need to monitor and track
 - out-of-network encounters and analyze the data to determine mental health delivery network adequacy and timeliness
 - processes for direct access to mental health specialists
 - crisis and post-stabilization services to ensure that payments are not denied and to identify inappropriate or avoidable use of crisis services related to lack of access to routine care
- MHOs need to have policies in place for developing, disseminating, and implementing mental health practice guidelines. MHOs need to track requests for mental health practice guidelines.
- MHOs need to ensure collection of complete data, and therefore analysis, of over- and underutilization of mental health services.

- MHOs need to formalize their grievance policies and procedures, including expedited resolution of grievances.
- MHOs need to encourage mental health providers to report enrollees' complaints and grievances to the MHO.

Performance improvement projects

CMS requires managed care plans serving Medicaid enrollees to conduct two PIPs each year with the goal of improving enrollees' clinical outcomes and health plans' administrative processes related to providing services for enrollees. Validation of these projects through the annual EQR ensures that these projects are designed, conducted, and reported according to CMS standards.

In 2012, AMH allowed each MHO to choose its own topic for one PIP. For the second PIP, the MHOs could either continue their current collaborative PIPs or adopt a new PIP focusing on members with serious and persistent mental illness (SPMI) and treatable medical conditions.

Acumentra Health reviewed 18 PIPs for 2012 (two MHOs submitted only one PIP apiece for review). All but one of the 18 PIPs were continued from 2011. Of the 9 plan-specific PIPs reviewed, 4 were scored as *fully met*, 2 as *substantially met*, and 3 as either *partially* or *minimally met*. Of the 9 collaborative PIPs reviewed, 2 were scored as *fully met*, 3 as *substantially met*, and 4 as either *partially* or *minimally met*. Detailed evaluations of the PIPs appear in separate reports for each MHO, submitted to AMH by Acumentra Health during 2012.

Recommendations for MHOs

The 2012 PIP reviews gave rise to two overall recommendations:

- MHOs need to thoroughly research the choice of each PIP topic, identify the root cause(s) of a quality problem, develop an appropriate intervention strategy, and evaluate the study results.
- MHOs need to make progress in their PIPs. In an ongoing PIP, the MHO may need several years to address all 10 standards. The first year may serve as a planning phase, the second year may present data from the baseline and first remeasurement, and the third year may obtain a second remeasurement.

This report also presents detailed recommendations and best practices related to each review standard, and summarizes the results of the individual PIPs that each MHO reported to AMH in 2012.

Performance measure validation and ISCA results

The purpose of the performance measure validation activity is to determine whether the data used to calculate AMH’s statewide performance measures are complete and accurate and whether the calculations adhere to CMS specifications. Acumentra Health typically reviews the performance measure methodology and code each year.

AMH defined statewide performance measures for MHOs, calculated the measures using data that the MHOs reported to AMH, and compiled the data by quarter. MHOs were required to submit data for four performance measures to AMH for calculation. In 2012, for the first time since 2009, AMH calculated performance measures for the plans, thereby improving their score from ”not compliant” to “partially compliant” per CMS specifications.

While many aspects of AMH’s analytic and reporting processes improved in 2012, other areas still need to be addressed. The 2012 review found that AMH lacked thorough documentation of the production process, including the flow of data used in calculating the measures and the steps for ensuring accuracy and completeness.

Recommendations for OHA

- OHA needs to finalize, adopt, publish, regularly calculate, and report on its statewide performance measures. OHA should work with MHOs on communicating and understanding these results.
- OHA needs to clearly define and identify the performance measures to be calculated and distribute this information to MHOs.

In 2012, Acumentra Health followed up with the MHOs regarding their 2011 ISCA results, reviewing their responses to specific findings and recommendations. Acumentra Health found that the MHOs were still in the process of addressing most recommendations from the 2011 ISCA. A few issues had been fully addressed, while some MHOs had made little or no progress in addressing numerous recommendations. As many MHOs were in the midst of the CCO transition, most chose to delay progress in certain areas due to limited resources and/or significant upcoming changes.

Recommendations for OHA and MHOs

- MHOs need to audit the encounter data submitted by providers against the providers’ clinical records regularly to validate the accuracy and completeness of encounter data.

- OHA and the MHOs need to develop disaster recovery plans and formal processes for regular review, auditing, and testing of the plans, and encourage provider agencies to do the same.
- MHOs should increase monitoring and oversight of organizations they contract with to provide IT services.
- MHOs need to reduce the amount of paper claims received. The Health Information Technology for Economic and Clinical Health (HITECH) Act requires that plans and providers move to electronic submission of claims and encounters.

INTRODUCTION

Acumentra Health, as AMH's external quality review organization, presents this report to fulfill the requirements of 42 CFR §438.364. The report describes how Acumentra Health aggregated and analyzed data from 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:

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

Separate reports delivered to AMH during 2012 assessed strengths and recommended improvements related to each MHO's regulatory/contractual compliance, PIPs, and information systems. This report summarizes the results of the MHO reviews.

OHP Managed Mental Health Care

Through July 2012, AMH contracted with the 10 MHOs to deliver managed mental health services for OHP enrollees on a capitated basis. The MHOs, in turn, contracted with provider groups, including community mental health programs and other private nonprofit mental health agencies and hospitals, to deliver treatment services. The MHOs were responsible for ensuring delivery of services in a manner consistent with legal, regulatory, and contractual obligations.

As of July 2012, the final month of the MHO contract, the 10 MHOs managed mental health services for more than 576,000 OHP enrollees throughout the state, as shown in Table 1.

Table 1. Geographic coverage and OHP enrollment of Oregon MHOs, July 2012.

MHO	Counties with the most enrollees	Total enrollees
ABHA	Benton, Lincoln, Linn	14,963
CMHO	Clackamas, Marion, Multnomah	27,731
FamilyCare	Clackamas, Multnomah, Washington	39,549
GOBHI	Baker, Clatsop, Columbia, Douglas, Harney, Hood River, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wasco	72,393
JBH	Coos, Curry, Jackson, Josephine, Klamath	80,351
LaneCare	Lane	54,131
MVBCN	Linn, Marion, Polk, Tillamook, Yamhill	112,493
PacificSource	Crook, Deschutes, Jefferson	31,365
VIBHS	Multnomah	94,873
WCHHS	Washington	48,770
Total		576,619

Source: Oregon Health Authority. State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by County and Mental Health Organization: 15 July 2012. Available at: http://www.oregon.gov/oha/healthplan/data_pubs/enrollment/2012/0712/mho.pdf.

Note: Counties listed for each MHO are those containing the majority of that MHO's enrollees.

AMH's Quality Assessment/Performance Improvement Activities

Managed care quality strategy

42 CFR §438.202 requires each state Medicaid agency contracting with managed care organizations (including both physical and mental health organizations) 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. Data obtained from the oversight activities described in the strategy are analyzed and evaluated as part of EQR activities.

OHA's quality strategy was completed in December 2012, and was accepted by CMS prior to the approval of the Medicaid waiver.

Quality improvement annual work plans

Each MHO submitted its annual quality improvement (QI) work plan to AMH for approval so that AMH could monitor the MHOs' QI activities and offer technical assistance. PIPs were an integral part of each MHO's QI program, and each MHO reported progress to its quality management committee, board of directors, and other stakeholders.

AMH required each MHO, as part of its quality assessment/performance improvement (QA/PI) program, to conduct at least two PIPs annually. As modified for October 2011–September 2012, the AMH contract required one PIP to focus on enrollees with SPMI who have a risk of increased morbidity and mortality due to treatable medical conditions caused by smoking, obesity, substance abuse, and other modifiable risk factors.

Service integration

Over the years, AMH has worked with DMAP to establish more consistent contract language to facilitate QI collaboration between MHOs and the physical health plans overseen by DMAP. Effective service integration for OHP enrollees is a major charge for the newly operating CCOs.

AMH's Integrated Services and Supports Rules (OAR 309-032-1500 through 309-032-1565) prescribe minimum standards for the services and supports furnished by all addictions and mental health providers, including outpatient community mental health services and supports for children and adults; intensive community-based treatment and support services for children; intensive treatment services for children; and outpatient and residential treatment services for alcohol and drug addiction and problem gambling.

Evidence-based practices

AMH lists approved evidence-based practices (EBPs) on its website. MHOs were allowed to adopt EBPs in lieu of the practice guidelines required by federal rules.

Among other EBPs, OHA and community partners are implementing the Statewide Children’s Wraparound Initiative (SCWI), which seeks to establish a statewide system of wraparound care as a foundation for integrating services and supports for children who have, or are at risk for having, a mental health, behavioral health, or substance abuse condition. Three demonstration sites were launched in July 2010, with three separate MHOs functioning as administrative service organizations for the project sites. The law mandates statewide implementation by 2015.

The demonstration sites in Washington County, Rogue Valley, and Mid-Valley focus on youths in the state foster-care system. All three sites had reached capacity of 340 children by January 2011. According to OHA’s July 2012 update report, data for 136 children who took part in SCWI since its inception show “a significant impact in moving children back into living arrangements with their parents or other relatives.” In many cases, children are able to exit state custody—a significant focus of the project’s goals at the outset. “The data also portray a pattern of stabilization in children’s lives, with decreased need for psychotropic medications, increased ability to refrain from harm to self and others, increased capacity to produce schoolwork commensurate with their ability levels, and a lower likelihood of running away or delinquent behavior.”¹

Residential mental health system change

In 2010, AMH undertook a system-change initiative with county governments to restructure publicly funded addiction and mental health services for people who were not covered by MHOs. AMH’s Adult Mental Health Initiative (AMHI) brought together MHOs, community mental health programs, providers, and consumers in an effort to improve coordination and community responsibility for adult mental health services at all levels of care in the system.

The initiative aims to increase the availability and quality of individualized community-based services and supports so that adults with mental illness can be served in the least restrictive environment appropriate for their needs. AMHI has also increased local accountability for improving treatment outcomes through performance-based contracting.

¹ See www.oregon.gov/oha/amh/child-mh-soc-in-plan-grp/reports/scwi-pro-review2012-07.pdf. Accessed January 4, 2013.

During its first year, AMHI decreased the average length of stay for individuals who were deemed “ready to transition” and awaiting discharge from the state hospital. The average length of stay decreased by half in the first year and again in the second year of AMHI. In its third year, AMHI made targeted reductions in long stays in the more restrictive levels of community-based licensed residential care.

With the transition of Medicaid managed care to CCOs, preventative integrated healthcare will be prioritized, and further improvement to health outcomes is expected while healthcare costs continue to be lowered.

EQR follow-up

Each year, AMH directed the MHOs to undertake corrective actions to address certain issues identified in the previous year’s EQR report. In 2012, AMH followed up with three MHOs regarding their findings from the 2011 compliance review. AMH worked with one MHO, MVBCN, to establish a work plan. JBH had come into compliance since the findings identified in the previous review, and GOBHI was in the process of addressing the compliance findings from the last review.

Consumer surveys

As an optional EQR activity, AMH annually surveys adult OHP enrollees receiving mental health services, the families of children receiving OHP mental health services, and service recipients aged 14 to 17 years about their perceptions of the services received and treatment outcomes. In 2012, Acumentra Health conducted the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey for Adults, the Youth Services Survey for Families (YSS-F), and the Youth Services Survey (YSS) on behalf of AMH.² For the first time, Acumentra Health conducted a separate survey of adult OHP members in residential services.

AMH has added questions to each survey to collect additional data that can help evaluate the progress of ongoing programs. Survey participants have the option to complete the survey online or on paper.

During 2012, Acumentra Health mailed more than 12,000 survey forms to adults and more than 10,000 YSS-F forms to family members of children receiving mental health services. Response rates were 24% for the outpatient adult survey,

² MHSIP is supported by the Substance Abuse & Mental Health Services Administration of the U.S. Department of Health and Human Services. The YSS-F is endorsed by the National Association of State Mental Health Program Directors. For more information, see the MHSIP website at www.mhsip.org.

24% for the adult residential survey, and 18.5% for the YSS-F. Acentra Health also contacted more than 3,500 young enrollees, of whom 17.9% submitted responses to the YSS.

In the 2012 adult survey, satisfaction scores fell in all but one domain (social connectedness) compared with the 2011 scores, reversing a trend of gradual year-to-year increases. Scores for four domains (access, outcomes, functioning, and participation) dropped to their lowest levels in five years.³

In the 2012 YSS-F survey, caregivers' positive responses rose slightly in all seven domains, with cultural sensitivity and social connectedness receiving the highest positive responses. Overall, domain scores have remained relatively stable over the past five years.⁴

³ Acentra Health. 2012 Oregon Mental Health Statistics Improvement Project Survey for Adults. January 2013.

⁴ Acentra Health. 2012 Oregon Youth Services Survey for Families and Youth Services Survey. January 2013.

RESULTS

Federal regulations identify *access* to care and the *quality* and *timeliness* of care as the cornerstones of EQR analysis (42 CFR §438.320). However, no standard definitions or measurement methods exist for access, timeliness, and quality. Acumentra Health used contract language, definitions of reliable and valid quality measures, and research literature to guide the analytical approach.

Access to Care

Access to care is the process of obtaining needed health care; thus, measures of access address the enrollee’s experience *before* care is delivered. Access depends on many factors, including availability of appointments, the enrollee’s ability to see a specialist, adequacy of the healthcare network, and availability of transportation and translation services.^{5,6,7} Access to care affects an enrollee’s experience as well as health outcomes.

Compliance

Strengths

- To assure that enrollees can understand how to obtain care and services, the MHOs’ member handbooks are written in easy-to-understand language. All MHOs make their handbooks available in alternative formats, including additional languages, large print, and Braille.

Areas for improvement

- Several MHOs need to provide names, locations, telephone numbers, and non-English languages spoken by contracted practitioners in the service area, and identify providers who are not accepting new clients.
- Several MHOs need to provide information that defines “emergency medical condition” and “post-stabilization services” according to state criteria.
- MHOs need to document their processes for monitoring out-of-network encounters, and analyze and use the information to improve network adequacy and timeliness.

⁵ Berk ML, Schur CL. Measuring access to care: improving information for policymakers. *Health Aff.* 1998; 17(1):180–186.

⁶ Institute of Medicine. *Coverage Matters: Insurance and Health Care*. Washington, DC: National Academy Press, 2001.

⁷ Sinay T. Access to quality health services: determinants of access. *J Health Care Finance*. 2002; 28(4):58–68.

- MHOs need to meet state standards for timely access to care and services, taking into account the urgency of enrollees' service needs.
- MHOs need to have formal processes in place to monitor for the use of second opinions.

PIPs

In 2012, four PIPs focused on improving access to care. Two of the PIPs proposed placing a primary care nurse or physician at a mental health clinic to facilitate access to physical health services; one PIP aimed to improve interpreter services and cultural competency to increase the service penetration rate for non-English enrollees; and one PIP addressed issues related to no-show appointments.

Quality of Care

Quality of care encompasses access and timeliness as well as the *process* of care delivery (e.g., through evidence-based practices) and the *experience* of receiving care. Although enrollee outcomes also can serve as an indicator of quality of care, outcomes depend on numerous variables that may fall outside the provider's control, such as enrollees' adherence to treatment.

Compliance

Strengths

- All MHOs' provider contracts require the providers to advocate on behalf of enrollees with regard to treatment options.
- Several MHOs implement policies and procedures to identify and assess enrollees with special healthcare needs.
- Several MHOs ensure coordination and continuity of care with other healthcare providers through a variety of initiatives, performing chart reviews, meeting with other allied agencies, and through community education programs.
- Several MHOs' treatment plans address additional care services, incorporate treatment recommendations of the provider agencies, and are developed with the participation of enrollees and their families.
- Two MHOs perform thorough oversight and engagement with their providers and subcontractors. They accomplish this through site reviews, clinical record audits, and provider relations.
- Most MHOs have adopted practice guidelines that are based on valid and reliable clinical evidence and that reflect the needs of enrollees.

- Most MHOs’ member handbooks inform enrollees about their right to file grievances and appeals and about the state’s fair hearing process.
- Most MHOs thoroughly monitor providers to ensure delivery of clinically justified and appropriate care for enrollees with special healthcare needs.
- Several MHOs have comprehensive QA/PI plans that include goals, measurable objectives, and interventions.
- LaneCare’s QA/PI workplan includes objectives designed to ensure appropriate utilization of resources.
- The MHOs operate health information systems that collect, analyze, integrate, and report data to identify unmet service needs.

Areas for improvement

- Several MHOs need to inform enrollees or their families or surrogates that they may file complaints about noncompliance with advance directives with the State Survey and Certification agency.
- MHOs need to have more thorough processes in place to monitor their providers’ grievance systems and to ensure the timeliness of notices of action, appeals, and resolutions.
- Several MHOs need to implement methods for following up on findings from monitoring by using a quality assurance process.
- Most MHOs need to document their processes for monitoring enrollees’ direct access to specialists.
- Several MHOs need to review the use of seclusion and restraints by contracted providers and facilities as part of their credentialing and recredentialing processes.
- MHOs need to have processes in place to monitor providers’ compliance with enrollees’ right to review their clinical records.
- Several MHOs need to monitor and track utilization of services to detect over- and underutilization.

PIPs

Ten PIPs focused on improving the quality of care for enrollees; all involved elements of care coordination, preventive screening, and consultation. Target populations included people with chronic conditions, such as diabetes or pain; issues with substance use, such as tobacco, chemical dependency, or antipsychotic

medications; and vulnerable populations such as young children or high users of hospital services.

Timeliness of Care

Timeliness of care can affect utilization, including both appropriate care and over- or underutilization of services. Presumably, the earlier an enrollee sees a mental healthcare professional, the sooner he or she can receive needed services. Postponing needed care may result in increased hospitalization and utilization of crisis services.

Compliance

Strengths

- Several MHOs fully meet the criteria for timely furnishing of services.

Areas for improvement

- Several MHOs need to implement policies and procedures for addressing expedited service authorizations.

PIPs

Three PIPs focused on timely care. Two adopted “initiation and engagement” as a measure of access, with defined time periods; one addressed timely mental health assessments for children in foster care.

COMPLIANCE REVIEW

During 2012, Acumentra Health reviewed five MHOs' compliance with regulatory and contractual standards governing the delivery of healthcare services through managed care. This review, covering the MHOs' 2011 program activities and documentation, sought to answer the following questions:

1. Does the MHO meet CMS regulatory requirements?
2. Does the MHO meet the requirements of its contract 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 2012. High-level summary results appear below.

Review Procedures

Data collection procedures, adapted from CMS protocols, consisted of the following steps.

1. Each MHO received a written copy of all interview questions and documentation requirements in advance of onsite interviews.
2. The MHOs uploaded the requested documentation to a secure data transfer site for Acumentra Health for review.
3. Acumentra Health staff visited the MHO 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 was adapted from CMS guidelines. 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.

Compliance Review Sections

Acumentra Health’s review of MHO compliance is organized in the 10 sections shown below. Each section contains review elements corresponding to relevant sections of 42 CFR §438, AMH’s contract with the MHOs, Oregon Administrative Rules, and other state regulations where applicable.

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 in 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 mental health 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 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.

Section 6: Contractual Relationships and Delegation. Address the MHO’s oversight of activities that are delegated to contracted agencies.

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

Section 8: Quality Assessment and Performance Improvement. 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 and the MHO’s process for monitoring adherence to mandated timelines.

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 MHO’s performance on each review element on a scale from 1 to 4 (see Table 2).

Table 2. Scoring scheme for elements in the compliance review.		
Rating	Score	Representation
Fully met	4	●●●●
Substantially met	3	●●●
Partially met	2	●●
Not met	1	●

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:

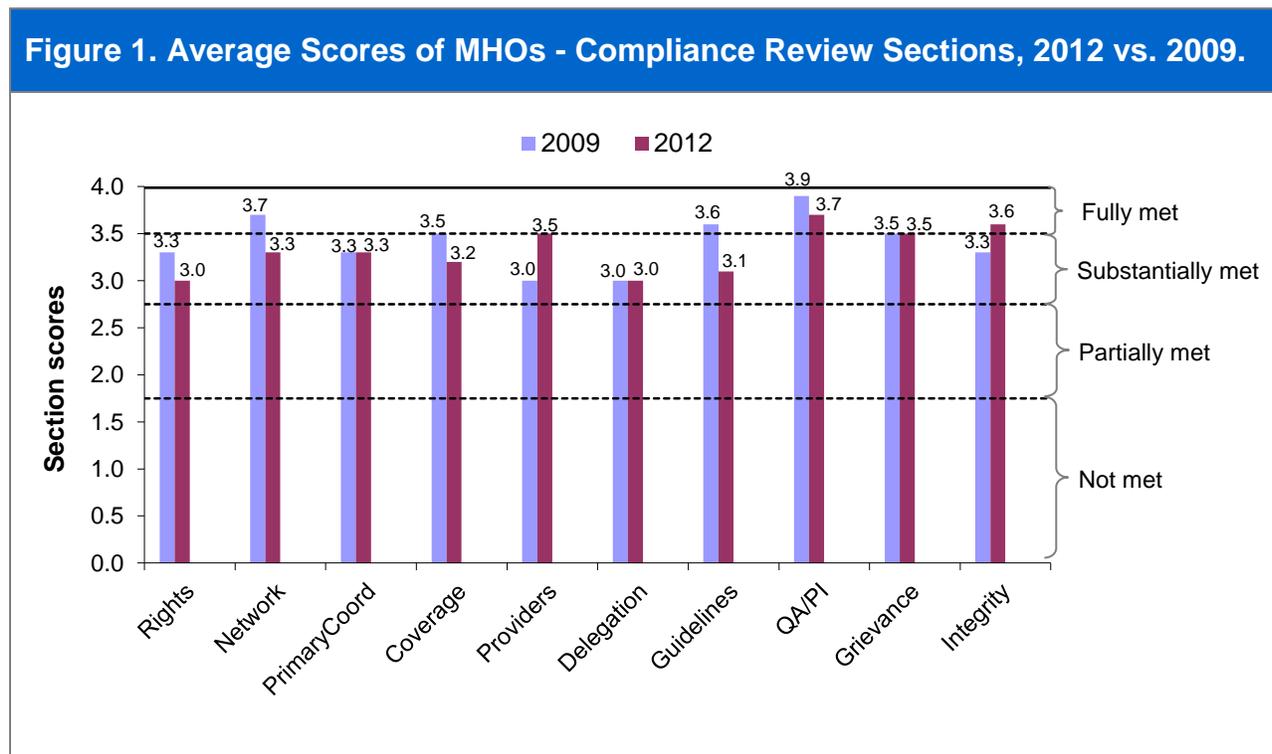
- 3.5 to 4.0 = Fully met
- 2.75 to 3.4 = Substantially met
- 1.75 to 2.74 = Partially met
- <1.75 = Not met

In scoring each section, Acumentra Health assigned “findings” for areas in which the MHO did not comply with federal and/or state requirements. The report lists recommendations on how to address any findings, and notes recommendations for improvement in areas where there were no findings but where MHOs did not clearly or comprehensively meet the requirements.

Review Results

Figure 1 shows the scores on each compliance review standard, averaged across the MHOs reviewed in 2009 and 2012. On average, the MHOs in 2012 *fully met* four standards and *substantially met* the remaining standards. For 5 of the 10 standards, the average compliance scores in 2012 were lower than the 2009 scores.

NOTE: In this and subsequent charts, the 2012 averages include scores for PacificSource, but the 2009 averages do not, since PacificSource was not reviewed until 2011.

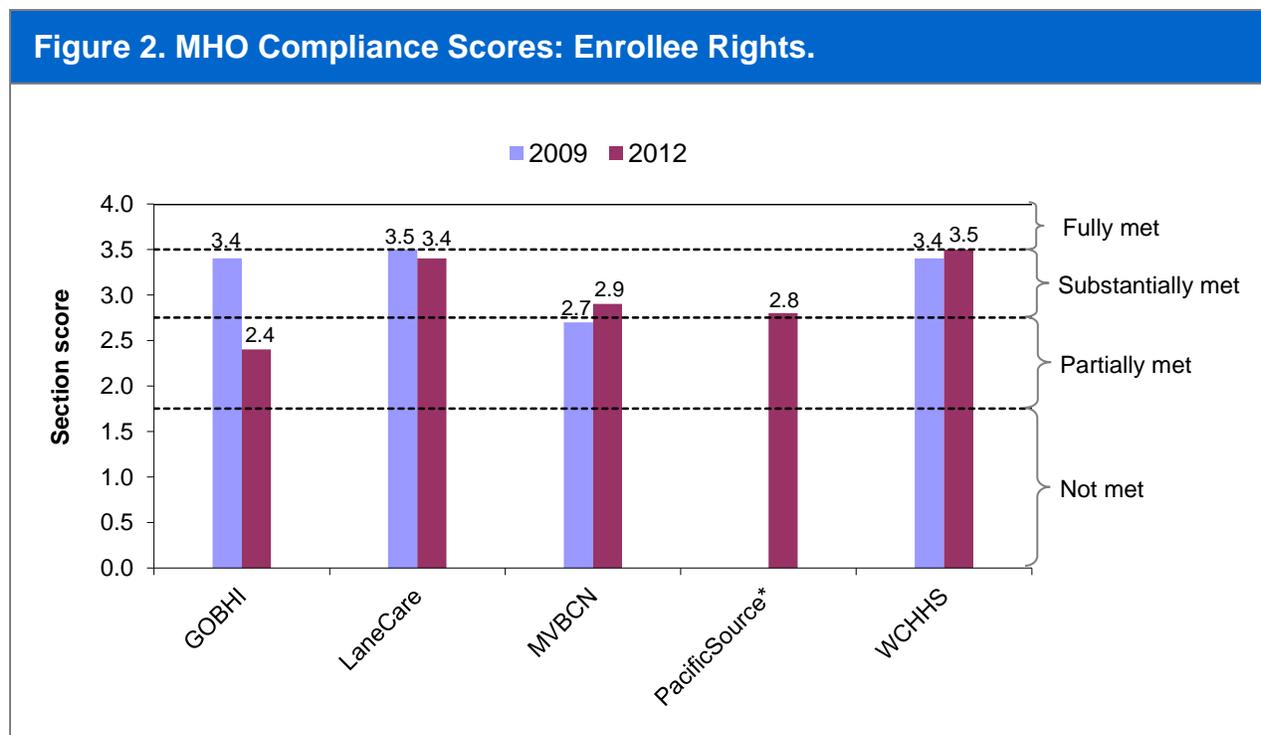


The following pages discuss the MHOs’ overall strengths and recommendations in each review section. The individual MHO reports delivered to AMH during 2012 contain further details.

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, only WCHHS *fully met* the criteria for the enrollee rights section in 2012, though three other MHOs *substantially met* the criteria. MVBCN's compliance score rose to *substantially met* from partially met in the previous review. Table 3 shows the most common opportunities for improvement and recommendations for this section.



*PacificSource was not reviewed in 2009.

Major strengths

- Most of the MHOs have mechanisms to ensure that enrollee rights are in place, communicated to enrollees, and honored by the agencies.
- All MHOs' member handbooks are written in easy-to-understand language. All MHOs make their handbooks available in alternative formats, including additional languages, large print, and Braille.

- All MHOs’ provider contracts, policies, and procedures include provisions regarding compliance with federal and state laws, and most MHOs perform monitoring to ensure that the providers comply.
- WCHHS’s certification reviews of providers address all required enrollee rights, including the right to be treated with respect and dignity, as well as confidentiality.
- All MHOs’ provider contracts require the providers to advocate on behalf of enrollees with regard to treatment options.

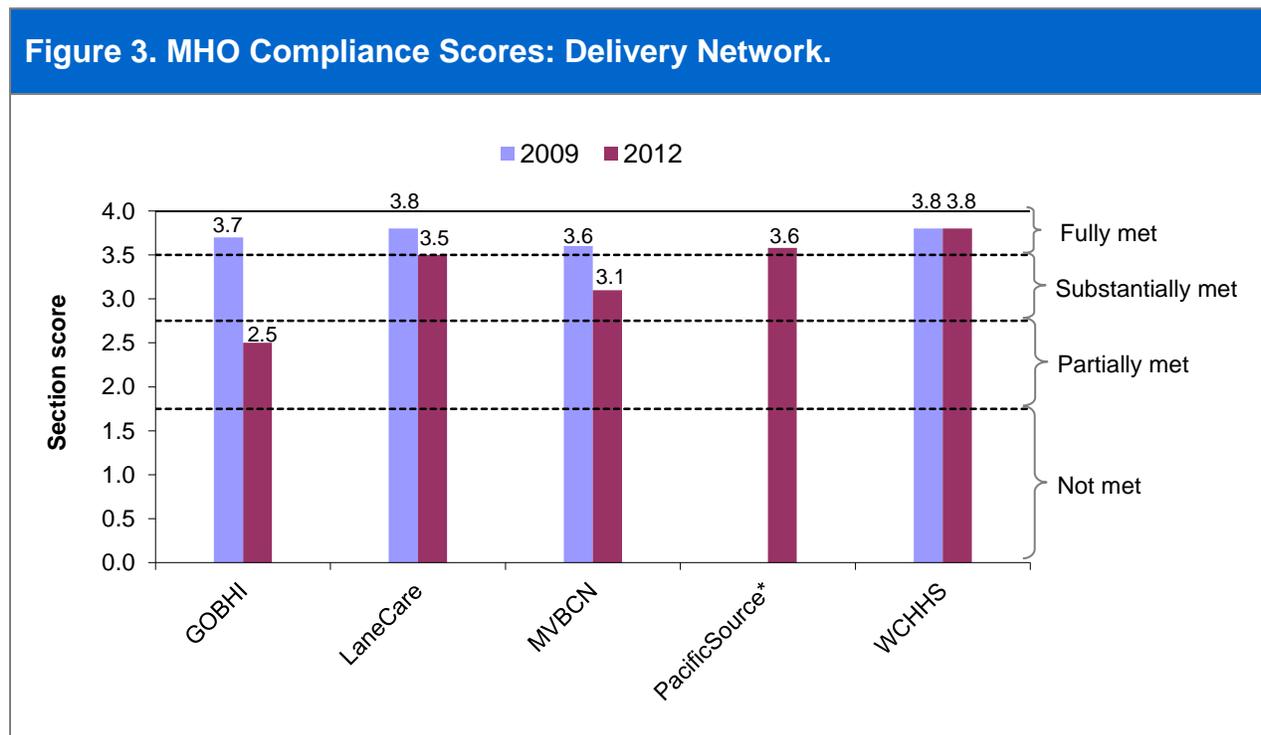
Table 3. Opportunities for Improvement and Recommendations: Enrollee Rights.

Opportunities for improvement	Recommendations
Three of the five MHOs continued to lack a documented process for monitoring the use of translation or interpretive services and of written information in alternative formats.	MHOs need to have documented processes for monitoring the use of translation or interpretive services and of written information in alternative formats.
Three of the five MHOs did not provide complete information on contracted practitioners in the enrollee’s service area, and did not identify providers who were not accepting new clients.	MHOs need to provide names, locations, telephone numbers of, and non-English languages spoken by contracted practitioners in the service area, and identify providers who are not accepting new clients.
Three MHOs did not inform enrollees regarding liability for payment for authorized services delivered by insolvent providers.	MHOs need to inform enrollees regarding lack of liability for payment for authorized services delivered by insolvent providers.
Most MHOs did not inform enrollees or their families or surrogates that they may file complaints about noncompliance with Declaration for Mental Health treatment directives with the State Survey and Certification agency.	MHOs need to inform enrollees or their families or surrogates that they may file complaints about noncompliance with Declaration for Mental Health treatment directives with the State Survey and Certification agency.
Four MHOs did not review the use of seclusion and restraints by contracted providers and facilities as part of their credentialing and recredentialing processes.	MHOs need to review the use of seclusion and restraints by contracted providers and facilities as part of their credentialing and recredentialing processes.
Four MHOs lacked a process to monitor providers’ compliance with enrollees’ right to clinical records.	MHOs need to have a process for monitoring providers’ compliance with enrollees’ right to clinical records.

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.

Figure 3 shows that three of the five MHOs reviewed in 2012 *fully met* the criteria for this section. However, both GOBHI and MVBCN, which had fully met the standards in 2009, fell to *substantially met* in 2012. Table 4 shows the most common opportunities for improvement and recommendations for this section.



*PacificSource was not reviewed in 2009.

Major strengths

- WCHHS has expanded its provider network to meet enrollees' needs, as identified through quality management indicator data, needs assessments, and capacity and gap reports.
- To assess network capacity, PacificSource reviews comprehensive utilization management reports and monthly acute care reports; monitors grievances, complaints, and compliance with access standards; and receives feedback from care managers during care coordination committee meetings.
- Several MHOs fully meet the criterion for cultural consideration.

- Four MHOs have a policy requiring out-of-network providers to coordinate with the MHO with respect to payment and to ensure that cost to the enrollee is no greater than it would be if services were furnished within the network.

Table 4. Opportunities for Improvement and Recommendations: Delivery Network.

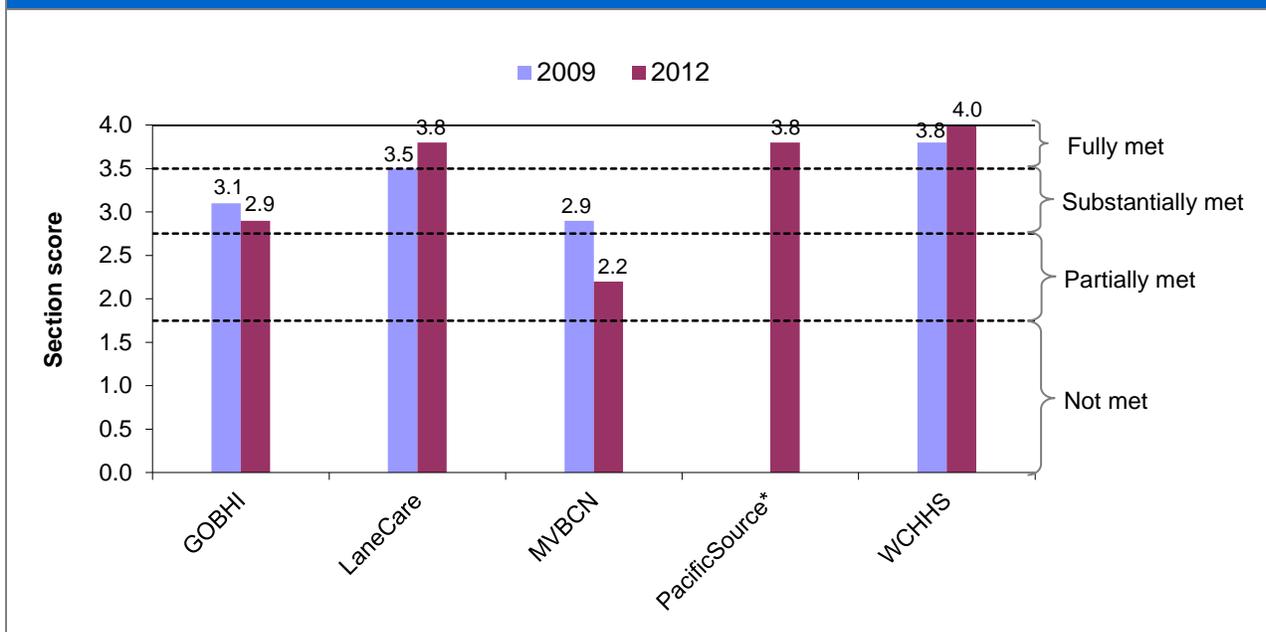
Opportunities for improvement	Recommendations
Three MHOs lacked documentation of their processes for monitoring out-of-network encounters.	MHOs need to document their processes for monitoring out-of-network encounters, and analyze and use the information to improve network adequacy and timeliness.
All MHOs had difficulty meeting and monitoring access-to-care standards.	MHOs need to implement mechanisms to meet and monitor standards for timely access to care.
Three MHOs lacked formal processes to monitor for the use of second opinions.	MHOs need to have formal processes in place to monitor for the use of second opinions.

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, three of the five MHOs reviewed in 2012 *fully met* the criteria for this section, with WCHHS fully meeting each individual criterion. Table 5 shows the most common opportunities for improvement and recommendations for this section.

Figure 4. MHO Compliance Scores: Primary Care and Coordination of Services.



*PacificSource was not reviewed in 2009.

Major strengths

- Three MHOs (LaneCare, PacificSource, WCHHS) have implemented policies and procedures to identify and assess enrollees with special healthcare needs.
- Three MHOs (GOBHI, MVBCN, PacificSource) ensure coordination and continuity of care with other mental healthcare providers through a variety of initiatives, performing chart reviews, meeting with other allied agencies, and through community education programs.
- Three MHOs' (LaneCare, PacificSource, WCHHS) treatment plans address additional care services, incorporate treatment recommendations of their

provider agencies, and are developed with the participation of enrollees and their families.

- PacificSource’s chart audit includes a comprehensive clinical review, covering intake assessments, referrals, treatment planning, consumer participation, progress notes, medication supervision, and discharge planning. All audit results are referred to the MHO’s quality committee for review and monitoring.

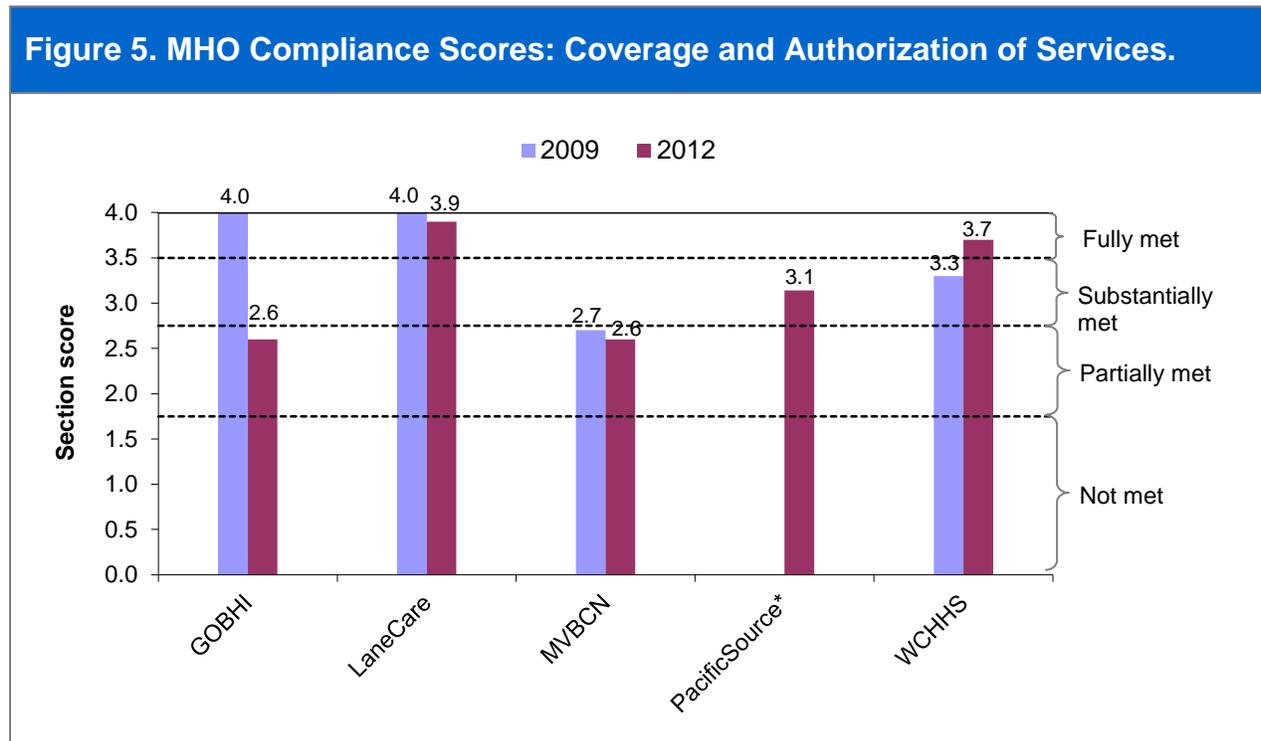
Table 5. Opportunities for Improvement and Recommendations: Primary Care and Coordination of Service.

Opportunities for improvement	Recommendations
Four MHOs did not document their processes for monitoring enrollees’ direct access to specialists.	MHOs need to document their processes for monitoring enrollees’ direct access to specialists.

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 LaneCare and WCHHS *fully met* the criteria for this section in 2012, while GOBHI's compliance score slipped from *fully met* to *partially met*. Table 6 shows the most common opportunities for improvement and recommendations for this section.



*PacificSource was not reviewed in 2009.

Major strengths

- Most MHOs have policies and procedures prohibiting compensation from being structured to provide incentives to deny, limit, or discontinue clinically necessary services to enrollees.
- Most MHOs ensure that contracted providers do not provide incentives to deny, limit, or discontinue clinically necessary services to enrollees.

Table 6. Opportunities for Improvement and Recommendations: Coverage and Authorization of Services.

Opportunities for improvement	Recommendations
Four MHOs lacked mechanisms to ensure consistent application of review criteria for service authorizations.	MHOs need to have mechanisms in place to ensure consistent application of review criteria for service authorizations.
Three MHOs did not monitor the use of crisis services for inappropriate or avoidable use related to access to routine care.	MHOs need to monitor the use of crisis services for inappropriate or avoidable use related to access to routine care.

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 three of the five MHOS reviewed in 2012 *fully met* criteria for this section. LaneCare and WCHHS, which had *fully met* the section in 2009, slipped to *substantially met* this year. Table 7 shows the most common opportunities for improvement and recommendations for this section.



*PacificSource was not reviewed in 2009.

Overall strengths

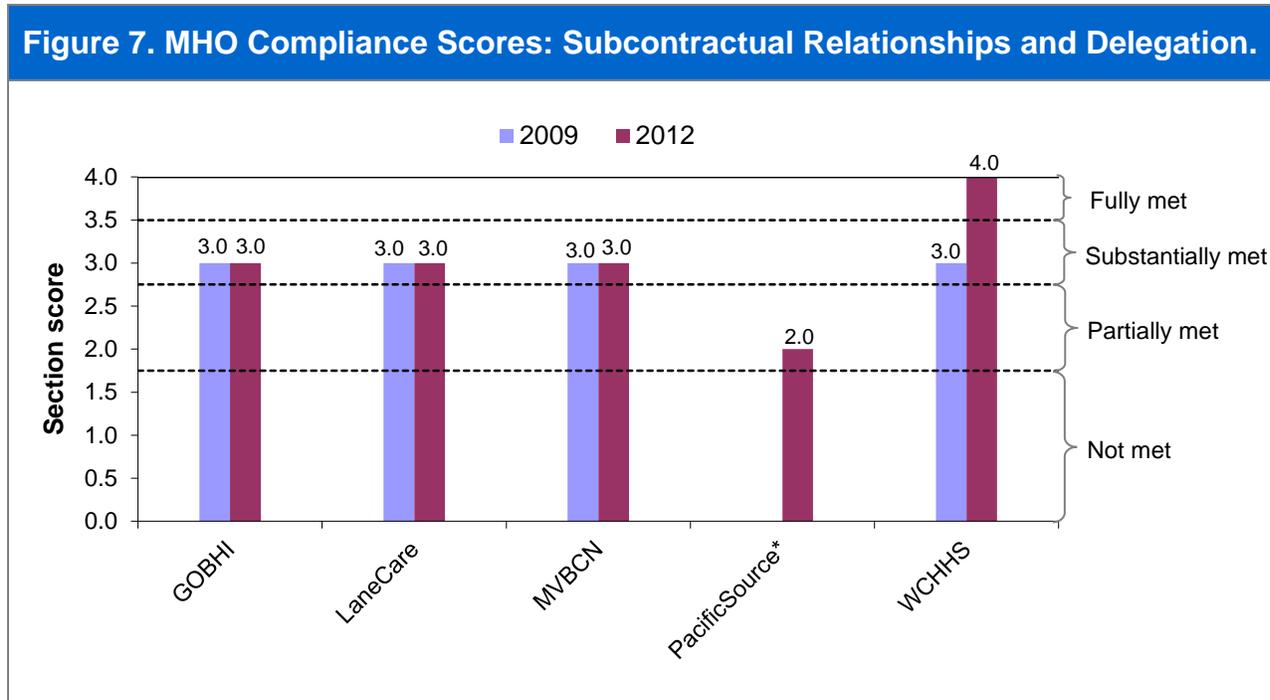
- Most MHOs have thorough credentialing/recredentialing policies and procedures in place.
- Most MHOs ensure a nondiscriminatory process for selecting and compensating providers.

Table 7. Opportunities for Improvement and Recommendations: Provider Selection.

Opportunities for improvement	Recommendations
Two MHOs did not routinely check during recredentialing whether individuals or organizations are excluded from participating in federal healthcare programs.	MHOs need to check for federal exclusion more often than at the time of credentialing.

Section 6: Subcontractual 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, only WCHHS *fully met* the criteria for this section in 2012. Table 8 shows the most common opportunities for improvement and recommendations for this section.



*PacificSource was not reviewed in 2009.

Major strengths

- Two MHOs perform thorough oversight and engagement with their providers and subcontractors. They accomplish this through site reviews, clinical record audits, and provider relations.

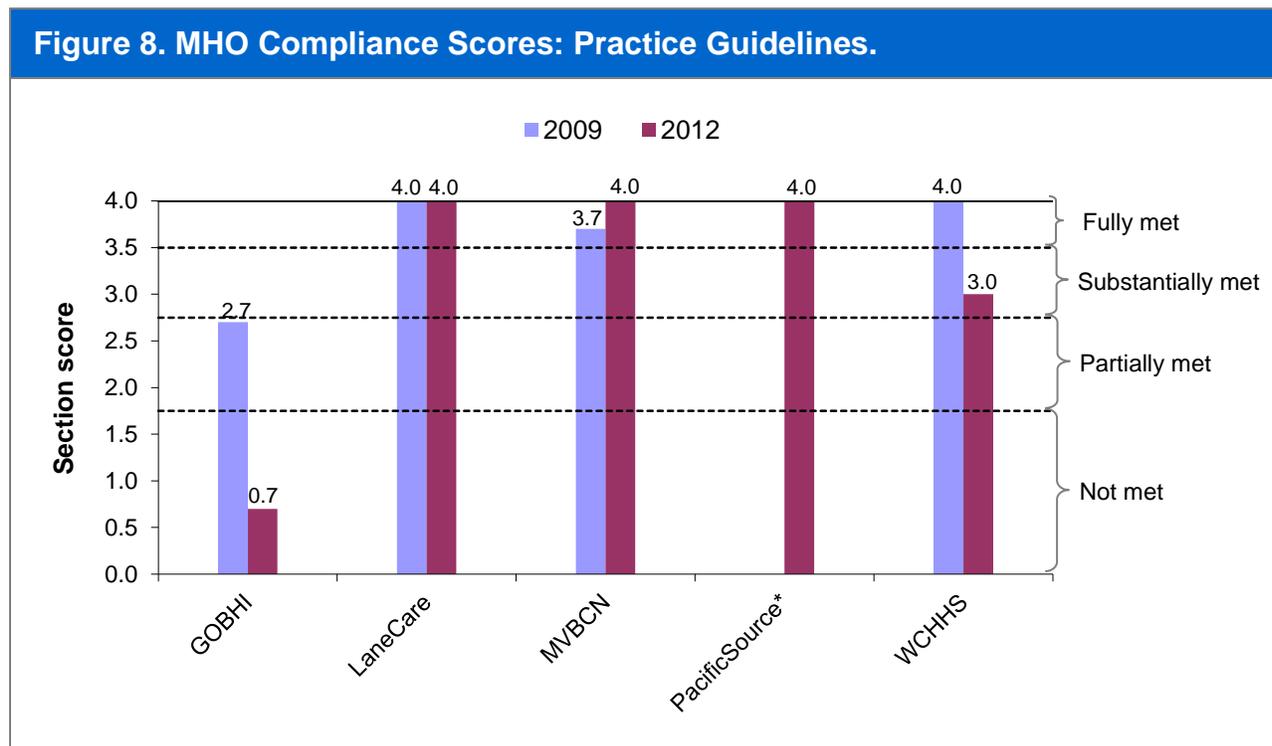
Table 8. Opportunities for Improvement and Recommendations: Subcontractual Relationships and Delegation.

Opportunities for improvement	Recommendations
Three MHOs did not monitor all providers to determine whether there are performance deficiencies.	MHOs need to monitor all providers to determine whether there are performance deficiencies.

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 LaneCare, MVBCN, and PacificSource *fully met* this standard with perfect scores in 2012, while GOBHI failed to comply with this standard. Table 9 shows the most common opportunities for improvement and recommendations for this section.



*PacificSource was not reviewed in 2009.

Major strengths

- Most MHOs have adopted practice guidelines that are based on valid and reliable clinical evidence and that reflect the needs of enrollees.
- Several MHOs incorporate the review of practice guidelines into their quality assurance committee activities.
- Several MHOs monitor the use of practice guidelines as a part of clinical record reviews.

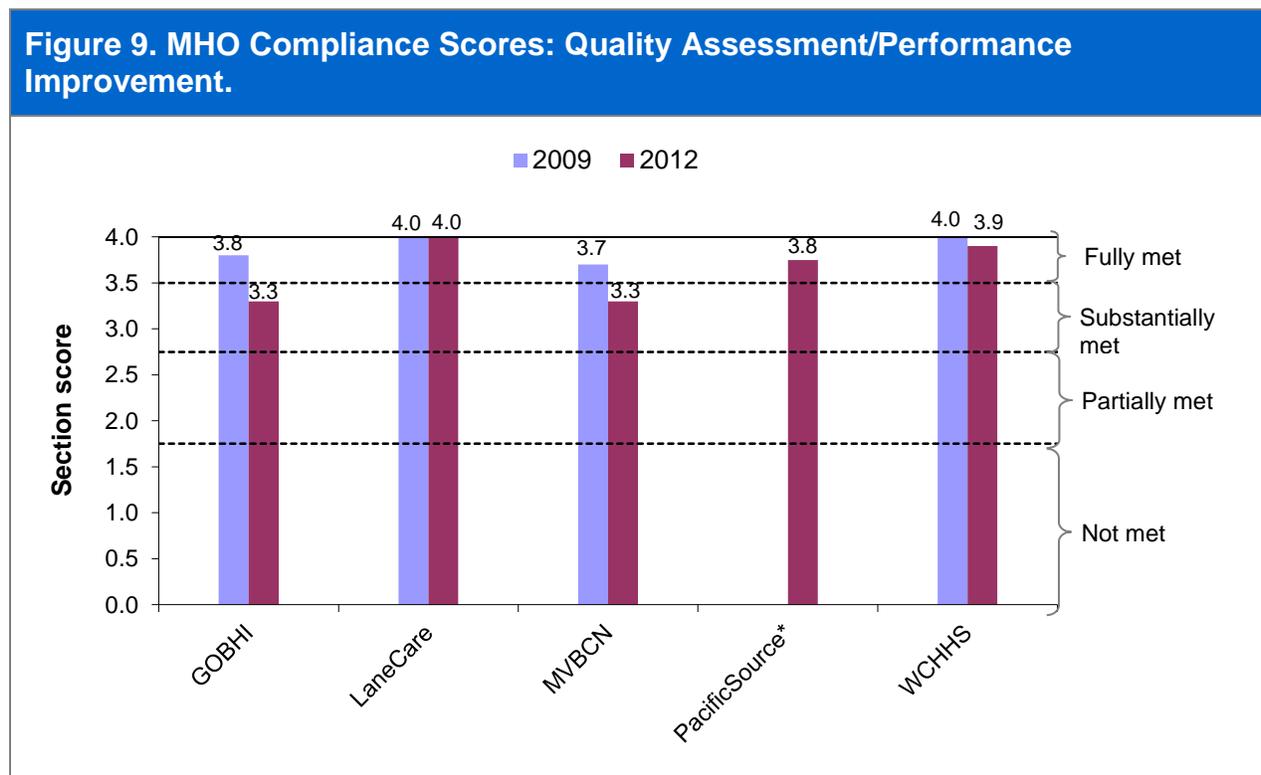
Table 9. Opportunities for Improvement and Recommendations: Practice Guidelines.

Opportunities for improvement	Recommendations
Three MHOs did not document dissemination of mental health practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	MHOs need to document dissemination of mental health practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

Section 8: Quality Assessment/Performance Improvement

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 three of the five MHOs reviewed in 2012 *fully met* the criteria for this section, and the other two MHOs *substantially met* the criteria. Table 10 shows the most common opportunities for improvement and recommendations for this section.



*PacificSource was not reviewed in 2009.

Major strengths

- Several MHOs have comprehensive QA/PI plans that include goals, measurable objectives, and interventions.
- LaneCare’s QA/PI workplan includes objectives designed to ensure appropriate utilization of resources.
- The MHOs operate health information systems that collect, analyze, integrate, and report data to identify unmet service needs.

- To identify underutilization, PacificSource reviews subcapitation amounts distributed to the counties and the percentage used for services; reviews county trends in services per member per month; and reviews the intensity of children’s services compared with family services.

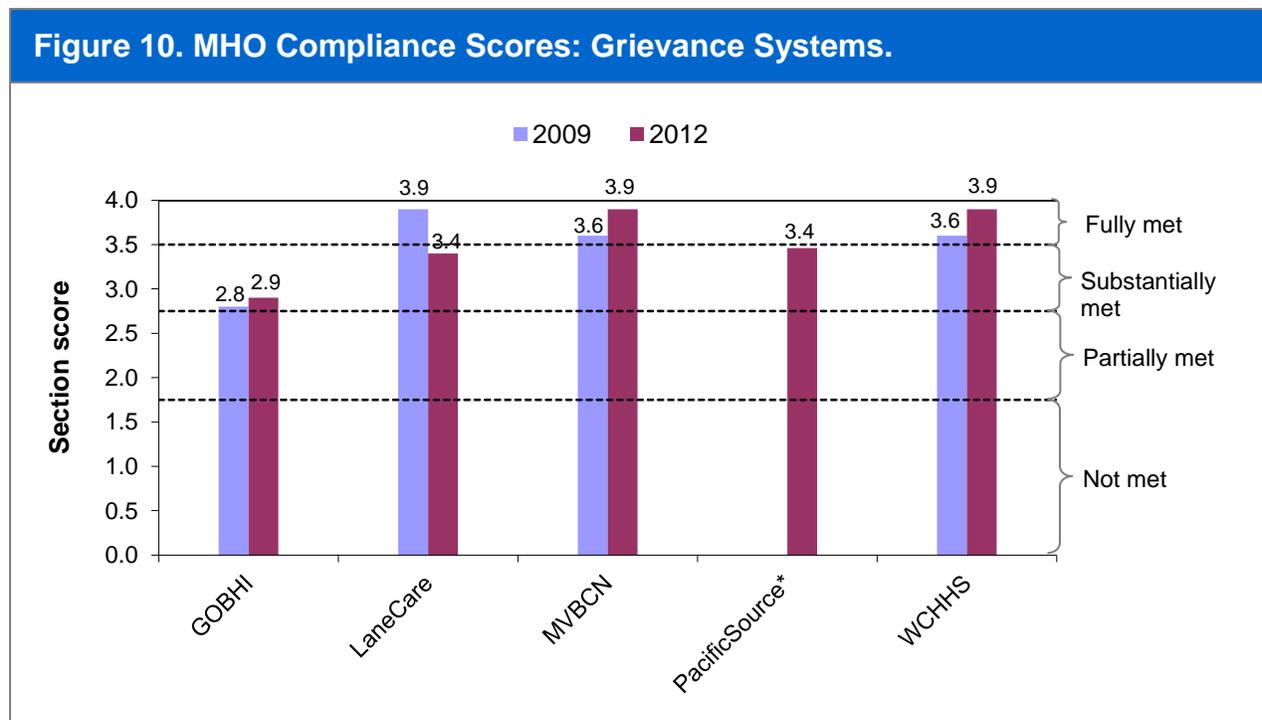
Table 10. Opportunities for Improvement and Recommendations: Quality Assessment/Performance Improvement.

Opportunities for improvement	Recommendations
Three MHOs did not monitor and track utilization of services to detect over- and underutilization.	MHOs need to monitor and track utilization of services to detect over- and underutilization.

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 to 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 MVBCN and WCHHS *fully met* criteria for this section in 2012, while LaneCare’s compliance score slipped from fully met in 2009 to *substantially met* this year. Table 11 shows the most common opportunities for improvement and recommendations for this section.



*PacificSource was not reviewed in 2009.

Major strengths

- Most MHOs’ member handbooks inform enrollees about their right to file grievances and appeals and about the state fair hearing process.
- Most MHOs’ notices of action are written in easily understood language and conform to content requirements.

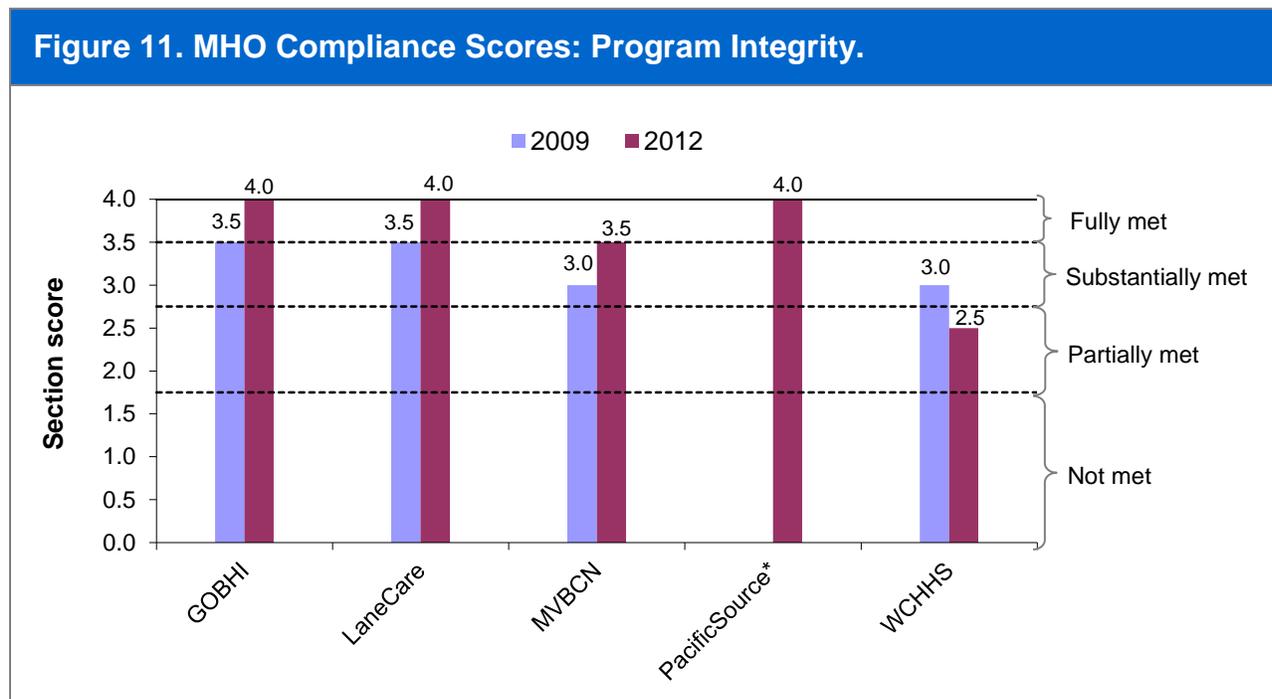
Table 11. Opportunities for Improvement and Recommendations: Grievance Systems.

Opportunities for improvement	Recommendations
All MHOs lacked thorough processes to monitor the timeliness of grievance systems, including the timeliness of notices of action.	All MHOs need to have more thorough processes in place to monitor their providers' grievance systems and to ensure the timeliness of notices of action, appeals, and resolutions.

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.

Figure 11 shows that four of the five MHOs reviewed in 2012 *fully met* criteria for this section, while WCHHS *partially met* the criteria. Table 12 shows the most common opportunities for improvement and recommendations for this section.



*PacificSource was not reviewed in 2009.

Major strengths

- Most of the MHOs have administrative and management arrangements and procedures in place to guard against fraud and abuse.

Table 12. Opportunities for Improvement and Recommendations: Program Integrity.

Opportunities for improvement	Recommendations
Two MHOs provided limited training for their compliance officers and staff.	MHOs need to provide more formalized training for compliance officers and staff.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

Under federal regulations, a managed care organization that serves Medicaid enrollees “must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas” (42 CFR §438.240(d)). Oregon MHOs are required to report on two performance improvement projects (PIPs) each year. Acumentra Health validates these PIPs as part of the EQR process to ensure that they are designed, conducted, and reported with sound methods.

In 2012, AMH allowed each MHO to choose its own topic for one PIP. For the second PIP, the MHOs could either continue their current collaborative PIPs or adopt a new PIP focusing on members with SPMI and treatable medical conditions. The MHO contract defined this new PIP topic as follows:

“Contractor shall perform a PIP that addresses Members with serious mental illness increased morbidity and mortality due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse and inadequate access to medical care.”

Acumentra Health reviewed 18 PIPs for 2012. Two MHOs submitted only one PIP apiece for review. All but one of the 18 PIPs were continued from 2011; one PIP continued a previous collaborative PIP topic, but with a new study population and intervention. Five continuing PIPs focused on the SPMI population, and four collaborative PIPs addressed this population as well. Detailed evaluations of the PIPs appear in separate reports for each MHO, submitted to AMH by Acumentra Health during 2012. Summary results appear below.

PIP Review Procedures

This is the eighth year that Acumentra Health has evaluated PIPs for AMH under EQR contracts. The CMS protocol has been adapted into a set of 10 standards with explicit criteria and scoring methods, as approved by AMH. The standards cover the following main elements.

- Introduce the study topic as an area of concern, supported by an investigation of local data and other sources, and describe how the topic was prioritized in relation to outcomes, satisfaction, or quality of care for the local Medicaid population (Standard 1).
- Produce a study question that establishes a clear framework for analysis, with a quantifiable indicator and well-defined terms (Standards 2 and 3).

- Provide operational definitions for the study population and the study indicator that include data sources, data collection procedures, data validation, a timeframe, and an analysis plan (Standards 4 and 5).
- Thoroughly describe the improvement strategy (intervention), including reasons for choosing it and methods to track implementation (Standard 6).
- Present, analyze, and discuss collected data from before and after the intervention, interpret the clinical significance of the project, and discuss barriers and confounding factors that may have affected the results (Standards 7 and 8).
- Follow the initial results with a second remeasurement, discuss barriers and modifications, lessons learned, and overall significance of the project (Standards 9 and 10).

The MHOs received a template explaining the standards, with detailed scoring criteria to assist them in developing high-quality projects. Each MHO submitted an initial report of its PIPs two weeks before a scheduled onsite interview. Acumentra Health's QI specialists reviewed the submitted documents and conducted the onsite interviews, discussing the study design and report for each PIP with the MHO staff responsible for the projects. The MHO then had the opportunity to submit a final report on the PIPs within two weeks following the interview date. PIPs were scored solely on the documentation provided in the final reports.

At the direction of AMH and DMAP, Acumentra Health reviewed each MHO/MCO collaborative PIP as a single project. The collaborative projects were submitted and reviewed through the MHO partner, and the evaluation and recommendations applied to both partners.

Compliance Rating

To determine the level of compliance with federal standards, Acumentra Health assigned a score to each PIP. The scoring methodology evaluated the MHO's performance on 10 standards (see Table 13). The first eight standards comprise the planning, implementation, and reporting phases for a complete project. The final two standards relate to sustained improvement and are counted in the scoring only after a second remeasurement, which may repeat or modify the plan and its implementation.

Table 13. Standards for PIP Validation.

Demonstrable improvement	
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 “real” change
Sustained improvement	
9	The MHO has documented additional or ongoing interventions or modifications
10	The 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 an overall PIP score. The overall score is weighted 90% for the baseline and the first remeasurement (Standards 1–8), and 100% for second remeasurement and sustained improvement in later years (Standards 9–10). Thus, for a PIP that has completed one remeasurement, the maximum overall project score is 90 points. If the PIP has progressed to at least a second remeasurement, enabling reviewers to assess sustained improvement, the maximum overall project score is 100.

Appendix B defines the specific criteria used to evaluate performance and presents a sample scoring worksheet.

Table 14 shows the compliance ratings and associated scoring ranges for PIPs rated on the 90-point and 100-point scales. (Note: these compliance rating ranges for the overall PIP score are different from the ranges used in assessing compliance for individual PIP standards.)

Table 14. Overall PIP Scoring Ranges.			
Compliance rating	Description	100-point scale	90-point scale
Fully met	Meets or exceeds all requirements; readers can have high confidence in the results	80–100	72–90
Substantially met	Meets essential requirements, has minor deficiencies that do not substantially affect the project; readers can have confidence in the results	60–79	54–71
Partially met	Meets essential requirements in most, but not all, areas, with substantial impact on the project; because of these deficiencies and/or the current stage of development, readers should have limited confidence in the project	40–59	36–53
Minimally met	Marginally meets requirements, with substantial impact on the project; because of these deficiencies and/or the current stage of development, readers should have low confidence in the project	20–39	18–35
Not met	Does not meet essential requirements; because of these deficiencies and/or the current stage of development, readers should have no confidence in the project	0–19	0–17

To calculate overall scores for PIPs, Acumentra Health used a weighting procedure introduced in 2011. The weighting emphasizes the importance of Standard 1, under which the study topic is developed. The score for Standard 1 is double the weight (20%) of the other standards in the base set of standards through Standard 8, which are all weighted equally (10%). The weights for Standards 9 and 10 are half that for other standards (5%).

As approved by AMH, Acumentra Health scores all PIP Standards 1 through 8. Standards that are not completed receive a score of zero. Standards 9 and 10 are excluded from the overall score until a second remeasurement occurs.

PIP Review Results

Since all but one of the PIPs reviewed in 2012 were continued from 2011, the following analysis uses the same categories as in last year's review: plan-specific and collaborative PIPs.

Plan-specific PIPs

Table 15 lists the MHOs' plan-specific PIP submissions in 2012.

- All nine PIPs were continued from 2011, including one PIP (LaneCare) that had been in very early development at the time of the 2011 review.
- One MHO (WCHHS) submitted two plan-specific PIPs (one initiated in 2011, the other initiated in 2010).
- One MHO (MVBCN) did not submit a plan-specific PIP, and received a score of zero.

The plan-specific PIPs had several common themes: two PIPs focused on initiation and engagement; two (including LaneCare's new PIP) on ACORN, an outcomes-informed care model; and two on mental health assessments for children. One continuing PIP addressed health status and antipsychotic medication use in the SPMI population.

Table 15. Plan-Specific PIP Topics by MHO.

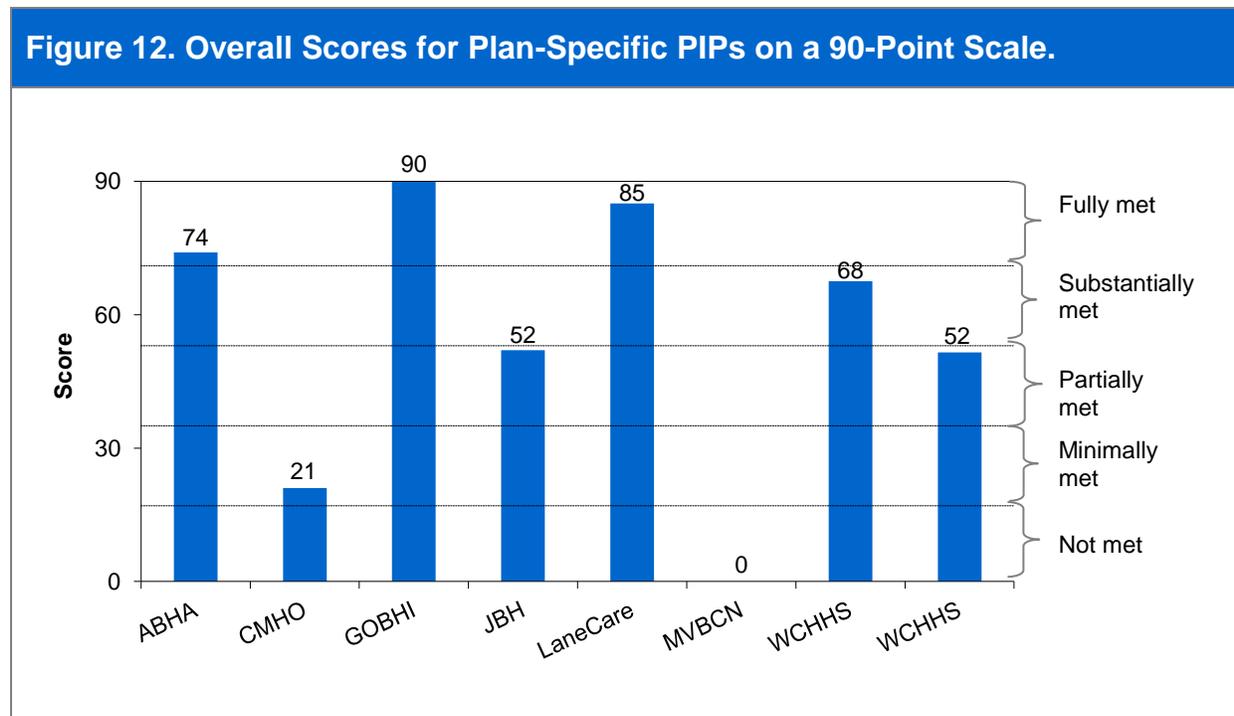
MHO	Year first reviewed	PIP topic	Study focus
ABHA	2010	Initiation and Engagement	Increase the percentage of individuals who engage in regular treatment following intake.
CMHO	2011	Improving No-Show Rates at Provider Agencies	Use a rapid-cycle process to better understand and address the issue of no-show appointments at provider agencies.
GOBHI	2011	Early Childhood Assessment and Intervention Training	Train providers in early childhood assessment and intervention for enrollees aged 5 and younger.
JBH	2011	Timely Mental Health Assessments for Children in Foster Care	Increase percentage of children in foster care who receive a mental health assessment within 60 days of placement.
LaneCare	2011	Implementation of an Outcomes-Informed Care Model (ACORN) (2012)	Measure the extent to which nine provider agencies successfully implement the ACORN model.
MVBCN	n.a.	No plan-specific PIP submitted	n.a.
PacificSource	2010	Initiation and Engagement	Increase the percentage of individuals who engage in regular treatment following intake.
VIBHS	2011	Clinical Outcomes of Mental Health Care using ACORN (“Outcomes Informed Care Initiative” in 2011)	Integrate enrollee feedback and outcomes into the clinical treatment process.
WCHHS	2010	Improved Cultural Competency	Train clinic staff in cultural competency and the use of interpreter services.
WCHHS	2011	Improving Documentation of Healthcare Status for Individuals on Antipsychotic Medications	Implement a standard protocol to document health status for enrollees taking antipsychotic medications.

Plan-specific PIP scores

Eight of the plan-specific PIPs were scored on a 90-point scale (see Figure 12).

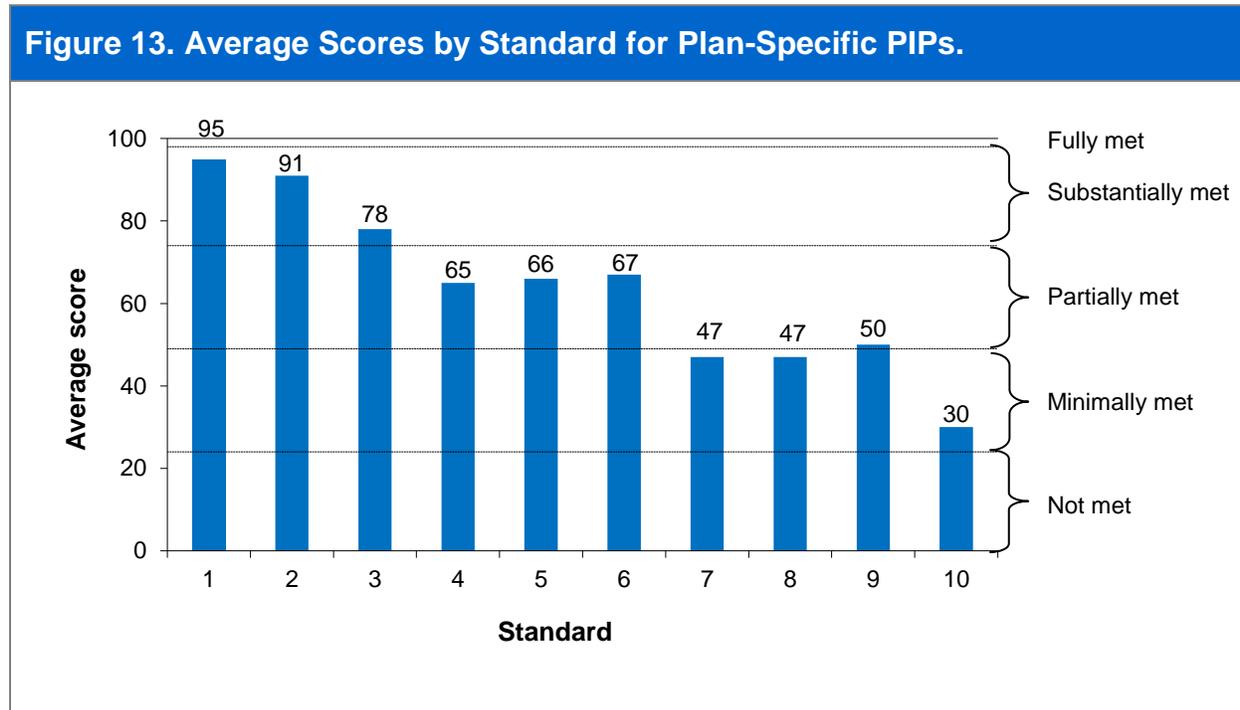
- Three PIPs were rated as *fully met*: ABHA, GOBHI, and LaneCare.
- One of the two WCHHS PIPs was rated as *substantially met*.
- Two PIPs were rated as *partially met* (JBH, WCHHS), one as *minimally met* (CMHO), and one as *not met* (MVBCN's PIP was not submitted).

Two plan-specific PIPs—PacificSource and VIBHS—were scored on a 100-point scale, with PacificSource rated as *substantially met* and VIBHS rated as *fully met* (see Figure 15 on page 50).



The average overall score for all plan-specific PIPs (including a score of 0 for the missing PIP) was 59 in 2012, compared with 39 in 2011. The lower average score in 2011 was influenced by the fact that the majority of PIPs were in the early stages of development. It is a reasonable expectation that by the second year, MHOs would have begun implementing the interventions (Standard 6), collected partial remeasurement data (Standard 7), and might be able to comment on changes in methodology and confounding factors (Standard 8). The average overall score for plan-specific PIPs in 2012 reflects the lower scoring of two PIPs that were discontinued during the review year.

Scores on the individual standards for the nine plan-specific PIPs in 2012 are shown in Figure 13. Only two PIPs completed second remeasurements and were reviewed under Standards 9 and 10. All PIPs addressed the study topic under Standard 1 and produced a study question under Standard 2. See Appendix A for scores on each standard for all MHOs.



Collaborative PIPs

Table 16 shows the collaborative PIPs submitted by MHOs for 2012 (conducted by each MHO in collaboration with a physical health managed care organization).

- Eight PIPs were continued from previous years.
- One PIP (VIBHS) was new for 2012, continuing last year's PIP topic but with a new study population and intervention.
- One MHO (FamilyCare) submitted two collaborative PIPs.
- One MHO (ABHA) did not submit a PIP to meet either this year's SPMI or collaborative requirement, and received a score of zero.
- CMHO submitted a collaborative PIP last year that did not meet contract requirements; it is unclear whether the PIP submitted by CMHO this year was intended to meet the 2012 contract requirement for an SPMI-related PIP. This PIP was reviewed among the collaborative PIPs last year.

The collaborative PIPs had several common themes. Two PIPs focused on chemical dependency, and four PIPs targeted the local SPMI population. Five of the ongoing PIPs (GOBHI, JBH, MVBCN, PacificSource, LaneCare) and the new PIP (VIBHS) documented the work of established partnerships. FamilyCare submitted PIPs that involved collaboration between its own mental and physical health managed care entities.

Table 16. Collaborative PIP Topics by MHO.

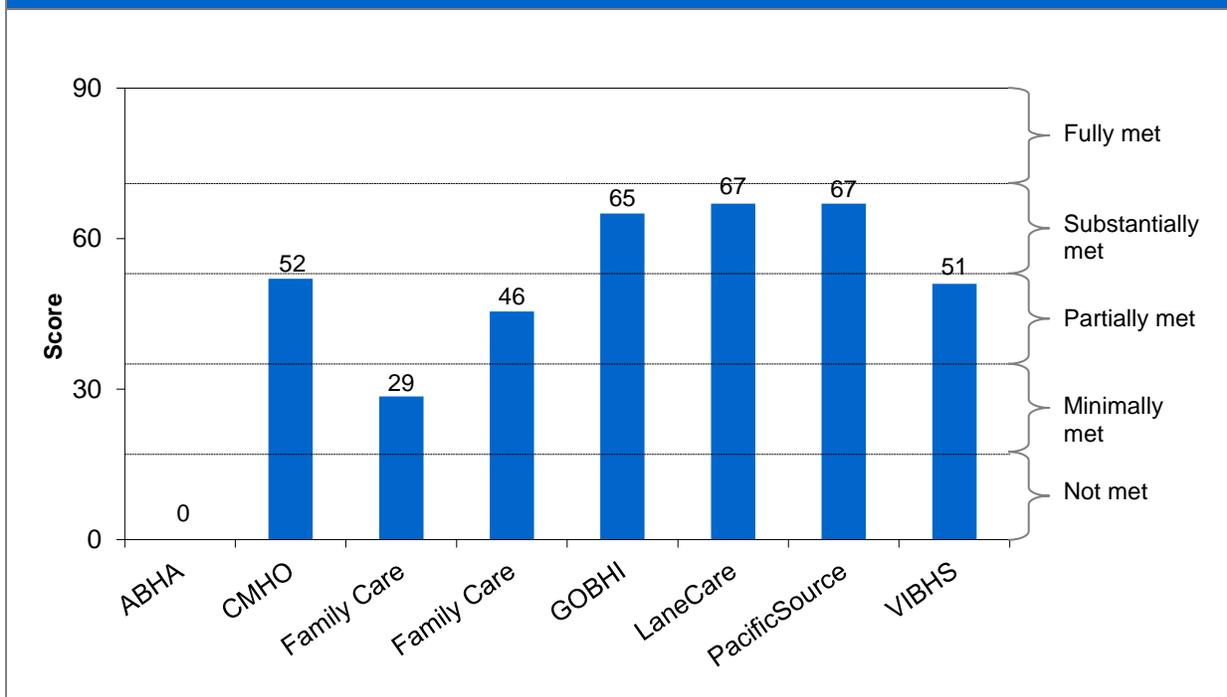
MHO/Partner	Year first reviewed	PIP topic (year first reviewed)	Study focus
ABHA	n.a.	No collaborative PIP submitted.	n.a.
CMHO/CareOregon	2011	Assertive Community Treatment (2011)	Develop Assertive Community Treatment programs at two provider agencies to reduce hospitalization rates.
FamilyCare MHO/ FamilyCare MCO	2011	Chemical Dependency Diagnosis and Mental Health Services with Physical Health Visits	Integrate and coordinate physical and behavioral health care for enrollees with comorbid chemical dependency and mental health issues.
FamilyCare MHO/ FamilyCare MCO	2011	Schizophrenia Diagnosis with Metabolic Testing	Develop metabolic syndrome testing for enrollees with schizophrenia who take antipsychotic medications.
GOBHI/ODS	2011	Screening, Brief Intervention, and Referral to Treatment	Educate providers in use of SBIRT tool.
JBH/FCHP providers	2009	Assessing and Promoting Smoking Cessation	Implement a standardized smoking cessation protocol.
LaneCare/Lane Individual Practice Association	2011	Integration of Physical, Mental, and Chemical Dependency Treatment	Integrate physical and behavioral health care in chemical dependency treatment.
MVBCN/Samaritan InterCommunity Health Network	2010	Improving Diabetes Care for Persons with Mental Illness	Improve screening measures for enrollees with diabetes and SPMI through collaborative care management.
PacificSource/ Mosaic Medical	2011	Physical Health Promotion for the SPMI Population	Promote physical health and preventive services among adults with SPMI.
VIBHS/CareOregon	2012	Integration of Physical and Mental Health Services for Children	Promote communication between physical and behavioral health regarding medication management for children.

Collaborative PIP scores

Eight of the collaborative PIPs were scored on a 90-point scale (see Figure 14). None of the MHOs achieved a rating of *fully met*, though GOBHI, LaneCare, and PacificSource achieved ratings of *substantially met*. The four remaining PIPs had scores of *partially met*, *minimally met*, or in the case of ABHA, *not met*.

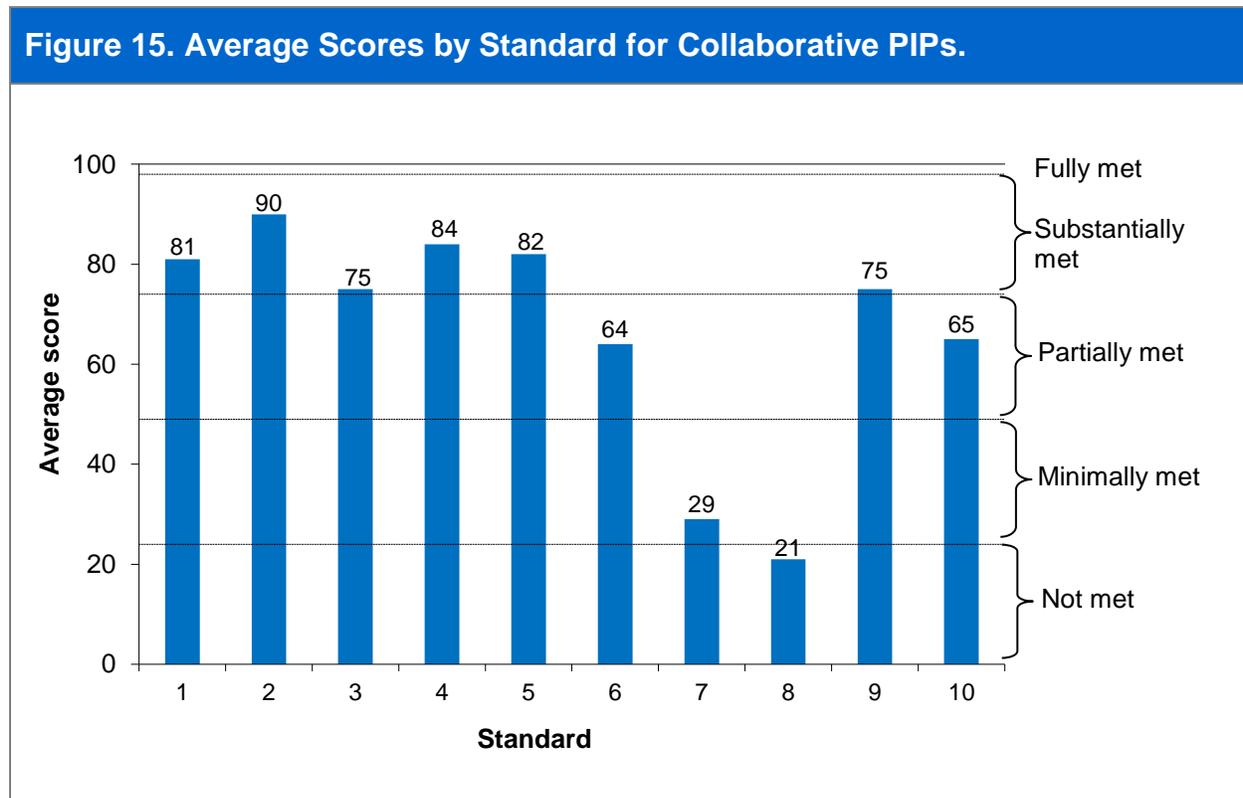
Two collaborative PIPs—JBH and MVBCN—were scored on a 100-point scale, both earning scores of *fully met* (see Figure 16).

Figure 14. Overall Scores for Collaborative PIPs on a 90-Point Scale.



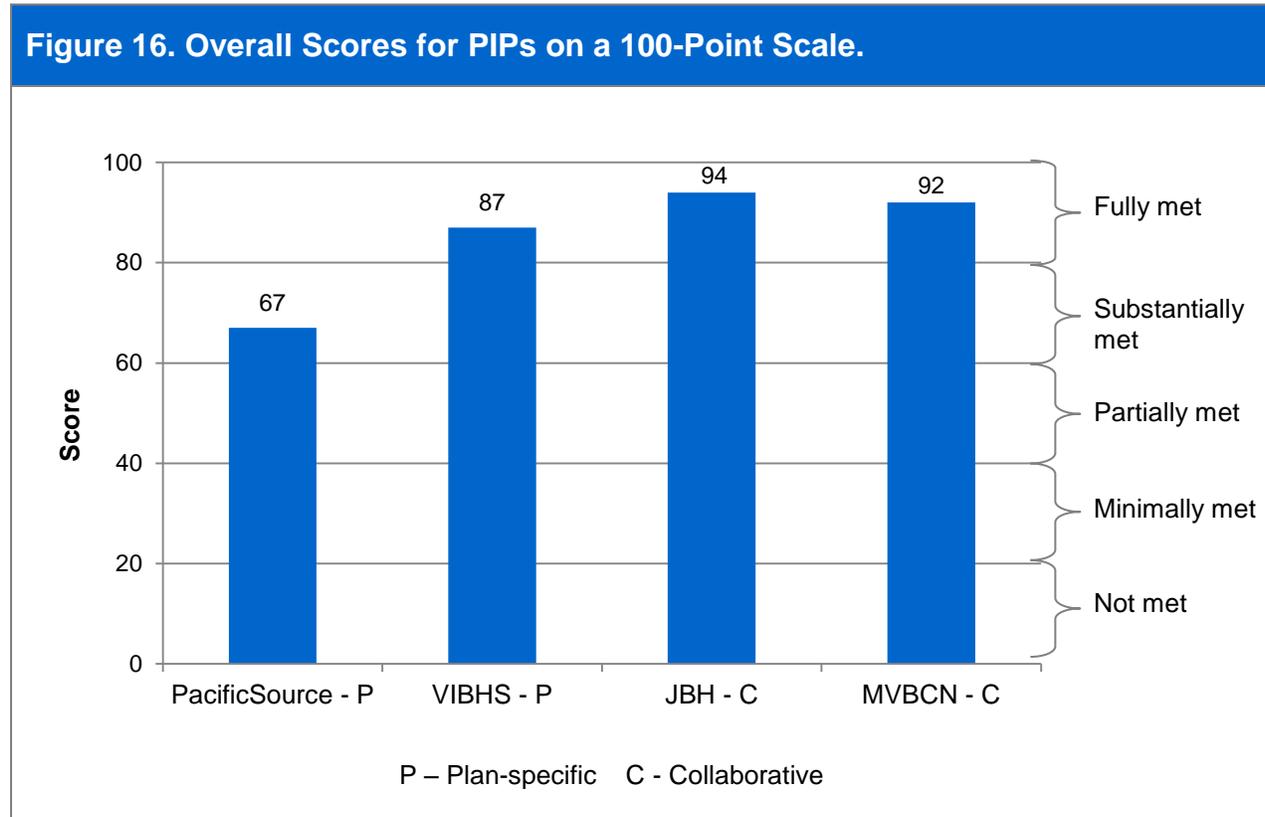
For the basic set of Standards 1–8, the average overall score for all collaborative PIPs (including a score of 0 for the missing PIP) was 55 in 2012, compared with 38 in 2011. As with the plan-specific PIPs, the majority of the collaborative PIPs were in the early stages of development in 2011. The 2012 collaborative PIP scores reflect the challenges of conducting a collaborative project and the prioritization of CCO development by many MHOs and their partners.

Figure 15 shows scores on individual standards for the nine collaborative PIPs submitted in 2012. Only two PIPs completed second remeasurements and were reviewed under Standards 9 and 10. All nine PIPs addressed Standard 1, produced a study question under Standard 2, and developed at least some study design elements under Standards 3–5. See Appendix A for scores on each standard for all MHOs.



PIP scores on 100-point scale

Figure 16 shows scores for the four PIPs (two plan-specific, two collaborative) scored on the 100-point scale. VIBHS, JBH, and MVBCN achieved *fully met* scores, while PacificSource’s plan-specific PIP was rated *substantially met*.



Progress over Time for Ongoing PIPs

Of 17 PIPs continued in 2012 from the previous year, 13 were scored on the 90-point scale (Figure 17). Approximately half of the PIPs reviewed in 2012 showed minimal or no change in the overall score from the previous year. The transition to CCOs caused great uncertainty for many MHOs regarding the future role of their organizations and status of their PIP projects, and resulted in a reallocation of time and resources to CCO development. Two MHOs (CMHO and JBH) discontinued their plan-specific PIPs and did not adopt new PIP topics or interventions. In contrast, LaneCare made impressive progress in 2012, with its collaborative PIP rated as substantially met and its plan-specific PIP rated as fully met. The ABHA plan-specific, GOBHI plan-specific, PacificSource collaborative, and one WCCHS plan-specific PIP also demonstrated significant progress from 2011.

The four PIPs scored on the 100-point scale (Figure 18) also present a diverse picture of progress over time. JBH's and MVBCN's collaborative PIPs were rated as fully met in 2011 (90-point scale), and earned the same rating in 2012 (100-point scale). MVBCN did not have access to second remeasurement data at the time of the PIP review and could not fully address Standards 9 and 10 (presenting and interpreting second remeasurement period results), resulting in only a minimally increased score. After the onsite interview, PacificSource revised its data analysis plan, improving the study design, but did not recalculate remeasurement data in order to meet the resubmission deadline. VIBHS' plan-specific PIP was rated as fully met in 2011 and again in 2012, though with a lower score in 2012 due to the MHO's having changed the study design without a corresponding change in data collection.

Figure 17. Overall Scores for Ongoing PIPs on a 90-Point Scale, 2011 vs. 2012.

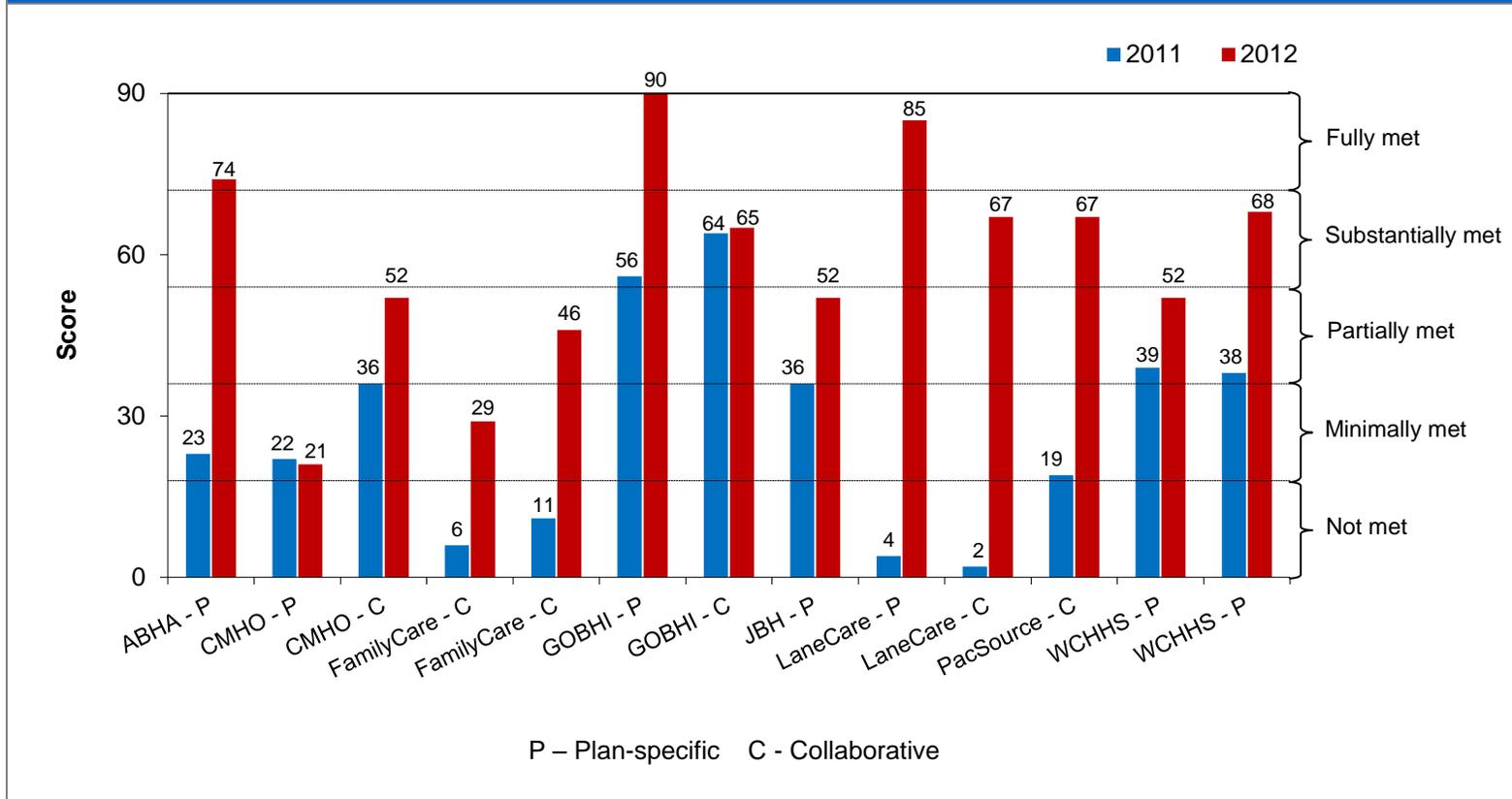
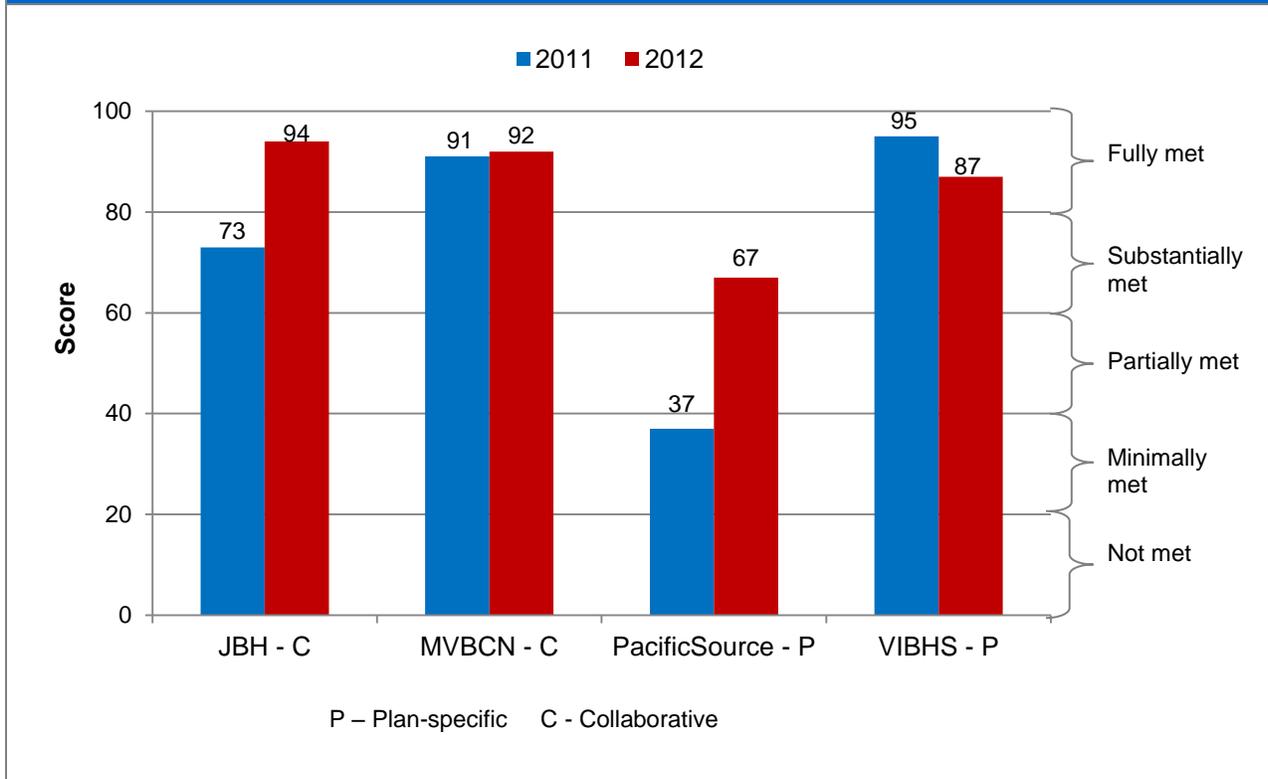


Figure 18. Overall Scores for Ongoing PIPs on a 100-Point Scale, 2011 vs. 2012.



Overall Recommendations

PIPs are an important feature of a quality management program. They enable a health plan to target an area of concern and intervene with a strategy to improve the quality and outcomes of care. Many factors are involved in designing and implementing a successful PIP. The first critical step—focusing on an actual problem or issue with a high priority—is often neglected.

Communication with active stakeholders can provide critical input in identifying a PIP topic. Stakeholder discussions, enrollee complaints and grievances, and feedback from providers and/or consumers are an important corollary to quantitative data collection in illuminating quality issues and developing effective interventions. Making the effort to include input from those who will help implement an intervention can improve the study design and promote cooperation throughout the project.

Recommendation: MHOs need to thoroughly research the choice of each PIP topic, identify the root cause(s) of a quality problem, develop an appropriate intervention strategy, and evaluate the study results.

The following points provide an overview of procedures to select, design, and execute an effective PIP. All of these steps should be planned and reported.

1. **Review and analyze available data.** Determine what data are available to help define the quality problem and the enrollee population involved. For example, describe how many enrollees the problem affects (prevalence) and the demographic and clinical characteristics of the population (e.g., gender, age, diagnosis, etc.).
2. **Identify barriers or root causes of a problem.** Analyzing barriers or root causes will help identify the reasons for poor performance and illuminate potential interventions. MHOs may identify barriers through data analysis, discussions with stakeholders, or by reviewing evidence from formal studies or case reports. Using local data sources will help ensure that the barriers identified are relevant for the local Medicaid population, provider network, and delivery system.
3. **Prioritize the topic.** Compare multiple potential topics. Focus on a high-risk population or a highly prevalent problem within the population. Feasibility considerations may include factors such as the availability of data, resources, and staff buy-in. MHOs should ultimately select PIP topics that offer an opportunity to make significant improvements, and for which resources are available and implementation of an intervention is feasible.

- 4. Select an appropriate intervention.** An intervention needs to respond to the root cause(s) of the quality problem to be addressed. For example, education and training probably will not produce a positive result if the barrier to improvement relates to lack of equipment or organizational capacity. The results of a barrier or root cause analysis will help the MHO select or design an intervention that is relevant to the problem. Interventions should be supported by a barrier analysis, evidence from previous studies, best-practice guidelines, expert advice, or local stakeholder experience.
- 5. Evaluate and interpret the study results.** The MHO should evaluate whether an intervention was implemented as planned, whether it resulted in significant improvement, and whether the study goals were achieved. Before implementing the intervention, the MHO should identify process measures that will track the extent to which the intervention was successfully implemented and reached the target audience. MHOs may solicit feedback from stakeholders to confirm that the intervention was implemented as planned and any positive or negative impacts perceived by stakeholders. MHOs should interpret statistical results to determine whether significant improvement occurred as a result of the intervention, taking into account potential differences between enrollee subgroups and confounding factors, if present. Finally, an evaluation of the overall project should discuss what worked and what did not work and why (barrier analysis), to identify modifications that may improve future iterations of the PIP.

Recommendation: MHOs need to make progress in their projects.

In an ongoing PIP, the MHO may need several years to address all 10 standards. The first year may serve as a planning phase, the second year may present data from the baseline and first remeasurement, and the third year may obtain a second remeasurement.

In 2012, 17 of the 18 PIPs reviewed were ongoing, and 12 of those were in their second year of development. Compared to the previous year, MHOs made the greatest amount of progress in the second-year PIPs in Standards 2 through 5. However, four MHOs did not document or only minimally documented an intervention strategy in Standard 6. As noted earlier, two MHOs in their second year discontinued all work on one of their PIPs.

Recommendations by Standard

Acumentra Health analysts considered the PIP results for all 10 MHOs to assess the group’s overall performance on each standard in the PIP process and to recommend steps for improvement. Results for the two missing PIPs are not included in this analysis.

Standard 1

The purpose of Standard 1 is for the MHO to establish the importance of the PIP topic for its local service population and to demonstrate that it used a systematic selection and prioritization process in choosing the topic.

<u>Rating:</u>	<u>Number of PIPs</u>
Fully met	10
Substantially met	5
Partially met	2
Minimally met	1
Not met	0

Recurring themes in recommendations for Standard 1 included the need to discuss how the MHO solicited input from Medicaid enrollees in the selection process; identify a local area of concern involving high risk, high cost, or a substantial number of individuals in the Medicaid population; and describe how the topic relates to enrollee outcomes, satisfaction, or quality of care.

Best practices

PIPs that fully met Standard 1 (by ABHA, GOBHI, JBH, LaneCare, MVBCN, PacificSource, VIBHS, WCCHS) identified an area of concern, using national data and citations, followed by corresponding local data and MHO data for the Medicaid-eligible population. They then discussed the selection process for the topic, involving input by a quality committee and/or different stakeholders, considering several options. Reasons for choosing the PIP topic were presented, related to improved enrollee outcomes, satisfaction, or quality of care.

Standard 2

The purpose of Standard 2 is to document a study question that provides a clear framework for data collection, analysis, and interpretation. The study question(s) should refer to the proposed intervention, the study population (usually the denominator), and the numerator (a quantitative measure of the desired outcome).

<u>Rating:</u>	<u>Number of PIPs</u>
Fully met	13
Substantially met	1
Partially met	4
Minimally met	0
Not met	0

Recommendations for Standard 2 addressed a need for more clarity in defining the numerator, denominator, metric, and intervention strategy.

Best practices

PIPs that fully met Standard 2 (ABHA, CMHO, GOBHI, JBH, LaneCare, MVBCN, PacificSource, VIBHS, WCHHS) presented the five distinct elements expected in a study question: (a) a defined study population, (b) an outcome measure (indicator), (c) an intervention, (d) an expected direction of change in the indicator, and (e) a metric for the indicator (e.g., a percentage, or average score).

Standard 3

The purpose of Standard 3 is to document the study indicators used to measure performance improvement. The MHO should also discuss the basis for adopting the study indicators as proxies for processes or outcomes of care.

<u>Rating:</u>	<u>Number of PIPs</u>
Fully met	5
Substantially met	7
Partially met	3
Minimally met	2
Not met	1

Recommendations for Standard 3 focused on a need to provide consistent definitions of the numerator, denominator, and key terms. Lower scores indicated that more terms were left undefined or defined inconsistently.

Best practices

PIPs that fully met Standard 3 (GOBHI, MVBCN, VIBHS, WCHHS) provided operational definitions for the study population and study indicator to explain how they would be measured. Definitions of these and other key terms were consistent throughout the documentation. The indicator was justified as a valid measure of enrollee outcomes, satisfaction, or quality of care.

Standard 4

Standard 4 requires the MHO to document all inclusion and exclusion criteria used to select the study population, and to document a method by which the MHO is certain that all eligible enrollees were captured in the study population.

<u>Rating:</u>	<u>Number of PIPs</u>
Fully met	6
Substantially met	4
Partially met	6
Minimally met	0
Not met	2

Recommendations for Standard 4 focused on a need to clarify study population or denominator inclusion criteria, document data sources (including table names, fields, and calculations) and describe data validation procedures.

Best practices

PIPs that fully met Standard 4 (GOBHI, LaneCare, MVBCN, PacificSource) defined all inclusion criteria for the study population, including Medicaid eligibility, and thoroughly described data sources and validation procedures for every data element.

Standard 5

The purpose of Standard 5 is to record procedures for collecting all study data, including which data elements are collected, the source of the data, and systematic methods for collection. Another purpose is to document a data analysis plan, citing the test of significance and probability level that the MHO will use to determine any statistical differences between baseline and remeasurement data.

<u>Rating:</u>	<u>Number of PIPs</u>
Fully met	3
Substantially met	8
Partially met	3
Minimally met	3
Not met	1

Recommendations for this standard highlighted the same elements noted in Standard 4 (definition of numerator inclusion criteria, identification of data sources, and documentation of data validation procedures) as well as a need to define clear measurement periods.

Best practices

PIPs that fully met Standard 5 (GOBHI, JBH, MVBCN) identified specific data sources and detailed data collection and data validation procedures for the numerator. The MHOs presented a study design that clearly defined all measurement periods and identified an appropriate statistical test for measuring change in the indicator.

Standard 6

The purpose of Standard 6 is to document an improvement strategy that will affect a wide range of enrollees or an at-risk enrollee population, and that is reasonably expected to result in measurable improvement. The MHO should document when the intervention was implemented, with the goal of collecting baseline data before implementation and remeasurement data after implementation.

<u>Rating:</u>	<u>Number of PIPs</u>
Fully met	5
Substantially met	6
Partially met	2
Minimally met	2
Not met	3

To improve performance on this standard, MHOs should report more information on tracking of the intervention to confirm that the intervention was implemented as planned; describe the intervention in detail, including dates of implementation; and demonstrate how the intervention will improve the study indicator.

Best practices

The PIPs that fully met Standard 6 (GOBHI, LaneCare, VIBHS) thoroughly described the intervention and justified it as an evidence-based practice to improve enrollee outcomes. The MHOs reported on a procedure to track the implementation of the intervention, and reported the date when the intervention was completed.

Standard 7

The purpose of Standard 7 is to analyze baseline and remeasurement data to determine whether the intervention strategy resulted in measurable improvement of the study indicator, and to report on the results of such an analysis. A second purpose is to identify any barriers to optimal performance or lessons learned in the PIP process, and document any follow-up activities to address these barriers.

<u>Rating:</u>	<u>Number of PIPs</u>
Fully met	3
Substantially met	3
Partially met	0
Minimally met	2
Not met	10

Recommendations for Standard 7 focused on the need to follow the analysis plan as stated at the beginning or to explain changes; report and analyze the data; and provide a thorough discussion of the barriers to successful implementation of the intervention and how the MHO addressed them.

Best practices

PIPs that fully met Standard 7 (GOBHI, LaneCare, MVBCN) presented baseline and remeasurement data according to the established study plan; conducted statistical analysis to detect significant change in the indicator; and discussed challenges in data collection and analysis, along with barriers to improvement for the study population that the intervention did not address.

Standard 8

The purpose of Standard 8 is to assess whether any reported improvement is “real” by documenting that baseline and remeasurement data were collected using the same methodology and therefore are comparable; by discussing improvement in processes related to the study question or in associated outcomes of care; by describing how the study intervention relates to the performance improvement; and by calculating and reporting statistical significance.

<u>Rating:</u>	<u>Number of PIPs</u>
Fully met	2
Substantially met	3
Partially met	2
Minimally met	1
Not met	10

Recommendations for this standard asked for an interpretation of the presented data to determine what actually occurred. MHOs need to describe changes in data collection methodology and any inconsistencies in measurement periods; discuss confounding factors; and explain how the intervention affected the study indicator.

Best practices

PIPs that fully met Standard 8 (GOBHI, LaneCare) discussed implications for clinical significance, discussed the effectiveness of the intervention and the impact on study results, identified confounding factors, and proposed possible solutions.

Standard 9

The purpose of Standard 9 is to assess whether the plan documented additional interventions or modifications to interventions, or changed other aspects of the PIP based on results from data or barrier analyses (i.e., lessons learned).

Four PIPs were scored on Standard 9. Two PIPs received a rating of *fully met*, one was rated *partially met*, and one was rated *not met*.

To improve performance on this standard, MHOs need to document modifications or changes and discuss lessons learned during the second remeasurement period.

Best practices

PIPs that fully met Standard 9 (JBH, VIBHS) discussed modifications made to the intervention as a result of reviewing first remeasurement period data and analyzing barriers.

Standard 10

The purpose of Standard 10 is to assess whether the plan documented sustained improvement by additional remeasurements conducted over comparable time periods. While sustained improvement is not required, plans should address whether the project demonstrated sustained improvement.

Four PIPs were scored on Standard 10. No PIP received a rating of *fully met*; one PIP was rated *substantially met*; two PIPs were rated *partially met*, and one was rated *not met*.

Recommendations for this standard focused on the need to report and analyze remeasurement data, confirm that data is collected and analyzed according to the study design, discuss the factors that contributed to the sustained improvement of the indicator over multiple remeasurement periods and overall conclusions.

PERFORMANCE MEASURE VALIDATION

MHOs serving Medicaid enrollees must submit performance measurement data annually as required by the state. Federal regulations require the annual validation of performance measure data submitted by MHOs. An associated Information Systems Capabilities Assessment (ISCA) evaluates the extent to which each MHOs information technology (IT) infrastructure supports the production and reporting of valid and reliable performance measures.

Process Description

The purpose of performance measure validation is to determine whether the data used to calculate each performance measure are complete and accurate and whether the calculation adheres to CMS specifications. 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.

This review reassesses 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 data to monitor their performance over time and to compare their performance with that of other health plans in Oregon and in other states?

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

- **Fully compliant:** Measure is complete as reported, accurate, and can be easily interpreted by the casual reader.
- **Partially compliant:** Measure is either complete as reported or accurate, but not both, and has deficiencies that could hamper the reader's ability to understand the reported rates.
- **Not valid:** Measure is either incomplete as reported or inaccurate.

Performance Measure Validation Results

AMH defined statewide performance measures for MHOs, calculated the measures using data that the MHOs reported to AMH, and compiled the data by quarter. MHOs were required to submit data for four performance measures to AMH for calculation. In 2012, for the first time since 2009, AMH calculated performance measures for the plans, thereby improving their score from "not compliant" to "partially compliant" per CMS specifications. Table 17 summarizes the results of this review.

Table 17. Performance Measure Validation Ratings, 2012.		
Performance measure	Definition	Rating
Percent of members who have had mental health service within 14 and 44 days of mental health assessment/evaluation	Number of enrollees who have had a mental health service within 14 days (initiation) and 44 days (engagement) of a mental health assessment/evaluation	Partially compliant
Percent of members 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 members 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 members seen within 7 days of discharge from acute care	Number of members seen in outpatient setting within 7 days of discharge from acute care for the time period/ total discharges for the time period	Partially compliant

Source code review results

Acumentra Health analysts reviewed the code that AMH used to calculate the performance measures. AMH made their code available in the form of a PDF titled "MHO Dashboard Process Version 2.0," dated July, 25, 2012. Acumentra Health analysts compared the calculation of the measures in this document with the methodology described in the 2012 HEDIS^{®8} data specifications, as specified by AMH.

⁸ HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

In 2011, Acentra Health noted that the state was working on improving several areas of the calculation and reporting process. However, in 2012, while many aspects of the state’s analytic and reporting processes had improved, other areas still need to be addressed. The 2012 review found that AMH lacked thorough documentation of the production process, including the flow of data used in calculating the measures and the steps for ensuring accuracy and completeness.

The “MHO Dashboard Process” did not include definitions or acronyms used in the document, and it lacked details about the flow of information from one process to the next. Data elements detailed in later steps were not included in the original SQL query. In order to understand or reproduce the results, MHOs or other reviewers would need verbal or written clarification.

The lack of specificity regarding the performance measure calculation and interpretation limits the utility of this process for reproducing the results. The quarterly report used in the 2011 EQR to communicate the results of the performance measures was not provided as a resource for the 2012 follow-up review. The absence of documentation interpreting the results continues to limit the utility of this process for communicating MHO performance and prevents the MHOs from comparing their results.

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

Strengths

- AMH calculated performance measures for the first time since 2009.
- The “MHO Dashboard Process” partially defines the measures with a numerator and denominator statement. A table lists the codes used in calculating the measures.
- The state has in place a formal 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.

Recommendations

- AMH needs to establish a system for electronic data validation for 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.
- AMH needs to clearly identify the performance measures to be calculated and distribute this information to MHOs.
- AMH needs to finalize, adopt, publish, regularly calculate, and report on its statewide performance measures. AMH should work with MHOs on communicating and understanding these results.
- AMH performance measures raise issues of comparability with similar widely accepted measures. AMH performance measures should be comparable with national standards, such as HEDIS. However, the performance measures lacked definitions, descriptions, and population criteria; the lack of specificity makes the performance measures difficult to interpret and compare with similar measures. To enable comparability and ease of calculation, it is important not to customize these measures.
- In order to compare performance among MHOs and with similar national measures or benchmarks, a published report needs to be utilized that explains 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.
- AMH needs to needs to further develop the process documentation related to performance measures calculation to more clearly define the transition of data from one processing platform to another.

Information Systems Capabilities Assessment Follow-Up

The ISCA assesses the integrity of the MHO's IT systems, data processing, and reporting functions. Acumentra Health conducts a full-scale ISCA for each MHO every other year, using review tools based on the relevant CMS protocol and approved by AMH, and a follow-up review for each MHO in alternate years. The ISCA protocol examines these categories:

Information Systems

- Data processing and personnel
- Staffing
- Hardware systems
- Security

Data Acquisition Capabilities

- Administrative data
- Enrollment systems (encounter data)
- Ancillary systems
- File consolidation
- Vendor Medicaid data integration
- Performance measure repository structure
- Report production
- Provider compensation structure

In 2012, Acumentra Health followed up with the MHOs regarding their 2011 ISCA results, reviewing their responses to specific findings and recommendations. The review identified some significant progress made, and various opportunities for improvement. Table 18 summarizes the results of this follow-up review.

Table 18. Status of ISCA Findings and Recommendations Identified in 2011.

MHO	Opportunities for improvement	Status
ABHA	11	2 not addressed—recommendations stand
		9 in progress
CMHO	14	6 not addressed—recommendations stand
		6 in progress
		2 addressed
FCI	7	1 not addressed—recommendation stands
		6 in progress
GOBHI	19	4 not addressed—recommendations stand
		13 in progress
		2 addressed
JBH	8	5 not addressed—recommendations stand
		3 in progress
LaneCare	7	5 not addressed—recommendations stand
		2 in progress
MCBCN	8	4 not addressed—recommendations stand
		4 in progress
PacificSource	9	3 not addressed—recommendations stand
		6 in progress
VIBHS	11	3 not addressed—recommendations stand
		5 in progress
WCHHS	8	3 not addressed—recommendations stand
		5 in progress

Overall Recommendations

Many ISCA recommendations require a significant planning effort in response. As a result, MHOs may not fully address all recommendations in the follow-up year. In 2012, Acumentra Health found that the MHOs were still in the process of addressing most recommendations from the 2011 ISCA. A few issues had been fully addressed, whereas some MHOs had made little or no progress in addressing numerous recommendations.

As many MHOs are in the midst of transitioning their IS environments to accommodate the new CCO model, most MHOs chose to delay progress in certain areas due to limited resources and/or significant upcoming changes planned. As

AMH and the MHOs transition into the new CCO model, they should include these recommendations in their discussions while developing their new IS environments.

AMH and the MHOs continued to struggle to address the following issues identified in the 2011 ISCA.

- AMH needs to establish a system for auditing MHO encounter data submissions against clinical records to assess accuracy and completeness of submitted data.
- AMH needs to develop and maintain a current disaster recovery plan that is frequently audited and tested to ensure that critical information systems can be maintained, resumed, and/or recovered as intended.
- In the areas of information systems, hardware systems, and security, MHOs should continue to increase monitoring and oversight of organizations they contract with to provide IT services.
- MHOs should audit encounter data received by provider agencies against clinical records to assess the accuracy and completeness of data.
- MHOs need to adopt and thoroughly document a system development life cycle. Strong development practices minimize the risk of excessive downtimes and excessive delays in recovering systems.
- MHOs need to continue to develop disaster recovery plans and formal processes for regular review, implement regular testing of those plans, and encourage any contracted IT services and provider agencies to do the same.
- MHOs need to reduce the amount of paper claims received. The Health Information Technology for Economic and Clinical Health (HITECH) Act requires that plans and providers move to electronic submission of claims and encounters.
- MHOs need to use encrypted media for offsite storage of backups to prevent unauthorized access to data.
- MHOs need to consistently monitor all contracted providers every year, including encounter data validation.

DISCUSSION AND RECOMMENDATIONS

The 2012 EQR results reflect progress made—and challenges encountered—by AMH and the MHOs in meeting Medicaid managed care requirements. By the end of 2012, most MHOs had been incorporated into CCOs as part of Oregon’s health care transformation process. The following recommendations are intended to guide OHA and the CCOs regarding ongoing opportunities for improvement as the CCOs integrate mental health providers into their provider panels.

Recommendations for OHA

- Medicaid mental health consumers in Oregon meet the federal definition of beneficiaries with “special healthcare needs.” OHA’s oversight of mental health providers needs to include clinical review of consumers’ participation in treatment and the content of treatment plans.
- OHA needs to create a process to monitor CCO implementation to ensure the delivery of high-quality and appropriate services for mental health enrollees.
- OHA should establish contractual requirements for CCOs to conduct regular audits to validate the encounter data submitted by providers.
- OHA should clarify to which state agency enrollees should direct complaints about CCO noncompliance with both medical and mental health advance directives.
- OHA should require CCOs to make consistent, timely progress in their PIPs, as required by federal regulations.
- With regard to statewide performance measures and information systems, OHA needs to
 - finalize, adopt, regularly calculate, and report on its statewide performance measures. OHA should work with CCOs on communicating and understanding these results.
 - clearly define and identify the performance measures to be calculated, and convey this information to CCOs
 - make performance measures comparable to national standards by not customizing the measures and ensuring measures include a specific definitions, descriptions, and population criteria

- establish a system for validating and auditing mental health encounter data submissions to ensure accuracy and completeness
- further develop the process documentation related to performance measures calculation to more clearly define the transition of data from one processing platform to another
- establish a system for electronic data validation for CCO data submissions to ensure accuracy and completeness and for following up with CCOs to resolve problems; as an alternative, OHA could contract with an external auditor for an annual audit of CCO data submissions
- needs to develop and maintain a current disaster recovery plan that is frequently audited and tested to ensure that critical information systems can be maintained, resumed, and/or recovered as intended

Recommendations for CCOs

- CCOs need to monitor mental health providers to ensure that
 - providers treat enrollees with respect, dignity, and privacy
 - providers comply with enrollees' right of access to their clinical records
 - clinical and authorization decisions are consistent with mental health practice guidelines
- CCOs need to develop and/or formalize processes to monitor mental health providers to ensure that enrollees have access to second opinions.
- CCOs need to monitor and track
 - out-of-network encounters and analyze the data to determine mental health delivery network adequacy and timeliness
 - processes for direct access to mental health specialists
 - crisis and post-stabilization services to ensure that payments are not denied and to identify inappropriate or avoidable use of crisis services related to lack of access to routine care
- CCOs need to have policies in place for developing, disseminating, and implementing mental health practice guidelines. CCOs need to track requests for mental health practice guidelines.
- CCOs need to ensure collection of complete data, and therefore analysis, of over- and underutilization of mental health services.

- CCOs need to formalize their grievance policies and procedures, including expedited resolution of grievances.
- CCOs need to encourage mental health providers to report enrollees' complaints and grievances to the CCO.
- CCOs need to thoroughly research the choice of each PIP topic and identify the root causes of quality problems.
- CCOs need to develop and implement PIP intervention strategies that address the identified challenges and barriers, and develop methods to track implementation.
- CCOs need to make timely progress in their PIPs.
- With regard to information systems, CCOs need to
 - audit the encounter data submitted by providers against the providers' clinical records regularly to validate the accuracy and completeness of encounter data
 - continue to increase monitoring and oversight of organizations they contract with to provide IT services
 - need to adopt and thoroughly document a system development life cycle; strong development practices minimize the risk of excessive downtimes and excessive delays in recovering systems
 - continue to develop disaster recovery plans and formal processes for regular review, implement regular testing of those plans, and encourage any contracted IT services and provider agencies to do the same
 - reduce the amount of paper claims received, moving to more electronic submissions, as required by the HITECH Act
 - use encrypted media for offsite storage of backups to prevent unauthorized access to data
 - consistently monitor all contracted providers every year, including encounter data validation

APPENDIX A. PIP SCORES

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 the Centers for Medicare & Medicaid Services.

Table A-1 on the following page lists the 2012 scores on all validation standards by MHO for the plan-specific PIPs. Table A-2 shows the scores for the collaborative PIPs. Each of the 10 performance standards in the validation review has a potential score of 100 points for full compliance. The following charts compare the MHOs' 2012 to 2011 scores for each PIP standard.

The scoring ranges and corresponding ratings are listed below.

Fully met	100
Substantially met	75–99
Partially met	50–74
Minimally met	25–49
Not met	0–24

Table A-1. MHO PIP Scores by Validation Standard, 2012: Plan-Specific PIPs.

Standard	ABHA	CMHO	GOBHI	JBH	LaneCare	Pacific Source	VIBHS	WCHHS*	WCHHS**
1	100	75	100	90	90	100	100	100	100
2	100	55	100	60	100	100	100	100	100
3	90	0	100	60	80	90	100	85	100
4	60	0	100	20	100	60	95	65	85
5	65	0	95	40	90	70	90	65	75
6	70	0	100	80	100	50	100	0	100
7	75	0	100	20	100	30	80	0	15
8	75	0	100	55	100	65	30	0	0
9	n.a.	n.a.	n.a.	n.a.	n.a.	0	100	n.a.	n.a.
10	n.a.	n.a.	n.a.	n.a.	n.a.	10	50	n.a.	n.a.

*Clinical PIP: Improving documentation of healthcare status for individuals on antipsychotic medications.

**Nonclinical PIP: Improving procedures for improved cultural competency.

Table A-2. MHO PIP Scores by Validation Standard, 2012: Collaborative PIPs.

Standard	CMHO	FCI*	FCI**	GOBHI	JBH	LaneCare	MVBCN	Pacific Source	VIBHS
1	85	35	65	100	100	100	100	95	50
2	100	70	90	50	100	100	100	100	100
3	75	45	45	60	100	90	100	90	70
4	50	60	85	100	70	100	100	100	95
5	45	40	75	100	100	95	100	85	95
6	75	0	25	100	90	85	75	85	45
7	0	0	5	40	95	0	100	20	0
8	0	0	0	0	90	0	95	0	0
9	n.a.	n.a.	n.a.	n.a.	100	n.a.	50	n.a.	n.a.
10	n.a.	n.a.	n.a.	n.a.	80	n.a.	50	n.a.	n.a.

*Chemical dependency collaborative PIP.

**Schizophrenia with physical health PCP and metabolic testing PIP.

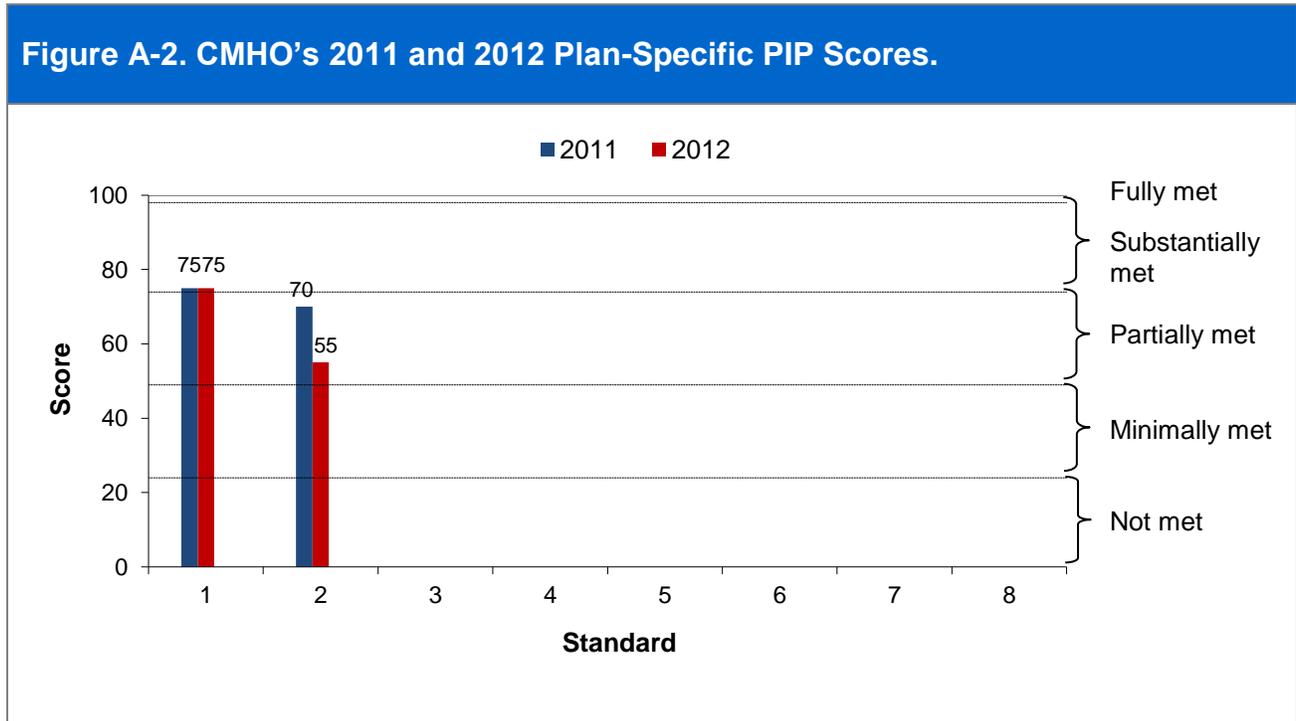
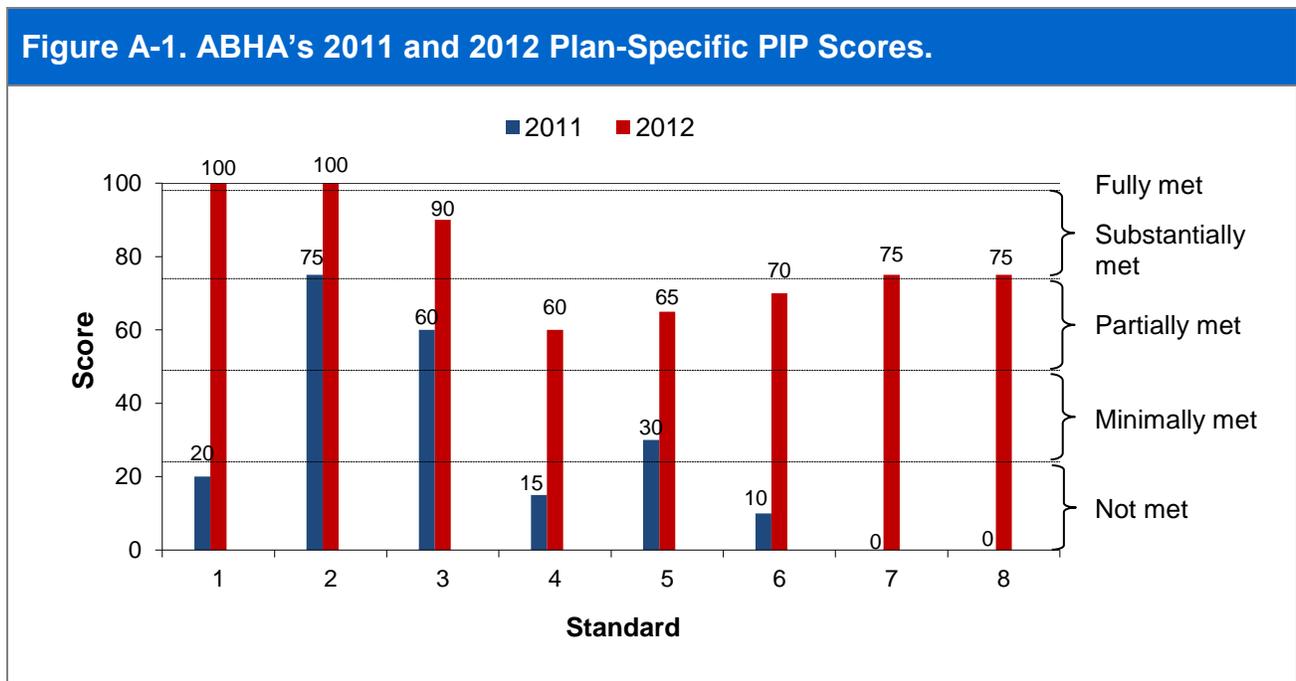


Figure A-3. CMHO's 2011 and 2012 Collaborative PIP Scores.

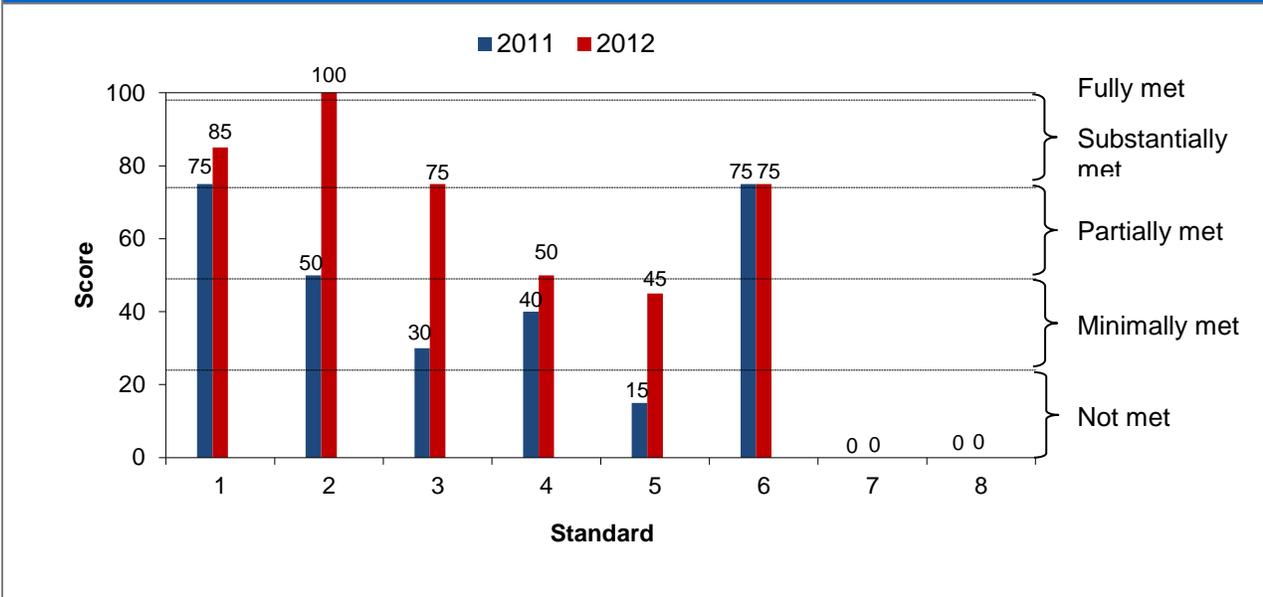


Figure A-4. FamilyCare's 2011 and 2012 Collaborative PIP (Chemical Dependency) Scores.

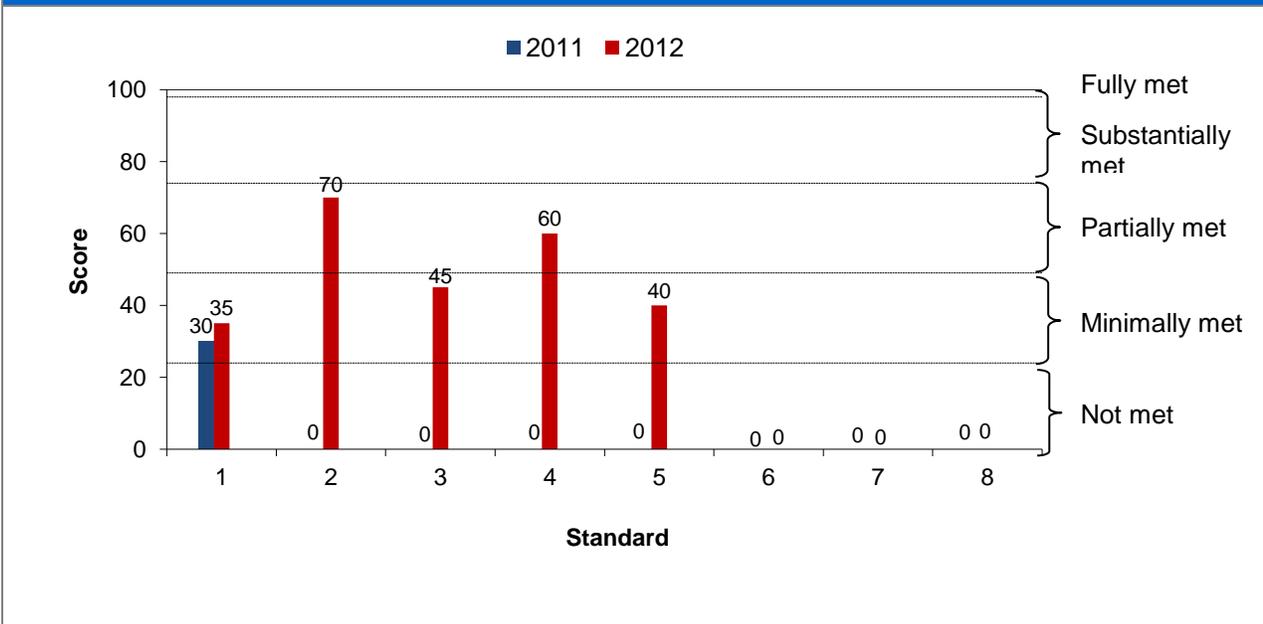


Figure A-5. FamilyCare’s 2012 Collaborative PIP (Metabolic Testing) Scores.

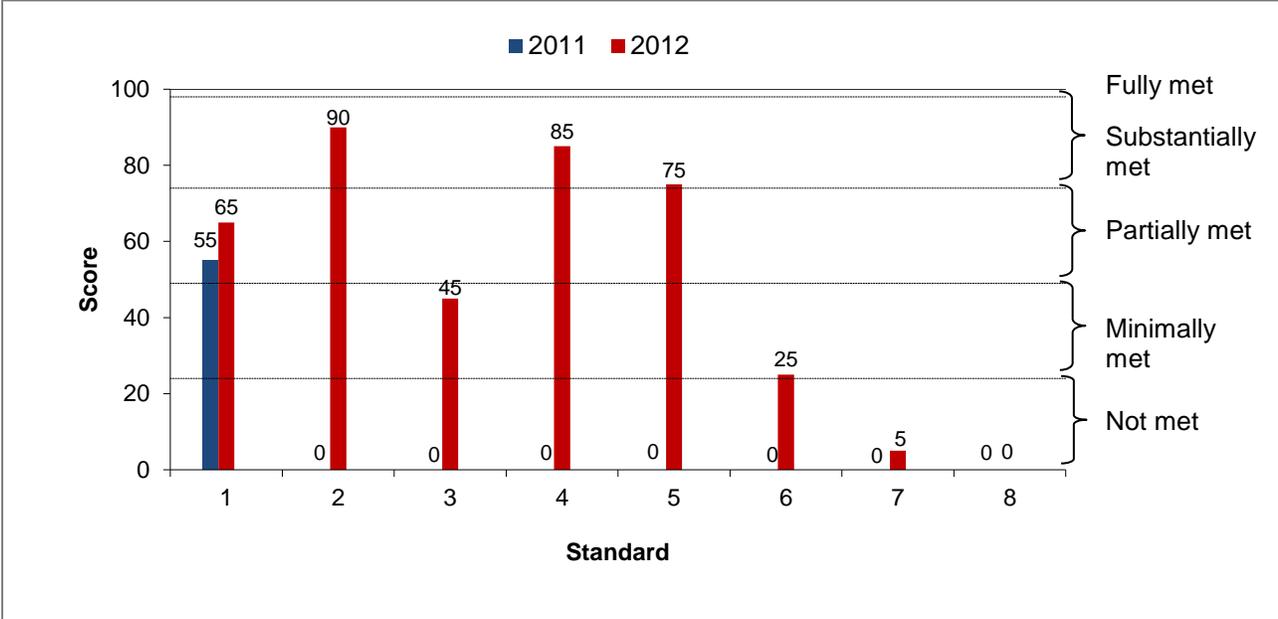


Figure A-6. GOBHI’s 2011 and 2012 Plan-Specific PIP Scores.

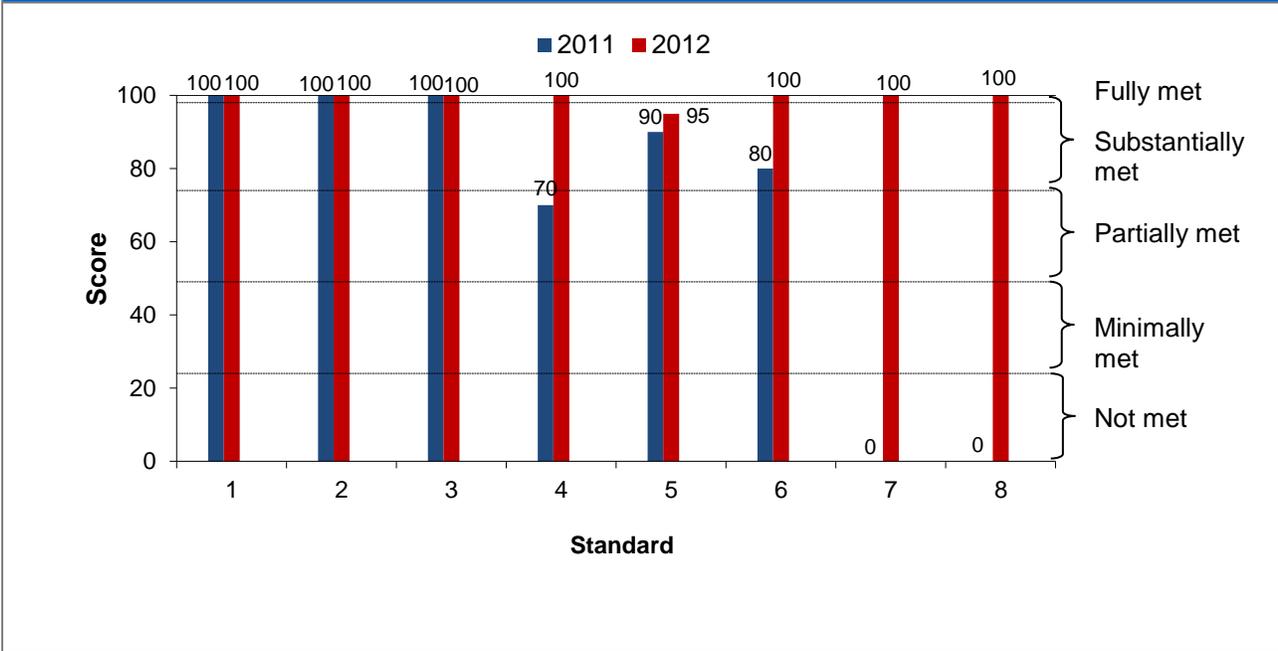


Figure A-7. GOBHI's 2011 and 2012 Collaborative PIP Scores.

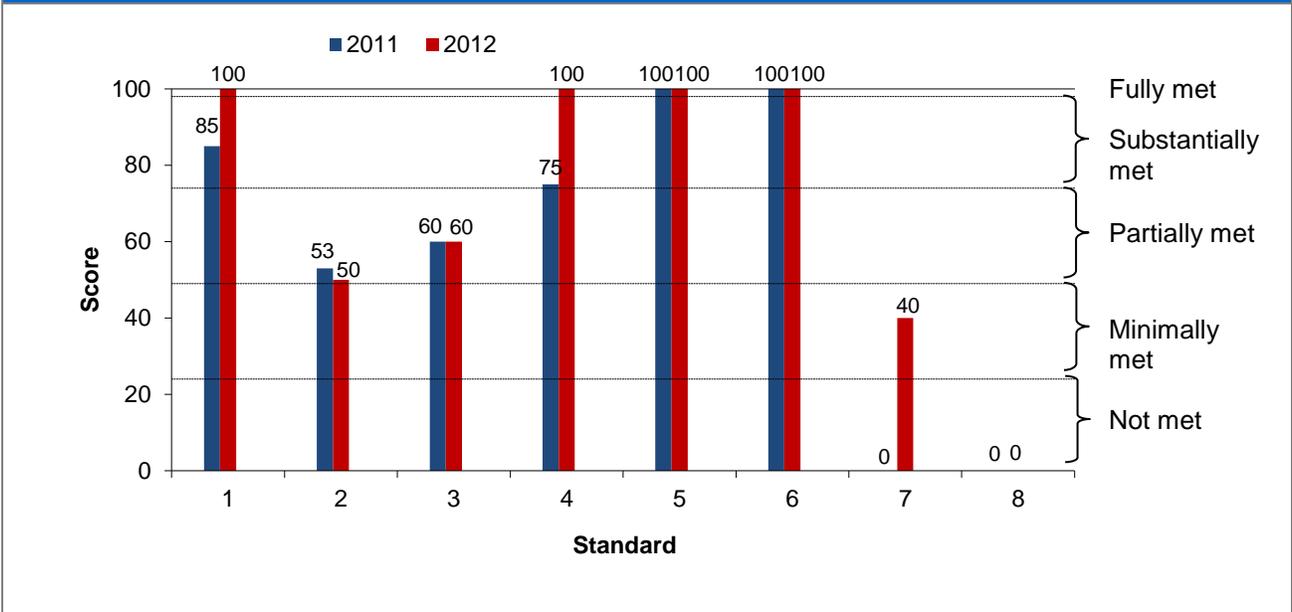
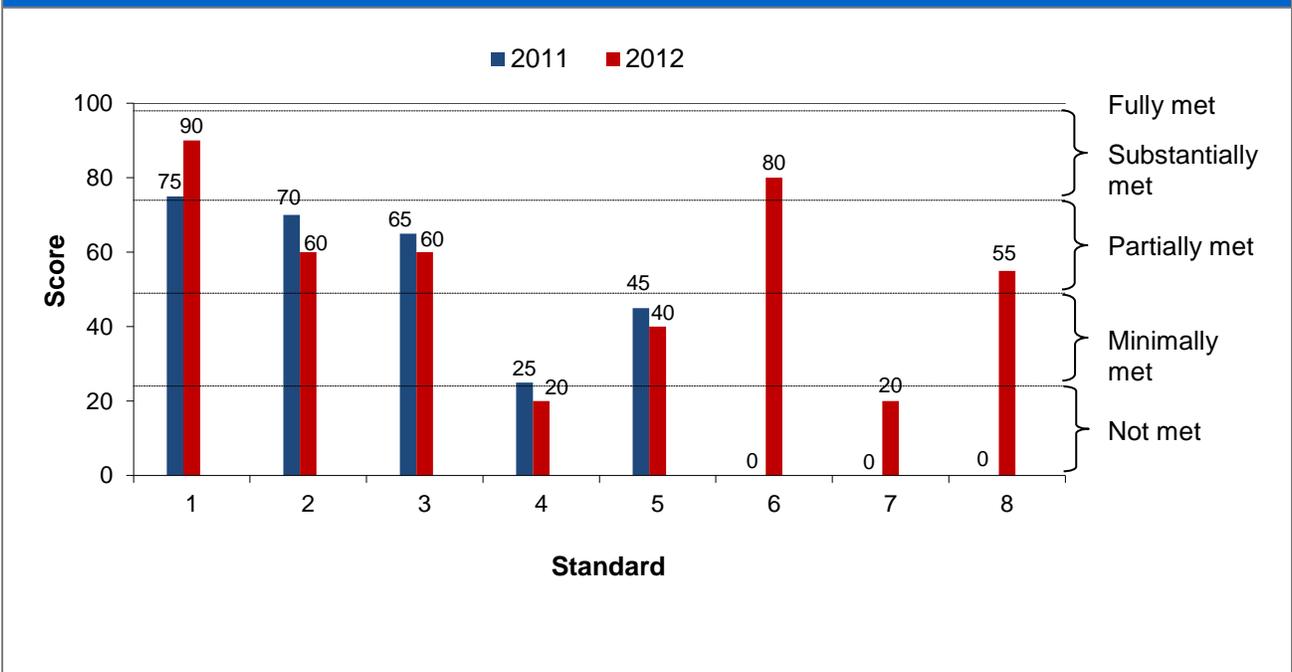


Figure A-8. JBH's 2011 and 2012 Plan-Specific PIP Scores.



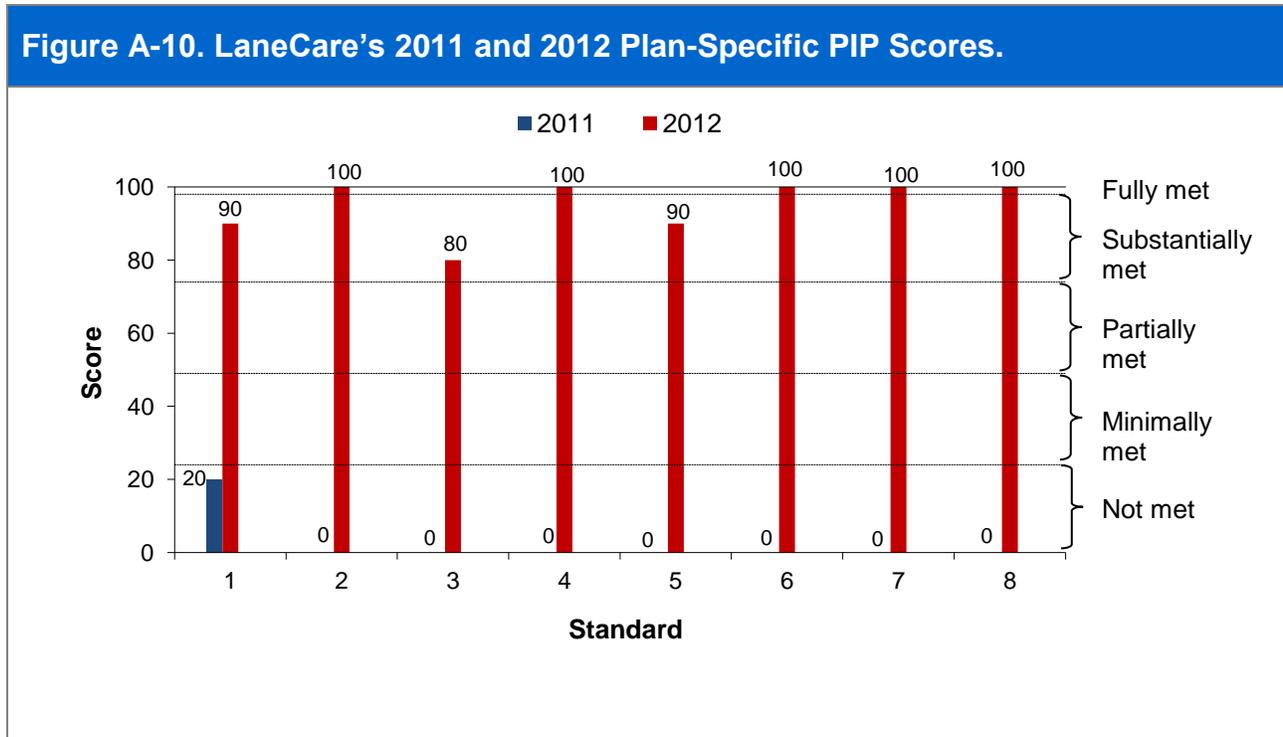
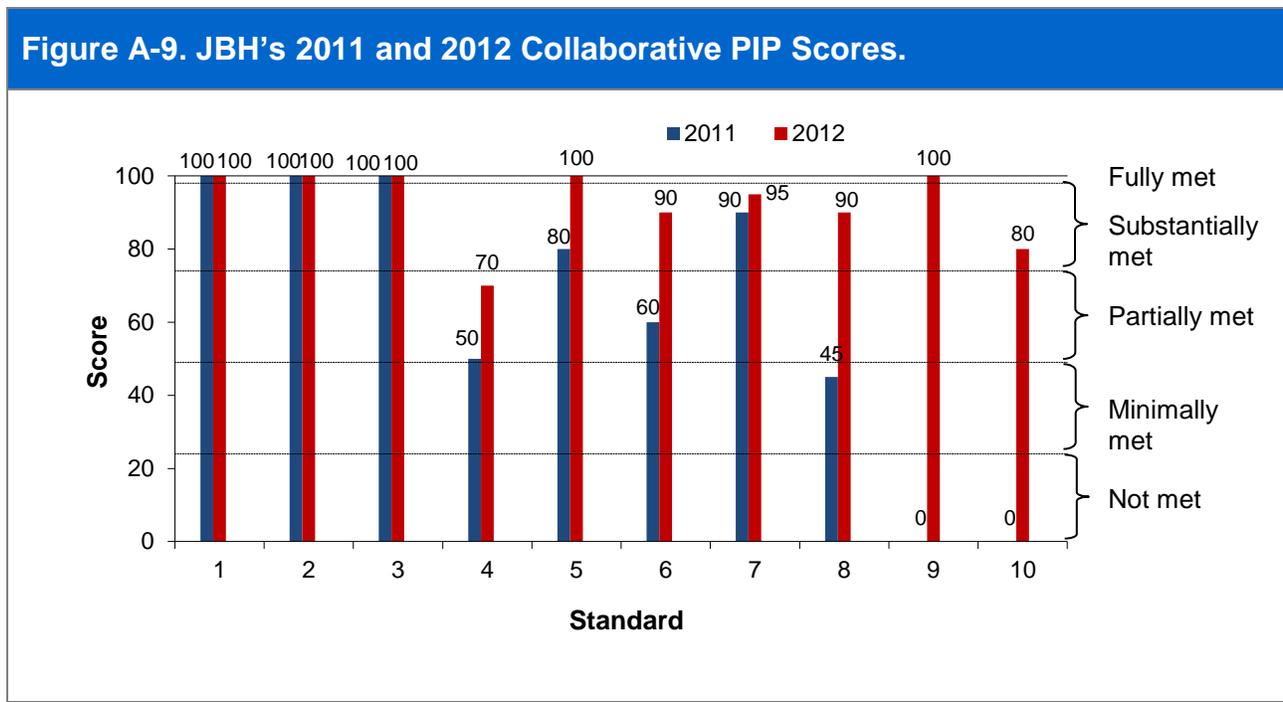


Figure A-11. LaneCare’s 2011 and 2012 Collaborative PIP Scores.

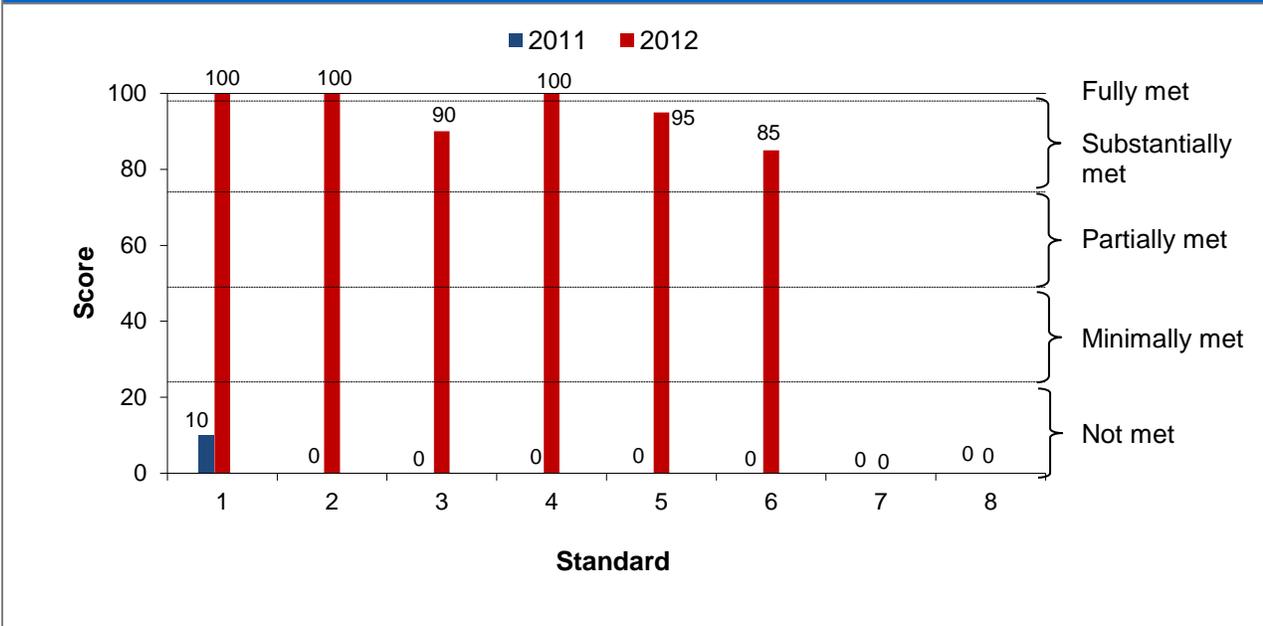


Figure A-12. MVBCN’s 2011 and 2012 Collaborative PIP Scores.

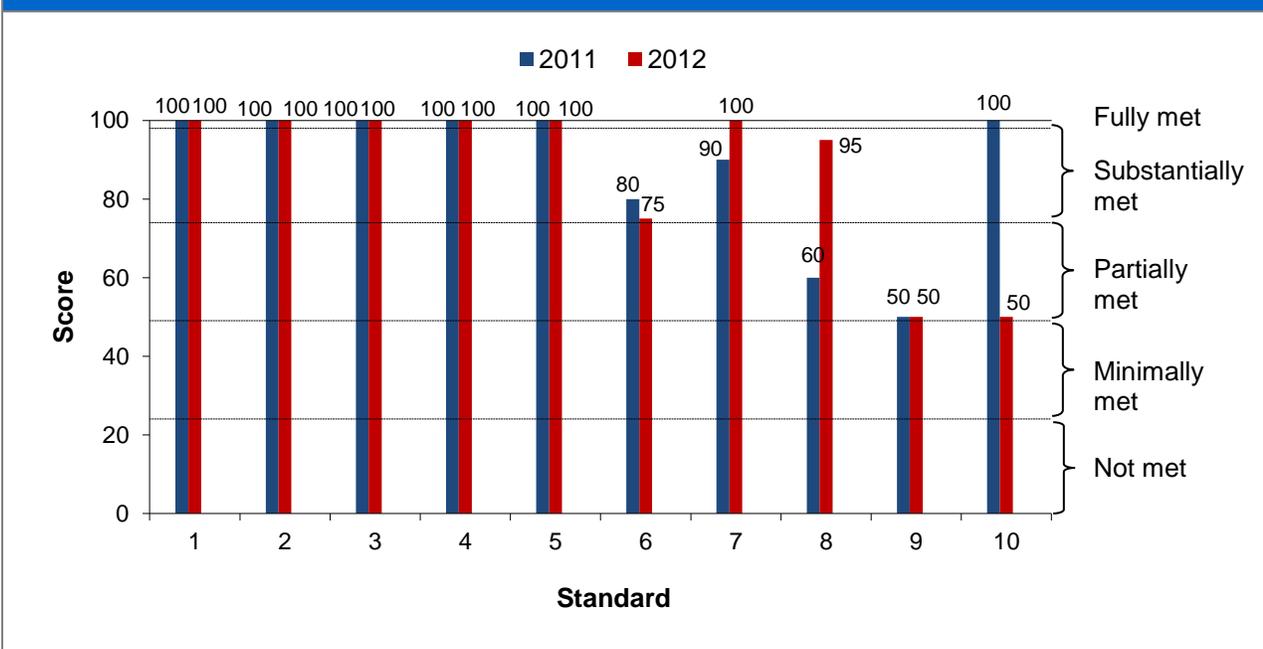


Figure A-13. PacificSource’s 2011 and 2012 Plan-Specific PIP Scores.

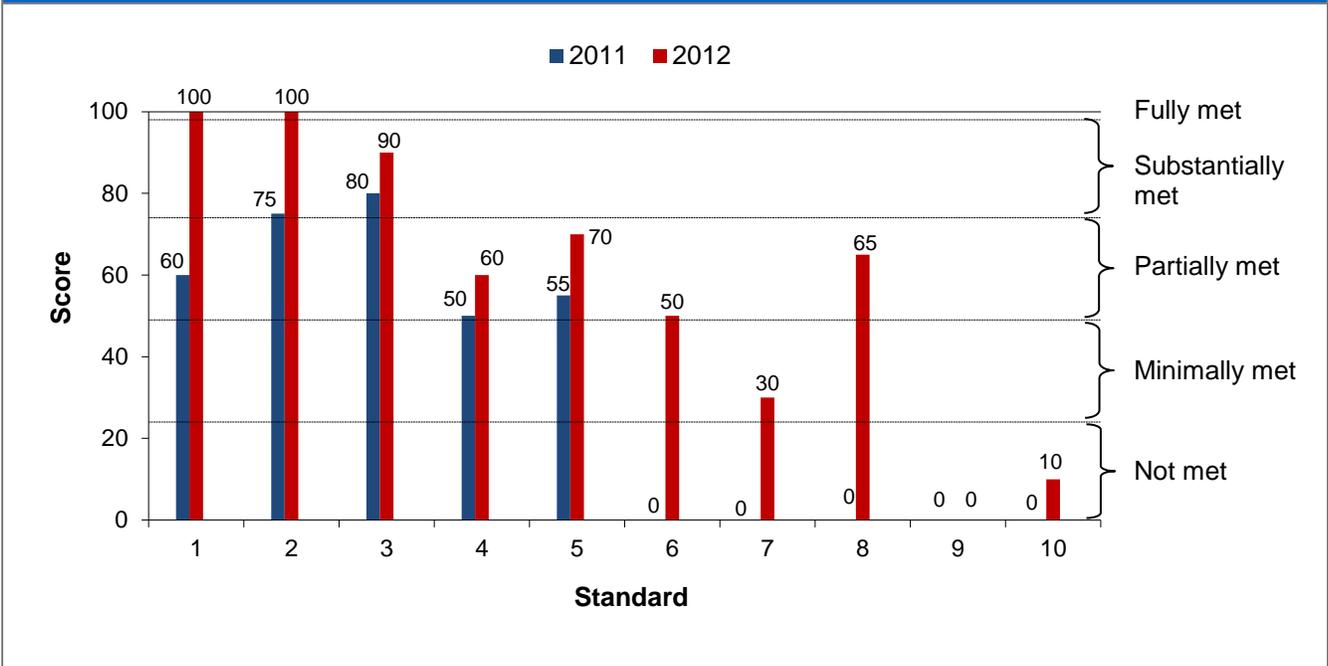


Figure A-14. PacificSource’s 2011 and 2012 Collaborative PIP Scores.

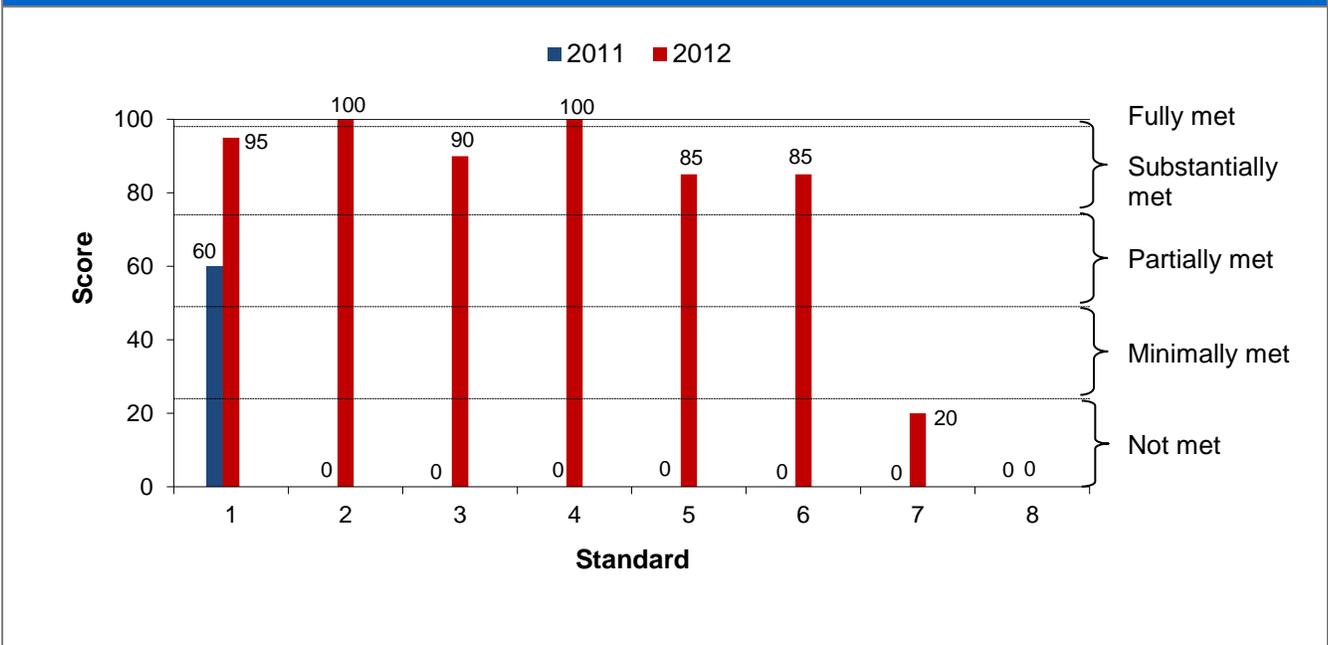


Figure A-15. VIBHS's 2011 and 2012 Plan-Specific PIP Scores.

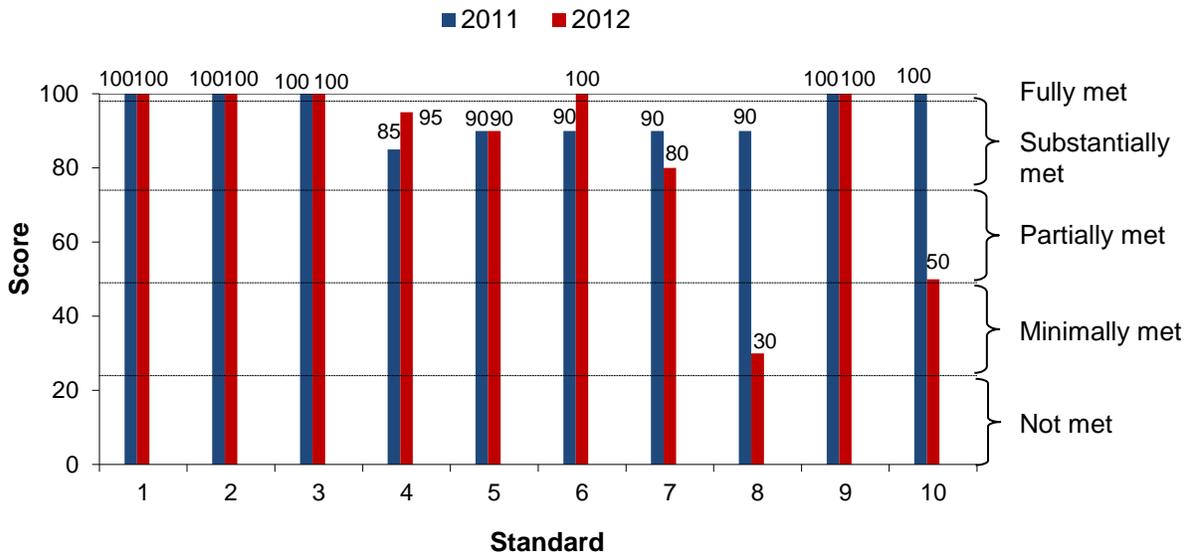


Figure A-16. VIBHS's 2012 Collaborative PIP Scores.

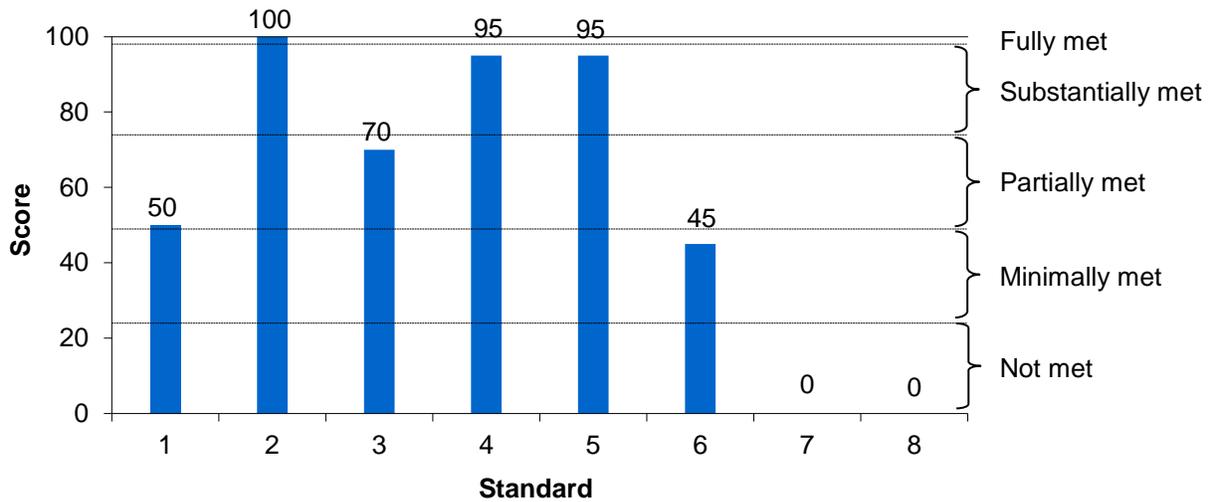


Figure A-17. WCHHS’s 2011 and 2012 Plan-Specific PIP (Antipsychotic Medications) Scores.

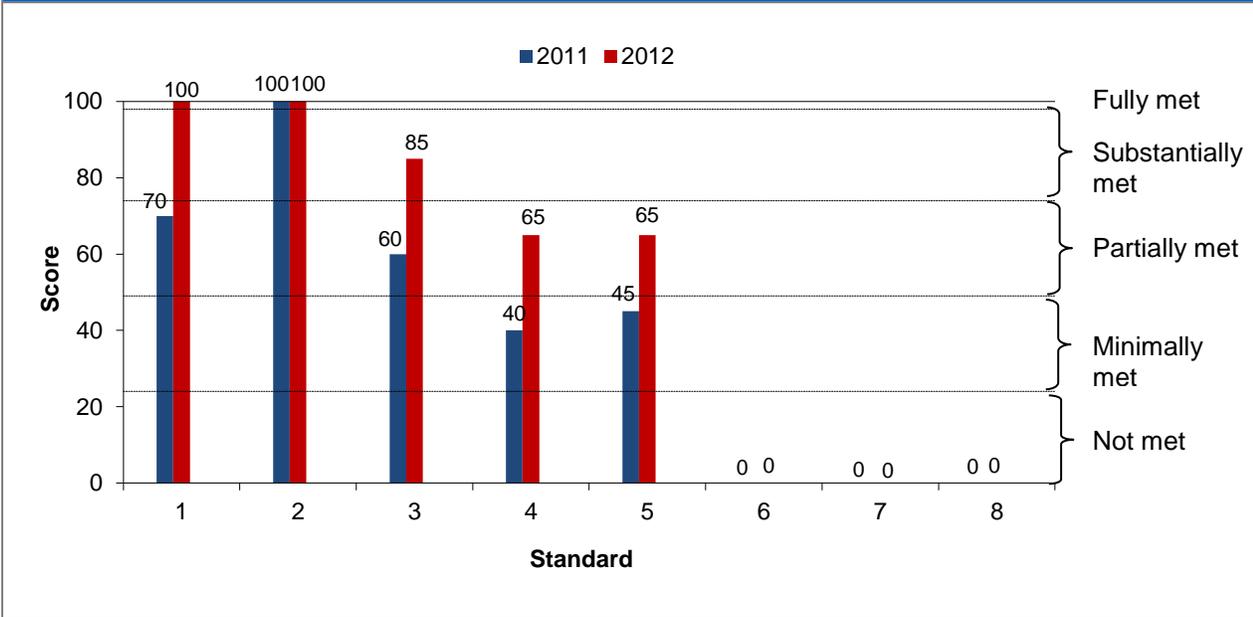
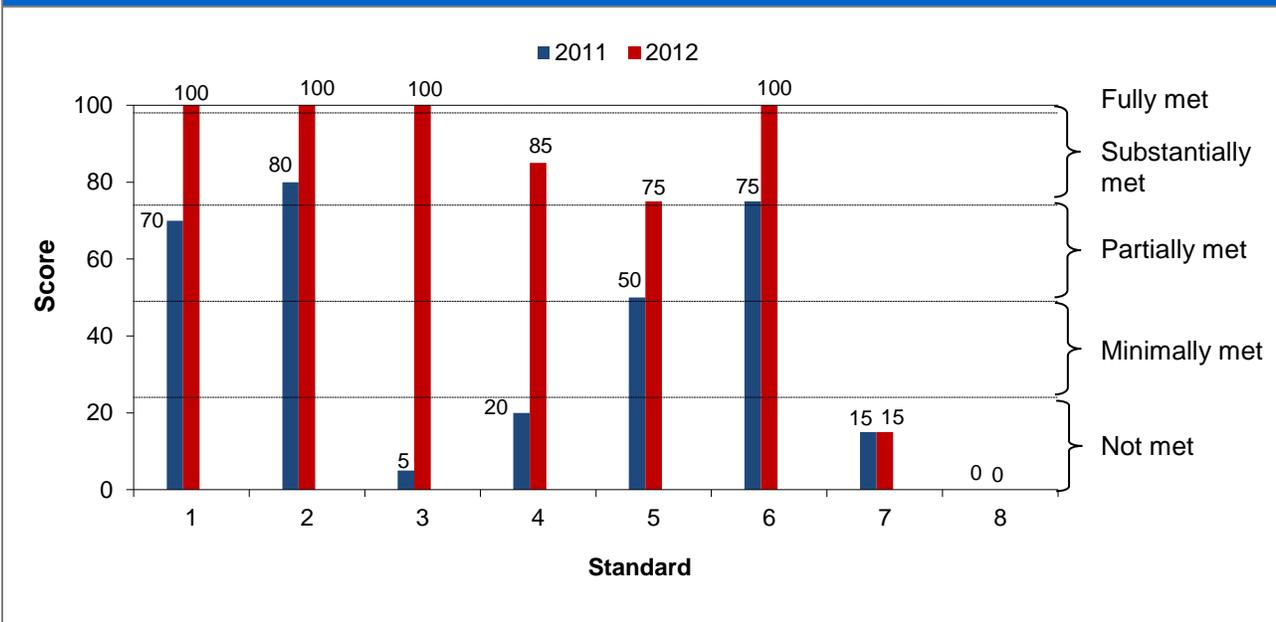


Figure A-18. WCHHS’s 2011 and 2012 Plan-Specific PIP (Cultural Competency) Scores.



APPENDIX B - PIP VALIDATION METHODOLOGY

All managed care organizations that serve Medicaid or Medicare enrollees must conduct two Performance Improvement Projects (PIPs) each year aimed at improving care outcomes. One of the PIPs must focus on improving clinical care, and the other on improving nonclinical services. To ensure that the PIPs are designed, conducted, and reported in a methodologically sound way, the PIPs are validated each year by external quality review.

The validation protocol presented here is based on the protocol published by the Centers for Medicare & Medicaid Services (CMS) in May 2002.¹ The validation procedure consists of the following activities:

Assessing the methodology for conducting PIPs

Assessing the PIP methodology consists of the following 10 steps.

- Step 1:** Review the study topic
- Step 2:** Review the study question
- Step 3:** Review the selected study indicator(s)
- Step 4:** Review the identified study population and sampling methods
- Step 5:** Review the data collection procedures
- Step 6:** Assess the improvement strategy
- Step 7:** Review the data analysis and interpretation of study results
- Step 8:** Assess the likelihood that reported improvement is “real” improvement
- Step 9:** Assess whether the MHO has documented additional interventions or modifications
- Step 10:** Assess whether the MHO has sustained the documented improvement

Each step addresses the extent to which the PIP complies with a particular standard in the CMS protocol. The specific criteria for assessing compliance with each standard are listed on the following pages.

¹ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Validating Performance Improvement Projects*. Final Protocol, Version 1.0. May 1, 2002.

Step 1. Review the study topic

Criterion 1.1. The topic was based on relevant information.

The topic must reflect the demographics, prevalence of diagnoses, potential risks, or service needs of the MHO's Medicaid population. Examples of relevant information from which the topic may be selected include

- utilization patterns that reflect deficiencies in service
- enrollee or provider input
- data from surveys or from grievance or appeals processes that indicate underlying issues in care or services
- data comparing the MHO's performance in standardized measures with the performance of comparable organizations

Criterion 1.2. The topic was determined through a systematic selection and prioritization process.

The topic must aim to improve care and services for a large portion of the MHO's Medicaid population. Examples of evidence for a systematic selection and prioritization process include

- descriptions of data that support the topic selection
- documentation of opportunities for soliciting enrollee or provider input

Example—clinical: Developing an algorithm to standardize prescribing patterns for specific diagnoses

Example—nonclinical: Assessing and improving the accessibility of specific services; reducing disparities in services provided to minority enrollees as compared with non-minority enrollees; designing processes to improve care coordination

Step 2: Review the study question

Criterion 2.1. The MHO has clearly defined the question the study is designed to answer. The question

- is stated so as to create a framework for data collection, analysis, and interpretation
- can be answered quantitatively or qualitatively by the PIP study

Step 3: Review the selected study indicator(s)

Each project should use at least one quality indicator for tracking performance and improvement.

Criterion 3.1. The indicator is an objective, measurable, clearly defined, unambiguous statement of an aspect of quality to be measured. The indicator statement clearly identifies

- who—the eligible population
- what—the care or service being evaluated
- when—the specific care or service time frame

The indicator description includes

- *definition of the denominator:* the eligible population, identifying inclusions and exclusions (criteria used to determine the eligible population, such as age, gender, and diagnosis and enrollment status)
- *definition of the numerator:* the outcome achieved or service rendered to the eligible population
- dates of service, procedure codes for administrative data, or acceptable medical record data
- the basis for adopting the indicators (e.g., that they are generally used in the industry—these are preferred; or if the MHO developed its own indicators either at the outset of the study or as a means of narrowing the focus for the study, a description of how the indicator was developed)

Criterion 3.2. The indicator can measure enrollee outcomes, enrollee satisfaction, or processes of care strongly associated with improved enrollee outcomes.

- Indicators for clinical care should include at least some measure of change in mental health status or functional status or process-of-care proxies for these outcomes.
- Process measures may be used as proxies for outcomes only if validity has been established in the literature or by expert consensus.

Step 4: Review the identified study population and sampling methods

Criterion 4.1. The study population is clearly defined and includes all MHO enrollees who are eligible for the study. The study population

- represents the MHO’s entire Medicaid population that fits the eligibility criteria described by the indicators
- is defined in terms of enrollment time frames

If the study population is an “at risk” subpopulation,

- the MHO has clearly defined the risk and the subpopulation
- the MHO has provided a rationale for selecting the subpopulation

The MHO may use a sample for the study. *If a sample is used*, the MHO must

- provide the rationale for using a sample
- explain the sampling methodology that produced a representative sample of sufficient size (see below)

Criterion 4.2. When the study includes the MHO’s entire eligible population, the data collection approach captures all eligible enrollees.

Criterion 4.3. If a sample is used, the MHO has described the method for determining the sample size.

If a clinical or service condition is being studied for first time, the true prevalence or incidence is not likely to be known. Large samples would be needed to establish a valid baseline. The sampling methodology should include the

- rationale for the size of the sample based on the MHO’s eligible population
- frequency of the occurrence being studied
- confidence interval and acceptable margin of error

Criterion 4.4. The sampling methodology is valid and protects against bias.

The description establishing validity and bias protection should include

- a description of the sampling type (e.g., probability or nonprobability; stratified random or convenience)
- the rationale for selecting the sampling type

Criterion 4.5. The sample is large enough to allow calculation of statistically meaningful measures.

Step 5: Review the data collection procedures

The data collection process must ensure that the data collected on the indicator(s) are valid and reliable. Validity indicates the accuracy of the data. Reliability indicates the repeatability or reproducibility of a measurement.

Criterion 5.1. The study design clearly specifies the data to be collected.

- Data elements are defined unambiguously.
- Descriptive terms (e.g., “high,” “medium,” “low”) are defined numerically.

Criterion 5.2. The data sources are clearly identified.

- Examples of data sources include medical records, encounter and claim systems, or surveys.
- Time frames for collecting baseline and remeasurement data are specified.

Criterion 5.3. The study design describes a systematic method of collecting valid and reliable data on all enrollees to whom the indicator(s) apply.

- *For administrative data* (claims or encounter data), the data are complete and include all data submitted by providers. If data collection is automated, the MHO has provided the data specifications and algorithms used.
- *For medical record abstraction* or review of other primary sources, the MHO has documented the steps taken to ensure that the data were consistently extracted and recorded.

Criterion 5.4. For manual data collection, the data collection instrument produces consistent, accurate data that are appropriate for the study indicator(s) and that can be used over the study time period.

- The data abstraction process is documented, including a data collection instrument with clear guidelines and definitions.
- Reviewer training is documented, including guidelines, definitions, instructions on how to use the instrument, and instructions on how to handle situations not covered in the documentation.
- Methods of ensuring inter-rater reliability are provided.

Criterion 5.5. The study design includes a prospective data analysis plan that specifies

- whether qualitative or quantitative data or both are to be collected
- whether data are to be collected on the entire population or a sample

- whether measures are to be compared to previous results or similar studies; if comparing measures between two or more studies, the appropriate statistical test must be identified
- whether the PIP is to compare to the performance of different sites or clinics; if comparing performance of two or more entities, the statistical design and analysis must reflect the comparisons

Criterion 5.6. For manual data collection, the study design includes the rationale and staff qualifications for the data abstraction. The documentation

- indicates that staff received training on the use of the data collection instrument
- indicates the inter-rater reliability of the data collection instrument

Step 6: Assess the improvement strategy

An improvement strategy is defined as an intervention or set of interventions designed to change behavior at an institutional, practitioner, or enrollee level. The effectiveness of the interventions is determined by measuring a change in performance based on the quality indicator(s).

Criterion 6.1. The MHO has reported on at least one intervention undertaken to address causes or barriers identified through the quality improvement process. The interventions were

- systemic—i.e., designed to affect a wide range of participants through long-term system change
- timed to effect change after the baseline measurement and prior to remeasurement
- effective in improving the indicator for the population(s) studied
- reasonably expected to result in measured improvement
- free of major confounding variables that were likely to affect outcomes

Step 7: Review the data analysis and interpretation of study results

The MHO calculated its performance in the indicators by adhering to appropriate statistical analysis techniques as defined in a data analysis plan.

Criterion 7.1. The analysis of the findings adheres to a data analysis plan that used an appropriate statistical methodology.

Criterion 7.2. The study results, including numerical results and findings, are presented in a manner that provides accurate, clear, and easily understood information.

Criterion 7.3. The analysis identifies

- baseline and remeasurement data
- the statistical significance of any differences between these data sets
- any factors that influenced comparability
- any factors that threatened the validity of the findings

Criterion 7.4. The analysis is based on continuous quality improvement and focused on delivery system processes.

- The interpretation of the success of the PIPs included lessons learned and identified barriers to success or presented a hypothesis about less-than-optimal performance.
- Follow-up activities addressed the barriers identified.

Step 8: Assess the likelihood that reported improvement is “real” improvement

The reported improvement represents “real” change and is not due to a short-term event unrelated to the intervention or to chance.

Criterion 8.1. The MHO has used the same methodology for measuring the baseline as for conducting remeasurement, or the MHO has described and justified a change in measurement methodology.

Criterion 8.2. The analysis discussion includes documentation of

- quantitative improvement in processes related to the study question
- improvements in associated outcomes of care

Criterion 8.3. The analysis discussion describes clearly how the interventions relate to the improvement in performance.

Criterion 8.4. The analysis includes an appropriate calculation of statistical significance, with a discussion of the test used to calculate significance. (There is no required level of significance.)

Step 9: Assess whether the MHO has documented ongoing or additional interventions or modifications

The MHO has documented sustained improvement by remeasuring performance on the initial study indicator(s) at regular intervals. (*Note:* Interventions may be modified between remeasurement periods to address barriers or to take advantage of study findings.)

Criterion 9.1. The MHO has documented ongoing or additional interventions or modifications that are based on earlier data analyses.

Step 10: Assess whether the MHO has sustained the documented improvement

Criterion 10.1. Sustained improvement is demonstrated by additional remeasurements conducted over comparable time periods.

PIP scoring

Each standard has a potential score of 100 points for full compliance, with lower scores for lower levels of compliance, as shown in Table B-1.

Table B-1. Compliance standard rating and scoring scheme.		
Compliance rating	Description	100-point scale
Fully met	Meets or exceeds all requirements	100
Substantially met	Meets essential requirements, has minor deficiencies	75–99
Partially met	Meets essential requirements in most, but not all, areas	50–74
Minimally met	Marginally meets requirements	25–49
Not met	Does not meet essential requirements	0–24

The scores for each standard are weighted and combined to determine the overall PIP score, as shown in Table B-2.

Table B-2. Weighting of standard scores in overall PIP score.		
Standard	Criterion number(s)	Scoring weight
<i>Demonstrable Improvement</i>		
1 Selected study topic is relevant and prioritized	1.1, 1.2	20%
2 Study question is clearly defined	2.1	10%
3 Study indicator is objective and measurable	3.1, 3.2	10%
4 Study population is clearly defined and, if sample is used, appropriate methodology is used	4.1, 4.2, 4.3, 4.4, 4.5	10%
5 Data collection process ensures that data are valid and reliable	5.1, 5.2, 5.3, 5.4, 5.5, 5.6	10%
6 Improvement strategy is designed to change performance based on the quality indicator	6.1	10%
7 Data are analyzed and results interpreted according to generally accepted methods	7.1, 7.2, 7.3, 7.4	10%
8 Reported improvement represents “real” change	8.1, 8.2, 8.3, 8.4	10%
Demonstrable Improvement Score		90%
<i>Sustained Improvement</i>		
9 Additional or ongoing interventions or modifications are documented	9.1	5%
10 Sustained improvement is documented	10.1	5%
Sustained Improvement Score		10%
Overall PIP Score		100%

The overall score is weighted 90 percent for demonstrable improvement in the first year (Standards 1–8) and 10 percent for sustained improvement in later years (Standards 9–10). Thus, for a PIP that has completed one remeasurement, the maximum overall score is 90 points (90 percent x 100 points for full compliance). If the PIP has progressed to a second remeasurement, enabling reviewers to assess sustained improvement, the maximum score is 100 points (10 percent x 100 points for full compliance).

Example scoring worksheet

Table B-3 shows an example scoring calculation for a PIP with both demonstrable and sustained improvement.

Table B-3. Example scoring worksheet.				
Standard	Compliance rating	Assigned points	Weight	Points score
<i>Demonstrable Improvement</i>				
1	Fully met	100	20%	20.00
2	Fully met	100	10%	10.00
3	Partially met	50	10%	5.00
4	Partially met	50	10%	5.00
5	Fully met	100	10%	10.00
6	Minimally met	25	10%	2.50
7	Partially met	50	10%	5.00
8	Partially met	50	10%	5.00
Demonstrable Improvement Score				62.50
<i>Sustained Improvement</i>				
9	Substantially met	75	5%	3.75
10	Partially met	50	5%	2.50
Sustained Improvement Score				6.25
Overall PIP Score				68.75