The Oregon Health Plan’s Managed Mental Health Care

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

Part 1: MHO PIP Validation, Performance Measure Validation, and Information Systems Capabilities Assessment

March 2009

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The Oregon Health Plan’s Managed Mental Health Care:
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March 2009

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

The Oregon Department of Human Services, 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 state Medicaid agencies to conduct or oversee annual EQR of the services provided to Medicaid enrollees through managed care.

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

This annual technical report summarizes EQR results in three major areas:

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

Part 1 of the annual report summarizes the results of Acumentra Health’s review of the MHOs’ PIPs, validation of statewide performance measures, and ISCA follow-up review. Part 2, submitted separately, summarizes the results of Acumentra Health’s review of MHO compliance with federal and state regulatory and contractual requirements.

EQR results

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

In 2008, AMH continued implementing the Children’s System Change Initiative (CSCI) and gathering data on clinical outcomes. The CSCI is designed to deliver mental healthcare services for children in the least restrictive environment by moving them, when appropriate, from psychiatric residential treatment facilities and state hospitals into community-based mental health services.
AMH, in partnership with the Division of Medical Assistance Programs (DMAP), continued to emphasize the importance and value of delivering integrated mental and physical healthcare services to OHP enrollees. Both the CSCI and integrated health care were subjects of quality improvement (QI) activities conducted by AMH and the MHOs.

**Performance improvement projects**

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

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

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

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

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

**Performance measure validation results**

AMH’s statewide performance measures for MHOs reflect the goal of reducing inpatient hospitalization. The previous EQR studies noted deficiencies with regard to how AMH’s quarterly utilization report explained the measure calculations and the limitations of the reported data. In addition, AMH lacked thorough internal documentation of the flow of data used in calculating the measures and of the steps taken to ensure accuracy and completeness.
The 2008 review clarified certain issues regarding the performance measures. However, as was true in 2007 and 2006, the measures comply only partially with CMS regulations. To date, AMH has not submitted formal revisions that address previous recommendations, including those regarding the quarterly report.

The 2007 ISCA review of DMAP and AMH information systems found that the state substantially met CMS data processing procedure standards to support the production of performance measures. However, the state only partially or minimally met CMS data acquisition standards, particularly those related to ensuring the validity and timeliness of encounter and claims data and the production of performance measure reports.

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

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

Response to previous EQR findings

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

Recommendations for AMH and MHOs

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

For AMH:

- Update the Medicaid Managed Mental Health Care Quality Assessment and Improvement Strategy to reflect new priorities and contract requirements that AMH has established for MHOs since 2006.
• Continue to provide in-depth PIP training for MHOs regarding best practices for data remeasurement, statistically valid analytic techniques, and appropriate methods for documenting the data collection process.

• Coordinate with DMAP to enable the MHOs and their collaborators in the mental/physical health integration PIPs to maintain a single PIP document and undergo a single annual project review with all partners present.

• Adopt the newly defined statewide performance measures following their approval by MHO contractors, operationalize the measures, and incorporate them into the Medicaid quality strategy.

• Address recommendations from previous reports. Acumentra Health continues to recommend that AMH
  o consider forming a QI committee to oversee MHO responsibilities and approve the annual work plan and the scope of work for the contract year
  o establish contractual requirements for MHOs to conduct regular audits to validate the encounter data submitted by providers

For MHOs:

• For collaborative mental/physical health integration PIPs, develop baseline data, implement the planned interventions, remeasure the study indicators, and perform statistical testing to determine improvements.

• For other ongoing PIPs, pursue consistent remeasurement of study indicators, perform appropriate statistical tests to assess the degree of sustained improvement due to the PIP interventions, identify barriers to improvement, and modify the interventions accordingly.

• Identify and document lessons learned from PIPs, as required by the PIP validation protocol.

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

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

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

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

This report (Part 1 of the 2008 EQR Annual Report) describes objectives, data collection and analysis methods, and conclusions drawn from the data obtained for the first two activities (including the ISCA associated with performance measure validation). Part 2 of the report presents the compliance review results.

Separate reports delivered to AMH during 2008 have assessed the strengths and weaknesses of each MHO’s PIPs and information systems and have presented recommendations for improvement. AMH has begun follow-up reviews with each MHO to determine the required response to the EQR recommendations.

OHP managed mental health care

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

- Accountable Behavioral Health Alliance (ABHA)
- Clackamas Mental Health Organization (CMHO)
- FamilyCare, Inc.
- Greater Oregon Behavioral Health, Inc. (GOBHI)
- Jefferson Behavioral Health (JBH)
- LaneCare
- Mid-Valley Behavioral Care Network (MVBCN)
- Multnomah Verity Integrated Behavioral Healthcare System (VIBHS)
- Washington County Health and Human Services (WCHHS)
The MHOs, in turn, contract with provider groups, including community mental health programs (CMHPs) and other private nonprofit mental health agencies and hospitals, to deliver treatment services. The MHOs are responsible for ensuring that services are delivered in a manner that complies with legal, regulatory, and contractual regulatory obligations to provide effective care.

The nine MHOs provide statewide mental healthcare coverage for OHP enrollees. In November 2008, the MHOs covered about 374,860 enrollees, a 9 percent increase in the population since 2007. About 57 percent of enrollees were female, and 56 percent were children age 18 or younger. Table 1 presents the counties served by MHOs, the number of OHP enrollees served, and the portion of the OHP enrollee population for each MHO.

Table 1. Geographic coverage and OHP enrollment of Oregon MHOs.

<table>
<thead>
<tr>
<th>MHO</th>
<th>Primary counties served</th>
<th>Number of OHP enrollees</th>
<th>% of OHP population served</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABHA</td>
<td>Benton, Crook, Deschutes, Jefferson, Lincoln</td>
<td>26,598</td>
<td>7.0</td>
</tr>
<tr>
<td>CMHO</td>
<td>Clackamas, Gilliam, Hood River, Wasco</td>
<td>25,440</td>
<td>7.0</td>
</tr>
<tr>
<td>FamilyCare</td>
<td>Clackamas, Multnomah, Washington</td>
<td>13,266</td>
<td>3.5</td>
</tr>
<tr>
<td>GOBHI</td>
<td>Baker, Clatsop, Columbia, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler</td>
<td>30,553</td>
<td>8.0</td>
</tr>
<tr>
<td>JBH</td>
<td>Coos, Curry, Douglas, Jackson, Josephine, Klamath</td>
<td>65,141</td>
<td>17.0</td>
</tr>
<tr>
<td>LaneCare</td>
<td>Lane</td>
<td>35,975</td>
<td>10.0</td>
</tr>
<tr>
<td>MVBCN</td>
<td>Linn, Marion, Polk, Tillamook, Yamhill</td>
<td>74,937</td>
<td>20.0</td>
</tr>
<tr>
<td>VIBHS</td>
<td>Multnomah</td>
<td>70,415</td>
<td>18.8</td>
</tr>
<tr>
<td>WCHHS</td>
<td>Washington</td>
<td>32,543</td>
<td>8.7</td>
</tr>
</tbody>
</table>

AMH’s quality improvement activities

Managed care quality strategy

42 CFR §438.202 requires each state Medicaid agency contracting with MCOs (including both physical and mental health managed care 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.

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

Quarterly utilization report

AMH’s quarterly utilization report incorporates the four statewide performance measures for mental health care (see page 25) and presents data on mental health services provided to OHP enrollees. As in 2007, AMH issued only one quarterly report in 2008, covering data from April 1, 2007, to March 31, 2008.

Quality improvement annual work plans

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

CSCI implementation

The goal of the CSCI, mandated by state lawmakers in 2003, is to serve children with serious emotional, behavioral, and mental disorders through least restrictive, culturally appropriate, evidence-based services and care coordination. A key goal is to move children from psychiatric residential treatment and state hospitals into community-based services under managed care, when appropriate.
Key structural aspects of the CSCI include the involvement of children and families in service delivery and system operation, a uniform level-of-need determination process, child and family teams, coordinated service plans, community care coordination committees, children’s system advisory committees, and a system-wide focus on outcomes and data dissemination.

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

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

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

**Consumer satisfaction surveys**

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

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

**Evidence-based practice initiative**

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

The EBPs targeted during CSCI implementation include wraparound services—informal supports and resources provided for children and their families to promote, maintain, or restore successful community living. The Statewide Children’s Wraparound Initiative, started in July 2008, seeks to build a community-based, coordinated system of services and supports for children with complex behavioral health needs and their families. Program deliverables include:

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

**Mental and physical health integration**

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

- identify and address local, regulatory, and other barriers to integration

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• provide assistance to identify and implement best practices
• explore state or federal resources available to assist with integration efforts

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

**EQR activities**

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

As part of the EQR contract, Acumentra Health also conducts PIP training for MHOs to help them comply more fully with PIP standards. Since the 2005 PIP validation reviews, Acumentra Health has conducted three training sessions for the MHOs and two separate sessions for the MHOs and their partners in the mental/physical health collaborative PIPs.
Performance Improvement Projects

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


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

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

Review procedures

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

Acumentra Health reviewed the PIPs for the following elements:

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

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

1. Selected study topic is relevant and prioritized
2. Study question is clearly defined
3. Study indicator is objective and measurable
4. Study population is clearly defined and, if a sample is used, appropriate methodology is used
5. Data collection process ensures valid and reliable data
6. Improvement strategy is designed to change performance based on the quality indicator
7. Data are analyzed and results interpreted according to generally accepted methods
8. Reported improvement represents actual change
9. MHO has documented additional or ongoing interventions or modifications
10. MHO has sustained the documented improvement
Each standard has a potential score of 100 points for full compliance. The total points earned for each standard are weighted and combined to determine the MHO’s overall performance score for the specific PIP.

Typically, the overall PIP scoring is weighted 80 percent for demonstrable improvement in a project’s first year (Standards 1–8) and 20 percent for sustained improvement in later years (Standards 9–10). Thus, for first-year PIPs, the highest achievable overall score is 80 points; for second-year or ongoing PIPs, the maximum PIP score is 100 if the MHO has completed multiple remeasurements, making it possible to assess sustained improvement. For PIPs rated on the 100-point scale, Acumentra Health also assesses the validity and reliability of PIP results. Table 2 shows the range of compliance ratings and associated scores.

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

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

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

**Review results**

Tables 3 and 4 summarize the plan-specific and collaborative PIPs reviewed for each MHO. Table A-1 in Appendix A reports all MHOs’ scores by standard.
Table 3. Plan-specific PIP topics by MHO.

<table>
<thead>
<tr>
<th>MHO</th>
<th>PIP topic</th>
<th>Study focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABHA</td>
<td>Implementation of Acceptance and Commitment Evidence-Based Practice Model of Care</td>
<td>This PIP seeks to reduce unnecessary hospitalization of enrollees with suicidal ideation. ABHA has adopted a system-wide recovery model of care (Acceptance and Commitment, or ACT) and has provided ACT training and support for all providers and their staffs.</td>
</tr>
<tr>
<td>CMHO</td>
<td>Increasing Percentage of Ambulatory Care Appointments Kept Within 7 Days of Psychiatric Hospital Discharge</td>
<td>CMHO implemented several interventions to increase the timeliness of post-discharge appointments. At remeasurement, CMHO reported having increased to 70 percent the proportion of members who received outpatient care within seven days, as well as improving other related processes.</td>
</tr>
<tr>
<td>FamilyCare</td>
<td>Community-Based Crisis Intervention</td>
<td>This PIP aims to reduce utilization of acute services for children and adolescents and thereby reduce inpatient costs. The MHO contracted with a community-based service provider to ensure that children and adolescent enrollees receive services at home, in school, and in the community.</td>
</tr>
<tr>
<td>GOBHI</td>
<td>Nonclinical PIP: Improving Data Integrity</td>
<td>This project seeks to improve the integrity of clinical records maintained by GOBHI’s mental health service providers. Interventions have included a “Data Integrity Boot Camp” and requiring each provider to design and submit a data integrity action plan.</td>
</tr>
<tr>
<td>MHO</td>
<td>PIP topic</td>
<td>Study focus</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>GOBHI</td>
<td>Clinical PIP: Increasing Services for Children in Child Welfare Custody</td>
<td>The goal of this PIP is to serve a greater proportion of children in the state’s child welfare system, who are at high risk of developing mental health problems. GOBHI has sent targeted information to providers concerning their service penetration rates for this population, expecting that providers will create their own interventions that best suit the needs of their particular locations and service population.</td>
</tr>
<tr>
<td>JBH</td>
<td>Dual Diagnosis Treatment Assessment</td>
<td>JBH committed to improving integration and coordination of care for enrollees with dual mental health and substance abuse diagnoses. JBH adapted a fidelity scale for co-occurring disorders (CODs) to measure whether providers were assessing CODs and incorporating the assessments into enrollees’ treatment plans. JBH plans to discontinue this topic next year.</td>
</tr>
<tr>
<td>LaneCare</td>
<td>Reducing Hospital Utilization Through Coordination of Enrollee Care</td>
<td>This PIP aims to increase the coordination of enrollee care among staff of the Sacred Heart Hospital psychiatric unit (the Johnson Unit), LaneCare, and the MHO’s contracted outpatient providers, and to reduce enrollee psychiatric admissions and length of stay. LaneCare expects these measures to increase the quality of enrollee care by increasing the availability of beds in the Johnson Unit and reducing the hours an enrollee must wait in the emergency department for a bed in the psychiatric unit.</td>
</tr>
</tbody>
</table>
### Table 3. Plan-specific PIP topics by MHO (cont.).

<table>
<thead>
<tr>
<th>MHO</th>
<th>PIP topic</th>
<th>Study focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>MVBCN</td>
<td>Increasing Access to Intensive, Community-based Treatment Services for Children and Families</td>
<td>This PIP attempts to increase treatment for children in locations other than mental health clinics and other traditional settings. The intervention involves hiring and training new mental health care coordinators and conducting fidelity monitoring to ensure that providers consistently apply the wraparound model of care.</td>
</tr>
<tr>
<td>VIBHS</td>
<td>Initiation and Engagement</td>
<td>VIBHS reported that in 2006, 38 percent of all enrollee complaints were related to post-intake appointment access. This PIP tracks changes in the percentage of enrollees who move beyond the initial phase of treatment. Interventions include adding measures of initiation and engagement (I&amp;E) to provider contracts, creating a plan for the MHO’s QI staff to visit provider agencies, and tracking quarterly results of the I&amp;E measures.</td>
</tr>
<tr>
<td>WCHHS</td>
<td>Improving Procedures for Authorization of Clinical Services</td>
<td>This PIP focuses on changing the process of authorizing clinical treatment for WCHHS’s Medicaid population. The MHO seeks to determine whether delegating preauthorization to its contracted providers will improve the rate of appropriate service authorizations and save administrative costs for the MHO and for providers.</td>
</tr>
</tbody>
</table>
Figure 1 shows MHO scores on the plan-specific PIPs (some clinical, some nonclinical) that were rated on the 80-point scale in 2008. Because none of these projects had progressed to a second remeasurement, it was not possible to gauge sustained improvement. However, GOBHI’s nonclinical PIP received a Fully Met rating on this scale.

![Figure 1. Overall scores for plan-specific PIPs scored on 80-point scale.](image)

Figure 2 shows MHO scores on plan-specific PIPs that were rated on the 100-point scale. These studies had progressed to at least two remeasurements, making it possible to assess sustained improvement. MVBCN’s nonclinical PIP received a perfect score, and GOBHI’s clinical PIP also received a Fully Met rating on this scale.

![Figure 2. Overall scores for plan-specific PIPs scored on 100-point scale.](image)
Figure 3 shows the scores by individual validation standard for plan-specific PIPs reviewed in 2008, averaged across MHOs. The standards are defined on page 12.

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

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

**Figure 3. Average scores on plan-specific PIP validation standards.**
### Table 4. Collaborative PIP topics by MHO.

<table>
<thead>
<tr>
<th>MHO/Partners</th>
<th>PIP topic</th>
<th>Study focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABHA</td>
<td>Effects of Co-Occurring Substance Abuse and Mental Health Problems on Physical Health</td>
<td>The partners collaborated to increase coordination of chemical dependency, mental health, and chronic physical health care services for OHP enrollees in Deschutes County. The project seeks to increase this population’s use of primary care and mental health services by distributing letters informing enrollees about their primary care physicians (PCPs), making appointments with PCPs, and available mental health services.</td>
</tr>
<tr>
<td>CMHO</td>
<td>None</td>
<td>CMHO did not participate in a mental/physical health collaborative PIP this year.</td>
</tr>
<tr>
<td>FamilyCare MHO</td>
<td>Integrated Care Methadone Treatment Care Coordination</td>
<td>This PIP aims to increase coordination of care for enrollees receiving methadone treatment for opioid addiction. An onsite care coordinator works with enrollees to establish relationships with the enrollees’ PCPs, seeking to reduce inappropriate and/or avoidable emergency utilization and hospitalization.</td>
</tr>
<tr>
<td>GOBHI</td>
<td>None</td>
<td>GOBHI did not participate in a mental/physical health collaborative PIP this year.</td>
</tr>
<tr>
<td>JBH</td>
<td>Standardized Referral Process</td>
<td>This PIP seeks to improve the process by which PCPs refer Medicaid enrollees to mental health services. The partners have assessed baseline PCP satisfaction with the referral process, designed a standardized referral process based on this feedback, and prepared to implement the process.</td>
</tr>
</tbody>
</table>
### Table 4. Collaborative PIP topics by MHO (cont.)

<table>
<thead>
<tr>
<th>MHO/Partners</th>
<th>PIP topic</th>
<th>Study focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>LaneCare</td>
<td>Improving Coordination of Mental, Physical, and Dental Healthcare</td>
<td>This PIP seeks to improve coordination of care through systematic healthcare referrals across mental, medical, and dental health plans. The partners expect that improved coordination of care across these systems will improve health outcomes for Lane County OHP enrollees.</td>
</tr>
<tr>
<td>Lane Independent Physician Association</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hayden Family Dentistry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ODS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MVBCN</td>
<td>Mental and Physical Health – Chronic Pain Consultation and Stabilization Service</td>
<td>The partners seek to improve treatment for enrollees with chronic pain and co-morbid addiction and mental health conditions. As their primary intervention, the partners opened a pain clinic in June 2008, aimed at shifting the focus of care from physician-centered services to self-care in the community.</td>
</tr>
<tr>
<td>Marion-Polk Community Health Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VIBHS</td>
<td>Increasing Coordination and Integration of Medical and Mental Health Services</td>
<td>This PIP seeks to provide coordinated and integrated mental and primary health care for VIBHS enrollees, particularly those with serious and persistent mental illnesses (SPMI). VIBHS placed a registered nurse in selected mental health facilities that serve a large number of people with SPMI, to screen enrollees for physical health risks, determine which enrollees lack a PCP, and coordinate enrollee care.</td>
</tr>
<tr>
<td>LifeWorks NW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cascadia Behavioral Healthcare System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CareOregon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WCHHS</td>
<td>Improving Exchange of Clinical Documentation Between Mental Health and Primary Care Providers</td>
<td>This PIP focuses on integrating physical and mental health care by improving communication across systems through more consistent exchange of clinical documentation. At the time of the PIP evaluation, the partners had not designed an intervention.</td>
</tr>
</tbody>
</table>
AMH did not require the MHOs’ collaborative PIPs to address all standards of the validation protocol in 2008. Of the seven MHOs that submitted collaborative PIPs for review, all addressed the first three standards; five MHOs addressed the first four standards; three MHOs addressed the first five standards; and one MHO addressed Standards 1–7. Figure 4 shows the average scores by standard. (For definitions of the standards, see page 12).

![Figure 4. Average scores on collaborative PIP validation standards.](image_url)

*a Average of 7 MHOs.  
*b Average of 5 MHOs.  
*c Average of 3 MHOs.  
*d Represents 1 MHO.
**PIP highlights and recommendations**

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

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

   A. Adding care coordinator(s) to staff

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

   B. Provider training

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

- GOBHI: Required each provider group to submit a data integrity action plan with objective, measurable steps to improve data integrity, and required clinical supervisors to attend “Data Integrity Boot Camp” in 2007. GOHBI went back into the charts in 2008 to see whether the improvement was sustainable.

- MVBCN: Conducted fidelity monitoring to ensure that providers consistently applied the wraparound model of care.

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

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

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

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

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

1. In formulating the study topic:
   a. Conduct analysis to identify system challenges and barriers to optimal performance.
b. Consult with multiple stakeholders (e.g., enrollees and their families, agency directors, medical staff and directors, community members) to identify issues with widespread impact and obtain stakeholder buy-in.

c. Examine local data to confirm that the identified issue is relevant to the local healthcare system or population

2. Develop data collection and verification procedures and an *a priori* data analysis plan. The MHO should document

a. critical data elements (e.g., specific service codes, presence/absence of test results)

b. whether data were collected manually, using a form, or electronically by query (attaching the form or query for review is a best practice)

c. staff training required

d. data verification procedures to ensure that data are accurate and reliable; e.g., comparing two different data sources (claims to chart, or state to plan-level data) or reviewing a sample for outliers and/or missing data

e. a precise statistical test (e.g., a chi-square test) and probability level (e.g., $p<.05$ or $p<.10$) for each comparison

f. study time frames, specifying the beginning and end of three study periods: baseline, intervention, and remeasurement

3. Design an intervention strategy to address the specific challenges and barriers identified through the system analysis. Supporting information may come from literature reviews, best-practice guidelines, and/or surveys of enrollees, practitioners, or other stakeholders.

4. Pursue consistent remeasurement of the study indicators, perform appropriate statistical tests to assess the degree of sustained improvement due to the intervention(s), identify barriers to improvement, and modify the intervention(s) accordingly.
Performance Measure Validation and ISCA Follow-Up

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

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

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

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

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

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

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

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

**Review procedures**

The performance measure validation process, adapted from the CMS protocol for this activity, included the following steps.

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

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

- **Fully compliant**—Measure was complete as reported, accurate, and could be interpreted easily by the casual reader.
- **Substantially compliant**—Measure was complete as reported, accurate, and had only minor points in calculation that did not significantly hamper the ability of the reader to understand the reported rate.
- **Partially compliant**—Measure either was complete as reported or was accurate, but not both, and had deficiencies in calculation that could hamper the reader’s ability to understand the reported rates.

---

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

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

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

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

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

Performance measure completeness and accuracy

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

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

The 2008 onsite review yielded some verbal clarification with regard to the performance measures. However, AMH has submitted no formal revisions that address previous recommendations. Consequently, the measures remain only partially compliant in 2008, as in the previous two years. Table 5 summarizes the validation ratings.

---

Table 5. Performance measure validation ratings, 2008.

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

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

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

**Strengths**

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

- The *OHP Mental Health Utilization Quarterly Report* partially defines all four measures with a numerator and denominator statement. An appendix lists the diagnosis and procedure codes used in calculating the measures.

- The report’s executive summary defines the study population in terms of Medicaid eligibility, enrollment, receipt of mental health services, and admission for acute care.

- The executive summary identifies some limitations of the report, including:
  - The absence of statistical significance testing of apparent differences among providers or across time periods
  - The 180-day interval between service delivery and when the service is contractually required to be billed
  - That the hospitalization data include transfers between facilities and readmissions within a 24-hour time frame (see second bullet under “Opportunities for improvement” below)

**Opportunities for improvement**

- Several shortcomings of the AMH performance measures raise issues of comparability with similar widely accepted measures, such as HEDIS®.
  - Unlike similar measures, the AMH performance measure definitions do not include a continuous enrollment criterion for the study population. As a result, the AMH measures are not comparable with similar measures that use that criterion. AMH’s quarterly utilization report does not address this.
  - The AMH performance measure definitions are imprecise about the circumstances in which enrollee transfers and readmissions may be counted as separate admissions (or episodes of care). The imprecise definition of an admission makes several of the performance measures difficult to interpret and compare with similar measures.

- Although AMH stated in the interview that it had developed a written process for quality control (defining staff responsibilities for analyzing data, creating reports, and writing program codes), AMH did not provide this document during the 2008 review.

- AMH lacks automated mental health-specific edits and audits to serve as logic checks for the encounter data received from DMAP—for example, to
ensure that diagnostic codes are assigned to appropriate age groups. AMH only checks for gross variations in the number of encounters submitted.

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

**Recommendations**

- AMH’s quarterly report should specify that the performance measures do not include a requirement for continuous enrollment in the study population, and thus are not directly comparable with similar measures.

- AMH needs to define hospital admissions and readmissions more precisely in terms of the circumstances in which a transfer or readmission may be counted as a separate admission for the same enrollee. AMH may wish to consult the HEDIS® technical specifications with regard to defining inclusion and exclusion criteria for counting admissions and discharges.

- AMH needs to develop and implement a formal process for applying mental health-specific edits and audits of encounter data received from DMAP.

- AMH needs to establish a system for validating MHO data submissions to ensure accuracy and completeness and for following up with MHOs to resolve problems. As an alternative, AMH could contract with an external auditor for an annual audit of MHO data submissions.

- For purposes of comparing performance among MHOs and with similar national measures or benchmarks, the quarterly report needs to explain the performance measure definitions and calculations more thoroughly to help readers assess the reported data. AMH should clearly define the numerators and denominators of the performance measures. The report’s executive summary should define the study population and the data limitations, stating why AMH does not perform statistical analyses among providers and across time periods and/or where this information can be found.

Table 6 shows the 2008 status of recommendations presented in previous EQR reports for improving the accuracy and completeness of AMH’s statewide performance measures.
Table 6. Update of recommendations for improving statewide performance measures.

<table>
<thead>
<tr>
<th>2005 recommendation</th>
<th>2006 status</th>
<th>2007 status</th>
<th>2008 update</th>
</tr>
</thead>
</table>
| Each measure should have a numerator and denominator statement that fully defines the population being measured, data sources used, and fields used to determine inclusion in the numerator and denominator. | The quarterly utilization report does not define numerators and denominators or explain the calculation of the measures. The report provides a list of diagnostic and procedure codes but does not specify which codes are used in calculating each measure. | The report lists a numerator and denominator for each measure, and it provides a list of codes used in calculating the measures. However, the report does not adequately define inclusions, exclusions, and data sources for each measure. | The report lists a numerator and denominator for each measure, but the descriptions are imprecise (e.g., unique enrolled per 1,000 members), and no formula is provided for the measures, such as:

  Total admissions

  Unique enrollees ÷ 1,000 |

<table>
<thead>
<tr>
<th>Analyze dually enrolled MHO members (those enrolled in both Medicaid and Medicare) separately or remove them from the total population.</th>
<th>Data in the report still include dually enrolled members. AMH has agreed to note this in future reports.</th>
<th>The executive summary notes that the report includes dual-eligible enrollees, but it defines such enrollees as those receiving mental health services and alcohol or drug treatment, rather than as those eligible for both Medicaid and Medicare.</th>
<th>AMH needs to note in its report whether the population includes enrollees dually enrolled in Medicare and Medicaid.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remove ineligible enrollees (e.g., those who have died or been disenrolled) from the denominator of the readmission and outpatient care measures, or report an estimate of the potential impact—for example, the death rate.</td>
<td>Enrollment data may include deceased or disenrolled members. AMH has agreed to note this in future reports.</td>
<td>The report does not address this limitation of the data.</td>
<td>The report still does not address this limitation.</td>
</tr>
</tbody>
</table>
Table 6. Update of recommendations for improving statewide performance measures (cont.).

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

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

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

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

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

Table 7 summarizes the 2007 ISCA section scores and ratings.
Table 7. Weighted average scores and ratings on ISCA sections, 2007.

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

The 2007 ISCA also showed that AMH needed to ensure the validity and timeliness of the encounter and claims data used in calculating performance measures, by implementing best practices that include:

- automated edit and validity checks of procedure and diagnosis code fields, timely filing, eligibility verification, authorization, referral management, and a process to remove duplicate claims and encounters
- a documented formal procedure for rectifying encounter data submitted with one or more required fields missing, incomplete, or invalid
- periodic audits (internal and external) of randomly selected records to ensure data integrity and validity
- online capabilities for viewing and correcting pended claims and encounters to reduce processing lags
- five to seven years of historical data available online

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

**2008 update:** AMH does not perform automated mental health-specific edits and audits of encounter data received from DMAP—for example, to ensure that diagnostic codes are assigned to appropriate age groups. As was the case in 2007, AMH only checks these data for gross variations in the number of encounters submitted. AMH uses a visual process to spot errors and may run cross-tabs of diagnostic codes and ages to check for problems.
AMH has no written policies and procedures for maintaining its performance measure data repository to streamline the association of data from different sources and periods for trend analysis, and to allow for quality-control checks or periodic audits of performance measure data.

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

**Strengths**

- DHS implemented a new MMIS in December 2008, replacing the old MMIS that was more than 30 years old. Adequate hardware and software are in place to support the MMIS, including maintenance and timely replacement of equipment, disaster recovery procedures, adequate training for staff, and a secure computing environment.

- AMH saves “snapshots” of the data used to generate performance measure reports so that measures for previous reporting periods can be recreated.

- Once the MHOs have submitted encounter and claims data to the state, DMAP sends a report back to the MHOs noting the number of claims and dollar amounts. This system enables each MHO to verify that the state has received all data submitted by the MHO and to reconcile discrepancies.

**Opportunities for improvement**

- The high-level documentation describing the flow of data from the mental health encounter to the performance measure report omits important details about data validation and processing and staff responsibilities.

- AMH has no written policies and procedures for maintaining its performance measure data repository—for example, to define how data snapshots occur.

**Recommendations**

- DMAP needs to continue to improve its documentation to provide more specific details about the flow of data from the mental health encounter to the performance measure report.

- AMH needs to develop written policies and procedures for maintaining its performance measure data repository, including an explanation of how data snapshots occur.
NOTE: Although a thorough evaluation of the newly implemented MMIS is outside the scope of the 2008 ISCA follow-up, Acumentra Health has identified several potentially serious issues resulting from the state’s transition to the new MMIS in December 2008.

1. Claims processing issues associated with the new MMIS left MHOs and providers unable to submit electronic claims or to verify OHP enrollee eligibility. The state needs to remedy these issues quickly or risk being unable to reconcile the weekly/monthly capitation with daily/monthly OHP enrollment. The state also risks being unable to collect valid data for generating performance measures and for supporting development of the MHOs’ PIPs.

2. The new MMIS allows providers to use only DMAP’s “legacy” numbers to identify the provider and the payer in billing for Medicaid reimbursement. HIPAA requires covered entities to use the approved National Provider Identifier numbers to identify providers on covered transactions that call for provider identifiers. Transactions that require the use of legacy identifiers to transmit provider information are noncompliant with HIPAA.

The 2009 ISCA will analyze these issues and the state’s response in greater detail.
MHO information systems

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

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

Figure 5 shows the scores by individual section of the ISCA protocol in 2005 and 2007, averaged across the nine MHOs. As shown, the MHOs have improved their compliance with most standards since the baseline assessment in 2005. Appendix B defines the criteria for meeting ISCA standards.

Figure 5. Average ISCA section scores for nine MHOs, 2005 and 2007.

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

Strengths

Infrastructure

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

Programming/Report development

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

Security

- Most MHOs had processes in place to meet HIPAA standards for protecting enrollee, encounter, and claims data from unauthorized access. In a few cases, however, the MHOs used insecure, non-HIPAA-compliant methods to transport encounter data files or backup tapes.

- The majority of the MHOs’ contracted providers submitted encounter data electronically in encrypted and/or password-protected files each month.

- All MHOs that maintained in-house database systems had good maintenance contracts in place for hardware and software to ensure timely support.

Table 8. Opportunities for improvement and recommendations for MHOs: Data Processing Procedures and Personnel.

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

**Strengths**

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

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

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

Table 9. Opportunities for improvement and recommendations for MHOs: Data Acquisition Capabilities.

<table>
<thead>
<tr>
<th>Opportunity for improvement</th>
<th>2007 recommendation</th>
<th>2008 update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Several MHOs had no formal controls in place to ensure that all Medicaid claims from hospitals were entered into the system when Medicare paid fully for mental health services.</td>
<td>MHOs need to have system controls in place to ensure proper accounting for all claims from hospitals.</td>
<td>No change.</td>
</tr>
<tr>
<td>Most MHOs exercise inadequate oversight of the contracted agencies’ processes for claims and encounter data submission.</td>
<td>MHOs need to audit the encounter data submitted by providers against clinical records regularly to validate the data’s accuracy and completeness. MHOs should consider contracting for annual independent audits to ensure adequate controls and checkpoints for integrity of encounter data.</td>
<td>Several MHOs have developed a process for auditing the encounter data submitted by providers against clinical records.</td>
</tr>
</tbody>
</table>
**Information Systems.** This section of the ISCA protocol focuses mainly on the software used to collect, store, and process encounter data. Desirable features of software include ease of use, scalability without degradation of performance with increased data volume, and integration with other software.

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

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

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

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**Figure 6. MHO compliance scores: Information Systems.**
**Staffing.** This section of the protocol applies to the MHO or TPA staff assigned to process encounter and claims data. A “Fully met” score reflects adequate numbers of trained staff for processing accurate, complete, and timely encounter data; a comprehensive, documented training process for new hires and seasoned employees; established and monitored productivity goals for data processing; and low staff turnover.

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

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

![Figure 7. MHO compliance scores: Staffing.](chart.png)
Hardware Systems. Quality and maintenance of computer equipment and software are important in ensuring the integrity and timeliness of encounter data submitted to the state. Desirable features include robust server equipment; hardware redundancy in terms of data storage devices and other key components; premium hardware maintenance contracts; software maintenance contracts for commercial database systems; and a standby server as a backup to the main production server.

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

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

![Figure 8. MHO compliance scores: Hardware Systems.](image-url)
**Security of Data Processing.** Acumentra Health evaluated the physical security of each MHO’s data as well as the MHO’s backup systems and methods for protecting the database from corruption.

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

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

![Figure 9. MHO compliance scores: Security of Data Processing.](image-url)
**Administrative Data.** In addition to assessing each MHO’s ability to acquire and report accurate, complete, and timely claims and encounter data, Acumentra Health interviewed each MHO’s contracted provider agencies to evaluate their processes for validating data, the diagnosis and procedure codes captured by their billing systems, their handling of Medicaid and Medicare dual enrollees, the types of encounters forwarded to the MHO, and data submission methods.

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

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

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

![Figure 10. MHO compliance scores: Administrative Data.](image)
**Enrollment System.** Timely and accurate eligibility data are essential for ensuring access to care for Medicaid enrollees. Eligibility information from DMAP is available for download on a weekly and monthly basis. Upon each download, the MHO should verify the file before incorporating it into the data warehouse or distributing it to contracted providers. This step helps to protect the database from potentially corrupted files.

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

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

![Figure 11. MHO compliance scores: Enrollment System.](image-url)
Vendor Medicaid Data Integration. The 2007 ISCA found that, where applicable, all MHOs collected member-level data from their contracted agencies and ensured that the data were compatible with the state’s data systems, fully complying with this standard. (Note: Acumentra Health defined vendors as TPAs that adjudicated claims, rather than as service providers.)

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

Figure 12. MHO compliance scores: Vendor Medicaid Data Integration.
Provider Compensation and Profiles. Acumentra Health evaluated each MHO’s provider compensation system to determine whether the compensation structure balanced contractual expectations, enrollees’ needs, and capitation rates set by AMH. Most MHOs had automated provider compensation on the basis of a rate list for each procedure code, per the provider’s credentials.

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

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

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

![Figure 13. MHO compliance scores: Provider Compensation and Profiles.](image-url)
Discussion and Recommendations

The 2008 EQR results reflect progress made—and challenges encountered—by AMH and the MHOs in meeting Medicaid managed care requirements. This discussion highlights continuing system-wide opportunities for improvement, in addition to the MHO-specific recommendations presented in individual reports throughout the past year.

Managed care quality strategy

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

PIP validation

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

Ongoing technical training can help the MHOs avoid these inconsistencies and problems. This annual report offers detailed recommendations (see pages 23–24) to guide MHOs in selecting PIP topics and intervention strategies that are likely to result in long-lasting and meaningful improvement.

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

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

Performance measure validation

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

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

Recommendations for AMH and MHOs

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

For AMH:

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

With regard to PIPs:

- Continue to provide in-depth training and information for MHOs regarding best practices for data remeasurement, statistically valid analytic techniques, and appropriate methods for documenting the data collection process.

- Consider supporting the development of a PIP knowledge base or similar repository to provide MHOs with a ready source of information about other
organizations' experiences in designing and documenting their PIPs, including best practices. The repository could be located on a password-protected section of AMH’s website.

- Coordinate with DMAP to enable the MHOs and their partners collaborating in mental/physical health integration PIPs to maintain a single PIP document and undergo a single annual project review with all partners present.

With regard to performance measures and information systems:

- Address the state-level ISCA recommendations listed on page 35.
- Adopt the newly defined statewide performance measures following their approval by MHO contractors, operationalize the measures, and incorporate them into the Medicaid quality strategy.
- Continue to work with MHOs to ensure the development of data systems that can capture and transmit high-quality encounter and claims data.
- In light of CMS concerns about the accuracy and completeness of Medicaid encounter data, establish contractual requirements for MHOs to conduct regular audits to validate the encounter data submitted by providers.

For MHOs:

With regard to PIPs:

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

With regard to information systems:

- Audit the encounter data submitted by provider agencies against providers’ clinical records regularly to validate the accuracy and completeness of encounter data.
Appendix A. MHO Scores on PIP Validation

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>ABHA</th>
<th>CMHO</th>
<th>Family Care</th>
<th>GOBHI</th>
<th>JBH</th>
<th>Lane Care</th>
<th>MVBCN</th>
<th>VIBHS</th>
<th>WCHHS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan-specific PIPs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall score</strong></td>
<td>38*</td>
<td>68**</td>
<td>36*</td>
<td></td>
<td>57**</td>
<td>39*</td>
<td>100**</td>
<td>70**</td>
<td>33*</td>
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<tr>
<td>Standard 1</td>
<td>35</td>
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<td>100</td>
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<td>100</td>
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<td>Standard 2</td>
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</tr>
<tr>
<td>Standard 3</td>
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<td>85</td>
<td>30</td>
<td></td>
<td>50</td>
<td>70</td>
<td>100</td>
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<td>65</td>
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<tr>
<td>Standard 4</td>
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<td>75</td>
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<td></td>
<td>80</td>
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<td>100</td>
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<td>Standard 5</td>
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<td>Standard 6</td>
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<td>Standard 7</td>
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<td>Standard 8</td>
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<td>25</td>
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<td>Standard 9</td>
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<td>75</td>
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<td></td>
<td>50</td>
<td>—</td>
<td>100</td>
<td>85</td>
<td>—</td>
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<tr>
<td>Standard 10</td>
<td>—</td>
<td>25</td>
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<td>0</td>
<td>—</td>
<td>100</td>
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<tr>
<td><strong>Collaborative PIPs</strong></td>
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<td></td>
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</tr>
<tr>
<td>Standard 1</td>
<td>50</td>
<td></td>
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<td>65</td>
<td>100</td>
<td>75</td>
<td>75</td>
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</table>

See footnotes on next page.
*80-point rating scale:  **100-point rating scale:
70–80 = Fully met  80–100 = Fully met
55–69 = Substantially met  60–79 = Substantially met
40–54 = Partially met  40–59 = Partially met
25–39 = Minimally met  20–39 = Minimally met
0–24 = Not met  0–19 = Not met

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

GOBHI’s PIP scores were as follows:

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<tr>
<th></th>
<th>Clinical</th>
<th>Nonclinical</th>
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<tr>
<td><strong>Overall score</strong></td>
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<td>78*</td>
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<td>Standard 10</td>
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Appendix B. Criteria for ISCA Standards

Data processing procedures and personnel

Information systems

A data storage and processing system that facilitates valid and reliable performance measurement would have the following characteristics:

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

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

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

- good documentation
- clear, continuous communication between the client and the programmers on client information needs (e.g., analysis needs, reports)
- a quality assurance process
- version control
- continuous professional development of programming staff
Staffing
Best practices for sustaining quality in processing encounter data include

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

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

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

Data security requires a comprehensive backup plan that includes, but is not limited to, scheduling, rotation, verification, retention, and storage of backups to provide additional security in the event of a system crash or compromised integrity of the data. Managers responsible for processing claims and encounter data, including the third-party administrator’s, must be knowledgeable of their backup...
schedules and of retention of backups to ensure data integrity. This information should be documented and easily accessible by managers and their staff.

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

For additional protection from corruption during database updates, databases should include transaction management, commits, and rollbacks. Transaction management is useful when making multiple changes in the database to ensure that all changes work without errors before finalizing the changes. A database commit is a command for committing a permanent change or update to the database. A rollback is a method for tracking changes before they have been physically committed to disk. This prevents corruption of the database during a sudden crash or some other unintentional intervention.

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

**Data acquisition capabilities**

**Administrative data**

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

To ensure the validity and timeliness of encounter data for performance measures, the MHO needs documented standards, formal quality assurance of input data sources and transactional systems, readily available historical data, and a system for electronic submission of data. Best practices include

- automated edit and validity checks of procedure and diagnosis code fields, timely filing, eligibility verification, authorization, referral management, and a process to remove duplicate claims and encounters

- a documented formal procedure for rectifying encounter data submitted with one or more required fields missing, incomplete, or invalid. Ideally, the data processor would not alter the data until receiving written notification via a paper claim or from the provider.
• periodic audits of randomly selected records conducted internally and externally by an outside vendor to ensure data integrity and validity. Audits are critical after major system upgrades or code changes.

• multiple diagnosis codes and procedure codes for each encounter record, distinguishing clearly between primary and secondary diagnoses.

• efficient data transfer (frequent batch processing) to minimize processing lags that can affect data completeness.

• online capabilities for viewing and correcting pended claims and encounters to reduce processing lags.

• availability of five to seven years of historical data.

**Enrollment system (Medicaid eligibility)**

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

**Vendor Medicaid data integration**

An ideal vendor data integration system would

• be capable of converting data, including code sets, for compatibility with the state’s data systems.

• receive only member-level data, as opposed to aggregate data.

• incorporate other data (e.g., dental care, primary care manager, history of care) to provide a more complete picture of a member’s care.

• ensure consistency in the data for required fields, including multiple diagnosis and procedures codes.

**Provider compensation and profiles**

An MHO designs its provider compensation structure to balance contractual expectations, the needs of enrolled populations, and capitation rates set by the state. To set appropriate capitation rates biannually, the state relies on accurate and timely encounter data.
A good payment structure is critical to ensure reasonable and timely compensation, which encourages an accessible, qualified community network of providers to continue to provide service to Medicaid enrollees.

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

DRAFT
MHO Performance Measures
QI Coordinators Work Group

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

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

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

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

The overarching goal of the ICTS movement is to increase the ability of a child to receive services within their home community. Residential levels of care are only to be utilized when clinically necessary. Anecdotal information from residential facilities indicate that prior to the implementation of the ICTS system DHS children were staying in Psychiatric Residential Treatment facilities an average of 120 days longer than non-DHS children. Current reports from ICTS providers indicate ongoing struggles with transitioning DHS children out of restrictive levels of care due to placement issues. In the interest of ensuring that children within the DHS Child Welfare system have equitable access to the least restrictive levels of care and that institutional levels of care are not over utilized, it will be important to monitor outcomes for both DHS and non-
DHS children. This data can serve to inform us of our outcome successes and/or highlight potential areas for additional attention.

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

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