Office of Mental Health and Addiction Services
2005 External Quality Review Annual Report
The Oregon Health Plan's Mental Health Care

OMHAS Contract #109162

December 2005

Presented by

OMPRO
A Healthcare Quality Resource

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The Oregon Health Plan's Mental Health Care: 2005 External Quality Review Annual Report

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Presented to the Oregon Department of Human Services,
Office of Mental Health and Addiction Services

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Executive Summary

The Oregon Department of Human Services, Office of Mental Health and Addiction Services (OMHAS) has contracted with OMPRO, a quality improvement organization, to perform an external quality review (EQR) of the delivery of services by mental health organizations (MHOs) to enrollees in the Oregon Health Plan (OHP). The Balanced Budget Act of 1997 requires an EQR in states such as Oregon that use a managed care approach to provide Medicaid services. This final report summarizes the EQR results in three major areas:

- assessment of the MHOs' compliance with contractual and regulatory obligations and the integrity of their information technology (IT) systems, data processing, and reporting functions
- assessment of the MHOs' performance improvement projects (PIPs)
- validation of the statewide performance measures that OMHAS uses to assess care provided by the MHOs, including an assessment of the State's IT systems related to calculating and reporting those measures

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

Standards for MHO performance have changed with the advent of the EQR process and input from the Centers for Medicare & Medicaid Services (CMS) with regard to contract expectations. At the time of the EQR audits, MHOs had just begun updating policies and procedures, enrollee information materials, and other operations to respond to the EQR requirements. The MHOs generally are dedicated to providing services to their enrollees and have made commendable efforts to maintain their effectiveness in the face of budgetary cuts.

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

Access to care

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

- Across Oregon, most MHOs provide good access for enrollees. The most substantial challenges occur in rural areas with scarce clinic locations, though some MHOs are testing innovative solutions such as variable clinic hours and mobile clinicians. Also, access is inconsistent for certain subsets of enrollees, such as seniors, minorities, and children.
- Many MHOs face a shortage of psychiatrists, especially child psychiatrists. Some have met their prescribing needs by using nurse practitioners and by coordinating with primary care physicians. In the Portland area, provider shortages make it difficult for some MHOs to provide routine appointments.
- All MHOs provide 24-hour emergency services and have contracts or agreements with hospitals or crisis services to cover enrollees' needs for urgent and emergent care.
- Several MHOs have targeted their PIPs at improving outreach to specific underserved populations or at changing their care delivery models to ensure that enrollees have access to routine appointments.
- To monitor the MHOs' performance in providing timely access, OMHAS has developed statewide measures for readmission to acute care and for appointments for enrollees in outpatient settings after discharge from acute care. However, these measures are defined ambiguously and are not comparable with MHO-generated measures or with other benchmarks.

Quality of care

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

- *Documentation*: While MHOs generally are fulfilling their substantive responsibilities in day-to-day operations, the MHOs' written policies and procedures are incomplete or outdated in many areas and do not meet CMS standards. Similarly, although all of the MHOs are conducting PIPs to improve the quality of care and services, they need to improve the documentation of their PIPs.
- *Enrollee rights:* All MHOs provide handbooks to inform enrollees of their rights; some also provide this information through websites and newsletters. However, none of the MHOs have implemented comprehensive policies and procedures in the area of enrollee rights. Most notify enrollees of their rights at enrollment but not annually, as required.
- *Primary care and coordination of services:* Some MHOs actively coordinate care for enrollees with complex needs. However, coordination of mental

health care with primary and specialty care is often lacking. Treatment plans often do not capture enrollees' physical care treatment needs. Some MHOs and contracted agencies need to become familiar with and apply OMHAS's definition of special healthcare needs.

- *Credentialing/recredentialing*: Most MHOs need to improve their oversight of contracted agencies in this area—for example, to ensure that agencies use the National Practitioner Data Bank to monitor for providers excluded from federal healthcare programs. The EQR audits found repeated examples of incomplete or dated materials in practitioner files.
- *Delegated activities:* MHOs' site reviews of contracted agencies provide important feedback to the agencies. In most cases, however, the MHOs do not consistently monitor all activities delegated to the agencies and their subcontractors to ensure compliance with managed care regulations.
- *Practice guidelines:* Four of the nine MHOs have developed practice guidelines that at least partially meet CMS requirements. The other MHOs either have no practice guidelines or need to update their guidelines.
- *Quality assessment/performance improvement:* All MHOs have quality improvement plans in effect that cover all OMHAS required domains, and all collect and report performance data to the State. Some MHOs have devoted considerable effort and funding to improve the quality of their claims and encounter data. However, further improvements are needed, as these data are integral for calculating statewide performance measures, setting capitation rates for MHOs, and analyzing service utilization.
- *Grievance systems:* Although all MHOs have processes in place to respond to enrollee grievances, all have inadequate written policies and procedures, and most fail to monitor the process adequately to ensure compliance. Also, the format of the OMHAS-approved complaint log omits some elements that are essential for effectively tracking complaints, grievances, and appeals.

Timeliness of care

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

- For the most part, MHOs offer timely first appointments, but some MHOs' enrollees face lengthy delays for follow-up appointments. MHOs generally need to address timely interventions and post-hospitalization care.

- Some MHOs fail to track the timing elements of steps in the grievance process to ensure timely response to complaints, grievances, and appeals.
- The majority of MHOs do not have adequate processes in place to ensure timeliness in sending notices of action to enrollees when decisions are made to deny or reduce services.

Recommendations

For OMHAS:

- Improve the definition of statewide performance measures that OMHAS has developed to track acute hospitalization, readmission to acute care following discharge, and the timeliness of appointments for enrollees in outpatient settings following discharge from acute care.
- Address elements of State information systems that raise concerns about compliance with the data security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These issues relate to the transfer of non-encrypted encounter data from the Office of Medical Assistance Programs to OMHAS's information system, and to the use of a dial-up connection to a bulletin board to receive Medicaid claims and encounter data from MHOs and from third-party billers.
- Provide training or clarification to MHOs on the definition of special healthcare needs and on approaches to providing care for enrollees with those needs.
- Revise the OMHAS-approved complaint log or develop another mechanism for MHOs to capture all required information related to complaints, grievances, and appeals.
- Revise the Managed Care Quality Strategy to address the issues identified by this EQR report.
- Provide leadership to advance the integration of the mental health and medical managed care systems.

For MHOs:

- Devote resources to updating and implementing a complete set of policies and procedures that comply with CMS standards.
- Establish mechanisms to ensure receipt of timely, accurate, and complete claims and encounter data from contracted agencies.
- Improve information materials and other communications for enrollees.
- Strengthen oversight and monitoring of activities delegated to contracted agencies and their subcontractors.

Introduction

OMPRO, as OMHAS's external quality review organization (EQRO), presents this report to fulfill the requirements of Code of Federal Regulations, Title 42, section 438.364. The report describes how data from OMHAS's EQR-related activities were aggregated and analyzed and how conclusions were drawn as to Oregon Medicaid enrollees' access to mental health services and the timeliness and quality of services furnished by MHOs.

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

- a review of each MHO's compliance with established standards for access to care, structure and operations, and quality measurement and improvement
- validation of PIPs required under 42 CFR 240(b)(1)
- validation of performance measures reported by managed care organizations or calculated by the State as required by 42 CFR 438.240(b)(2)

This report describes objectives, data collection and analysis methods, data obtained, and conclusions drawn from the data for each EQR activity. Separate reports delivered to OMHAS during 2005 have assessed each MHO's strengths and weaknesses with respect to quality, timeliness, and access to care, and have recommended ways for each MHO to improve its performance. OMHAS will determine the required action for each MHO.

OHP mental health care

Between 1995 and 1997, OHP phased in coverage of mental health services, delivered through contracts with MHOs on a capitated basis. This responded to Oregon lawmakers' adding mental health conditions to the prioritized list of conditions eligible for OHP coverage in 1993. Currently, the MHOs provide mental health services throughout the state. OHP contracts with nine MHOs:

- Accountable Behavioral Health Alliance (ABHA)
- Clackamas County Mental Health Organization (CCMHO)
- 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, contractual, and regulatory obligations to provide effective care.

As of the second quarter of 2005, the nine MHOs served a total of 380,825 OHP enrollees, broken out as shown in Table 1.

Table 1. Geographical coverage and enrollment of Oregon MHOs.

MHO	Counties served	Number of enrollees[a]
ABHA	Benton, Jefferson, Lincoln, Deschutes, Crook	27,265
CCMHO	Clackamas, Hood River, Gilliam, Sherman, Wasco	26,211
FamilyCare	Clackamas, Multnomah, Washington	12,074
GOBHI	Baker, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler, Clatsop, Columbia	31,597
JBH	Coos, Curry, Klamath, Jackson, Douglas, Josephine	66,731
LaneCare	Lane	36,201
MVBCN	Linn, Marion, Polk, Tillamook, Yamhill	72,161
VIBHS	Multnomah	74,609
WCHHS	Washington	33,976

[a] Data from Oregon Department of Human Services, MHO Utilization Quarterly Report, 2nd Quarter 2005.

OMHAS's quality improvement activities

Quality Strategy

42 CFR 438.202 requires each state Medicaid agency contracting with a managed care organization 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. States either must adopt CMS protocols for independent external review of the organization's compliance with federal quality standards, released in February 2003, or must implement protocols consistent with CMS protocols.

OMHAS plans to revise its Managed Care Quality Strategy in 2006 to address issues identified by the 2005 EQR. The new strategy document will summarize OMHAS's approach to measuring, assessing, and improving services provided by the MHOs.

MHO Utilization Report

OMHAS produces a quarterly MHO Utilization Report that incorporates the statewide mental health care performance measures and presents information about mental health services provided to OHP enrollees across the state.

Quality improvement annual work plan

Each MHO submits its quality improvement (QI) annual work plan to OMHAS for approval. This process enables OMHAS to standardize its QI criteria and to monitor and offer technical assistance for the MHOs' QI activities.

Surveys

OMHAS has conducted annual surveys of the caregivers of children who receive outpatient mental health services to determine their levels of satisfaction with the quality of services received. OMHAS contracted with OMPRO to conduct the 2005 Youth Services Survey for Families. The 2005 survey differed from previous surveys in that it collected information on the caregivers' satisfaction with

- residential and day treatment services for children
- the individual MHOs' service delivery
- the coordination of care between mental health care providers and government agencies that serve children

OMPRO's final report of survey results is scheduled for completion and delivery to OMHAS in late 2005.

OMHAS also has conducted annual surveys of the care received by adults, using an adapted version of the Mental Health Statistics Improvement Program survey. The most recent survey was completed in the fall of 2005. OMHAS plans to conduct the next adult survey beginning in 2006.

Statewide PIP

As part of its overall Quality Strategy, OMHAS is planning to conduct its first statewide PIP. A possible focus of the project is the Children's System Change Initiative, a program mandated by the state legislature aimed at moving children from psychiatric residential treatment and state hospitals into community-based mental health services under managed care.

Evidence-based practice initiative

The Oregon legislature has mandated that increasing amounts of state funds be focused on services that are based on scientific evidence of effectiveness. OMHAS is using this opportunity to work with stakeholders to restructure the mental health

and substance abuse delivery systems for adults and youth. The shift to evidence-based practices includes a focus on lifelong recovery for people with mental illness and for those with substance abuse disorders. OMHAS will oversee and provide support (e.g., training and approved treatment lists) for MHOs during the transition to this new system.

EQRO contract

In May 2004, OMHAS contracted with OMPRO to review compliance with regulations governing the delivery of services by Oregon MHOs. The conclusions of the review are intended to guide OMHAS in identifying the system's strengths and weaknesses, with the ultimate goal of facilitating continuous improvement of the mental health care provided by the MHOs.

The remainder of this report addresses distinct review activities within the EQR. Each review section

- presents an overview of results, a discussion of the review methodology, and summary performance scores
- identifies specific strengths and opportunities for improvement
- recommends ways for OMHAS or the MHOs to achieve compliance with federal or state regulations

MHO Compliance Review

Overview

As part of the EQR, OMPRO reviewed the performance of the nine MHOs that contract with OMHAS to deliver mental health services to OHP enrollees. The review of each MHO sought to answer the following questions:

1. Does the MHO meet CMS regulatory requirements?
2. Does the MHO meet the contractual requirements in its agreement with the State of Oregon and OMHAS?
3. Does the MHO provide a capable and valid information system for its billing, utilization management, quality measurement, and service-tracking data needs?
4. Does the MHO monitor and oversee contracted agencies in their performance of any delegated activities to ensure regulatory and contractual compliance?
5. Does the MHO design, conduct, and report the two required PIPs in a methodologically sound manner?

Detailed results of the MHO reviews appear in individual reports submitted to OMHAS throughout 2005. High-level summary results appear below, with opportunities for improvement and recommendations listed in Table 2.

Strengths

- MHO and contracted agency staff members are dedicated and committed to providing services for OHP members.
- MHOs' agency site reviews are constructive and provide important feedback to the contracted agencies.
- All MHOs provide *Member Handbooks* to address enrollees' information needs; some also provide this information for their enrollees and providers through websites and newsletters.
- Most MHOs work to identify enrollees with special healthcare needs and to coordinate services for them.
- Some MHOs have "flex" funds that provide monies for support services, either to help stabilize enrollees or to conduct pilot programs.
- Some MHOs use electronic medical record (EMR) systems to collect and track data that support clinical and administrative functions.

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

Opportunity for improvement	Recommendation
MHOs' written policies and procedures are incomplete or outdated in many areas.	All MHOs need to devote considerable effort to bring their policies and procedures into compliance.
Information materials for enrollees often fail to address enrollee rights, access to services, and grievance processes.	Each MHO needs to update or revise its *Member Handbook* and other materials to comply with information criteria.
MHOs generally fail to provide detailed information to enrollees about individual practitioners within the network.	Each MHO needs to make available a list that includes practitioners' identity, location, telephone number, staff's non-English-speaking abilities, and whether the office complies with requirements of the Americans with Disabilities Act (ADA).
Many MHOs lack complete procedures for offering advance directives and mental health directives to enrollees; most providers do not offer both types of directives or do not understand how they differ.	Every MHO needs to make these directives available to enrollees and to educate providers about their use; providers need to note in enrollees' charts whether the directives are active.
Coordination of care with primary care providers and medical specialists is limited.	In addition to obtaining information releases, MHOs need to provide training to effect coordination and follow-up by contracted agencies and providers.
Some MHOs fail to ensure access to certain services or access for specific populations such as minorities, seniors, and rural residents.	The MHOs need to develop procedures and/or projects to contact and engage all enrollees in effective care.
The majority of MHOs do not have adequate processes in place to ensure timeliness in sending notices of action to enrollees when decisions are made to deny or reduce services.	MHOs need to update, develop, or implement policies and procedures and improve monitoring to ensure that notices of action comply with information requirements and are sent within required time frames.

Opportunity for improvement	Recommendation
Most MHOs' oversight of activities delegated to contracted agencies is inadequate.	Each MHO needs to strengthen policies and procedures in this area; some need to improve monitoring of delegated entities or subcontractors.
MHOs generally are deficient in credentialing and recredentialing, both with regard to their own policies, procedures, and files, and in oversight of contracted agencies.	Each MHO needs to improve its oversight of contracted agencies and to ensure use of all available references, such as the National Practitioner Data Bank and updated criminal background checks.
The majority of MHOs either have no practice guidelines or have not updated or fully implemented their guidelines.	MHOs need to develop or update their practice guidelines, apply them in the service utilization process, and make them available to providers.
Most MHOs fail to obtain accurate, timely, and complete encounter data for use in setting capitation rates and measuring under- and overutilization of services.	Most MHOs need to improve their processes for obtaining and analyzing encounter data, including by monitoring the contracted agencies and training them in data submission.
MHOs' grievance system policies, procedures, and monitoring systems (including complaint logs) are incomplete or out of date; many MHOs fail to adhere to timing and content requirements for enrollee notification.	Each MHO needs to revise, update, or implement policies and procedures regarding the grievance system; revise the complaint log to capture all necessary elements; and improve monitoring.

Methodology

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

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

The scoring system was adapted from CMS guidelines by OMPRO and approved by OMHAS. Oral and written answers to the interview questions were scored by the degree to which they met contractual and regulatory criteria, and then were weighted according to this system.

In coordination with OMHAS, OMPRO organized the compliance review into the nine sections shown on page 13. Each section contained a number of review elements corresponding to sections of the Code of Federal Regulations.

Within each section, OMPRO used the written documentation provided by the MHO and the answers to interview questions to score the MHO's performance on each review element on a scale from 1 to 5. OMPRO combined the scores for the individual elements and used a predetermined weighting system to calculate a weighted average score for each section of the compliance review. Section scores were rated according to the following scale:

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

Compliance Review Sections

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

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

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

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

Section 5: Provider Selection. Assess the MHO's policies and procedures for ensuring the appropriate mix of providers for the enrollee population and for credentialing and recredentialing providers and agencies.

Section 6: Contractual Relationships and Delegation. Address the MHO's management responsibilities related to overseeing activities that are delegated to contracted agencies.

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

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

Section 9: Grievance Systems. Evaluate the MHO's policies and procedures regarding grievance and appeal processes and State fair hearings and the MHO's process for monitoring adherence to mandated timelines.

Review results

Table A-1 in Appendix A summarizes the scores of all nine Oregon MHOs on each section of the compliance review. The following pages discuss specific strengths and weaknesses observed in each review section.

Some notable themes underlie the reported scores. First, the MHOs exhibited dedication to providing services for OHP enrollees and in setting goals for improved performance. Most of the plans were forthcoming, open to suggestion, and interested in improving performance. Staff members were highly skilled, expert in clinical procedures, and respectful of enrollees and the many struggles that result from their illnesses.

Individual MHOs' performance depended largely on underlying geographic, demographic, and economic factors. More often than not, the MHO's focus was "how to do more with what we have." This focus has resulted from years of funding cuts while the acuity and expectations of marginalized and high-need populations have increased, along with the drive to incorporate improvements in technology and service delivery.

At the time of the EQR audits, MHOs had just begun the process of revising and updating their policies and procedures, documentation, enrollee rights, and other essential aspects of their operations to respond to increased expectations for compliance with the Medicaid managed care standards. A primary example is the set of requirements for practice guidelines, which most MHOs had not focused on incorporating into their operations until the EQR process began.

As the EQR effort continues and other statewide QI initiatives are implemented, MHOs will face continuing challenges to comply fully with all regulatory requirements while operating with limited resources. To meet those challenges, MHOs will depend on guidance and support from OMHAS and good working relationships with OMHAS and other entities.

Section 1: Enrollee Rights. All MHOs provided their enrollees with a *Member Handbook* upon enrollment. Some provided information on enrollee rights through newsletters and/or websites. However, these materials complied only partially with requirements in this area. Most omitted common items such as:

- the right to respect, dignity, and consideration for privacy
- the right to a second opinion
- the right not to be restrained or secluded
- discussion of treatment options and alternatives with enrollees at levels appropriate to the enrollee's ability to understand
- availability of both advance directives and mental health directives
- information on emergency and post-stabilization services
- enrollees' right to request that their medical records be corrected or amended

Only two MHOs, CCMHO and VIBHS, notified enrollees of their rights annually. None of the MHOs complied with the requirement to make available *a list of individual practitioners*, including their non-English-speaking abilities, for enrollees upon request.

In general, the MHOs monitored their contracted agencies for compliance with enrollee rights criteria—for example, by conducting enrollee satisfaction surveys, conducting site visits at agencies, and ensuring that enrollee rights were posted in each agency's lobby. However, many MHOs did not monitor their agencies for *use of restraints and seclusion* or to ensure the *privacy of examining rooms and other protections*. Also, many agency staff did not understand the differences between advance directives and mental health directives.

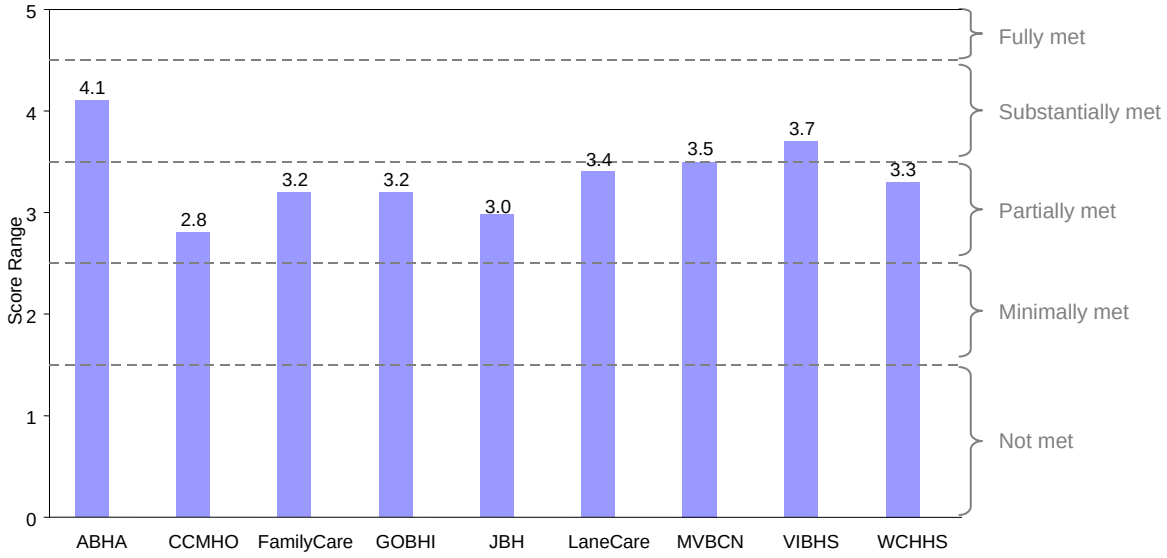

Figure 1. MHO compliance scores: Enrollee Rights.

Section 2: Delivery Network. All MHOs at least partially met requirements related to service availability, out-of-network services, and cultural competency. However, many lacked formal policies and procedures for providing *second opinions* for enrollees. Similarly, while every MHO had at least an informal process to respond to enrollees' needs and requests for *out-of-network services*, many had no policies and procedures to address delivery of those services.

Network planning documents (such as utilization management guidelines) are important in formulating how to manage resources while factoring in enrollee access issues (such as for those with disabilities) and geographic and demographic variables. However, the majority of MHOs failed to address certain criteria in their planning documents, such as the access needs of enrollees in rural areas.

Some MHOs need a more comprehensive process for monitoring the contracted providers' compliance with standards of *timely access*. Several MHOs had long waiting periods for second appointments or other access problems due to rural settings or limited clinical resources for the area.

Some MHOs showed strong *cultural awareness*—for example, by providing their *Member Handbook* in several languages. Some had bilingual staff members, although this area offers room for improvement. Almost all offered translation services, and some offered training to providers for cultural competency. Several MHOs had targeted their PIPs at underserved populations, such as Hispanic enrollees and teens, to improve outreach services to those members.

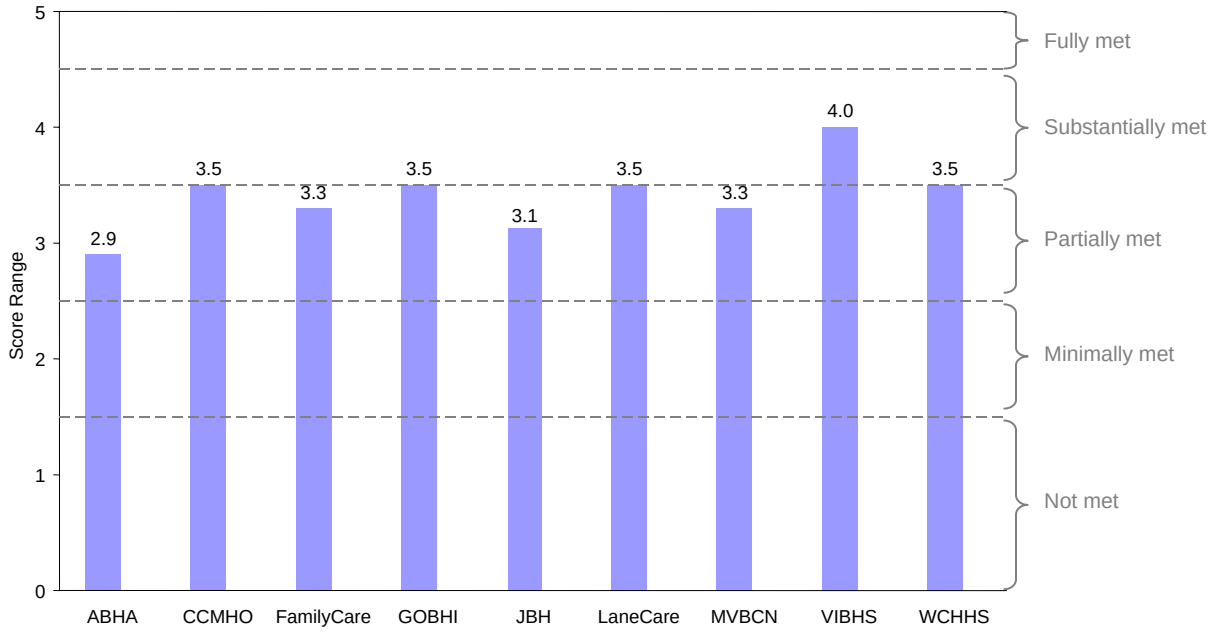

Figure 2. MHO compliance scores: Delivery Network.

Section 3: Primary Care and Coordination of Services. Coordination of mental health care with other treatment services is the key to effective and sustained treatment as Oregon's population ages and as chronic health problems like obesity, diabetes, and depression increase.

The majority of MHOs substantially met requirements in this area. Most had taken the constructive step of assigning staff members as case coordinators, and many coordinated mental health care with alcohol and drug treatment, either through MHO staff or by arrangement with outside service providers. Mental health care providers generally had been obtaining releases of information from enrollees and sending the releases to their PCPs with a letter. However, ongoing coordination between the contracted agencies and the PCPs or medical specialists often was lacking. For example, the coordination may have addressed medication management but not the maintenance of regular physical care or treatment of complex medical conditions or developmental disabilities.

All of the MHOs conducted chart reviews to assess coordination of care. However, OMPRO's review showed that the majority of treatment plans identified few or no concerns regarding physical health issues. The charts typically contained progress notes but often omitted the enrollee's history, physical exam, and lab results.

Some MHOs and their contracted agencies need to become more familiar with the OMHAS's definition of *special healthcare needs* and to train their intake staff and contracted clinicians to incorporate special healthcare needs into treatment plans. Also, some MHOs need to develop formal mechanisms for providing *direct access to specialists* and to monitor the contracted agencies for providing that access.

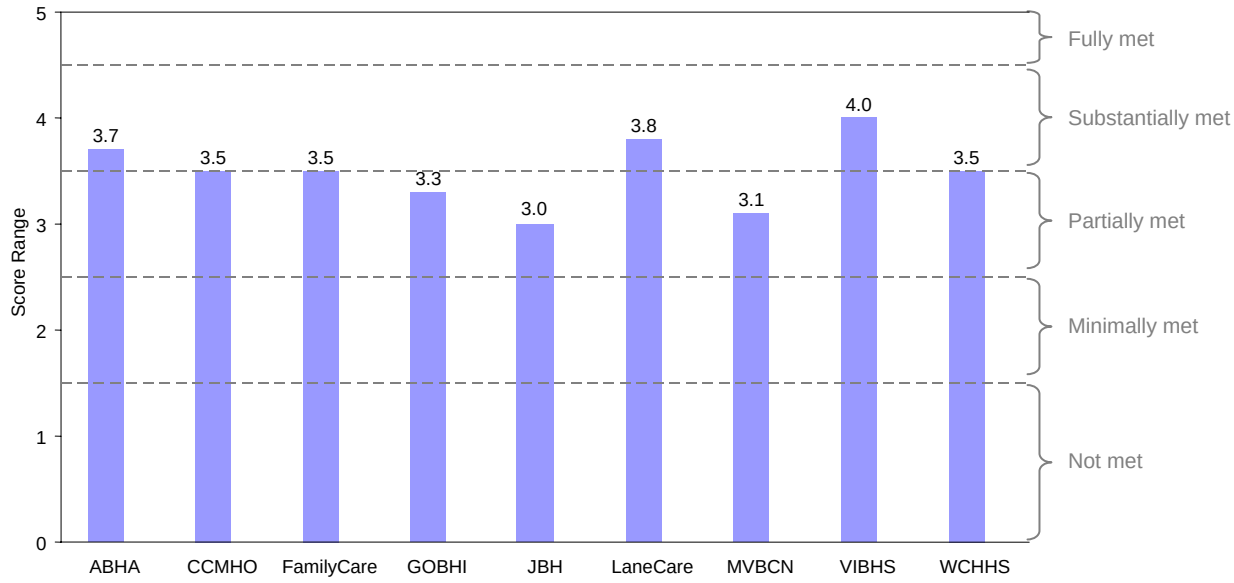

Figure 3. MHO compliance scores: Primary Care and Coordination of Services.

Section 4: Coverage and Authorization of Services. All MHOs complied at least partially with requirements for authorizing services in a timely manner and for covering emergency and post-stabilization services. Each MHO had a process and criteria for responding to requests for authorization of services. However, many needed to update or implement policies and procedures specifying the process for making *utilization management decisions* and defining the staff members whose clinical experience qualifies them to make those decisions. Also, many needed to improve their documentation of who makes the decisions and who is notified.

Typically, the MHOs' policies did not stipulate notifying providers about adverse decisions or notifying the enrollee in writing. Many MHOs failed to ensure that timely *notices of action* were sent to enrollees about decisions to deny or reduce services. Some MHOs conducted site visits to monitor the time frames for decision making, but others lacked a process for handling standard and expedited service requests.

MHOs' handbooks often did not include a complete list of emergency and post-stabilization services. In addition, most MHOs need to develop methods to track or monitor the *use of emergency room services* to determine appropriateness, since these services are provided through the Office of Medical Assistance Programs.

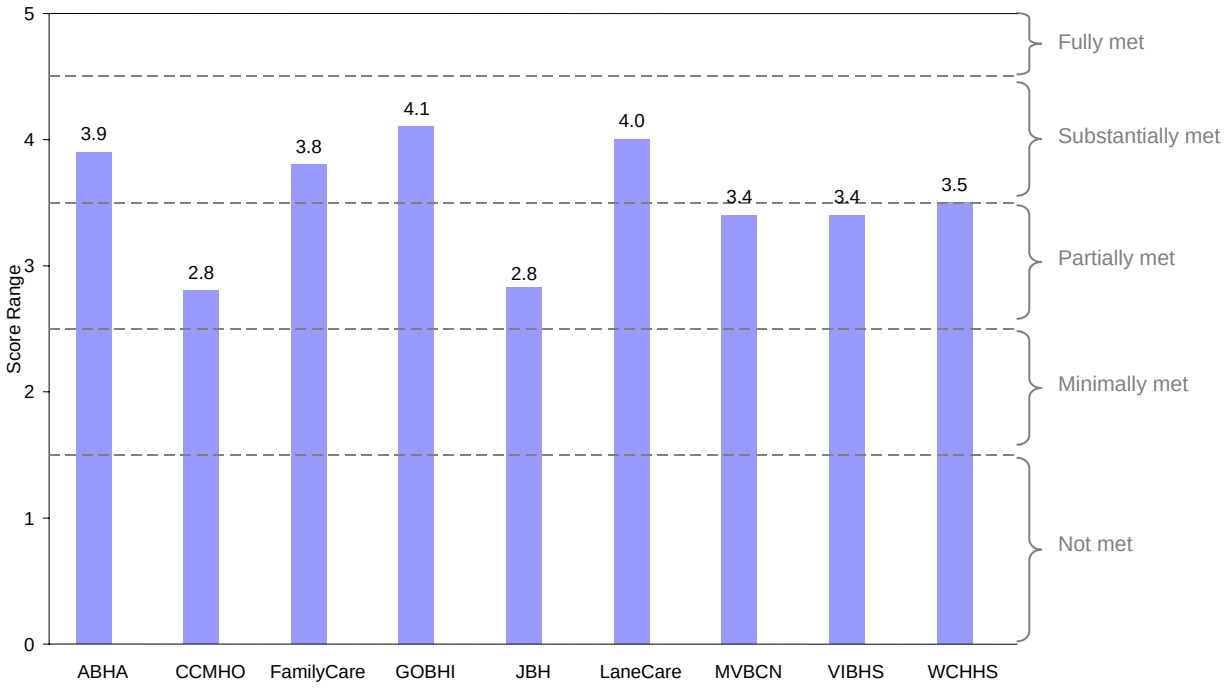

Figure 4. MHO compliance scores: Coverage and Authorization of Services.

Section 5: Provider Selection. This section of the Medicaid managed care regulations is complex because of the MHOs' obligation to ensure adequate numbers of capable providers to meet enrollees' needs. All of the MHOs needed to revise or develop policies and procedures for this area, particularly to address oversight of agencies' selection processes and monitoring for discrimination against providers and for employment of providers who have been excluded from federal healthcare programs.

A key responsibility of the MHO and its contracted agencies is reliable monitoring of *credentialing and recredentialing*. The MHOs generally need to improve their policies and procedures and oversight in this area. The EQR audits found repeated examples of incomplete or dated materials in practitioner files. Contracted agencies often lacked current copies of a provider's license or verification of insurance, or they failed to use the National Practitioner Data Bank (NPDB) to screen providers. Often the MHO had completed initial credentialing but had conducted only partial recredentialing or none at all. In some cases, the MHO did not know full details of how a contracted agency conducted credentialing and recredentialing.

Such lapses in oversight, particularly the failure to perform NPDB background checks, raise concerns about ensuring that enrollees receive safe and effective treatment. For example, in some cases, after initial hiring, a search of the NPDB never was repeated, creating the risk that a disqualified practitioner might remain employed by the MHO.

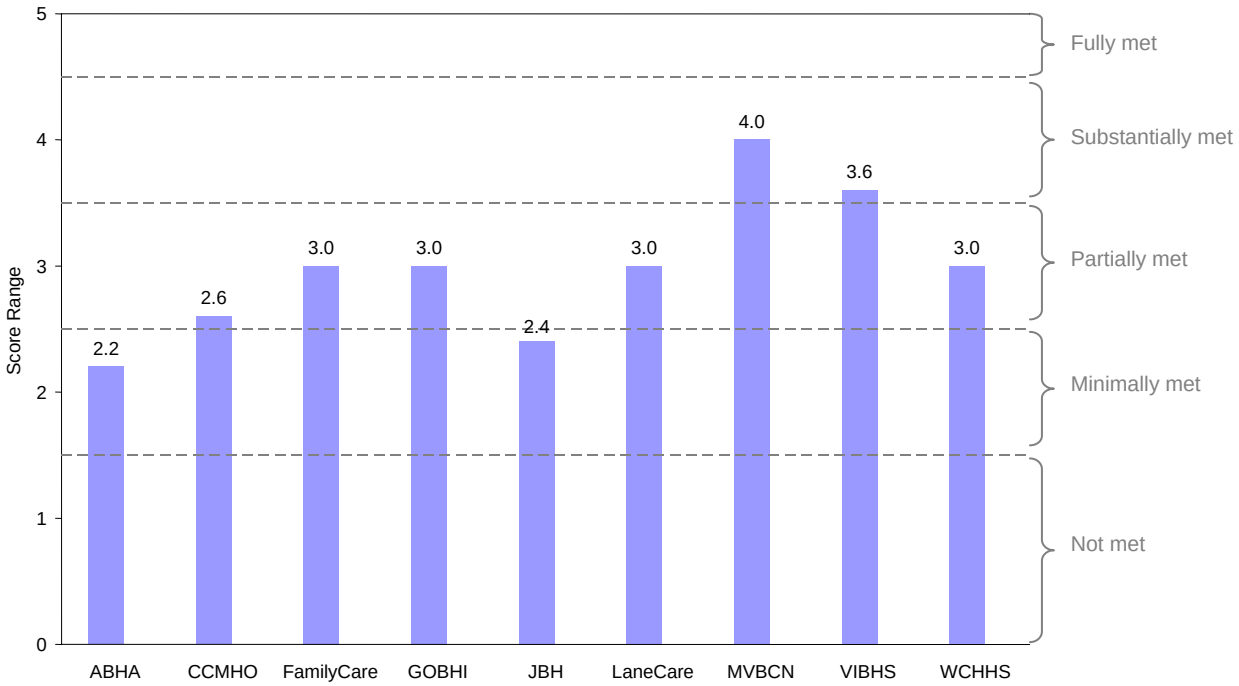

Figure 5. MHO compliance scores: Provider Selection.

Section 6: Contractual Relationships and Delegation. Issues related to this section of the regulations are important for a conventionally structured MHO and even more so when duties and responsibilities are diffused throughout a system of contracted and subcontracted agencies. Consistent monitoring of delegated functions may help to ensure more effective delivery of care to enrollees.

All nine MHOs need to revise or develop formal policies and procedures for addressing contracted and/or delegated responsibilities. Typically, although the MHOs conducted site visits and might check the contracted agency's credentialing records, the MHOs did not consistently monitor all activities delegated to the contracted agencies or subcontractors. In some cases, it was hard to ascertain the degree of oversight or whether the subcontractor was meeting its responsibilities. There is a general need for stronger oversight of subcontractors, either by the contracted agencies or by the MHOs themselves.

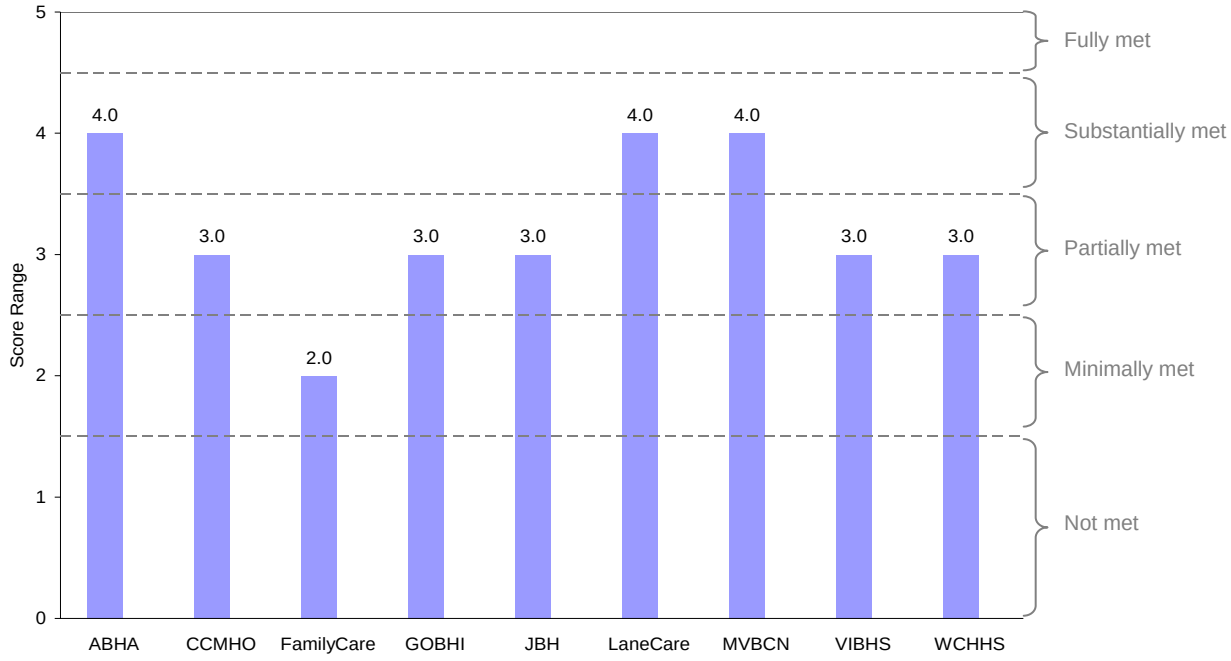

Figure 6. MHO compliance scores: Contractual Relationships and Delegation.

Section 7: Practice Guidelines. This section of the CMS protocols was not a major focus of Oregon's mental health managed care system before the advent of the EQR process. The EQR audits revealed that the majority of MHOs either had no formal practice guidelines or had guidelines that were outdated or not fully disseminated to providers. In some cases, the contracted providers were not familiar with the MHO's practice guidelines or where to obtain them. The three MHOs that met the criteria in this area either fully or substantially—FamilyCare, LaneCare, and MVBCN—had developed guidelines that reflected the needs and demographic mix of their enrollee populations.

The MHOs' application of practice guidelines in making utilization management decisions was mixed. Most of the MHOs needed to build their practice guidelines into the utilization and treatment decision processes. Generally, the MHOs needed to research current guidelines, obtain input from their enrollees and providers in selecting guidelines, and then provide education for the contracted agency providers.

Regulatory requirements in Oregon have moved toward the use of *evidence-based* practices, and most MHOs are working with their contracted agencies to ensure the use of those practices. In developing and updating practice guidelines, the MHOs should work toward incorporating the more complex and demanding requirements for evidence-based practice.

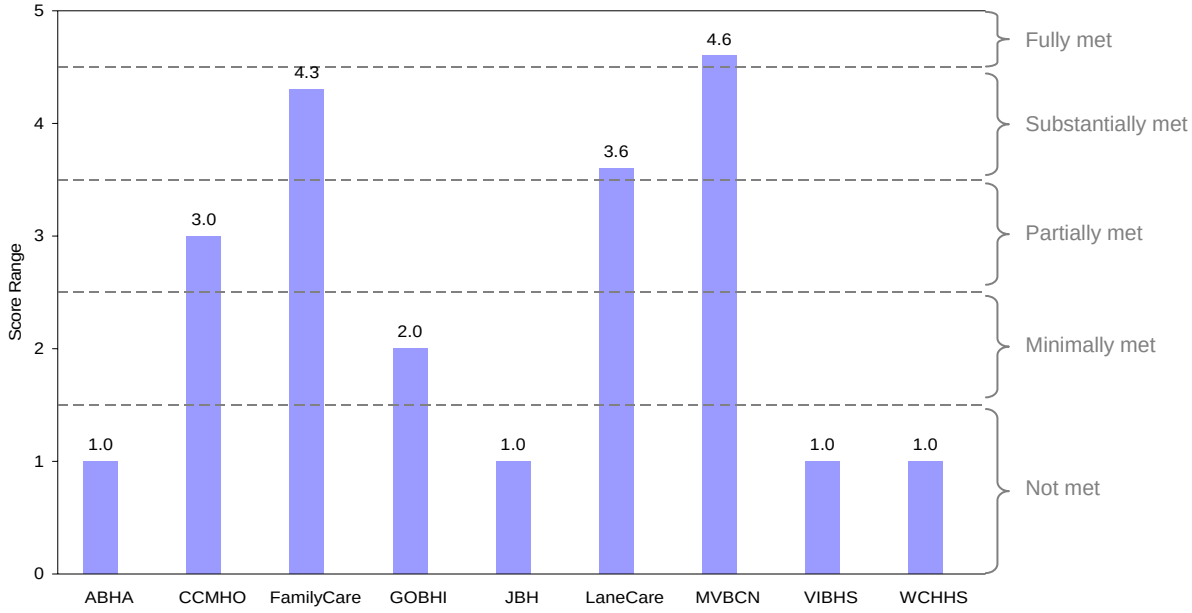

Figure 7. MHO compliance scores: Practice Guidelines.

Section 8: Quality Assessment and Performance Improvement (QA/PI). In addition to QA/PI practices per se, the scoring for this section reflects an evaluation of the MHO's information system or that of the third-party data administrator. Accurate, timely claims and encounter data are important in relation to the MHO's billing and reimbursement needs, as the State uses these data to set capitation rates. Good encounter data also are important for analyzing utilization patterns—central to an MHO's ability to monitor enrollees' service needs and to evaluate overall resource management—and for tracking enrollee access and timeliness of appointments.

All but one MHO met overall QA/PI standards substantially or fully. MVBCN's outstanding practices earned a "Fully met" rating. Each MHO had a program to evaluate its own QI process. All had QI plans in effect that covered all required domains and were approved by OMHAS, and all collected and reported performance data to the State.

As MHO operations become more data-driven, developing expertise in *data analysis* becomes more crucial. For the most part, the MHOs had mechanisms in place to track utilization decisions. Often, though, the MHOs lacked expertise to evaluate the reliability and validity of available data. Although the MHOs had conducted QI initiatives since before the EQR audits began, PIPs were new to most MHOs. Most needed to improve their analytical plans and to define their use of available data in the PIPs, as well as in analyzing utilization patterns, quality of care, and special healthcare needs.

Some MHOs' billing departments were not receiving complete and/or accurate encounter submissions from providers. Many agencies were reporting one or more diagnosis and/or procedure code for enrollees. If only the first diagnosis is reported, the data may not be adequate for developing a complete picture of an enrollee with a dual diagnosis. OMPRO recommends that the MHOs monitor the number of diagnoses and procedures their agencies can submit and are submitting, and, if appropriate, follow up with agencies that submit only one diagnosis and/or procedure code.

Among individual MHOs, GOBHI stood out in its efforts to assess and train its agencies to improve and standardize their encounter submissions. Several other MHOs had made effective business decisions with regard to meeting their needs for data services, such as by choosing an appropriate third-party vendor or by converting to a fee-for-service delivery model.

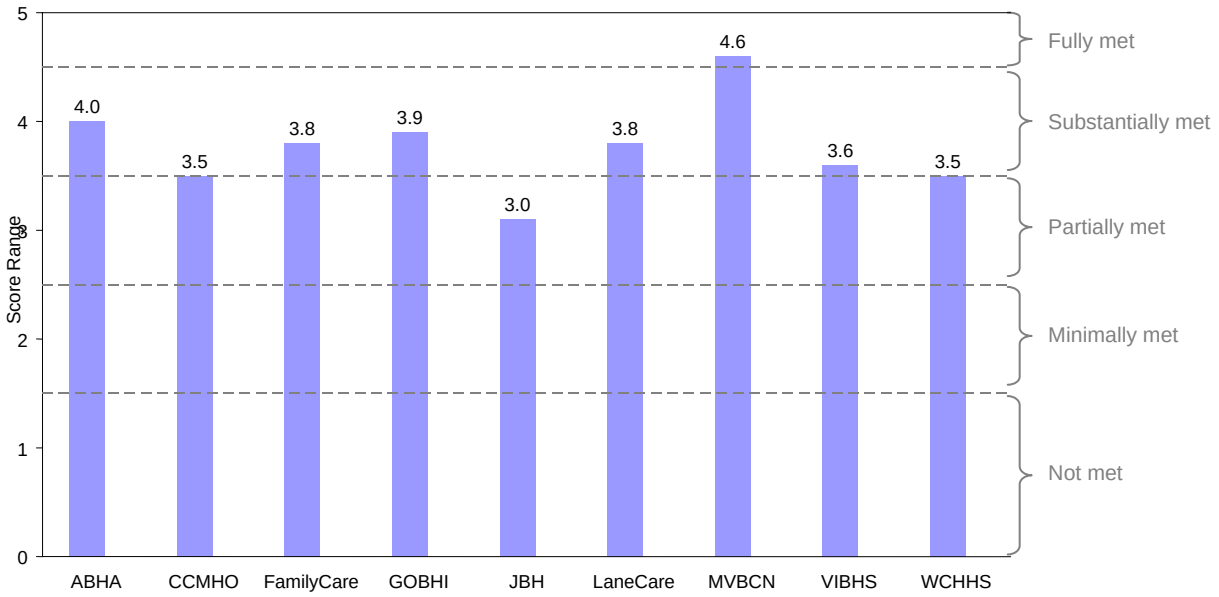

Figure 8. MHO compliance scores: Quality Assessment and Performance Improvement.

Section 9: Grievance Systems. Compliance in this area requires considerable oversight by the MHO and its contracted agencies to enforce, manage, and monitor enrollee rights and the provision of services. The majority of MHOs substantially met the contractual and regulatory requirements. Each MHO had in place a basic system for addressing grievances, and each informed enrollees about this process through the *Member Handbook* and other materials. MHO staff consistently showed concern for responding to enrollees' complaints. Many MHOs reported no history of State fair hearings, and some reported few or no grievances or appeals. Those situations could be due either to having met all enrollee needs appropriately or to providing inadequate information or support for enrollees to file grievances or appeals.

An effective grievance system depends on developing and disseminating comprehensive information about complaints, grievances, appeals, and State fair hearings. *Written policies and procedures* are key, and many MHOs need to update these to address all enrollee rights and other criteria for this section.

For example, the MHOs need to ensure that the complete set of enrollee rights is listed in the *Member Handbook* and posted in every contracted agency's lobby so that enrollees know of and understand their right to file complaints, grievances, appeals, and requests for State fair hearings, and the process for doing so. All nine MHOs need to revise or expand their policies and procedures in this area, which often did not specify that

- the MHO provides reasonable assistance in completing forms, including interpreter services and toll-free numbers for enrollees
- the enrollee's provider or representative may file a grievance, appeal, or request for a State fair hearing on the behalf of the enrollee
- no punitive action may be taken against a provider who supports an enrollee's appeal
- the enrollee and his or her representative have a right to examine the case file
- an appeal must be as expeditious as the enrollee's health condition requires and that the time frame may be extended at the enrollee's request
- the MHO pays for services during a pending appeal

Appeals forms and/or policies often omitted the elements related to *expedited resolution*. In several cases, the MHO failed to provide notice in the prevalent non-English language of the service area. The MHOs generally need to make translation, interpretive services, and alternative formats available and to list these services in the notices to enrollees.

Most of the MHOs ensured that their contracted agencies posted materials about the grievance process in their lobbies. However, some MHOs' providers were unfamiliar with the State fair hearing process and with enrollee rights in that area. Monitoring often was inadequate; many MHOs lacked a process for tracking denied requests for services and/or for notifying enrollees of such denials.

Most MHOs showed deficiencies in maintaining records of the grievance process, largely because the complaint log approved by OMHAS omits elements such as

- the identity of the person filing the grievance or appeal
- whether the grievance or appeal was received in writing or orally
- the resolution outcome and date
- requests for State fair hearings
- whether the MHO provided disputed services promptly when a State fair hearing reversed a denial of service

None of the MHOs had complete policies and procedures on providing *notices of action*. In the majority of cases, the MHO failed to meet criteria for the content and/or timing of notices.

Typically, the contracted agencies sought to resolve enrollees' concerns quickly but might not report such issues to the MHO unless and until they rose to the level of formal appeals or grievances. This raises questions about whether the MHOs are fully informed about what their enrollees are reporting to the agencies and whether that information is shared equally with OMHAS.

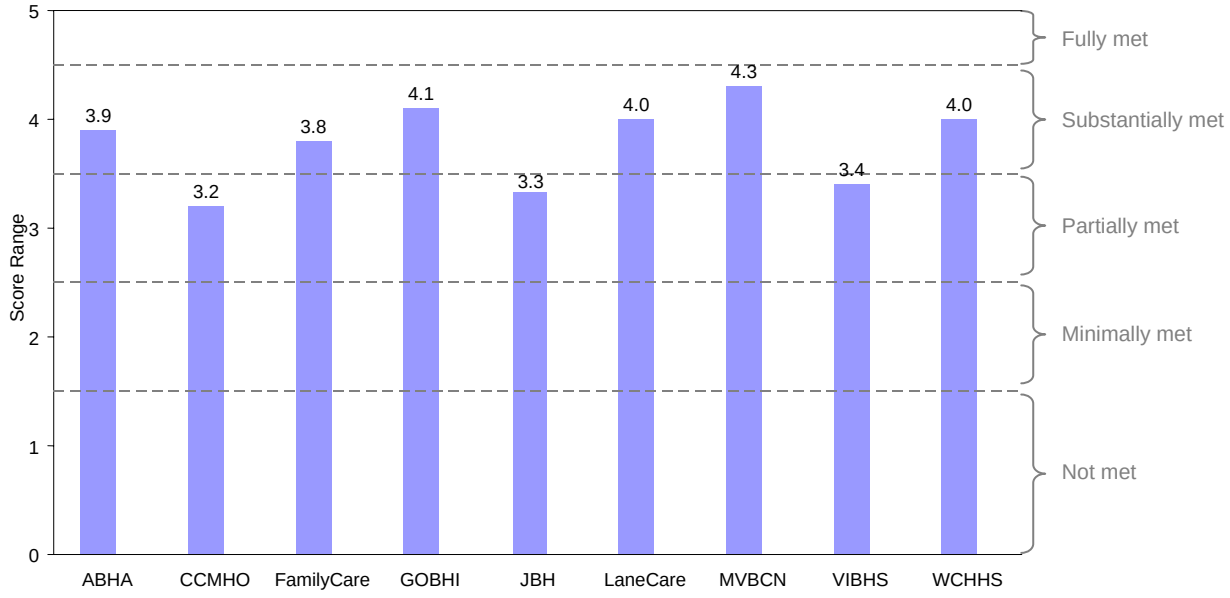

Figure 9. MHO compliance scores: Grievance Systems.

Performance Improvement Projects

Overview

All managed care organizations that serve Medicaid or Medicare enrollees must conduct two PIPs each year aimed at improving care outcomes. The PIPs make it possible to assess and improve the processes and, in turn, the outcomes of care. For interested parties to have confidence in an MHO's reported improvements, a PIP must demonstrate that it results in real improvements in care. Therefore, PIPs are validated each year through the EQR process to ensure that they are designed, conducted, and reported in a methodologically sound way.

Detailed results of the PIP evaluations for each MHO appear in individual reports submitted to OMHAS throughout 2005. High-level summary results appear below.

Although many of the MHOs had conducted QI projects for some years, few, if any, had experience conducting formal studies of these projects according to the criteria laid out for PIPs. As a result, none of the 18 PIPs (two for each MHO) fully met the requirements for a sound study, although 5 PIPs substantially met the requirements. A primary reason for the relatively low PIP scores was that most MHOs had not completed their PIPs at the time of assessment. The incomplete status of the PIPs also prevented OMPRO from conducting the full PIP analysis, which would have included evaluating the validity and reliability of PIP results.

A general shortcoming was the lack of *documentation* of the PIP plan and process. Also, many PIPs lacked a prospective analysis plan, an essential component of valid and reliable data analysis.

As MHOs develop future PIPs or refine their current PIPs, OMPRO recommends that the MHOs

- fully document the process by which they select the topics of their PIPs
- fully document a prospective analysis plan for each PIP that includes
  - clear definitions of all indicators, including their numerators and denominators
  - a statistical calculation of the sample size needed to compare differences if the PIP does not cover the MHO's entire enrollee population
  - the methodology for comparing baseline and remeasurement data for statistical differences

OMPRO also recommends that OMHAS continue to provide ongoing technical assistance, such as "how to" seminars, as MHOs conduct their PIPs.

Methodology

Data collection tools and procedures, adapted from the CMS protocols, involved document review and onsite interviews from November 2004 through August 2005. OMPRO scored the information collected from each MHO according to the criteria listed in the document titled *Performance Improvement Project Validation*, adapted from the CMS protocol and approved by OMHAS.

OMPRO reviewed the nine MHOs' PIPs for the following elements:

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

Scoring for the PIPs involved rating the MHOs' performance on eight 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

Each standard had a potential score of 100 points for full compliance, with lower scores for lower levels of compliance. The total points earned for each standard were weighted and combined to determine the MHO's overall performance score for the specific PIP.

As approved by OMHAS, the overall PIP scoring was to be weighted 80 percent for demonstrable improvement in the first year and 20 percent for sustained improvement in later years. Therefore, for first-year PIPs, such as those reviewed in this EQR, the highest achievable overall score was 80 points, with compliance ratings broken out as shown in Table 3. In future EQR studies, the maximum PIP score will be 100 if OMPRO is able to assess the sustained improvement of the PIP. In addition, future PIP evaluations will assess the validity and reliability of PIP results if the PIP is complete.

Table 3. PIP compliance rating and scoring system.

Compliance rating	Description	Score
Fully met	Met or exceeded all criteria	70–80
Substantially met	Met essential requirements, had minor deficiencies	55–69
Partially met	Met essential criteria in most areas but not in others	40–54
Minimally met	Marginally met requirements	25–39
Not met	Has not met essential requirements	0–24

Review results

Of the two PIPs to be conducted, one project must focus on improving clinical care and the other on nonclinical aspects of service delivery. Tables 3 and 4 display the clinical and nonclinical PIP topics studied by each MHO, with their associated study topics.

Although the PIPs varied widely in their focus, several clinical PIPs dealt with issues pertaining to hospitalization. Young enrollees were the most common subpopulation studied. The most common theme of the nonclinical PIPs was improving enrollees' access to mental health services.

Table 4. Clinical PIP topics by MHO.

MHO	PIP topic	Study question/topic
ABHA	Community Integrated Support for Children in Oregon	Will reducing the complexity of the mental health status measurement tool in terms of reading level and number of questions asked increase compliance by providers?
CCMHO	Discharge Planning	Was discharge or long-term stabilization planning a part of each consumer's plan of care?
FamilyCare	Improving the Rate of 7-Day Ambulatory Follow-Up After Inpatient Psychiatric Discharge	Can the 7-day ambulatory follow-up rate for Oregon Health Plan Medicaid enrollees be improved?
GOBHI	Regional Youth Resource Program	Would the hiring of a Regional Youth Resource Specialist result in a decrease in hospitalization for children?
JBH	Dual Diagnosis Treatment Assessment	What percentage of mental health assessments that identify a dual disorder have identified treatment plan goals related to dual disorder treatment interventions?
LaneCare	Teen Suicide Prevention Project	Train students at every middle school in Lane County about suicide awareness and prevention and reduce the number of attempted and successful teen suicides in the county.
MVBCN	Treatment of Co-occurring Disorders	Integrate contracted agencies' treatment of co-occurring disorders to ensure that an enrollee with mental health and substance abuse disorders is treated concurrently by the same qualified provider.
VIBHS	Reducing Inpatient Utilization	Has implementation of intensive case management services through the Community Outreach, Recovery and Engagement (CORE) project reduced inpatient utilization?
WCHHS	Reducing Rates of Psychiatric Hospitalization	Can implementation of a strengths-based, level-of-care delivery system decrease psychiatric hospitalization rates?

Table 5. Nonclinical PIP topics by MHO.

MHO	PIP topic	Study question/topic
ABHA	Oregon Change Index	Will providing intensive services for children in a more flexible manner result in shorter lengths of stay in higher-intensity service settings?
CCMHO	Access Tracking	Can service delivery intake [i.e, first routine appointments] consistently meet contractual access requirements?
FamilyCare	Improving Identification of Behavioral Health Special Needs of Members and Access to Needed Services	Can identification of OHP members' behavioral health special needs and access to needed services be improved?
GOBHI	Encounter Data Manual	Can the new encounter data and training process increase the volume and value of encounter data?
JBH	Language Communication Access Project	Does increasing the availability of Spanish-language resources increase enrollment?
LaneCare	LaneCare Evaluation Instrument (LCEI)	Examine the average change over time in LCEI scores across agencies to identify agencies that may have either better treatment protocols or deficiencies in care.
MVBCN	Improve Mental Health Services to Hispanic Members	Improve mental health services to Hispanic members by increasing these members' access to services and increasing community awareness of Hispanic members' mental health needs.
VIBHS	Engagement of Outpatient Clients	Will changing VIBHS's business and clinical models increase the percentage of enrollees who are engaged in outpatient treatment?
WCHHS	Fee-for-Service Conversion	Does the move to an FFS structure increase the volume of outpatient services per member month?

Figure 10 shows the scores of the clinical and nonclinical PIPs for each MHO. As noted above, because this was the first year in which the MHOs conducted PIPs, it was not possible to gauge sustained improvement; therefore, the highest achievable overall score was 80 points.

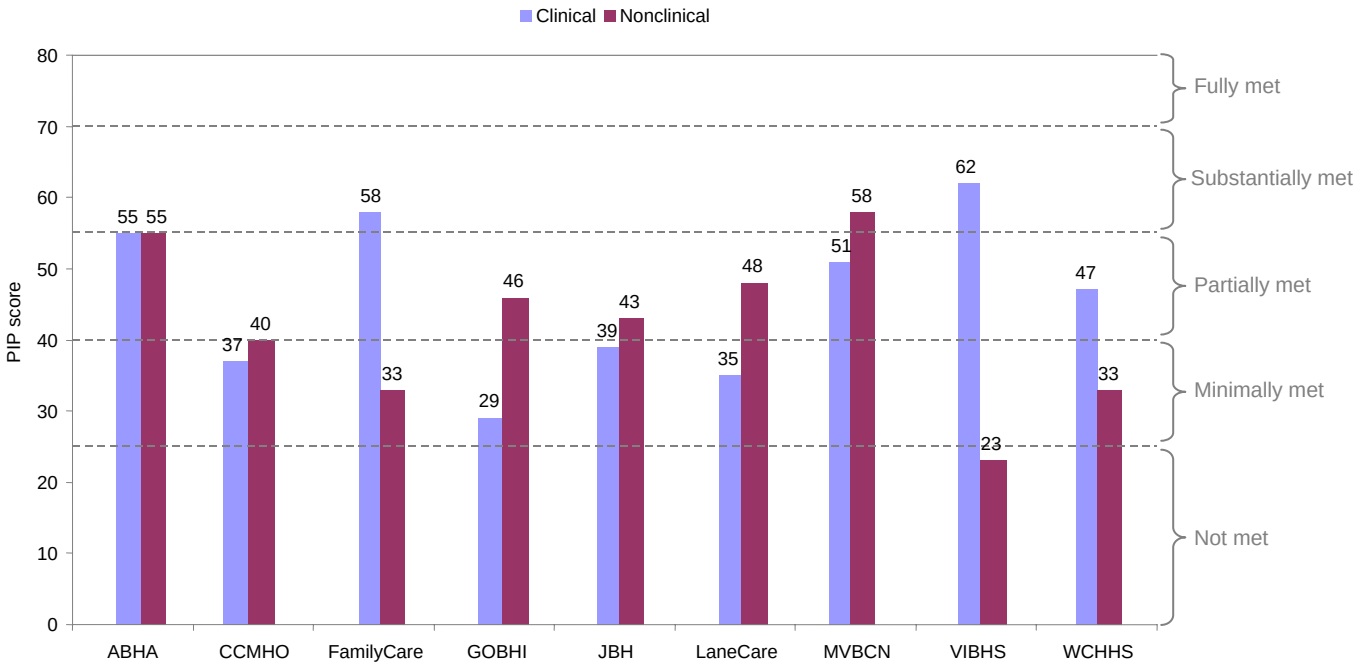

Figure 10. Overall PIP scores by MHO.

None of the eighteen PIPs (two for each of the nine MHOs) received a "Fully met" rating, indicating that all MHOs have room for improvement regarding their PIP processes. Five received a "Substantially met" rating, scoring between 55 and 70. Most PIPs scored only in the "Partially met" or "Minimally met" range, indicating substantial deficiencies in some areas.

The relatively low PIP scores can be attributed in large part to the fact that most MHOs had not completed their PIPs at the time of their assessment. Incomplete sections, particularly Standards 7 and 8, automatically brought down the scores, making a "Fully met" score impossible.

Figure 11 shows the score for each *standard* in the PIP validation, averaged across the nine MHOs. The average standard score was computed separately for clinical and nonclinical PIPs. (Table A-2 in Appendix A displays the scores on all PIP standards by MHO for both clinical and nonclinical PIPs.)

A general shortcoming was the lack of *documentation* of the PIP plan and process. During interviews, MHO representatives were able to articulate the PIP process, but they often lacked the written documentation needed to support the information

provided in the interview. Disparities often arose between what MHOs had written and what they reported during the interview regarding the exact study question, indicators, measurement, and goals. Proper documentation is essential to ensure that the implementation of the PIP is consistent with its original design and is executed consistently across the MHO's settings of care, allowing for successful evaluation. Many PIPs lacked a prospective analysis plan, an essential component of Standard 5.

There were few score differences between clinical and nonclinical PIPs, showing that MHOs were able to implement the PIP process across a broad domain of topics.

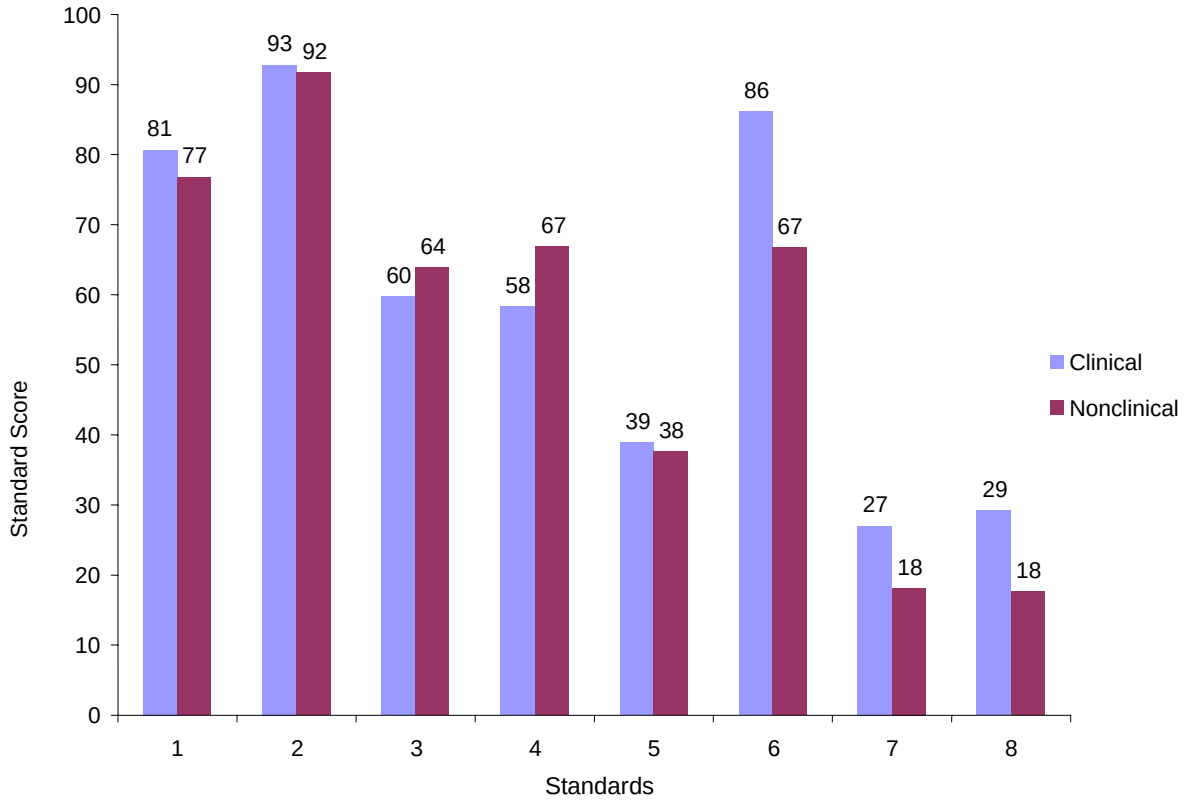

Figure 11. Average scores on PIP validation standards across MHOs.

Standard 1: Selected study topic is relevant and prioritized. MHOs generally did well in this area. Most need to work on documenting how they chose their topics and whom they consulted to help make the decision. An essential element is to show data (plan-specific findings or research-based information) that support the need to address the particular issue.

Standard 2: Study question is clearly defined. MHOs scored highest on this standard, which involves designing a study question that addresses a specific issue and a measurable outcome.

Standard 3: Study indicator is objective and measurable. Although MHOs generally had a fundamental sense of what they wanted to measure, they had difficulty defining indicators using the level of detail needed to implement a successful PIP. Specific information as to how the MHO will calculate the numerator and denominator of each indicator is essential to meeting this standard successfully. The definitions of the numerator and denominator also should include the data fields used to determine their calculation.

Standard 4: Study population is clearly defined and, if a sample is used, appropriate methodology is used. Most MHOs measured their entire enrollee population for their PIPs. Those that measured a sample of enrollees instead of the entire population generally failed to calculate a sample size large enough to ensure assessing enough enrollees so that the MHO could identify an actual change resulting from the PIP. As with Standard 3, the shortcomings within Standard 4 tended to involve lack of precision when defining indicators—in this case, the population. Exceptions, criteria for inclusion, and time frame of measurement all need to be documented carefully.

Standard 5: Data collection process ensures valid and reliable data. Overall, the MHOs scored poorly on this standard, primarily because they lacked written analysis plans that included a strategy for statistically comparing baseline and remeasurement data. Some MHOs may need to seek external technical support to meet this standard successfully, as some expertise in statistics is needed.

Standard 6: Improvement strategy is designed to change performance based on the quality indicator. Although many of the MHOs have been conducting QI initiatives for some time, they had not clearly identified which aspects of these initiatives would form the basis of their PIPs. MHOs that had identified a specific PIP generally provided good documentation of the intervention. However, those that had not defined the elements of their PIPs sufficiently before the interview could not describe how they planned to change operating procedures to improve the quality of their organization and/or care provided.

Standard 7: Data are analyzed and results interpreted according to generally accepted methods. Because too few MHOs got this far in the PIP process, a summary of performance on this standard is not meaningful. To score well on this standard, the MHO must follow its prospective analysis plan as outlined in Standard 5.

Standard 8: Reported improvement represents actual change. Because too few MHOs got this far in the PIP process, a summary of performance on this standard is not meaningful.

Performance Measure Validation

Overview

OMHAS develops statewide performance measures for MHOs and calculates them using data collected from the MHOs by the Office of Medical Assistance Programs (OMAP). OMHAS reports the findings back to the MHOs in the MHO Utilization Report. OMPRO's review focused on validating OMHAS's function in this process and sought to answer the following 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 the current IT infrastructure support timely and accurate reporting of performance measure data? Are the software and hardware sufficient to handle the quantity and type of data involved? Is the function adequately staffed with experienced personnel?
5. Can OMHAS and the MHOs use the MHO Utilization Report to monitor their performance over time and to compare their performance with that of other health plans in Oregon and in other states?

OMPRO's review covered the performance measurement report process and the information systems in use from July 2002 through June 2003. OMPRO delivered its detailed review of the performance measures and the Information Systems Capabilities Assessment (ISCA) to OMHAS in March 2005. High-level summary results appear below.

OMPRO also conducted an ISCA for each MHO. Since the statewide performance measures are based on encounter and claims data submitted by the MHOs, the validity and reliability of the performance measures depend on the accuracy and completeness of the MHO data.

Performance measures

OMPRO assessed four performance measures—one for acute hospitalization, two for hospital readmissions, and one for care following discharge—to determine whether the data used to calculate each measure were complete and accurate and whether calculation of the measures adhered to CMS specifications.

All four measures *partially complied* with CMS requirements. OMPRO's review identified opportunities for improving the definition and analysis of performance measures and the documentation of quality control.

Information systems

The goal of the ISCA was to determine to what extent OMAP's IT systems and OMHAS's data processing and reporting functions ensured that the process for creating performance measures was tested, documented, understood and capable of being completed by more than one programmer, and subject to quality control.

OMPRO found that State hardware systems and data acquisition capabilities *substantially met* best-practice standards. Data processing procedures and staffing *partially met* those standards; security and file consolidation *minimally met* those standards; and the performance measure repository structure and report production system *failed to meet* minimal standards.

Major compliance issues

1. Data transfers between OMAP's Medicaid Management Information System (MMIS) and OMHAS's Sybase™ system were not encrypted. This raises concerns about protection of enrollee information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). OMPRO highly recommends encryption for all data transfers between systems responsible for encounter data.
2. The current method of using a dial-up connection to a bulletin board to receive Medicaid claims and encounter data from MHOs and from third-party billers raises concerns about data security in the event of system failure.

Reviewers noted that OMHAS was in the process of changing data systems and had developed a plan to address concerns found in the review. OMHAS's new data system will incorporate major enhancements to enable it to process HIPAA-compliant transactions.

Among other detailed recommendations, OMPRO recommended that OMHAS create a data warehouse for performance measures. The design of such a data repository should include criteria for hardware redundancy, maintenance contracts, disaster recovery procedures, and acceptable time to recovery. OMPRO also recommended that OMAP staff perform periodic audits of randomly selected encounter records, and that OMHAS establish processes to verify that the claims and encounter data received from OMAP are accurate and complete.

Methodology

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

1. OMHAS and OMAP were sent written copies of all interview questions prior to onsite interviews.
2. OMPRO used the written answers from OMHAS and OMAP personnel to refine the questions to be asked at the onsite interviews.
3. Oral and written responses to all questions were compiled and scored.

Answers to interview questions were weighted and combined by topic for scoring by sections. OMPRO adapted the scoring schemes from CMS guidelines.

OMPRO assessed the four performance measures to determine whether the claims or encounter data used to calculate the measures were complete and accurate and whether the calculations adhered to CMS specifications for all components (e.g., member ID, clinical codes, member months, specified time parameters). OMPRO's assessment used the following ratings adapted from the CMS protocols.

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 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 was not complete as reported or was inaccurate. This designation also is assigned to measures for which no rate was reported, although reporting of the rate was completed in prior periods and no reason for the removal of the measure is stated in the report.

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

OMPRO performed the ISCA through an electronic survey, document review, and onsite interviews. The review covered encounter data processing, data integration and control, performance measure calculations, and performance measure reporting in the August 2003 MHO Utilization Report.

For OMHAS and for each MHO, OMPRO scored the performance on each element of the assessment on a range from 1 to 5. After scoring the individual elements, OMPRO combined the scores and used a predetermined weighting system to calculate a weighted average score for each section, rated according to the following scale:

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

Review results

The following pages present additional details of OMPRO's assessment of the statewide performance measures and of information systems capabilities at the State and MHO levels.

Performance measure completeness and accuracy

Table 6 summarizes the performance measure validation ratings.

Table 6. Performance measure validation ratings.

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

Table 7 identifies opportunities for improving the performance measure process and lists OMPRO's associated recommendations. OMHAS has planned to address these concerns in tandem with the conversion to its new data system.

Table 7. Opportunities for improvement and recommendations for statewide performance measures.

Opportunity for improvement	Recommendation
The performance measures are defined ambiguously.	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.
Because inclusion in the measures depends on the MHO of record at the time the service is provided, one MHO's treatment can count as another MHO's outcome if a member moves to a new county within the measurement period.	Each measure should include a continuous enrollment definition and/or a definition of member-months to ensure that the data can be used to compare MHO treatment services accurately and can be used by the MHOs in their QI initiatives.
Encounters for members enrolled in both Medicaid and Medicare may not be reported to the MHO in a timely manner—or at all—if the primary payer is contacted first for payment. This could result in underreporting and could affect all the measures.	Analyze dually enrolled MHO members separately or remove them from the total population.
The two measures that include members readmitted to hospitals after discharge and the measure that includes members seen in outpatient settings after discharge from acute care could count individuals in the denominator who are not eligible for the numerator—for example, members who have died.	Remove those individuals from the denominator or include a statement in the report that estimates the potential impact—for example, the death rate.
With regard to the *percent of eligibles seen within 7 days of discharge from acute care* measure, the MHO's system cannot capture mental health services provided by a primary care physician or by a social worker in a nursing home.	Reporting on this measure should include an explanation of the potential for undercount in the numerator.

Information Systems Capabilities Assessment—State review

A process for producing accurate, valid, and reliable performance measures must be well tested and documented and subject to rigorous quality control. More than one programmer should be able to understand and complete the process. Changes in the code used to create performance measures should be tested and documented, and older versions of code should be archived. Any change to the source data should be communicated to the analyst calculating the measure. Without such checkpoints and controls, reporting anomalies or errors can go undetected.

At the time of the State ISCA review, OMAP received Medicaid claims and encounter data from MHOs and third-party billers via a dial-up connection to a bulletin board system. Data were transferred to OMAP's MMIS through an unsecured File Transfer Protocol (FTP) connection, then processed and validated by using batch COBOL programs. After validating the data, OMAP created an extract of behavioral health data and transferred it to the OMHAS Sybase system by using a mainframe utility "bulk copy" process. Following post-editing of the data, the extract was ready for analysis and reporting.

Table 8 summarizes the State's score on each section of the ISCA, based on review of the system described above.

Table 8. Section scores and ratings for the State ISCA.

Review section	Score	Rating
Data Processing Procedures and Personnel		
Information systems	2.8	Partially met
Staffing	3.0	Partially met
Hardware systems	3.6	Substantially met
Security	2.3	Minimally met
Data Acquisition Capabilities		
Administrative data	3.7	Substantially met
File consolidation	2.1	Minimally met
Performance measure repository structure	1.0	Not met
Report production	1.1	Not met

Adequate hardware and software were in place to support MMIS and the Sybase system, including maintenance and timely replacement of computer equipment, disaster recovery procedures, adequate training of support staff, and a secure computing environment. MMIS staff incorporated sound programming practices, including good documentation, a process for gathering data requirements, a quality assurance process, and version control.

Table 9 lists OMPRO's recommendations for improving the State's information systems to meet all ISCA criteria. Following OMPRO's review of the system used in producing the August 2003 MHO Utilization Report, OMHAS began operating a new information system, the Decision Support Surveillance and Utilization Review System, in September 2003. This system is expected to provide a more robust and scalable platform for improved data quality, analysis, and reporting.

Table 9. Opportunities for improvement and recommendations for State information systems.

Opportunity for improvement	Recommendation
As encounter data are updated weekly, the data used are not archived for a given report run. This makes it impossible to repeat the results or to test new algorithms on previous data and compare those results with previous statistics.	Create a performance measure repository in the form of a data warehouse. Elements could include numerators and denominators used in performance measures for each report run; information to uniquely identify encounters used in calculating each measure; benchmark data; past and current performance measures; definitions, such as inclusion and exclusion criteria for numerators and denominators; and a copy of the report from each run.
The system lacks sufficient documentation and relies heavily on the expertise of the individual who generates the report for the performance measure being validated. The loss of this individual could prove very disruptive to the system.	Document the entire process for producing performance measures, including steps for importing data, building tables, creating reports, and archiving data; data sources; edit and validation routines; current data dictionary; and the person or position responsible (including team or unit) for each part of the production process. Provide cross-training to other team members.
The performance measure reports are not subject to formal quality control.	Incorporate a standard process for version control of programs, including those used for generating reports and analysis plan. This would ensure that the correct version of a program is in use and would enable OMHAS to revert quickly to a previous version.
There are no documentation system controls to verify the accuracy and completeness of data submissions to OMAP and downloads to OMHAS.	Establish and document system controls to ensure that encounter and claims data are complete and accurate.

Opportunity for improvement	Recommendation
The system allows OMAP to change the content of data fields in encounters and claims without alerting the group responsible for analytic reporting.	Develop communications among those responsible for processing and cleaning claims and encounter data and those responsible for analytic reporting.
Variations in encounter and claims data content are not documented in sufficient detail for the OMHAS analyst completing the performance measure to control for differences in submission processes and detect anomalies in the encounter data.	Standardize the information contained in encounter data submissions from the MHOs. Monitor and enforce compliance with the standards.

Information Systems Capabilities Assessment—MHO review

OMPRO conducted an ISCA for each MHO through electronic surveys, document review, and onsite interviews with the MHOs and their contracted agencies. This section of the EQR report compiles observations from the individual MHO assessment reports submitted to OMHAS during 2005.

The Administrative Simplification provisions of HIPAA require MHOs to meet strict standards related to confidentiality of enrollees' records and standardization of codes. MHOs may either upgrade their own information processing systems or contract with third-party administrators (TPAs) to ensure compliance. At the time of the ISCA audits, six of the nine Oregon MHOs contracted with TPAs to process their encounter and claims data and submit the data to the State. For these MHOs, the scores for some ISCA sections reflect the evaluation of TPA operations.

Also during the ISCA audits, OMHAS had not yet completed its transition to a new HIPAA-compliant system of encounter and claims data administration. The first phase of this transition was to convert from the State's old set of encounter and claims codes (called "BA" codes) to the standardized codes used in the HIPAA-compliant system. The next phase was to convert the State's system from the old "NSF" data format to accept and process encounter and claims data in the HIPAA-compliant "837" format. This conversion is expected to be completed during 2006. At the time of this EQR report, the State and the MHOs were testing data submissions in the new HIPAA-compliant format.

While the majority of the MHOs have been successful in addressing HIPAA compliance issues, delays in converting the State's system to HIPAA standards have resulted in extreme delays in collecting encounter data from some contracted agencies. Some agencies have had to revert to an earlier system to be compatible with the State's system; in a few cases, agencies decided not to revert. As a result, some MHOs were achieving less than 75 percent completeness of encounter data three months after the close of the reporting period.

Table 10 shows the weighted average scores and ratings for the group of nine MHOs on each section of the ISCA. Table A-3 in Appendix A presents each MHO's score for each review category.

Table 10. Average ISCA section scores and ratings for nine MHOs.

Review section	Score	Rating
Data Processing Procedures and Personnel		
Information Systems	3.8	Substantially met
Staffing	4.0	Substantially met
Hardware Systems	4.1	Substantially met
Security of Data Processing	4.1	Substantially met
Data Acquisition Capabilities		
Administrative Data (Claims/Encounter Data)	4.0	Substantially met
Enrollment System (Medicaid Eligibility)	4.8	Fully met
Vendor Medicaid Data Integration	4.2	Substantially met
Provider Compensation and Profiles	3.5	Substantially met

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 TPAs employed robust mid-range machines for processing data.

Programming/Report development

- Of the majority of MHOs that maintained in-house database warehouses, including commercial EMR systems, each incorporated quality assurance processes for application development and software upgrades.

Security

- All MHOs had processes in place to meet HIPAA standards for protecting enrollee, encounter, and claims data from unauthorized access.
- The majority of the MHOs' contracted agencies submitted encounter data electronically as encrypted and/or password-protected zipped e-mail file attachments on a monthly basis.
- The majority of MHOs had software maintenance contracts for their EMR systems, ensuring timely access for support.
- Of MHOs that processed data in-house, the majority had good maintenance contracts in place for IT equipment, including desktop computers.

Table 11. Opportunities for improvement and recommendations for MHOs: Data Processing Procedures and Personnel.

Opportunity for improvement	Recommendation
The majority of MHOs do not incorporate version control for reports developed in-house to be distributed to contracted agencies, or in some cases, for applications developed in-house.	MHOs need to have in place a version control process for all programming code and reports.
A few MHOs had no standby database server. If a failure were to occur, these MHOs would have to rebuild the server and recover data from backup tapes, causing potential delays in reporting data to the State.	As part of disaster recovery preparation, some MHOs need to consider options for providing more comprehensive hardware redundancy of their production server(s). MHOs with a single database server might find it beneficial to add a standby server as a backup.
Several MHOs that processed data in-house lacked comprehensive backup rotational schedules.	A robust backup rotation schedule would include monthly or quarterly and three to five years of annual full backups to be stored off site.

Data Acquisition Capabilities

Strengths

Enrollment

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

Encounter data

- All MHOs were able to track the history of enrollees with multiple enrollment dates and whether enrollees were dually enrolled in Medicare and Medicaid.
- Eight of the nine MHOs had formal documentation for processing claims and encounter data.
- Seven of the nine MHOs had instituted multiple checkpoints for validation of encounter data, resulting in a rate of less than 1 percent for encounters denied by the State.

Auditing

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

Table 12. Opportunities for improvement and recommendations for MHOs: Data Acquisition Capabilities.

Opportunity for improvement	Recommendation
Two MHOs had no formal controls in place to ensure that all Medicaid claims from hospitals were entered into the system.	Incorporate a database or system controls to ensure that all claims are accounted for.
Several MHOs, including one that contracted with a TPA, could not accept electronic submissions of encounter data in the standard HIPAA-compliant format.	Use HIPAA-compliant software to ensure the capability to send and/or receive claims and encounters in the HIPAA standard electronic format.
The majority of MHOs exercise minimal oversight of the contracted agencies' processes for claims and encounter data submission.	The MHOs need to monitor data submissions by contracted agencies, document data submission standards, and provide training opportunities for agencies. Each MHO should consider contracting for an annual independent audit to ensure adequate controls and checkpoints for integrity of encounter data.

Information Systems. Evaluation of MHO information systems primarily focused on the software used to collect, store, and process encounter data. Desirable characteristics of software included ease of use, scalability without degradation of performance with increased data volume, and integration with other software (e.g., reporting packages or databases).

LaneCare, MVBCN, and WCHHS each contracted with Phtech as their TPA. Phtech incorporated excellent computer programming practices, including good documentation, a quality assurance process, and version control, and could accept electronic encounter data in both the HIPAA-compliant 837 format and the old NSF format. Phtech's software packages, including a secure web-based system application for providing up-to-date OMAP eligibility status, were scalable and easily integrated with other packages for generating reports. As a result, Phtech had the flexibility to rapidly accommodate changes to encounter data collection and submission. The merits of Phtech's reported performance were evident in rapid claims processing and payment (within 12 days of the date received) and in accurate encounter data forwarded to the State.

CCMHO and VIBHS used formal quality assurance processes for application development, including a test environment defined as a database separate from the live or production database. Other MHOs met the criteria less fully for various reasons, such as that they (1) lacked documentation for processing encounter data, (2) could not accept electronic submissions of encounter data in HIPAA-compliant 837 format, (3) did not incorporate version control for report or application development, and/or (4) lacked a formal quality control process for reviewing utilization reports developed in-house.

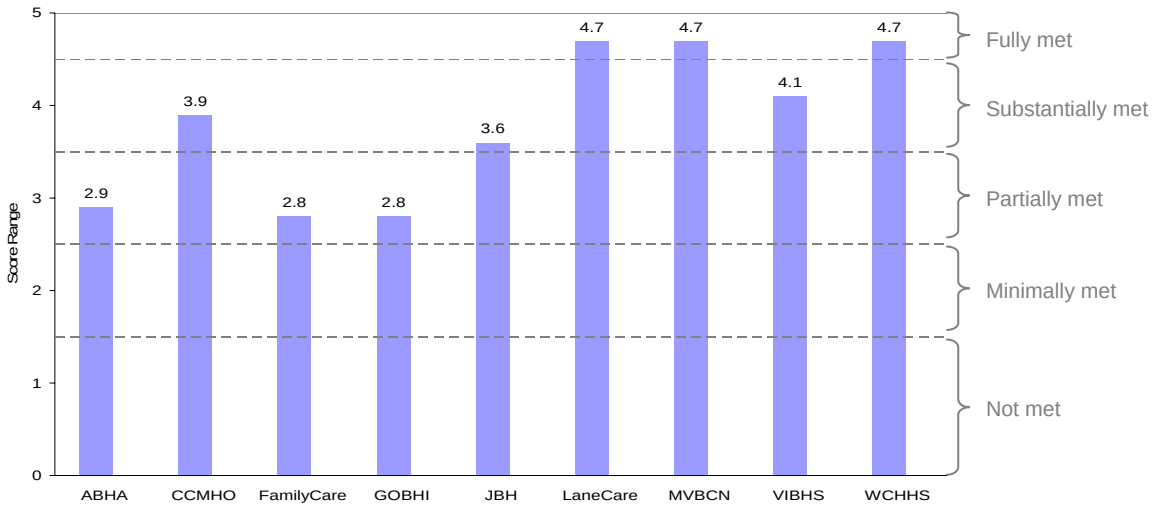

Figure 12. MHO compliance scores: Information Systems.

Staffing. Evaluation of MHO or TPA staff pertained to those responsible for processing encounter and claims data. The review assessed each MHO's productivity goals for data processing, the number of knowledgeable staff, and training of new hires and seasoned employees. A "Fully met" score indicated adequate trained staff for processing encounter data; a comprehensive, documented formal training process; established and monitored productivity goals; and low staff turnover.

The majority of MHOs fully or substantially met these criteria. However, one MHO that minimally met the standards had only one staff member familiar with the proprietary database used to process encounter data, and the MHO failed to provide training opportunities, such as cross-training with other claims/encounter processing staff. Some MHOs had no budget for training of the claims processing staff, including the claims analyst.

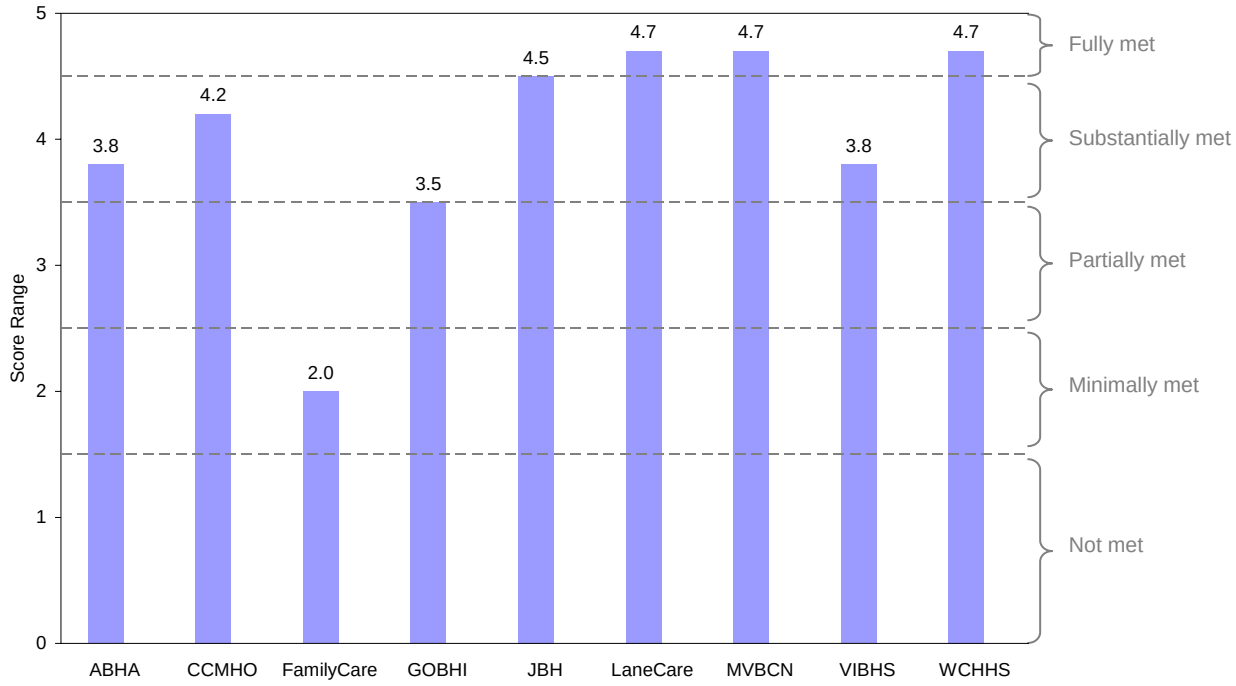

Figure 13. MHO compliance scores: Staffing.

Hardware Systems. Quality and maintenance of computer equipment and software are of paramount importance 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 or EMR systems; and a standby server as a backup to the main production server.

The majority of MHOs, including those contracting with an outside vendor, fully or substantially met these criteria. The two lowest scores were due to the lack of a standby server for in-house production systems.

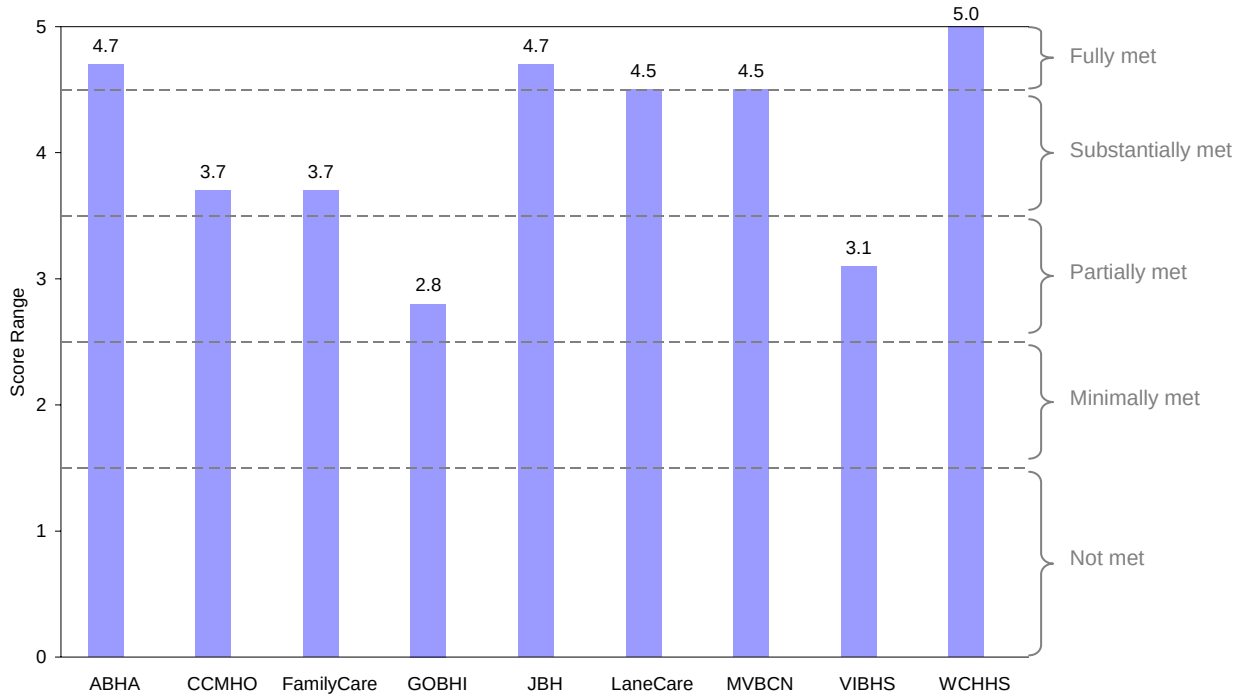

Figure 14. MHO compliance scores: Hardware Systems.

Security of Data Processing. In addition to the physical security of data, OMPRO evaluated the MHOs' backup systems, mechanisms for protecting the database from corruption, and accounting for all claims. For MHOs that contracted with an outside vendor, OMPRO also evaluated the MHO manager's familiarity with and documentation of the backup rotational schedule provided by the vendor.

MHOs that did not meet these criteria fully were deficient in one or more areas: (1) lack of familiarity with the vendor's backup rotational schedule, (2) a less than comprehensive rotation schedule, or (3) lack of a process for tracking fee-for-service claims. OMPRO suggests that the MHOs retain two to five years of annual full data backups stored off-site. Two of the MHOs lacked formal controls to ensure that all Medicaid claims were entered into their systems; their only indication of a missing claim was a telephone call from a provider.

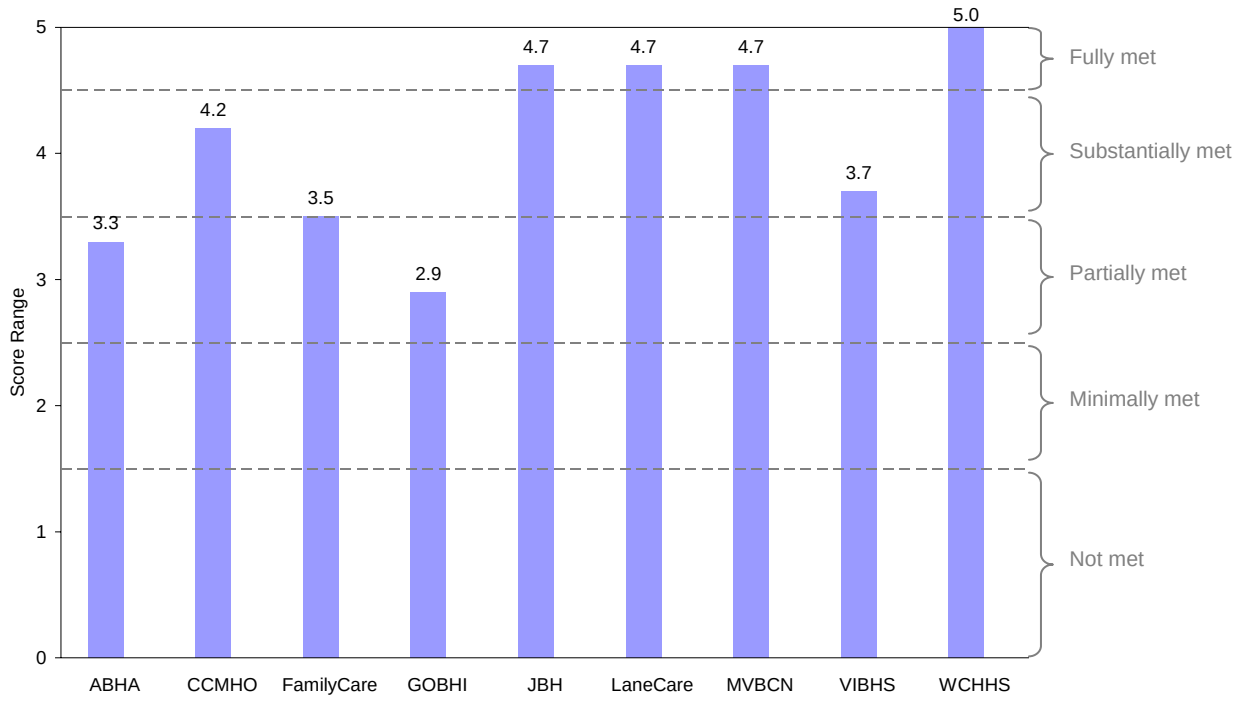

Figure 15. MHO compliance scores: Security of Data Processing.

Administrative Data. In addition to assessing each MHO's ability to acquire accurate and timely claims and encounter data, OMPRO interviewed contracted agencies to evaluate their processes for validating data, familiarity with diagnosis and procedure codes captured by their billing systems, handling of Medicaid and Medicare dual enrollees, types of encounters forwarded to the MHO, and methods for submitting claims and encounter data.

Most MHOs met these criteria less than fully because they lacked systematic processes for monitoring the data submitted by contracted agencies, or because the MHO lacked a process for auditing its own electronic billing system. OMPRO recommends that MHOs perform periodic audits to verify that the data in their electronic billing systems agree with clinicians' records. Also, MHOs' on-site audits of the contracted agencies should include sample chart reviews to compare chart data with encounter data submitted by the agencies.

GOBHI and FamilyCare provided comprehensive training for provider staff in encounter data collection and submission. Each provider group was audited regularly, and all agency staff had to pass a certification test in order to submit encounter data. GOBHI's and VIBHS's websites provided clear instructions for submitting encounter data. Phtech developed a method for cross-county reconciliation for MHOs serving multiple counties, providing an accurate measure of the number of encounters for clinics. JBH's administrator waited to incorporate encounter data into its data warehouse until after the data had been validated internally and verified by the State.

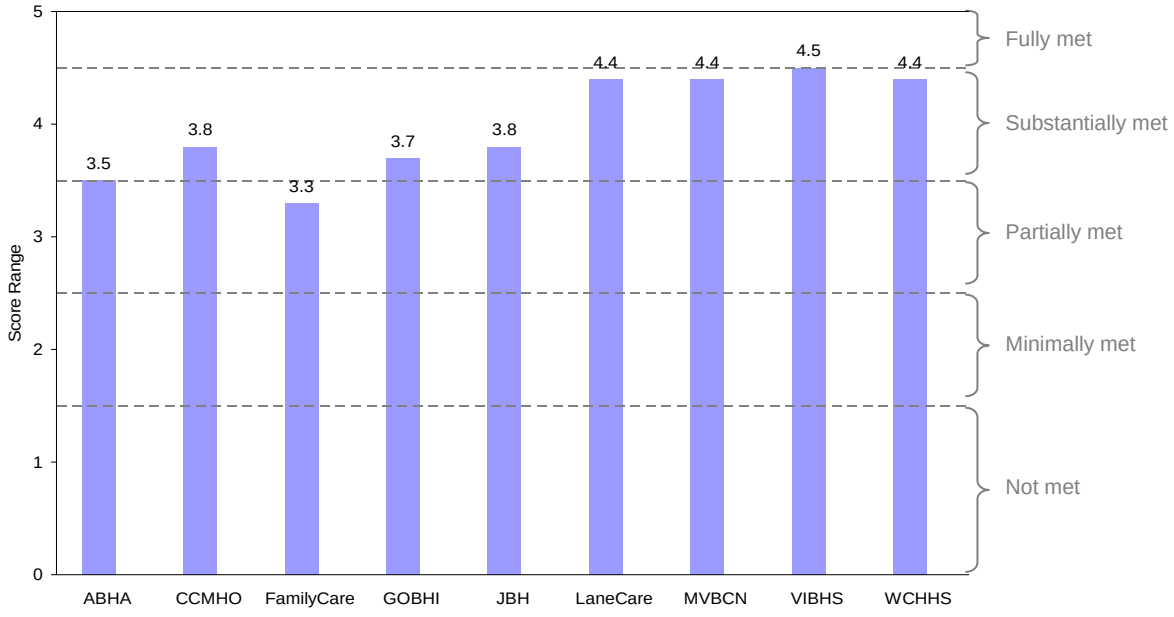

Figure 16. MHO compliance scores: Administrative Data.

Enrollment System. Timely and accurate eligibility data are paramount for ensuring access to care for Medicaid enrollees. Eligibility information from the State 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 agencies. This step helps to protect the database from potentially corrupted files.

Only one MHO lacked a process for verifying each eligibility file download. With each eligibility update, the majority of MHOs or their administrators checked each record in the files before incorporating new data into the system. All of the MHOs were able to track the history of enrollees with multiple enrollment dates and across insurance product lines. Among best practices, Phtech provided easy access to up-to-date member eligibility status via a secure web-based system that displayed the member's mental healthcare provider, primary care manager, third-party resources, long-term care provider, and dental care organization.

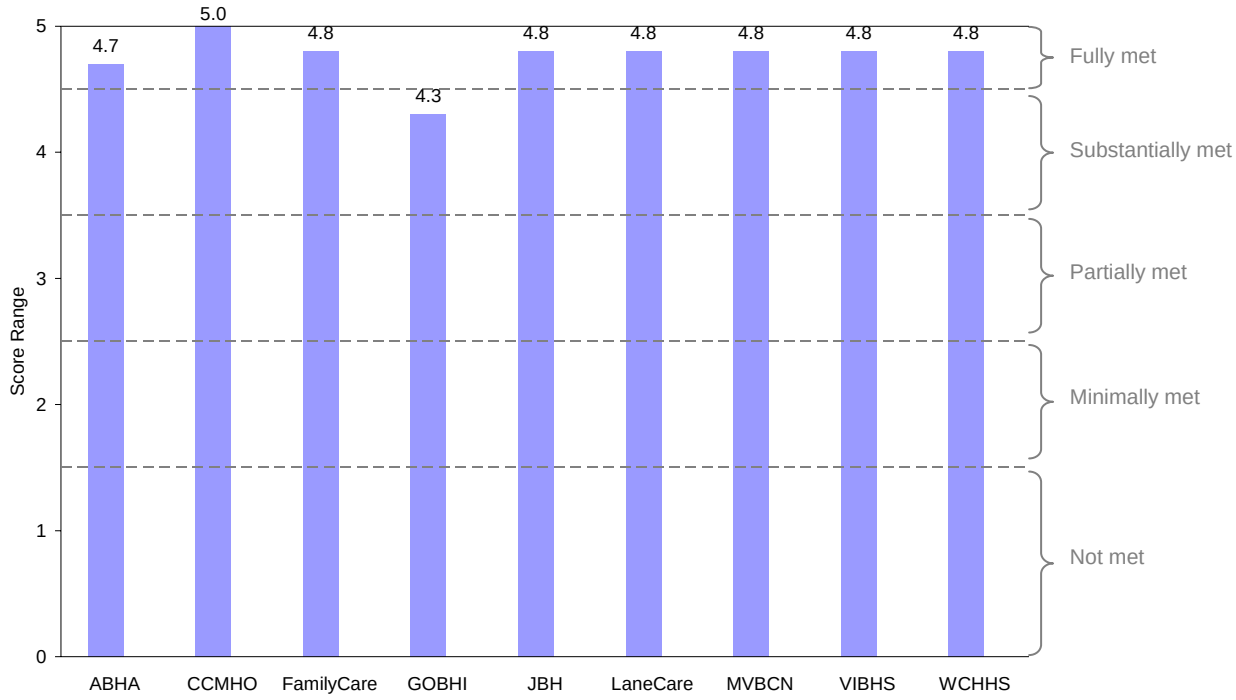

Figure 17. MHO compliance scores: Enrollment System.

Vendor Medicaid Data Integration. All of the MHOs collected member-level data from their contracted agencies and ensured that the data were compatible with the State's data systems. Among best practices, the majority of JBH's contracted agencies were submitting multiple diagnosis and procedure codes. However, most MHOs were receiving only one diagnosis per enrollee, either because of the configuration of billing software or because agency policy directed that only one diagnosis code be submitted.

OMPRO suggests that, if applicable to the encounter or claim, each MHO should ask its contracted agencies to submit more than one diagnosis code. Inclusion of multiple diagnosis codes would provide more relevant information on enrollees' conditions and a more comprehensive review of service utilization.

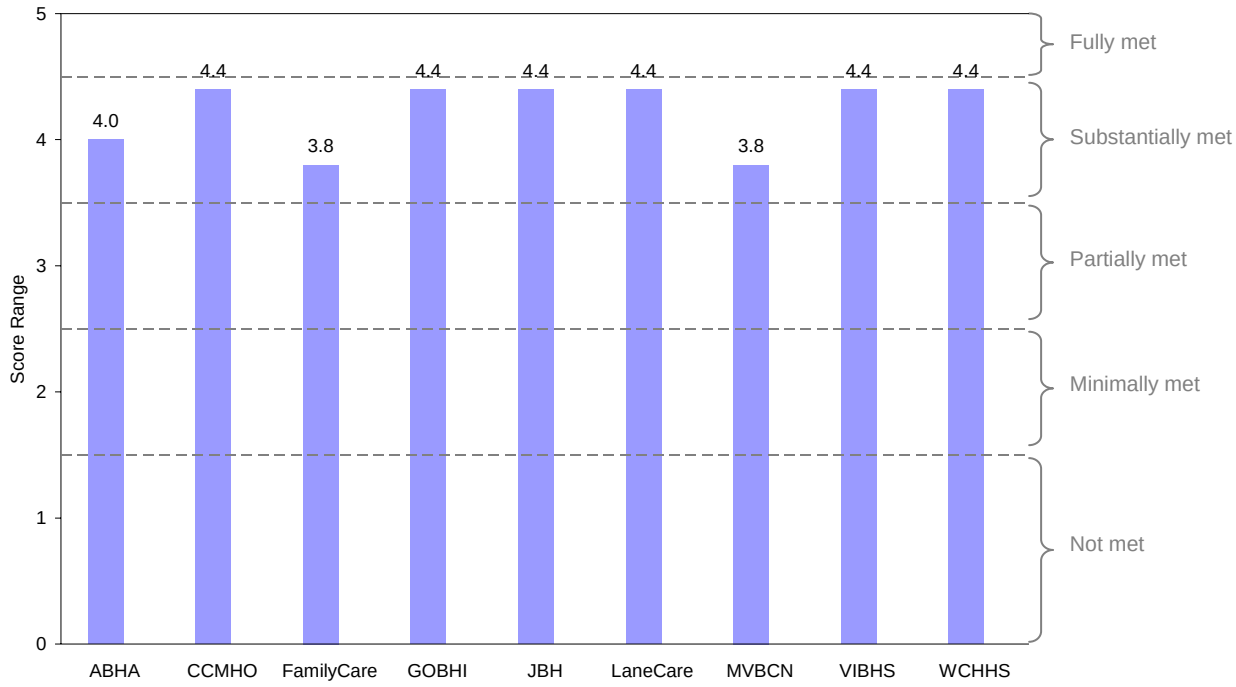

Figure 18. MHO compliance scores: Vendor Medicaid Data Integration.

Provider Compensation and Profiles. OMPRO evaluated each MHO's system for provider compensation to determine whether the compensation structure balanced contractual expectations, enrollees' needs, and capitation rates set by OMHAS. A system for reasonable and timely compensation helps to encourage an accessible, qualified network of providers to continue to provide service to enrollees. The majority of MHOs had automated provider compensation on the basis of a rate list for each procedure code per the provider's credentials.

OMPRO reviewed whether each MHO provided an accessible directory (electronic and paper) of qualified providers to enable enrollees to make informed choices. The review examined MHO websites for accuracy of information and, if the MHO served multiple counties, for the contact information of their contractors.

The majority of directories reviewed, including those provided online, lacked essential information such as clinicians' gender, credentials, and/or treatment specialties, whether the provider offered interpretive services, and whether the office was ADA-certified. However, VIBHS's website listed crisis contact information in 15 languages and listed clinic locations in five. LaneCare's website featured a provider directory by agency, with text in English or Spanish, identifying agencies that met ADA accessibility standards.

MHOs would benefit from making provider profiles available online and accessible by providers, clinical staff, and enrollees. If the MHO uses a central website for this purpose, the website should list current clinic locations or contact information for member counties. Provider profiles (online or hard copy) should include the essential information listed above.

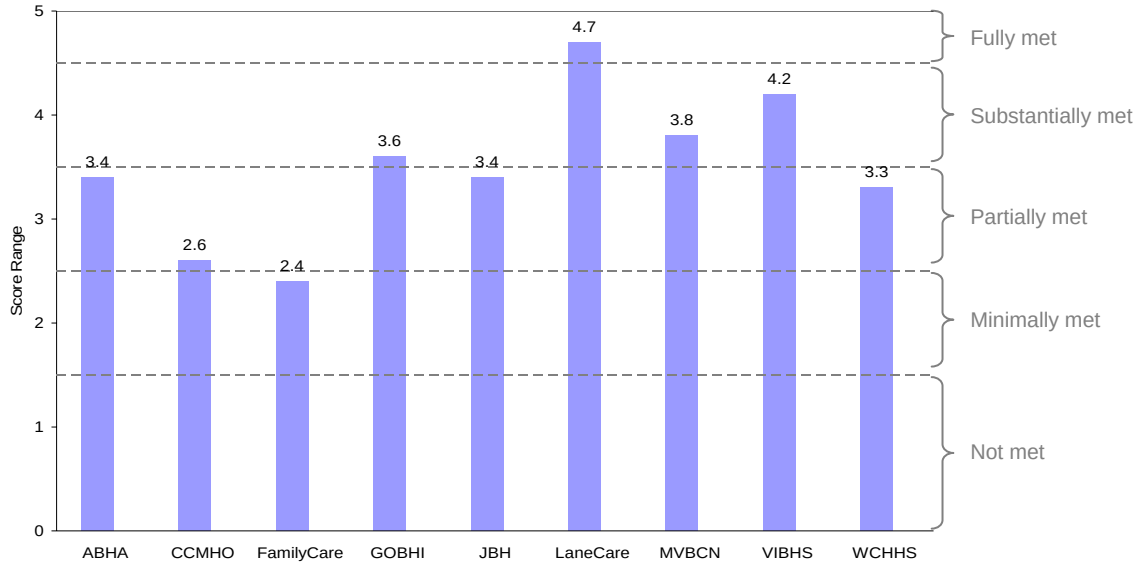

Figure 19. MHO compliance scores: Provider Compensation and Profiles.

Conclusions and Recommendations

OMHAS and the Oregon MHOs underwent EQR audits during the transition into a new regulatory environment for Medicaid managed care and during a change in the IT systems for administering the mental health care system. OMHAS has taken steps to address concerns identified in the performance measure validation review and the ISCA. In general, the MHOs are dedicated to meeting enrollees' service needs in the face of budgetary cuts, but they will face continuing challenges to comply fully with all contractual and regulatory requirements with limited resources.

The conclusions of this review are aimed at facilitating continuous improvement of the mental health care provided by the MHOs. With that goal in mind, OMPRO offers the following broad recommendations for OMHAS's consideration.

- MHOs will depend on guidance and support from OMHAS in meeting all regulatory standards and contractual needs for Medicaid managed care. To that end, OMHAS should incorporate the results of this EQR report into the revision of its Quality Strategy. In addition, OMHAS needs to provide guidance in specific areas highlighted in this report, such as the content of grievance reporting, the definition and treatment of enrollees with special healthcare needs, and the requirements for advance directives.
- MHOs would benefit by continuing to develop a collaborative approach of sharing their knowledge, practices, and expertise to advance improvements in all MHO systems for the benefit of enrollees. This collaboration should address the development of
    - written policies, procedures, and documentation covering all areas of operations
    - information materials for enrollees, especially communications about enrollee rights
    - practice guidelines for treatment in conjunction with efforts to establish evidence-based practices
    - best practices for oversight and monitoring of activities delegated to contracted agencies and their subcontractors
- To ensure delivery of effective integrated care, OMHAS should provide guidance and work with MHOs to increase coordination of their mental health services with the services provided by medical managed care organizations and other entities.

- MHOs need to devote resources to continuous improvement in data system management, especially with regard to enhancing internal QI reporting capabilities and analysis of trends based on encounter and claims data.
- OMHAS should work with MHOs to ensure the development of EMR systems, aimed at capturing high-quality encounter and claims data submissions that can enhance clinical processes, including treatment planning, monitoring, and coordination of care.

Appendix A. MHO scores on compliance standards, PIP review, and Information Systems Capabilities Assessment by section

Table A-1. Comparison of MHO compliance scores by review section.

Review section	ABHA	CCMHO	Family Care	GOBHI	JBH	Lane Care	MVBCN	VIBHS	WCHHS
Enrollee Rights	4.1	2.8	3.2	3.2	3.0	3.4	3.5	3.7	3.3
Delivery Network	2.9	3.5	3.3	3.5	3.1	3.5	3.3	4.0	3.5
Primary Care/Coordination of Services	3.7	3.5	3.5	3.3	3.0	3.8	3.1	4.0	3.5
Coverage and Authorization of Services	3.9	2.8	3.8	4.1	2.8	4.0	3.4	3.4	3.5
Provider Selection	2.2	2.6	3.0	3.0	2.4	3.0	4.0	3.6	3.0
Contractual Relationships and Delegation	4.0	3.0	2.0	3.0	3.0	4.0	4.0	3.0	3.0
Practice Guidelines	1.0	3.0	4.3	2.0	1.0	3.6	4.6	1.0	1.0
Quality Assessment and Performance Improvement	4.0	3.5	3.8	3.9	3.0	3.8	4.6	3.6	3.5
Grievance Systems	3.9	3.2	3.8	4.1	3.3	4.0	4.3	3.4	4.0

Rating scale:

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

Table A-2. Comparison of MHO PIP scores by review standard.

	ABHA	CCMHO	Family Care	GOBHI	JBH	Lane Care	MVBCN	VIBHS	WCHHS
Clinical PIP									
Overall score	**55**	**37**	**58**	**29**	**39**	**35**	**51**	**62**	**47**
Standard 1	88	74	75	50	75	88	100	88	88
Standard 2	100	60	100	100	100	75	100	100	100
Standard 3	63	68	63	13	55	38	75	88	75
Standard 4	88	30	75	25	63	25	31	100	88
Standard 5	69	46	50	6	35	17	33	69	25
Standard 6	75	70	100	100	80	75	100	75	100
Standard 7	50	13	44	6	5	31	38	56	0
Standard 8	44	13	75	6	0	25	44	56	0
Nonclinical PIP									
Overall score	**55**	**40**	**33**	**46**	**43**	**48**	**58**	**23**	**33**
Standard 1	88	74	75	38	90	88	75	75	88
Standard 2	100	60	100	100	90	75	100	100	100
Standard 3	63	50	50	50	73	88	75	63	63
Standard 4	88	50	50	75	63	75	88	50	63
Standard 5	54	66	38	31	54	58	38	0	0
Standard 6	100	75	50	100	75	50	100	0	50
Standard 7	56	25	0	13	0	25	44	0	0
Standard 8	19	9	0	44	0	31	56	0	0

Rating scale:

70–80 = Fully met
55–69 = Substantially met
40–54 = Partially met
25–39 = Minimally met
0–24 = Not met

Table A-3. Comparison of MHO ISCA scores by review section.

Review section	ABHA	CCMHO	Family Care	GOBHI	JBH	Lane Care	MVBCN	VIBHS	WCHHS
Data Processing									
Information Systems	2.9	3.9	2.8	2.8	3.6	4.7	4.7	4.1	4.7
Staffing	3.8	4.2	2.0	3.5	4.5	4.7	4.7	3.8	4.7
Hardware Systems	4.7	3.7	3.7	2.8	4.7	4.5	4.5	3.1	5.0
Security of Data Processing	3.3	4.2	3.5	2.9	4.7	4.7	4.7	3.7	5.0
Data Acquisition									
Administrative Data	3.5	3.8	3.3	3.7	3.8	4.4	4.4	4.5	4.4
Enrollment System	4.7	5.0	4.8	4.3	4.8	4.8	4.8	4.8	4.8
Medicaid Data Integration	4.0	4.4	3.8	4.4	4.4	4.4	3.8	4.4	4.4
Provider Compensation and Profiles	3.4	2.6	2.4	3.6	3.4	4.7	3.8	4.2	3.3

Rating scale:

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