The Oregon Health Plan's Mental Health Care

Oregon Department of Human Services
Addictions and Mental Health Division
2006 External Quality Review Annual Report

December 2006

Contract #109162

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December 2006

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

OMHAS-EQR-OR-06-12

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Executive Summary

The Oregon Department of Human Services, Addictions and Mental Health Division (AMH) has contracted with Acumentra Health, a quality improvement organization, to perform an external quality review (EQR) of the delivery of mental health services to Oregon Health Plan (OHP) enrollees. The Balanced Budget Act of 1997 requires an EQR in states such as Oregon that use a managed care approach to provide Medicaid services.

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

This is the second annual EQR report produced for AMH by Acumentra Health. The report summarizes the EQR results in three major areas:

- assessment of the MHOs' performance improvement projects (PIPs)
- review of AMH's managed care quality strategy to assess its compliance with federal standards
- validation of the statewide performance measures that AMH uses to assess care provided by MHOs, including an assessment of the State information systems related to calculating and reporting those measures

Highlights appear below. More detailed results and recommendations are presented in each section of the EQR report.

EQR results

The 2006 EQR results reflect the continuing transition to a new regulatory and administrative environment for AMH and for the MHOs.

During 2006, AMH began to implement the Children's System Change Initiative (CSCI), a legislatively mandated program aimed at serving children in the least restrictive environment by moving them from psychiatric residential treatment facilities and state hospitals into community-based services under managed care. The CSCI serves as a focal point for quality improvement (QI) activities conducted by AMH and the MHOs.

Performance improvement projects

All managed care organizations that serve Medicaid enrollees must conduct two PIPs each year aimed at improving clinical outcomes and administrative services. PIPs are validated each year through the EQR to ensure that they are designed,

conducted, and reported according to standards established by the Centers for Medicare & Medicaid Services (CMS).

In 2006, five of the 18 PIPs (two per MHO) fully met the CMS standards, and six PIPs substantially met the standards. Almost across the board, the MHOs scored higher on the individual PIP validation standards, compared to their 2005 scores. As a group, the MHOs substantially met federal requirements for defining and documenting their study indicators and study populations, data collection and analysis plans, and intervention goals and strategies. They also progressed further in measuring and analyzing the results of their interventions, though generally not far enough to meet federal standards in those areas.

The 2005 EQR had found that none of the 18 initial PIPs fully met CMS standards, largely because most MHOs had not completed their studies at the time of review. Their documentation of the PIP design and process typically was inadequate, and many PIPs lacked a prospective analysis plan. Since June 2005, AMH has offered four separate training sessions for MHO staff to review aspects of PIP methodology and statistical analysis.

AMH has held discussions with the MHOs concerning a possible joint PIP aimed at improving the coordination of mental health care with the services provided by medical managed care organizations and other entities.

AMH quality strategy review

AMH's Medicaid Managed Mental Health Care Quality Assessment and Improvement Strategy describes the agency's plan for overseeing the MHOs' delivery of services for OHP enrollees and for ensuring access to timely, appropriate, and high-quality behavioral health care.

Acumentra Health's 2006 review found that although the AMH quality strategy successfully addresses some elements of the state's duties, the strategy does not fully address the majority of the Medicaid managed care regulations. The strategy needs to provide more concrete details about what MHOs are expected to do and how AMH will oversee the MHOs to hold them accountable. A clear definition of responsibilities would make it easier for the MHOs to apply the strategy effectively to their business practices and to align them with AMH's goals for the delivery of services to OHP enrollees.

Statewide performance measures

AMH's four statewide performance measures for MHOs, reported in the *MHO Utilization Quarterly Report*, reflect the goal of reducing acute hospitalization in favor of outpatient treatment.

Since the 2005 validation review, AMH has improved some aspects of the definition, documentation, and analysis of performance measures. For example, AMH has revised the calculation of member months to make the measures more consistent with those used by other health plans and other states. However, the utilization report still provides insufficient information to explain the context of the performance measures and how they are defined and calculated. Also, the report does not identify certain limitations of the data reported.

With regard to the information systems used to produce the performance measures, the implementation of the Decision Support Surveillance and Utilization Review System has enhanced protection of confidential enrollee data. In addition, the use of encrypted electronic mailboxes in place of the previous bulletin board system provides more secure transfer of encounter and claims data. The 2005 review had raised concerns about the protection of enrollee confidentiality and about data security in the event of system failure.

To encourage providers to submit more complete and accurate encounter data, several MHOs have moved to implement fee-for-service payment systems that link reimbursement directly to services provided, rather than to enrollment.

Response to 2005 EQR findings

The 2005 EQR identified many areas in which the MHOs fell short of meeting federal standards. AMH has issued corrective action plans to the MHOs and has monitored their response as described in the Introduction on page 9.

Some of the 2005 EQR recommendations addressed areas in which AMH needed to provide more oversight and technical assistance to guide the MHOs in their compliance efforts. Most notably, AMH has responded by

- working with the MHOs to develop a standardized complaint log
- working with residential treatment facilities to develop a system for monitoring the use of seclusion and restraints
- allowing MHOs to implement evidence-based practices in lieu of adopting the practice guidelines required by federal regulations
- clarifying the MHO contract provisions regarding the required content of listings of provider agencies
- beginning discussions with the MHOs about requirements for the needs assessment that each MHO must perform to ensure that all eligible enrollees have access to the delivery network

Recommendations

With the goal of continuous quality improvement, Acumentra Health offers the following recommendations, building on those from the 2005 EQR.

For AMH:

- Continue to support the joint PIP with MHOs to increase coordination of mental health services with the services provided by medical managed care organizations and other entities.
- Continue to strengthen the *MHO Utilization Quarterly Report* presentation and report production process by implementing the recommendations from the performance measure validation review.
- Revise the managed care quality strategy to
  - address the many standards upon which the strategy is now silent
  - make it easier to understand the specific roles of AMH and the MHOs—for example, by listing the federal standards and describing the oversight design for each standard
  - incorporate the results of the 2006 EQR activities
  - incorporate best practices obtained from site reviews, MHO contractor or QI coordinator meetings, or a review of practices in other states
- Consider forming a quality improvement committee within AMH that would oversee MHO responsibilities and approve the annual work plan and the scope of work for the contract year.
- Continue to clarify language in the managed care contract and provide other guidance for MHOs to support their compliance with regulatory standards—for example, by defining special healthcare needs so that the MHOs can identify those enrollees and develop treatment plans for them.
- Continue to work with MHOs to ensure the development of data systems that can capture and transmit high-quality encounter and claims data

For MHOs:

- With regard to PIPs, devote the necessary resources to
  - conduct ongoing remeasurement of study indicators
  - perform the appropriate statistical tests to assess the degree of sustained improvement due to the PIP interventions
  - identify barriers to improvement and modify interventions accordingly

Introduction

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

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

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

This report describes objectives, data collection and analysis methods, and conclusions drawn from the data obtained for the first two activities. Because Acumentra Health conducted and reported on the required review of MHO compliance in 2005, this report does not address compliance issues.

Separate reports delivered to AMH during 2006 have assessed the strengths and weaknesses of each MHO's PIPs and have recommended ways for the MHOs to improve the PIPs. AMH will determine the required action for each MHO.

OHP mental health care

Mental health services for OHP enrollees are delivered through contracts with MHOs on a capitated basis. Currently, these nine MHOs provide behavioral health services throughout the state under contract with AMH:

- 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 1st Quarter 2006, the nine MHOs served about approximately 376,000 OHP enrollees, broken out as shown in Table 1. About 57 percent of enrollees were female, and 57 percent were children under age 18.

Table 1. Geographical coverage and enrollment of Oregon MHOs.[a]

MHO	Counties served	Number of enrollees
ABHA	Benton, Jefferson, Lincoln, Deschutes, Crook	26,746
CCMHO	Clackamas, Hood River, Gilliam, Sherman, Wasco	25,833
FamilyCare	Clackamas, Multnomah, Washington	10,987
GOBHI	Baker, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler, Clatsop, Columbia	31,747
JBH	Coos, Curry, Klamath, Jackson, Douglas, Josephine	65,350
LaneCare	Lane	35,700
MVBCN	Linn, Marion, Polk, Tillamook, Yamhill	72,695
VIBHS	Multnomah	73,986
WCHHS	Washington	32,976

[a] Source: *MHO Utilization Quarterly Report*, 1st Quarter 2006.

AMH's quality improvement activities

Managed care 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 or must implement protocols consistent with those of CMS.

AMH's 12-page Medicaid Managed Mental Health Care Quality Assessment and Improvement Strategy describes AMH's plan for overseeing the MHOs that serve OHP enrollees. Adopted in August 2003 and revised in August 2005, the quality strategy incorporates elements of state and federal regulations and of the MHO

contract. Data obtained from the oversight activities described in the strategy ultimately are analyzed and evaluated as part of the annual EQR technical report. As part of the 2006 EQR, Acumentra Health reviewed the strategy for compliance with federal standards. (See results beginning on page 22.)

MHO Utilization Quarterly Report

AMH's *MHO Utilization Quarterly Report* incorporates the four statewide performance measures for mental health care and presents information about services provided to OHP enrollees across the state.

Quality improvement annual work plans

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

AMH is working with the MHOs to incorporate the PIPs into their work plans. In addition, AMH has held discussions with the MHOs concerning a possible joint PIP aimed at improving the coordination of mental health care with the services provided by medical managed care organizations and other entities. Coordination of care is considered a key practice for improving mental health outcomes and is a major focus of the CSCI.

CSCI evaluation

The goal of the CSCI, mandated by state lawmakers in 2003, is to serve children with serious emotional, behavioral, and mental disorders through least restrictive, culturally appropriate, evidence-based services and care coordination. A key objective is to move children from psychiatric residential treatment and state hospitals into community-based services under managed care.

AMH contracted with Portland State University's Regional Research Institute for Human Services to evaluate the implementation of the CSCI between October 2005 and August 2006. The draft report, submitted for review in October 2006, found evidence of substantial progress, including

- considerable system-wide infrastructure development
- a philosophical shift in the culture of service delivery toward a more family-focused, strengths-based and coordinated system
- enhanced service capacity, including a network of care coordinators[1]

[1] Portland State University, Regional Research Institute for Human Services, Graduate School of Social Work. *Oregon Children's Mental Health System Change Initiative Implementation Evaluation*. Draft for review. October 10, 2006.

The report recommended a series of measures related to resource allocation, financing, and improving communication, care coordination, and collaboration among the system partners.

Consumer satisfaction surveys

AMH conducts the annual Youth Services Survey for Families to ask the caregivers of children who receive mental health services about their satisfaction with these services. The agency has adapted the survey to collect data that can contribute to evaluating the progress of the CSCI. AMH also conducts annual surveys of satisfaction with the care received by adults, using a modified version of the Mental Health Statistics Improvement Program survey.

AMH contracted with Acumentra Health to conduct both surveys in 2006. The surveys were mailed to approximately 12,000 adults and 10,500 parents and guardians. Response exceeded 20 percent for each survey. The final reports of survey results are scheduled for delivery to AMH in January 2007.

Evidence-based practice initiative

State lawmakers have mandated that increasing proportions of state funds be allocated for services that are based on evidence-based practices (EBP). By the 2009–2011 biennium, 75 percent of AMH funds to serve populations at risk of emergency psychiatric services and/or criminal or juvenile justice involvement must support EBP. AMH assumes that this requirement applies to virtually all of its clinical and prevention services. Currently, an estimated 56 percent of public funds spent for alcohol and drug abuse prevention and treatment and 33 percent of funds spent for mental health services support EBP.[2]

AMH has established an internal steering committee to direct a system-wide approach to ensuring the adoption of EBP. The agency also has established a policy and procedure for identifying, evaluating, approving, and listing relevant practices and programs on its public website. AMH has determined that MHOs may adopt EBP in lieu of the practice guidelines required by federal regulations. As part of its technical assistance program, AMH makes teams of consultants on EBP adoption available to providers at little or no cost.

[2] Oregon Department of Human Services, Addictions and Mental Health Division. *Progress Report on the Implementation of Evidence-Based Practices*. Presentation to the Joint Interim Judiciary Committee. September 20, 2006.

EQR activities

In May 2004, AMH contracted with Acumentra Health (then known as OMPRO) to conduct the annual EQR of mental health care under the OHP. The EQR conclusions are intended to guide AMH in identifying the mental health care system's strengths and weaknesses, with the goal of facilitating continuous improvement of the care provided by the MHOs.

The initial EQR audits in 2005 took place during the transition to a new regulatory environment for Medicaid managed care and during a change in the information systems for administering the mental health care system. As a result, the review identified many areas in which the MHOs fell short of meeting federal and state standards, especially regarding written policies and procedures (P&P). The 2005 EQR Annual Report discussed those findings in detail.[3]

Response to 2005 EQR findings

Upon receiving the 2005 compliance reports, AMH notified each MHO of the findings and identified the required corrective action. Each MHO submitted updated P&P or an action plan for revising the P&P. AMH has reviewed the submissions and prepared for focused site reviews of the MHOs in 2007. A portion of the 2007 reviews will focus on evidence that the MHOs have implemented the revised P&P.

AMH also responded to compliance findings in the following broad areas:

- The MHOs' member handbooks generally were found to require many revisions to comply with federal regulations. AMH directed the MHOs to revise the handbooks for re-review during the normal contract cycle for handbook submission. AMH has reviewed all revisions and will forward them to CMS for approval.
- Following the first year of PIP validation reviews, AMH provided technical assistance and training for the MHOs on PIP standards and expectations. AMH required some MHOs to submit revision plans to ensure that their PIP scores would improve by the time of the 2007 review.
- AMH viewed the 2005 Information Systems Capabilities Assessment results as a baseline and as a learning opportunity for the MHOs. AMH will take action as deemed necessary following the reassessment of the MHOs' information systems in 2007.

[3] OMPRO. The Oregon Health Plan's Mental Health Care: 2005 External Quality Review Annual Report. December 2005.

Some of the 2005 EQR recommendations addressed areas in which AMH needed to provide more oversight and technical assistance to guide the MHOs in their compliance efforts. Most notably, AMH has responded by

- working with the MHOs to develop a standardized complaint log
- working with residential treatment facilities to develop a system for monitoring the use of seclusion and restraints
- allowing MHOs to implement evidence-based practices in lieu of adopting the practice guidelines required by federal regulations
- clarifying the MHO contract provisions regarding the required content of listings of provider agencies
- beginning discussions with the MHOs about requirements for the needs assessment that each MHO must perform to ensure that all eligible enrollees have access to the delivery network

Performance Improvement Projects

All managed care organizations that serve Medicaid 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 or enrollee service. PIPs are validated each year as part of the EQR process to ensure that they are designed, conducted, and reported in a methodologically sound way.

Detailed results of Acumentra Health's PIP evaluations for each Oregon MHO appear in individual reports submitted to AMH throughout 2006. High-level summary results appear below.

In 2006, five of the 18 PIPs (two per MHO) fully met the CMS standards, and six PIPs substantially met the standards. Almost across the board, the MHOs scored higher on the individual PIP validation standards, compared to their 2005 scores. As a group, the MHOs substantially met federal requirements for defining and documenting their study indicators and study populations, data collection and analysis plans, and intervention goals and strategies. They also progressed further in measuring and analyzing the results of their interventions, though generally not far enough to meet federal standards in those areas.

These results largely reflect a successful response to recommendations from the 2005 EQR, which found that none of the 18 initial PIPs fully met federal standards, mainly because most MHOs had not completed their studies at the time of review. Documentation of the PIP design and process generally was inadequate, and many PIPs lacked a prospective analysis plan, an essential component of valid and reliable data analysis. MHOs that discontinued their 2005 PIPs and began new projects for 2006 achieved better results due to better understanding of the PIP process and documentation requirements.

As MHOs develop future PIPs or refine their current PIPs, Acumentra Health recommends that the MHOs devote the necessary resources to

- conduct ongoing remeasurement of study indicators
- perform the appropriate statistical tests to assess the degree of sustained improvement due to the PIP interventions
- identify barriers to improvement and modify the interventions accordingly

Acumentra Health also recommends that AMH continue to provide ongoing technical assistance as MHOs conduct their PIPs.

PIP highlights

During 2006, the MHOs conducted a variety of PIPs that addressed access to mental health care and the quality and timeliness of care, the three broad performance domains for managed care identified by CMS.

Access to care. Several MHOs designed PIPs to improve outreach to underserved populations or to ensure access to routine appointments, both of which were cited as areas of concern by the 2005 EQR. For example:

- FamilyCare sought to improve access to services for new enrollees with behavioral health special needs. The MHO identified these enrollees through its new-member survey and used telephone assessments and referrals to connect the enrollees with providers for treatment. Remeasurements indicated significant improvements in the rate of completed telephone assessments and in referrals accepted by members, compared to the baseline period. This PIP fully met the CMS standards.
- JBH, in an effort to increase the delivery of services for Hispanic enrollees, studied the impact of improving the availability of culturally competent and Spanish-language resources. This PIP, begun in 2005 and modified in response to recommendations from the 2005 EQR, substantially met the CMS standards.
- MVBCN's nonclinical PIP, aimed at improving access to community-based services for children, substantially met the CMS standards. The goal of these interventions is aligned with that of the CSCI.

Quality of care. Several MHOs' PIPs used evidence-based community treatment models in preventive interventions to reduce the rate of enrollee hospitalization and the length of hospital stays. For example:

- VIBHS demonstrated a sustained reduction in hospitalization rates by using intensive case management and evidence-based practices, including Assertive Community Treatment and Dialectical Behavior Therapy. This PIP fully met the CMS standards.
- WCHHS sought to reduce its high rates of psychiatric hospitalization and average length of hospital stays by allowing providers to develop intensive community-based treatment plans for adult members with severe and persistent mental illness. This PIP substantially met the CMS standards.

Timeliness of care. Timely outpatient care following psychiatric hospitalization can reduce the need for rehospitalization. As a statewide performance measure, AMH tracks whether the MHOs provide follow-up appointments in an outpatient

setting within 7 days of when an enrollee is discharged from acute hospital care. The 2005 EQR found that the MHOs generally needed to address timely post-hospitalization care. From 2nd Quarter 2005 through 1st Quarter 2006, the statewide average percentage of enrollees discharged from acute care who received an outpatient visit within 7 days ranged from 43 to 58 percent.

In 2006, FamilyCare and CCMHO conducted PIPs to improve the rate of 7-day follow-up. Both PIPs fully met the CMS standards.

- FamilyCare used discharge planning to establish a mental health service provider for each hospitalized enrollee before discharge. Remeasurements indicated substantial improvements in timely follow-up rates over the baseline period.
- CCMHO's interventions involved improving case management, care coordination, and community-based support. First-year results showed a higher 7-day follow-up rate and fewer rehospitalizations.

Methodology

Data collection tools and procedures, adapted from the CMS protocols, involved document review and onsite interviews from February through August 2006. Acumentra Health evaluated the information collected from each MHO according to the criteria specified in the document titled *Performance Improvement Project Validation*, adapted from the CMS protocol and approved by AMH.

Acumentra Health reviewed the PIPs for the following elements:

- a clear, concise statement of the topic being studied, the specific questions the study is designed to address, and the quantifiable indicators that will answer those questions
- a sampling methodology that yields a representative sample large enough for statistical comparisons (if needed)
- a written project plan with a study design, an analysis plan, and a summary of results
- an analysis plan that addresses project objectives, defines indicators clearly, specifies the population being studied, identifies data sources and/or the data collection procedure, and discusses the methodologies proposed for analyzing the data, statistical tests to be performed, and sampling procedures, if applicable
- validation of data at the point of data entry for accuracy and completeness
- when claims or encounter data are used for population-based analysis, assessment of data completeness

- validation rules created in the data entry database to determine whether data were missing or whether data fell within valid parameters
- in the case of data collection that involves a medical chart review, a check on inter-rater reliability
- a clear statement of the improvement strategies, their impact on the study question, and how that impact will be assessed and measured
- a summary of results that covers all data collection and analysis, explaining limitations inherent in the data and discussing whether the strategies resulted in improvements

Scoring for the PIPs involved rating the MHOs' performance on 10 standards:

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

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

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

Table 2. PIP compliance rating and scoring system.

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

Review results

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

Five of the nine clinical PIPs dealt directly with issues pertaining to psychiatric hospitalization—reducing the rate of hospitalization and/or improving follow-up with enrollees discharged from the hospital. The nonclinical PIPs addressed a broad range of topics related to improving administrative processes and enrollees' access to services. Four PIPs—two by FamilyCare and one each by ABHA and VIBHS—were continuations of studies reviewed for the 2005 EQR.

Table 3. Clinical PIP topics by MHO.

MHO	PIP topic	Study question/topic
ABHA	Ensuring Timely Level-of-Need Determinations	Ensure that 90 percent of all members referred for assessment under the Children's System Change Initiative will receive a level-of-need determination within three days of when the MHO receives all necessary referral information.
CCMHO	Ambulatory Care Appointments Following Hospital Discharge	Reduce the number of rehospitalizations and length of stay for enrollees through an emphasis on post-hospital care.
FamilyCare	Improving the Rate of 7-Day Ambulatory Follow-Up After Inpatient Psychiatric Discharge	Can the 7-day ambulatory follow-up rate for OHP enrollees be improved by ensuring that each enrollee has established a provider prior to discharge?
GOBHI	Increasing Services for Children in Child Welfare Custody	Can services to children in Child Welfare care be increased by at least 15 percent by providing targeted information to the providers and by individualized responses by providers?
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	Reducing Hospital Utilization Through Preventive Interventions	Will enrollee involvement with the Transition Team reduce the average length of stay for enrollees admitted to psychiatric hospitals?
MVBCN	Implementing the Multi-Family Psychoeducation (MFPE) Model	Will the strategy to support implementation of the MFPE model and monitor fidelity result in improved functional outcomes for clients whose families/caregivers participate?
VIBHS	Reducing Inpatient Utilization	Reduce overall hospitalization by performing level-of-care assessments for members with the highest hospital utilization and providing community-based services according to evidence-based models.
WCHHS	Reducing Psychiatric Hospitalization Through Intensive Community Treatment	Will implementation of an Intensive Community Treatment level of care for targeted members result in decreased admissions to inpatient psychiatric hospital facilities and decreased lengths of stay in psychiatric hospitals?

Table 4. Nonclinical PIP topics by MHO.

MHO	PIP topic	Study question/topic
ABHA	Increasing Use of the Oregon Change Index	Measure the effect of additional interventions on increasing the number of clinicians who use the Oregon Change Index survey tool.
CCMHO	Increasing Treatment Follow-Through	Gather concrete data about enrollees with mental health service needs who do not engage in treatment, and about their satisfaction with the process of care.
FamilyCare	Improving Identification of Behavioral Health Special Needs and Access to Needed Services	Can identification of OHP members' behavioral health special needs and access to needed services be improved by using the Health Information Form and following up with at-risk individuals by telephone?
GOBHI	Improving Inter-Rater Reliability of Chart Audits	Can the inter-rater reliability of the current clinical chart audit form be improved by providing training on the chart audit form itself?
JBH	Improving Access for Hispanic Enrollees	Does increasing the availability of culturally competent and Spanish-language resources increase the percentage of Hispanic enrollees who receive services?
LaneCare	Timely Resolution of Pended Authorizations	Determine whether a new tracking system and other administrative measures will reduce the time required to authorize services for enrollees who visit agencies other than their lead provider agencies.
MVBCN	Increasing Access to Community-Based Treatment Services	Increase the number of nontraditional community-based mental health services provided for children and their families.
VIBHS	Initiation and Engagement	What enrollees are receiving services for new episodes of care? What percentage of enrollees receive a second visit within 14 calendar days after intake for a new episode of care?
WCHHS	Implementing a Fee-for-Service Payment System	Will implementation of a fee-for-service payment system result in an increase in the overall number of encounter claims? Will matching service intensity to members' assessed needs result in more services for members who are assessed to have the highest level of impairment and/or the most serious mental health conditions?

Figure 1 shows MHO scores on the clinical PIPs that were rated on the 80-point scale in 2005 and 2006. Figure 2 shows scores on the nonclinical PIPs rated on the same scale in the same two years. Because none of these studies had progressed to remeasurement, it was not possible to gauge sustained improvement.

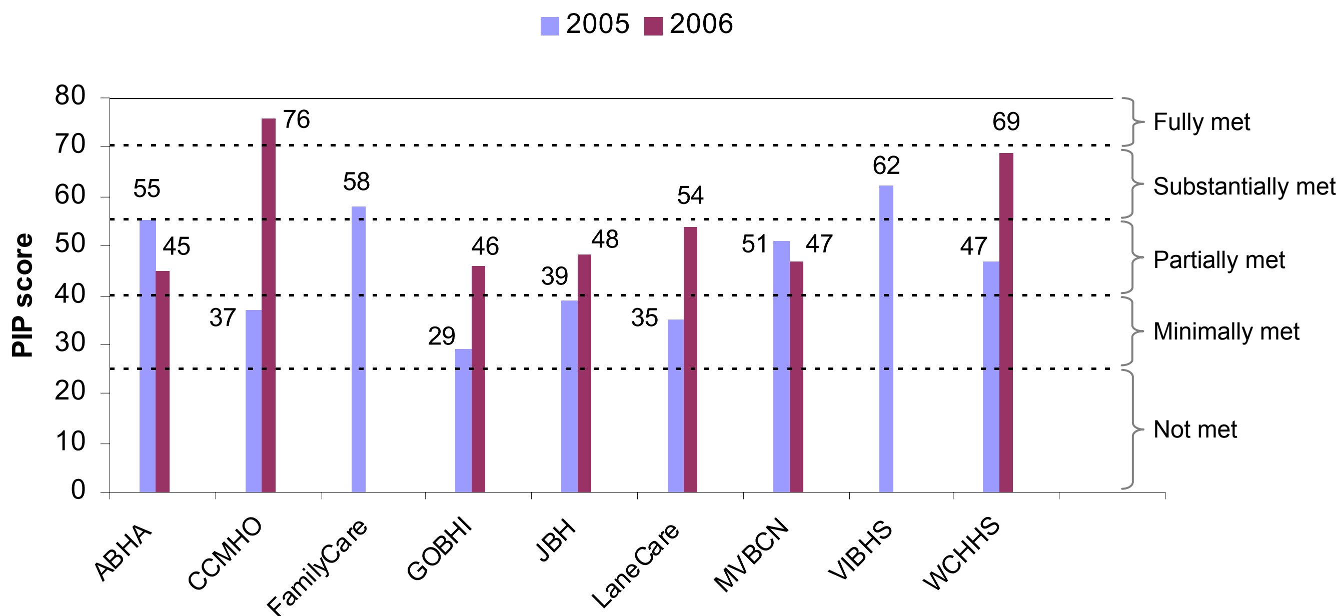

Figure 1. Overall scores for clinical PIPs scored on the 80-point scale.

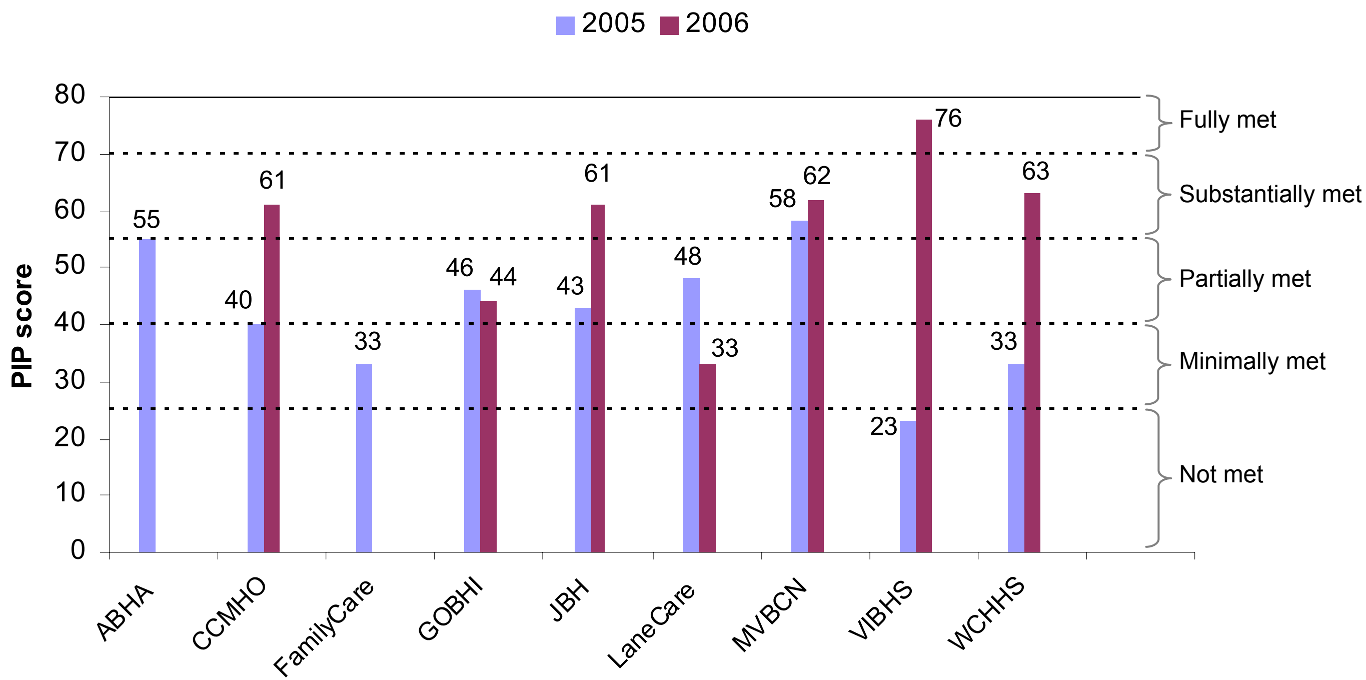

Figure 2. Overall scores for nonclinical PIPs scored on the 80-point scale.

Figure 3 shows scores on the four PIPs rated on the 100-point scale in 2006. These studies had progressed to at least one remeasurement and reported evidence of sustained improvement in the study indicators. Both of FamilyCare's PIPs fully met the CMS standards, as did VIBHS's clinical PIP, while ABHA's nonclinical PIP partially met the standards.

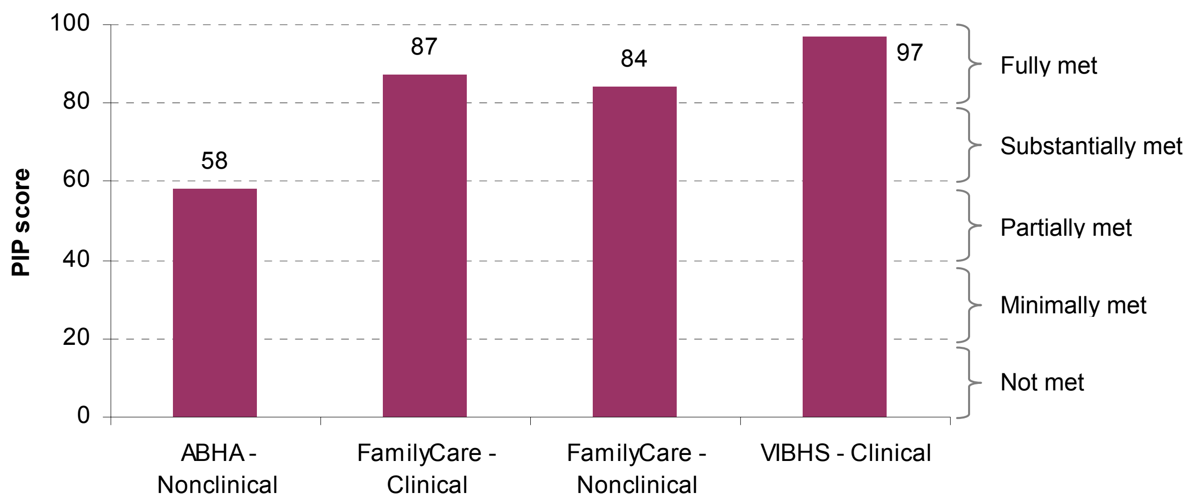

Figure 3. Overall scores for PIPs scored on the 100-point scale.

Figure 4 shows the scores by individual *validation standard* for the clinical PIPs reviewed in 2005 and 2006 (excluding Standards 9 and 10), averaged across the nine MHOs. Figure 5 shows the equivalent data for the nonclinical PIPs. (Table A-1 in Appendix A arrays the 2006 scores on all validation standards by MHO for both clinical and nonclinical PIPs.)

Compared to the 2005 scores, the average scores in 2006 were higher almost across the board. As a group, the MHOs substantially met the requirements reflected in Standards 1–6. The MHOs improved their documentation of the PIP plan and process, and in particular, they did a better job of defining their study indicators, population, data collection and analysis plans, and intervention goals and strategies. The most notable improvement was evident in Standard 5, which requires the MHO to demonstrate a sound plan for statistical analysis and a collection process that ensures valid and reliable data.

As a group, the MHOs progressed further in measuring and analyzing the results of their PIP interventions, and thus improved their scores on Standards 7 and 8. On average, however, the scores on those two standards still reflect only minimal compliance with the federal requirements.

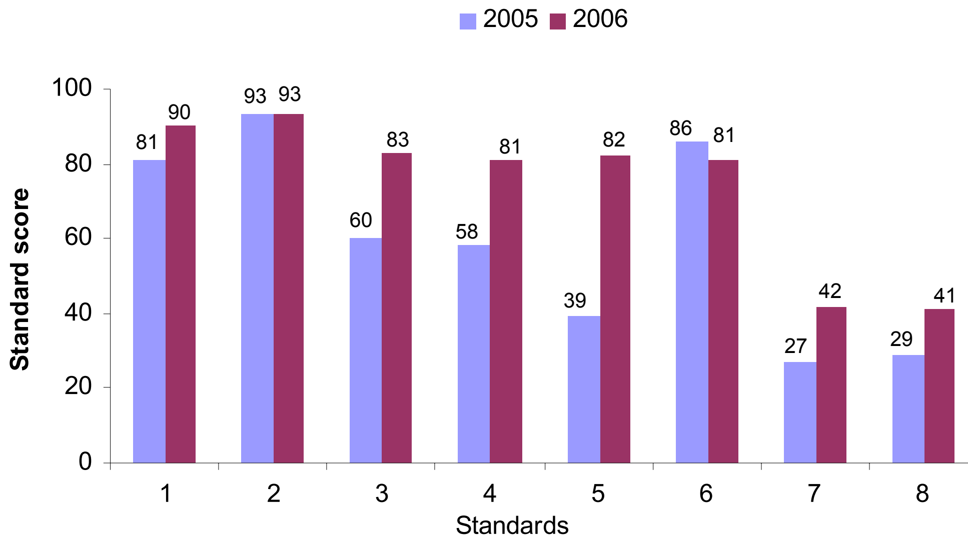

Figure 4. Average scores on clinical PIP validation standards across MHOs.

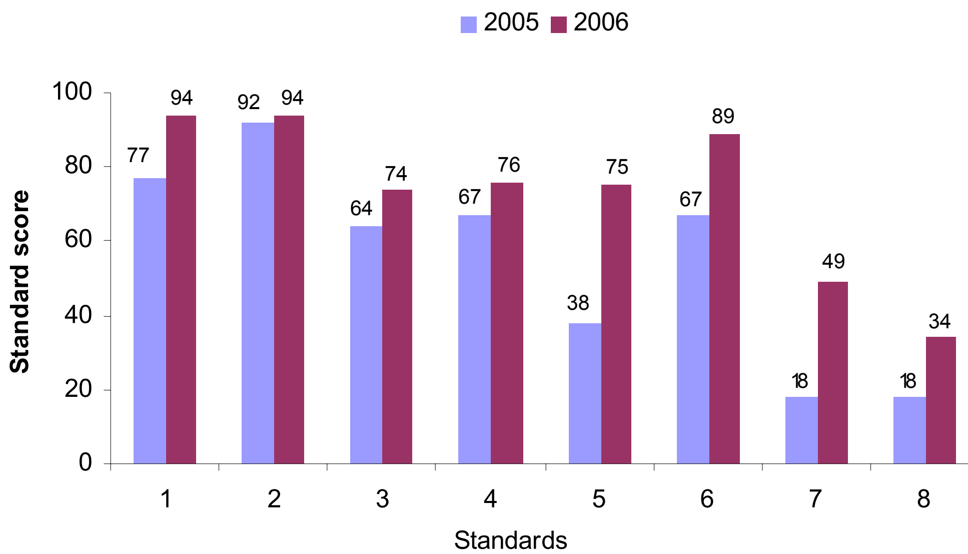

Figure 5. Average scores on nonclinical PIP validation standards across MHOs.

AMH Managed Care Quality Strategy Review

Under the federal Balanced Budget Act (BBA) regulations, a state that contracts with managed care organizations (MCOs) to provide Medicaid services must have a written strategy for quality assurance and performance improvement (QAPI). The state must review the quality strategy periodically to evaluate its effectiveness and must update the strategy as needed. Also, the state must ensure that MCOs comply with QAPI standards established in accordance with the managed care regulations (42 CFR §438, Subpart D). At a minimum, the strategy must contain

- the MCO contract provisions that incorporate the standards specified in Subpart D;
- procedures that
    - assess the quality and appropriateness of care and services furnished to Medicaid enrollees and to people with special healthcare needs
    - identify the race, ethnicity, and primary language spoken of each Medicaid enrollee
    - regularly monitor and evaluate MCO compliance with the standards
- for MCOs, any national performance measures and levels that may be identified and developed by CMS
- arrangements for annual external reviews of the quality outcomes and the timeliness of and access to services covered under each MCO contract
- appropriate use of intermediate sanctions to be imposed on MCOs that violate legal or contractual provisions
- an information system that supports operation and review of the quality strategy
- standards at least as stringent as the federal standards for access to care, MCO structure and operations, and quality measurement and improvement

Acumentra Health reviewed AMH's Medicaid Managed Mental Health Care Quality Assessment and Improvement Strategy for compliance with the federal standards that address state QAPI responsibilities, enrollee access, managed care structure and operation, measurement and improvement, and EQR. For each section of the regulations, Acumentra Health determined whether the quality strategy met, partially met, or did not meet the relevant standards. Acumentra Health then recommended improvements for AMH's next revision of the strategy, which has been drafted for review and is scheduled for completion in August 2007.

Review results

AMH's quality strategy successfully addresses some elements of the state's duties in ensuring quality and appropriateness of behavioral health care, enrollee access, and services for enrollees with special healthcare needs. However, the strategy needs to provide more concrete details about what MHOs are expected to do and how AMH will oversee the MHOs to hold them accountable. A more detailed framework would make it easier for the MHOs to apply the strategy effectively to their business practices and to align them with AMH's goals for the delivery of services to OHP enrollees.

The current draft of the quality strategy is vague in many areas. For example, some sections simply refer to AMH's MHO contract without citing specific provisions that relate to the federal standards. As a result, the strategy does not fully address the majority of the Medicaid managed care regulations.

Table 5 presents summary results of the quality strategy review by section. Full details appear in the separate report of the quality strategy review.[4]

Recommendations

AMH needs to revise its quality strategy to address a large number of standards upon which the strategy is now silent. In addition, Acumentra Health offers the following recommendations for structural changes that would enable AMH to move beyond the compliance environment to a more proactive strategy.

Goals

AMH may wish to evaluate its goals to determine how they apply in the new BBA environment and whether they align with the overall strategic plan of DHS. Ideally, AMH would incorporate its goals throughout the quality strategy and would consider those goals in prioritizing decisions that affect oversight of the managed care program.

Structure of the quality strategy

AMH should organize the strategy document in a manner that makes it easy to understand the specific roles of AMH and the MHOs. For example, instead of simply stating that the MHO contract incorporates federal standards, the strategy should list the standards and then describe the oversight design for each standard in terms of the separate duties of the MHO and the EQRO. The 2005 EQR Annual Report found that MHOs were deficient in compliance in many areas.

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[4] Acumentra Health. OMHAS [AMH] 2005 Quality Strategy Review. May 2006.

Table 5. Summary results of AMH managed care quality strategy review.

Standards and citation	Compliance status	Comments
State responsibilities 42 CFR §438.202, 438.204	Partially met	AMH has complied with regulations related to its responsibilities in developing and reviewing the quality strategy. However, the strategy omits some required elements of state quality strategies and only partially addresses others.
Enrollee access 42 CFR §438.206–438.210	Not met	The strategy does not address most elements of these standards and only partially addresses others. In particular, it omits language about ensuring coordination and continuity of care for all enrollees and about ensuring coverage and authorization of services.
Structure and operations 42 CFR §438.214, 438.218, 438.224–438.230	Not met	The strategy does not address most of these standards and only partially addresses others. It does not refer to federal requirements related to enrollee confidentiality, enrollment and disenrollment, grievance systems, and subcontractual relationships and delegation. The 2005 EQR Annual Report identified the latter area as a particular problem, as most MHOs lacked policies for monitoring and managing the activities delegated to contractors and subcontractors.
Measurement and improvement 42 CFR §438.236, 438.240, 438.242	Partially met	The strategy refers to QAPI programs that form part of the MHOs' QI work plans. However, it does not fully address the requirement for MHOs to develop and use practice guidelines. References to performance measurement and to MHOs' PIPs do not identify these as key components of QAPI programs. The strategy touches on basic elements of health information systems but not on requirements for MHOs to collect encounter data from providers, verify the data, and report to AMH.
External quality review 42 CFR §438.358	Substantially met	The strategy addresses requirements related to contracting with an independent EQRO and conducting the annual EQR, and it covers the mandatory and optional EQR activities. However, it omits mention of a provision that allows the EQRO to provide technical assistance to groups of MHOs in conducting EQR-related activities.

For guidance on improving the structure of the quality strategy, AMH may wish to refer to the CMS EQR protocols and to other states' quality strategies. For example, Minnesota's quality strategy[5] defines the duties, oversight, and evaluation related to each federal standard in a helpful manner. Such a structure would identify specific expectations for AMH and the MHOs and would make it convenient for AMH to revise the fundamental elements of its oversight activities.

Best practices

The BBA regulations give state Medicaid agencies flexibility in adopting federal managed care standards. The state must establish specific and clearly stated expectations for the MHOs to attain the standards; in turn, the MHOs must meet the requirements of documentation and other compliance activities.

AMH may wish to consider incorporating examples of best practices into the quality strategy. These examples could be obtained from site reviews with the MHOs, information from MHO contractor or QI coordinator meetings, or a review of practices in other states. However, providing that type of information in significant detail would demand additional resources.

Moving beyond compliance

The relatively new environment surrounding the application of BBA regulations challenges state Medicaid agencies and health plans to comply with the standards without losing sight of what they are intended to accomplish. AMH and the MHOs are still in the process of implementing many of the BBA requirements.

An integrated, comprehensive, and transparent system of managed care can help AMH achieve its goal of improving access to behavioral health care and the quality and timeliness of care for OHP enrollees. AMH can facilitate the transition to such a system by clearly defining expectations for the MHOs.

To that end, AMH may wish to consider forming a quality improvement committee within the agency that would be responsible for overseeing MHO responsibilities. Committee members would approve the annual work plan and the scope of work for the contract year.

[5] Minnesota Department of Human Services. Quality Strategy, June 2003. Available online at: www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs_id_009237.pdf. Accessed November 28, 2006.

Performance Measure Validation

AMH has developed statewide performance measures for MHOs and calculates them using data collected from the MHOs by the Division of Medical Assistance Programs (DMAP). AMH reports the findings in the *MHO Utilization Quarterly Report*. The four statewide performance measures are:

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

Acumentra Health's validation review 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 information technology (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 AMH and the MHOs use the *MHO Utilization Quarterly Report* to monitor their performance over time and to compare their performance with that of other health plans in Oregon and in other states?

As part of the 2005 EQR, Acumentra Health (then known as OMPRO) assessed and reported on the performance measure process and on the information systems in place from July 2002 through June 2003.[6] That report identified numerous opportunities for improvement and outlined recommendations to address them. Acumentra Health conducted an annual review of the performance measure process as part of the 2006 EQR. Complete details of the review appear in a March 2006 EQR report to AMH.[7]

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[6] OMPRO. OMHAS [AMH] Performance Measure Validation. December 2005.
[7] Acumentra Health. OMHAS [AMH] Performance Measure Validation 2006. March 2006.

Validation procedures

Steps in the validation process, adapted from the CMS protocols, were:

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

The compliance ratings, adapted from the CMS protocol for this activity,[8] were:

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

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

Partially compliant—Measure either was complete as reported or was accurate, but not both, and had deficiencies in calculation that could hamper the reader's ability to understand the reported rates.

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

Review results

Performance measure completeness and accuracy

Acumentra Health assessed the four performance measures to determine whether the claims or encounter data used to calculate each measure were complete and accurate and whether the calculation adhered to CMS specifications for all components (e.g., member ID, clinical codes, member-months calculation, and specified time parameters).

[8] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Validating Performance Measures*. Final Protocol, Version 1.0. May 1, 2002.

The 2005 EQR assessment found that all four performance measures *partially* complied with the CMS protocol. The most notable deficiencies were the ambiguity of the measure definitions and the inadequate documentation of the process used to generate the measures, which made it difficult or impossible to reproduce the measures reported in the utilization report. Acumentra Health recommended changes to help facilitate analysis of the measures and to improve user confidence in data accuracy.

2006 review results: AMH has improved some aspects of the definition, documentation, and analysis of performance measures. However, the *MHO Utilization Quarterly Report* still provides insufficient information for readers to understand how the performance measures are defined and calculated. Also, the utilization report does not identify certain limitations of the data reported. The needed improvements primarily relate to how the report explains the calculation of the performance measure data.

- AMH has revised the *calculation of member months* to make the measures more consistent with those used by other health plans and other states. Previously, the calculation for each quarter was based on the total monthly enrollment for each MHO, summed and divided by three to produce a monthly average for the quarter.
- AMH provided more thorough *internal documentation of the analytical process* used to generate the performance measures. The document titled "MHO Utilization Process for Medicaid Clients Only" describes how enrollment data are pulled and how the measures are calculated. However, the documentation was inconsistent regarding the formulas for calculating certain measures.
- The utilization report needs to provide a more thorough *explanation of the numerators and denominators and of the limitations of the reported data*. The report lists diagnostic and procedure codes but does not specify which codes are used in calculating each measure.

Between the 2005 and 2006 reviews, DMAP instituted checks and balances (including weekly balancing reports) to ensure that encounter data files received from MHOs contained data in all required fields. However, the 2006 review found that AMH reviewed the data received from DMAP only to check for gross variations in the number of encounters submitted. Acumentra Health recommended that AMH establish criteria for determining when to follow up with an MHO to resolve problems with data submission.

Table 6 summarizes the performance measure validation ratings in 2005 and 2006.

Table 6. Performance measure validation ratings, 2005 and 2006.

		Compliance status	
Performance measure	**Definition**	**2005**	**2006**
Acute hospital admissions/1,000	Number of admissions in time period/ (enrollees for time period/1000)	Partially compliant	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	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	Partially compliant
Percent of eligibles seen—7 days of discharge from acute care	Number of eligibles seen in outpatient setting within 7 days of discharge from acute care for the time period/ total discharges for the time period	Partially compliant	Partially compliant

Strengths

- AMH provided more thorough in-house documentation of the analytical process for producing the *MHO Utilization Quarterly Report*.
- AMH has developed specifications for calculating the performance measures, which were not available at the time of the 2005 review.
- AMH has changed the calculation of member months to make the measures more consistent with industry standards and has highlighted this change in the report's executive summary.
- The executive summary notes that the hospital data reflect a 180-day lag in encounter data submissions.
- DMAP has instituted checks and balances for ensuring the completeness of encounter data it receives from the MHOs. A weekly balancing report enables DMAP to reconcile data sent with data received. In addition, DMAP continues to use a system of edits and audits to verify the accuracy of the submitted data.

Opportunities for improvement

- The *MHO Utilization Quarterly Report* omits definitions of the numerator, denominator, and calculation formula for each measure.
- The report does not define the population to which the measures apply.
- The report does not explain that the data include dual enrollees of Medicare and Medicaid, creating the potential for underreporting since encounters for dual enrollees may not be reported to the MHO in a timely manner—or at all—if the primary payer is contacted first for payment.
- The report does not specify that
  - the data in each new report are not comparable to data in previous reports
  - counting each encounter as separate admission for the performance measure calculation—regardless of when the admission occurred or if it occurred because a member transferred from one facility to another—creates the potential for overcounting
  - the rehospitalization and follow-up measures include all members who were enrolled at the time of their hospital stay, even though some could die or be disenrolled during the measurement time frame
- AMH's internal documentation for the process of calculating certain performance measures is inconsistent with the actual formulas used to generate data for the *MHO Utilization Quarterly Report*.
- AMH lacks sufficient in-house documentation of the performance measure production process, including the flow of data used in calculating the measures and the steps for ensuring accuracy and completeness.
- AMH has no process in place to perform mental health-specific edits and audits of encounter data—for example, to ensure that diagnostic codes are assigned to appropriate age groups.

Recommendations

- The *MHO Utilization Quarterly Report* needs to present a thorough explanation of the performance measure definitions and calculations to help readers assess the reported data. In particular, the report needs to specify
  - in the executive summary, that the study population includes all Medicaid-eligible people, ages 0–65
  - the numerator, denominator, inclusions, calculation formula, and data sources for each performance measure
  - that each encounter is counted as a separate admission for the performance measure calculation, regardless of when the admission occurred or if it occurred because a member transferred from one facility to another

- AMH needs to correct the portions of its internal documentation related to calculating certain performance measures to make the documentation consistent with the actual formulas used.
- AMH needs to document the entire process for producing performance measures, including steps for importing data, building tables, creating reports, and archiving data; the data sources; editing and validation routines; the data dictionary; and the person or position responsible (including team or unit) for each part of the process.
- AMH needs to establish criteria for determining when to follow up with an MHO to resolve problems with submission of data.
- AMH needs to develop a process to ensure that the encounter data submitted by MHOs are complete. If data are found to be incomplete, AMH needs to work with the MHOs to ensure completeness.

Table 7 summarizes the status of the 2005 EQR recommendations for improving the accuracy and completeness of statewide performance measures.

State information systems

Acumentra Health also assessed the State's response to recommendations arising from the 2005 Information Systems Capabilities Assessment (ISCA). A key finding of the ISCA was that data transfers between DMAP's Medicaid Management Information System (MMIS) and AMH's Sybase™ system were not encrypted. This raised concerns about the protection of enrollee information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, the use of a dial-up connection to a bulletin board system (BBS) for receiving encounter and claims data from MHOs and from third-party billers raised concerns about data security in the event of system failure.

2006 review results: AMH has replaced Sybase with the Decision Support Surveillance and Utilization Review System (DSSURS), a database warehouse located with an offsite vendor. DSSURS provides a more robust platform for improved data quality, analysis, and reporting, and it should enable the State to process HIPAA-compliant transactions. As recommended in 2005, DMAP has moved from the unsecured BBS to an encrypted system of electronic mailboxes to provide secure transfer of encounter and claims data. Data management should improve further when the transition to the new MMIS II is complete.

Table 7. Status of 2005 recommendations for improving statewide performance measures.

Opportunity for improvement	2005 recommendation	2006 status
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.	The *MHO Utilization Quarterly Report* does not define numerators and denominators or explain the calculation of the measures. The report lists diagnostic and procedure codes but does not specify which codes are used in calculating each measure.
Because inclusion in the measures depends on the MHO of record at the time service is provided, one MHO's treatment can result in 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.	AMH has revised the calculation of member months to make the performance measures more consistent with those used by other health plans and other states. The revised calculation is based on the full count of unique enrollees for each quarter.
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. The potential underreporting could affect all the measures.	Analyze dually enrolled MHO members separately or remove them from the total population.	Data in the report still include dually enrolled members. AMH has agreed to note this in future reports.
The two measures of hospital readmissions and the measure of outpatient care following discharge from acute care could count individuals in the denominator who are not eligible for the numerator—for example, enrollees 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.	Enrollment data still may include deceased or disenrolled members. OMHAS has agreed to note this in future reports.

Table 7. Status of 2005 recommendations for improving statewide performance measures (cont.).

Opportunity for improvement	2005 recommendation	2006 status
The performance measure production process lacks sufficient documentation and relies heavily on the expertise of the individual who generates the report for each performance measure.	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; data dictionary; and the person or position responsible (including team or unit) for each part of the process. Provide cross-training to other team members.	AMH has documented its in-house analytic plan, but the documentation is inconsistent with the actual calculation of certain performance measures. Also, AMH needs to develop written procedures describing the entire process of performance measure production.
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.	AMH does not retain the raw data because of the problem of storing large files. Currently, AMH has no plans to create a performance measure repository. AMH has agreed to specify in the executive summary of the *MHO Utilization Quarterly Report* that the reported data are not comparable from one quarter to the next.
Internal documentation does not specify which versions of programs are used to calculate the performance measure results.	Incorporate a standard process for version control of programs used for generating reports and analysis plan. This would ensure that the correct version of a program is in use and would enable AMH to revert quickly to a previous version.	AMH has documented its process for pulling data and which programs are used to analyze the data, but the documentation does not specify which versions of the programs are used.

Table 7. Status of 2005 recommendations for improving statewide performance measures (cont.).

Opportunity for improvement	2005 recommendation	2006 status
The system allows DMAP 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.	DMAP sends email messages to all data users regarding field changes or other changes and errors.
Variations in encounter and claims data content are not documented in sufficient detail for the AMH 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.	A HIPAA-compliant system is in place for submitting encounter data, but AMH has not established standards regarding the number of diagnoses accepted or required in encounter submissions from MHOs.

Conclusions and Recommendations

The 2006 EQR results reflect the continuing transition to a new regulatory environment for AMH and for the MHOs that serve OHP enrollees. With the goal of facilitating continuous improvement, Acumentra Health offers the following recommendations, building on those from the 2005 EQR.

For AMH:

- Continue to support the joint PIP with MHOs to increase coordination of mental health services with the services provided by medical managed care organizations and other entities.
- Continue to strengthen the *MHO Utilization Quarterly Report* presentation and report production process by implementing the recommendations from the performance measure validation review.
- Revise the managed care quality strategy to
  - address the many standards upon which the strategy is now silent
  - make it easier to understand the specific roles of AMH and the MHOs—for example, by listing the federal standards and describing the oversight design for each standard
  - incorporate the results of the 2006 EQR activities
  - incorporate best practices obtained from site reviews, MHO contractor or QI coordinator meetings, or a review of practices in other states
- Consider forming a quality improvement committee within AMH that would oversee MHO responsibilities and approve the annual work plan and the scope of work for the contract year.
- Continue to clarify language in the managed care contract and provide other guidance for MHOs to support their compliance with regulatory standards—for example, by defining special healthcare needs so that the MHOs can identify those enrollees and develop treatment plans for them.
- Continue to work with MHOs to ensure the development of data systems that can capture and transmit high-quality encounter and claims data.

For MHOs:

- With regard to PIPs, devote the necessary resources to
  - conduct ongoing remeasurement of study indicators
  - perform the appropriate statistical tests to assess the degree of sustained improvement due to the PIP interventions
  - identify barriers to improvement and modify interventions accordingly

Appendix A. MHO Scores on PIP Validation Reviews

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

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

During 2006, FamilyCare continued the two PIPs initiated in 2005. ABHA continued one of its 2005 PIPs, as did VIBHS. All other MHOs began new PIPs in 2006 and thus were rated only on their performance on Standards 1–8.

Table A-1 on the following page arrays the 2006 scores on all validation standards by MHO, for both clinical and nonclinical PIPs.

Table A-1. MHO PIP scores by validation standard, 2006.

	ABHA	CCMHO	Family Care	GOBHI	JBH	Lane Care	MVBCN	VIBHS	WCHHS
Clinical PIP									
Overall score	**45***	**76***	**87****	**46***	**48***	**54***	**47***	**97****	**69***
Standard 1	100	100	88	65	88	100	100	100	70
Standard 2	65	100	75	100	100	100	100	100	100
Standard 3	88	80	95	75	90	85	70	100	65
Standard 4	88	100	75	100	60	85	40	95	90
Standard 5	84	93	55	90	92	78	68	100	80
Standard 6	45	100	100	50	50	100	100	80	100
Standard 7	0	81	83	0	20	0	5	100	88
Standard 8	0	70	88	0	8	0	0	100	100
Standard 9	—	—	100	—	—	—	—	100	—
Standard 10	—	—	100	—	—	—	—	100	—
Nonclinical PIP									
Overall score	**58****	**61***	**84****	**44***	**61***	**33***	**62***	**76***	**63***
Standard 1	100	100	100	100	98	75	100	98	75
Standard 2	100	75	75	100	100	100	100	100	100
Standard 3	40	85	85	78	95	25	100	95	63
Standard 4	65	85	80	83	88	30	100	100	50
Standard 5	69	85	73	63	90	55	84	100	56
Standard 6	70	100	100	50	100	80	100	100	100
Standard 7	44	63	80	0	30	0	38	93	90
Standard 8	43	17	70	0	8	0	0	71	100
Standard 9	50	—	100	—	—	—	—	—	—
Standard 10	50	—	70	—	—	—	—	—	—

*80-point rating scale:

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

**100-point rating scale:

80–100 = Fully met
60–79 = Substantially met
40–59 = Partially met
20–39 = Minimally met
0–19 = Not met