STATE OF WEST VIRGINIA

FULL PERFORMANCE EVALUATION OF THE

Department of Health and Human Resources
Office of Behavioral Health Services

The Largest Single Source of Funding for Behavioral Health Providers, Medicaid Fee-for-Service Reimbursements, has Fallen Drastically in Recent Years While General Revenue Appropriations have Increased

The Office of Behavioral Health Services Lacks Adequate Measures of Behavioral Health Program Outcomes

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July 2000

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July 9, 2000

The Honorable Edwin J. Bowman
State Senate
129 West Circle Drive
Weirton, West Virginia 26062

The Honorable Vicki V. Douglas
House of Delegates
Building 1, Room E-213
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0470

Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a Full Performance Evaluation of the *Department of Health and Human Resources - Office of Behavioral Health Services*, which will be presented to the Joint Committee on Government Operations on Sunday, July 9, 2000. The issues covered herein are *"The Largest Single Source of Funding for Behavioral Health Providers, Medicaid Fee-for-Service Reimbursements, has Fallen Drastically in Recent Years While General Revenue Appropriations have Increased; and The Office of Behavioral Health Services Lacks Adequate Measures of Behavioral Health Program Outcomes."*

We conducted an exit conference with the *DHHR* on June 27, 2000. We received the agency response on July 3, 2000.

Let me know if you have any questions.

Sincerely,

John Sylvia
Acting Director

JS/wsc

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In the early 1990's West Virginia redirected State funding for behavioral health services from direct allocations to matching funds for federal Medicaid expenditures. A provider tax was also enacted, to provide for increased State matching funds for Medicaid. Programs such as child care and elderly services were reorganized to become licensed behavioral health programs eligible for Medicaid reimbursement. These factors encouraged Behavioral Health Centers (BACs) to substantially expand Medicaid billings. As a result of the State's aggressive encouragement of Medicaid billing, behavioral health's billing of Medicaid grew quickly until Medicaid accounted for nearly 80 percent of the funding for West Virginia's publically funded behavioral health services. The State's Behavioral Health Centers expanded rapidly, primarily through the enhanced level of Medicaid funding. The administrative systems at both the State and provider levels did not keep pace with this expansion, leaving the behavioral health system vulnerable to Medicaid auditing problems, especially in the area of determination of medical necessity and client documentation.

In June 1998, a representative of federal Health Care Financing Authority (HCFA) reviewed Medicaid claims records drawn from six behavioral health providers. The review involved the examination of claims documentation to determine whether the services were eligible for Federal Financial Participation (FFP) under Medicaid. The review included examinations of diagnoses, treatment plans, individual client notes describing the services provided and interviews with State officials.

The review found that the Department of Health and Human Resources (DHHR) does not effectively monitor claims for rehabilitative services. HCFA recommended that the State develop and implement an effective system to monitor claims for rehabilitative services to ensure that Medicaid claims are allowable and that services are provided economically and efficiently. The review also recommended that the State should conduct comprehensive audits of behavioral health centers' claims for rehabilitative services, identify any unallowable amounts claimed under Title XIX and return FFP for any unallowable claims. HCFA's final recommendation was that the State should establish policies and procedures that ensure future claims for rehabilitative services are in accordance with Federal regulations and are consistent with the economical and efficient administration of the Medicaid program.

In response to HCFA's recommendations, the DHHR agreed to have the Surveillance and Utilization Review (SUR) Unit conduct reviews on the six entities previously reviewed by the HCFA. Further SUR Unit reviews of other providers were to follow as the HCFA expressed the opinion that all of the State's behavioral health providers should be examined. The DHHR also made changes to the Rehabilitation Services Manual in 1998, following the HCFA review.

These revisions included service limits, clarification of services covered, the addition of utilization standards, changes in service definitions and the addition of language to prevent duplicate billings for a single service.

An earlier management initiative taken by the DHHR was the implementation of the New Directions Program in 1996, as a move towards gathering data for increased utilization management. New Directions was also designed to provide assessment information to aid in the development of treatment and service plans.

An examination of Medicaid reimbursements made to behavioral health providers from Fiscal Years 1997-1999 illustrates the development of certain trends. Overall, reimbursements have fallen from $121,583,479.29 in FY 1997 to $87,477,032.91 in FY 1999. This represents a 28% reduction in Medicaid reimbursements. At the same time, the number of providers who receive large amounts of Medicaid funds has fallen. Forty-two providers received at least $500,000 in FY 1997. Only 32 providers received at least $500,000 in FY 1998. By FY 1999, only 28 providers received such large reimbursements. The general trend towards lower levels of Medicaid reimbursements has coincided with an increase in State General Revenue appropriations. It can be concluded that as Medicaid fee-for-service funding has been reduced in recent years, the State has been forced to replace the resulting shortfalls in funding for behavioral health providers.

The changes in behavioral health funding indicate that while Medicaid fee-for-service reimbursements have generally fallen in recent years, this is not the case with the Mentally Retarded and Developmentally Disabled Waiver Program (MR/DD). This program's funding has increased during the three fiscal years examined, from $46.2 million in FY 1997 to $72 million in FY 1999. Funding for Intermediate Care Facilities for Individuals with Mental Retardation and/or Related Conditions (ICF/MR) has decreased gradually over the three-year period, from the FY 1997 high of $51.3 million to the low of $46.9 million in FY 1999.

Recommendation 1:

The DHHR should consider the impact that changing patterns in Medicaid funding has had on individual behavioral health providers when allocating General Revenue and grant-related funds.

Recommendation 2:

The DHHR should continue monitoring Medicaid reimbursement procedures followed by behavioral health providers in order to assure compliance with Federal guidelines and thereby reduce the risk of future deferrals.

Issue Area 2: The DHHR lacks a means to evaluate behavioral health program performance, though recent improvements have been made

The DHHR currently does not possess sufficient data to assess behavioral health program outcomes. A system of outcome measures would enable the Department to assess the impact of

program activities upon the communities they serve, especially with respect to program goals and objectives. The data presently collected by the Department is focused on the demographic characteristics, care utilization and short-term assessment instruments of the clients served by community mental health centers and other providers. The significance of this lack of performance measures lies in the importance of services to individuals and family members struggling with mental health, mental retardation/developmental disability and substance abuse issues, as well as the size of the agency's annual budget for behavioral health.

The DHHR has taken some initiative in this area in recent years during its transition to managed care and the development of new demographic data and some indicators. The responsibility for data collection has fallen primarily on providers, who have had to adjust to increasing data reporting requirements for both Federal and State programs. Certain data must be collected in order to comply with data reporting requirements for Federal grants, as will be explained later. Furthermore, the need to provide increasingly detailed records for Medicaid documentation has been particularly demanding on the time and resources of providers. State programs, such as the New Directions Program, have introduced yet more data reporting requirements.

A range of demographic statistics is maintained by the Department from data submitted by providers. Much of this data, which is collected as part of the New Directions initiative, is gathered from customers at intake to a behavioral health facility, at least every 180 days while in care, and at discharge. Except for care satisfaction survey data, no data is routinely collected on clients after they leave a facility.

Possibly the greatest single impediment to creating an effective system of client outcomes measures has been the DHHR's lack of means to identify individual clients. Without a unique client identifier, the progress made by individuals treated by behavioral health providers cannot be systematically tracked with respect to outcomes measures such as employment status or housing. Another resulting problem is that demographic data that is currently collected counts some clients multiple times due to the fact that they may have multiple diagnoses and cannot be identified as individuals. If the Department could track program outcomes by ***individual client***, it would enable the study of other demographic attributes such as county of residence, sex and diagnosis as they relate to client outcomes.

The Office of Behavioral Health Services (OBHS) is required to collect performance measures for programs funded by the Federal Community-Based Mental Health Services Block Grant. The Division of Mental Health and Community Rehabilitation Services, which lies organizationally under the authority of the OBHS, collects and analyzes data on State behavioral health hospitalization utilization. Data collected include admissions by service area, recidivism rates, and length of stay in the community between hospital admissions. ***The OBHS has, therefore, shown that it can and does collect program outcomes data in the case of individual programs. It does not, however, do so on a systematic basis for all clients who receive behavioral health services.***

Some behavioral health providers have begun to collect program outcomes measures on their own in the absence of directives to do so from the OBHS. ***The Department should consider***

reviewing data presently collected by individual behavioral health providers in order to establish standardized outcome measurements. These could be incorporated into the data collected for the New Directions Program. Consulting with BHCs would enable providers to contribute to the process of developing new outcomes measures while designing performance measures that will be useful for BHCs as well as the Department.

Recommendation 3:

The OBHS should modify its data collection systems to include a client identifier.

Recommendation 4:

The OBHS should direct the West Virginia Department of Health and Human Resources Advisory Council to participate in the development of a standardized system of program outcome measurements to be used by all providers.

Objective, Scope and Methodology

This full performance evaluation of the West Virginia Department of Health and Human Resources was conducted in accordance with the West Virginia Sunset Law, Chapter 4, Article 10 of the West Virginia Code. A full performance evaluation is a means to determine whether or not an agency is operating in an efficient and effective manner and to determine whether or not there is a demonstrable need for the continuation of the agency. The evaluation will help the Joint Committee on Government Operations determine the following:

- if the agency was created to resolve a problem or provide a service;
- if the problem has been solved or the service has been provided;
- the extent to which past agency activities and accomplishments, current projects and operations and planned activities and goals are or have been effective;
- if the agency is operating efficiently and effectively in performing its tasks;
- the extent to which there would be significant and discernable adverse effects on the public health, safety or welfare if the agency were abolished;
- if the conditions that led to the creation of the agency have changed;
- the extent to which the agency operates in the public interest;
- whether or not the operation of the agency is impeded or enhanced by existing statutes, rules, procedures, practices or any other circumstances bearing upon the agency's capacity or authority to operate in the public interest, including budgetary, resource and personnel matters;
- the extent to which administrative and/or statutory changes are necessary to improve agency operations or to enhance the public interest;
- whether or not the benefits derived from the activities of the agency outweigh the costs;
- whether or not the activities of the agency duplicate or overlap with those of other agencies, and if so, how the activities could be consolidated;
- whether or not the agency causes an unnecessary burden on any citizen by its decisions and activities; and,
- what the impact will be in terms of federal intervention or loss of federal funds if the agency is abolished.

The reported inquiry relates to the statutory compliance and efficiency issues of the Bureau for Behavioral Health and Health Facilities Office of Behavioral Health Services. This report covers the period of Fiscal Year 1997 to Fiscal Year 1999. This report is part of the ongoing full performance evaluation of the West Virginia Department of Health and Human Resources.

This evaluation includes a planning process and the development of audit steps necessary to collect competent, sufficient and relevant evidence to answer the audit objectives. Physical, documentary, testimonial and analytical evidence used in the evaluation was collected through interviews, review of agency records, outside research and site visitations. The evaluation was conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS) issued by the Comptroller General of the United States.

Mission of the Office of Behavioral Health and Health Facilities
To ensure that positive meaningful opportunities are available for persons with mental illness, chemical dependency, developmental disabilities and those at-risk. To provide support for families, providers and communities in assisting persons to achieve their potential and to gain greater control over the direction of their future.

The objective of this review is to examine trends in funding for behavioral health services in West Virginia and to make recommendations regarding the DHHR's response to changing funding patterns. This review also evaluates the program outcomes performance measurements maintained by the OBHS and the OBHS's need for improvements in data collection. The scope of this review focuses in particular on the effects that changing patterns of Federal Medicaid funding have had on the behavioral health system. The data needs of the OBHS, behavioral health providers, clients served and for Federal reporting purposes are another focus of this report.

The agency reviewed is the Department of Health and Human Resources Bureau for Behavioral Health and Health Facilities. The emphasis of this report is on the Office of Behavioral Health Services, which lies organizationally under the authority of the Bureau. The methodology included analysis of data drawn from a number of sources, including budget documents, Medicaid funding data, DHHR policies and procedures manuals, DHHR client services data and Federal grants monitoring reports.

Background

There are five bureaus within the West Virginia Department of Health and Human Resources (DHHR). Those bureaus are: Public Health, Children and Families, Behavioral Health and Health Facilities, Child Support Enforcement and Medical Services. Each bureau is administered by a commissioner who reports directly to the Deputy Secretary and Secretary. Since the Bureau for Medical Services (BMS) is the single state agency that administers the Medicaid Program and the Bureaus for Public Health, Children and Families and Behavioral Health and Health Facilities serve behavioral health consumers covered by Medicaid, it is essential that these agencies work closely together and have good communication and close coordination.

The Office of Behavioral Health Services

The focus of this report is on the Office of Behavioral Health Services (OBHS) which lies organizationally under the authority of the Commissioner of the Bureau for Behavioral Health and Health Facilities. This report covers the period from Fiscal Year 1997 to Fiscal Year 1999. The OBHS is responsible for the development, coordination and monitoring of departmental policy for all behavioral health services in the state. It sets directions for clinical practice, evaluates the efficiency of services, ensures service quality, helps defray cost of indigent care and develops methods to ensure that other department funds are targeted to those most in need of services and used in the most cost-effective manner. The OBHS administers state and federal funds for the operation of community-based services. Services are provided in the home, the community, hospitals, residential facilities and long-term care facilities operated by the state or by contract agencies. The OBHS also contracts with the Bureau for Medical Services to manage the MR/DD Waiver Program.

Community Mental Health Centers

In West Virginia, there are 18 designated non profit, comprehensive community behavioral health centers (CBHC), each with its own catchment area. This includes four centers that serve only persons with mental retardation and/or developmental disabilities. The term CBHC is used interchangeably with the term Behavioral Health Center (BHC) in this report. The OBHS contracts with a CBHC in each of the Service Areas for the delivery of mental health, substance abuse and mental retardation/ developmental disability services. The Department also has the authority to contract with other service providers within a Service Area. There are approximately 90 licensed behavioral health providers in West Virginia. Contracts are performance-based and focus on attaining specific goals and objectives identified through negotiations between the providers and the Department.

Each of the contract CBHCs administers services in a geographic Service Area of two to eight counties. Although the main site of the CBHC is usually comprehensive in its service delivery, the sites it administers throughout its region are usually organized around the provision of one or more specific services which address the particular needs in the surrounding locality or community. The areas of focus for adult programming at the CBHC level includes case management, housing, employment and crisis services. Areas of service focus for children at the CBHC level include case

management, family preservation, crisis services and assessment services. Although each CBHC is funded to provide a comprehensive array of services, it is the option of the CBHC to provide services directly or through a contract to a community-based agency.

Issue Area 1: The Largest Source of Funding for Behavioral Health Providers, Medicaid Fee-For-Service Reimbursements, Has Fallen Significantly in Recent Years While General Revenue Appropriations Have Increased.

HCFA Deferrals and Changes in Medicaid Funding

In the early 1990's West Virginia reduced State funding for behavioral health services and encouraged Behavioral Health Centers to substantially expand Medicaid billings. As a result of the State's aggressive encouragement of Medicaid billing, behavioral health's billing of Medicaid grew quickly until Medicaid accounted for nearly 80 percent of the funding for West Virginia's publically funded behavioral health services. The State's Behavioral Health Centers expanded rapidly, primarily through the enhanced level of Medicaid funding. The administrative systems at both the State and provider levels did not keep pace with this expansion, leaving the behavioral health system vulnerable to Medicaid auditing problems, especially in the area of determination of medical necessity and client documentation.

Within a few years, Medicaid expenditures expanded to the point that the State viewed Medicaid expenditures as being in a state of crisis. In 1995, a Medicaid Crisis Panel, convened to make recommendations to bring Medicaid expenditures under control, called for a $160 million reduction in Medicaid expenditures including a $40 million reduction in behavioral health expenditures.

Medicaid audits conducted by the Health Care Financing Authority (HCFA) identified provider discrepancies in compliance with service, placement and documentation requirements leading to Medicaid deferrals. Deferrals are an action by HCFA in which HCFA indicates that payment of a Medicaid claim is on hold pending the State submitting documentation to further support the claim. The first Medicaid behavioral health deferral issued in 1992 was ultimately settled in 1997. The original deferral amount of $14 million was reduced to $2.3 million after discussions between HCFA and the DHHR. When West Virginia received notice of the HCFA deferral in 1992, the State appealed the deferral by supplying additional documentation to support the original claim. A second deferral of $2.9 million was issued by HCFA in 1997, and HCFA and the State have been negotiating a resolution. Recent HCFA audits of individual behavioral health centers continue to identify significant administrative deficiencies that have not yet been resolved, leaving the OBHS and the behavioral health centers anticipating that there will be additional HCFA deferrals in the future.

HCFA deferrals resulting from audits resulted in a 9.5% reduction in total Medicaid revenues received by behavioral health centers in FY 1996, followed by a reduction of 19.8% in FY 1997. Centers that were not quick to react to these funding changes or were not closely monitoring costs soon found themselves in dire financial difficulties because of the dramatic decrease in revenue. Out of eight centers examined by the June 1999 Technical Review Report, completed to monitor uses of funds from the Substance Abuse Prevention and Treatment (SAPT) Block Grant, one center became bankrupt and closed. Its successor center was formed as a result of the purchase by a

hospital of the former center's assets. Another is being directed by a turn-around specialist who is currently working through a three-year plan to reach solvency. Most of the other centers are responding to financial difficulties by making substantial managerial changes, evaluating break-even points for providing specific services, revising personnel procedures, reducing staff and redesigning treatment processes in an effort to reduce costs.

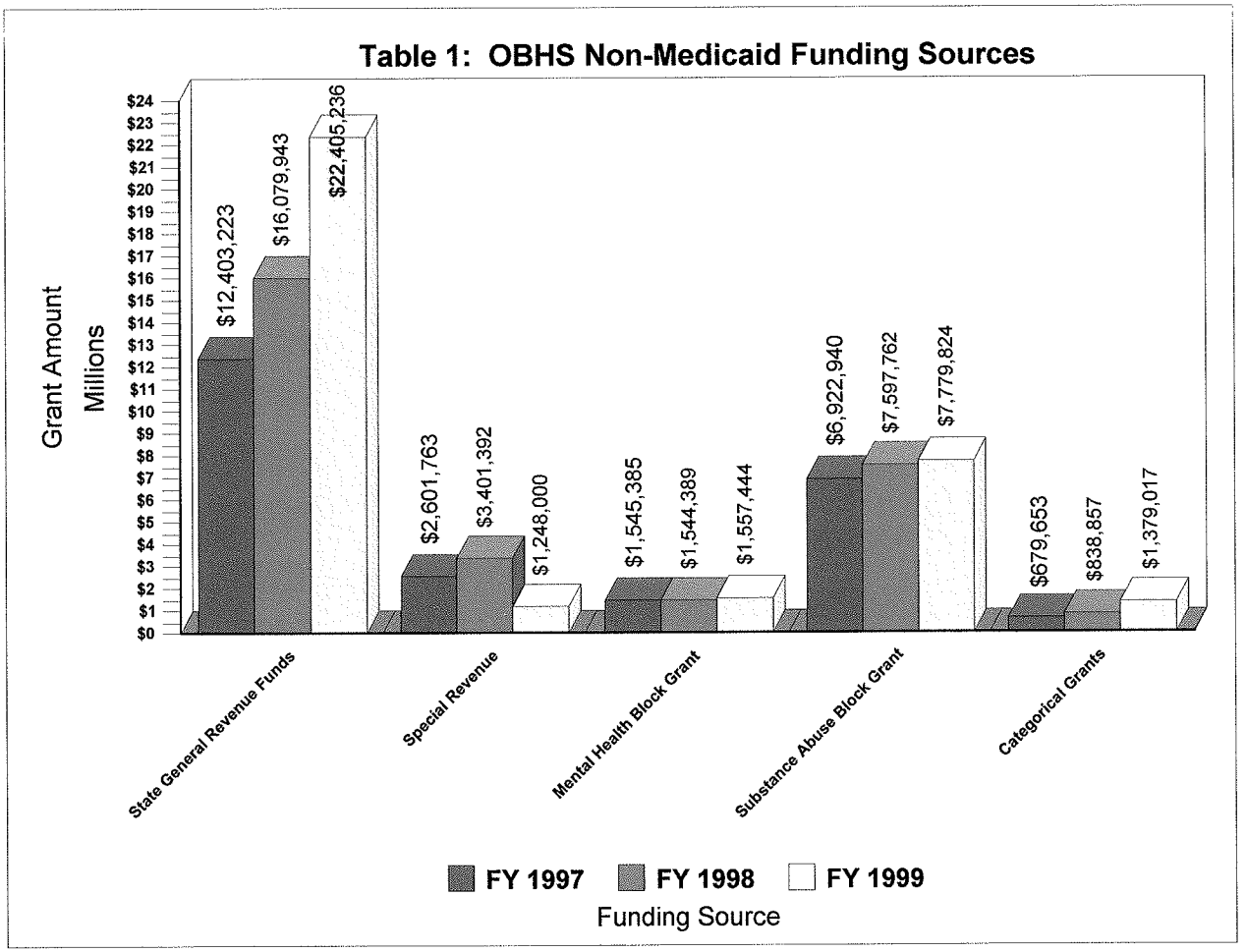
West Virginia claims Federal Financial Participation (FFP) under Title XIX for rehabilitative services for Medicaid clients. In June 1998, a representative of HCFA reviewed Medicaid claims records drawn from six behavioral health providers. The review involved the examination of claims documentation to determine whether the services were eligible for FFP under Medicaid. The review included examinations of diagnoses, treatment plans, individual client notes describing the services provided and interviews with State officials.

The review found that DHHR does not effectively monitor claims for rehabilitative services. HCFA recommended that the State develop and implement an effective system to monitor claims for rehabilitative services to ensure that Medicaid claims are allowable and that services are provided economically and efficiently. The review also recommended that the State should conduct comprehensive audits of behavioral health centers' claims for rehabilitative services, identify any unallowable amounts claimed under Title XIX and return FFP for any unallowable claims. HCFA's final recommendation was that the State should establish policies and procedures that ensure that future claims for rehabilitative services are in accordance with federal regulations and are consistent with the economical and efficient administration of the Medicaid program.

In response to HCFA's recommendations, the DHHR agreed to have the Surveillance and Utilization Review (SUR) Unit conduct reviews on the six entities previously reviewed by the HCFA. Further SUR Unit reviews of other providers were to follow as the HCFA expressed the opinion that all of the State's behavioral health providers should be examined. The DHHR also made changes to the Rehabilitation Services Manual in 1998 following the HCFA review. These revisions included service limits, clarification of services covered, the addition of utilization standards, changes in service definitions and the addition of language to prevent duplicate billings for a single service. A further step taken by the DHHR was the implementation of the New Directions Program, which will be discussed later, as a move towards increased utilization management.

Trends in Behavioral Health Funding

Table 1 illustrates the various non-Medicaid funding sources for the OBHS using data that was current as of June 1999. The State's General Revenue appropriations have almost doubled from $12,403,223 in FY 1997 to $22,405,236 in FY 1999. This represents an 80.6% increase in General Revenue appropriations during this time period. Special Revenue has varied from a high of $3,401,392 in FY 1998 to a low of $1,248,000 in FY 1999. Increases in General Revenue Appropriations during FY 1998 and FY 1999 included $3,000,000 allocated each year to fund client care costs which are not eligible for Medicaid funding. Funds from the Mental Health Block Grant have remained fairly constant over the period examined, while funds from the Substance Abuse Block Grant have gradually increased from $6,922,940 in FY 1997 to $7,779,824 in FY 1999. The



level of funding from various categorical grants has also gradually increased from $679,653 in FY 1997 to $1,379,017 in FY 1999. The categorical grants include grants for such special purposes as funding homeless programs and improving data systems.

An examination of Medicaid reimbursements made to behavioral health providers from Fiscal Years 1997-1999 (see Table 2) illustrates the development of certain trends. Overall, reimbursements have fallen from $121,583,479.29 in FY 1997 to $87,477,032.91 in FY 1999. This represents a 28% reduction in Medicaid reimbursements. At the same time, the number of providers who receive large amounts of Medicaid funds has fallen. Forty-two providers received at least $500,000 in FY 1997. Only 32 providers received at least $500,000 in FY 1998. By FY 1999, only 28 providers received such large reimbursements. While the general trend has been towards lower total amounts for Medicaid reimbursements, one provider, Action Youth Care, has received increasing amounts of Medicaid funds over the three-year period studied. Shawnee Hills, Inc. has consistently received the greatest amount of Medicaid reimbursements, but the total received has fallen considerably from $15,697,641.58 in FY 1997 to $10,108,271.08 in FY 1999. The general trend towards lower levels of Medicaid reimbursements has coincided with the increase in State General Revenue appropriations that was mentioned earlier. It can be concluded that as Medicaid fee-for-service funding has been reduced in recent years, the State has been forced to replace the resulting shortfalls in funding for behavioral health providers.

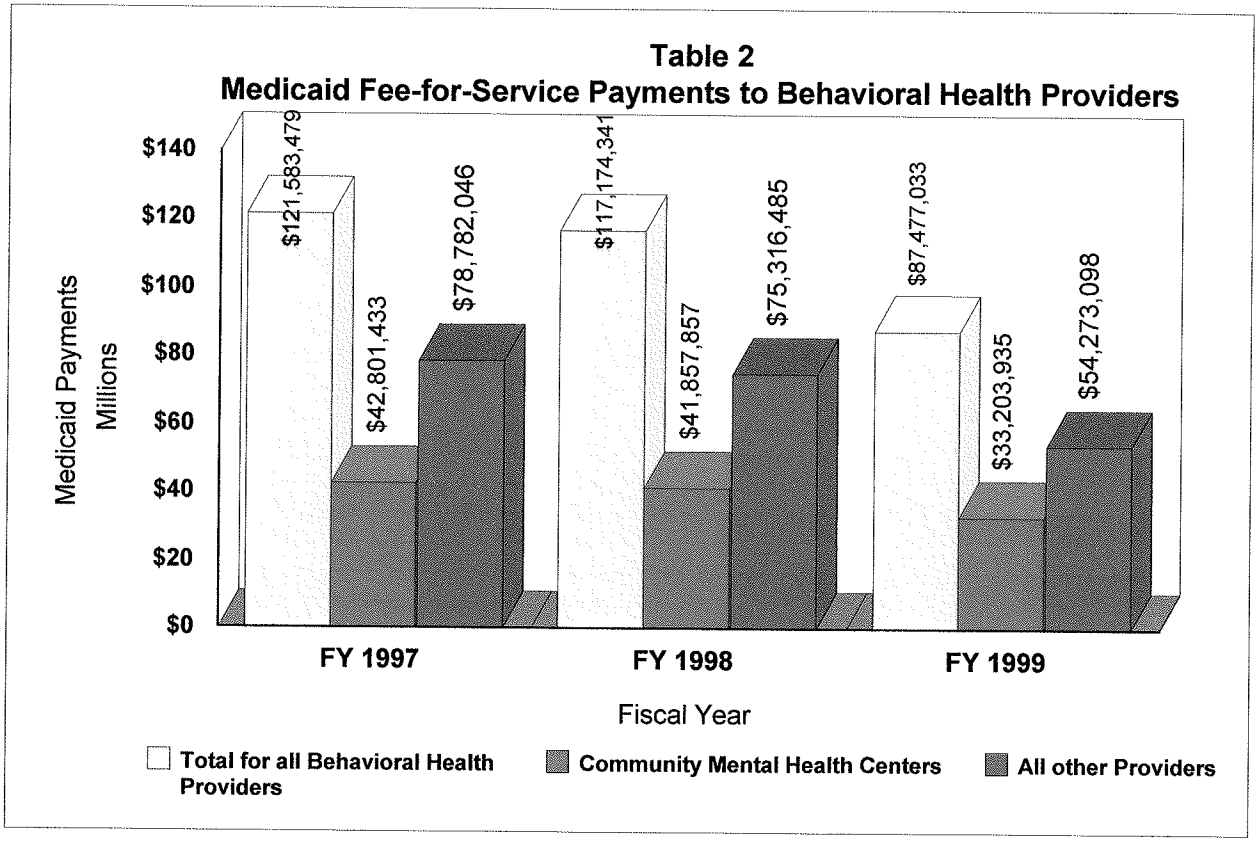


Table 2
Medicaid Fee-for-Service Payments to Behavioral Health Providers
Medicaid Payments
Millions
$140
$120
$100
$80
$60
$40
$20
$0
$121,583,479
$42,801,433
$78,782,046
$117,174,341
$41,857,857
$75,316,485
$87,477,033
$33,203,935
$54,273,098
FY 1997
FY 1998
FY 1999
Fiscal Year
Total for all Behavioral Health Providers
Community Mental Health Centers
All other Providers

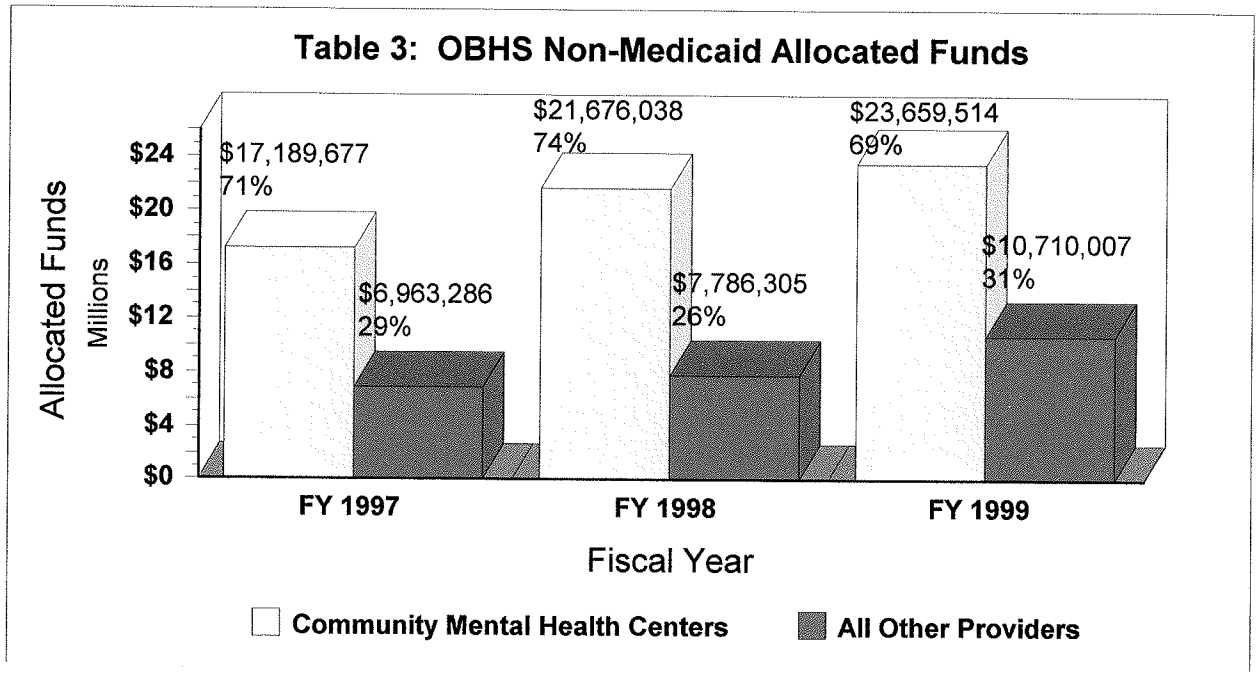


Table 3: OBHS Non-Medicaid Allocated Funds
Allocated Funds
Millions
$24
$20
$16
$12
$8
$4
$0
$17,189,677
71%
$6,963,286
29%
$21,676,038
74%
$7,786,305
26%
$23,659,514
69%
$10,710,007
31%
FY 1997
FY 1998
FY 1999
Fiscal Year
Community Mental Health Centers
All Other Providers

As Table 3 illustrates, the allocation of non-Medicaid funding has been heavily weighted in favor of the community mental health centers, which are capable of offering a wide range of services unlike many smaller behavioral health providers. The community mental health centers consistently received approximately 70% of allocated funds for each of the three fiscal years examined.

Table 4 shows that the distribution of non-Medicaid funds to Behavioral Health Centers is skewed in favor of two particular providers, the Prestera Center and Shawnee Hills, Inc. The Prestera Center received the largest level of funding for any single provider for the period examined, with a total allocation of $5,369,917 for FY 1999. The Prestera Center received 15.4% of non-Medicaid funding distributed to Behavioral Health Centers in FY 1997. This increased to 22.7% in FY 1999. During the same time period, the proportion of non-Medicaid funding received by Shawnee Hills declined somewhat from 22.5% in FY 1997 to 18.7% in FY 1999. These two providers are also among the largest recipients of Medicaid reimbursements for behavioral health services (see appendix).

Table 4: Allocation of Non-Medicaid Funding Among Providers
Comprehensive Behavioral Health Centers Only

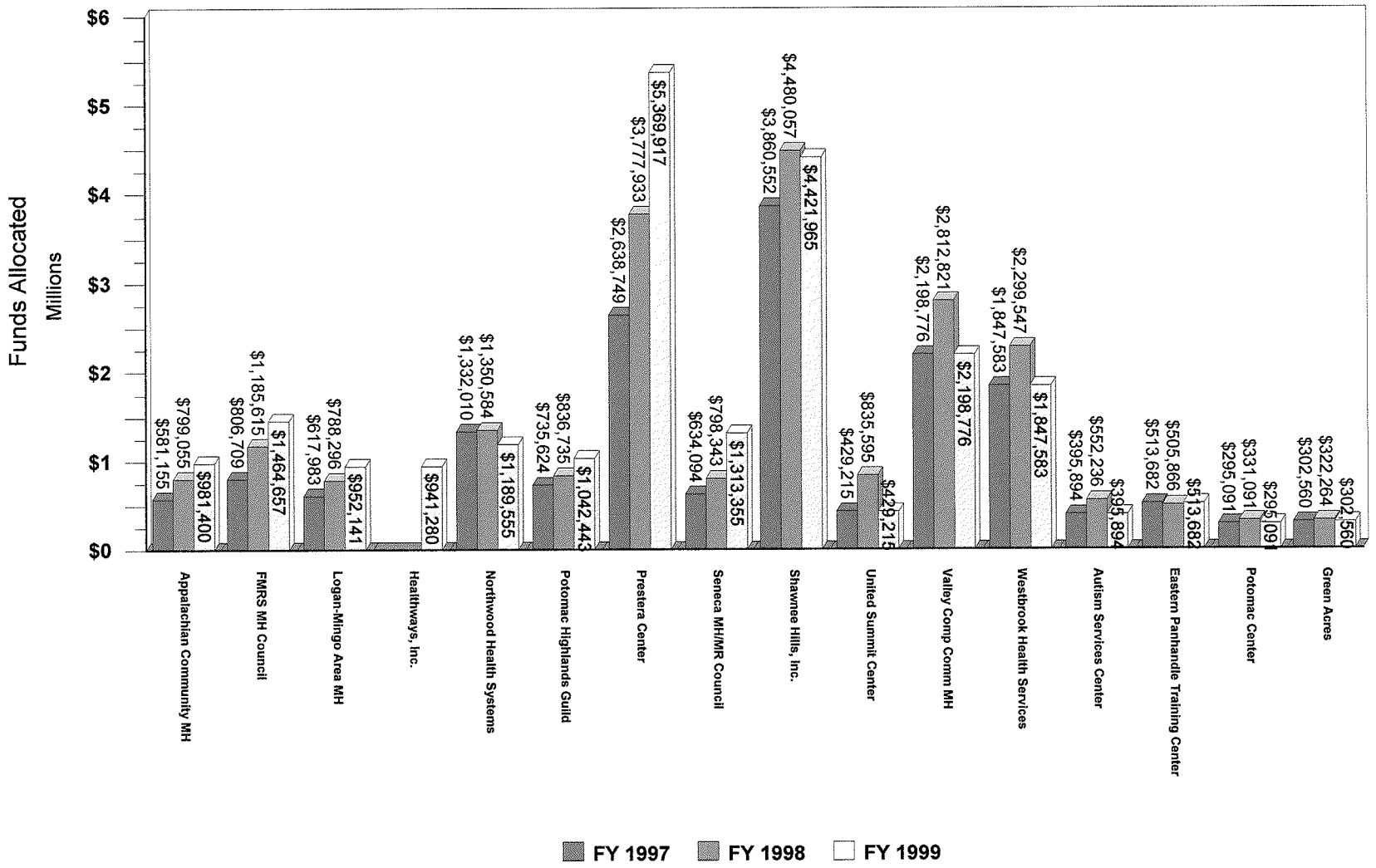
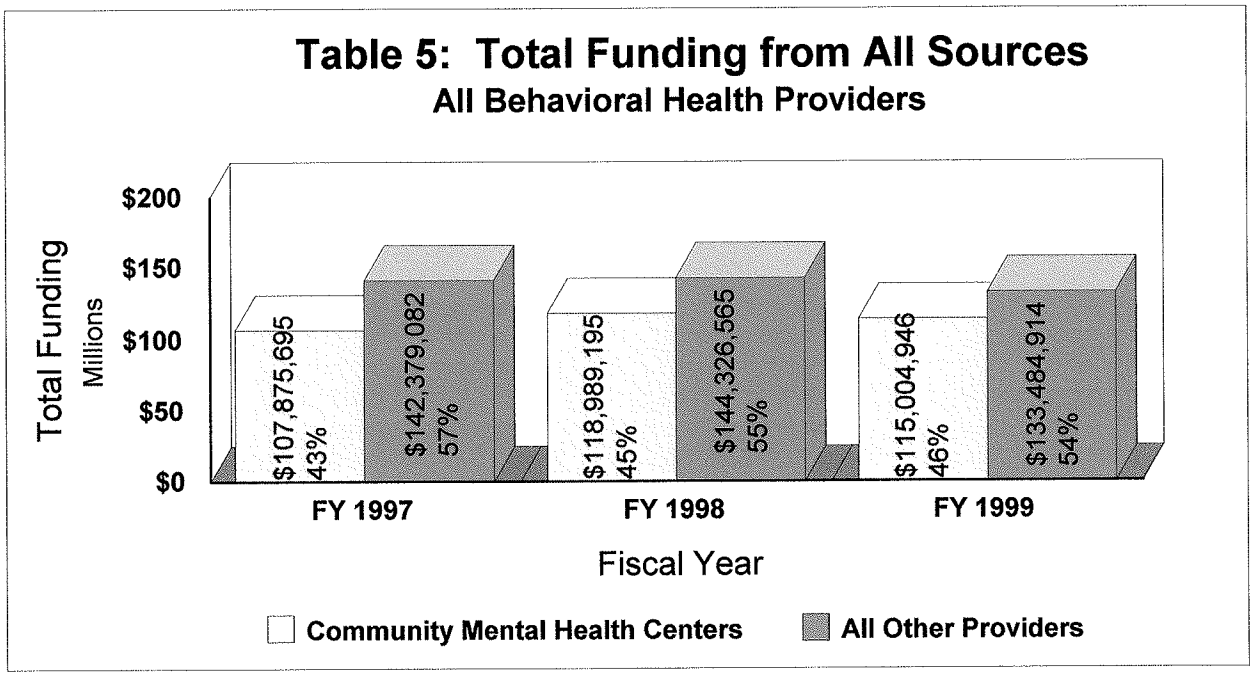


Table 5 shows the total amount of funding received from all sources by all behavioral health providers for the period examined. The total proportion of all funding allocated to Community Mental Health Centers has remained fairly constant while, at the same time, the total dollar amount fell slightly in FY 1999. Community Mental Health Centers received $118,989,195 in FY 1998 and $115,004,946 in FY 1999. This represents a 3.3% decrease in the last year following a slight increase in total funding which took place in FY 1998.

This same trend has occurred with total funding for all other behavioral health providers. Funding fell from $144,326,565 in FY 1998 to $133,484,914 in FY 1999. This represents a decline in total funding of 7.5% from FY 1998.



The changes in behavioral health funding indicate that while Medicaid fee-for-service reimbursements have generally fallen in recent years, this is not the case with the Mentally Retarded and Developmentally Disabled Program (MR/DD) (see Table 6). Funding for the Mentally Retarded and Developmentally Disabled Program (MR/DD), which is mostly fee-for-service in nature, has grown steadily over the three-year period. The number of clients served by the MR/DD Program has grown accordingly.

Funding for Intermediate Care Facilities for Individuals with Mental Retardation and/or Related Conditions (ICF/MR) has decreased during the three fiscal years examined. ICF/MR funding is cost-based reimbursement. Due to the closure of the Colin Anderson Center and a moratorium on additional ICF/MR beds, a decrease in the number of clients served by this program has resulted. It must be noted, however, that providers receiving funding from the ICF/MR Program are frequently group homes, and because of the types of services they offer, these providers tend to receive less fee-for-service funding than those who do not have residential care facilities.

Table 6: Other Sources of Medicaid Funds

Fiscal Year	Intermediate Care Facilities with Mental Retardation and/or Related Conditions	Mental Retarded and Developmentally Disabled Program
FY 1997	$51,270,256	$46,162,406
FY 1998	$49,988,621	$59,415,291
FY 1999	$46,864,637	$72,013,443

Conclusion

In the last three fiscal years, behavioral health providers have experienced a decline in Medicaid reimbursements, which grew to constitute the most important source of funding for providers after the late 1980's. At that time, the State sought to encourage providers to bill Medicaid for more services while decreasing State funding levels for behavioral health programs. As Medicaid billings increased, the HCFA identified provider discrepancies in compliance with service, placement and documentation requirements leading to Medicaid deferrals. The first deferral occurred in 1992, and another followed in 1997. In response to the HCFA, the DHHR agreed to have the SUR Unit conduct reviews on the six entities previously reviewed by the HCFA. Other DHHR policy changes followed to facilitate adherence to Federal guidelines.

Since the decline in Medicaid fee-for-service reimbursements began, General Revenue appropriations have increased in response to changing funding patterns. Reductions in Medicaid fee-for-service funding levels has affected BHCs to a proportionally lesser extent than other behavioral health providers due to the larger allocations they receive from General Revenue and grant-related funds.

Increases in other types of Medicaid funding for the ICF/MR Program have primarily benefitted providers of residential services who are not among the largest recipients of Medicaid fee-for-service reimbursements. This indicates that changes in the distribution of Medicaid funding have adversely affected some providers while benefitting others.

Recommendation 1:

The DHHR should consider the impact that changing patterns in Medicaid funding has had on individual behavioral health providers when allocating General Revenue and grant-related funds.

Recommendation 2:

The DHHR should continue monitoring Medicaid reimbursement procedures followed by behavioral health providers in order to assure compliance with Federal guidelines and thereby reduce the risk of future deferrals.

Issue Area 2: The Office of Behavioral Health Services Lacks Adequate Measures of Behavioral Health Program Outcomes.

The OBHS currently does not collect data from providers that would enable it to develop adequate performance measures. The data presently collected by the OBHS is focused on the demographic characteristics, hospital utilization and short-term assessment instruments of the clients served by community mental health centers and other providers. The significance of this lack of performance measures lies in the size of the budget for various behavioral health services funded by the OBHS and Medicaid (in excess of $100,000,000) and the fact that it cannot determine to what extent it is able to effectively assist its clients. Given the absence of data for clients after they have received services and attempt to function in the community, it is not possible to measure program outcomes.

The responsibility for data collection has fallen primarily on providers, who have had to adjust to increasing data reporting requirements for both Federal and State programs. Certain data categories must be collected in order to comply with data reporting requirements for Federal grants, as will be explained later. Furthermore, the need to provide increasingly detailed records for Medicaid documentation has been particularly demanding on the time and resources of providers. State programs, like the New Directions Program, have introduced yet more data reporting requirements. These additions to the data that providers must collect and report have frequently been made without permitting providers any input in the development of the new data categories. A well-designed data collection system would include program outcomes-related data and would involve all interested groups in the design of the system. Providers, clients served by the behavioral health system and their families are among the groups who could benefit from the collection of performance data focusing on program outcomes.

One important use for program outcomes measures would be for making needs assessments for the allocation of resources. The OBHS has had difficulty in the past with the collection of useful data necessary to determine the needs for different substance abuse services. In 1997 the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) funded two surveys intended to gauge the need for substance abuse services in West Virginia. These surveys were the Substance Abuse Need for Treatment among Arrestees (SANTA) Study and the Integrated Analysis Study. Unfortunately, the OBHS feels that the data obtained from these surveys is not useful for planning purposes because the data was not collected on a county basis, but rather gives totals for the State as a whole. Currently, the OBHS relies on "perceived needs and information provided through the informal needs assessment conducted by the State Substance Abuse Advisory Council (SSAAC)." Based on a regional assessment of needs, the SSAAC determined priorities for the State.

Data Currently Maintained by OBHS

A range of demographic statistics is maintained by the OBHS from data submitted by providers. This data is gathered from customers at intake to a behavioral health facility, at least every 180 days and at discharge. No data is routinely collected on clients after they leave a facility; therefore, the progress made by clients after they receive treatment is not monitored . Unfortunately,

much of the data collected is not accurate enough to be useful for management purposes. Many of the demographic measures reported in the OBHS Annual Client Reports contain large numbers of customers in categories labeled unknown. Several of these measures contain 40% or more of customers in the unknown category. These include measures of the total number of inpatient psychiatric admissions in the last ninety days, the number of substance abuse admissions in the last ninety days, each customer's lifetime total number of substance abuse admissions and mental health medications taken by customers. The OBHS clearly needs to monitor data reported by providers and to include additional data categories that will be useful for management purposes.

Possibly the greatest single impediment to creating an effective system of client outcomes measures has been the DHHR's lack of means to identify individual clients. Without a unique client identifier, the progress made by individuals treated by behavioral health providers cannot be systematically tracked with respect to outcomes measures such as employment status or housing. Another resulting problem is that demographic data that is currently collected counts some clients multiple times due to the fact that they may have multiple diagnosis and cannot be identified as individuals.

The OBHS is required to collect performance measures for programs funded by some Federal grants. The Community-Based Mental Health Services Block Grant, for example, has data reporting requirements which include certain performance measures relating to program outcomes:

1. The current level of school functioning, as measured by grade point average, for seriously emotionally disturbed (SED) children who are served.
2. Percentage of SED children receiving services who reside in a stable environment, i.e. have resided in their current placement for 180 days or more.
3. The number of homeless SED children receiving services.
4. The number of SED children who have contact with the juvenile justice system.
5. The number of school days missed by SED children due to behavior problems.
6. The percentage of persons receiving treatment in a community-based setting for at least a year, who have received a functional assessment at least twice in that year and who have improvements in at least two areas of functioning.

The Division of Mental Health and Community Rehabilitation Services, which lies organizationally under the authority of the OBHS, collects and analyzes data on state hospitalization utilization. Data collected include admissions by service area, recidivism rates and length of stay in the community between admissions. Although this data is useful, it focuses on hospital utilization and not on other measures that might give a more complete picture of a client's quality of life.

The OBHS has, therefore, shown that it can and does collect program outcomes data in the case of individual programs. It does not, however, do so on a systematic basis for all clients who receive behavioral health services.

The New Directions Project

The West Virginia Department of Health and Human Resources (DHHR) implemented the New Directions Project in 1996 as a means of assessing clients for appropriate services. The Project was the DHHR's response to the recommendations of Governor Caperton's Medicaid Crisis Panel.

The Panel recommended the decrease of Medicaid expenditures overall by $160 million, $40 million of which was targeted as a reduction to behavioral health. The Project was also the outcome of the DHHR's great need to have an informational tool for policy and planning which can describe the number of people it serves by disability grouping or related subgrouping. The system established by New Directions was intended to achieve the following:

1. Better define medical necessity;
2. Establish eligibility for Clinic and Rehabilitation services based on assessment of need;
3. Establish a database that characterized the behavioral health consumer and that could be used to:

    - Meet Federal reporting requirements;
    - Could be used to make policy decisions related to the direction of managed care; and,
    - If managed care was not practical in the next two years, serve as a utilization management system to match levels of care to levels of need.

The system depends on collecting information on the following data elements to establish medical necessity:

- demographic information (such as age, sex, where customers live, etc.)
- diagnosis
- functional level (as measured by standardized assessments)
- clinical stability
- level of social support

Recording these particular data elements was intended to reflect patterns in the utilization of services. This system was designed to facilitate a more efficient allocation of resources among possible services. Although the efficient utilization of resources is an important management concern, other measures are needed in order to obtain a picture of the ability of customers to function in the community after receiving services.

A June 1999 Technical Review Report of the OBHS Division on Alcoholism and Drug Abuse, which was prepared for the Division of State and Community Assistance, Center for Substance Abuse Treatment, confirms the need for improved outcomes measures.

> Generally, West Virginia's BHCs (Behavioral Health Centers) appeared to be reasonably sophisticated with respect to the need for outcome measures and their prospective utility. Some BHCs reported running a parallel data system (to that of New Directions) with some outcome data. Discussions with BHC staff suggested, however, that much of what has been described as outcome data are actually measures of program process and performance rather than client outcomes. Good client outcome measures would be focused on symptom decrease and other measures of successful resolution, such as employment, familial adjustment and legal

involvement.

New Direction's possible use for outcome measurement has caused many BHCs to contemplate the use of outcomes as a mechanism for continuum development. One urban BHC that serves both clients from its own catchment area as well as clients from neighboring States has modified its service continuum in direct response to consumer feedback and internal data collection, creating new programs that meet consumer needs.

The OBHS should consider reviewing data presently collected by individual behavioral health providers in order to establish standardized outcome measurements. These could be incorporated into the data collected for the New Directions Program. Consulting with BHCs would enable providers to contribute to the process of developing new outcomes measures while designing performance measures that will be useful for BHCs as well as the OBHS.

The June 1999 Technical Review Report went on to state that "the essential data elements for determining medical necessity are client Medicaid number, diagnosis, dates of eligibility period, and identifying demographic information." The Report identified the need to reduce the burden of New Directions data reporting on BHCs and the expectation that data collection requirements will be greatly reduced. "Data will only be collected if the data meet one of the following criteria: required for Federal reporting, needed for responding to legislative requests, specifically useful to clinicians, or needed for algorithms." Algorithms will be used for placement and utilization management.

This seems to indicate that data collected for New Directions will be aimed at certain narrowly-defined uses for the foreseeable future. It can be concluded that the implementation of the new program will not be adequate for all of the OBHS's data collection needs with respect to outcomes measurement and other types of management information unless modified from its present form .

Another problem with data currently collected for New Directions deals with the accuracy and completeness of data collected from BHCs. A review of services data submitted in FY 1998, the year before the program was fully implemented, indicated that some BHCs did not report any service data and others reported inaccurate or incomplete data. The OBHS does not have clearly defined financial consequences for failure to report accurate data.

Possible Performance Measures

Examples exist of the types of performance measures that would be appropriate for the services offered by OBHS providers. The State of Florida's Department of Children and Families administers the State's Alcohol, Drug Abuse, and Mental Health Services programs. The

Department has developed a range of measures related to the goal of keeping adults with severe and persistent mental illness in the community where services are less expensive.

The system of performance-based budgeting used by the State of Florida focuses on the need

for agencies to develop strong accountability systems that enable the Legislature and the public to assess program performance. An accountability system consists of four key elements: program purpose or goals, performance measures, a process for valid and reliable data, and credible reports of performance that can be used to manage the program. Establishing standards for comparison is an important part of this process.

The Florida Legislature established five performance measures for the Department of Children and Families, which included the following:

1. The average number of days per month that clients spend in the community rather than in mental health institutions, crisis stabilization units or other treatment facilities, in jail or homeless;
2. The average number of days that clients work for pay each month;
3. The average monthly income of clients;
4. Clients' average mental functioning level as measured by the Global Assessment of Functioning scores; and
5. Client satisfaction with services they receive, based on average scores clients give on the Behavioral Healthcare Rating Scale.

These are only a few examples of possible outcomes measures that could be adopted by the OBHS as it considers those measures already collected by behavioral health providers.

Information presented to the Health Oversight Committee on Insurance and Mental Health indicated that the OBHS is currently considering the introduction of some outcomes measures in addition to utilization assessments. Possible outcomes measures include "assessment of employment status of persons served, living status of consumers and the extent to which individuals are referred by the criminal justice system." The OBHS needs to continue to develop these measures in order to incorporate them into New Directions data reporting.

The West Virginia Mental Health Planning Council, originally established as a requirement of Federal legislation related to the Mental Health Block Grant, is an organization of providers, State agency officials (education, rehabilitation services, social services and the Courts), consumers of services and their families. The Council has a membership of 36 persons. Representation is a combination of Federally-required positions, regional representation and at-large membership. The Council creates plans for the entire mental health system.

In order to expand input from interested groups, the Council began quarterly meetings of Council Plus, which is a meeting between Council members, consumers, their families and providers. Council Plus meetings are intended to allow input from all interested parties.

The Mental Health Planning Council and Council Plus meetings could be a means to examine possible outcomes measures and design a standardized data collection system for all providers that would provide data measures that would be useful for providers and clients, as well as the OBHS and Federal reporting requirements. The many changes over the years in data elements collected have taken place without adequate input from affected parties such as providers and clients. The

involvement of the Council could permit changes that would be useful for all involved parties and result in programs outcomes measures that would be meaningful for all interested parties.

Conclusion

The OBHS currently collects demographic and short-term assessment data on clients served by behavioral health providers. A considerable amount of the data that has been collected from providers has been incomplete or inaccurate, therefore limiting its usefulness. There are currently no financial consequences for providers who fail to submit accurate data to the OBHS. The OBHS does not collect program outcomes data on all of the clients served; however, it does collect some program outcomes data for Federal grants data reporting requirements. This shows that the OBHS has the capacity to collect program outcomes data and should develop a standardized system of measures that apply to all clients served.

The New Directions Project was implemented in 1996 in order to contain growth in State Medicaid and behavioral health expenditures. Data elements collected for New Directions is intended to reflect the utilization of services. Some BHCs collect outcome measures they have developed themselves in addition to New Directions data. Other states also collect behavioral health program outcomes data, such as those collected in Florida. Although the OBHS has already begun to examine the possibility of collecting outcomes data, the agency should consider types of data already collected for Federal grant reporting purposes by providers and by other states and develop a standardized system of program outcomes measurements.

The involvement of the Mental Health Planning Council would make it possible for all interested groups to participate in the development of a standardized program outcomes data collection system to be used by all providers. This would help to ensure that providers who are impacted by changes in data collection requirements have input into future changes and that the new data categories collected will be meaningful to providers and clients.

Recommendation 3:

The OBHS should modify its data collection systems to include a client identifier.

Recommendation 4:

The OBHS should direct the West Virginia Department of Health and Human Resources Advisory Council to participate in the development of a standardized system of program outcomes measurements to be used by all providers.

APPENDIX A

Transmittal Letter to Agency

WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

Antonio E. Jones, Ph.D.
Director

June 15, 2000

Ms. Joan E. Ohl, Cabinet Secretary
Department of Health and Human Resources
Building 3, Room 206
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305

Dear Secretary Ohl:

Enclosed is a draft of the performance evaluation of the Office of Behavioral Health Services. We would like to tentatively schedule an exit conference on Friday, June 23, 2000 so that it can be presented during the July Interims to the Joint Committee on Government Operations. At that time we can discuss any concerns you may have with the draft report.

If you have any questions please contact me or Russell Kitchen, Research Analyst.

Sincerely,

Brian Armentrout

Brian Armentrout
Research Manager

cc: John Bianconi, Director, Office of Behavioral Health Services

Joint Committee on Government and Finance

APPENDIX B

Agency Response

RESPONSE TO REPORT OF
PERFORMANCE, EVALUATION, AND RESEARCH DIVISION
WEST VIRGINIA LEGISLATURE

JUNE 2000

OFFICE OF BEHAVIORAL HEALTH SERVICES
BUREAU FOR BEHAVIORAL HEALTH AND HEALTH FACILITIES
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Submitted by:

Joan E. Ohl

Joan E. Ohl, Secretary
Department of Health and Human Resources

RESPONSE TO REPORT OF PERFORMANCE, EVALUATION, AND RESEARCH DIVISION (PERD) WEST VIRGINIA LEGISLATURE

Office of Behavioral Health Services

The Department of Health and Human Resources (DHHR) appreciates the report prepared by the Performance, Evaluation, and Research Division of the West Virginia Legislature. The focus of the report, to examine trends in funding for behavioral health services , evaluate performance measures and program outcomes, and the need for improvements in data collection is both relevant and welcomed by the Department. In addition to its stated purposes, the Department views the report as a point-in-time status review of several issues which might influence the continuing system reform activities at work in the Department.

This report is an excellent platform and opportunity for the Department to illustrate the progress made in efforts to move the behavioral health system from a 1970's culture to a dealing with 21st century realities. The report also provides an opportunity to further discuss resolution to issues and problems that challenge all stakeholders in the behavioral health system.

Although the PERD report covers the time period of Fiscal Years 1997 through 1999, it is necessary to place it in a larger context. This response provides additional background information that can enable an "environmental scan" for use in the needed dialogue.

It is important to note that DHHR provided PERD with all relevant documents to assist reviewers in making an assessment and recommendations regarding their charge. This process began prior to the end of Fiscal Year 1999, with input lasting through the end of calendar year 1999. The information provided to PERD outlined progress made by the behavioral health system, continuing problems in the system, and strategies to address many of the issues for the time period assessed.

Everyone involved in the behavioral health care system would embrace the goal that the system "(provide) and (reimburse) for the right care, delivered at the right time, in the right setting, and with appropriate outcomes while enhancing the consumer's quality of life."[1] It is in the spirit of this goal — recognized by American Psych Services, the new contracted Administrative Services Organization (ASO) for Medicaid-reimbursed behavioral health services, as the Department's goal — that this response is written.

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[1] Statement from the response to Request for Proposals for an administrative services organization from American Psych Services. American Psych Services has been awarded a contract to provide utilization management services for the behavioral health services reimbursed by Medicaid.

American Psych Services, in its winning bid proposal, noted that one of several reasons the State desired to engage an ASO was to address the readiness level of the behavioral health system for managed care. The bid proposal described this readiness:

- Behavioral health centers currently are not ready for risk-based managed care;
- Readiness problems center on deficiencies in quality of data and information technology capacity;
- West Virginia's behavioral health centers are well behind public providers in many states;
- Only one of the fourteen comprehensive centers is accredited by the Joint Commission on Health Care Organizations;
- Twelve of the fourteen comprehensive centers utilize the CMHC software system; one uses the BTI system; and one uses a custom-developed system;
- None of the behavioral health centers utilize the full managed care capacity of their systems;
- Outdated hardware and inadequate system support hinders all behavioral health centers to some degree;
- Other challenges include logistical problems in managing remote rural sites, recruiting and staffing problems, data integrity problems, the increased burden of more detailed eligibility assessments, and morale/retention issues resulting from all these pressures.

Challenges that the accomplishment of this goal present are overshadowed by many environmental influences. Certainly, a continuing litigious environment, combined with continued Court oversight of the behavioral health system, delays immediate and continuous attention to this overarching goal. Two consent decrees, referred to as *Hartley* and *Medley*, have framed the legal parameters and resource intensive plans since the early 1980's. These decrees have been the basis of deinstitutionalization efforts and community-based system development. Additional litigation against DHHR has been initiated or continued throughout the time period of this review and continue to this day.

> Three behavioral health centers filed suit in 1996, claiming the Department provided insufficient resources while mandating that certain services be provided. One of the providers dropped out of the suit; one has settled; and one is in settlement discussions. All three centers have new Chief Executive Officers and two have new Chief Financial Officers. None of the centers have found it necessary to cease operating, as was predicted when the suits were filed.
>
> A Temporary Restraining Order (TRO) was filed in Kanawha County Circuit Court in 1998, prohibiting the Department from fully implementing changes in its Rehabilitation Services Manual — placing the State and providers at continued risk of disallowances for practices deemed by the Health Care

Financing Administration (HCFA) as both inappropriate and inadequately documented. Continued discussions with providers of strategies to better serve consumers and meet the requirements of HCFA have only recently resulted in sufficient progress to warrant requesting the lifting of the TRO.

Benjamin H. is a lawsuit filed in 1999 involving accessability to the MR/DD Community-based Medicaid Waiver. The Department's responses, coupled with the Legislature's approval of a process to waive Certificate of Need requirements and allocation of $4.9 million in additional match for the Waiver, has resulted in at least a temporary resolution of the issues in this lawsuit.

The Department continues to negotiate and/or formally appeal each disallowance issued by HCFA, currently totaling $9.4 million

Most recently, a lawsuit was filed by four behavioral health agencies (*Prestera, et. al.*) regarding monitoring by the Bureau for Medical Services.

West Virginia and other states are also responsible to continue deinstitutionalization and development of integrated community settings as a result of the United States Supreme Court *Olmstead* decision, which is based on the Americans with Disabilities Act.

The Department is of the belief that in spite of this litigious environment, much progress has been made toward the goal of the right care, delivered at the right time, in the right setting, at the right cost, and with appropriate outcomes while enhancing the consumer's quality of life. The PERD report helps to support our belief.

Issue Area 1: The Largest Source of Funding for Behavioral Health Providers, Medicaid Fee-For-Service Reimbursements, Has Fallen Significantly in Recent Years While General Revenue Appropriations Have Increased

DHHR, particularly the public behavioral health system represented by the Bureau for Behavioral Health and Health Facilities and the Office of Behavioral Health Services, has operated under the oversight of two Court Decrees — *Hartley* and *Medley* — for over two decades. These resource intensive plans have operated to deinstitutionalize many of the State's fifteen State psychiatric hospitals and residential facilities for people with mental retardation or other developmental disabilities and State-operated residential treatment programs for substance abuse. Over this 20-year period, much has been accomplished, as evidenced by the fact that the State has only 240 beds in its two remaining acute care psychiatric hospitals. West Virginia is one of only eight states that does not operate residential programs for persons with mental retardation and/or other developmental

disabilities. These accomplishments would not have occurred if services were not developed and provided in a community-based setting by the 85 licensed providers throughout the State.

One of the financing mechanisms to accomplish this development of community-based services was the maximization of Medicaid-reimbursed services. With this strategy, certain decisions were made by the West Virginia Legislature and the Administration in the early 1990's. One of those decisions involved the re-direction of State appropriations for behavioral health programs over a two year period (Fiscal Years 1993 and 1994). This resulted in moving about $20 million from OBHS-administered funds for reimbursement for behavioral health services to serve as State match ($3 in Federal funds for every $1 of State funds) for Medicaid reimbursement. There was no increase in appropriations to OBHS between FY 1993 and FY 1997.

It is important to note that while there were increases in Medicaid funding for behavioral health services in the late 1980's and early 1990's, Medicaid reimbursement for other health services also increased. This "explosion" of Medicaid dollars in West Virginia followed national trends — and the State was one of many subjected to increased oversight and accountability by HCFA. The Medicaid Crisis Panel, referenced in the PERD report, added to HCFA efforts to control the growth of Medicaid.

The increase in funding between FY 97 and FY 99, referenced in the PERD report, is only tangentially related to Medicaid decreases. The Department requested, and the Legislature approved a plan to increase funding from General Revenue to help reimburse for uncompensated care for behavioral health services over a three year period. The plan was for an increase of $3 million per year for three years. Allocations from General Revenue were increased by the Legislature for FY 98 and 99. Funding was not forthcoming for FY 2000, but the Department was able to transfer sufficient funds to enable completion of the plan. The relationship to Medicaid decreases is twofold: the decreases disabled utilizing Medicaid income for otherwise uncompensated care and funds were needed for services not appropriately reimbursed by Medicaid. The primary focus of the increased appropriations, however, was to provide compensation for services for persons not eligible for Medicaid and without any other benefit.

Related to this issue, PERD makes two recommendations:

> *"The DHHR should consider the impact that changing patterns in Medicaid funding has had on individual behavioral health providers when allocating General Revenue and grant-related funds."*
>
> *"The DHHR should continue monitoring Medicaid reimbursement procedures followed by behavioral health providers in order to assure compliance with Federal guidelines and thereby reduce the risk of future deferrals."*

The Department concurs with these recommendations. Several recent and continuing activities will contribute to the Department's abilities to respond:

— The Department retained a portion of the uncompensated care funds budgeted by the Department in Fiscal Year 2000. OBHS was able to allocate some of these funds to meet residential support needs not otherwise compensated due to changes in Medicaid reimbursements.

— The Department is working with providers and other stakeholders to create a new service, called assertive community treatment (ACT), for a segment of the consumers served which will decrease reliance on services not supported by HCFA. Medicaid will reimburse for this service to Medicaid-eligible consumers. Uncompensated care funds will be utilized for those persons without Medicaid or other benefits.

— The Department is working with a network of providers — First Choice — to create a better understanding among providers of Federal requirements for clinical practice and documentation of services provided. One desired outcome of this process will be decreased Federal disallowances.

— It is anticipated that the new contract for an ASO, with American Psych Services, will increase in-State oversight of Medicaid utilization, while enhancing the ability of providers to document the need for and appropriateness of services provided.

The Department takes pride in its typical forthright response to the Legislature. While additional response to these recommendations for this issue may be relevant, the Department is impeded in doing so because of the current lawsuit by four providers concerning monitoring and because of the current HCFA disallowances.

Issue Area 2: The Office of Behavioral Health Services Lacks Adequate Measures of Behavioral Health Program Outcomes.

The Department appreciates reference to the work done by the Office of Behavioral Health Services relative to performance measures developed and reported as a part of the application and implementation reporting for the Community-Based Mental Health Services Block Grant. These measures have been developed using data submitted by contracted providers of behavioral health services.

The combination of reporting performance measures for this Block Grant and the monitoring of services by the Mental Health Planning Council have been recognized nationally by the Center for Mental Health Services and the National Association of Mental Health Planning Councils. West Virginia's approach regarding the Block Grant and the

steering provided by its Planning Council have been presented at two national conferences on technical assistance for the Block Grant.

The issue of outcomes and performance measures raised in the PERD report is noteworthy. It presents a challenge to DHHR, a "wake-up call" to providers, and a method for Legislators, administrators, providers, consumers, and families to look at results and the effectiveness of services. Much effort has been expended by states throughout the nation regarding the development, implementation, and most importantly, the use of outcomes in a performance measurement system. In fact, most states who have and use outcomes were either mandated by their state legislatures to develop them or implemented them with the onset of managed care. The Florida example in the PERD report was a result of a legislative mandate.

We acknowledge PERD's assessment that OBHS does not use systematic outcome measures for all clients who receive behavioral health services. What will follow in this response will document the planning and implementation efforts to date involving moving the behavioral health system to an outcome performance measurement system. It will be demonstrated that OBHS can and does collect program data that can measure outcomes.

Prior to the New Directions initiative in 1996, OBHS implemented two outcome demonstration initiatives. The lessons learned helped to shape the planning efforts which led to the New Directions development. The major issues were selecting outcomes which would be useful, could be measured, and could be used in assessing consumer and/or program outcomes. Information system capability and reporting performance were two additional key factors.

The foundation on which to develop performance and outcome measures for the publically funded behavioral health system was laid with the implementation of the New Directions reporting process started in 1996 but not fully implemented until 1998. The New Directions initiative was started simultaneously with recommendations of another large group of stakeholders who developed "Generic Performance Indicators." Additional activity in this time period included the work of a Quality Council, composed of representatives of all behavioral health system stakeholders and the work of Expert Panels convened to recommend approaches to establishing a foundation for managed behavioral health care for each of the populations served. These expert panels were composed of administrators, clinicians, consumers, and family members. All the assessment instruments were selected by these panels.

From the beginning of the New Directions program, the quality of data and provider involvement/impact has been a concern. From April 1996 through September 1996 meetings were held throughout the State with providers, family members, and consumers to establish who would be assessed, how they would be assessed, how the data would be provided and what assessment instruments would be used. After much discussion, the

instruments were chosen, but it was decided that more data was needed from the instruments before it could be determined what specific services were needed for any given client. It was decided that in the beginning only eight fields would be required to be completed correctly or the client would not receive Medicaid Clinic or Rehabilitation funding: 1) Agency License Number; 2) Client ID at the agency; 3) Client Initials; 4) Medicaid Number; 5) Birth date; 6) Date the form was completed; 7)Disability Group; and 8) Diagnosis. This was called the minimal data set and was used to begin processing and looking at client need.

The system was established in November of 1996, but compliance was voluntary. Teleconferences and meetings were held on a regular basis with providers. The system and all forms were re-worked at least once during this period and procedures were established to report on quality of data and if medical necessity had been established. The target date for implementation was July 1, 1997. Concerns by the providers caused the implementation to be postponed until April 1998. On April 4, 1998 the billing link for New Directions was instituted to authorize Medicaid payment for clinic and rehabilitation services. After some discussion with providers the implementation date was extended to July 1, 1998. Cognizant of the range of expertise in data collection and reporting, the Department invested in scanning technology to enable data to be submitted even by providers without computer capability.

In January 1999 OBHS began negotiation with providers to expand the minimal data set, especially as it related to clients for whom the agencies expected to use OBHS funding. OBHS considered the minimum data set insufficient for management purposes and saw that voluntary compliance with the requirements was resulting in non-compliance. A new minimal data set was established. The new minimal data set would apply to OBHS clients only and that a period of three months would be given during which time OBHS would be required to fulfill all its contract obligations to provide report and fine indicators to the agencies as if the fine had been implemented but that the agency would not be fined.

In July 1999, the FY 2000 contract specifically spelled out the implementation of the agreement negotiated in that any client for whom a contracted agency expected to use OBHS money must meet OBHS client definition and no less that 85% of the OBHS clients reported by the agency and confirmed by OBHS as OBHS eligible clients could have any "unknown", "blank" or "non-responsive" answers on any critical field. The instrument that would indicate that the agency was using OBHS fund was the Client Service Data Report (CSDR). This report (a required part of the OBHS contract for many years) requires each contract agent to submit monthly a list of each client served with the type and quantity of service received. Failure to submit an acceptable CSDR resulted in a fine of $250 for each day the report was late. If the agency indicated OBHS as the billing source for a client the clients qualifications were checked against the data received for that client. If no data were present for this client or if the data present did not indicate the client qualified as an OBHS client, the agency's allocation was subject to $100 fine. Once the OBHS clients were

established a quality check indicates whether or not the agency had met the 85% accuracy bench mark. Failure to reach this quality bench mark would result in an allocation reduction of $1000 for each month the agency failed to live up to their contract obligation. The implementation of the provider portion of this contract was moved first to July 2000. It is now anticipated that the first fines, if any, will be levied in August 2000 against the July 2000 service data.

The Department has provided or arranged for substantial technical assistance for providers to improve the quality of data submitted. It is anticipated a majority of providers will be able, in Fiscal Year 2001, to meet the quality criteria established in the Grant Agreement. Nearly half of the providers submitting data are now in compliance with quality criteria.

The New Directions effort, and the resulting reporting potential has closely paralleled national efforts in this regard. OBHS will begin reporting to providers on some of the measures as a part of the FY 2001 Grant Agreement with the comprehensive behavioral health providers. These reports include: the number of children served who attend school regularly, by age and by disability; the percentage of children served who reside in a stable environment, by age and by disability; the percentage of children served who have contact with the juvenile justice system, by age and by disability; employment status of all adults served, by age and by disability; living arrangements of all adults served, by age and by disability; contact with the justice system of all adults served, by age and by disability; the number of pregnant women with chemical dependency or chemical addiction who are served by the Grantee; the number of IV drug users served; the number of persons served, by Target Funded services or programs, and the type and quantity of such services.

This reporting activity has been developed in conjunction with providers through a process which has included technical assistance in developing quality data reporting, showcasing providers who have managed to achieve quality data reporting and internal use of data generated, and establishing quality targets which could result in sanctions or fines if data reporting does not achieve an agreed-to level of quality. Providers are currently reporting data for most of the measures referenced in the new Grant Agreement.

For several years, OBHS has supported the development and refinement of consumer satisfaction surveys and satisfaction surveys for family members of consumers. Results from the surveys are being analyzed by the agencies conducting the surveys — West Virginia Mental Health Consumers' Association, Mountain State Parents CAN, and NAMI West Virginia. The results will be made available to the OBHS, the provider community, and the public. While the surveys are focusing on adults with mental illnesses and children with serious emotional disturbance, prototypes have been developed which are applicable to all populations served by behavioral health centers.

Funding has also been provided by the Office for consultation to providers to develop outcome measurement software which will graphically present changes in level of functioning of individual consumers, specific programs within a behavioral health center, or entire center services. This software, using assessment information required by the New Directions initiative, is currently being piloted at five provider agencies. Modifications to the software should be completed by late July 2000. The consultant, Jim Sorensen of the University of Denver, will present on this activity at the National Rural Mental Health Association conference. The Office is also funding an enhancement to the CMHC software (eCET) used by most of the comprehensive behavioral health providers. This enhancement will computerize the assessments enabling providers to have immediate access to data with which to monitor outcomes.

Finalization of the Standardized Chart of Accounts should be completed by late July 2000. The standardized chart of accounts will allow reporting of financial information in a consistent format across comprehensive behavioral health providers. Comparability of financial data will be improved and the Department will be better able to establish costs for services across the system.

OBHS has also funded the piloting of a quality focused planning process at nine providers. This effort will require the use of outcome measures to determine the degree to which the plan was accomplished. The project uses the Malcolm Baldrige Health Care Criteria for Performance Excellence as the foundation for the planning process. It is expected that the plans of operations submitted by each comprehensive behavioral health provider will be modified for FY 2002 to reflect this planning model.

In addition to these activities focusing externally to OBHS, efforts have been undertaken to improve the capacity within OBHS to review and analyze data available internally. Programming consultants have developed software for OBHS staff to use to analyze provider performance and individual consumer outcomes. This will enable ad hoc report generation for use in monitoring providers. Information will also be shared with the general public via the OBHS webpage, set to become available July 1, 2000.

These activities related to performance measures have been presented to the DHHR Behavioral Health Advisory Council. It is anticipated that monitoring activities and performance measures developed and reported by the Mental Health Planning Council will serve as a foundation for the Advisory Council in developing measures which consider all behavioral health populations in conjunction with the ASO.

Related to this issue, PERD makes two additional recommendations:

> *"The OBHS should modify its data collection systems to include a client identifier."*

"The OBHS should direct the West Virginia Mental Health Planning Council to participate in the development of standardized program outcome measurements to be used by all providers."

The Department appreciates these recommendations and believes much has been done to assure implementation:

— The Department already includes a consumer identifier in its consumer reporting system. The OBHS system as it currently exists can identify unique consumers served by any contract agency. It does not have a uniquely assigned number for each consumer in the system. The addition of Social Security Number as a required field in the OBHS minimal data set should now rectify that problem for OBHS funded clients. Individuals with Medicaid benefits are similarly tracked with Medicaid benefit numbers and Social Security numbers.

— It is difficult to track consumers who are discharged from treatment. In many states, this issue has been resolved with legislation requiring state agencies to share data in a manner that would enable continuous tracking for outcome measures.

— While the work of the Mental Health Planning Council should be recognized, it is not appropriate for it to assume the developing standardized outcome measures for the system. In fact, that work was completed in 1996, as noted above. Data exist to report out measures of performance and outcome. The DHHR Behavioral Health Advisory Council is assuming the role of developing systemic outcome and performance measures in conjunction with the ASO. In addition, the Department has funded consultation to several providers to implement the Malcolm Baldrige Health Care Criteria for Performance Excellence in performance measurement.

Concluding Remarks

The PERD report will be helpful to the Department in its continuing efforts to improve behavioral health services and outcomes for people with behavioral health needs, while establishing fiscal stability.

It is unfortunate that the time period studied is also a time period in which the Department, through its Office of Behavioral Health Services and Bureau for Medical Services, was preparing the behavioral health system to move from a 1970's culture of behavioral health services to a 21st century approach — from total dependence on publicly funded services to a focus on self determination and recovery and from a fiscal system founded on grants and fees for service to true managed care system which provides for "the right care, delivered at the right time, in the right setting, and with appropriate outcomes while enhancing the consumer's quality of life."

The kind of change required for this evolution in any state is ripe for a litigious environment, which has certainly been the case in West Virginia. It is always heartening to be able to see progress even in the light of this environment. The Department believes the PERD report will assist us in continuing to seek achievement of our goals.

A separate document, detailing information which may be helpful in editing and revising statements of fact, has been submitted to PERD.