JIM PETRO
AUDITOR OF STATE

STATE OF OHIO

HAMILTON COUNTY MANAGED CARE PERFORMANCE AUDIT

AUGUST 16, 2001

STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

To Ms. Barbara Manuel, Acting Director of Hamilton County Department of Job and Family Services, Members of the Partnership Team and Council Agencies, the Hamilton County Commissioners, and Citizens of Hamilton County.

The State Auditor's Office is pleased to provide the completed performance audit of selected contract provisions between Hamilton County Department of Job and Family Services (HCDJFS) and its two contracted managed care organizations, Magellan Behavioral Health and Creative Connections. HCDJFS requested the performance audit to help improve contract expenditure management and service delivery of behavioral health services to children and parents of Hamilton County. The State Auditor's Office conducted this independent review of selected provisions of the Magellan Behavioral Health and the Creative Connections contracts with the objective of examining financial management and reporting, performance measurement and provider network development, and technology management in relation to contract provisions. A limited review of the *Any Willing Provider* issue and its potential impact on HCDJFS was also included in the performance audit. Recommendations provided to HCDJFS focused on contract compliance, as well as areas where HCDHS or the contractors could improve operational efficiency and service delivery through the implementation of recommended and best practices.

The performance audit focused on three core aspects of each contracted managed care organization's operations as related to the provisions of each contract: financial management and reporting, performance measurement and provider network development, and technology management. The performance audit contains recommendations based on best practices and industry standards for improved efficiency, enhanced service delivery, and increased contract performance, as well as commendations highlighting best practices within each contracted managed care organization.

Executive summaries have been prepared for the performance audit reports on each respective contracted managed care organization. The summaries include the project history, purpose and objective of the performance audit, and summary of each of the three areas examined. The executive summaries also include a summary of findings, commendations and recommendations related to the respective contractor. An executive summary is also included for the *Any Willing Provider* issue.

Additional copies of this performance audit can be requested by calling the clerk of the bureau at (614) 466-2310 or the toll free number in Columbus, 800-282-0370. In addition, this performance audit can be accessed online through the Office of the State Auditor's Web site at http://www.auditor.state.oh.us by choosing the *on-line audit search* option.

Sincerely,

JIM PETRO
Auditor of State

August 16, 2001

EXECUTIVE SUMMARY

Project History

At the request of the Hamilton County Department of Human Services (HCDHS), the Auditor of State's Office performed a performance audit to review various contractual provisions of the Magellan Behavioral Health Contract (the contract) beginning in July 2000. HCDHS, Hamilton County Mental Health Board and Hamilton County Alcohol and Drug Addiction Services Board (ADAS) provide behavioral health managed care services to clients through its contract with Magellan Behavioral Health (Magellan or MBH). HCDHS acts as the primary liaison and contract manager for the three County agencies, known as the Partnership Team, because the majority of clients are referred to Magellan by the Children's Services Division at HCDHS. HCDHS requested a comparison of various contractual provisions to services rendered, an assessment of the manner in which the Partnership Team entities function in accordance with the contract, recommendations for improvements to future contracts and identification of best practices in managed care. Meetings between the Auditor of State's Office and County management were held to discuss the scope and objectives of the performance audit.

As a result of these discussions, it was determined that the performance audit would focus on the following areas:

- Financial management and reporting;
- Performance measurement and provider network development; and
- Technology.

Planning for the MBH performance audit began in April 2000, and the actual performance audit was conducted primarily during the months of July through December 2000.

Objectives and Scope

A performance audit is defined as a systematic and objective assessment of the performance of an organization, program, function or activity to develop findings, conclusions and recommendations. Performance audits are usually classified as either economy and efficiency audits or program audits.

Economy and efficiency audits consider whether an entity is using its resources efficiently and effectively. They attempt to determine if management is maximizing output for a given amount of input. If the entity is efficient, it is assumed that it will accomplish its goals with a minimum of resources and with the fewest negative consequences.

Program audits normally are designed to determine if the entity's activities or programs are effective, if it is reaching its goals and if the goals are proper, suitable or relevant. Program audits often focus on the relationship of the program goals with the actual program outputs or outcomes. Program audits attempt to determine if the actual outputs match, exceed or fall short of the intended outputs. The performance audit conducted on the MBH contract is predominantly a program performance audit focusing on contract compliance.

The Auditor of State's Office has designed this performance audit with the objective of reviewing systems, organizational structures, finances and operating procedures to assess the implementation of contract provisions and the development of the behavioral health managed care program by MBH. Specific objectives of this performance audit include the following:

Financial Management and Reporting

- Assess the appropriateness of the billing and claims reconciliation process in comparison to stipulations of the contract;
- Assess the level of service denials in comparison with contract stipulations
- Assess the implementations of the 15 percent savings plan and the process used to establish savings.

Performance Measurement and Provider Network Development

- Evaluate the content and utility of performance measurement reports in comparison with the contract requirements;
- Analyze the application of MBH financial performance incentives by HCDHS;
- Assess the appropriateness of service provider locations as per contract requirements;
- Review credentials, licensing and provider insurance based on contract provisions;
- Assess the completeness of the client rights and confidentiality policies and procedures; and
- Review MBH policies and procedures governing client complaints and grievances in relation to contract requirements, and assess the adequacy of the documentation of incidents and training received by complaint resolution staff.

Technology

- Assess the functionality of management information systems;
- Assess compliance with training requirements;
- Evaluate existing hardware and software capabilities to determine if stated functionality exists;
- Assess network connectivity between MBH, HCDHS and providers; and
- Review hardware and software support system based on staffing, hours of availability, provider satisfaction and assistance wait time.

Methodology

To complete the performance audit, the auditors gathered and assessed a significant amount of data pertaining to MBH operations including financial and performance measurement records and policies and procedures related to the behavioral health managed care program; conducted interviews with various groups associated with HCDHS and MBH, as well as accreditation organizations and federal oversight agencies; and reviewed reports and recommendations from various private nonprofit, state and Federal entities responsible for Medicaid and managed care program implementation and monitoring. The methodology is further explained below.

Studies, reports and other data sources

In assessing the various performance audit areas, MBH was asked to provide any previous studies or analyses already prepared on the subject areas. In addition to reviewing this information, the auditors spent a significant amount of time gathering and examining other pertinent documents or information. Examples of the studies, reports and other data sources which were studied include the following:

- Partnership Team and MBH request for proposal and contract
- MBH annual reports to the Partnership Team
- MBH policies and procedures
- HCDHS clinical, financial and performance reviews of MBH
- Child Welfare League of America (CWLA), Recommended Practices
- United States General Accounting Office (GAO), *Child Welfare - Early Experiences Implementing a Managed Care Approach*
- Substance Abuse and Mental Health Services Administration (SAMHSA), Management Information System Recommendations
- Health Care Financing Administration (HCFA), Managed Care Recommended Practices

Interviews, Discussions and Surveys

Numerous interviews and discussions were held with many levels and groups of individuals involved internally and externally with MBH. These interviews were invaluable in developing an overall understanding of MBH's operations. Examples of the organizations and individuals that were interviewed include the following:

- MBH personnel
- HCDHS personnel
- Various service providers
- HCFA representatives

Benchmark Comparisons

Benchmark comparisons were developed from accreditation organizations and the best practice agencies included in their studies and recommendations, and federal oversight agencies. Performance indicators were established for the various performance audit areas to develop a mechanism to compare how effectively and efficiently MBH provides and coordinates services. The information was obtained primarily through information requests and interviews held with the appropriate personnel selected from best practice agencies. These agencies included the following:

- Child Welfare League of America
- Health Care Financing Administration
- Substance Abuse and Mental Health Services Administration
- Ohio Department of Mental Health
- Department of Health and Human Services, Office of the Inspector General
- Government Accounting Office

Overview of the MBH/HCDHS Contract

In FY 1996, the Hamilton County Department of Human Services (HCDHS), Hamilton County Mental Health Board and Hamilton County Alcohol and Drug Addiction Services Board (ADAS) formed a partnership and established a contract with Magellan Behavioral Health (MBH), a Management Services Organization (MSO), to administer managed care to County agency clients. The three agencies, known as the Partnership Team, recognized the need to integrate their services because significant numbers of children and families involved with the Children's Services Division of HCDHS often suffer from a wide range of issues related to mental health, alcohol and drug problems. A five-year contract was established between the County agencies (Partnership Team) and MBH to create a service delivery system blending behavioral mental health and children services goals in a managed care environment.

Because of the wide range of services needed by County agency clients and the increasing costs of care, the Partnership Team contracted MBH to coordinate and administer child welfare and mental health services to identified at-risk children and their families through a network of service providers. The implementation of managed care and the development of a provider network was recognized as a method to reduce local costs through the consolidation of administrative and management services to achieve economies of scale and increased quality of care. In addition, MBH was contracted to develop and administer a management information system to manage claims and case data. Through the contract agreement, MBH manages a variety of tasks on behalf of the County agencies, some of which were untried in MSO/Medicaid managed care relationships.

Key Findings/Recommendations

The performance audit report and executive summary contain a number of findings and recommendations pertaining to the MBH and HCDHS contract, its management, the implementation of best practices, and the improvement of contract outcomes. The following are the key findings and related recommendations:

- MBH receives a fixed profit amount of 5 percent based on the contract budget. Although MBH has produced a favorable budget variance during the first three years of the contract, the fixed profit and risk sharing incentives do not reward economy or efficiency on the part of MBH.

  The Partnership Team should continue providing MBH with a fixed profit amount for its services and should include incentives for improved economy and efficiency in future contracts. Basing MBH's profit on a fixed amount that is independent of the dollar amounts identified in the contract budget, coupled with a performance incentive for planning, budgeting and expenditure reductions, would improve financial oversight, maintain MBH's incentive to perform efficiently, and potentially create cost savings.

- Providers often bill for services to State or local funds when Medicaid funds are available for the client, which increases costs to HCDHS and can result in overpayment.

  HCDHS and MBH should consider developing an incentive or disincentive system to encourage providers to bill to Medicaid.

- Service providers can submit claims to MBH for processing up to one year after the date of service. There is no incentive plan for timely submission of claims, nor is there legal support outside of the contract to fortify MBH's insistence on the timely submission of claims.

  MBH should develop policies and procedures within the Administrative Manual requiring service providers to submit claims for reimbursement in a more timely manner. MBH should consider narrowing the time allowed to submit Medicaid claims to the MBH system from one year to three months after the date of service. Medicaid claims that are not submitted to MBH within the time frame and then are subsequently denied by Medicaid should not be paid by MBH.

- When entering claims information, the providers can submit a bundled or all-inclusive fee for Medicaid eligible services which may be used to cover the per diem rate. Bundled service fees were originally negotiated between MBH and the service providers to maximize Medicaid funding and limit local liability. This arrangement has caused the service providers

to be paid twice for some out-of-home care charges. HCDHS does not perform sample reconciliations between line items in bundled charges and itemized services.

MBH should require each service provider to perform a monthly reconciliation between total claims billed and total payment received from MBH. HCDHS should also require Magellan to submit reconciliations for each service provider and the corresponding explanation of benefits on a monthly basis. Furthermore, HCDHS should perform sample testing of the line item detail of bundled charges on a regular, periodic basis. Sample testing should be performed on each provider at least annually to ensure that ineligible costs have not been included in bundled rates.

- Upon receipt of MBH monthly invoices, HCDHS performs a cursory review of the service and administrative costs to determine if the totals appear reasonable. HCDHS is managing the MBH contract without a designated financial monitor. By not having filled this position, HCDHS may not have an accurate depiction of the current financial condition or potential difficulties facing the contract.

  HCDHS should perform a line by line and aggregate reconciliation of provider claims through identifying a financial monitor within the Contract Management Department's current resources.

- MBH is required to provide financial reports to the Partnership Team as a component of the financial monitoring plan. During the course of the contract, MBH and the Partnership Team have modified the financial reporting requirements through discussions at the bi-weekly Partnership Team meetings or less formal discussions between MBH and HCDHS representatives. However, no documentation of the changes or authorizing authority has been retained, nor are there minutes kept from the meetings.

  Any changes in financial reporting requirements, modified through discussion between MBH and the Partnership Team, should be documented and formally established as written addendums to the contract.

- Although HCDHS reviews MBH's compliance with the contract , the most recent HCDHS review of Magellan's operations covered the period January 9, 1998, through December 31, 1998 and was approximately one year out-of-date.

  HCDHS should complete its annual and quarterly performance reviews on MBH in a more timely manner. Because HCDHS is at least one year behind in its annual and quarterly performance reviews, Magellan may be challenged to reconstruct the factors which contributed to operational performance for a particular time in the past.

- MBH is not in compliance with the contract regarding provider evaluations which should be contained in quarterly service reviews. Instead, MBH only provides aggregate reports which show provider utilization within the network. The format of the reports does not reflect utilization rates of individual providers. Furthermore, MBH does not maintain service provider profiles which would provide information to HCDHS and MBH about each service provider in the network.

  MBH should provide an individual assessment of each provider through quarterly service reviews in order to fulfill the requirements of the contract. These provider evaluations should be documented and reported to HCDHS as well as to the evaluated providers. In addition, utilization information should be compiled separately for each provider and included as a component of the quarterly service review. MBH should also create service provider profiles to complement quarterly service reviews and to garner valuable information regarding the characteristics, abilities and financial performance of each service provider.

- Magellan credentials and re-credentials providers on a biannual basis. During the credentialing process, Magellan verifies the credentials, experience and licensure of those agencies and staff members responsible for the delivery of contracted services. Also, Magellan uses a five-point rating scale during site visits to determine contracted providers' compliance with the credentialing standards. According to credentialing evaluation letters to contracted providers, plans of correction are expected to be implemented and follow-up visits may be conducted by Magellan to ensure that contracted providers are taking the necessary steps to meet the established credentialing standards.

  Magellan should conduct mandatory follow-up site visits for any provider who requires a plan of correction based on the credentialing process, and the MSO should also develop a system of incentives to ensure that service providers implement plans of correction for credentialing shortcomings.

- According to the contract, Magellan is required to develop a process for tracking and monitoring complaints that are lodged on behalf of any client. Magellan has an established process for handling client complaints which is consistent with the responsibilities outlined in the contract. Numerous complaints regarding a particular service provider often prompt quality of care reviews in which Magellan conducts site visits to investigate areas of concern. Findings and plans of correction are subsequently developed to assist the provider in improving the conditions which initially provoked complaints.

  MBH should formally establish the specific conditions which would necessitate quality of care reviews. By formalizing the conditions which would trigger a quality of care review, MBH would be less likely to overlook problematic operations within the network while prioritizing those cases which would necessitate review.

- Magellan is in the process of upgrading the user interface on the MIS to a browser user interface (BUI) system. The Magellan MIS Department will be responsible for programming in the BUI environment. Because of the programming complexities and the length of time anticipated for full conversion, upgrades will be phased in. MBH will also upgrade system hardware to support the BUI conversion.

  The Partnership Team should approve implementation of hardware upgrades as soon as possible to accommodate the implementation of the BUI software. Hardware upgrades would cost approximately $280,000 to implement. To improve the BUI transition process and increase the service level of support personnel, an additional MBH programmer should be hired. The cost to hire an additional MIS employee would be approximately $75,000 including 25 percent for benefits.

- The contract turn-key provision allows the Partnership Team to assume operation of the MIS at the conclusion of the contract period. However, the Partnership Team has not designated staff to learn the processes used by the Magellan MIS Department. Although HCDHS does not have plans to assume operation of the MIS, Magellan has discontinued its role as MIS manager and/or MSO in several other Medicaid managed care contracts.

  HCDHS should immediately implement procedures to ensure the Department's ability to assume operation of the CMHC system if the turn-key provision is exercised by either party. HCDHS, the Mental Health Board and ADAS should determine which operational areas each agency would take on while HCDHS should take responsibility for ensuring the continued operation of the technology component of the behavioral health managed care system. HCDHS should ensure that the MIS Department has sufficient knowledge of the CMHC software to manage the system in the event that MBH is no longer involved in this process. The cost to hire additional HCDHS MIS personnel to serve as the turn-key transition team would be approximately $270,000.

The remainder of this executive summary is organized by report sections in order to highlight additional findings and recommendations, as well as commendations from those areas of the audit report.

Financial Management and Reporting

Findings:

- MBH renders provider and care management services to the Partnership Team at a budgeted cost of $3.2 million per year for each year of the contract. In the first two contract years, budgeted to actual expenses had an average favorable variance of 14.5 percent. Applying this average variance for FY 1998 and FY 1999, the forecasted MBH budget would be approximately $1.5 million under original project budget amounts for the remaining three-year period.

- Providers must obtain preauthorization from MBH in order to submit claims for reimbursement. This process enables MBH to manage the cost of care provided to Partnership Team clients. This process has reduced the number of claims labeled as denied or pending.
- During FY 1998, an independent audit determined that MBH made overpayments to service providers totaling approximately $265,000. MBH is developing a process to eliminate overpayments.
- MBH has ensured a savings of 15 percent for each year of the five-year contract. However, a FY 1998 review by an independent audit agency determined total savings at 6.4 percent.

Recommendations:

- The Partnership Team should identify the appropriate legal procedure for contract amendments and budget revisions. Because wide variances in budgeted versus actual amounts have not been reconciled, HCDHS and MBH may overestimate resource needs in some areas.
- The Partnership Team should require MBH to develop annual strategic planning documents, which should correlate to planned annual activities and budget documents.
- In order to reduce the number of claims being labeled as denied or pending, the service providers should be made aware of any change in Medicaid eligibility status.
- Claims submitted after May 2000, if appealed, should be resolved in a timely manner as stipulated in the True Care Partnership Manual.
- HCDHS should actively participate in the development of the Medicaid reconciliation processes.
- HCDHS should consider creating a financial review committee to monitor the financial relationship between itself, MBH and the contracting service providers.
- The Partnership Team and MBH should examine the viability of the 15 percent savings in relation to actual savings.

Performance Measurement and Provider Network Development

Findings:

- Continuous Quality Management (CQM) requirements are satisfied and represented through the Quality Improvement Report (QIR) produced by MBH. While Magellan has complied with CQM reporting requirements, there is a need to codify the existing practice of compiling and/or streamlining reports for practical purposes.
- MBH has modified its reporting practices to streamline the information contained in the reporting requirements. The current frequency with which MBH generates reports for the Partnership Team best represents the accumulation of relevant data for the time period. A comparison of Magellan's performance measures to the most common performance measures used by managed behavioral health care entities identified by the CWLA showed that the benchmarks currently used by MBH are highly-detailed, and specifically address each of the established performance measures.

- MSO Performance Standards were developed to provide benchmarks for MBH's service delivery. Each outcome has a monetary incentive and/or disincentive established for the achievement of or failure to meet the standard. In FY 1998, MBH earned only $10,100 or 10.1 percent of possible incentives. When added to the disincentives results, MBH was actually accessed a disincentive for the year of $19,411.
- Magellan uses a standardized agreement with each provider, outlining responsibilities and defining covered services. However, provider agreements do not contain the RFP criteria used to assess the provider's ability or inability to participate in the managed care network. Furthermore, provider agreements do not include the credentialing requirements with which providers must comply as a condition to remaining in the managed care network
- Magellan has created an On-line Referral System that enables its intake care managers to select the most appropriate types of providers for each client. The automated system then matches the client criteria against provider specialization, location and available programs, and determines the best-suited provider. HCDHS's 1998 annual performance review revealed that Magellan met the outpatient location standard by providing services for all outpatient clients within 30 minutes of their homes.
- Provider agreements stipulate that providers must maintain professional liability insurance, list Magellan as an additional insured and notify Magellan at least 30 days in advance in case of cancellation, non-renewal or material amendment. Only one of five providers listed Magellan as an additional insured.
- Magellan monitors service providers to ensure that written policies are in place regarding client rights and responsibilities, and that clients are informed of these rights and responsibilities. Furthermore, Magellan has developed a client rights and responsibilities pamphlet to inform clients and/or their family members of their right to file a complaint about the quality, availability or appropriateness of provided services. Magellan also maintains a comprehensive policy with detailed procedures which provides guidelines for safeguarding confidential client information in accordance with State and federal law, industry standards and professional ethics.

Commendations:

- Magellan consistently reports its performance in relation to the benchmarks as stated in the contract. The use of CWLA benchmark guidelines has helped Magellan develop performance measures that adequately evaluate the quality of services provided and increase the likeliness of providing mental health services at a fiscally responsible cost.
- Through the use of the On-line Referral System, Magellan is able to match clients with the most appropriate and best-suited service provider in the network. Providers are chosen based on their ability to address the individual needs of the client and their proximity to client residences.
- Magellan assesses provider compliance with professional standards of care through the credentialing process. MBH uses a variety of methods to verify the existence and monitor the status of provider and staff licenses. Biannual credentialing site visits enable Magellan to ensure that providers maintain written policies and procedures whereby clients are

informed of their rights and responsibilities regarding service delivery.

- MBH has clearly defined policies and procedures for the timely investigation and subsequent resolution of client complaints and grievances. Magellan also maintains a highly-detailed and comprehensive policy on client confidentiality. In addition, Magellan's recommended client rights and responsibilities for service providers are consistent with client/consumer bill of rights developed by national advocacy groups.

Recommendations:

- Any future contract between the Partnership Team and a Managed Services Organization (MSO) should contain a specific section devoted to operationalizing reporting requirements. This reporting section should contain language which grants a MSO, in consultation with the Partnership Team, the latitude to reduce duplicate reports, and to modify the frequency of reporting to convey an exact snapshot of relevant data for a specific time frame.
- MBH should consider including the credentialing requirements as addendums to provider agreements. Magellan should periodically update its standards for both outpatient mental health and out-of-home care placement service providers through consultation with national accreditation agencies.
- MBH should furnish service providers with suggested policies and procedures to rectify credentialing shortcomings. Quality assurance staff should also verify that Magellan is listed as an additional insured or certificate holder on providers' insurance policies.
- HCDHS should require Magellan to initiate the necessary procedures to create and maintain a centralized complaint/grievance database, instead of the current practice of maintaining a complaint/grievance file in a word processing software folder.
- MBH should develop and initiate periodic training sessions on client confidentiality for its staff as well as for service provider clinicians. These training sessions should mirror the confidentiality training attended by HCDHS' Children's Services staff.

Technology

Findings:

- MBH has developed and implemented an up-to-date case management and claims processing software system. The case management and claims processing systems appear to fulfill SAMHSA criteria for high performing managed care information systems. Magellan has also purchased additional hardware and software to accommodate the unexpectedly large number of referrals and client records which need to be processed and maintained.
- Quad ISDN lines are used to transmit data between MBH and the Partnership Team and providers typically use a point-to-point, 10 base T-line (telephone line). Although the present MIS cabling configuration is adequate to handle current traffic, the transition to a BUI system will require faster data transmission and access speeds to accommodate the larger memory requirements of the software.
- MBH provides ongoing MIS training to HCDHS, ADAS and providers on a quarterly and bi-weekly basis. Refresher courses provide MIS updates to providers who do not attend the

bi-weekly training sessions. Evaluations of MIS training by providers showed a highly favorable response to training programs. However, HCDHS caseworkers were only recently provided access to the MIS and have not received training on the system.

- MBH provides user support to the Partnership Team and to contracted providers and meets contractually required response times. However, MBH support staffing levels are minimal and current staffing levels allocate approximately one FTE per 250 users. Continued expansion of MIS usage may necessitate greater support staffing levels.

Commendations:

- The system developed by Magellan's MIS for use in the True Care Partnership project fulfills the criteria of a high performing management information system. Also, Magellan has monitored provider needs and advancements in technology and provided enhancements to the MIS. The upgrades provided to the Partnership Team and providers by Magellan have increased the utility of the MIS.
- Magellan has enhanced its training program beyond the requirements of the contract. Evaluations of training programs reflect high provider satisfaction levels. Also, Magellan has improved support service response times to meet and exceed contract obligations. The Partnership Team and providers appear to be satisfied with current service levels.

Recommendations:

- To accommodate the BUI connectivity needs, MBH should install T-1 lines, DSL lines or cable communication lines between MBH, the Partnership team and providers. Also, HCDHS caseworker training should be completed regardless of the BUI implementation status. Delayed training dilutes the benefits received by HCDHS through implementation of the MIS.
- Magellan should take measures to increase attendance at update and user group training sessions and should investigate methods to improve training delivery outside of face-to-face training sessions. Training manuals should be updated and modeled after the HCDHS supervisor/caseworker manual. MBH should also consider developing customized reference guides for the MIS for each user group. MBH should consider providing training CD-ROMs on the CMHC system and BUI upgrades through the MBH MIS Department to the 500 Partnership Team and provider users. The cost to implement training CD-ROMs would be approximately $1,250. Finally, MBH should prepare an analysis of the make-up and skill level of its computer user population to determine the necessary staffing to provide the desired quality of support services.

Background

Contract History and Purpose

In FY 1996, the Hamilton County Department of Human Services (HCDHS), Hamilton County Mental Health Board (MHB) and Hamilton County Alcohol and Drug Addiction Services Board (ADAS) formed a partnership with the intention of establishing a contract with a Management Services Organization (MSO) to administer managed care to County agency clients. The three agencies, known as the Partnership Team, recognized the need to integrate their services because significant numbers of children and families involved with the Children's Services Division of HCDHS often suffer from a wide range of issues related to mental health, alcohol and drug problems. In addition, national trends indicated that, in the previous ten-year period, federal costs for child welfare services had increased nearly fivefold to $4.2 billion. The Congressional Budget Office estimated that child welfare costs would continue to rise to $5.9 billion by FY 2002. In Hamilton County, expenditures for Children Services increased from $30.9 million in FY 1992 to $60 million in FY 1997. In response to rising costs associated with child welfare and health care, the Partnership Team wanted to consolidate a number of behavioral mental health services for its child welfare population under the management of a MSO.

In its efforts to establish a contract with a MSO to coordinate behavioral mental health services for the County's Children's Services population, the Partnership Team embarked on a fairly unique endeavor that few states or counties had ever experienced. Traditionally, HCDHS Children's Services caseworkers processed countless referrals and maintained working relationships with numerous service agencies in the behavioral mental health field. By entering into a contract with a MSO, the Partnership Team wanted to streamline the preexisting process and create a seamless system of child welfare and mental health services for children and families in Hamilton County. The contract was established to accomplish the following objectives:

- Coordinate and administer child welfare and mental health services to identified at-risk children and their families through a network of service providers
- Establish agreements with service providers and prepare them for a managed care environment
- Reduce total costs to the Partnership Team and community through the consolidation of administrative and management services to achieve economies of scale
- Develop and administer a management information system which would be used by the Partnership Team as well as contracted service providers

Magellan Behavioral Health (MBH or Magellan), a subsidiary of Magellan Health Services, Inc., was one of three organizations to submit proposals pursuant to the Partnership Team's Request for Proposal (RFP) and was selected as the managed care entity. In FY 1997, a five-year contract was established between the Partnership Team and Magellan to create a service delivery system blending behavioral mental health and children services goals in a managed care environment. According to the contract, Magellan would manage a variety of tasks some of which were untried in MSO/Medicaid managed care relationships. The following table illustrates Magellan's primary tasks and responsibilities pursuant to the contract with the Partnership Team.

Table 2-1: MBH's Primary Tasks and Responsibilities

Protocols	• Develop and implement service protocols • Develop and implement utilization review processes • Develop and implement standardized approaches to gate-keeping decisions
Data Collection and Reporting	• Develop and oversee the data collection system • Collect, evaluate, monitor and report on elements regarding program, fiscal, provider, outcome and service data • Develop, implement and manage an automated/standardized clinical record, billing and tracking system
Outcome and Quality Management	• Develop, review and report on service outcomes and standards • Implement a continuous quality management program
Provider Network	• Assist in the development, implementation and maintenance of a mental health service continuum provider network • Develop and monitor provider agreements/contracts, credentialing standards and processes
Client Care	• Coordinate client care and tracking

Source: RFP for Managed Services Organization

In carrying out its responsibilities, the Partnership Team is accountable to the Hamilton County Commissioners and to the Trustees of the County Mental Health and Alcohol Drug Addiction Services Boards. HCDHS acts as the Partnership Team's primary representative and liaison to Magellan because the majority of children and families are referred to Magellan through the Children's Services Division at HCDHS. Furthermore, HCDHS provides funding for 85.5 percent of the costs associated with the Magellan contract while ADAS and the Mental Health Board pay the remaining 14.5 percent.

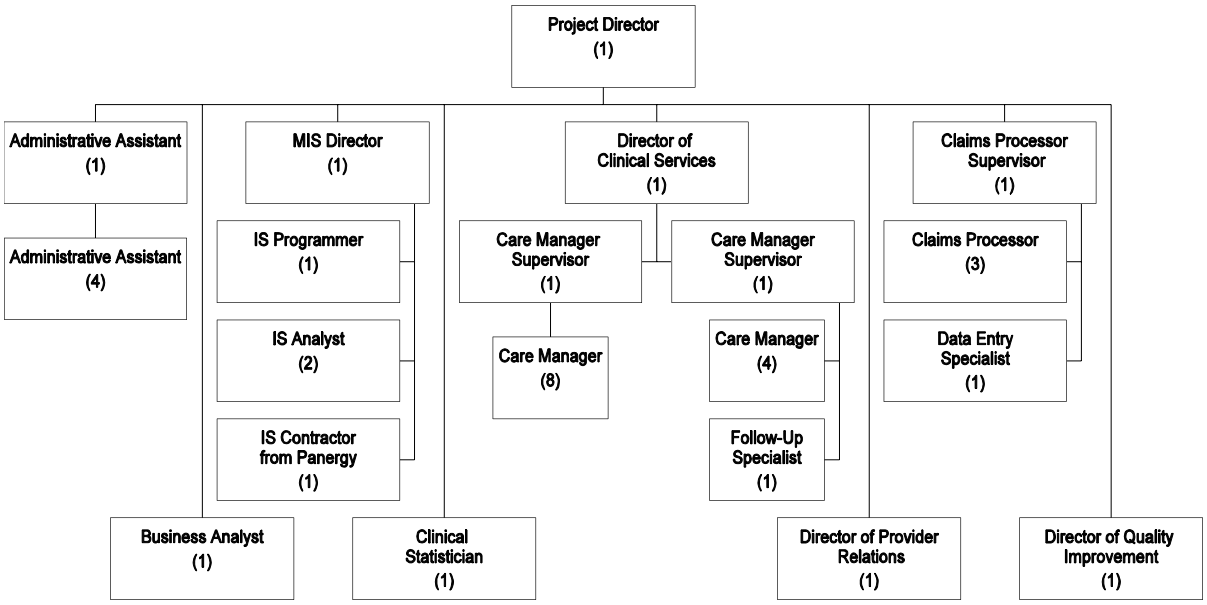
As the primary representative of the Partnership Team, HCDHS oversees and monitors Magellan's performance as the managed care entity. Pursuant to the contract, Magellan is responsible for developing and maintaining a network of service providers through which children and families receive outpatient mental health and out-of-home care placement services. Magellan and the network of service providers must adhere to the legal mandates of the Ohio Department of Job and Family

Services and the Ohio Mental Health Board, including the judicial orders of the court and the clinical authority legislated by the Mental Health Act and the Ohio Revised Code (ORC).

Organizational Chart

As the contracted Management Services Organization (MSO) for the Partnership Team, Magellan's regional office in Hamilton County consists of 36 full-time equivalents (FTEs). The chart below provides an overview of Magellan's organizational structure and staffing levels. All positions are shown in FTEs.

Chart 2-1: Magellan Behavioral Health



Summary of Operations

Children and families become involved with HCDHS' Children Services Agency when children are found to be at continuing risk of neglect, physical abuse, sexual abuse or dependency. Generally, reports are made by community members and HCDHS or the Hamilton County Juvenile Court responds to the report, investigates the case and makes any necessary referrals. Significant numbers of these children and their family members suffer from mental health problems. Some children were born affected by drugs and/or alcohol, and many children exhibit learning disabilities and hyperactivity disorders. Family members coping with these issues benefit from case management services, counseling and other mental health interventions. Through the implementation of behavioral health managed care, the Partnership Team expected to constrain rising health care costs while offering clients a fully integrated service delivery system based on managed care principles.

Upon receipt of a referral call, Children's Services caseworkers at HCDHS are responsible for determining if information provided by the reporter constitutes a report of alleged child abuse and neglect. Requirements for screening child abuse and neglect reports are detailed in Ohio Administrative Code (OAC) §5101:2-34-06. Information provided to childrens services agencies is kept confidential, unless it is in the best interests of the child to disclose information. OAC §5101:2-34-38 contains procedures for disclosing child abuse and neglect information maintained by children's services agencies.

Once the report of abuse, neglect or dependency has been substantiated, HCDHS Children's Services intake workers are responsible for performing investigations of reported information. At this point, a determination is made of the origin, type and extent of risk to the child. OAC §5101:2-34-32 to §5101:2-34-36 contain requirements for assessments and investigations. Intake workers are also responsible for establishing contact with case principles within State mandated time guidelines to complete risk assessments regarding the safety of alleged child victims. Time frames for implementing the Family Risk Assessment Model and procedures for developing this plan are also found in OAC §5101:2-34-331 and §5101:2-34-37.

If Children's Services determines that the child or family members involved in the case are in need of behavioral mental health services, a referral is made to Magellan who facilitates access for outpatient mental health and/or out-of-home care placement services. A designated Magellan intake care manager receives an initial telephone call from the Children's Services caseworker via a 24 hour direct referral line. Client records are also sent to Magellan through inner-office mail or by courier. The referral and accompanying client records are assigned to a Magellan care manager within three hours of receiving the initial referral. The Magellan intake care manager, in conjunction with the Children's Services caseworker, makes a preliminary determination of the urgency of the case and determines the appropriate level of care necessary to meet the needs of the client. Once the initial assessment and treatment plan have been completed by the Magellan intake care manager, the client is referred to a network provider capable of rendering the authorized services. Magellan's intake care

managers use an online referral system which helps in matching a client's identified needs with the *best suited* network service provider. The referral system enables Magellan to select providers based on their proximity to a client's home, school and community. The system also takes individual provider characteristics into account, including cultural background, gender and possible language barriers.

In collaboration with the Partnership Team, Magellan initially developed a network of 22 provider agencies. Currently, Magellan manages a network of 28 provider agencies who offer outpatient mental health and out-of-home care placement services to Hamilton County's Children Services client population. Under the coordinated direction of Magellan, the network of providers offers the following services:

- Psychiatric evaluations and psychological assessments
- Emergency mental health treatment
- Home and community-based therapy
- Neighborhood-based services
- In-home behavior management training
- Sexual abuse treatment
- Day treatment
- Pre and post adoptive counseling and group services
- Therapeutic foster care placements
- Group home placements
- Semi-independent and independent living arrangements
- Residential treatment

Magellan care managers monitor a client's progress through written service delivery plans furnished by provider agencies. In conjunction with HCDHS caseworkers, Magellan authorizes or denies authorization for any additional services requested by provider agencies. Magellan care managers monitor a client's progress until a case is closed and behavioral mental health services are no longer needed.

Financial Management Reporting Relationships and Responsibilities

The costs of the behavioral health managed care program comprise administrative expenses paid to MBH and payments made for claims submitted by service providers. Administrative expenses total approximately $3.2 million annually and the annual cost of claims is approximately $12.4 million. In accordance with the MBH contract, Magellan is compensated for its administrative services on a monthly basis by invoicing each member of the Partnership Team for the administrative services rendered for the previous month. Administrative costs for the MBH contract are shared among the members of the Partnership Team and based on the following fixed percentages: 85.5 percent for HCDHS, 12.5 percent for ADAS and 2.0 percent for MHB. Administrative expenses include the following costs and fees:

- Labor costs consisting of salaries, benefits and consultant fees;
- Variable costs consisting of travel, training, education, repairs and office supplies;
- Fixed costs which include rent, utilities and amortization costs;
- Supplemental costs consisting of project startup and ongoing Management Information System (MIS) costs; and
- Profit fee of 5.0 percent assessed on the total costs excluding supplemental costs.

Pursuant to the MBH contract, Magellan accepts and reviews claims submitted by contracted providers for behavioral mental health services covered under the MBH contract. Magellan maintains a separate account with a nationally chartered bank that has offices located in Hamilton County for all monies and funds for which Magellan has disbursement authority. On a monthly basis, Magellan notifies HCDHS of the service provider claims which have been approved for payment. As the primary representative of the Partnership Team, HCDHS transfers money into the account for the payment of approved claims incurred by service providers and processed by Magellan. Before approving a claim for payment, however, Magellan must verify that the claim has been submitted properly and that there is no duplication of payments for that claim. If Magellan denies payment of any properly submitted claim, Magellan is required to provide the contracted provider with a full explanation of the denial. Magellan is also required to maximize alternative funding sources including, third-party insurance and Medicaid Title XIX and IV-E monies before drawing HCDHS levy money for claims payment.

By establishing a contract with a managed care organization, the Partnership Team expected to control rising health care costs by consolidating a number of mental health services under the management of a MSO. In order to control costs, the Partnership Team included a cost savings plan in the MBH contract. The plan sets a target savings for Magellan equal to 15 percent of HCDHS' annual total expenditures for behavioral mental health services in FY 1996. Although the cost savings target would remain fixed at 15 percent throughout the life of the MBH contract, the Partnership Team realized that the actual dollar amount of cost savings would vary due to such factors as inflation, number of clients served and/or court-mandated requirements. The MBH

contract stipulates the method for calculating Magellan's annual cost savings level. Furthermore, the cost savings target of 15 percent is used as a performance standard/indicator to assist the Partnership Team in gauging Magellan's overall performance with regards to the MBH contract.

Performance Measurement and Quality Assurance Contractual Requirements

Pursuant to the MBH contract, Magellan is required to establish a comprehensive Continuous Quality Management (CQM) program that defines, operationalizes, and monitors the quality of care and services delivered to the Partnership Team and clients. In designing its CQM program, Magellan consulted various national accreditation groups including the National Committee for Quality Assurance (NCQA) and the Council on Accreditation (COA). In order to monitor Magellan's performance, the Partnership Team developed 20 standards and indicators with correlating incentives and disincentives totaling $100,000 each. At the end of each contract year, the Partnership Team reviews Magellan's performance and calculates the aggregate difference in total incentives and disincentives. In addition, Magellan prepares and furnishes Quality Improvement (QI) reports to the Partnership Team on a quarterly basis. The QI reports are used to monitor Magellan's operational performance on the various standards and indicators throughout the contract year. Examples of the performance standards and indicators include the following:

- Provider claims are paid on a timely basis
- Magellan maintains a competent provider network and monitors its performance
- Clients are satisfied with services and are provided with timely responses and resolutions to complaints and/or grievances
- Magellan provides timely, useful and complete data reports to the Partnership Team including status and progress information on individual Clients
- Magellan efficiently manages the provider network and HCDHS service dollars

In addition to the QI reports, Magellan is responsible for producing other quarterly and semiannual reports to assist the Partnership Team in measuring performance as well as in assessing Magellan's compliance with the MBH contract. For example, the MBH contract requires Magellan to perform quarterly service reviews on each contracted service provider. The reviews are intended to assist Magellan and the Partnership Team in evaluating provider performance by identifying strengths, weaknesses and areas that necessitate improvement. Magellan is also required to provide a variety of financial reports to assist the Partnership Team in overseeing Magellan's financial activities with regard to covered services.

As part of the CQM program, Magellan verifies the credentials, experience and licensure of those agencies and staff members responsible for the delivery of contracted services. In order to verify the credentials of service providers, Magellan performs biannual site visits both to ensure that network providers meet minimum standards of care and to assist providers with the transition into a managed

care environment. The credentialing process enables Magellan to identify the strengths and weaknesses of contracted providers compared to professional standards of care.

In accordance with the CQM program, Magellan has developed a complaint and grievance resolution process to ensure that the needs and interests of clients are adequately addressed and reported to the Partnership Team. Furthermore, considering consumers of substance abuse and mental health treatment services are especially vulnerable to being stigmatized by public disclosure of information, the Partnership Team realized the need for Magellan to develop a client rights and responsibilities doctrine. Magellan developed a doctrine that not only protects the rights of clients but also remains consistent with ODMH and ODJFS rules and regulations regarding care, supervision and discipline of children (OAC § 5122:2-1-02 and § 5101:2-7-09). Through credentialing site visits, Magellan is able to verify that service providers maintain the rights and responsibilities doctrine which includes the right to privacy and confidentiality of all records.

Technology Contractual Requirements

In contracting with a MSO, the Partnership Team recognized the need for a state-of-the-art Management Information System (MIS) which would be a critical component in the effective management and oversight of a child welfare and mental health service delivery system. As a result, and in accordance with the MBH contract, Magellan has developed and currently maintains a two-tiered MIS network. In the first tier of the MIS network, operational client data is entered and maintained by front-line employees within provider agencies. In conjunction with the Partnership Team, Magellan monitors and evaluates client data within the second tier of the MIS network. Management and oversight functions are performed through the analyses of data at both the individual provider and network system-wide levels. System-wide management and mandatory provider applications are listed in the following table. In addition, Magellan provides all software, equipment, supplies and personnel to carry out the tasks identified in **Table 2-2**.

Table 2-2: Required MIS Applications

Applications	System-Wide Management Level	Individual Provider Level
Central Administration of Multiple Sites	Yes	No
Master Patient Index	Yes	No
Automatic Creation of Patient Registration	Yes	No
System-wide Ability to Generate Real-time Site or System Reports	Yes	No
Claims Adjudication	Yes	No
Credentialing	Yes	No
Service Authorization	Yes	No
Client Registration and Eligibility	Yes	Yes
Appointments and Recalls	Yes	Yes
Treatment Plans and Planning	Yes	Yes
Client and Patient Assessment	Yes	Yes
Standardized Medical Records	Yes	Yes
Clinical Histories	Yes	Yes
Electronic Claims Submission	Yes	Yes
Progress Notes, including family relationships	Yes	Yes
Insurance Billing	Yes	Yes
Automated Collections	Yes	Yes
Provider Information Referrals	Yes	Yes
Email	Yes	Yes
Word Processing	Yes	Yes
Standardized Reporting	Yes	Yes

Source: HCDHS RFP for a Management Services Organization

The MBH contract details the required system specifications that Magellan must provide to the Partnership Team, and contracted service provider agencies. Furthermore, Magellan is responsible for the testing, configuration and installation of all new and existing hardware at Partnership Team and service provider facilities. Magellan is also required to train the Partnership Team and the provider agencies in the use of the MIS network, hardware, licensed programs and data collection systems. If the Partnership Team or the provider agencies experience difficulties with the MIS network, Magellan on-call support staff is available to provide computer maintenance and to answer MIS-related questions. Upon the expiration of the MBH contract, Magellan agrees to transfer control and operation of the entire MIS network to the Partnership Team.

Child Welfare Managed Care Arrangements

Generally, public child welfare agencies plan and develop their managed care models to address specific needs which are unique to their community. In developing the overall design of their managed care arrangements, child welfare agencies must consider funding streams, target populations, available MSOs and level of community support. Generally, child welfare managed care initiatives can be classified under the four separate arrangements discussed below.

- *The public model* constitutes the lowest level of operational change from the traditional service delivery system generally used by public child welfare agencies. The public model presumes that service delivery and care coordination activities will remain the responsibility of the public entity. However, managed care principals are incorporated into reimbursement procedures for contracted service providers. Additionally, the public model introduces performance measures into provider contracts to ensure high quality services. As of FY 1998, the public model was used in 10 child welfare managed care initiatives throughout the United States.

- *The lead agency model*, used in 19 state and local managed care initiatives by FY 1998, describes public child welfare agency operations where the agency contracts with a MSO to assume the responsibility for coordinating service delivery to a defined group of clients. The MSO becomes the lead agency in service delivery and its functions include: developing case plans, monitoring client progress and authorizing treatments. In this managed care arrangement, the lead agency provides all of the direct services or it may subcontract with a network of provider agencies.

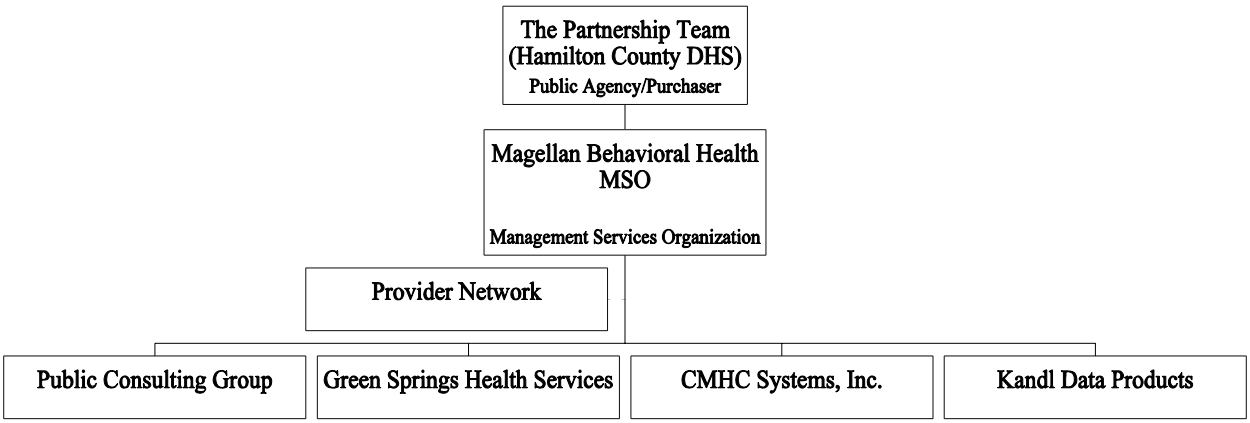
- *The Administrative Services Organization (ASO) model* arrangement is typified by public child welfare agency contracting for the administrative and/or management services of a private entity. The private entity, or ASO, is responsible for a variety of administrative activities including billing, reimbursement, MIS network development, technical support and training. Direct service delivery, however, remains the responsibility of the public child

welfare agency or becomes the responsibility of another contracted private agency. As of FY 1998, the ASO model was used in only three managed care arrangements nationwide.

- *The Managed Care Organization (MCO) model*, used in four child welfare managed care initiatives in FY 1998, requires a public child welfare agency to establish a contract with a MCO to administer service delivery through a panel or network of service providers. The MCO is responsible for developing the network of provider agencies and, in collaboration with the public child welfare agency, the MCO arranges, coordinates and authorizes services. As compared to the lead agency model, the MCO does not provide direct service delivery to children or families.

As of FY 1998, the GAO identified the Partnership Team's contract with Magellan Behavioral Health (formerly Magellan Public Solutions) in Hamilton County, Ohio as the largest child welfare managed care initiative operating under the MCO model. **Chart 2-2** presents the managed care/child welfare relationship in Hamilton County as of January 1998 which is most similar to managed care arrangements in the health care industry.

Chart 2-2: Organizational Relationship, Magellan and Partnership Team (MCO model)



Since FY 1998, significant changes have occurred in the organizational relationship between the Partnership Team, Magellan and its subcontracted agencies. Public Consulting Group, (PCG) a nationally recognized management consulting firm with experience in designing and implementing public managed care programs, was initially subcontracted by Magellan to assist the managed care entity in revenue maximization and claims processing oversight. As of FY 1998, PCG had assisted more than a dozen government clients in revenue maximization efforts, recovering more than $250 million in federal reimbursement. However, PCG's contract with Magellan is no longer active. Currently, Magellan is in the process of hiring a consultant to takeover the functions formerly performed by PCG, specifically maximizing outside revenue and Medicaid funding.

Kandl Data Products (KDP or Kandl) is a computer hardware supplier that was initially subcontracted to provide and install Magellan's MIS network, while also providing ongoing technical support and maintenance for network hardware installations. Kandl has since changed its name to Panurgy and is currently under contract with Magellan to provide hardware maintenance services and network administration support. CMHC Systems, Inc. was also subcontracted to develop and implement the managed care information system, accompanying software applications and automated clinical records associated with the initiative. As of FY 1998, CMHC Systems, Inc. had implemented provider-based information systems in over 600 sites nationally. The software supplier provided initial computer training on the MIS network for the Partnership Team, Magellan and provider agencies. Currently, CMHC Systems, Inc. remains under contract with Magellan offering network support services and implementing various software applications.

Green Spring Health Services (GSHS) was initially subcontracted by Magellan to manage outpatient behavioral mental health services available through the provider panel. GSHS was also responsible for credentialing the outpatient behavioral mental health providers within the network. As of FY 1998, GSHS was the third largest behavioral health care management agency in the country, coordinating services for 13.5 million clients. However, in FY 1999, Magellan purchased GSHS and assumed the responsibility of administering the outpatient services for the Partnership Team's managed care initiative.

Currently, Magellan is operating in contract year three of its five-year contract with the Partnership Team and has assumed internal performance of the responsibilities formerly subcontracted to Public Consulting Group and Green Spring Health Services. Magellan assumed the responsibilities in an effort to streamline its operations and reduce costs.

Managed Care Initiatives, National Examples

Nationally, the implementation of managed care in child welfare is a relatively new approach in serving the needs of identified abused and/or neglected children and their families. This managed care approach to child welfare has been fueled by a dramatic increase in child welfare caseloads, and in turn, rising costs associated with service delivery and administrative oversight. According to the

United States General Accounting Office (GAO), most managed care child welfare initiatives are small in scale, serving targeted populations of children and families in a limited number of locations around the country. The majority of child welfare managed care initiatives have only been in operation since FY 1996. Only Kansas and Sarasota County, Florida have implemented comprehensive managed care operations to serve all of the children and families involved in their child welfare systems. As of FY 1998 only 4.0 percent of the nation's child welfare population was covered under managed care arrangements operating in 13 states with a total of 36 initiatives underway.

Based on a GAO survey conducted in March 1998, **Table 2-3** presents information on 17 of the 36 ongoing child welfare managed care initiatives nationwide.

Table 2-3: Ongoing Child Welfare Managed Care Initiatives, FY 1998 [1]

Location and Project Name	Date of Implementation	Geographic Scope	Total Clients Served	Covered Population and Child Welfare Program
Kansas, Foster Care, Privatization [2]	March 1997	Statewide	4,950	All foster care
Massachusetts, Commonworks	January 1997	Statewide	683	Foster care for adolescents needing group care or residential treatment
Georgia, Multi-Agency Team for Children (MATCH)	July 1994	Statewide	660	Residential treatment services for severely emotionally disturbed children
Tennessee, Continuum of Care Contracts	July 1996	Statewide	2,500	Foster care for older children with moderate to severe emotional and behavioral problems
Wisconsin, Safety Services Program	January 1998	One County	750	Family preservation services for non-court families in Milwaukee County
Illinois, Performance Contracting [2]	July 1997	One County	23,200	Relative foster care in Cook County
Indiana, The Dawn Project	May 1997	One County	106	Wraparound services for seriously emotionally disturbed children served in multiple systems in Marion County
Florida, District 8 Privatization Pilot	January 1997	One County	420	All children needing protective services, foster care and adoption in Sarasota County
Colorado, Integrated Managed Partnership for Adolescent Community Treatment (IMPACT)	July 1997	Countywide	270	Foster care for adolescents needing group care or residential treatment in Boulder County
Colorado, Child Welfare Pilot	October 1997	Countywide	1,687	All child welfare services in Jefferson County
Colorado, Child Welfare Pilot [2]	January 1998	Countywide	320	All child welfare services in Mesa County
New York, Family Support Center Program	October 1994	Countywide	155	Emergency foster care services for children in Onondaga County
New York, N/A	January 1989	Countywide	1,750	Preventative services for children in Albany County
Wisconsin, Wraparound Milwaukee	June 1996	Countywide	600	Wraparound services for at-risk children in need of residential treatment in Milwaukee County
Ohio, True Care Partnership [2]	November 1997	Countywide	3,220	Outpatient and out-of-home care placement services for children in Hamilton County
Michigan, Interagency Family Preservation Initiative	October 1995	Selected Cities	166	Wraparound services for seriously emotionally disturbed children served in multiple services in select cities.
Florida, Privatization Pilot	October 1997	District-wide	318	Foster care and independent living arrangements for adolescents in District Four

Source: GAO Report, *Child Welfare - Early Experiences Implementing a Managed Care Approach*

[1] Information is only provided for initiatives serving 100 or more children and families.

[2] Locations with multiple ongoing initiatives

The remaining 19 child welfare managed care initiatives, excluded from the preceding table, serve fewer than 100 children and are primarily implemented on the local level. For example, with the exception of Hamilton County, three counties in Ohio have implemented child welfare managed care programs serving an average of 22 children each. As of FY 1998, the majority of children served in managed care settings included children in need of mental health services, residential or group home services. The large number of children served and the multiple managed care initiatives currently underway in Hamilton County (see **Table 2-3**) indicates that the Partnership Team and Magellan (True Care Partnership) is at the forefront of this relatively new approach to service delivery in child welfare.

Medicaid, Waivers and Any Willing Provider

Medicaid programs, administered by states and implemented by counties, have increasingly been converted from traditional to managed care delivery systems for the purposes of improving service quality, client access and cost predictability. Between FY 1993 and 1998, the number of clients enrolled in Medicaid managed care programs quadrupled, growing from 4.8 million to 16.6 million enrollees. In FY 1997, approximately 48 percent of the country's Medicaid population was enrolled in managed care delivery systems for physical healthcare. As of December 1999, eleven Medicaid managed care plans were in operation in the State of Ohio, offering physical healthcare services to Medicaid-eligible clients in 16 counties. Children Services agencies often provide services for the same clients receiving health care services under the Medicaid program. The growing number of Medicaid managed care programs has prompted many child welfare agencies to look towards managed care to help control rising costs and to help consolidate the often fragmented services necessary to address the needs of the Children Services population.

According to the Balanced Budget Act (BBA) of 1997, states need to obtain waivers (under authority of Section 1915(b) or 1115 of the Social Security Act) from the federal government in order to implement mandatory managed care plans for Medicaid recipients. A component of the waiver program was called *Medicare + Choice* and allowed greater use of managed care among state and local social service Medicare agencies. The waiver authority, allows states to waive certain Medicaid requirements for innovative efforts designed to achieve program objectives, including managed care initiatives. Tennessee, Oregon and Hawaii implemented statewide Medicare and Medicaid reforms under the waiver demonstration projects.

The managed care programs which operate under the authority of 1915(b) or 1115 waivers use closed systems in which clients may only receive services from providers who are in the managed care network. As a result, the closed system limits provider choice but increases the control managed care entities have in coordinating service delivery and controlling costs. Cost controls can also be achieved through the use of a capitation payment system in which MSOs and, in turn, network providers are prepaid a fixed amount for rendered services. According to the GAO report *Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal*

Costs, the GAO found that three of the four states evaluated in the report did not maintain cost neutrality (as required under the demonstration projects) and could actually increase federal Medicaid expenditures for states operating under a 1115 waiver. Although the State of Ohio has been granted a 1115 waiver, it has not been implemented and the State does not plan on renewing the waiver. In Hamilton County, the Partnership Team intended on implementing a capitation payment system with Magellan, but has chosen to maintain a fee-for-service payment system because its managed care network is not closed.

In addition to 1115 and 1915(b) waivers, Department of Health and Human Services (HHS) may establish child welfare demonstrations which waive certain requirements in Title IV-E (foster care) funding. The Adoption and Safe Families Act of 1997 gave HHS the authority to annually grant Title IV-E waivers for 10 states from FY 1998 through 2002. In its agreement with Magellan Behavioral Health, Hamilton County operates under a Title IV-E waiver for the provision of therapeutic foster care services and other out-of-home care placement services. However, the majority of available behavioral mental health services offered to clients, pursuant to the MBH Contract, are funded by the Community Mental Health Medicaid Program (Community Medicaid Program) and administered through a series of agreements with entities such as the Ohio Department of Mental Health (ODMH), ODJFS, HCDHS and Hamilton County Mental Health Board (MHB). The Partnership Team members, through Magellan, contracted with mental health provider agencies for the provision of Medicaid eligible services. The Title IV-E waiver allows HCDHS to merge its Medicaid funding sources with those of other Partnership Team agencies to fund behavioral health managed care initiatives, in essence creating a Medicaid block grant for mental health services in Hamilton County.

Because Ohio's 1115 waiver has not been implemented, Magellan's provider network can not be closed. In addition, the Any Willing Provider (AWP) clause of the Social Security Act requires managed care entities to permit and pay for Medicaid recipients to receive services from any Medicaid-approved provider of choice which increases costs to HCDHS and the Partnership Team. Except in limited cases, HCDHS does not track costs associated with clients who seek services outside the network due to the AWP clause and the total annual costs incurred by the Partnership Team for AWP services is unknown.

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Financial Management and Reporting

Performance Measures

The following is a list of performance measures that was used to conduct the review of the financial management and reporting component of the contract between Magellan Behavioral Health (MBH) and the Hamilton County Department of Human Services (HCDHS).

- Evaluate administrative fee billing
- Assess the appropriateness of the billing process in comparison to stipulations of the contract
- Analyze the claims reconciliation process
- Assess the timeliness of claims entry into the billing system
- Assess the level of service denials in comparison with contract stipulations
- Assess the implementations of the 15 percent savings plan and the process used to establish savings
- Evaluate the content and utility of financial reports in comparison with the contract requirements
- Assess the usage of blended funding
- Analyze the application of Magellan financial performance incentives by HCDHS

Findings/Commendations/Recommendations

Administrative Fee Billing

F3.1 MBH renders provider and care management services to the Partnership Team at a budgeted cost of $3.2 million per year for each year of the contract. This amount consists solely of administrative costs comprised of the following:

- **Labor Costs:** salaries, benefits, and consultant costs
- **Variable Expenses:** travel, training, education, repairs, office supplies and other items
- **Fixed Expenses:** rent, utilities, and amortization costs
- **Supplemental Costs:** project start-up and ongoing MIS costs
- **Profit:** 5.0 percent of expenditures excluding supplemental costs

In 1998, the total amount for claims paid by HCDHS to MBH was $12,459,783. The total allocation from the county, therefore was approximately $15.6 million. This information for subsequent fiscal years has not been calculated. During the first two years of the five-year contract, MBH billed lower administrative costs than initially projected. In FY 1998, the difference between budgeted and actual costs was $580,586 or 19.0 percent and, in FY 1999, the difference between budgeted and actual costs was costs $317,044 or 10.1 percent. Generally, budgeted amounts and actual costs should have a minimal variance. **Table 3-1** presents the budgeted and actual costs for years one and two of the contract.

Table 3-1: Actual and Projected Administrative Expenses, FY 1998 and 1999

	Year One Projected[1]	Year One Actual	Variance $ %	Year Two Projected[1]	Year Two Actual	Variance $ %
Labor	$1,619,313	$1,061,063	($558,250) (34.5%)	$1,712,496	$1,483,346	($229,150) (13.4%)
Variable	$450,822	$419,744	($31,078) (6.9%)	$566,759	$547,174	($19,585) (3.5%)
Fixed	$260,115	$269,753	$9,638 3.7%	$260,115	$241,796	($18,319) (7.0%)
Profit[2]	$116,512	$116,508	($4) n/a[3]	$126,969	$126,972	$3 n/a[3]
Supplemental	$611,802	$610,910	($892) (.01%)	$483,989	$433,996	($49,993) (10.3%)
Total	**$3,058,564**	**$2,477,978**	**($580,586) (19.0%)**	**$3,150,328**	**$2,833,284**	**($317,044) (10.1%)**

Source: Magellan budgeting documents
[1] Projected costs for year one and two are original budget costs.
[2] Profit is assessed at 5.0 percent of labor, variable and fixed costs expenditures.
[3] n/a- negligible

The significant differences in **Table 3-1** are discussed below.

- *Labor costs for FY 1998 and FY 1999 were under budget:* In FY 1998, labor costs were under budget by approximately 34.5 percent due to staffing vacancies of 5.48 FTE's. In addition, MBH acquired Green Springs Consultants, which was previously included as a labor expense.

- *Variable costs for FY 1998 and FY 1999 were under budget:* For FY 1998 and FY 1999, variable costs were under budget 6.9 percent and 3.5 percent, respectively, due to lower than expected costs for overtime, education and seminars, printing and copying, and telephone expenses.

- *Fixed costs exceeded budgeted amounts in FY 1998 and were under budget for FY 1999:* In FY 1998, rent costs exceeded the original budgeted amount. For FY 1999, another increase in rent expenses was offset by a significant decrease in taxes and insurance costs.

- *Profit costs for FY 1998 and 1999 did not experience significant fluctuations:* Profit is assessed at 5.0 percent of labor, variable and fixed cost expenditures. While these areas were under budget, the profit expense charged did not fluctuate accordingly. MBH representatives stated that the 5.0 percent profit cost as based on the project

budget and would not reflect cost savings, although this issues is not addressed in the contract. HCDHS representatives concurred that the 5.0 percent profit cost would not deviate from project budget amounts during the contract period.

- *Supplemental costs for FY 1999 were under budget:* For FY 1999, supplemental costs were under budget by approximately 11.5 percent due to decreased software expenses.

Budget variances should not exceed an established minimal amount. This will prevent both overspending and potential overestimation of resource needs.

R3.1 Because wide variances in budgeted versus actual amounts have not been reconciled, HCDHS and MBH may overestimate resource needs in some areas. An established minimal variance would help MBH and HCDHS fiscal staff better forecast total contract costs and maintain control over expenditures.

F3.2 The project budget has been amended twice since the inception of the contract, once in September 1999 and again in July 2000. Budget amendments to the contract are allowable with agreement from each party and became necessary to reflect lower levels of spending. **Table 3-2** contrasts the budget amendments for Sept. 1999 and July 2000 with the original budget from Oct. 1997.

Table 3-2: Administrative Expense Budget Amendments

	Original Budget October 1997	Budget Amendment September 1999	Variance 1997 vs.1999 $ %	Budget Amendment July 2000	Variance 1997 vs. 2000 $ %
Labor	$8,727,635	$8,461,674	($265,961) (3.0%)	$8,121,471	($606,164) (6.9%)
Variable	$2,812,823	$2,926,419	$113,596 4.0%	$2,844,018	$31,195 1.1%
Fixed	$1,300,575	$1,448,740	$148,165 11.4%	$1,527,807	$227,232 17.5%
Profit[1]	$642,679	$642,679	$0 n/a	$642,678	($1) n/a
Supplemental	$2,547,758	$2,487,746	($60,012) (2.4%)	$2,436,873	($110,885) (4.4%)
Total	**$16,031,470**	**$15,967,258**	**($64,212) (0.4%)**	**$15,572,846**	**($458,624) (2.9%)**

Source: Project budget and Magellan budget amendments.
[1] Profit is assessed at 5 percent of total expenses (labor, variable, fixed)

Although MBH and HCDHS amended the budget to reduce variances, the differences between projected amounts (**Table 3-1**), amended amounts (**Table 3-2**), and actual expenditures remains high. HCDHS and MBH appear to be unable to accurately project the future costs of the project. While underspending budgeted amounts is generally considered a positive attribute, unspent funds also indicate a weak correlation between the budget and strategic plans. The legal level of appropriation of the contract should be reviewed to create a more direct flow from the governing authority to MBH leadership.

The current process to amend the contract is not conducive to regulating budget amounts. Several County offices, including the Prosecutor's Office and the Commissioner's Office, are included in the amendment process. The unprecedented nature of the contract and the limited past expenditure history necessitates budget revisions. Accordingly, efforts should be made to ensure that the budget amendment process if facilitated by an appropriate legal level of approval.

R3.2 HCDHS has been hesitant to amend the contract because of the cumbersome amendment process. The amendment process should follow the process used to approve the original contract. While the standard approval process must be used for contract amendments and changes, The Partnership Team should develop a system to expedite amendments due to the unique nature of the contract.

F3.3 **Table 3-3** shows forecasted administrative expenses for MBH during the remaining three years of the contract, based on the identified budget variance experienced in the first two years of the contract.

Table 3-3: Forecasted Administrative Expenses

Year 3 Budgeted	Year 3 Projected [1]	Variance $	Year 4 Budgeted	Year 4 Projected [1]	Variance $	Year 5 Budgeted	Year 5 Projected [1]	Variance $
$3,214,195	$2,748,137	($466,058)	$3,476,766	$2,972,635	($504,131)	$3,570,623	$3,052,883	($517,740)

Source: Magellan Budgeting Documents

[1] Projected expenses are based on the average of FY 1998 and 1999 actual variances from budgeted expenses.

The trend established in the first two contract years is an average variance of 14.5 percent. Applying the average of the variances from budgeted to actual expenses for FY 1998 and FY 1999, (14.5 percent), the forecasted MBH budget would be approximately $8.8 million for the three-year period. This amount is $1.5 million under original project budget amounts for the remaining three-year period.

R3.3 The Partnership Team should require MBH to develop annual strategic planning documents, which should correlate planned annual activities with required resources. The annual budget should be based on planned activities and should be amended as needed throughout the year.

HCDHS and the Partnership Team members should continue to include a proposed budget in future Request for Proposals (RFPs), but should plan to amend the contracts based on the actual resources used by the contracted management services organization (MSO). Tying the budget to annual plans will provide a greater level of stability within the budgeting process and should reduce the level of variances experienced by the Partnership Team and the MSO.

The Partnership Team should continue providing MBH with a fixed profit amount for its services but the fixed amount should not be directly tied to the dollar amounts included in the contract budget. The fixed profit amount should be articulated in the contract under compensation. In addition, the Partnership Team should include incentives for improved economy and efficiency. MBH does not currently benefit from economizing or budgetary revisions, although Magellan has provided cost savings when compared to expected financial outlays. Basing MBH's profit on a fixed amount, coupled with a performance incentive for planning, budgeting and expenditure reductions, would improve financial coordination, maintain MBH's incentive to perform efficiently, and potentially result in additional cost savings to the Partnership Team.

Claims Processing

F3.4 Service providers are responsible for administering the level of care (LOC) to clients as directed by HCDHS and Magellan. Service providers enter all required client encounter data into the Managed Care Information System (MCIS) within ten working days of the date on which such services and care are rendered. The required encounter information includes the following:

- Date the service was provided;
- Time the service was rendered;
- Duration of the provided services;
- Applicable service code(s); and
- Authorization number.

MBH staff has the responsibility of data entry, which includes authorization numbers and service codes into the CMHC information system. The MBH Information Systems Department runs a nightly production job which compares the data entered into the CMHC system to the encounter data entered into the MCIS by the service providers. The nightly job electronically imprints authorization numbers, corresponding service code(s) and units authorized by MBH intake care managers and HCDHS to a designated provider. This electronic imprint serves as pre-authorization enabling the service provider to enter claims only for a particular client, type of service and at a certain rate. Claims without prior authorization or which lack required data are considered to be in pending or denied status.

MBH advises providers of a claim in denied or pending status within 24 hours. Claims with prior authorization and sufficient information are considered clean and will be paid.

F3.5 HCDHS, MBH and the providers use the Multiple Agency Community Services Information Systems (MACSIS) to process Medicaid eligible claims. MACSIS is Ohio's statewide processing system for Medicaid claims, which enables HCDHS to monitor state and local funds, and private funds available for client claim reimbursement. MACSIS is a client-centered system designed to capture information at the client level and link the information to the responsible local government board. In MACSIS, each local government board is set up as a company. When the claims data is received from an agency, it is linked to a board via the Universal Client Identifier (UCI) and benefit plan. MACSIS will extract Community Medicaid claims and forward them to the Ohio Department of Job and Family Services (ODJFS) for determination of the Federal Financial Participation (FFP) payment. In cases where the client is Medicaid eligible, all applicable services should be billed to Medicaid.

Service providers can submit Medicaid and non-Medicaid claims to MBH for processing. Only Medicaid approved service providers are able to provide and bill for Medicaid reimbursable services. These claims are submitted electronically to MACSIS, and then forwarded on to the Ohio Department of Mental Health (ODMH). Non-Medicaid claims are referred to as True Care claims, and are paid for by the True Care Partnership.

The CHMC computer system connects HCDHS, MBH and the providers. Each of the three parties has varying capabilities within the system. The automated billing process is one component of the total system. MBH and the providers have access to the billing subsystem for entering information. DHS has access only to view information. MBH enters preauthorizations for services detailing the client name, provider, and units of services authorized. Providers enter claims in the system throughout the month. Each night, these systems batch together claims entered by providers that match authorizations entered by MBH and the batches are marked for payment. If a claim does not match the authorization, the claim is pending or denied.

In order for a provider to receive payment for services rendered during the month, the provider has until the tenth of the following month to enter claims. After the tenth of a month, the provider cannot enter any old claims until the first of the following month. For example, the provider has until July 10 to input June claims. After July 10, June claims cannot be entered until August 1. Claims for the current month can be entered anytime during that month. The provider must obtain initial authorization from MBH in order to render services for reimbursement. Currently, the MBH care manager faxes or mails a copy of the authorization with supporting materials to the provider. In order to monitor services provided and to ensure that the services provided are medically necessary for the client, the

preauthorization of services is a required and necessary process. Also, authorization of services enables HCDHS to manage the cost of care provided to its clients.

Currently, the service providers must submit a Concurrent Clinical Service Request (CCSR) for re-authorization of continuing services for existing clients. This process, designed by MBH, ensures that continued care is medically appropriate and approved by clinical staff at MBH. The CCSR process for re-authorization of services has reduced the number of claims labeled as denied or pending by MBH. By reducing the number of claims which are denied and/or pending, the actual cost of providing services will more closely follow the date of service. **Table 3-4** reflects the decrease in denied claims through implementation of the CCSR in May 2000.

Table 3-4: Number of Claims Denied ,Year 2000

Month Denied	Total Billed	Total Denied	Percentage Decrease
January	$1,663,878	$256,929	19.0%
February	$1,540,332	$228,545	18.0%
March	$1,782,524	$384,037	28.0%
April	$1,592,698	$250,854	19.0%
May	$1,690,776	$154,872	10.0%
June	$1,594,169	$144,980	10.0%
July	$1,594,375	$104,574	7.0%
August	$1,519,633	$82,180	6.0%
September	$1,143,170	$94,813	9.0%

Source: Magellan Claims Processing Department

Other savings experienced by MBH include the following:

- The elimination of two temporary billing positions created primarily for work on claims appeals has led to a savings of $19,200 over a six-month period
- Approximately 100 labor hours per month, based on 500 CCSR's processed and approximately 10-15 minutes saved per request
- The payment of less overtime for regular FTE's, and approximately 1100 hours of saved time for billing and clinical staff, as well as for management for the 7,000 claims processed over the course of six months (June- Dec. 2000)

C3.1 By implementing the CCSR process in May 2000 for re-authorization of continued services for existing clients, MBH has reduced the number of claims being denied due to unauthorized claim status from a high of 28.0 percent in March 2000, to a low of 6.0 percent in August 2000. HCDHS required the service providers to complete and return the CCSR

form beginning May 1, 2000. Beginning August 1, 2000, MBH required the CCSR form to be filed electronically, thereby reducing the time required to process the authorization request. By filing the CCSR electronically, MBH and HCDHS case workers are able to access clinical information regarding current and past clients with relative ease. **Table 3-5** shows further analysis of the reduction of claims experienced by MBH.

Table 3-5 CCSR Claims Denial Rates

	FY 1999	Jan. - May 2000	June - Dec. 2000
Denied for No Prior Authorization[1]	21,376	13,683	7,433
Total Approved Claims	174,980	82,143	111,798
Total Claims Processed	205,915	102,503	120,766
Percent Denied vs. Total Claims Processed	10.3%	13.3%	6.1%

Source: MBH

[1] These figures represent original denied claims and do not represent the current status of a claim, i.e., a claim that had been denied could currently be in a paid status

R3.4 In order to reduce the number of claims being labeled as denied or pending, the service providers should be made aware of any change in Medicaid eligibility status. On a monthly basis, MBH should supply the service providers a list of Medicaid eligible client numbers with the corresponding beginning and end dates of Medicaid eligibility for each client. MBH should suggest that providers obtain the requisite T-1 or fiber optic level of connectivity for downloading the MACSIS reports and ensuring front-end Medicaid eligibility of clients.

By verifying Medicaid eligibility of clients on the front end of claim submission, MBH will reduce the amount of administrative time spent on adjudicating claims through the appeal process. Service provider verification of Medicaid eligibility before claim submission to MBH will reduce the number of claims in denied status. By reducing the number of claims in denied status, the provider will also spend less time adjudicating the denied claims.

The Ohio Department of Administrative Services (ODAS) should assist MBH by providing training on the entire Medicaid Management Information System (MMIS) software suite, in order to minimize or eventually eliminate the manual review of Medicaid claims. ODAS consultation to either use MMIS or to purchase another software application to this end could result in a savings of between 90 to 120 work hours per month, which could be allocated to other tasks.

F3.6 Currently, the service providers can submit claims to MBH for processing up to one year after the date of service. MBH does not have an incentive or disincentive plan, which would prompt providers to submit claims for processing in a more timely manner, nor is there legal support outside of the contract to fortify MBH's insistence for the timely submission of claims. The contract between the service providers and MBH does not have language to require service providers to submit claims for processing in a timely fashion. Because service providers can submit Medicaid claims for processing at any time during the 12 months following the date of service, and have been allowed to submit claims over 2 years old, HCDHS is not aware of the true dollar cost of incurred services, not yet submitted for payment. Without a deadline for claim submission, the time required to adjudicate discrepancies between the service providers and MBH increases, as the time frame to investigate could potentially be one year or more prior to the current date.

R3.5 MBH should develop policies and procedures within the Administrative Manual requiring service providers to submit claims for reimbursement in a more timely manner. In order to expedite the filing of claims by the service providers, MBH should consider narrowing the time allowed to submit Medicaid claims to the MBH system from one year to three months after the date of service. Medicaid claims that are not submitted to MBH within the time frame and then are subsequently denied by Medicaid should not be paid by MBH. Also, HCDHS should consider penalizing service providers for non-Medicaid claims submitted beyond the three-month deadline. A sliding percentage scale financial penalty could be used to discourage late submission of claims.

Furthermore, HCDHS should require MBH to provide a monthly report detailing the dollar value of claims for services that have been rendered, but remain unpaid. The Issued But Not Received Report (IBNR), is currently produced by client only on a quarterly basis. The IBNR should be produced as a monthly summary on an aggregate level for providers as well as for clients. HCDHS should determine the format in which this information should be presented to ensure reliability and usefulness. By having the dollar value of unpaid claims provided on a monthly basis as a component of current management reports, HCDHS will be able to better project their current liability.

F3.7 The MACSIS system is extensively used to monitor the Medicaid eligibility of clients. MACSIS has the ability to automatically update the client's Medicaid eligibility information. Monitoring the correct eligibility status of clients is a significant problem encountered by the service providers and MBH. Providers must check to determine if clients are covered for Medicaid services. Often, providers bill for services to state or local funds when Medicaid funds were available for the client, which increases costs to HCDHS. By maintaining current Medicaid eligibility data, MACSIS can help maximize Medicaid reimbursement, which in turn allows for better use of state and local funds.

R3.6 HCDHS and MBH should consider developing an incentive or disincentive system to encourage providers to bill to Medicaid. The brief time required to check Medicaid eligibility would be offset by decreased total costs to DHS. Additional information on the use of MACSIS can be found in **F3.5**.

F3.8 Three possible scenarios currently exist which may result in service providers receiving an overpayment for rendered services. The following three scenarios have been documented as occurring during the contract period and include:

- Service providers billing Medicaid directly;
- Service providers billing bundled or all-inclusive rates; and
- Service providers billing for services with the same date of service in different billing cycles.

Each of the conditions listed above can cause an excessive transfer of funds from HCDHS to MBH for provider services. During FY 1998, an independent audit determined that MBH made overpayments to service providers totaling approximately $265,000. This amount is 2.1 percent of the total amount paid by DHS to Magellan, $12,459,783, and was withheld from the following fiscal period's budget allocation. The FY 1999 reconciliation is in progress.

Approved Medicaid service providers can submit Medicaid eligible claims to MBH for processing each month. When entering claims information, the providers can submit a bundled or all-inclusive fee for Medicaid eligible services which may be used to also cover the per diem rate. A bundled or all-inclusive fee includes charges for services such as psychiatric counseling and therapy. Bundled service fee line items are not presented in such a way as to allow for easy scrutiny. Fee packages of this nature should permit reviewers to analyze the detail of each service provided and if necessary, generate documentation to this effect. Bundled service fees were originally negotiated between MBH and the service providers to maximize Medicaid funding and limit local liability.

F3.9 During FY 1998 and through June 1999, service providers were billing MBH a Medicaid bundled or all-inclusive service fee and were billing the Hamilton County Community Mental Health Board (Mental Health Board) directly for out-of-home care charges. The billing arrangement caused the service providers to be paid twice for the out-of-home care charges: one payment was made from the Mental Health Board and an additional payment was made from MBH. This type of error can still occur; however, MBH has developed a control feature to reduce the probability of this fault by performing a post-edit of paid Medicaid claims.

Beginning on July 1, 1999, Medicaid claims were submitted from MBH to the Mental Health Board. The Mental Health Board began performing pre-edits to monitor for duplicate claim checks prior to sending the claim file to MACSIS at the state level for Medicaid processing. The State sends a file to Mental Health Board identifying which claims can be successfully paid and which claims have been denied or rejected. Mental Health Board pays 100 percent of a claim that MACSIS deems payable. A receipt of payment from Medicaid, called an ERA, is submitted to Mental Health Board. Mental Health Board forwards the ERA to MBH showing only Medicaid claims pertaining to MBH clients. The Mental Health Board then pays the County agency responsible for each Medicaid eligible claim. The Mental Health Board later receives reimbursement from ODJFS for Medicaid eligible claims. After the Mental Health Board pays the Medicaid claims, MBH reconciles their Medicaid claims to the ERA. The post-edit is performed to ensure that only clients of HCDHS are allowed to access funds designated for them and that duplicate payments made to providers are prevented.

F3.10 Service providers have billed MBH for Medicaid eligible services with the same date of service (DOS) rendered to an existing client in different billing cycles causing an overpayment to occur. Service providers sometimes submit all-inclusive or bundled service fee claims in one billing cycle and then submit a Medicaid reimbursable claim using a regular outpatient service fee code in a different billing cycle. MBH reimburses the all inclusive or bundled fee and also submits payment for the Medicaid match portion.

Although MBH has the responsibility to detect Medicaid duplicate billing, system short falls and the complexity of the Medicaid claims processing practices, make monitoring of overpayment difficult. HCDHS and Medicaid may both render payment for an individual service more than once, resulting in an overpayment to service providers. According to the Health Care Financing Administration (HCFA), "the bundled rate methodologies do not produce sufficient documentation of accurate and reasonable payments, and may result in higher payments than would be reasonable on a fee-for-service basis for each individual service and thus do not meet the statutory intent of the law." Furthermore, § 1902 (a)(30)(A) of the Social Security Act, requires that states have methods and procedures to assure payments are consistent with efficiency, economy, and quality of care. Bundled rates submitted and paid without supporting line item detail are not consistent with economy since the rate does not accurately reflect true costs and services provided can not be determined. The bundled rate methodology is inconsistent with efficiency, since it can require additional time to adjudicate claim(s) and complete reconciliations.

MBH can provide HCDHS with a detailed report listing line items in each bundled fee for each client. HCDHS management stated that claims reports were originally prepared in this manner, but the volume of information involved eventually overloaded the HCDHS Oracle

database system. HCDHS does not perform sample reconciliations between line items in bundled charges and itemized services.

R3.7 HCDHS should perform sample testing of the line item detail of bundled charges on a regular, periodic basis. The financial monitor (see **R3.14**) should be responsible for correlating bundled charges with line items for units of service provided. Sample testing should be performed on each provider at least annually to ensure that additional ineligible costs have not been included in bundled rates. By examining only the bundled service fee, MBH and HCDHS lose the detail to support each of the services provided. Also, the reconciliation of services provided to Magellan payment disbursements can become difficult because HCDHS does not have a documented audit trail of provided services. Service providers also have the ability to circumvent the system, leading to excessive payments rendered by HCDHS. Sample testing should be sufficient to determine if ineligible charges have been included in the bundled rates. If HCDHS determines that ineligible charges are frequently included, then HCDHS should require that the service providers submit claims for each individual service code provided, not in a bundled format.

F3.11 MBH has the capability to edit claim submissions for Medicaid eligible claims with the same DOS to the same client submitted in the same billing cycle. MBH manipulates the claim information from the service providers, in order to compare the dates of service corresponding to the service codes to the client's identification number, thereby, allowing MBH to document services provided to a client which may already be included within the bundled service fee. MBH nets the bundled fee with the individual service fee to arrive at the total service fee to be processed and paid. However, if the bundled service fee is entered by the service provider in a different billing cycle than the individual service fee code, MBH is unable to detect duplicate services. Currently, MBH is developing a process of system edits to ensure that Medicaid eligible claims submitted for payment in different billing cycles, with the same DOS, and with the same client will not result in overpayment.

HCDHS requires service providers to use a special code when submitting bundled service fees, linking that code to an all-inclusive rate. Use of the special code by the service providers ensures that any therapeutic charges are deducted from the bundled service fee and billed to Medicaid. Any per diem fee above therapeutic charges is paid by MBH.

The first year of the contract, FY 1998, was exploratory for the participants in this contract. Because of the unique nature of this contract, comparable results from like arrangements were unavailable to HCDHS and MBH. MBH is also working with the Mental Health Board to receive admittance advice in a timely manner, which will aid in the reconciliation of possible overpayments. In an effort to ensure that Medicaid overpayments are minimized, MBH has begun to develop a Medicaid reconciliation process and format. The reconciliation process and formats are being presented to providers at provider user meetings.

C3.2 It appears that MBH has used best efforts, as required by the contract, to ensure that duplicate payments are minimized and investigated. MBH is also required to ensure that any overpayment for services are investigated and recovered. MBH has recognized that the potential to submit claims for duplicate payment on Medicaid eligible services exists and has begun development of a novel duplicate claims reconciliation software package. MBH has quantified the amount of overpayment rendered due to this complex billing practice and has presented the overpayment calculations to HCDHS and the service providers for comments and final reconciliation of the FY 1998 contract period.

R3.8 In order to avoid a material amount of overpayments due to the payment of duplicate Medicaid eligible services, HCDHS should make every effort to actively participate in the development of the Medicaid reconciliation processes. Due to the extensive effort required to implement MACSIS, MBH has fallen behind in regards to reconciling paid Medicaid claims. HCDHS should coordinate the efforts between MBH, the Mental Health Board and the service providers in order to develop a management action plan ensuring that overpayments due to Medicaid eligible claims are minimized in the future. The coordination of efforts by HCDHS could include the following:

- Appoint a joint effort committee with representatives from all involved parties inclusive of HCDHS to discuss Medicaid overpayments and other difficulties encountered;
- Enforce mandatory monthly meetings to discuss the current condition; and
- Commission a study in an effort to understand how other government agencies address similar issues.

Also, MBH should develop system edits and/or required procedures to ensure that duplicate payments for Medicaid eligible services are not processed and reimbursed twice. HCDHS should require MBH to ensure that a duplicate claim edit exists at time of service provider data entry. This edit should flag or alert the service provider that a duplicate claim line may have been entered preventing further processing of the claim in question. The flag should not be released until an appointed service provider representative manually releases the flag. This internal control would require the service provider to investigate the possible duplicate before submitting a claim to MBH.

MBH claims processing should develop a more sophisticated duplicate claims system edit in the CMHC system. The edits should be designed to review service provider submitted claims for duplicate billings occurring in bundled and itemized claims from the same or different billing cycles with the same date of service to the same client. This edit level would further decrease the possibility of overpayment for duplicate claims.

The current process for claim editing is a staff of 4 MBH personnel with average salaries of $25,000 each spending approximately 7.5 hours a day, 3 to 4 days a month to manually review all submitted claims to ensure that no duplicate claims are processed. The Recipient Eligibility Subsystem Key Panel within MMIS allows for each client to be filtered by name to determine payment history. This equates to an amount of labor hours between 90 to 120 hours, with an associated monthly payroll cost between $1,080 and $1,440. Further, the Claims Processing Department has received limited training on only a minimal number of applications within the MMIS software package.

Finally, MBH should pursue a comprehensive training program in order to fully maximize the potential of existing software. The savings to be captured from automating current manual procedures presents expenditures for further training in a cost-beneficial light, and can serve as an impetus for implementing more technology in daily tasks.

F3.12 Magellan does not conduct a monthly overpayment analysis for each participating provider. The contract states that, "MBH will diligently pursue all reasonable means of recovering such overpayment." Currently, Magellan conducts an annual overpayment reconciliation which has not been completed in a timely manner. The overpayment reconciliation takes several months to complete and investigate in order to adjudicate any existing discrepancies. The reconciliation for FY 1999 overpayments to providers has not yet been finalized. In general, annual reconciliation processes should be completed within three months of the close of the contract year. By paying for services twice or paying more for services than the required fee, HCDHS is not correctly capturing the actual monthly cost of service fees. Also, HCDHS is not receiving reimbursement for overpayments in a timely manner. The lost HCDHS cash flow could be used for other programs or for investing activities.

F3.13 If MBH denies payment of any properly submitted claim, in whole or in part, MBH will provide the contract provider an explanation for the denial, a description of the information required to perfect the claim, an explanation of why the required materials are necessary and a description of the steps to be taken if the provider wishes to submit the claim for review. Denial of a claim can result from the following conditions:

- Clients not enrolled in the plan;
- Services not authorized;
- Services not in scope of work;
- Providers not approved;
- Service units provided exceeding authorized units;
- Progress notes and treatment plans excluded;
- Service treatment plans not meeting current clinical protocol; and
- Claims submissions duplicated.

A service provider first becomes aware of a denied claim upon receipt of the monthly EOB. The EOB is sent to each provider by MBH and represents the reconciliation between submitted claims and total claims reimbursed to the provider. This report details each claim line submitted by the provider to MBH, the client's identification number, the cost per unit for each service rendered and the total amount for each provided service. The EOB also documents the payment or denial of a claim. MBH indicates the reason for each denial, enabling the service provider to investigate and correct any errors.

If a claim submitted by a service provider is missing any of the required client or provider information, the claim will be placed in a pending or denied status. This triggers the denial status of a claim reported on the monthly EOB. MBH provides the required information in order to update the claim for procesing to each provider by fax or by mail. Service providers are given the opportunity to correct any errors and resubmit the denied claims for payment.

F3.14 According to the True Care Provider Manual, service providers have the option of refuting a MBH claim denial based upon technical medical protocol through a written appeal process. The internal written appeal process gives providers the ability to correct non-clinical denials of claims. The internal process gives the provider 60 days from date of denial notice to respond. The response from the provider should include the original claim, information noting the denial, member's medical records and a description of the basis for appeal. Within 60 days of receipt of the appeal request, MBH must review the information submitted by the provider and respond back to the provider that the denial is either upheld or overturned.
Service providers also have the option of refuting a MBH claim denial for clinical reasons through a written appeal process. Within 30 days of receipt of the denial notification, the service provider may request an external appeal in order to refute the denial of a claim due to clinical reasons. An independent clinician, along with a claims processor, will review the appeal and respond to the provider within 30 days of MBH receipt of the written appeal. The decision of the MBH claims processor and the independent clinician is final. No further means of appeal avenues currently exist.

MBH is currently in the process of appealing administrative claims from FY 1999. The implementation of the CCSR report in May 2000 has prevented many of the data entry errors of required information that have caused claim denials (see **F3.4**). Claims should be adjudicated and resolved within the stipulated time lines expressed in the True Care Manual. The prolonged adjudication of disputed claims prevents MBH from effectively managing its current workload of claims and may lead to a possible disruption in services provided to clients.

R3.9 Claims submitted after May 2000, if appealed, should be resolved within the timely manner provided for in the True Care Partnership Manual. Language in the contract and policies and

procedures should reflect this as well. The CCSR, as an element of claims processing, precludes lengthy claims appeals, and as such, claim appeals which extend beyond contract stipulations should be systematically denied.

Financial Reporting

F3.15 As established by the contract, MBH is required to supply HCDHS with a variety of financial reports which can be utilized by HCDHS to monitor and manage the overall contract. **Table 3-6** illustrates the contract required reports, completion status, and if the contract reports have been forwarded to HCDHS.

Table 3-6: Contract Required Financial Reports

Report Required by Contract	Completed by MBH	Provided to HCDHS Report Title
Financial Monitoring Plan *(A - H are required elements)*		
A. Track contract cost Monthly Administrative Invoice Monthly Service Cost Invoice	YES	YES
B. Reconciliation of payments to Providers Monthly explanation of benefits	YES	YES
C. Reconcile receipts to service payments Monthly Bank Reconciliation	YES	NO
D. Monitor authorized claims not yet paid HCDHS terminated distribution	YES	NO
E. Monitor provider service activities & report the percentage of placement dollars paid to providers	NO	NO (HCDHS terminated distribution)
F. Assist HCDHS to develop financial goals, benchmarks and payment rates	YES - During Initial contract set-up and during partnership team meetings. Note: no written minutes of the partnership meetings have been recorded.	This contract requirement is obtained verbally, no hard copy report is forwarded to HCDHS. We do suggest that minutes of all partnership meetings are recorded and filed.
G. Develop action plans to address providers in financial problems	Written plans have not been developed. However, MBH has provided advances to trouble providers. MBH has also performed business practices reviews on troubled providers.	This contract requirement is obtained verbally, no hard copy report is forwarded to HCDHS. We do suggest that minutes of all partnership meetings are recorded and filed.
H. Project Future Service Costs	YES - During initial contract set-up and during Partnership meetings. Note: No written minutes exists.	This contract requirement is obtained verbally, no hard copy report is forwarded to HCDHS. We do suggest that minutes of all partnership meetings are recorded and filed.
Monthly Summary Report *(A - D are required elements for each service provider)*		
A. Overall expenditures	NO	NO
B. Services authorized	NO	NO
C. Number of placements	NO	NO
D. Per capita cost	NO	NO
Monthly receipts of MPS Monthly Service Cost Invoice	YES	YES
Monthly disbursements Monthly Service Cost Invoice	YES	YES
Monthly administrative fees Monthly Admin. Cost Invoice	YES	YES

Source: Magellan Contract

Magellan provides monthly invoices to HCDHS detailing the total service cost incurred by all contracting service providers, and the total administrative cost incurred by Magellan to facilitate the contract. Service costs represent the cost of services rendered by providers to clients. Upon receipt of the invoice for both service and administrative costs, HCDHS performs a cursory review of the service cost and administrative costs to determine if the totals appear reasonable. Providers do not perform regular reconciliations. The average monthly service cost and administrative cost are $1.2 to $1.4 million and $180,000 to $200,000, respectively. These monthly costs are material to Hamilton County because of the large dollar amounts and warrant a detailed review by HCDHS personnel ensuring that they are reasonable and accurate.

R3.10 MBH should require each service provider to perform a monthly reconciliation between total claims billed and total payment received from MBH by including this provision as part of policies and procedures in the Administrative Manual. HCDHS should also require Magellan to submit reconciliations for each service provider and the corresponding explanation of benefits on a monthly basis. The reconciliations from each service provider and from Magellan should be sent directly to the HCDHS contract financial monitor (see **R3.14**). The financial monitor should review reconciliations from both MBH and the service providers for the following standards:

- Mathematical Accuracy;
- Comparable service costs to current trends; and
- Comparable number of denied claims to current trends.

HCDHS should review several claim lines from each service provider to ensure that the services billed are services currently rendered by the service provider, and that the cost of the individual service is accurate.

After reviewing the service provider and MBH monthly reconciliations for the above suggested areas, HCDHS should ensure that the total claims submitted for each service provider, less adjustments for denied or pending claims, agrees with the monthly summary invoice, the explanation of benefits and the reconciliation from MBH. A suggested format for the monthly reconciliation is shown in **Table 3-7**.

Table 3-7 : Sample Reconciliation Format

Provider X, Reconciliation of Claims Paid for the Month Ended August, 2000	
Total Billed claims for August	$65,000
Less: Claims Denied - No Authorization	($ 5,000)
Claims Denied - Duplicate Submission	($ 1,000)
Claims Denied - Invalid Client ID	($500)
Total - Claims Less Adjustments (Total reimbursement from Magellan)	$58,500

The financial monitor should also complete a monthly review of administrative expenses charged by MBH. This review would ensure that the total administrative expense appearing on the monthly invoice is reasonable, accurate, actual, and that no individual line item exceeds the budget by more than 10 percent. If any line item exceeds the budget by more than ten percent, an explanation of variances documenting the reason(s) for those occurrences should be on file. By performing a monthly review of the administrative expense cost, HCDHS would obtain a general understanding of the administrative cost ensuring that the monthly administrative expense is reasonable, accurate and actual. Upon receipt of the administrative invoice, HCDHS should review the following points:

- The mathematical accuracy of administrative expenses charged;
- The percentage variance between budget and actual, ensuring that no single line item exceeds the budget by more than 10.0 percent;
- The correlation between expense line items and original invoices and requesting that MBH forward copies in support of the monthly line items appearing in the administrative expense; and
- The documentation of any allocation methodologies used by MBH to charge HCDHS a portion of any incurred expenses. Once the understanding of allocation methods is gained and documented, HCDHS should randomly verify these allocations.

F3.16 MBH provides each service provider with an explanation of benefits on a monthly basis. The explanation of benefits details each claim submitted by the service provider and indicates if each claim has been either denied or paid. The explanation of benefits is the current tool used by MBH to reconcile claims submitted to the transfer of funds to each service provider and is also used by service providers to adjudicate denied claims. The explanation of benefits provides the following information:

- Client I.D. number;
- Date of service;

- Service code;
- Funding source (Medicaid, private insurance or 100 percent True Care claims);
- Authorization number;
- Authorized units;
- Dollar amount paid; and
- Status of claims, either paid or denied.

The explanation of benefits provides the above information by client and is sorted by date of service. The explanation of benefits sums the dollar value of paid claims and represents the admittance advice to the service providers. The Current Year Cost is comprised of the total of all expenditures for covered services for the period plus Medicaid overpayments. As Medicaid overpayment amounts rise, so does the adjusted current year cost, and inversely, the cost savings percentage.

R3.11 HCDHS should require MBH to change the current format of the explanation of benefits to include additional detail corresponding to the denial reason(s) of denied claims. An electronic version of the explanation of benefits should be forwarded to each of the service providers, and an explanation of benefits and denials if applicable, should be provided to HCDHS. In order to improve the format of the explanation of benefits, the following information should be included:

- All services corresponding to a single client should be grouped together;
- A sub-total by client should be added; and
- A field should be added to indicate when a re-authorization of services is required.

In order to improve the current adjudication process between MBH and the service providers, the explanation for any denial of payment should be included within the explanation of benefits. Currently, when a claim has been denied by MBH, a two letter code will appear within the explanation of benefits. To expedite the reconciliation process and to decrease the time required to adjudicate previously denied claims, a verbal explanation should be included for every denied service.

By requiring MBH to enhance the current format and to include an explanation for denied claims, the explanation of benefits will be a useful reconciliation tool for the service providers. Further, a more detailed examination between services rendered and services will expedite the reconciliation process, decrease the time required to adjudicate previously denied claims, and lead to the reduction of duplicate claims.

F3.17 Magellan has not compiled and submitted a corporate compliance plan to HCDHS for review and sign-off as required by the contract. MBH is required to draft a corporate compliance plan, submit that plan to HCDHS for approval and distribute the plan to each of the

contracted service providers assuring that the service providers abide by the corporate compliance plan. The corporate compliance plan is required to meet all state and federal requirements. According to the Office of the Inspector General (OIG) of the Department of Health and Human Services, an effective compliance plan provides a mechanism that brings the public and private sectors together to reach mutual goals of reducing fraud and abuse, improve operational quality, improve the quality of health care, and reduce the costs of those services. While no specific formula exists for a corporate compliance plan, the OIG of the Department of Health and Human Services suggests the following elements, at a minimum, to be present in a corporate compliance plan:

- Development and distribution of written standards of conduct, as well as written policies and procedures that promote the billing company's commitment to compliance and address specific areas of potential fraud, such as the claims submission process, code gaming and financial relationships with its providers;

- Designation of a chief compliance officer and other appropriate bodies, such as a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance plan who report directly to the CEO and the governing body;

- Development and implementation of regular, effective education and training programs for all affected employees;

- Creation and maintenance of a process, such as a hotline, to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect callers from retaliation;

- Development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations, or Federal, State or health care program requirements;

- Utilization of audits and/or other risk evaluation techniques to monitor compliance and assist in the reduction of identified problem areas; and

- Investigation and correction of identified systemic problems and the development of policies addressing the non-employment of sanctioned employees.

R3.12 MBH should develop a corporate compliance plan and submit the plan to HCDHS for review and sign off approval. Once approval has been granted by HCDHS, MBH should implement a review committee with the responsibility to ensure that the corporate compliance plan has

been distributed to contract service providers and is instituted in the daily business practices of each service provider. A representative of HCDHS should be included as a member of the review committee.

F3.18 MBH has not provided monthly summary reports for each service provider to HCDHS. As detailed above, MBH is required to report the overall expenditures, services authorized, number of placements and per capita cost for each of the network service providers. By not supplying HCDHS with financial information regarding each service provider, HCDHS is unaware of the current financial condition of the service providers. This limits the ability of HCDHS to actively participate in the management of the contract with MBH in regards to service provider performance. Also, HCDHS does not have a formal financial review committee. The Health and Human Services Office of the Inspector General (OIC) suggests that a financial review committee can increase the likeliness of financial stability assuring that the child welfare program can continue to provide needed services to clients. Financial review committees are usually responsible for the following areas:

- Monthly forecasting;
- Annual budgeting;
- Monitoring and analyzing current administrative and service cost trends;
- Monitoring the financial performance of network service providers;
- Analyzing current market trends of other mental health behavioral programs;
- Ensuring that financial policies and procedures developed by HCDHS are adhered to by the service providers and MBH;
- Assisting MBH in constructing plans for providers experiencing financial difficulties; and
- Monitoring the billing procedures followed by MBH and the service providers.

Without the creation of a financial review committee, HCDHS is unable to actively contribute to the management of the child welfare program. By understanding the financial aspects of the contract, HCDHS assumes fiscal responsibility. To ensure that the clients of Hamilton County continue to receive quality services and the cost of those services are financially responsible, HCDHS needs to participate in and monitor the financial management of the program.

R3.13 HCDHS should consider naming a financial review committee with the responsibility of monitoring the financial relationship between itself, MBH and the contracting service providers. The committee's main responsibilities could be comprised of the following areas:

- Ensuring that services billed from providers were actually received by clients;
- Reconciling HCDHS funds used to reimburse providers to services rendered by the contract service providers;

- Ensuring that any overpayments are corrected and returned to HCDHS;
- Monitoring the service providers financial performance;
- Analyzing service fees charged by the providers;
- Monitoring the Medicaid portion of the program;
- Managing the coordination of benefits or maximization of funds;
- Monitoring administrative fees incurred by MBH and charged to HCDHS;
- Monitoring the current systems performance;
- Monitoring authorized claims not yet paid to understand any required encumbrances;
- Developing and mange financial goals of the HCDHS program;
- Assisting in the development of future service costs; and
- Attending monthly or quarterly meetings with service providers and MBH to understand the current business environment and to contribute to problem solving.

In addition to these responsibilities, the HCDHS financial review committee should develop formal monitoring strategies including regular reporting, formal and informal site visits to the service providers and MBH, and ad hoc requests for needed financial reporting from MBH. Formal monitoring meetings and/or visits to service providers and MBH should be conducted by HCDHS to review specific areas of project performance. HCDHS should use these site visits to set a clear precedent for MBH to expect followup and a sharp focus on completing tasks in a timely manner. The HCDHS committee should also develop informal monitoring of the performance of MBH. Informal monitoring may include casual conversation, attendance at provider meetings, and involvement in consumer and family advocacy meetings. Firsthand observation of MBH and service providers activities can be extremely helpful in anticipating and managing problematic issues.

HCDHS should ensure that MBH provides a reporting package for each of the service providers and for the total service provider network, which may address the following OIC criteria:

- Overall expenditures;
- Services authorized;
- Number of placements;
- Per capita cost;
- Cost for each service rendered;
- Estimates of claims incurred but not yet reported;
- Patterns of utilization at different levels of care;
- Utilization by provider;
- Utilization by age category;
- Readmission rates; and
- Clinical outcomes indicators.

An appropriate reporting period and manageable reporting format should be determined by the financial review committee.

F3.19 Currently, HCDHS is managing the MBH contract without a designated financial monitor. Until January 2000, HCDHS had a designated financial monitor for the contract. However, the individual retired and HCDHS has not yet filled the position. The duties for this position included responsibility for the daily, quarterly and annual management oversight of the contract with MBH. By not having filled this position, HCDHS may not have an accurate depiction of the current financial condition of, and potential difficulties and problems facing the contract.

R3.14 In order to actively participate in the management and monitoring of the contract, HCDHS should engage in a line by line and aggregate reconciliation of provider claims. Monitoring the financial position of the contract and the behavioral health managed care program should be provided a high priority within HCDHS. Contract monitoring should be completed through existing resources in the Contract Management Department by designating a member of the department as the contract financial monitor for the MBH contract.

F3.20 Written documentation or minutes are not recorded during Partnership Team meetings. Service providers have the responsibility to communicate all difficulties related to the effective delivery of services to MBH. Providers are expected to notify the appropriate MBH personnel of any problems and to fully participate in the bi-weekly provider meetings. The partnership bi-weekly meetings are an important source of information for the service providers, MBH and HCDHS. Discussion with HCDHS officials and representatives from MBH has indicated that the bi-weekly partnership meetings have been used as an open forum to communicate the following:

- Provider training issues;
- Payment discrepancies;
- Medicaid rules & regulations
- Projection of future service costs;
- Budgeted administrative cost; and
- System issues.

The Partnership Team meetings are beneficial to all present, however, any verbal addendums or other agreements between any members of the partnership team can not be referred to at a later date because of the absence of written documentation of previous meetings, or recorded minutes.

R3.15 The Partnership Team and MBH should discuss proposed changes to the contract, develop a written recommendations for changes, and present any proposed changes to the appropriate parties for approval. Any changes to the contract should be documented in contract addendum and affixed to the contract. Formal contract modifications will reduce confusion as to the status of contractually required reports and services. The Partnership Team representatives should refrain from making informal verbal modifications to the contract as informal changes may affect the legal implications of the contract for the Partnership Team and MBH. (see **R4.5**).

Financial Management Benchmarking

F3.21 The monitoring, evaluation, and improvement of network service providers' performance by MBH is crucial to the success of the contract. Effective monitoring and management of providers' performance by MBH can provide HCDHS valuable information. A financial monitoring plan, according to the current contract, should be prepared by MBH, presented to HCDHS for review and implemented as a management tool. This plan is intended to account for all aspects of the flow of funds, including financial reporting, claims payment and accounting procedures. In order to monitor the objectives and requirements of the financial monitoring plan, MBH and HCDHS use several benchmarks to measure the financial performance of the contract. **Table 3-8** lists the contract requirements of the financial monitoring plan and the benchmarks used to assess them.

Table 3-8: Financial Performance Benchmarks

Financial Monitoring Plan Requirements	Financial Performance Benchmarks
Track Contract Costs	No actual individual administrative expense line item shall exceed the budget line item by more than 10% without HCDHS approval.
Monitor & Reconcile Payments to Providers	No benchmarks indicated
Reconcile Receipts with Service Payments	No benchmarks indicated
Monitor Authorized Claims Not Yet Paid	No benchmarks indicated
Monitor Provider Service Activities & Report the percent of all Placement Dollars Paid to Providers	No benchmarks indicated
Assist DHS to Develop Financial Goals, Benchmarks and Payment Rates	DHS revenue shall be $112,405 in year one, $374,685 for every year thereafter. 95% of child welfare providers in the network have been trained on revenue maximization. 15% total service dollars will be saved as a result of efficiency measures.
Develop Action Plans for Financial Problems Experienced by Service Providers	No benchmarks indicated
Account for all Aspects of Claims Payments	90 percent of all claims paid in 30 days of receipt of clean billing data, remaining 10 percent are resolved within 60 days.
Financial Reporting Provided by MBH	All data will be available via the MIS system within 10 business days after the occurrence. 95 percent of reports will be provided within 15 business days of request. Ad hoc reports will be available within five business days of request. Changes to reporting contents and formats will be completed within 15 business days.

Performance measures are customer-focused quantified indicators that allow an organization to measure progress on goals and objectives and management tools that assist supervisory staff in evaluating work performed and results achieved. These same measures form a basis for management to plan, budget, structure programs, and control results. Measurement for performance helps to ensure a continuous provision of efficient and effective services. While

benchmarks are in place to monitor the financial monitoring plan, additional benchmarks should be identified and implemented by HCDHS and MBH.

R3.16 HCDHS and MBH should develop additional benchmarks to monitor the financial condition of the contract and behavioral health managed care program. **Table 3-9** presents the financial monitoring plan contract requirements in the left column and suggested OIC benchmarks in the right column. The implementation of these additional benchmarks will give HCDHS' management the ability to monitor and react to the current financial performance of the contract. Implementing benchmarks does not guarantee improved financial performance, however, management will be better enabled to steer the program toward success.

Table 3-9: Suggested Financial Performance Benchmarks

Financial Monitoring Plan Requirements	Suggested Financial Performance Benchmarks
Track Contract Costs	• No actual individual administrative expense line item shall exceed the budget line item by more than 10 percent without HCDHS approval. • During the remaining life of the contract, MBH controllable costs such as payroll and administrative should decrease by XX percent in comparison to years one, two and three. • Costs for identical services administered by any given network service provider shall not exceed, by XX percent, the cost for those same services provided by any other network service provider.
Monitor & Reconcile Payments to Providers	• The reconciliation of payments to providers should be completed monthly by HCDHS no later than ten days following the current billing cycle. • No "unidentified" reconciling items should be acceptable. All discrepancies should have an explanation and a date of expected correction attached. • Time lag between MBH receipt of payment and fund transfer to any service provider shall not exceed 2 business days.
Reconcile Receipts with Service Payments	• The reconciliation of payments to providers should be completed monthly by MBH no later than ten days following the current billing cycle. • No "unidentified" reconciling items should be acceptable. All discrepancies should have an explanation and a date of expected correction attached.

Monitor Authorized Claims not yet Paid	• Authorized claims not yet paid should not exceed X percent of the average monthly service cost of claims submitted by any network service provider. • An authorized, but unpaid claims report should be presented to HCDHS for review no later than 15 days following the financial close of the current month. This report should be detailed by provider and include up to twelve months of prior history. This report should also include a summary "roll-up" of all network service providers.
Monitor Provider Service Activities & Report the percent of all Placement Dollars Paid to Providers	• No information is currently being compiled for this requirement.
Assist DHS to Develop Financial Goals, Benchmarks and Payment Rates	• DHS revenue shall be $112,405 in year one, $374,685 for every year thereafter. This benchmark should be evaluated on a yearly basis. The dollar value of revenue to be achieved should be realistic and should correlate the recent financial performance of MBH. • Costs for identical services administered by any given network service provider shall not exceed, by XX percent, the cost for those same services provided by any other network service provider. • Ninety-five percent of child welfare providers in the network have been trained on revenue maximization. • Fifteen percent of total service dollars will be saved as a result of efficiency measures.
Develop Action Plans for Financial Problems Experienced by Service Providers	• No benchmarks suggested
Project Future Service Costs	• Future increases of service costs should not exceed the consumer price index suggested inflationary rate.
Account for all Aspects of Claims Payments	• Ninety percent of all claims paid in 30 days of receipt of clean billing data, remaining 10 percent are resolved within 60 days. • The occurrences of overpayment to service providers may not exceed a certain percentage of the number of claims submitted. • The final adjudication of any and all overpayments for Non-Medicaid claim lines shall be resolved within three months of the date of overpayment. • Adjudication of 95 percent of Medicaid claims should be resolved no later that 30 days following the Medicaid claim filing deadline.

Financial Reporting Provided by MBH	• All data will be available via the MIS system within 10 business days after the occurrence. • Ninety-five percent of reports will be provided within 15 business days of request. • Ad Hoc reports will be available within five business days of request. • Changes to reporting contents and formats will be completed within 15 business.

The addition of the above mentioned benchmarks will provide both HCDHS and MBH with a much broader depiction of the program's performance. Such benchmarks could be used to tailor future contracts and determine future performance expectations.

Application of Financial Performance Incentives

F3.22 MBH can earn incentives totaling $100,000 by achieving specific performance and service outcomes outlined in the contract. Each outcome has either a monetary incentive and/or disincentive established for the achievement of or failure to meet the standard. The cumulative amount for the incentives totals $100,000, while the disincentive total also equals $100,000. This amount is a part of the 5.0 percent profit (see **F3.1)** for which Magellan is eligible, and reflects the intent of the contract toward sharing risk by assigning performance risk directly to MBH. An atmosphere of shared-risk fosters collaborative efforts toward efficient performance.

These indicators are used as benchmarks for measuring the success of the MBH contract each year. MBH and HCDHS, in collaboration with a Duke University behavioral health consultant, developed the performance and service standards. Quality Improvement Reports are provided to the Partnership Team on a quarterly basis and as an annual report. This document lists each performance indicator, the benchmark required, comments on MBH progress, an action or intervention plan undertaken to achieve the measurement, and perceived barriers that have been or will be encountered. An example of how benchmarks are displayed is shown in **Table 3-10**.

Table 3-10: Sample of QIR benchmark

Service Standard #8	Benchmark	Comments	Intervention or Action Plan	Barriers
Services are culturally competent	MSO has stipulated competent cultural competency in provider credentialing	The cultural competency of treatment Providers will be included in the credentialing standards in development	Corporate credentialing standards for an organization will be utilized as a basis for the development of standards specific to the True Care Project.	None noted at this time

Source: Quality Improvement Report, Second Quarter 1999

The QIR benchmarks are used to determine if MBH has met the requirements of the contract in several performance areas. This determination then indicates whether incentives or disincentives will be levied. HCDHS and MBH have indicated that they are flexible in their evaluation and re-establishment of certain benchmarks for indicators. Because this particular contract was created without precedent, the need to possibly change benchmarks along the way has been discussed. HCDHS has increased the frequency of monitoring MBH performance incentives from an annual basis to a quarterly basis, beginning with the first quarter of 2000. MBH and HCDHS meet to discuss the results yielded from this assessment and to, if necessary, develop action/intervention plans to rectify any identified problems or issues.

C3.3 Increased monitoring of financial performance benchmarks will help to ensure the effectiveness of action plans and interventions as well as to validate the viability of the benchmarks. In addition, the county and MBH are in communication with a contracted individual affiliated with Duke University on a periodic basis regarding contract compliance and MBH's performance. This relationship will help in establishing performance measurement criteria for not only this but also future contracts of this nature.

F3.23 MSO Performance Standards were developed to provide benchmarks for MBH's service delivery, and oversight functions. The frequency with which these are measured varies from monthly, to quarterly, to semi-annually. The tools used to gather this information are internal reports generated by MBH from their database, as well as customer satisfaction surveys. **Table 3-11** shows the MSO Performance Standards with their frequency of reporting, and the associated incentive and/or disincentive.

Table 3-11: The MSO Performance Standards

Performance Standard	Frequency	Financial Assessment
Providers are paid claims on a timely basis	Quarterly	Disincentive: $8,000 (Year 1) $10,000 (Years 2-5)
Provider Network	Quarterly (semi-annual reporting of the monitor provider network indicator)	Incentive: $15,000
Consumer satisfaction	Semi-annual	Incentive: $5,000
Timely Information	Quarterly	Incentive: $5,000 Disincentive: $10,000 (Year 1) $5,000 (Year 2-5)
MSO shall maximize revenues	Quarterly	Incentive: $15,000 Disincentive: $5,000
MSO efficiently manages the provider network and DHS service dollars	Quarterly	Disincentive: $6,000
PT and Provider Satisfaction with problem resolution	Semi-annual	Incentive: $5,000
Implementation Time line will be completed timely	Monthly	Disincentive: $4,000 (Year 1)
MIS Hardware will be maintained with a standards based approach and continue to be state of the art and meet PT needs.	Monthly	Disincentive: $5,000 (Year 1) $6,000 (Year 2-5)
CMHC Software will remain state-of-the-art, and current to industry standards and responsive to PT and provider needs	Monthly	Disincentive: $5,000 (Year 1) $6,000 (Year 2-5)
MIS Help Desk will provide accurate and appropriate and timely assistance to the PT and their provider networks	Monthly	Disincentive: $5,000 (Year 1) $6,000 (Year 2-5)
The MSO will provide to PT staff and providers timely and competent training	Quarterly	Disincentive: $5,000 (Year 1) $6,000 (Year 2-5)

Source: Exhibit 7

Also, MSO service standards provide a measurement of the effectiveness of the care management system established by the MSO for DHS referred customers. There are monthly, quarterly and semi-annual assessments of consumer improvement within the provider network and of the quality of treatment delivered. **Table 3-12** shows the MSO service standards, the frequency with which they are reported, and the associated incentive and/or disincentive.

Table 3-12: MSO Service Standards

Service Standard	Frequency	Financial Assessment
Children and families will receive timely services	Quarterly	Incentive: $18,000 Disincentive: $18,000
Services are appropriate to the needs and provided in the least restrictive setting	Quarterly	Incentive: $15,000
Services are available to meet the needs of children and families	Quarterly	Disincentive: $9,000
Children and families will accept and participate in offered services	Semi-annual	Incentive: $7,000
Continuity of care for services provided	Semi-annual	Incentive: $5,000 Disincentive: $9,000
Ensure children's safety and quality of care	Monthly	Incentive: $4,000 Disincentive: $10,000
Service impact with families (Improved functioning)	Semi-annual	Incentive: $3,000
Services are culturally sensitive and competent	Semi-annual	Incentive: $3,000

Source: Exhibit 7

The current controls used by MBH to monitor the service provider network are sufficient and relevant to meeting contract requirements. The MSO Performance and Service standards are consistent with Child Welfare League of America (CWLA) criteria used in establishing managed care approaches for child welfare programs. These criteria include the following issues:

- The broad goals of the program;
- The population covered and service need characteristics;
- The services and supports included in the plan;
- The clarification of management responsibilities and delivery of services;
- The definition and measurement of outcomes and quality assurance; and
- The system's funding and risk sharing.

Through quarterly review, MBH monitors the service providers' performance and allows for the opportunity for suggestion and comment geared toward improving the overall program. The results of the quarterly reviews are forwarded to HCDHS for review and comment in the bi-weekly operations meetings with MBH staff. This discourse enables HCDHS to have an active, participatory role in monitoring and managing the service provider network.

F3.24 The FY 1998 independent review of MBH by an independent audit agency on performance and service standards provided the results summarized in **Table 3-13.** Though all indicators

were reviewed, not all of the benchmarks within each indicator were reviewed as some information was deemed inappropriate in terms of content by MBH and HCDHS (see **F4.1**). The results contained in **Table 3-13**, therefore, represent the most accurate assessment of the indicators for FY 1998.

Table 3-13: FY 1998 MSO Service and Performance Incentive Evaluations

	Incentives Earned	Disincentives Earned	Total
Service Measures	$2,600	($14,488)	($11,888)
Performance Measures	$7,500	($15,023)	($7,523)
Total	**$10,100**	**($29,511)**	**($19,411)**

Source: FY 1998 Grant Thornton audit of DHS

Out of $100,000 of possible incentive dollars, MBH earned only $10,100 or 10.1 percent. When added to the disincentives results, MBH was actually accessed a disincentive for the year of $19,411. This monetary assessment was withheld from the next fiscal year's allocation.

15 Percent Savings Plan and Savings Determination

F3.25 Magellan Behavioral Health has ensured a savings of 15 percent on HCDHS' total expenditures for mental health and placement services for each year of the five-year contract. If MBH exceeds the 15 percent savings goal, MBH can earn a 5 percent bonus for any additional savings between the goal of 15 percent savings up to 21 percent. The base time period used for the calculation of the target savings for MBH is the period of April 1996 through March 1997. A series of adjustments are made to HCDHS's total expenditures for outpatient services and out- of- home placements to arrive at the base cost, from which the target savings is established.

The base cost is adjusted for inflation specific to the Cincinnati area, and is adjusted further to account for any increase in the yearly caseload from the base period to the next year. The adjusted base cost is then compared to the total of the actual expenses, less the cost of mandated services, to arrive at the actual yearly service cost. An amount equal to 15 percent of the base cost (before adjustments) is the target savings, and the amount of actual savings is the adjusted base cost less the actual yearly service cost. Comparisons are made between the two to determine the performance of MBH. This base period is calculated for each year of the five-year contract period.

MBH achieved a savings level of $907,484, falling short of the target savings amount of $1,962,828 by achieving only 42 percent of this target amount. This calculation was

performed on the first full year of the contract. A FY 1998 review of MBH's savings on behalf of HCDHS by an independent audit agency was determined a 6.4 percent savings. MBH attributes this lower level of savings to Medicaid billings and a provider rate increase above the Hamilton County inflation rate. A 4.0 percent savings is viewed as more realistic by MBH.

R3.17 The Partnership Team and MBH should examine the viability of the 15 percent savings in relation to actual savings. Some methods used in other states in monitoring Managed Care cost overruns might be of use for this contract. Massachusetts and Michigan have both lower cost savings thresholds, 5 and 10 percent respectively, as well as special considerations for what they term risk corridors. Massachusetts limits risk to lead agencies (regional offices throughout the state) by placing them in "held harmless" status for the first 18 months of a contract. Michigan includes the following risk-control caveats as part of contract negotiations:

- Sharing of financial risk based on risk corridors
- Creating collaborative agreements with other local agencies and organizations, not to shift costs of care, but to share costs with appropriate wraparound services for "community kids"
- Creating a risk pool through the use of "saved" funds, to help shelter the contractor from the risk of catastrophic losses in the event of unexpected fluctuations in utilization of services

This should be considered after the second annual review of the cost savings calculation, or, if a more detailed review is done on a quarterly basis, after three consecutive quarters of a failure to meet quarterly benchmarks. If elimination of this benchmark is not feasible, it should at the very least be reduced to some obtainable level. The only factor that can be controlled by MBH is the overpayment/claims appeal cost for Medicaid overpayments. Further, the "no eject/no reject" level of care ensured by the Partnership Team guarantees a high level of quality care, and should not be compromised to achieve savings. Reduction of the targeted savings amount will allow MBH to focus on Medicaid overpayments in its claims processing operations and allow for HCDHS and MBH to focus on improving in areas of performance that are within their control.

MBH should consider developing detailed and timely quarterly updates regarding the savings plan. Closer monitoring on the part of HCDHS and MBH is needed to provide target amounts for each quarter of the five-year contract, actual amounts spent, and explanations of the variances. Action/intervention plans should be developed by MBH in consultation with HCDHS to correct or make adjustments to the budget lines of MBH which may affect the net savings. By more closely examining quarterly goals, MBH and HCDHS may be able to more readily identify problematic issues and make adjustments on a quarterly basis to improve performance.

Performance Measurement

Performance Measures

The following list of performance measures was used to conduct the review of the performance measurement and provider network management components of the contract between Magellan Behavioral Health (MBH or Magellan) and Hamilton County Department of Human Services (HCDHS).

- Assess the content and timeliness of quarterly reports in relation to contract provisions
- Compare criteria for the selection of contract providers in comparison to contract provisions
- Assess the implementation of service provider profiles
- Assess the appropriateness of service provider locations as per contract requirements
- Review credentials, licensing and provider insurance based on contract provisions
- Assess completeness of the client rights and confidentiality policies and procedures
- Review Magellan policies and procedures governing client complaints and grievances in relation to contract requirements, and assess the adequacy of the documentation of incidents and training received by complaint resolution staff

Findings/Commendations/ Recommendations

Quarterly Report Assessment

F4.1 In accordance with the contract, Magellan provides certain performance measurements reports to the Partnership Team. These reports are explained in **Table 4-1**.

Table 4-1: Service Delivery Reports

Report	Contract Provisions
Quarterly Service Reviews Submitted to HCDHS	• Assessment and discussion of strengths, weaknesses, gaps, and overall performance of the contract provider network for the quarter
Utilization Reporting Submitted to HCDHS	• Client access to covered services and the geographic locations of clients' residences • Waiting lists for contract providers • Claims paid for each client and contract provider • Analyses of service referrals and service utilization • Timeliness of services provided • Authorization and reauthorization data • Patterns of services approved for clients • Referrals and utilization of services provided by non-network providers and/or funded by non-contracted sources • Contract provider capacity
Continuous Quality Management Report (CQM) Submitted to HCDHS and MHB	• Service accessibility, flexibility and client satisfaction • Effectiveness of contract providers • Effectiveness in achieving mental-health and child-welfare goals • Effectiveness in providing family-centered services • Evidence of continuous quality improvement • Professional and competent staff • Interagency linkages for continuity of care • Provision of care in the least restrictive settings • Provision of appropriate levels of care • Analysis of length of treatment and cost per client • Client served by type of service
Financial Monitoring Submitted to the Partnership Team	• Summary report of all cash activity • Monthly cash reconciliation reports • Aggregation of monthly reports and documentation of service-cost accruals
Complaint Reports Submitted to the PT	• Summary of complaint information including the frequency and outcomes of complaints and resultant management and program changes
Client Protections Submitted to the Partnership Team	• Summarized all family education and related activities • Guarantees an accessible client advocate

Source: Magellan/HCDHS Contract

MBH has exercised discretion in modifying its reporting practices to reflect more practical communication of specific information. MBH, in consultation with HCDHS, found that many of the elements of some individual reports were duplicated in others, and that in a few cases, the production of some reports on a quarterly basis was unnecessary. As a result, the current frequency with which MBH generates reports for the Partnership Team best represents the accumulation of relevant data for the time period.

R4.1 Any changes in reporting by MBH should be supported by changes to the language in the contract. Although MBH consults the Partnership Team before implementing changes, the public nature of the contract necessitates that any mutually-agreed upon variations in reporting be specified by language granting such latitude to MBH and the Partnership Team. Further, it is in the interests of MBH and the Partnership Team to avoid the perception of inconsistent information disclosure. For example, a situation in which a report is presented on a semi-annual basis yet is stipulated in the contract to be disclosed quarterly, would give the appearance of infrequent documentation to an outside observer (see **R3.15** and **R4.5**).

F4.2 The Quality Improvement Report (QIR), developed by Magellan, is provided to the Partnership Team on a quarterly basis. The QIR contains performance and service standards which help Magellan and the Partnership Team measure Continuous Quality Management (CQM) efforts. Also, the QIR reflects the three basic categories of training that are provided by MBH: Clinical, Management Information Systems (MIS), and Managed Care. The QIR also contains other reports provided as attachments which are deemed applicable for quarterly, semi-annual and annual distribution. Any discrepancies between contract and actual reporting is at the discretion of MBH (see **F4.1**). Some of the required reports have been assimilated into the Quality Improvement Reports (QIR) as performance and service indicators (see **Table 4-2**).

According to the U.S. Department of Health and Human Services' *Contracting for Managed Substance Abuse and Mental Health Services, A Guide for Public Purchasers*, "The contract should clarify what information must be included and the time frames for submission of different types of reports. Sanctions should be available to the purchaser in the event that the reports are not submitted in a timely fashion or do not include the information required." While MBH has complied with reporting requirements, there is a need to codify the existing practice of compiling and/or streamlining reports for practical purposes.

R4.2 Although the current contract has a separate section devoted to reporting requirements, any future contract between the Partnership Team and a Managed Services Organization (MSO) should contain detailed information on the manner in which reporting requirements should be operationalized. This reporting section should contain language which grants a MSO, in consultation with the Partnership Team, the latitude to reduce duplicate reports, and to

modify the frequency of reporting to convey an exact snapshot of relevant data for a specific time frame.

F4.3 MBH is not in compliance with the contract regarding provider evaluations contained in quarterly service reviews (see **Table 4.1**). The contract stipulates that, on an individual basis, providers should be furnished with an assessment of their performance which identifies strengths, weaknesses and any apparent areas which require improvement. According to Magellan, however, providers are initially evaluated based on their submitted responses to the Request for Proposal (RFP) issued by the Partnership Team (see the ***Credentialing, Licensing and Insurance Verification*** subsection). Subsequent evaluations occur biannually through the credentialing process.

In addition to credentialing, the provider network is examined through the contract's various performance standards. Components of the MSO performance standard #2, regarding the maintenance the provider network, address contract requirements by assessing the following criteria on a quarterly basis within the QIR:

- 100 percent of providers will be certified agencies or licensed independent practitioners for services provided;
- Proportion of clinical staff has at least one year relevant experience;
- 90 percent of initial credential applications are completed within 30 days;
- 85 percent of providers in network meet performance standards and outcomes as approved by Partnership Team; and
- 90 percent of providers are trained and competent in managed care technologies, while 10 percent are monitored for competency.

While the information provided in the QIR could be used to enhance the contractually-required individual provider evaluations, the data included in the QIR is insufficient to fulfill the requirements in the contract.

R4.3 MBH should provide an individual assessment of each provider through quarterly service reviews in order to fulfill the requirements of the contract. The contract states that performance evaluations must be conducted on each contracted provider, identifying strengths, weaknesses and service gaps throughout the network. These provider evaluations should be documented and reported to HCDHS as well as to the evaluated providers. The evaluations contained in quarterly service reviews will furnish providers with the information necessary to improve performance and to establish organizational goals and priorities.

F4.4 Pursuant to contract provisions, Magellan provides the appropriate information contained in utilization reports (see **Table 4.1**). Elements addressing the reporting criteria for MBH are contained within the QIR and are documented in the performance and service standards and

the Consumer Satisfaction Surveys. Components of the MSO service outcome standard #1, regarding the delivery of behavioral mental health services to children and families, assesses the following State-mandated criteria on a quarterly basis within the QIR:

- 95 percent of provider assessments are completed within specified time frames;
- 95 percent of care managers are assigned within specified time frames;
- 95 percent of outpatient services are available within contracted time frames;
- 95 percent of emergent and urgent outpatient services are available within specified time frames;
- 90 percent of placements are made within specified time frames;
- Emergent and urgent placements are available within specified time frames; and
- 100 percent of off-panel referrals which are not made are documented.

MSO performance standard # 1, regarding the providers' timely submission of claims, also contains the following benchmarks:

- 90 percent of claims are paid within 30 days;
- 10 percent of remaining claims must be resolved within 60 days; and
- 90 percent of unpaid claims are reconciled within 60 days.

The fourth quarter Consumer Satisfaction Survey, which is attached to the 1999 Annual Quality Improvement Report and issued by Magellan, further assesses the utilization reporting requirements by evaluating consumer/client responses in the following areas:

- Timeliness of appointments;
- Geographic access of providers;
- Phone calls returned by providers;
- Client perception of the treating provider;
- Client perception of the treatment process; and
- Overall client satisfaction with treatment services.

These reports fulfill the requirements of the contract and they are sufficient to adequately represent provider utilization within the network. However the current format of the reports does not reflect utilization rates of individual providers. While an aggregate utilization report is vital for management decision-making, the ability to view utilization in conjunction with individual provider assessments would provide MBH a more comprehensive understanding of trends within the network.

R4.4 Although Magellan is in compliance with the contract, utilization information should be compiled separately for each provider and included as a component of the quarterly service review (see **F4.3**), in addition to being provided as an aggregate report in the QIR. The

various evaluation instruments sufficiently address utilization issues to the extent specified in the contract. However, by providing the summary and detail reports on providers in a single document, MBH will provide greater accessability to the Partnership Team and MBH staff responsible for addressing utilization and provider issues.

F4.5 Magellan is required to perform Continuous Quality Management (CQM) as a component of the contract. This is accomplished through performance standards contained in the QIR. An example of a performance standard that satisfies a facet of the contract's CQM requirements is displayed in **Table 4-2**.

Table 4-2: Sample Performance Standard

Performance Indicator Number 8	Benchmark	Comments	Intervention or Action Plan	Barriers
Services are culturally competent	MSO has stipulated competent cultural competency in provider credentialing	The cultural competency of treatment Providers will be included in the credentialing standards in development	Corporate credentialing standards for an organization will be utilized as a basis for the development of standards specific to the True Care Project.	None noted at this time

Source: Quality Improvement Report, Second Quarter 1999

Magellan is in compliance with the CQM requirements of the contract (see **Table 4-1**). CQM requirements are satisfied and represented in 8 service standards and 12 performance standards contained in the QIR (see **F3.24**).

F4.6 MBH is required to provide financial reports to the Partnership Team as a component of the financial monitoring plan. The A-K report is a compilation of the reports shown in **Table 4-3** and satisfies the financial reporting requirements of the contract.

Table 4-3: Supplemental Financial Reporting Requirements

Report Required by Contract	Completed by MBH	Provided to HCDHS	Report Title
Financial Monitoring Plan (A - H are required)			
A. Track contract cost	YES	YES	Monthly Administrative Invoice & Service Cost Invoice
B. Reconciliation of payments to providers	YES	YES	Monthly Explanation of Benefits (EOB)
C. Reconcile receipts to service payments	YES	NO	Monthly Bank Reconciliation
D. Monitor authorized claims not yet paid	YES	NO	HCDHS Terminated Distribution
E. Monitor provider service activities and report the percentage of placement dollars paid to providers	NO	NO	HCDHS Terminated Distribution
F. Assist HCDHS to develop financial goals, benchmarks and payment rates	YES During Initial contract set-up and during Partnership Team meetings. Note: no written minutes of the partnership meetings have been recorded.	N/A	
G. Develop action plans to address providers in financial problems	Written plans have not been developed. However, MBH has provided advances to troubled providers. MBH has also performed business practices reviews on troubled providers.	N/A	
H. Project Future Service Costs	YES During initial contract set-up and during Partnership meetings. Note: No written minutes exists.	N/A	
Monthly Summary Report (A - D are required elements for each service provider)			
A. Overall Expenditures	NO	NO	
B. Services Authorized	NO	NO	
C. Number of Placements	NO	NO	
D. Per Capita Cost	NO	NO	
Monthly Receipts of MPS	YES	YES	Monthly Service Cost Invoice
Monthly Disbursements	YES	YES	Monthly Service Cost Invoice
Monthly Administrative Fees	YES	YES	Monthly Administrative Cost Invoice

Source: MBH Contract

During the course of the contract, MBH and the Partnership Team have modified the financial reporting requirements. For example, the A-K report was distributed by MBH to HCDHS on a quarterly basis, however HCDHS discontinued the distribution of these reports in March 2000. All of the A-K reports can now be accessed by HCDHS on line. Changes to the reporting requirements have been modified through discussions at the bi-weekly Partnership Team meetings or less formal discussions between MBH and HCDHS representatives. However, no documentation of the changes or authorizing authority has been retained, nor are there minutes kept from the meetings.

Table 4-3 illustrates the verbally-agreed upon modifications to the reports MBH is required to provide to the Partnership Team. The informal nature of these changes could have an impact on the content and consistency of future financial reports. Coupled with staff turnover at MBH and HCDHS, informal changes to reporting requirements could contribute to inconsistent reporting.

R4.5 The Partnership Team and MBH should discuss proposed changes to the contract, develop a written recommendations for changes, and present any proposed changes to the appropriate parties for approval. Any changes to the contract should be documented in contract addendum and affixed to the contract. Formal contract modifications will reduce confusion as to the status of contractually required reports and services. The Partnership Team representatives should refrain from making informal verbal modifications to the contract as informal changes may affect the legal implications of the contract for the Partnership Team and MBH. New employees at MBH and HCDHS would benefit from these formalized changes in reporting requirements which would help ensure the consistency, frequency, and content of financial reports.

F4.7 Currently, HCDHS and Magellan use several benchmarks to measure the performance of Magellan in improving behavioral health care and obtaining savings in facilitating the child welfare program. The following list of current MBH benchmarks covers financial and clinical areas of measurement:

- Children & families will receive timely services;
- Services are appropriate to needs & provided in the least restrictive setting;
- Services are available to meet the needs of children and families;
- Family involvement;
- Continuity of care for services provided;
- Children's safety is ensured and risk of harm is reduced;
- Improved functioning;
- Services are culturally sensitive and competent;
- Providers are paid claims on a timely basis;
- Competent provider network must be maintained;

- Client satisfaction with services provided;
- Timely information will be provided to DHS;
- MSO shall maximize revenues;
- MSO efficiently manages the provider network and DHS service dollars;
- PT and provider satisfaction with problem resolution;
- Implementation line will be completely timely;
- MIS hardware will be maintained with a standards based approach and continue to be state of the art and meet PT needs;
- CMHC software will remain state of the art current to industry standards and responsive to PT and provider needs;
- MIS helpdesk will provide accurate, appropriate and timely assistance to the PT and their provider networks; and
- The MSO will provide to PT staff and providers timely and competent training.

With the exception of the benchmarks measuring clinical care levels, MBH's performance on the various benchmarks is evaluated in the appropriate sub sections of this performance audit. Each of the above benchmarks include detailed performance measures used to ensure the achievement of each benchmark. MBH analyzes each of the above benchmarks on a quarterly basis, summarizes its findings in the Quality Improvement Report (QIR) and forwards the report to HCDHS for review and sign-off. Included in the quarterly QIR are action plans required to improve areas deemed as deficient in comparison to the current benchmarks. The completion of the QIR, with HCDHS's involvement, is evidence of cooperation in achieving programmatic goals.

C4.1 Magellan effectively and consistently reports its performance in relation to the benchmarks as stated in the contract (see **F4.7**). In addition, MBH's action plans regarding deficient practices help to ensure that operations are improved to levels that are amiable to the Partnership Team and comparable to benchmarks.

F4.8 According to the Child Welfare League of America (CWLA), evaluators of managed behavioral health care plans generally look at the following performance measurements:

- Access to services;
- Appropriateness of services;
- Quality of providers;
- Positive client outcomes;
- Satisfaction; and
- Costs of system performance.

Table 4-4 presents a comparison of Magellan's performance measures to the most common performance measures used by managed behavioral health care entities identified by the CWLA.

Table 4-4: Performance Measurement Comparison

CWLA Survey - Performance Measures	MBH - Performance Measures
Access to services	Services are available to meet the needs of children
Appropriateness of services	Services are appropriate to needs & provided in the least restrictive setting Ensure Child's safety and reduce the risk of harm
Quality of providers	Children & families will receive timely services Services are culturally sensitive and competent MBH will provide providers timely and competent training Maintain a competent provider network
Positive Client outcomes	Improved Functioning Client satisfaction with services provided Family involvement Continuity of care for services
Satisfaction	Provider satisfaction with problem resolution
Cost of system performance	MBH shall maximize revenues MBH will efficiently manage the provider network and HCDHS service dollars Providers are paid claims on a timely basis Timely information will be provided to HCDHS

N/A	MIS Hardware will be maintained with a standards based approach CMHC software will remain state-of-the-art current to industry standards MIS helpdesk will provide accurate and appropriate assistance to the provider network

Source: CWLA

An effective performance measurement system should provide information that is meaningful and useful to decision-makers, well-supported by management and integral in an entity's daily operations. The benchmarks currently used by MBH are highly-detailed, and specifically address each of the established performance measures. For example, in order to test whether providers are reimbursed for provided services in a timely manner, MBH uses the following benchmarks:

- 90 percent of all claims are paid in 30 days of receipt of clean billing data in the approved format;
- 10 percent of the remaining claims are resolved within 60 days; and
- 90 percent of unpaid claims are reconciled within 60 days.

The above benchmarks are regularly reviewed by HCDHS and, in the Agency's reviews, appear reasonable and appropriate in determining if providers are reimbursed in a timely fashion. This type of information can be valuable to HCDHS in monitoring MBH contract performance. An effective measurement system should satisfy the following criteria:

- **Results** - Focusing primarily on outcomes and outputs;
- **Selectivity** - Concentrating on the most important indicators of performance;
- **Utility** - Providing information of value to the agency and decision-makers;
- **Accessibility** - Providing periodic information about results; and
- **Reliability** - Providing accurate, consistent information over time.

On an annual basis, HCDHS performs a detailed review of MBH's operations focusing on the following areas:

- Adequacy of MBH case file setup;
- MBH compliance with established billing and accounts payable requirements;
- MBH compliance with the 12 administrative performance standards; and
- MBH compliance with the eight service standards.

The most recent review of Magellan's operations, performed by HCDHS, covered the period January 9, 1998, through December 31, 1998. HCDHS's annual reviews are conducted to ensure that MBH is managing the program in accordance with the contract. In addition, HCDHS began to conduct quarterly performance reviews of MBH's operations for the first quarter of FY 2000. HCDHS believes the quarterly performance reviews provide more timely information and feedback pertaining to Magellan's operations.

C4.2 The annual review conducted by HCDHS is comprehensive and highly detailed. HCDHS has provided well organized and pertinent suggestions as to how each area reviewed can be improved. By implementing the most common performance measures indicated by the CWLA, Magellan has developed performance measures which will effectively evaluate the quality of services provided and will increase the likeliness of providing mental health services at a fiscally responsible cost.

R4.6 HCDHS should complete its annual and quarterly performance reviews on MBH in a more timely manner. Because HCDHS is at least one year behind in its annual and quarterly performance reviews, Magellan may be challenged to reconstruct the factors which contributed to operational performance for a particular time in the past. HCDHS's performance reviews may reveal operational deficiencies and/or management practices which are inconsistent with the contract and the expectations of the Partnership Team. As a result, untimely reviews may impede HCDHS in monitoring MBH for contract compliance and in ensuring the continuous provision of efficient and effective services.

Selection of Contracted Service Providers

F4.9 Prior to inception of the contract, HCDHS and Hamilton County Community Mental Health Board (Mental Health Board) sent out a request for proposal (RFP) for mental health managed care network providers to its existing contracted service providers. The existing providers were given the opportunity to respond to the RFP in order to become candidates for the network or panel of service providers. Once the Partnership Team contracted Magellan as the managed care entity, HCDHS and Magellan selected providers for the panel based on the written proposals submitted in response to the RFP. Since the RFP was released before Magellan was contracted, the criteria in the RFP were used for the initial development of the provider panel, not the contract.

For the purpose of evaluating and selecting providers, submitted proposals were divided into three sections, each with corresponding values. The first section, Program Content, comprised 55 percent of the total evaluation score. The criteria contained in the Program Content section of the RFP are summarized below:

- **Availability of proposed services:** Providers must demonstrate the type, location and times that services will be available to clients. Providers must also estimate the number and types of family members to be served.

- **Service description:** Providers must specify objectives, clinical strategies, time tables, specifications and activities involved in the provision of services. Provider must also describe how the progress of family members will be monitored, as well as how activities with other agencies will be coordinated.

- **Evidence of effectiveness:** Providers must demonstrate how services will meet the specialized needs of the Children's Services population and remain outcome-based and time-limited. Providers must also describe how family members will be engaged in service delivery. Supporting research and evidence is necessary for this criteria.

- **Proposed staffing patterns:** Providers must identify the number of staff assigned for each service as well as the required credentials, training, education, experience and salary range to properly deliver identified services. Providers must also describe job duties, supervisor to staff ratios and level of qualifications of supervising staff.

F4.10 The second section, Systems Questions, made up 30 percent of the total evaluation score. The RFP required highly detailed responses to meet the criteria stipulated in the section on Systems Questions. The criteria for the Systems Questions section is summarized below:

- **History of organization:** Providers must supply a brief history of their organization and state briefly the programmatic and administrative experience qualifying the organization in the areas of child welfare, managed care and behavioral health services. The provider may also include any additional strengths that may distinguish itself in its field of expertise.

- **Administrative structure:** Providers must demonstrate the relationship between proposed services, pursuant to the RFP, to the total agency in a table format.

- **Provider capacity to meet requirements of RFP:** Providers must describe their ability to meet the general requirements for the provision of services specified in the RFP.

- **Continuing quality improvement and evaluation:** Providers must list indicators and measures to be used for monitoring, evaluating and improving proposed services. Providers must describe staff responsibilities, qualifications, experience and procedures used for collecting data with regards to the quality assurance program.

- **Reporting capabilities:** Providers must describe their ability to provide reports on utilization, cost containment, clinical quality, customer service and child welfare outcomes.

- **Certification and Medicaid eligibility:** Providers must supply documentation verifying ODMH certification and Medicaid eligibility.

- **Malpractice insurance:** Providers must describe any malpractice or other lawsuits they have been involved with over the past five years. In addition, insurance information regarding limits per claim, limits per year, amount of deductible and frequency of utilization must be provided.

- **Service transition:** Providers must demonstrate how clients will transition from the current service delivery system to a managed care model.

- **Professional references:** Providers must furnish at least five professional references for the Partnership Team and/or Magellan.

F4.11 The third section, Fiscal Operations, constituted 15 percent of the total evaluation score. Providers submitted supporting materials in accordance with the criteria in the Fiscal Operations section. The criteria for the Fiscal section is summarized below:

- **Audits:** Providers must submit a FY 1995 audit and/or tax form 990 for the entire organization. Providers must also include a list and explanation of all revenue sources, including MHB, Medicaid reimbursements, third party payments and individual fees.

- **Budgeting:** Providers must furnish a narrative that demonstrates how budget items are related to the service objectives and activities presented in the proposal while justifying staff salaries. In addition, providers must submit a projected budget for the implementation of the proposed services.

- **Cost containment and billing procedures:** Providers must describe procedures for monitoring and managing the cost of service delivery and for obtaining cost effectiveness. Providers must also submit an explanation of their billing procedures, including those to be used for the implementation of proposed services.

F4.12 The evaluation process was conducted in three stages whereby 110 provider proposals were submitted and subsequently assessed against the criteria contained in the Program Content, Service Questions and Fiscal Operations sections of the RFP. In stage one of the evaluation process, submitted proposals had to meet certain minimum requirements in order for the provider to be deemed *qualified* for further review. The minimum requirements in stage one involved the timely submission and level of completeness of proposals. According to the RFP, proposals must be received by the Partnership Team at the appropriate address and by the specified date and time. In addition, proposals must contain the required number of copies, complete program narrative, and complete program budget. Proposals that did not meet all the minimum requirements were deemed *non-qualified* and placed in the inactive file.

F4.13 In stage two, *qualified* proposals were evaluated by review committees which were comprised of representatives from the Partnership Team and Magellan. All *qualified* proposals were reviewed by the committees using a standard evaluative rating sheet, tailored specifically for the RFP. Rating sheets were completed by the committees for each of the three proposal areas. The number of evaluation points for each area varied according to the value assigned to that particular area of the program. The ranking system used by the review committees is illustrated in **Table 4-5**.

Table 4-5: Evaluative Ranking System

0 Ranking	**Inadequate or unacceptable response:** The bidder (provider) did not respond to the questions or the response reflects no understanding of the requirements.
1 Ranking	**Minimal acceptance:** The bidder (provider) demonstrates a minimal understanding of the requirements, but does not provide adequate detail or reflects more deficits than strengths.
2 Ranking	**Fair:** The bidder's response exceeds minimal requirements and demonstrates some strengths, but also demonstrates some deficits.
3 Ranking	**Good:** The bidder's response reflects a solid understanding of the issues and satisfies all the requirements.
4 Ranking	**Very good:** The bidder's response satisfies all requirements and exceeds some requirements.
5 Ranking	**Excellent:** The bidder's response is complete and exceeds all requirements

Source: RFP for Mental Health Managed Care Network Providers, issued by the Partnership Team

In addition to the individual rating sheets, provider selections were based on the following criteria:

- Partnership Team's need to ensure service availability to all geographic areas within Hamilton County;
- Partnership Team's need to ensure availability of specific specialized services;
- Provider's capability to serve the ethnic/linguistic needs of the population being served; and
- Provider's service capacity.

The individual rating sheets and additional criteria were used to determine the group of potential providers for the managed care network. According to the RFP, a final composite rating sheet will be maintained on file at HCDHS that includes the prioritized providers' rankings. After the completion of stage two, the Partnership Team and Magellan used the results of the ranking process to compile a prioritized list of service providers. Using the criteria and evaluation process, Magellan and HCDHS developed a short list of approximately 22 candidates for the initial provider panel.

F4.14 In stage three of the evaluation process, providers from the prioritized list began negotiations with Magellan. If contract terms could not be mutually agreed upon, providers would not be eligible for participation in the managed care network. Ultimately, however, all 22 candidates from the short list agreed to contract terms with Magellan. Contract terms discussed during the negotiations included cost of service, method of reimbursement, operating procedures and hours of operation. Once Magellan and service providers agreed to contract terms, the Partnership Team approved the pending contracts to complete the initial provider panel.

C4.3 The criteria used to evaluate potential providers for the managed care network is highly detailed. Service providers had to submit comprehensive proposals to meet the criteria and requirements of the RFP. Coupled with the evaluation process, Magellan and HCDHS were able to develop an initial network capable of providing timely, accessible and cost-effective services.

F4.15 Following the initial development of the provider panel, Magellan added five new providers to meet the service needs of clients. In accordance with the contract, the Partnership Team and Magellan reserved the right to reissue the RFP to fill any service gaps in the provider panel. In joining the network, additional providers were required to submit proposals demonstrating their ability to meet the criteria in the RFP. However, Magellan did not follow the ranking process used by the Partnership Team during the initial development of the provider panel. Rating sheets were not used by Magellan in assessing the new providers' ability to meet the criteria in the RFP. Rather, new providers were assessed on their ability

to provide particular services which would not only meet the identified needs of clients, but would ensure the availability of specific specialized services.

R4.7 In conjunction with representatives from HCDHS, Magellan should follow the same process for ranking providers as the Partnership Team had followed during the initial development of the provider panel (see **F4.13**). By using the rating sheets to formally assess potential providers, Magellan will remain consistent in its initial evaluations of providers throughout the life of the contract. Furthermore, rankings may be used to compare current providers with potential providers in their ability to meet the criteria and requirements in the RFP. For example, potential providers offering therapeutic foster care could be compared to current providers offering the same service. By continuing to use the ranking system for new providers, Magellan will be able to better identify the most qualified provider of specialized services while remaining consistent in its evaluation process. In future contact periods, HCDHS and MBH should include the RFP as a component of the contract. All network providers should be required to meet the criteria outlined in the RFP and should continue to demonstrate the desired characteristics throughout the contract period.

F4.16 According to the contract, it is Magellan's responsibility to develop and maintain the network of providers, and the Partnership Team's responsibility to oversee and monitor Magellan on these activities. In addition, Magellan may not add or remove service providers without first consulting HCDHS in writing. The Partnership Team has participated in reviews of potential providers for the initial network and has continued to participate in reviews for any new providers added to the network. Provider reviews consist of matching offered services with the identified needs of children and family members. Typically, HCDHS supervisors assist Magellan in evaluating provider's submitted responses to the RFP. Following the review, a joint decision is made as to the provider's ability to meet the identified needs of clients in a managed care environment.

C4.4 In taking an active role in the provider selection process, HCDHS is able to ensure that contracted providers are not only qualified to join the network but are capable of providing timely, accessible and cost-effective services. HCDHS exceeds contract stipulations by actively participating in the selection of service providers. Furthermore, in making mutually-agreed upon decisions with regard to provider candidates, HCDHS is able to foster a collaborative relationship with Magellan.

F4.17 Pursuant to the contract, Magellan enters into agreements with each service provider in the managed care network. Magellan uses a standardized agreement with each provider, outlining responsibilities and defining covered services. However, provider agreements do not contain the RFP criteria used to assess the provider's ability or inability to participate in the managed care network. Furthermore, provider agreements do not include the

credentialing requirements with which providers must comply as a condition to remaining in the managed care network (see **F4.22**).

R4.8 Magellan should consider including the credentialing requirements as addendums to provider agreements. By including the requirements, providers are immediately made aware of the criteria which must be met to remain in the provider panel. In addition, providers may begin to implement the policies, procedures, or operational changes necessary to meet the credentialing requirements. By including credentialing criteria at the inception of the agreement, providers would be able to seek direction and assistance from Magellan in developing their own internal processes to best meet the needs of children in the managed care environment.

F4.18 Approximately 20 percent of MBH's providers (5 of the 27) were selected from the managed care network to assess whether they continue to meet the RFP criteria initially used to develop the provider panel. A sample of criteria, drawn from the three major sections of the RFP, was used to verify providers' continued compliance with the criteria. **Table 4-6** illustrates the selected providers' continued compliance with a sample of RFP criteria.

Table 4-6: Providers' Continued Compliance with RFP Criteria

RFP Criteria	Group Home Provider	Therapeutic Foster Care Provider	Residential Treatment Provider	Outpatient Provider	Therapeutic Foster Care Provider
Program Content: Provider must demonstrate the type, location and times that services will be available to clients	Yes	Yes	Yes	Yes	Yes
Systems Questions: Provider must supply documentation verifying ODMH certification and Medicaid eligibility	N/A [1]	Yes	N/A [1]	Yes	Yes
Fiscal: The provider must submit a projected budget for the implementation of the proposed services	Yes	Yes	Yes	Yes	Yes

Source: RFP responses and contracted providers

[1] These providers do not provide Medicaid eligible services or require ODMH certification

All of the selected providers were able to verify the type, location and times of services available to clients referred by Magellan. In addition, selected providers furnished evidence of ODMH certification and Medicaid eligibility if it was applicable to their agency. Projected budgets for proposed services were also furnished by the selected providers.

Service Provider Profiles

F4.19 Currently, MBH does not maintain service provider profiles. The focus of service provider profiles is to isolate each provider and highlight similarities to, and differences from, other providers and the provider network as a whole. The purpose of a service provider profile is to provide information to HCDHS and MBH about each service provider in the network, specifically addressing the following capabilities:

- Number and types of clients served by each service provider;
- Service provider performance on key quality indicators and outcomes; and
- Service provider's performance against the performance of the entire provider network as a whole.

Discussion with MBH personnel has indicated that the development of service provider profiles is desirable, however prioritization of work to be performed has delayed the creation of the profiles.

R4.9 In order to better manage the performance of the service provider network, MBH should create service provider profiles, from which a substantial amount of useful information can be developed. Service provider profiles could be developed using provider evaluations, maintained in quarterly service reviews (see **R4.3**), as well as provider rankings as discussed in **R4.7**. Service provider profiles can be used to achieve the following objectives:

- Comparing the performance of providers of similar services;
- Enhancing the design of the quality improvement program at MBH;
- Distributing incentives or enacting sanctions;
- Establishing corrective action plans; and/or
- Providing the basis for continued measurement in the network.

By not developing and maintaining profiles for each of the service providers, MBH forfeits obtaining valuable information regarding the characteristics, abilities, and financial performance of each service provider. In addition, maintaining profiles prevents MBH and HCDHS from making decisions which may negatively impact each provider and the provider network as a whole.

Service Provider Locations

F4.20 Once Magellan and HCDHS determine that a client needs treatment, Magellan is contractually required to refer the client to a provider for the necessary services. The contract stipulates that Magellan will use its best efforts in ensuring that services and providers are available at convenient times and places to accommodate client schedules, including during normal business hours and evening hours Monday through Saturday. The contract also states that sufficient services must be made available, depending on the level of care required, 24 hours a day and 7 days a week for urgent and/or emergency needs and within 7 days of referral for other reasonable and necessary client needs. Furthermore, locations must be concentrated in the following four sets of neighborhoods where large Children Services' populations are located:

- West End, Mt. Auburn, Corryville and Over-the-Rhine;
- Avondale, Walnut Hills, Evanston, Madisonville and Bond Hill;
- South Cumminsville, Milvale, North Fairmont and English Woods; and
- Northside, Winton Hills, Price Hill, College Hill and Westwood.

Services must also be available to children and families in the home when appropriate, as well as in outpatient, in-patient or other residential settings.

Per contract requirements, Magellan's services are available during convenient times and appropriate locations to accommodate client schedules. Urgent and/or emergency needs can also be addressed based on Magellan's hours of operation and referral system. In order to meet contract requirements regarding provider locations, Magellan has created an On-line Referral System that enables its intake care managers to select the most appropriate types of providers for each client based on the following criteria:

- Proximity of provider to the client's home, school or workplace;
- Specialty treatment requirements of client;
- Cultural awareness of provider;
- Provider practice patterns;
- Professional expertise of provider; and
- Other provider characteristics (gender, ethnicity and language).

The On-line Referral System matches this criteria against the database of provider information gathered during the provider credentialing process (see **F4.22**). The automated system then matches the client criteria against provider specialization and available programs, and determines the best-suited provider. Additionally, Magellan care managers confirm and review the client's referral initially via telephone confirmation and then by

writing a service delivery plan. Any problems with the service delivery plan result in a consultation between Magellan care managers and the provider.

C4.5 Through the use of the On-line Referral System, Magellan is able to match clients with the most appropriate and best-suited service provider in the network. Providers are chosen based on their ability to address the individual needs of the client. Additionally, the On-line Referral System enables Magellan to place clients and/or offer services in locations which are in close proximity to their homes.

F4.21 HCDHS staff determined Magellan's compliance with service location standards in its 1998 annual review. The standard for outpatient services requires providers to be located within 30 minutes of the client's residence. The location standard for out-of-home placement services requires Magellan to maintain 60 percent of its client population within Hamilton County and 95 percent within Hamilton and/or adjacent counties. The annual review revealed that Magellan met the outpatient location standard by providing services for all outpatient clients within 30 minutes their homes. The review also disclosed that 69.8 percent of out-of-home clients were placed in Hamilton County, 9.8 percent above the 60 percent benchmark. Furthermore, Magellan was only 4.5 percent below the 95 percent benchmark for Hamilton and/or adjacent county placements. HCDHS used the Internet, specifically "Map Blast," to measure distances between client addresses and provider locations.

Credentialing, Licensing and Insurance Verification

F4.22 In order for Magellan and HCDHS to determine if network providers continue to meet criteria as stipulated in the RFP, Magellan credentials and re-credentials providers on a biannual basis. During the credentialing process, Magellan verifies the credentials, experience and licensure of those agencies and staff members responsible for the delivery of contracted services. The intent of the credentialing site visit is to ensure that network providers meet minimum standards of care while assisting providers with the transition into a managed care environment. The credentialing process enables Magellan to identify the strengths and weaknesses of contracted providers compared to professional standards of care.

Magellan and the provider community cooperatively developed two separate sets of credentialing standards; one set was developed to evaluate out-of-home care providers while the other set was developed to evaluate outpatient providers. Several weeks before the credentialing site visit, a letter is sent to providers detailing the credentialing standards and the documents which will be reviewed. Outpatient credentialing standards are based on the mental health standards developed by Green Springs, a company formerly subcontracted to manage network providers responsible for outpatient mental health services. Due to the recent purchase of Green Springs, however, management of outpatient service providers has been taken over by Magellan. Standards for out-of-home care providers are primarily based

on standards developed by Council on Accreditation for Families and Children (COA). Both sets of credentialing standards are highly detailed. Examples of the credentialing standards for therapeutic foster care in each of the five major areas of evaluation include the following:

- **Administrative Functions**: The provider has a clearly defined governing body and is established as a legally recognized entity in the state in which it is located. The program is licensed by the state to provide covered services. The provider has written policies, procedures and plans for quality improvement and utilization review functions in place.

- **Clinical Functions**: The provider has written policies and procedures for designing and implementing outcome-based individualized treatment plans, including client involvement, family involvement, clinical team involvement and discharge planning.

- **Clinical Human Resources**: The provider has a policy addressing payment to foster parents for their services and payment is commensurate with the cost of maintaining the child, the standard of living in the community and the special needs of the child. The provider has an established mechanism for the ongoing monitoring of staff licensure and certification.

- **Clinical Documentation**: Medical records include specific demographic information regarding the client, authorizations to disclose information, client's name and identification number, progress notes and discharge information.

- **Physical Plant and Safety Issues**: The provider maintains documentation that demonstrates its compliance with all applicable health, safety and fire codes. The provider has written policies and procedures governing proper medication administration and storage.

R4.10 Although Magellan recently developed its credentialing standards based on COA recommendations for out-of-home care providers, it should periodically update its standards for both outpatient mental health and out-of-home care placement service providers through consultation with national accreditation agencies including: Joint Commission on Accreditation of Healthcare Organizations (JCAHO); National Committee for Quality Assurance (NCQA); Commission on Accreditation of Rehabilitation (CARF); and COA to search for new developments and innovations in credentialing.

A recommendation provided by NCQA suggests that managed care organizations be careful in not being overly restrictive with staffing credentials. Service providers should be enabled to hire non-academic but highly-experienced staff and remain fully credentialed. A significant percentage of direct service staff in the substance abuse field, for example, are

people in recovery who have not pursued academic degrees but are nonetheless highly effective in certain clinical settings. Overly restrictive credentialing standards might prohibit the use of such staff in the managed care network. Although Magellan uses minimum standards for its provider staffing requirements, recommendations from national accreditation agencies could assist MBH in ensuring professional standards of care in the future. By periodically updating its standards, Magellan will remain consistent with national trends and will be enabled to adopt new and innovative approaches in credentialing managed care network providers.

F4.23 Magellan uses a five-point rating scale during site visits to determine contracted providers' compliance with the credentialing standards. The rating scale and its corresponding interpretations are illustrated in **Table 4-7**.

Table 4-7: Credentialing Rating Scale

Rating	Interpretation
1.0 - 2.5	The standards were consistently met.
2.6 - 3.9	The standards were not consistently met and a plan of correction is required for specific areas noted.
4.0 - 5.0	The standards were not met and significant improvement is required. A mutually agreed upon plan of correction is required.

Source: MBH credentialing evaluation letter to contract provider

Upon the completion of the first phase of credentialing, contracted providers were required to submit a plan of correction for any deficiencies identified by Magellan in the credentialing process. However, providers were not excluded from the network based on the first phase of credentialing, yet providers would have been excluded if they failed to develop and implement an appropriate plan of correction for any identified deficiencies.

Plans of correction are required for any areas rated 2.6 or greater within 30 days of the issuance of the credentialing evaluation letter. According to credentialing evaluation letters to contracted providers, plans of correction are expected to be implemented and follow-up visits may be conducted by Magellan to ensure that contracted providers are taking the necessary steps to meet the established credentialing standards.

R4.11 Magellan should conduct mandatory follow-up site visits for any provider who requires a plan of correction. Mandatory follow-up site visits would ensure that plans of correction are implemented for any deficiencies identified through credentialing. Because the contract is in effect for five years and credentialing occurs biannually, Magellan is limited in the time it has to ensure that contracted providers are meeting professional standards of care in the managed care environment. Therefore, more emphasis should be placed on follow-up site

visits to verify that contracted providers not only meet the established credentialing standards but that they are capable of providing timely and effective services to clients and their family members.

F4.24 All contracted providers are required to maintain a professional liability insurance policy in the minimum amount of one million dollars per claim and three million dollars in the annual aggregate to cover any loss, liability or damage. The Partnership Team initially required providers to submit the following information in addition to the RFP criteria:

- Limit per claim;
- Limit per year;
- Amount of deductible; and
- Frequency of utilization.

Providers were also required to describe any malpractice or other law suits that they had been involved with over the previous five-year period. In accordance with the credentialing process, providers must also submit the front sheet of their liability policy in order for Magellan to verify that the insurance is in effect throughout the life of the provider agreement.

Currently, provider agreements stipulate that providers must maintain professional liability insurance, list Magellan as an additional insured and notify Magellan at least 30 days in advance in case of cancellation, non-renewal or material amendment. Also as an additional insured, Magellan would be notified by the insurance company in the event of any changes in policy status. In an examination of submitted provider insurance policies, only one of five providers listed Magellan as an additional insured. Without being listed on the provider's insurance policy, Magellan has no guarantee of notification if changes are made to the insurance policy. Although provider insurance would cover any loss, liability or damage during the delivery of subcontracted services, subcontracting has only been used for one client throughout the history of the contract.

R4.12 Through the credentialing process, quality assurance staff should verify that Magellan is listed as an additional insured or certificate holder on providers' insurance policies. Although providers agree to notify Magellan in the event of cancellation, renewal or material amendment to their insurance policies, there is no guarantee that Magellan would be notified if changes in policy status were to occur. By being listed as an additional insured or certificate holder, Magellan further safeguards itself as a MSO from potential lawsuits and liabilities stemming from provider malpractice. Furthermore, clients and their family members receiving services would be financially protected in the case of accidents or damages alleged to have been committed during the course of service delivery.

F4.25 A random sample was conducted to verify provider compliance with selected credentialing standards. Credentialing standards were drawn from each of the five major areas of evaluation that correspond with both outpatient and out-of-home care providers (see **F4.22**). The sample includes three providers constituting approximately 10 percent of the managed care network. A random sample of credentialing evaluation letters was used to determine provider compliance to the selected credentialing standards. **Table 4-8** illustrates the providers' compliance with the selected credentialing standards.

Table 4-8: Provider Compliance with Credentialing Standards

Credentialing Standards	Provider 1	Provider 2	Provider 3
Administrative: The program is licensed by the state to provide covered services.	Yes	Yes	Yes
Administrative: The provider maintains written documentation of quality improvement activities via committee minutes and quarterly reports.	Yes	Yes	Yes
Clinical: The provider maintains written policies and procedures which define pre-admission, intake, screening and referral protocols.	Yes	Yes	Yes
Human Resources: The provider has an established mechanism for the ongoing monitoring of staff licensure and certification.	No	No	No
Documentation: Authorizations to disclose information are completed appropriately	No Percentage of cases was not indicated	No 56 percent of cases did not have authorizations	No 60 percent of cases did not have authorizations
Physical Plant and Safety: The provider maintains documentation that demonstrates its compliance with all applicable health, safety and fire codes.	Yes	Yes	Yes

Source: Service providers and credentialing evaluation letters

All three providers from the sample were licensed by either ODJFS and/or ODMH to provide covered services in Ohio. In addition, written documentation of quality improvement activities and policies and procedures defining clinical protocols was verified through the sample. The sample also indicates, that in the majority of cases, authorizations to disclose information in clinical documents were not completed in an appropriate manner. Additionally, none of the providers from the sample have an established mechanism for the continual monitoring of staff licensure and certification.

C4.6 Through the credentialing process, Magellan is able to assess provider compliance with professional standards of care while identifying provider strengths and weaknesses in various areas of administration and service. Although providers may not meet all the standards, Magellan is able to identify the areas in which providers need to improve their operations to comply with the standards. For example, the sample from **Table 4-8** indicates that providers do not have an established mechanism for the continual monitoring of staff licensure and certification, and that authorizations to disclose information in clinical documents were not completed in an appropriate manner. Although the sampled providers do not meet the standard, the credentialing process enables Magellan to identify the need for improvement and to require a plan of correction. As discussed in **R4.11**, mandatory follow-up visits would ensure that providers have implemented an established mechanism for the ongoing monitoring of staff licensure and that authorizations to disclose information are completed in an appropriate manner. Therefore, the credentialing process is an effective tool for Magellan in monitoring provider compliance with professional standards of care.

R4.13 In conjunction with the Partnership Team, Magellan should develop a system of incentives to ensure that service providers implement plans of correction for credentialing shortcomings. Currently, providers are removed from the network if they fail to develop and implement an appropriate plan of correction for identified credentialing shortcomings. However, pursuant to the contract, Magellan is subject to financial incentives based on various aspects of performance, therefore service providers could also be subject to such incentives. If service providers fail to implement plans of correction for credentialing shortcomings, they are automatically removed from the network. Alternatively, if service providers implement plans of correction in an effective and efficient manner, Magellan should be able to reward providers for their compliance with credentialing standards. Coupled with mandatory follow-up visits (see **R4.11**), a system of incentives would provide Magellan with the capability to ensure provider compliance with professional levels of care. In addition, Magellan should furnish service providers with suggested policies and procedures to rectify credentialing shortcomings. For example, Magellan could require providers to adopt a protocol which would guide staff in appropriately completing authorizations disclose information.

F4.26 Pursuant to the contract, Magellan warrants that all contracted providers are duly licensed in accordance with the appropriate State licensing board. In addition, Magellan is responsible for regularly monitoring the licensure status of each contracted provider and its employees. In response to the RFP criteria, each provider was initially required to submit copies of their Ohio Department of Mental Health (ODMH) and/or Ohio Department of Job and Family Services (ODJFS) certification for the provision of identified services. The RFP also stipulates that all services must be provided by licensed/certified practitioners. In signing the provider agreements to join the panel, providers warranted that all licenses would remain in effect and all employees would remain certified to deliver covered services.

Agency and staff licenses are also verified during credentialing site visits (see **F4.22**). In order to verify the existence and status of practitioners' licenses, Magellan selects a random sample of ten employee files from the provider and examines the licenses. During the site visits, Magellan also verifies that contracted providers have established policies and procedures to monitor staff licensing and certification. Although **Table 4-8** indicates that the sampled providers do not have an established mechanism for the ongoing monitoring of staff licensure and certification, Magellan checks staff licensure during the credentialing process and has made recommendations to providers for establishing an internal mechanism for monitoring staff licenses. In order to achieve this credentialing standard, Magellan recommends that providers require staff members to register their licenses on a Web site developed by the Counselor and Social Work Board. The Web site allows providers, as well as Magellan, to periodically monitor the status of staff licenses.

License renewals for contracted providers are monitored by Magellan through the credentialing process. Credentialing site visits enable Magellan to check the status of the provider license and to verify the renewal dates. Additionally, if any problems exist with a provider's license, the provider is contractually obligated to report the issue to Magellan and HCDHS. Furthermore, ODJFS and/or ODMH inform(s) the Partnership Team of the provider's licensure problem if one was detected by State licensing specialists.

C4.7 Magellan uses a variety of methods to verify the existence and monitor the status of provider and staff licenses. By obtaining copies of provider licenses from the RFP response, Magellan can be assured that services are delivered by ODJFS and/or ODMH certified agencies. Furthermore, the credentialing process enables Magellan to effectively monitor the licensure status of providers as well as their staff members. By verifying provider and staff licenses, children and family members are safe from receiving services from unlicenced providers and practitioners. In addition, Magellan can be more assured that services are delivered properly and in accordance with State standards.

Policies and Procedures Governing Client Complaints and Grievances

F4.27 According to the contract, Magellan is required to develop a process for tracking and monitoring complaints that are lodged on behalf of any client. Other MBH responsibilities regarding client complaints and grievances, as detailed in the contract, include the following:

- Designating a staff person who will be responsible for receiving, addressing and resolving complaints from 8:00 a.m. to 6:00 p.m., at least five days each week;
- Maintaining and making available to clients, contracted providers and advocates a separate, toll-free phone number for receipt of calls. Magellan will ensure sufficient staffing of this number so that calls are answered, in person, in a timely and efficient manner;
- Investigating complaints within one working day of the lodging of the complaint;
- Completing its plan for addressing and resolving complaints and submit it to the Partnership Team for its review and approval within 60 days of the effective date of the contract;
- Submitting quarterly reports to the Partnership Team summarizing complaint information, including the frequency and outcomes of complaints as well as any operational changes that have been made as a result of complaints;
- Training its complaint resolution staff to handle questions or complaints with courtesy and proficiency;
- Ensuring that contracted providers maintain policies and procedures regarding client rights and responsibilities. Additionally, procedures must be in place to inform clients of their rights and responsibilities concerning the process for lodging complaints; and
- Developing a client rights and responsibilities plan and submit it to the Partnership Team for approval within 60 days of the effective date of the contract.

F4.28 Magellan has an established process for handling client complaints which is consistent with the responsibilities outlined in the contract. Clients may lodge complaints in writing or via Magellan's toll-free access line. Magellan has three employees dedicated to complaint resolution. These staff members direct incoming client complaints to the Magellan care manager directly responsible for the complainant's services. In all cases, a consumer/client comment form is filled out and forwarded to the director of quality improvement for the

purpose of tracking and monitoring client complaints. All complaints must be investigated within 24 hours and resolved within 10 business days. However, complaints deemed clinically urgent must be resolved within 24 hours. If the care manager cannot resolve the complaint to the satisfaction of the client, a formal grievance may be submitted to the project director and Quality Assurance Committee for review.

Although a formal grievance has never been filed, Magellan has established procedures for the investigation and resolution of client grievances. Grievances are considered more serious than complaints and would require more formal action by Magellan. Magellan is also required to forward client grievances to ODMH and/or ODJFS. In accordance with the established procedures for handling grievances, the project director is required to mail written acknowledgment of the grievance to the client within 24 hours and to assume responsibility for the investigation and resolution of the grievance. In conjunction with the quality assurance committee, the project director reviews all materials related to the grievance and determines a final resolution. A written response, detailing the final resolution, is sent to the client within 30 calendar days. Upon final resolution of the grievance, the project director completes the client comment form and forwards it to the MIS director for entry into the complaint-tracking log. Finally, the project director issues a monthly grievance report to the Partnership Team.

C4.8 Magellan has clearly defined policies and procedures for the timely investigation and subsequent resolution of client complaints and grievances. Magellan's established protocols for complaint handling appear to be consistent with the contract requirements. The establishment of such procedures ensures that the needs and interests of clients are adequately addressed and reported to the Partnership Team. In addition, the complaint procedures provide Magellan with the means to assess operational performance while establishing a measure of accountability for the delivery of services.

F4.29 In order to monitor and track complaints, Magellan furnishes Quality Improvement Reports (QIRs) to the Partnership Team which include a table detailing complaints and comments received throughout the quarter. The table provides the following information regarding complaints:

- Name of the provider
- Date complaint received by Magellan
- Content and source of complaint
- Date of Magellan's response
- Urgency of complaint
- Date of resolution

The table also details the type of corrective action taken to resolve the complaint. The Partnership Team is able to use the table to monitor Magellan's performance with regard to complaint handling. For example, the Partnership Team can assess Magellan's timely response and resolution to client complaints and/or grievances.

R4.14 HCDHS should require Magellan to initiate the necessary procedures to create and maintain a centralized complaint/grievance database, instead of the current practice of maintaining a complaint/grievance file in a word processing software folder. All relevant information about complaints and grievances should be captured by Magellan's complaint resolution staff and entered into Microsoft Access or SQL Server to create and maintain a centralized complaint/grievance database (see the ***software/licensed programs*** section). Meaningful statistics concerning complaints can be generated from the database.

Database reports furnished to the Partnership Team can identify trends in complaints and grievances among the different providers and be used to determine areas of weakness within the network. These trends could be analyzed for specific providers or the network as a whole. Furthermore, Magellan could discuss network trends regarding complaints at provider forum meetings. Ultimately, the reports generated from the database would assist the Partnership Team and Magellan in responding to external concerns and improving services to clients and their family members.

F4.30 Based on third and fourth quarter 1999 Quality Improvement Reports, the majority of complaints received by Magellan complaint resolution staff are made by HCDHS caseworkers and Guardians ad Litem, who serve as advocates for clients. Furthermore, these complaints are generally lodged against service providers. **Table 4-9** illustrates the number and type of complaints received by Magellan complaint resolution staff during the third and fourth quarters of 1999.

Table 4-9: 1999 Third and Fourth Quarter Complaints

	Against provider	Against Magellan	Against HCDHS	Against Foster Parent	Total
Third quarter	18	0	0	0	18
Fourth quarter	4	1	2	1	8
Total	22	1	2	1	26

Source: Quality Improvement Reports

The most common complaint against service providers involves their poor correspondence with the various parties involved in client cases. Several complainants expressed dissatisfaction with service providers who failed to maintain scheduled appointments or to provide proper notification regarding scheduling changes. For example, a HCDHS caseworker filed a complaint on behalf of a client alleging that a service provider therapist had rescheduled an initial appointment several times and was regularly late to meetings.

Numerous complaints regarding a particular service provider often prompt quality of care reviews in which Magellan conducts site visits to investigate areas of concern. Quality of care reviews are often conducted based on the severity of a particular complaint. During the reviews, Magellan's quality assurance staff examines clinical documentation and conducts interviews in order to identify any problems. Findings and plans of correction are subsequently developed to assist the provider in improving the conditions which initially provoked complaints. Magellan has not formally established criteria under which quality of care reviews should be performed.

R4.15 In conjunction with the Partnership Team, Magellan should formally establish the specific conditions which would necessitate quality of care reviews. Such conditions could include a predetermined number of complaints regarding a particular service provider, or particular types of complaints that would merit immediate action. For example, a quality of care review would be conducted on any service provider who received five or more complaints in a given quarter. A centralized complaint/grievance database, as outlined in **R4.14**, could monitor the established conditions and automatically notify Magellan staff of the need for a quality of care review. Although Magellan should formally establish the specific conditions, Magellan's quality assurance staff should maintain some discretion in initiating such reviews. By formalizing the conditions which would trigger a quality of care review, however, Magellan would be less likely to overlook problematic operations within the network while prioritizing those cases which would necessitate review.

F4.31 Magellan's complaint resolution staff does not receive any formal training on complaint and grievance handling or resolution procedures. According to the contract, Magellan is required to train its staff to answer client questions with courtesy and proficiency regarding complaints and comments (see **F4.27**). Although complaint resolution staff members follow the policies and procedures on complaint handling, formal training on complaint handling has not been provided.

R4.16 In order to enhance its ability in handling complaints in an appropriate and professional manner, Magellan should consider providing formal training sessions to complaint resolution staff. Seminars or training sessions on customer service or conflict resolution techniques could improve complaint resolution procedures by decreasing overall response time while providing staff with the means to develop more creative and effective solutions to

complaints. Additional training may also allow Magellan staff to foster and promote a more consumer-focused complaint resolution environment. Formal training sessions that promote courteous and proficient complaint resolution techniques will serve the dual purpose of helping to ensure Magellan's compliance with the contract provisions on complaint handling while increasing the Partnership Team's confidence in Magellan's ability to effectively resolve complaints.

Policies and Procedures Governing Client Confidentiality and Client Rights

F4.32 Prior to 1993, practices by managed care organizations (MCO) that ignored client/consumers' rights have often resulted in inadequate care. In 1993, the federal government passed the Model Managed Care Consumer Protection Act, which established standards for client/consumer protection against MCOs whose policies and/or fiscal incentives led to inadequate care. Furthermore, many advocacy and professional organizations have established comprehensive *bills of rights* linked to the full spectrum of services to which clients of managed behavioral health care and their families may be entitled. One such organization, the Bazelon Center for Mental Health Law, developed a *bill of rights* which includes the following standards:

- No managed care entity may discriminate on the basis of disability, race, religion, national origin, income, gender or sexual orientation.
- Clients have the right to be fully involved in all treatment decisions and to participate in the development of their service plan.
- Clients have the right to give or withhold consent to their service plan and to amend their consent as their plan is modified.
- Children with a serious emotional disturbance should be in an interagency, interdisciplinary service plan developed with their family and approved by their parent or guardian.
- Treatment plans must respect the individual client's choice of service and service setting.
- Clients have the right to refuse any treatment they do not feel is appropriate and may not be disenrolled because they have refused treatment.
- Clients may not be denied services that are appropriate to their needs because of their decision not to accept other services.

- Managed care entities must ensure confidentiality of records, guarantee clients full access to their own records and protect individual privacy.

- Clients have the right to establish psychiatric advance directives or durable powers of attorney specifying how they wish to be treated in an emergency or if they are incapacitated. The managed care entity should be required to educate its providers on the use of advance directives.

- Clients have the right to appeal decision about their treatment when they disagree. The managed care entity must have an effective, expeditious, accessible, fair and uniform grievance procedure to allow clients to appeal decisions about care they receive or services they are denied.

- Clients have the right not to be disenrolled from the plan without just cause.

F4.33 Magellan monitors service providers to ensure that written policies are in place regarding client rights and responsibilities, and that clients are informed of these rights and responsibilities. As service providers join the managed care network, Magellan recommends that providers develop a well-publicized doctrine that informs clients of their rights and responsibilities. Through the credentialing process (see **F4.22**), Magellan verifies that service providers maintain such a doctrine that includes the following client rights and responsibilities:

- Timely and affordable behavioral healthcare services;

- Ongoing and up-to-date information and assistance about services and available resources;

- Full participation in the service planning and delivery process;

- Involvement with the choice of providers and facilities, with the role of families as primary decision makers and care givers;

- Sufficient information to enable the client to render informed consent to treatment except in emergencies;

- Knowledge of the name, professional status and function of those behavioral healthcare practitioners involved in the care and treatment of clients and their families;

- Accommodation, through every reasonable effort, to the client's cultural language or gender preferences in the selection of a provider;

- Privacy and confidentiality of all records and communications, such that only people directly involved in the specific client's case have access to them;

- Upon request, receipt of copies of all treatment records sent to third-party payers;

- Information about any behavioral outcomes-related research in which Magellan or a provider is involved and the right to agree or refuse to participate in this research; and

- Information about the complaint, grievance and appeal processes should a dispute arise over treatment and/or claims.

C4.9 Biannual credentialing site visits enable Magellan to ensure that providers maintain written policies and procedures whereby clients are informed of their rights and responsibilities regarding service delivery. In addition, Magellan's recommended client rights and responsibilities for service providers are consistent with client/consumer *bill of rights* developed by national advocacy groups. Therefore, Magellan is enabled to ensure that the network has built-in safeguards which not only protect clients' rights, but also foster higher standards of care.

F4.34 Magellan has developed a client rights and responsibilities pamphlet to inform clients and/or their family members of their right to file a complaint about the quality, availability or appropriateness of provided services. The rights and responsibilities pamphlet is made available to clients upon their first appointment with a service provider. The pamphlet is highly detailed and provides clients with background information on the relationship between Magellan, DHS and service providers. The pamphlet also informs clients of their various rights and responsibilities (see **F4.33**). Most importantly, however, the pamphlet describes the process by which clients can lodge complaints or seek redress of grievances.

C4.10 By distributing the rights and responsibilities pamphlet to clients upon their first appointment with a service provider, Magellan can be assured that clients and their family members are informed of their right to file a complaint regarding the quality, availability or appropriateness of provided services. In addition, the pamphlet provides highly detailed information that not only delineates clients' rights but also describes the intent and philosophy behind Magellan's coordination of covered behavioral mental health services.

F4.35 The right to confidentiality is an essential component of the therapist-patient relationship, and the risk of breaches in client confidentiality are significant in the context of managed

care. The complexity of a managed care system to provide the most appropriate services are not inherently conducive to protecting the confidentiality of clients, due to the passage of client information between different parties. Furthermore, consumers of substance abuse and mental health treatment services and their families are especially vulnerable because of information that may be disclosed when they seek authorization for treatment or are referred from one practitioner or provider to another. Therefore, it is necessary for a managed care entity to have comprehensive policies and procedures in place governing client confidentiality.

Magellan maintains a comprehensive policy with detailed procedures which provides guidelines for safeguarding confidential client information in accordance with State and federal law, industry standards and professional ethics. As required by the contract, Magellan's comprehensive policy is consistent with the confidentiality requirements as set forth in part 2 of title 42 of the Code of Federal Regulations (CFR) and chapter 51 of the Ohio Revised Code (ORC). In addition to federal and State requirements, Magellan's policy includes specific guidelines for staff to follow in situations where there is a high risk of breaching client confidentiality, including the following scenarios:

- When calling a client or his or her designated representative, staff must confirm that the client is on the phone by requesting the client to state his or her entire name prior to disclosing confidential information.

- When a client's treatment record involves other parties, the authorization of each party must be obtained prior to affording the client access to his or her treatment record.

- If the client is incapacitated, information needed for diagnosis and emergency care may be released without written consent. The clinician who releases such information must immediately inform the appropriate management staff.

- Prior to disclosing information pursuant to a written authorization, Magellan staff is required to check the expiration date on the authorization form to assure that the authorization is in effect on the date disclosure is contemplated.

- When preparing an *Authorization for Release of Records or Information* form for a client's signature, Magellan staff assures that the form properly identifies the requested information.

C4.11 Magellan maintains a highly-detailed and comprehensive policy on client confidentiality. The policy not only outlines applicable federal and State confidentiality requirements, but also addresses how guidelines on confidentiality apply to daily operations. By specifically

identifying the various scenarios in which issues of confidentiality arise, Magellan has established effective safeguards to protect clients from breaches in confidentiality. The importance of these confidentiality protections is enhanced due to the sensitive nature of client information and the complexities of the managed care environment.

F4.36 Newly-employed staff members at Magellan are informed of the protocol for confidentiality and of their legal and ethical duty to maintain client confidentiality during orientation. In addition, a signed confidentiality agreement is secured from individual staff members and kept in their personnel files throughout their employment. However, periodic training sessions on confidentiality policies and procedures are not conducted.

Network service providers agree to maintain policies on client confidentiality which are consistent with federal and State laws applicable to the storage and maintenance of medical and mental health records, disclosure of client information and privacy. Procedures for the maintenance of client records and other measures instituted to assure client confidentiality are verified and evaluated during credentialing site visits (see **F4.22**). However, service provider clinicians do not receive periodic training on client confidentiality from Magellan.

R4.17 In conjunction with the Partnership Team, Magellan should develop and initiate periodic training sessions on client confidentiality for its staff as well as for service provider clinicians. These training sessions should mirror the confidentiality training attended by HCDHS' Children's Services staff. In a managed care setting it is necessary to pass client information among a number of different parties to deliver the most appropriate services, therefore, the likelihood of breaching a client's confidentiality becomes increasingly probable. Therefore, Magellan should place more emphasis on safeguarding client confidentiality and privacy through the development and initiation of periodic training. Such training sessions would not only inform staff members of changes in federal or State confidentiality laws but could also be used to reeducate those staff members who have been employed for an extensive period of time. Periodic training sessions on client confidentiality should address a variety of issues and topics including the following:

- Reviewing the techniques and methods used to inform clients of their right to confidentiality;
- Reviewing all standard confidentiality forms, including the *Authorization for Release of Records or Information* form;
- Reexamining all applicable federal and State confidentiality regulations, including: part 2 of title 42 of the Code of Federal Regulations (CFR), chapter 51 of the Ohio Revised Code (ORC) and the ODJFS *Public Records and Confidentiality Laws* manual, OAC §5101:2-34-38;

- Reviewing all possible scenarios in which breaches in client confidentiality are most likely to occur;

- Reviewing all credentialing standards on confidentiality by which service providers are evaluated;

- Reviewing the crisis protocol for high profile cases that includes time frames, staff responsibilities and media relations; and

- Discussing issues pertaining to confidentiality and the managed care information system, including: firewall installations, security clearances and client identifier codes.

Periodic training sessions would prepare Magellan and service provider staff in making appropriate and sound decisions involving client confidentiality. Informed decision-making on confidentiality issues enhances the safety and protection of children and their family members while safeguarding employees from potential liability issues.

Technology

Performance Measures

The following is a list of performance measures that was used to conduct the review of the technology component of the contract between Magellan Behavioral Health (MBH) and the Hamilton County Department of Human Services (HCDHS).

- Assess the functionality of management information systems
- Analyze compliance with contract stipulations for hardware and software purchases and installation
- Assess compliance with training requirements
- Evaluate technology training and operations manual
- Evaluate existing hardware capabilities to determine if stated functionality exists
- Evaluate existing software/licensed program capabilities to determine if stated functionality exists
- Assess network connectivity between MBH, HCDHS and providers
- Review hardware support system based on staffing, hours of availability, provider satisfaction and assistance wait time
- Review software support system based on staffing, hours of availability, provider satisfaction and assistance wait time

Findings / Commendations / Recommendations

F5.1 As a component of the contract, MBH has developed and implemented an up-to-date case management and claims processing software system based on CMHC software. The contract requires Magellan to operate the case management and claims processing system at two levels:

- **Individual Provider/Agency Level:** The system consists of a client, patient, practice management, and health care record fields. This system is similar to *IDX*, *Medical Manager*, *Medic*, or *Versys*. Magellan is required to upgrade the practice and agency management of providers and the Partnership Team through the implementation of the system, while realizing both present and future cost savings for providers and the community.

- **Management Oversight Level:** The system is similar to those third and fourth generation systems that allow roll up functions across all providers. Roll up functions allow data to be analyzed at both the provider level and at a network level within the same system. The management oversight reports encompass claims authorization and payment; credentialing; case management; utilization review and quality assurance for case management, fee-for-service; and capitation environments.

Magellan is also required to provide all software, equipment, supplies, and personnel to carry out all assigned tasks. Although personnel and training issues were present during the initial implementation of the system, these issues had been resolved prior to the beginning of this audit. According to HCDHS and MH management, MBH has fulfilled the requirements of the contract in the development of the case management and claims processing systems (see also **C5.1**, **F5.3**, **F5.4**, **F5.7** and **F5.8**).

F5.2 The Substance Abuse and Mental Health Services Administration (SAMHSA) developed guidelines for management information systems (MIS) used in Medicaid managed care environments. An ideal system, as recommended by SAMHSA, should have the following attributes:

- Person-centered;
- Integrated; and
- Operational (useful).

The system should be able to maintain and integrate the management services organization (MSO), provider and patient information and records. **Table 5-1** compares additional SAMHSA recommendations with the current Magellan system.

Table 5-1: Comparison of SAMHSA Recommendations to Magellan System

SAMHSA Criteria	Magellan System
Management of Eligibility Information	Providers can access eligibility information through CMHC. CMHC is updated through Blue software.
Provider Credentialing	Credentials maintained in CMHC for contracting purposes. MBH is in the process of implementing credential and performance measurement fields for providers.
Exchange of Data between Providers and MSO	Providers generally use telephone connections, although two have Quad ISDN lines.
Standardization of Clinical Assessments	Standards are maintained in CMHC system. Standardized assessments have been developed for HCDHS caseworker, provider treatment plans and case notes.
Outcome Evaluation	Some outcome reports may be possible, but current focus is on contractually required performance measures.
Utilization Management and Treatment Authorization Process	CMHC provides utilization management through requiring provider treatment authorization. Authorizations are responded to within seven days for non-emergency cases. A copy of the authorization letter is faxed to the provider when on-line approval has been granted.
Case Management	Although CMHC contains case management software, the MBH MIS director has identified several areas of underutilization.
Services Tracking	Services Tracking can be accomplished through CMHC.
Claims Processing	CMHC has claims processing capabilities.
Implementation of Performance Criteria	The MBH MIS gathers data for performance reporting, allowing for monitoring of data and potential implementation of improvements.
Reporting	Reporting is accomplished through SQL Server and Crystal Reports with data drawn from the CMHC system.
Quality Assurance	CMHC tracks critical incidents, provider meeting attendance, history and trends of denials and other quality assurance issues.
Incident Reporting	Incidents can be reported and tracked via the CMHC system.

Source: SAMHSA MIS Criteria, MBH MIS Department

Based on SAMHSA criteria, the Magellan MIS appears to fulfill the criteria of a high performing managed care information system. According to MBH representatives, the two software packages used to create the MBH MIS were each strong software packages– one contained case management software, while the other contained claims processing software. The large investment in technology and the sophisticated system developed by MBH provides a wide array of potential electronic records for use by HCDHS and providers.

C5.1 The system developed by Magellan's MIS for use in the True Care Partnership project fulfills the criteria of a high performing management information system. Systems of similar architecture and capabilities have not been developed in other jurisdictions. CMHC combines the functionality of case management software with claims processing software to provide a holistic approach to Medicaid managed care behavioral health management for Hamilton County residents.

R5.1 MBH should ensure complete implementation of the credential and performance measurement fields for providers. In addition, outcome reports should be emphasized in future report development and MBH should encourage the Partnership Team to consider the addition of outcome measure reports in future contracts. Finally, the MIS director should increase training for providers on the case management components of CMHC software and should ensure full utilization of the CMHC case management functions by MBH care managers, providers and DHS personnel.

F5.3 Magellan is required to provide certain hardware to the Partnership Team as a component of the contract. The contract Project Budget itemizes the hardware needed to create and operate the MIS. **Table 5-2** details the hardware and the associated costs for the 5 year contract.

Table 5-2: Hardware per Contract

Type of Hardware	Number	Designer/Model	5 Year Cost
Access Server	2 (at HCDHS) 1 (at MBH)	Cisco AS5200	$122,985
SQL Server NT	1	Compaq P500	$55,166
Exchange Server	1	Compaq P2500	$69,591
File Server and Redundant Back-up	2 (at HCDHS)	AIX (Unix)	$231,200
Switch	1 (at HCDHS) 1 (at MBH)	Cisco Backbone Switch	$12,915
PCs	60 [1]	Compaq Disc Pro's	$244,281
Notebooks	N/A [2]	IBM	$12,284
Existing PC Upgrades	N/A [2]	Intel 10T	$1,146
Router A	1	Cisco 1604	$18,520
Router B	0	Cisco 1005	$0
Printer A	N/A [2]	CMHC App Printer	$109,562
Printer C	N/A [2]	HP 5N	$17,056
Modem w/cable	60 [1]	USR	$19,671
Total			**$914,377**

Source: Exhibit 4 - Project Budget

[1] MBH estimated that 60 PCs and modems/network cards were now in use.

[2] Data was not available.

The providers and the Partnership Team confirmed receipt and installation of all required hardware as outlined in the Implementation Plan (Exhibit 8). The Partnership Team and providers also confirmed compliance with the Acceptance Test Plan (Exhibit 1), which tested the functionality and required parameters of the MIS.

F5.4 Additional hardware has been purchased by Magellan to address user needs and maintain a state-of-the-art system. Proposed additional purchases were presented by Magellan to the Partnership Team for approval. The following additional items were approved and have been purchased and implemented:

- Memory upgrades for the UNIX server and the NT servers;
- Additional modems and monitors; and
- A laptop computer and a desktop scanner.

These hardware items were needed to maintain the integrity of the technology currently in place as well as enhance capability of the MIS.

C5.2 Magellan has monitored provider needs and advancements in technology and provided enhancements to the MIS. Through enhancements, MBH ensures that the system meets user needs and adequately supports the MSO and provider functions.

F5.5 Based on the technology budget included in the contract and actual expenditures, MBH technology expenditures are under budget for the first two years by approximately $261,799. Expenditures are tracked by vendor, not type of purchase and hardware versus software expenditures can not be distinguished. **Table 5-3** compares the actual hardware and software expenditures to the technology budget for the first two years of the contract.

Table 5-3: Actual vs Budget Computer Costs

Vendor	1998 Budget	1998 Actual	Variance	1999 Budget	1999 Actual	Variance
CMHC	$253,654	$123,240	(51.4)%	$123,240	$73,240	(40.6)%
KDP	$168,152	$128,760	(23.4)%	$170,753	$128,760	(24.6)%
Totals	$421,806	$252,000	(40.3)%	$293,993	$202,000	(31.3)%

Source: Magellan Financial Reports

During each of the first two contract years, Magellan's technology expenditures were under budget by 40.3 and 31.3 percent respectively. The lower expenditures are attributed to the planned implementation of browser user interface (BUI) based software and anticipated future expenditures for hardware upgrades. In each year, the Partnership Team must approve

any budget changes and all expenditure requests. MBH was conservative in technology expenditures to reserve approximately $280,000, which will be needed for hardware upgrades in FY 2001 (see **F5.9**).

F5.6 Two MIS servers are located at HCDHS, including the primary and back-up server, and the two NT servers used for functions such as electronic mail. All of the server hardware will become the property of the Partnership Team at the end of the contract.

Magellan does not provide PCs to the Partnership Team. The Partnership Team uses its own equipment to access the system, thereby maintaining agency system integrity, agency standards, and existing fire walls. Hardware is provided by Magellan to each of the provider agencies, but specific hardware requirements differ depending on which agency initially contracted with the provider . ADAS providers receive one PC, one monitor and one printer which are connected to the MBH network. HCDHS providers who perform only HCDHS work receive the same package. Providers that serve both HCDHS and ADAS also receive two computers, monitors, and printers to facilitate data entry. The HCDHS and ADAS systems appear on the desktop of each computer.

F5.7 Magellan was required to purchase and implement several software/licensed programs under the requirements of Exhibit 2 of the contract. **Table 5-4** shows the required software. All of these programs have been implemented and are operational.

Table 5-4: Contractually Required Licensed Programs

Manufacturer	Product Name	User Thresholds	Scope of Use
MISPro	CMHC Claims Processing	600 Installs, 10,000 Users	Claims processing for HCDHS and ADAS providers
Microsoft	Windows 95	Unlimited	Desktop operating system
	Windows NT	Unlimited	Network operating system
	Office 97	Unlimited	Desktop applications
	Exchange Server	Unlimited	Office-based electronic messaging-client
	Exchange Client	Unlimited	Office-based electronic messaging-client
Cisco	CiscoVision	50,000 Users	Remote monitoring and management of routers
SMC	EliteView	50,000 Users	Remote monitoring and management of individual network interface cards

Source: Contract for Services, Exhibit 2

During the acceptance test, the Partnership Team observed a demonstration of the CMHC/MIS operation and verified that the system contained all required software. Log on capabilities were tested at a later date through daily access of the system and ongoing

monitoring of the system's performance. All of the contractually required licensed programs are installed and operational on the MIS.

F5.8 Magellan has upgraded the software included in the MIS to meet the changing needs of the Partnership Team. The upgrades and additional software purchases made to the MIS include the following:

- eCet Clinical content package from CMHC Systems;
- SQL Drivers for the CMHC/MIS application;
- SQL Server;
- AIX upgrade from 4.2.1 to 4.3.3;
- ABC Claim Check;
- Blues Terminal Emulator for Magellan MIS; and
- Seagate Crystal Reports.

MBH purchased more software licenses and upgraded some of the programs beyond the contractually specified levels because of the unexpectedly large number of referrals and client records which need to be processed and maintained. For example, Microsoft Access was the program initially installed for database purposes, but the program was replaced by Microsoft SQL Server because of increased data processing needs. Access can only accommodate 100,000 records while SQL Server, coupled with Crystal Reports, manages the approximately 700,000 records currently on the system with ease. As a result of the upgrades and Magellan's attention to the needs of the system users, the Partnership Team has received software and licenses beyond the required contract provisions. Because of the relative newness of Medicaid managed care information systems, the upgrades initiated by Magellan were not predictable.

C5.3 The upgrades provided to the Partnership Team and providers by Magellan have increased the utility of the MIS. MBH has responded to unanticipated demands on the MIS and, with the approval of the Partnership Team, has upgraded the software to meet the demands of the system users. Initiatives such as the upgrade to Microsoft SQL Server from Microsoft Access and the purchase of the terminal emulator *Blues for Windows,* allow MBH to maintain an up-to-date and effective MIS in a changing environment. Furthermore, MBH's willingness to accommodate the needs of the users beyond the contract parameters demonstrates a desire to fulfill the intent of the contract beyond stated provisions.

F5.9 The user interface on the MIS was scheduled to be upgraded to a BUI system on or before January 1, 1999. MBH did not implement the conversion because a new upgrade for the system was only recently made available. CMHC provided Magellan with browser/user interface (BUI) functionality as a component of CMHC maintenance and upgrades during FY 2000. MBH worked with providers for HCDHS and ADAS, and Internal Care Managers

to prioritize the screens that will be upgraded. The Magellan MIS Department will be responsible for actual programming in the BUI environment. Upgrades will be rolled out in phases because of the programming complexities and the length of time anticipated for full conversion. Standard user interfaces will remain available in the BUI environment for screens that have not been upgraded.

Full implementation of the upgrade will not be possible until new software and hardware are implemented by MBH. Hardware capabilities and probable usage rates are being measured to determine system needs to handle the increased data volume that accompanies a change from character based information to graphic based information.

R5.2 MBH should present a budget amendment to the Partnership Team to accommodate expenditures for hardware upgrades. As implementation of the BUI software is dependent on hardware upgrades, the Partnership Team should approve implementation of the new hardware as soon as possible. MBH estimates that the new servers required to operate the BUI software will cost approximately $280,000.

Financial Implication: New hardware to operate the BUI software will cost the Partnership Team approximately $280,000 net.

F5.10 HCDHS runs an internal MIS in addition to the CMHC system. HCDHS installed Oracle financial software in FY 1998. The Oracle program interfaces with the Magellan MIS to update the claims database when payments are made. Financial data is exchanged through an ASCII file accessible to HCDHS through the Magellan website. HCDHS MIS staff access the file and update the information on a daily basis.

Client demographic data from HCDHS is created by the caseworkers and downloaded from the HCDHS MIS to the MBH system on a nightly basis. The client information corresponds to the financial data and is used to define the population covered by provider claims. The electronic data interchanges (EDIs) are audited at the end of each year to reconcile the claims and demographic data to the payments made by HCDHS. HCDHS has set a target date of mid-2001 to have a system capable of verifying checks as they are cut.

F5.11 Magellan is required to develop a training plan and to provide ongoing training to HCDHS, ADAS and providers. The training plan must be approved by the Partnership Team. MBH proposes an agenda for each training session specifying the intended subject audience, the expected duration of the training, approximate session dates and suggested locations. For each training session, Magellan also develops a training curriculum that includes resource materials, training outlines and structured activities.

A comprehensive training program is necessary to familiarize employees with the new system when a new technology system is implemented within an organization. The training programs provided by MBH are intended to fulfill both the requirements of the contract and address the needs of the providers and system users. The addition of providers to the network increases the need for ongoing training, as providers have little past experience with case and claims management software.

F5.12 Magellan is also required to hold ongoing training sessions at least quarterly, and to organize additional training sessions whenever systems or procedures are altered. According to Magellan staff, training is accomplished in three phases. Initially, MBH provides an introductory training to acquaint users to the MIS. MBH also provides quarterly update training to its users. Finally, the MIS staff conducts bi-weekly user group training for HCDHS and ADAS providers, and Internal Care managers. During the bi-weekly user group sessions, Magellan notes any issues that may necessitate additional training, updates the training curricula as the system changes, and answers specific questions from the user groups.

Magellan also conducts a provider refresher course and ongoing ADAS training, which is tailored to ADAS user needs. The refresher courses allow users who do not attend the user group meetings to receive additional training. Magellan receives feedback on training and system issues through the monthly clinical director's meeting.

Training requirements are based on the contract which states,

> "(MBH) shall develop and provide to the Partnership Team and Contract Providers such Training and Operations Materials as appropriate to the efficient and orderly operation of the Managed Care Information System."

The contract also states that MBH shall train the Partnership Team in the use of hardware, licensed programs, and the data collection system. Exhibit 7 contains performance indicators and benchmarks for technology training. The performance indicator states that "the MSO will provide to PT (Partnership Team) staff and providers timely and competent training." The incremental benchmark states that 95 percent of the training will be provided timely and competently.

While the contract stipulations and the performance measures are general in nature, MBH appears to provide a sufficient number and range of training opportunities to users. Although bi-weekly user group meetings are not required by the contract, user group training enhances providers' understanding of the information system and increases the utility of case management and claims processing software.

C5.4 Magellan's training is timely and is more extensive that required by the contract. Magellan has enhanced its training program beyond the requirements of the contract through the implementation of bi-weekly user group training. Bi-weekly training provides several benefits for MBH and system users which are listed below:

- Provides an additional opportunity for updated training;
- Allows providers to ask questions about the MIS;
- Provides users with a forum to receive answers to questions and clarify procedures;
- Provides a personalized instruction atmosphere;
- Augments the Help Desk function; and
- Allows flexibility and responsiveness to user and industry changes.

F5.13 MBH is required to provide training to HCDHS caseworkers and supervisors. Only training for supervisors had been completed at the time of this audit. The training program for HCDHS caseworkers was started in July 2000, but HCDHS postponed the training as a result of limited hardware (PCs) and system access for caseworkers.

HCDHS provided hardware and system access to caseworkers after July 2000, but has not initiated training with Magellan. HCDHS cited training space and time requirements as a barrier to commencing training. Training would require two to three consecutive days in a location to house 250 staff members. The current upgrade to a BUI system(see **F5.9**) also is partially responsible for the delay. MBH and HCDHS intend to delay training until system upgrades have been implemented.

R5.3 HCDHS and Magellan should work together to ensure that HCDHS caseworker training is completed as soon as possible. A date has not been identified for completion of implementation of the BUI and further training delays dilute the benefits received by HCDHS through the contract. HCDHS should conduct preliminary training for all caseworkers and should reserve training facilities once the BUI update has been installed. Initial caseworker training should be conducted in smaller groups; a class size of 12 (the maximum that can be accommodated in the MBH and HCDHS computer labs) is recommended. By conducting training in small groups, MBH and HCDHS will not need a large auditorium and a large portion of caseworkers would remain on the job, while a smaller number received training. Although the training would take approximately one and one-half months of continuous rotations, small group settings would benefit both HCDHS and MBH and allow HCDHS to phase in use of the system. For more information about training facilities and methods, see **F5.15, F5.16, R5.4** and **R5.5.**

F5.14 Magellan evaluates its training programs through a pre-test/post-test evaluation and through a written evaluation, which is completed at the end of each training session. The data from

evaluations is compiled and analyzed statistically by the Magellan clinical statistician. The analyses document both objective and subjective comments from each respondent.

An evaluation process is essential in training programs to ensure that training is effective and that it addresses the issues that are pertinent to users. Although several methods of program evaluation exits, collecting data from training participants provides the greatest level of objective and subjective data. Likewise, a pre-test/post-test methodology allows the trainer to impartially evaluate the effectiveness of training on the participant's knowledge base. MIS pre-tests/post-tests and evaluations show both an increase in user technology through training and an overall improvement in training service delivery during the contract period.

An independent assessment of the effectiveness of the training program for providers was conducted via a non-statistical, random telephone survey of 25 percent of the provider network. Respondents were asked to rate the following on a five point scale:

- General impression of the training program;
- Effectiveness of the training program;
- Effectiveness of the trainers;
- Topics selected for training; and
- Relevancy and completeness of the training program.

Eighty percent of the respondents found the training to be good to excellent and 100 percent of the respondents rated the choice of topics as good or excellent. The trainers were also rated as good or excellent by 80 percent of the respondents.

The survey results correspond findings from Magellan evaluations. Respondents noted, in 40 percent of responses, that the MIS Department and the training program have improved since Magellan assumed the training responsibility from CMHC. A comparison of results from the HCDHS first-year review and the past quarter review indicate an improvement in the training curriculum and effectiveness.

C5.5 The MIS Department and the training program have shown marked improvement in objective analysis and provider satisfaction levels. MBH offers a more focused and user friendly training program which improves the users understanding of the MIS. Shifting training responsibility from CMHC to an in-house setting provides much greater control and concentration to the MBH training and MIS staff.

F5.15 Magellan uses a variety of media and locations to conduct training for system users. Formal training takes place in the training laboratories at Magellan and HCDHS. The labs are equipped with projection machines and work stations so the class is able to apply the lesson to the MIS as they learn the material. PowerPoint presentations are sometimes used to

emphasize aspects of the training programs. User groups and other informal training sessions takes place at MBH headquarters. However, training programs are generally not provided at individual provider sites.

The contract does not contain provisions to guide the location of training and types of training tools to be used. Best practice data suggests that the "see it, say it, do it" method provides the greatest retention of detail-oriented task training. Allowing users to operate the computers as they learn system functions improves retention and increases user skill levels. Also, training provided through an auditory medium is recognized as the least effective method of communication and, as a result, visual materials and hands-on experiences are crucial to an effective training program.

The training labs and visual presentations offered by MBH indicate a strong interest in supplying high quality training programs. As indicated by survey respondents (see **F5.14**) the training program currently in use is superior to the training provided by CMHC during the first year of the contract. Most providers recognize the benefits of training and appear to have increased their performance levels on pre-test/post-test instruments. However, some providers have not used the training programs and lack the skills to effectively use the CMHC system.

C5.6 Magellan provides a supportive learning environment using best practice training methods. Hands-on training, which occurs in MBH and HCDHS labs, is of particular importance in increasing user familiarity with the system and ensuring the retention of training information.

R5.4 Magellan should offer training at provider sites to ensure that all providers and their employees are trained on the CMHC system. MBH has two basic options in implementing training at provider locations including:

- Conducting user group meetings at different provider sites on a rotating basis; or
- Conducting update training throughout the user locations on an individual basis.

Mandatory or 100 percent attendance could be achieved by conducting training at each separate provider location. Provider employees would be able to directly apply lessons to their records. Also, conducting training at user sites would allow the trainers to observe any unique problems providers have with the MIS and implement on-the-spot intervention programs.

F5.16 Records and interviews show that the training programs developed and presented by MBH are attended by most providers. However, MBH indicated that there are some providers who do not attend the update or user group training sessions regularly. In order to maximize the efficient and effective use of the MIS, it is important that the training programs are attended

by all users. While it is not possible to mandate that the providers attend the training programs, increasing attendance rates may influence the data entry accuracy levels and reduce other usage problems associated with the system.

R5.5 Magellan and HCDHS should take measures to increase attendance at update and user group training sessions. MBH should also investigate methods to improve training delivery outside of face-to-face training sessions. MBH should investigate conducting on-line discussion groups or using streaming video within the server to conduct scheduled training. On-line discussion groups would be the most cost effective option as MBH and HCDHS have the applicable hardware and software to operate such a program. Streaming video would require a faster server, but might be feasible with planned hardware upgrades (see **F5.9**). Other potential communication methods include implementing Net Meeting, which would allow MBH MIS personnel to view and operate provider computer desktop screens from the MBH location. Net Meeting would also allow MBH support staff to view provider problems and either talk the provider through the solution or implement the solution from the MBH office location.

Magellan should also consider changing the format of update training to include a quarterly or semi-annual update video or CD-ROM, which could be distributed to all users. This approach to update training would ensure that all users receive and have an opportunity to view the MBH training. MBH recently bought a CD writer and has considered developing training CDs. A training CD-ROM would cost approximately $2.50 per disk for a production cost of $500 to create 200 disks for system users.

Financial Implication: The cost to provide training CD-ROMs to the estimated 500 Partnership Team and provider users would be approximately $1,250.

F5.17 The contract requires that Magellan develop and provide all training and operations materials necessary for the efficient and orderly operation of the MIS Training manuals should provide the user with an accessible reference source after the training is completed. MIS manuals should also contain procedural instruction to assist novice users in navigating the MIS. In a Medicaid managed care environment, manuals should contain applicable steps to follow in the billing, claims, and case management processes. Magellan has developed training manuals for providers, HCDHS caseworkers and ADAS caseworkers, as well as a technical manual used by MBH MIS Department personnel.

The HCDHS supervisors/caseworkers manual contains very clear and complete information on the use of the MIS. The manual has good explanations of every screen and the information on the screens, allowing a user to fully understand the capabilities of the system. The HCDHS supervisors/caseworkers manual contains the following information:

- A table of contents that lists the various functions of the MIS;
- Illustrations of every screen encountered by a user;
- Detailed explanations of each function available to a user;
- Examples of possible data inputs into each screen;
- Lists of shortcuts within the system that are accessible on each screen; and
- Explanations of each term used within the system.

The other manuals developed by Magellan do not include as thorough descriptions and only partially illustrate the various screens encountered by a user.

R5.6 Magellan should update the training manuals for providers and model the new manuals after the HCDHS supervisors/caseworkers manual. A more complete manual for providers may reduce the number of requests for assistance as users would have a reference to guide them through the system. Additionally, MBH should consider placing all training manuals on-line to improve accessibility and reduce costs associated with printing, distribution and updates. If the manuals are made available on-line, users can access instructions for updates as soon as they are placed on the system. Furthermore, pop-up help menus should be included as a component of the BUI upgrades discussed in **F5.9**.

Magellan should also consider developing customized reference guides to the MIS for each user group. Many software programs come with reference guides that allow users to complete the most common tasks within a system without referring to a large, bulky manual. Since the complete MIS manual would be cumbersome, a reference guide would provide users the answers to the most commonly asked questions. Improved reference manuals would potentially reduce training questions, errors, and Help Desk requests for assistance. The MIS department at Magellan could update the manuals and place them on-line at no additional cost by incorporating the task into the Department's work schedule.

F5.18 There is a turn-key provision in the contract that allows the Partnership Team to assume operation of the MIS at the conclusion of the contract period. However, the Partnership Team has not designated staff to learn the processes used by the Magellan MIS Department. In order for HCDHS to use the turn-key provision, HCDHS employees must be able to perform the functions of the Magellan MIS staff and must be fully informed about the status of the MIS.

The decision to exercise the turn-key provision rests with the County Commissioners and the directors of the respective Partnership Team agencies. No decisions have been made to date although the topic is under discussion. HCDHS management indicated that MIS administration will most likely continue to be contracted out and the turn-key option will not be employed.

Although HCDHS does not have plans to assume operation of the MIS, Magellan has discontinued its role as MIS manager and/or MSO in several other Medicaid managed care contracts. Representatives of the Partnership Team expressed concern that Magellan may not renew its MIS role in the contract at the end of the five-year period.

R5.7 HCDHS should immediately implement procedures to ensure the Department's ability to assume operation of the CMHC system if the turn-key provision is exercised by either party. The large investment in the contract should not be compromised by uncertainty surrounding this issue. HCDHS, the Mental Health Board and ADAS should determine which operational areas each Agency would take on while HCDHS should take responsibility for ensuring the continued operation of the technology component of the behavioral health managed care system. The HCDHS MIS department does not currently have sufficient resources to undertake the management of the CMHC system nor are Department personnel sufficiently acquainted with the system to ensure adequate trouble-shooting and repair capabilities. HCDHS should ensure that the MIS Department has sufficient knowledge of the CMHC software to manage the system in the event that MBH is no longer involved in this process.

To prepare for potential MIS transitions, HCDHS and the HCDHS MIS Department should consider implementing the following steps:

- Allocate funding to support MIS Department training on the CMHC system;
- Identify programming and procedural issues that will be essential to understand and operationalize under the turn-key provision;
- Designate a CMHC manager to liaison with Magellan IT personnel on issues of programming;
- Designate an additional three to five staff members to liaison with Magellan MIS staff on issues of procedures and processes; and
- Complete turn-key training requirements prior to termination of contract and ensure that HCDHS MIS personnel are continually included in Magellan MIS decision-making and implementation processes.

Based on HCDHS pay grades for IT personnel, the cost to hire an MIS manager would be approximately $75,000 including 25 percent for benefits. It would require a full-time commitment from HCDHS for at least eighteen months for an MIS representative to fully learn the CMHC system. The addition of three staff members would cost HCDHS approximately $195,000 including 25 percent for benefits. However, the Partnership Team will have invested approximately $15 million in the development and implementation of the contract which will not be recoverable without the implementation of a MIS turn-key transition team.

Financial Implication: HCDHS would incur an additional annual cost of at least $270,000 in salaries and benefits for additional MIS personnel to serve as the turn-key transition team. HCDHS, the Mental Health Board and ADAS would incur additional costs to assume the responsibilities of MBH's general operations. However, the addition of such personnel will offset the potential termination of the program resulting in a potential net savings.

MIS Support

F5.19 MBH provides user support to the Partnership Team and to contracted providers. The contract requires MBH to maintain a toll-free telephone support line for use by Partnership Team personnel. Magellan staffs the support line between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday, as required by the contract. Calls that are placed outside of normal business hours are routed to on-call Magellan support staff. All calls are logged and Magellan guarantees that all major problems are responded to within one hour. Problems requiring a one-hour response are investigated by an on-site representative within four hours of the initial call. Support logs are maintained by Magellan and provided to HCDHS as a component of the Quality Improvement Report.

Minor hardware and software problems are addressed within one business day. If a minor problem cannot be resolved by telephone within the time limit, MBH sends a skilled technician to the site to solve the problem. Magellan also provides the same service levels for problems that are related to the back-up UNIX server, but all calls, regardless of urgency, require a one-hour response and one-day resolution time frame.

HCDHS conducted a review of compliance with contract Exhibit 7 hardware support, software support and Help Desk operations performance measures. The review encompassed January 9, 1998 through December 31, 1998. Exhibit 7 requires the following:

- MIS hardware and software must be state of the art and meet Partnership Team needs;
- MBH must respond in a timely manner to system related problems experienced by users;
- 90 percent of problems are responded to within one hour during regular business hours; and
- 100 percent of the time the core server is not down more than one hour.

HCDHS concluded that Magellan responded to problems within one hour during regular business hours only 81.7 percent of the time. MBH also did not differentiate between hardware and software requests for assistance. MBH improved its response times between January 1 and July 31, 2000 to a 98.2 percent one hour response rate. The core server has only failed once during the contract period. The backup server immediately responded and

performed effectively and the 100 percent benchmark was achieved. The change in support service levels was attributed to the new Magellan director of MIS, who has focused Department attention on support services.

Telephone interviews conducted with providers (see **F5.14**) indicated a high level of provider satisfaction with Magellan MIS support. Respondents to the survey noted the effectiveness of Help Desk resolutions and improvements in MIS response time. Providers did not report poor service or long wait times.

C5.7 Magellan has improved support service response times to meet and exceed contract obligations. Providers also appear to be satisfied with current service levels.

R5.8 Magellan should distinguish between hardware and software requests for support assistance in the tracking system to improve contract compliance with required service levels. Distinguishing between types of assistance requested would help Magellan focus training sessions and support services to the areas where they are most needed. Furthermore, tracking users identified problems would provide MBH with data for strategic technology planning, particularly in the area of planned training and system updates.

F5.20 MBH employs a total of five individuals within the MIS Department including: the MIS director, two analysts, one programmer and one network administrator. All employees within the MIS Department provide support to Partnership Team and provider and agency users, which currently number approximately 500. The MIS director, network administrator and programmer dedicate less time to support functions because of competing responsibilities.

The Gartner Group, a leading information technology consulting firm, advises organizations to consider the makeup of their computer user population when determining appropriate levels of technical staffing. The firm suggests employing a three-tiered classification structure, and finds that the following ratios of support person to end user tend to exist for these three general classifications within organizations surveyed:

- Power user (technologically sophisticated user) 1:30
- Office user (uses office software and business applications software, e-mail and Internet) 1:60 to 1:100
- General (minimal user of computers) 1:125 to 1:300

MBH currently has the equivalent of 2.0 full-time employees to provide support functions, which provides users with approximately one FTE per 250 users. If the MIS director, network administrator and programmer are included at 25 percent, MBH allocates one FTE per 181 users.

According to the benchmark ratios, this level of support would correspond to a user population comprised predominantly of general, or minimal, computer users. Although the user population has not been classified in terms of the Gartner Group hierarchy, it is questionable that an ability to adequately support only the lowest level of computer users should be considered sufficient or desirable, especially in light of the continued expansion of technology and the upcoming inclusion of approximately 250 additional users.

R5.9 MBH should prepare an analysis of the make-up and skill level of its computer user population, employing either the Gartner Group hierarchy or any other rational methodology. Analyzing the components of the user population served is a necessary step in establishing strong supporting evidence on which to base staffing or organizational decisions. After identifying and evaluating the abilities of its computer users, MBH should request Partnership Team approval for any adjustments in staffing that may be necessary to provide the desired quality of support services. The MIS Department currently anticipates needing at least one additional programmer that would cost MBH approximately $75,000 including 25 percent for benefits for a programmer with some work experience.

Financial Implication: An additional programmer with some work experience would cost MBH approximately $75,000 annually, including 25 percent for benefits.

F5.21 CMHC software is used for the data capture and reporting function of the MIS. The software was designed by CMHC Systems. CMHC is a comprehensive software package designed around the principal of system integration which collects and displays demographic, clinical, service, financial and outcome information. The following list highlights the data capturing capabilities of the CMHC program:

- Patient information;
- Member eligibility information;
- Provider (multiple);
- Diagnosis (multiple);
- Integrated service notes;
- Case notes (unlimited);
- Medications (multiple);
- Therapies and procedures (In-patient and out-patient);
- Insurance verification; and
- Critical incident reporting.

The CMHC software also contains the ability to generate standardized provider reports such as operating costs and benefits, and patient discharge reports, as well as user customized reports. All reports are available in hard copy or on-line. The system also retains query data for report generation and identifies frequent queries into the system for quality assurance activities.

Magellan uses the CMHC reporting functions for small reports because the size of the database makes the use of CMHC reporting functions inefficient for the creation of large reports. SQL Server is used to process larger reports for HCDHS and providers. MBH extracts data from the database and enters it into SQL, which then sorts the information and creates the desired reports (through Crystal Reports) for the requesting entity.

C5.8 Magellan has reduced the amount of time necessary to create reports and improved the efficiency of the MIS through implementing SQL Server for report generation. More expedient reporting functions increase service levels to the Partnership Team, provider network and clients.

F5.22 Data entry into the MIS by providers has been identified as a source of system and computation errors. Providers do not always enter the information into the system in a timely manner. MBH has considered withholding payment to providers if data is not entered in a timely manner but, at the time of reporting, no penalties for late entry exist.

Timely data entry is important in both the billing process and case management. Providers who neglect to enter case management information into the CMHC delay case management activities at HCDHS. In addition, late billing prevents HCDHS from adequately monitoring and adjusting monthly expenditures for behavioral health services.

The complexities and newness of the CMHC system have been cited as reasons for untimely data entry. However, training has been offered to providers and the system has been in use for over two years. As indicated in the claims processing section, some providers have held claims well beyond the allowed submission period.

R5.10 The Partnership Team should require all providers to enter claims data for non-Medicaid claims within 60 days of the end of the month during which the service was provided. Providers should be notified of the time limitations and encouraged to enter data as soon as possible after the service to increase accuracy and detail of the data. The Partnership Team should monitor data submission and include prompt reporting in a contract amendment or in the next contract RFP.

In the case of Medicaid claims, the Partnership Team should require providers to report the service and cost that will be billed to Medicaid during the 60 day window. Although

Medicaid allows providers to bill up to one year from the date of service, the Partnership Team can encourage prompt Medicaid reporting through denying late claims that are rejected by Medicaid. If a claim is reported through CMHC but rejected by Medicaid, MBH should promptly reimburse the provider. However, if the claim is a non-Medicaid claim or is a rejected Medicaid claim that has not been reported as required, MBH should deny payment. Any changes to the reporting methodology should be phased in over a six month period and stressed in all MBH, Partnership Team and provider communications.

Connectivity

F5.23 The MIS network is connected to individual providers and members of the Partnership Team. Quad ISDN lines are used to transmit data between MBH and the Partnership Team, while the providers typically use a point-to-point, 10 base T-line (telephone line). Provider connections have been characterized as slow and unpredictable, with a maximum data transmission speed of only 56 kilobits (kbps) per second.

The Quad ISDN lines transmit at 256 kbps. Stability is maintained because these lines are solely dedicated to processing data specific to the MIS. Providers have the option of increasing connection speed and maintaining stability by using Magellan Quad ISDN lines for an additional charge or by purchasing an additional user license.

MBH performance in maintaining connectivity is monitored through Performance Standard 10. Performance Standard 10 requires that 95 percent of all transmissions will take no longer than two seconds, and that the remaining 5 percent will take no longer than ten seconds. Transmission times are tracked by HCDHS on an ongoing basis and HCDHS and the Partnership Team has determined that connectivity meets contract requirements. However, several providers stated that connectivity remains an issue, specifically the slow transmission speeds and unreliable connections. Connectivity and transmission times at the provider level has not been assessed as a component of contract compliance.

C5.9 Magellan enjoys a strong record of satisfaction with the Partnership Team in regard to connection rates. The contract specialists at HCDHS, on behalf of the Partnership Team, analyzed connectivity performance standards to determine the progress of MBH on meeting the contract goals per the implementation schedule. It was determined that all connectivity requirements and parameters were being satisfied, and that there was no need to continue tracking connectivity as a performance standard.

F5.24 Although the present MIS cabling configuration is adequate to handle current traffic, future MIS requirements, user needs and caseload data requirements indicate that upgrades will be needed. Transition to a BUI system will require faster data transmission and access speeds to accommodate the larger memory requirements of the software.

Many companies and public agencies have shifted from 10 base T-lines or QUAD IDSN lines to optical fiber and T-1 lines. The current industry trend shows that larger systems, like the Magellan MIS, use optical fiber or T-1 lines to transmit and access data. T-1 lines are the current minimum industry standard for digital transmission in North America, processing data at a rate of 1.544 Mbps (megabits per second) while optical fiber cabling transmission speeds are currently constrained by the speed of the desktop computer coprocessor.

Although data transmission is currently satisfactory for the Partnership Team, the implementation of the BUI upgrade (see **F5.9**) will require new communication lines to maintain a high service level. Upgrades in the cabling configuration were not factored into the project budget.

R5.11 To accommodate future connectivity needs, MBH should install T-1 lines, DSL lines or cable communication lines between MBH, the Partnership team and providers. Each type of high speed connection has benefits and limitations, which must be examined by the MIS Department and the Partnership Team to determine the best type of connection for the CMHC system. T-1 lines connect locations from point-to-point and are highly secure but may be prohibitively expensive in relation to other connections available. T-1 lines would cost approximately $1,000 per month per location, which could run over $375,000 annually ($12,000 per provider).

DSL and cable lines, a more economical alternative, are not point-to-point connections and would require the implementation of a virtual private network to manage provider connections to the CMHC servers. Yet DSL and cable lines are less expensive than T-1 lines and would cost each provider approximately $360 annually. Security is a critical aspect in connectivity and MBH and the Partnership Team should investigate the most up-to-date security features if a virtual private network is used.

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EXECUTIVE SUMMARY

Project History

At the request of the Hamilton County Department of Human Services (HCDHS), the Auditor of State's Office performed a performance audit to review key contractual provisions of the Creative Connections contract (the contract) beginning in July 2000. Hamilton County's five primary child-serving agencies: Department of Human Services (HCDHS), Mental Health Board, Alcohol and Drug Addiction Services Board (ADAS), Board of Mental Retardation and Developmental Disabilities (MRDD), and Juvenile Court provide behavioral health and substance abuse managed care services to 286 of the County's most troubled youth through a managed care arrangement with Creative Connections, a division of Beech Acres. The contract is managed by the Family and Children First Council (FCFC) on behalf of the County agencies (or Council agencies) who serve as a governing board. HCDHS refers a majority of clients to Creative Connections through the Children's Services Division at HCDHS. HCDHS requested a comparison of various contractual provisions to services rendered, an assessment of the manner in which the Council agencies' funding is arranged and utilized, recommendations for improvements to future contracts and identification of best practices in managed care. Meetings between the Auditor of State's Office and County management were held to discuss the scope and objectives of the performance audit.

As a result of these discussions, it was determined that the performance audit would focus on the following areas:

- Financial management and reporting;
- Performance measurement and provider network development; and
- Technology.

Objectives and Scope

A performance audit is defined as a systematic and objective assessment of the performance of an organization, program, function or activity to develop findings, conclusions and recommendations. Performance audits are usually classified as either economy and efficiency audits or program audits.

Economy and efficiency audits consider whether an entity is using its resources efficiently and effectively. They attempt to determine if management is maximizing output for a given amount of input. If the entity is efficient, it is assumed that it will accomplish its goals with a minimum of resources and with the fewest negative consequences.

Program audits normally are designed to determine if the entity's activities or programs are effective, if it is reaching its goals and if the goals are proper, suitable or relevant. Program audits often focus on the relationship of the program goals with the actual program outputs or outcomes. Program audits attempt to determine if the actual outputs match, exceed or fall short of the intended outputs. The performance audit conducted on the Creative Connections contract is predominantly a program performance audit focusing on contract compliance.

The Auditor of State's Office has designed this performance audit with the objective of reviewing systems, organizational structures, finances and operating procedures to assess the implementation of contract provisions and the development of the behavioral health managed care program by Creative Connections. Specific objectives of this performance audit include the following:

Financial Management and Reporting

- Analyze the budgeting and expenditure reporting requirements in relation to Creative Connections' practices;
- Assess line item billing amounts for administration, care management and overhead;
- Review reconciliation process in relation to requirements and allowances of the contract;
- Evaluate the maximization of funding;
- Assess financial monitoring activities; and
- Examine the methodology used to determine funding percentages and the relationship between funding and clients served.

Performance Measurement and Provider Network Development

- Assess the development and implementation of the Continuous Quality Management Program (CQMP) as required by the contract;
- Assess the capturing and reporting capabilities of Creative Connections regarding performance measures and benchmarks as stated in the contract;
- Analyze the application of financial penalties based on established performance indicators as stated in the contract;
- Evaluate the FCFC and Council agencies' monitoring of Creative Connections;
- Assess Creative Connections ability to coordinate and monitor the service provider network
- Assess the implementation of service provider profiles;
- Review credentials, licensing and provider insurance based on contract provisions;
- Assess client rights and confidentiality policies and procedures; and
- Review policies and procedures governing client complaints and grievances in relation to contract requirements.

Technology

- Assess the completeness and functionality of management information systems (MIS);
- Evaluate technology policy training and operations manuals;
- Evaluate existing hardware capabilities to determine if stated functionality exists;
- Evaluate existing software/licensed program capabilities to determine if stated functionality exists;
- Assess network connectivity and its impact on information systems utilization; and
- Review MIS support based on staffing, provider satisfaction and assistance wait-time.

Methodology

To complete the performance audit, the auditors gathered and assessed a significant amount of data pertaining to Creative Connections' operations including financial and performance measurement records and policies and procedures related to the behavioral health managed care program; conducted interviews with various groups associated with HCDHS and Creative Connections, as well as best practice entities; and reviewed reports and recommendations from various private nonprofit, State and Federal entities responsible for Medicaid and managed care program implementation and monitoring. The methodology is further explained below.

Studies, Reports and Other Data Sources

In assessing the various performance audit areas, Creative Connections was asked to provide any previous studies or analyses already prepared on the subject areas. In addition to assessing this information, the auditors spent a significant amount of time gathering and assessing other pertinent documents or information. Examples of the studies, reports and other data sources which were studied include the following:

- Council agencies' agreement with FCFC;
- FCFC contract with Creative Connections;
- Creative Connections' quarterly and annual reports to the contract manager;
- Creative Connections' policies and procedures;
- HCDHS clinical reviews of Creative Connections;
- The contract manager's financial and performance reviews of Creative Connections;
- Child Welfare League of America (CWLA), Recommended Practices;
- Select United States General Accounting Office (GAO) reports;
- Select Substance Abuse and Mental Health Services Administration (SAMHSA), Recommended Practices;
- Health Care Financing Administration (HCFA), Managed Care Recommended Practices;
- Wichita State University, School of Urban and Public Affairs Sedgewick County study;
- Bazelon Center for Mental Health Law study on public management of mental health care;

- Annie E. Casey Foundation, Managed Care Report; and
- American College of Mental Health Administrators Summit Report on Managed Care.

Interviews, Discussions and Surveys

Numerous interviews and discussions were held with many levels and groups of individuals involved internally and externally with Creative Connections. These interviews were invaluable in developing an overall understanding of Creative Connections' operations. Examples of the organizations and individuals interviewed include the following:

- Creative Connections personnel;
- Beech Acres personnel;
- FCFC personnel;
- HCDHS and other Council Agency personnel;
- HCFA representatives; and
- UNI/Care representatives.

Benchmark Comparisons

Benchmark comparisons were developed from regulatory and industry measures. Performance indicators were established for the various performance audit areas to develop a mechanism to compare how effectively and efficiently Creative Connections provides and coordinates services. The information was obtained primarily through information requests and interviews held with the appropriate personnel selected from regulatory and accreditation agencies. These agencies included the following:

- Child Welfare League of America;
- Health Care Financing Administration;
- Substance Abuse and Mental Health Services Administration;
- Ohio Department of Mental Health;
- Department of Health and Human Services, Office of the Inspector General;
- Government Accounting Office;
- Wichita State University;
- Bazelon Center for Mental Health Law study on public management of mental health care;
- Annie E. Casey Foundation, Managed Care Report; and
- American College of Mental Health Administrators Summit Report on Managed Care.

Overview of the Creative Connections Contract

In FY 1993, the Council agencies met to initiate discussion on how to better coordinate funding and service delivery for multiple needs children who traditionally crossed social service systems. As a result of these discussions, the Council agencies agreed that managed care could be used to control the rising costs associated with serving the County's most troubled youth. In addition, the Council agencies negotiated a pooled funding agreement which would facilitate the sharing of costs associated with serving these children and their families.

A not-for-profit company was established in the spring of 1994 for the purpose of applying managed care to control costs and to coordinate service delivery for Council Agency clients. After a few years of operation, however, Family and Children's First Management Inc. (FCFM) began to experience financial difficulties and was especially having problems reducing the costs for out-of-home care services. These and other factors placed FCFM into financial trouble with a projected debt of $1.5 million in 1998. Inefficiencies in organizational and financial management led to the eventual disbanding of FCFM.

Although FCFM failed to control costs and to achieve financial predictability, the Council agencies were generally pleased with the quality of services delivered to the County's most troubled youth. As a result, one of FCFM's contracted care management agencies, Beech Acres, was approached by the Council agencies to create a new, provider-based system to serve the 286 children previously under the care of FCFM. An agreement was established between the Council agencies and Hamilton County FCFC, in which the Council agencies agreed to provide funding for the contract while FCFC agreed to monitor the contract and report on contract compliance to the Council agencies.

In accordance with the County Agreement, FCFC established a four-year contract with Beech Acres on November 1, 1998, to purchase, administer, monitor and evaluate specified social services for clients referred to Beech Acres by the Council agencies. Beech Acres created an intensive services program, Creative Connections, to administer and implement contract provisions using managed care techniques. Although Creative Connections operates as a separate program within Beech Acres, certain management and administrative functions are performed by Beech Acres, such as quality assurance, financial management and information services. Creative Connections is one of 14 separate programs administered by Beech Acres. The Creative Connections program, however, maintains its own staff who are specifically devoted to a majority of the duties outlined in the contract.

Key Findings/Recommendations

The performance audit report and executive summary contain a number of findings and recommendations pertaining to the Creative Connections contract, its management, the implementation of best practices, and the improvement of contract outcomes. The following are the key findings and related recommendations:

- Beech Acres prepares an annual project budget for Creative Connections and provides the proposed budget to FCFC and the Council agencies for approval before the beginning of the contract year. Beech Acres does not submit its organization's budget. The Council agencies are only provided with the budgeted revenues and expenditures for Creative Connections.

  The Council agencies should require Beech Acres to develop an appropriate budget reflecting the incorporation of managed care principles and the expenditures necessary to meet the requirements of the contract. Revenues should be projected on past year's receipts and Beech Acres should maximize Medicaid and 1st and 3rd party insurance. The Council agencies should require the non-profit organization, in this case Creative Connections and the parent organization Beech Acres, to submit the annual budget and actual expenditures in aggregate form for the entirety of the non-profit organization.

- Creative Connections often refers children to residential foster care and therapeutic treatment programs managed by Beech Acres. Self referrals comprised approximately 30 percent of Beech Acres' revenues for FY 1998.

  The Council agencies should closely monitor the usage of self-referrals by Beech Acres. Self referrals should be detailed by client and by cost on a monthly basis and submitted to the contract manager. The contract should include a trigger so that, when self-referrals exceed a predetermined percentage, a review of utilization is conducted.

- Beech Acres does not provide FCFC with detailed expenditure information to support administrative, care management or direct service costs. Cost amounts for overhead and depreciation total approximately $700,000 annually but these charges lack detailed invoices to support the expense. Also, direct service charges are billed in a bundled format and are based on the capitated amounts stipulated in the budget. Bundled charges may include Medicaid eligible services which, when not itemized, are often paid with local dollars.

  The Council agencies should immediately obtain detailed reports of all expenditures billed to the Council agencies through the life of the contract. The contract manager should review the billed amounts and provide a report to the Council agencies on the legitimacy of costs billed by Creative Connections. Furthermore, FCFC and the Council agencies should require Beech Acres to submit monthly detailed invoices to appropriately account for revenues and

expenditures. Monthly invoices should include line-item accounting of accounts payable and payroll activities. The Council agencies should require all line items billed to be unbundled and detailed by expenditure on a monthly basis. A detailed expenditure report should be provided to the contract manager. If detailed expenditure and depreciation reports are not provided, the Council agencies should discontinue payment on these amounts.

- The Council agencies and contract manager do not have a consolidated means to examine the financial position of Creative Connections. Reports are fragmented and do not contain sufficient analyses to highlight the successes and limitations of the contracted relationship.

  Creative Connections should produce all contractually specified reports within the appropriate time frames as outlined in the contract. FCFC should serve as a vehicle to modify reports to Council Agency needs by communicating all reporting changes among the Council agencies, Creative Connections and Beech Acres.

- Because the client population required immediate transition of services, the Council agencies did not use a formal RFP process. Instead, the contract with Beech Acres was developed over several months and was not signed by the contract parties until well into the first contract year. Although Creative Connections persists in noncompliance with the contract, FCFC and HCDHS have provided only limited assistance or direction to remedy noncompliance issues. Reasons behind the limited assistance and minimal efforts to clarify the policy appear to be numerous and based outside of the constraints of the contract. Also, because Creative Connections did not have an opportunity to agree to an RFP and ensure the requested tasks could be completed, continued noncompliance is aggravated by the contracted entity's inability to bring operations up to the level of contract expectations

  In future contractual agreements between the Council agencies and an MCO, the requirements and expectations of the relationship should be detailed through a formal RFP.

- Performance measures requiring decreased use of out-of-region institutional placements and out-of-county foster care do not focus on appropriateness of services and may be difficult to meet given provider conditions within Hamilton County. Creative Connections does not develop formal partnerships with providers and has not implemented utilization review processes to demonstrate the appropriateness of placements.

  The Council agencies should require Creative Connections to formalize partnerships with local providers to develop services which meet client needs identified through utilization review processes. Also, Creative Connections should develop and implement the necessary policies and procedures to ensure that clients are in clinically appropriate settings through utilization review.

- Reimbursable performance indicator penalties have not been effective in influencing Creative Connections' performance. Creative Connections staff members are not aware of how their performance affects the application of financial penalties and penalty amounts do not act as a disincentive. Proposed amendments to the performance indicator penalties weigh each indicator according to its importance in relation to program goals but do not increase the overall amount of the penalty. Additionally, the FCFC annual evaluation does not provide supporting information regarding penalties or recommendations for improved performance.

  In future contracts, FCFC and the Council agencies should revise the performance penalties. Additionally, Beech Acres management should stress the importance of contract compliance in Creative Connections' operations. In instances where financial penalties are insufficient to ensure contract compliance, the Council agencies should consider the legal options available to remedy noncompliance with contractual provisions.

- Creative Connections did not use a request for proposal (RFP) process for selecting service providers for its network and many providers became part of the network because they were providing services at the time of referral. Also, Creative Connections has not negotiated rates with providers within its network in an effort to control costs. During the first two years of the contract, Creative Connections did little to manage or monitor the service provider network and has been slow to implement the policy and procedure initiatives developed to achieve this requirement. Creative Connections does not maintain service provider profiles. Credentialing was not initiated until the third year of the contract. Creative Connections verifies provider agency and staff licenses during credentialing site visits. However, the credentialing policy does not provide for mandatory follow-up site visits or sanctions for failure to comply with credentialing standards. Additionally, provider agreements do not contain the credentialing requirements or specific performance expectations.

  Creative Connections should immediately complete implementation of the provider relations initiatives to monitor and manage the service provider network. Creative Connections should develop service provider profiles and implement formal credentialing policies and procedures including administrative, clinical and safety standards. Beech Acres should include the credentialing requirements and provider expectations as addendums to provider agreements and monitor providers' compliance with credentialing standards. Also, Creative Connections should conduct mandatory follow-up site visits to ensure that corrective action plans are implemented and institute sanctions for providers' failure to comply with credentialing standards.

- The contract does not clearly communicate the expectations of the Council agencies in several areas including reporting and network management. Also, appropriate channels of communication have not been defined to ensure messages are consistent and clear and Beech Acres and Creative Connections personnel are not regularly invited to attend the Intersystem Oversight Committee or the System Refinance Committee meetings.

To facilitate clear communication to Beech Acres and Creative Connections, FCFC and the contract manager must be used to a greater extent as an intermediary between the Council agencies and the contracted entity. Additionally, the Intersystem Oversight Committee should establish a quality assurance and improvement subcommittee and meet regularly to discuss issues related to performance standards and reporting requirements. The Creative Connections' executive director (or designee) and QA/I representative should be included in these subcommittee meetings and should regularly report on the progress of the CQMP.

- Creative Connections has management information system fragmentation problems experienced by many collaborative managed care efforts. There is no automated sharing of diagnostic standards or comparison of the contract's key indicators to treatment outcomes. UNI/Care has not developed procedures for integrating its system with Beech Acres' accounting software. Reports are prepared by separate departments from separate computer systems. Additionally, Beech Acres management has not required use of automated systems although employees received appropriate training.

  Beech Acres should integrate its care management and financial reporting systems so that management information systems (MIS) reports will provide the Council agencies with more holistic program measures. Also, Beech Acres should develop reports that provide information to audit contract compliance and to make multiple management decisions. Beech Acres and Creative Connections should realign key business processes to take full advantage of UNI/Care automated features and reporting capabilities.

- Beech Acres did not purchase certain UNI/Care modules which could have improved performance in meeting the reporting and management requirements under the contract. Also, UNI/Care has not completed the promised interface between the Great Plains accounting software and the UNI/Care modules. Differences between UNI/Care's reported features and Creative Connections' experience with the software are directly related to Beech Acres' decision not to install the Uni/Care Care Management module.

  Creative Connections should immediately begin the implementation of the modules needed to fulfill contract requirements. Creative Connections should also ensure that its software heightens cooperation between clients, Creative Connections, providers and the Council agencies.

- There is incomplete documentation of the total cost incurred by Beech Acres for the technology needed for the Creative Connections project. Beech Acres does not clearly define the nature of expenses and does not distinguish between equipment assigned to Creative Connections and other Beech Acres programs.

Beech Acres should segregate the Creative Connections technology costs from Beech Acres technology costs. Creative Connections costs should be incorporated into the total administrative costs reported in the annual project budget.

The remainder of this executive summary is organized by report sections in order to highlight additional findings and recommendations, as well as commendations from those areas of the audit report.

Financial Management and Reporting

Findings:

- Creative Connections does not have a program specific strategic plan to guide resource allocation. Strategic plans are highly recommended to guide short and long-term programmatic and operational goals. Strategic plans should encompass three to five years of operations and include goals, action steps to achieve goals, costs, time-lines and responsible individuals.
- Creative Connections has increased staffing above budgeted and approved levels. Increases in staffing result in increases in Creative Connections' payroll costs and increases in overall expenditures.
- Beech Acres has not demonstrated a plan to maximize existing revenue sources, or to seek other revenue streams. Based on year three, first quarter reports from Beech Acres, 39 of their providers or 71 percent were not Medicaid eligible. Non-Medicaid providers served 56.3 percent of the client population and encompassed 77.5 percent of aggregate service costs. Furthermore, during contract year three, there were several outliers that were not properly identified and, by the fifth month of the contract, Beech Acres had an unreimbursed outlier expenditure of approximately $400,000.
- Beech Acres authorizes service units to be performed by selected providers for either Medicaid or non-Medicaid treatment as determined by providers' Medicaid eligibility. Providers have 30 to 60 days after the end of the month to bill Beech Acres for Medicaid and non-Medicaid services provided. Non-Medicaid claims billed to Beech Acres after the 60 day limit are permanently denied. Also, Medicaid claims subsequently denied by Medicaid are not paid by Beech Acres unless Beech Acres has been notified of the claim being submitted to Medicaid within the 60 day window.
- Creative Connections is required to report the number of claims paid, pending and denied on a quarterly basis. The report was not provided to the FCFC contract manager during FYs 1998-99 and 1999-00.
- The role of the FCFC contract manager is not defined in the contract. The contract manager currently reviews financial data and serves as an intermediary between Creative Connections and Beech Acres and the Council Agency representatives.
- The Council agencies, prior to contracting with FCFM, developed a shared funding agreement based on the number of children served by each agency that met specific criteria

for critical needs. The Council agencies identified 286 children for inclusion in the program and divided the costs among the agencies based on the percentage of children by agency out of all children served. The Council agencies also developed a shared funding agreement based on the number of children served by each agency that met specific criteria for critical needs.

Commendations:

- Beech Acres has developed a strict 60-day cutoff for reimbursement of non-Medicaid claims. The strict 60-day limit for providers to submit claims ensures timely submission of claims and provides Beech Acres with greater levels of control in projecting revenues and expenditures.
- The current pooled funding agreement represents a delicate balance between what the Council agencies can afford, or elect to contribute, and their actual number of referred clients in the system. The level of coordination between the Council agencies and Beech Acres, coupled with the benefits received by the client population, outweigh the inequities of cost distribution or risk sharing

Recommendations:

- The Council agencies should require all line items billed to be detailed by expenditure on a monthly basis. A detailed expenditure report should be provided to the contract manager.
- The Council agencies should require Creative Connections to develop annual strategic planning documents which would correlate planned costs and activities with required resources.
- Creative Connections should maintain staffing levels within budgeted levels. The costs for any unapproved changes in staffing levels should not be charged to the Council agencies.
- Beech Acres should use existing personnel to aggressively pursue grants and Medicaid reimbursements. Beech Acres should consult with Magellan Behavioral Health (MBH), or a reputable public consulting group with expertise in the health care field to assure that a large majority of providers are Medicaid eligible. If Creative Connections was able to maximize Medicaid eligible providers, an annual cost savings or cost off-set of up to $1.4 million could be realized.
- The Council agencies should require Beech Acres to provide a monthly report no later than 10 days after the close of the month detailing claims pending related to outlier status. In addition, all outlier treatment plans should undergo utilization review on a monthly basis to determine if the treatment is appropriate for the clinical needs of the child.
- Beech Acres should implement a review process to identify the reasons claims are labeled pending or denied. Once the reasons have been identified, Beech Acres should develop and implement a process to reduce the number of claims labeled as pending or denied.
- The role of FCFC and the contract manager should be more clearly defined through an amendment to the current contract and the inclusion of language in future contracts. The

contract manager position should be provided a level of autonomy so that the management of the contract is coordinated through a single entity.

- Costs for program services should be closely monitored by all parties to the contract and Beech Acres should immediately implement managed care principles within Creative Connections.

Performance Measurement Section

Findings:

- Beech Acres CQMP is a component of its accreditation by the Council on Accreditation for Children and Family Services (COA) and certification by the Ohio Department of Mental Health (ODMH). However, Creative Connections QA/I and program evaluation activities do not adequately meet the requirements of the contract.
- The original and proposed performance indicators are consistent with best practice recommendations of national organizations. However, performance indicators are spread throughout 11 separate contract exhibits. Indicators, measures, benchmarks and data/reporting requirements are not closely correlated. Proposed amendments to the exhibits and indicators streamline the contract exhibits and contain measures and benchmarks that are more focused on outcomes and evaluation and integrate financial and clinical benchmarks.
- Creative Connections has not completed implementation of its information systems and has not developed comprehensive procedures for capturing and reporting data or incorporating outcomes into the decision-making process. Therefore, Creative Connections' reports do not meet contractual requirements and do not provide analysis of the captured data.
- Beech Acres does not integrate or coordinate information for reports to FCFC and Creative Connections' management does not have input into the contractually required reports. Also, the reports do not provide FCFC with sufficient information to conduct a comprehensive evaluation of Creative Connections' performance. Amendments to the contract performance indicators eliminated duplication and streamlined indicators but there is a need to collapse reporting requirements to create more practical and functional management reports.
- Creative Connections added a delegated oversight component to its credentialing program giving accredited providers responsibility for ensuring the appropriate certification, licensure, and experience of their staff while Creative Connections maintains oversight responsibilities.
- Beech Acres requires network service providers to maintain a professional liability policy. However, Beech Acres does not require providers to list Beech Acres as an additional insured party and therefore has no guarantee of notification if changes are made to the insurance policy.
- The contract does not specify the responsibilities of Creative Connections regarding client complaints and grievances and does not require tracking or reporting of client complaints or grievances to FCFC or the Council agencies. Also, HCDHS does not have a centralized method for capturing complaint and grievance information from its contracted entities. Beech Acres maintains formal written grievance procedures in its clients' right policy.

However, policies establishing time frames for initiating or completing an investigation are not clearly stated in writing. Additionally, provider agreements do not contain specific requirements for complaint and grievance procedures.

- Beech Acres maintains a written client rights policy and requires that clients receive a copy of the policy and that staff reviews the policy with each client. The Beech Acres' policy meets Mental Health Board and ODMH requirements. However, the statement does not address some nationally recommended standards for a patients' bill of rights. Also, provider agreements do not include Beech Acres' clients' rights policy or provide direction to the provider regarding the development of a clients' bill of rights.
- Creative Connections has not developed specific program procedures to safeguard confidential client information. Also, Creative Connections conducts a comprehensive review of medical record keeping practices during the initial site visit with a service provider but procedures have not been developed for continued monitoring of provider compliance with confidentiality requirements.

Commendations:

- Beech Acres has met the contract requirements for the CQMP through COA accreditation. Beech Acres accreditation demonstrates that the organization meets the performance standards for quality child welfare services.
- Creative Connections, FCFC and the Council agencies collaborated to streamline the contract exhibits and amend the performance indicators. The revised benchmarks and measures better address the goal of achieving quality and containing costs by integrating clinical and financial measures within each indicator and are consistent with best practices recommended by national organizations.
- The delegated credentialing and re-credentialing agreement allows Creative Connections to delegate certain credentialing activities to accredited providers while maintaining oversight and monitoring of those activities. Through delegation, Creative Connections eliminates duplication of credentialing activities that have already been completed by the accrediting organization.
- Creative Connections verifies documentation and monitors the status of provider and staff licenses and certifications. By obtaining copies of provider licenses during the application process, Creative Connections verifies that services are delivered by certified provider agencies.
- Beech Acres' grievance procedures are provided to clients at the time of intake and reviewed with staff. Beech Acres keeps a record of the client's review and receipt of this information. Providing written information describing the client's right to complain increases Beech Acres accountability in providing efficient and effective services.
- The Beech Acres client rights policy meets Mental Health Board and ODMH approval and is consistent with Bazelon's recommendations for client's bill of rights. Beech Acres informs clients of their rights both in writing and through a one-on-one review with staff.

Recommendations:

- Beech Acres should ensure that QA/I and program evaluation activities meet the requirements of the contract and the needs of the Council agencies, as well as adequately address the performance of Creative Connections as a managed care, contracted entity.
- Beech Acres should implement adequate information systems and reporting procedures to ensure that performance measurement information is accessible, reliable, and useful to FCFC and the Council agencies and in compliance with the original contract requirements. Creative Connections should use the proposed performance indicators as a framework for developing the systems and procedures for monitoring, evaluating and improving quality and reporting progress toward CQMP goals as required by the contract. Creative Connections, FCFC and the Council agencies should study the outcomes of performance measures over time.
- The Council agencies and FCFC should determine the reporting format and frequency necessary to provide performance data to assist in evaluation and planning efforts. Creative Connections' reports should include the integrated financial and care management information required in the contract as well as an analysis of the information and proposed corrective action for program deficiencies.
- In future contracts, the Council agencies and FCFC contract manager should examine and prioritize the implementation of the contractually required performance indicators and corresponding reporting requirements. Non-compliance with reporting requirements should trigger a review of the agreement by the Council agencies.
- The FCFC annual evaluation should be used by Creative Connections, Beech Acres and the Council agencies to assess contract compliance and program performance and should include supportive evidence and recommendations for improved performance.
- The Council agencies should ensure that future contracts specify whether the MCO should use a competitive, noncompetitive, or mixed process to procure provider services. The contract should also establish time lines for the development of the network and detailed criteria for selection of providers into the network. In addition, the MCO and provider contracts should specify the rates that will be paid by HCDHS for client services purchased by the MCO.
- The Council agencies should ensure that Beech Acres amends its provider agreements to require that they are listed as an additional insured party or certificate holder on providers' insurance policies.
- In future contracts, the Council agencies should include specific requirements for complaint and grievance procedures. Beech Acres should modify its grievance policy and procedures to require that staff investigates and responds to complaints and grievances within predetermined time frames. When contracting with providers, Beech Acres should include specific requirements for the complaint and grievance procedures in the provider agreement. Furthermore, Creative Connections should report complaints and grievances made against the program or its service providers to FCFC on a regular basis. HCDHS should develop a centralized database to capture complaint and grievance information from all of its contracted providers and managed care entities.

- Beech Acres should amend its client bill of rights to include the right to interagency treatment planning and to establish advance directives and durable powers of attorney. Also, Beech Acres should require service network providers to develop a client rights policy in accordance with the principles of Beech Acres client rights policy. The service providers' client rights policy should include the grievance procedures that clients can follow should they have concerns about their care.
- Creative Connections should develop and implement detailed procedures for safeguarding confidential client information that are specific to the situations encountered by Creative Connections and network personnel. Creative Connections should verify provider procedures for the maintenance of client records and other measures instituted to ensure client confidentiality through the service provider credentialing and re-credentialing process. Creative Connections should also develop and initiate periodic, mandatory training sessions on client confidentiality for its staff and service providers.

Technology

Findings:

- The contract does not contain detailed management information systems (MIS) specifications and does not identify the responsibilities of each of the parties to ensure fulfillment of the MIS contract requirements.
- Creative Connections has a general description and contractual information suggesting that UNI/Care can meet all of the information requirements of the Council agencies. However, the Council agencies and FCFC stated that Creative Connections cannot adequately provide the reports required by the contract. Furthermore, Beech Acres did not purchase the UNI/Care Care Management module although the treatment planner subset may have fulfilled many of the performance and outcome measures required by the contract.
- The FY 1999-2000 Beech Acres Information Services Department (ISD) turnover rate was 40 percent. Beech Acres has a policy of looking for employees internally at first, and considers employment in all cases to be conditional pending criminal offense record checks.
- The MIS function has not been guided by a Technology Steering Committee or long-term strategic plan. The Technology Plan Draft partially describes the relationship between existing resources and required resources to better achieve organizational goals.
- Beech Acres covers key information security techniques through a combination of hardware, software, and internal policies and procedures. However, Beech Acres does not have a formal disaster recovery plan for technology services.
- The Beech Acres network does not have cable that matches the speed of its other network equipment. However, Beech Acres has taken cost efficient steps to protect servers and software and meet technology industry standards. All servers are locked in rooms only accessible by ISD staff members, but no logs of their access are kept. Beech Acres installed halon fire extinguishers, but did not indicate if this addition lowered its insurance premiums.
- Creative Connections transmits confidential data through diskettes and email to the Council

agencies and FCFC. Beech Acres does not use encryption software to protect the data in confidential electronic transmission and there are not firewalls or other security protections on the Creative Connections end of the modem connection with the Mental Health Board.

- The ISD created and conducted several basic computer technology courses once it realized that many employees needed such training. Creative Connections employees in positions most likely to use the UNI/Care system received frequent training on the system. Representatives of FCFC and the Council agencies have not received formal training on the UNI/Care system. Also, Beech Acres stopped attending UNI/Care user group meetings in 1999.

Commendations:

- Beech Acres generally meets current technology industry standards for safeguarding software source code (programming data) and network hardware. Beech Acres employed simple, cost effective measures to limit access to these assets and to minimize potential damage from fire and water.
- Beech Acres effectively reduced its maintenance, labor, and hardware acquisition and upgrade costs by installing Metaframe. Metaframe allows individual users high speed access to all remote and network files and devices regardless of the memory, connectivity, and storage capabilities of the individual computer.

Recommendations:

- Any renegotiated agreement should specify the labor and technology resources pledged by the Council agencies, Beech Acres and FCFC. In addition, the agreement should identify the MIS requirements and the parties responsible for implementation.
- Creative Connections should clearly indicate and distribute information demonstrating how UNI/Care meets contract information requirements to FCFC and the Council agencies. Creative Connections should also cite the names and dates of system reports and the files or databases used as part of quarterly and annual reports. Also, Creative Connections should purchase the UNI/Care Care Management module and electronic system interface capabilities to ensure compliance with the original contract requirements.
- Beech Acres should reorganize the ISD to enable the full-time administrative assistant who currently divides her time between training and administrative tasks to work exclusively on training issues. In order to fully comply with the contract, many Beech Acres employees will need training on new systems and procedures designed to increase the use of well-integrated automation. Additionally, Beech Acres should raise salaries, create career ladders, and seek internal and external recruits in order to reduce turnover in its technology staff.
- Beech Acres should create the Technology Steering Committee and the proposed Planning Team that includes users and external report recipients, as well as ISD management. The committees should meet regularly to set priorities, develop and revise plans, and evaluate the

progress of implementation of technology projects. Beech Acres management must fully support the Technology Plan with adequate funding.

- The ISD policies should be adjusted in order to enhance the compatibility of all technology components and increase the overall level of security. Changes should include standardization of hardware, ISD involvement in all hardware and software purchases, and mandatory, regular changes of passwords. Also, Beech Acres should develop written disaster recovery procedures and a policy that requires periodic updates to those procedures.
- Beech Acres should replace the 10-Base-T lines with faster fiber-optic cable. Additionally, Beech Acres should investigate whether the purchase of the halon fire extinguishers might lower its insurance premiums. The ISD should also establish a log of all individuals accessing the network facilities or software cabinet in order to establish accountability for any incidents related to the network or software source code.
- Beech Acres should investigate and install cost-effective methods to ensure the confidentiality of client data in electronic transmissions.
- Because of continued case management data reporting deficiencies, Beech Acres should consider mandatory retraining of care managers on an annual basis. Creative Connections should also invite representatives from FCFC and the Council agencies to attend formal UNI/Care system demonstrations or training sessions so that those organizations can achieve a better understanding of the system's capabilities. Also, Beech Acres should attend all annual UNI/Care user group meetings and any other opportunities made available by the vendor to learn more about the system's capabilities.

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Background

Council Agency Agreement History

In FY 1993, Hamilton County's Family and Children First Council (FCFC) brought together representatives from the County's primary child-serving agencies to initiate discussion on how to better coordinate funding and service delivery for multiple needs children who traditionally crossed social service systems. Hamilton County's five primary child-serving agencies: Department of Human Services (HCDHS), Mental Health Board (MHB), Alcohol and Drug Addiction Services Board (ADAS), Board of Mental Retardation and Developmental Disabilities (MRDD), and Juvenile Court decided to form an independent, non-profit company to coordinate services for the County's most troubled youth. As a result, Family and Children's First Management Inc. (FCFM) was established in the spring of 1994 with the purpose of applying managed care techniques to improve the coordination of service delivery for Hamilton County's multiple needs children and to control the rising costs associated with serving these children.

Hamilton County's five primary child-serving agencies (Council agencies) negotiated a pooled funding agreement which would facilitate the sharing of costs associated with serving FCFM's client population. Initial funding was based on a survey, conducted by each Council Agency, that identified a total of 286 children who potentially would require the services of FCFM. To be referred to FCFM, a client would have to fit the following multi-problem care criteria:

- Placement in residential treatment on two or more occasions;
- Being under the age of 11 and in the Juvenile Court system;
- Having a dual diagnosis which is not treated by standard means; and
- Residing in a mental hospital for over six months.

Initially, FCFM managed to control costs by moving children out of $200-per-day residential treatment facilities and into less costly therapeutic foster care and group homes. Throughout the majority of the first contract term (June 1995 to December 1996), FCFM spent approximately $3,760 per child, per month, instead of the budgeted $3,911. Approximately half of FCFM's client population were children referred by HCDHS. However, it was determined that costs associated with mental health services were three times Mental Health Board's initial funding contribution. As a result, funding amounts were recalculated for the next contract term (January 1997 to June 1998) to represent a more equitable share of costs among the funding agencies. **Table 2-1** illustrates the recalculated, pooled funding allocations.

Table 2-1: Council Agencies' Pooled Funding Allocations

Funding Agency	Percent of Total Annual Costs	Number of Enrollee Slots per Agency	Percentage of Enrollee Slots per Agency
HCDHS	72.89%	142	49.65%
Juvenile Court[1]	4.36%	85	29.72%
MR/DD	7.79%	40	13.98%
Mental Health	14.47%	17	5.94%
ADAS	.49%	2	.71%

Source: FCFC

1 The Juvenile Court is not required to share costs but chooses to participate according to the above percentage.

FCFM was staffed with 10 employees who enrolled clients, assigned cases and managed a network of 22 service providers. However, the company subcontracted its care management duties to three network service providers: Beech Acres, Lighthouse Youth Services and St. Joseph Orphanage. By the outset of the second contract period, FCFM was operating at full capacity, serving 286 children. The second contract totaled $13 million in which each Council Agency paid its share at the beginning of each quarter. HCDHS contributed $9.5 million or approximately 73 percent of the total cost of the project. Although project funding increased from the first contract term, FCFM began to experience financial difficulties and was especially having problems reducing the costs for out-of-home care services. These and other factors placed FCFM into financial trouble with a projected debt of $1.5 million in 1998. Inefficiencies in organizational and financial management led to the eventual bankruptcy of FCFM.

Beech Acres/Creative Connections Contract History

Although FCFM failed to control costs and to achieve financial predictability, the Council agencies were generally pleased with the quality of services delivered to the County's most troubled youth. As a result, one of FCFM's contracted care management agencies, Beech Acres, was approached by the Council agencies to create a new, provider-based system to serve the 286 children previously under the care of FCFM. The Council agencies bypassed the issuance of a formal request for proposal due to the immediate need of a Management Services Organization (MSO) to fulfill the responsibilities of FCFM. The Council agencies also determined that a different management structure would be necessary to improve oversight and better protect their interests and resources. To facilitate this new structure, an agreement (County Agreement) was established between the Council agencies and the Hamilton County Family and Children First Council (FCFC), designating FCFC as the intermediary between Beech Acres and the Council agencies.

The County Agreement, effective November 1, 1998 through June 30, 2002, outlines the relationship between FCFC and the Council agencies for the provision and management of social services for the

County's most troubled youth. Furthermore, the County Agreement defines the various responsibilities of FCFC and the Council agencies in relation to the Beech Acres contract. In accordance with the County Agreement, the Council agencies agreed to provide funding for the contract while FCFC monitors the contract and reports to the Council agencies. With assistance from Council Agency representatives, FCFC employs a full-time contract manager to fulfill these functions. Funding allocations for the contract with Beech Acres would remain the same as the recalculated formula used for FCFM (see **Table 2-1**).

In accordance with the County Agreement, FCFC established a five-year contract with Beech Acres on November 1, 1998, to purchase, administer, monitor and evaluate specified social services for clients referred to Beech Acres by the Council agencies. The contract was established to achieve the following objectives:

- Develop an innovative system of administering and delivering social services for the County's most troubled youth;
- Create a system of shared financial responsibility between Beech Acres and the Council agencies;
- Achieve enhanced budget predictability for FCFC and the Council agencies; and
- Achieve quality enhancements and cost efficiencies through the effective management and delivery of social services.

To achieve the intended objectives of the County Agreement and the contract (referred collectively herein as the contract), Beech Acres created an intensive services program, known as Creative Connections, to administer and implement contract provisions using managed care techniques. Although Creative Connections operates as a separate program within Beech Acres, certain management and administrative functions are performed by Beech Acres such as quality assurance, financial management and information services. Creative Connections is one of 14 separate programs administered by Beech Acres, however Creative Connections maintains its own staff who are specifically devoted to the duties outlined in the contract. **Table 2-2** illustrates the portions of the contract assessed by this performance audit, as not all Creative Connections' functions were examined.

Table 2-2: Creative Connections's General Responsibilities

Direct, Administrative and Management Services	• Develop and implement cost-efficient, direct services either through contracted providers or self-referrals via Beech Acres; • Establish contracts with and manage a group of providers in sufficient number and in appropriate locations to deliver direct services that satisfactorily meet client needs; • Develop and implement policies and procedures (level of care) to effectively coordinate and facilitate the delivery of direct services; • Establish, coordinate and maintain a Utilization Review Program designed to promote appropriate and quality services; and • Establish, coordinate and maintain a Continuous Quality Management Program consistent with appropriate industry standards.
Financial Management and Reporting	• Develop and implement a financial monitoring plan to help guide the financial monitoring and reporting of information related to service delivery; • Provide FCFC and Council agencies with quarterly and annual financial reports detailing costs for administration, management and direct service delivery; • Annually report planned, billed and realized Medicaid services; • Provide actual versus projected surplus/deficit report on an annual basis. • Maximize alternative funding from all possible sources for eligible services and manage costs efficiently to offset costs reimbursed by Council agencies; and • Limit administrative and care management costs to contract-stipulated formulas.
Management Information Systems	• Utilize Unicare software or another clinical tracking system with Electronic Data Interchange (EDI) capabilities to track and report data to FCFC and Council agencies; and • Develop a written Long Term Information System (IS) Implementation Plan to describe specific methods for capturing information related to all services, standards and measures.

Source: Contract (FCFC and Beech Acres)

Pursuant to the County Agreement, HCDHS works in conjunction with FCFC to monitor Creative Connections' financial and administrative performance for the following reasons:

- The majority of children are referred to Creative Connections through the Children's Services Division at HCDHS.
- HCDHS provides funding for 72.9 percent of the costs associated with the Beech Acres contract.
- HCDHS has a larger pool of personnel resources than the other Council agencies.

HCDHS assists in the monitoring of Creative Connections through semi-annual chart audits which evaluate Creative Connections's performance in relation to State and Federal reporting requirements and review the appropriateness of clinical decisions. Creative Connections and its network of service providers must adhere to the legal mandates of the Ohio Department of Job and Family Services (ODJFS) and the Ohio Mental Health Board, including the judicial orders of the court and the clinical authority legislated by the Mental Health Act and the Ohio Revised Code (ORC). The

Hamilton County Commissioners and the Trustees of the County Mental Health and Alcohol Drug Addiction Services Boards are ultimately responsible for monitoring and safeguarding public resources as they relate to the Beech Acres contract.

HCDHS and the other Council agencies meet frequently in committees to discuss the financial and clinical performance of Creative Connections within the structure of the contract. A description of the various contractually-specified committees is shown below.

- *System Refinancing Committee* comprises Council Agency directors or designees and is primarily responsible for pooled funding proportional allocations, approval of annual budget, and outlier reimbursement and eligibility.

- *Intersystem Oversight Committee* is responsible for monitoring the project deficit and negotiating the annual budget. The committee functions as a fiscal subgroup and is made-up of Council Agency representatives.

- *Mid-Level Managers Committee* includes representatives from Council agencies, FCFC and Creative Connections (director, director of operations and clinical manager). Although the committee's duties are not outlined in the contract, its members meet to discuss operational matters relating to the contract.

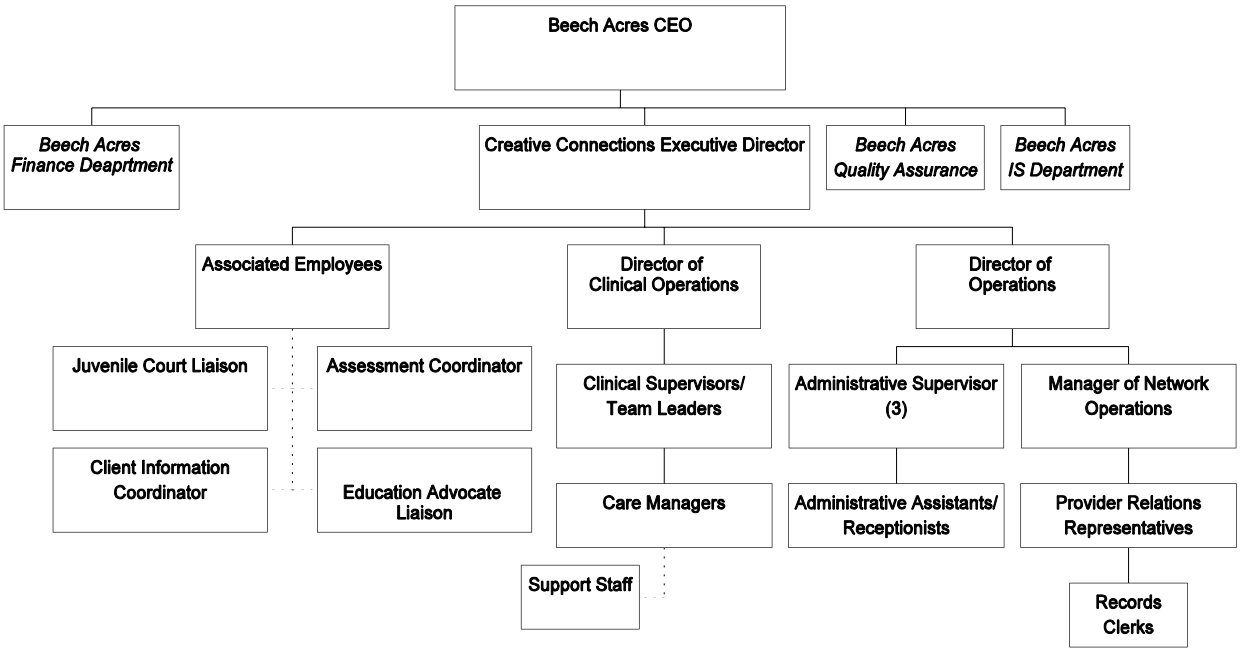
- *Service Coordination Committee* comprises Council Agency representatives and the FCFC contract manager. Neither this committee nor its duties are outlined in the contract. The Service Coordination Committee is responsible for case management, referrals, dis-enrollments, clinical oversight, and issue resolution.

The various committees provide Council Agency representatives several opportunities to discuss funding and reporting issues, as well as clinical issues related to agency referrals and Creative Connections case management.

Organizational Chart

As the contracted MSO for the Council agencies, Creative Connections consists of 65.1 full-time equivalent (FTE) employees, including vacancies, as of February 2001. The chart below provides an overview of Creative Connections' organizational structure and staffing levels. All positions are shown in FTEs.

Chart 2-1: Creative Connections Organizational Structure, February 2001



Staffing

Tables 2-3 presents staffing level information by functional classification for Creative Connections for FYs 1998-99, 1999-00 and 2000-01. The staffing levels include Beech Acres employees who are allocated to Creative Connections. The number of staff was calculated using FTEs as applied to the individual's responsibilities.

Table 2-3: Creative Connections FTEs, FY 1998-99 through FY 2000-01

Titles	FY 1998-99	FY 1999-00	FY 2000-01 [1]
Creative Connections Administrators	**6.0**	**7.0**	**5.3**
Program Executive Director	1.0	1.0	1.0
Network Manager	0.0	0.0	1.0
Supervisor	5.0	5.0	2.3
Clinical Manager	0.0	1.0	1.0
Beech Acres Financial Management	**9.0**	**7.1**	**6.0**
Administrators	*2.0*	*2.0*	*2.0*
Accounting Manager	1.0	1.0	0.0
Accountant	1.0	1.0	0.0
Financial Analyst	0.0	0.0	1.0
Finance Manager	0.0	0.0	1.0
Accounts Payable/Receivable	*2.0*	*2.0*	*2.0*
A/P Clerk	2.0	2.0	0.0
AR Specialist	0.0	0.0	2.0
Medicaid	*5.0*	*3.1*	*2.0*
Medicaid Specialist	1.0	0.0	0.0
Medicaid Supervisor	1.0	0.7	0.0
Medicaid Support	3.0	2.4	0.0
Adjudication Clerk	0.0	0.0	1.0
Medicaid technician	0.0	0.0	1.0
Beech Acres Information Technology	**1.0**	**1.0**	**0.0**
IS Technician	1.0	1.0	0.0
Beech Acres Quality Assurance	**0.0**	**3.0**	**4.0**
PIQA	0.0	0.5	1.0
Program Evaluation	0.0	0.5	2.0
Program Evaluation Coordinator	0.0	0.5	0.0
Prog. Eval Staff	0.0	1.5	0.0
Q.A. assistant	0.0	0.0	1.0
Case Management	**37.0**	**40.5**	**41.0**
Case manager/Resource Manager	8.0	10.0	28.0
Provider Relations/UR	1.0	1.0	1.0
Primary Clinical Service Provider	24.0	24.0	0.0
Records	3.0	3.0	2.0
On-call	1.0	0.0	0.0
Case aid	0.0	1.0	0.0

Assessment Coordinator	0.0	1.0	0.0
Care Management Trainer	0.0	0.5	0.0
Provider Representatives	0.0	0.0	5.0
Contract Employees	0.0	0.0	4.0
Wraparound consultant	0.0	0.0	1.0
Support Staff	**6.0**	**5.0**	**8.8**
Administrative Assistants, Receptionists and Support Staff	6.0	5.0	8.8
Total staff	**59.0**	**63.6**	**65.1**

Source: Creative Connections payroll records and annual budgets
Note: Budgeted FTEs are shown due to high degrees of variability in staffing levels during each contract year.
[1] FY 2000-01 includes both reported FTEs and unfilled positions shown in the budget and organizational chart.

Creative Connections raised staffing levels to accommodate the rapid expansion of its programs under the contract. The contract requires the disclosure of all FTEs, their annual hours worked and corresponding salaries. Any changes in FTE levels must be approved by the System Refinance Committee which comprises Council Agency representatives. FTEs and associated budgeted and actual positions are discussed in the ***financial management*** section.

Summary of Operations

Children and families become involved with Creative Connections through referrals from the five Council agencies. Clients referred to Creative Connections have specific clinical needs which may necessitate treatment for physical abuse, sexual abuse, dependency, alcohol or drug addiction, mental retardation, or severe occurrences of delinquent and unruly behavior. Most children referred to Creative Connections have already received treatment through Council Agency providers and may be in placement at the time of referral to Creative Connections. A large portion of Creative Connections' population has extreme clinical needs requiring lock-down facilities, medical intervention and/or extended, intensive therapy. Prior to the implementation of FCFM and Creative Connections, service coordination and the use of multiple interventions was infrequent. The purpose of the contract is to better coordinate services between Council agencies and, by implementing multiple interventions simultaneously, the contract serves to decrease the length of stay in treatment, reduce overall costs and improve treatment outcomes.

Creative Connections manages a network of approximately 110 provider agencies who offer mental health and out-of-home care placement services to children enrolled in the program. Under the coordinated direction of Creative Connections, the network of providers offers the following services:

- Diagnostic and evaluative services;
- Medical/Somatic services;
- Individual, family, and group psychotherapy;

- Home-based intervention services;
- Community support services;
- Outpatient partial hospitalization services;
- Foster care services;
- Group care services;
- Residential care services;
- Respite services;
- Crisis services; and
- Independent living services.

Creative Connections' care managers monitor a client's progress through written service delivery plans furnished by provider agencies. Creative Connections requires providers to participate in Child and Family Teams for each client they serve. The Child and Family Team develops the Plan of Care which defines the level of services for each client. The Child and Family Team meets quarterly to review the plans of care. Creative Connections care managers lead the Child and Family Teams and are responsible for determining the final plan of care. Creative Connections care managers monitor a client's progress until a case is closed and clients can be served by traditional forms of care.

Financial Management Reporting Relationships and Responsibilities

Costs for the contract are identified as administrative, care management and direct service costs. Administrative costs are costs associated with program support and management which include the salaries of administrators, managers, clerks, supervisors, and support personnel. During FY 1999-00, administrative costs totaled approximately $2.07 million. Care management costs (approximately $2.15 million during FY 1999-00) are costs related to the provision of care management (case management) services by Beech Acres and the providers. Administrative and care management costs have prescribed limits which are determined by the following formulas:

- Administrative costs may not exceed 14.0 percent of the total project costs (administrative cost cap) in any budget year, except by an amount equal to the cost cap plus an allowed variance of 5.0 percent of the budgeted cost (administrative cost variance). The addition of the cost cap and the cost variance form the administrative cost limit.

- Care management costs are not to exceed 8.0 percent of total costs (care management cost cap) plus an allowed variance of 10.0 percent of the budgeted costs (care management variance). If the actual costs exceed the cost limit in any year, Beech Acres must provide the Council agencies with a detailed line item report indicating the reasons that the costs exceeded the prescribed limits.

Direct service costs are costs which are incurred in the provision of direct services to clients. These represent the actual provider costs to administer residential care, psychological services, counseling

and other behavioral health therapies. Direct service costs were approximately $11.3 million during FY 1999-00. The total program cost for FY 1999-00 was approximately $15.5 million. The Council agencies pay Beech Acres a capitated amount for each client served by Creative Connections. A capitated payment is a precalculated amount paid per enrollee each month using the County case rate ($3,130 during the first contract year, and increased annually in subsequent years according to the consumer price index). The capitated amounts have been insufficient to cover direct care and Creative Connections has posted a deficit in each year of operations. The deficit, above a certain dollar amount, is shared equally by Creative Connections and the Council agencies.

Beech Acres bills administrative, care management and direct service charges in a bundled format (enrollee months) based upon the capitated rate, and these charges are reconciled within 30 days of the end of each contract year to the annual client census summary report. Beech Acres and the Council agencies review the difference between enrollee months paid in advance by the Council, and enrollee months utilized during that year.

Beech Acres relies on several funding sources to pay direct care claims. These include Medicaid funding, the County contribution (paid by the Council agencies), 1st and 3rd party insurance, State Cluster Funds, the agreed upon Outlier Reimbursement, and interest income earned by the Beech Acres endowment.

The claims adjudication process at Beech Acres has a series of checks that validate payment for the service. Providers have 30 to 60 days after the end of the month to bill Beech Acres for Medicaid and non-Medicaid services provided. Some of Beech Acres more important claims processing steps are as follows:

- Non-Medicaid claims billed after the 60-day limit are permanently denied.
- Claims that are bundled and include Medicaid and non-Medicaid reimbursable services may receive payment from Beech Acres for the Medicaid and non-Medicaid portion after the 60-day limit has expired, as long as Beech Acres was notified within 60 days after the date of service, that a Medicaid claim was pending for the service.
- Medicaid services are processed through the Multiple Agency Community Services Information Systems (MACSIS) and are documented by the Hamilton County Community Mental Health Board. Providers have up to one year after the date of service to process Medicaid claims in MACSIS.

Beech Acres is required by the contract to develop and maintain a regular system of financial reporting. FCFC, and in particular, the contract manager serve as the medium through which the financial position of Beech Acres is communicated to the Council agencies. The financial reporting has improved in the past year and includes more pertinent information about the costs of the program. However, Creative Connections and Beech Acres have not provided the Council agencies and/or contract manager with detailed expenditure reports.

Performance Measurement and Quality Assurance Contractual Requirements

Pursuant to the contract, Creative Connections is required to establish a comprehensive Continuous Quality Management Program (CQMP) consistent with industry standards and in compliance with the standards and reporting requirements in the contract. Beech Acres is accredited by the Council on Accreditation for Children and Family Services (COA) which includes standards requiring a continuous quality improvement program. In order to monitor Creative Connections' performance, a committee of Council agencies and Beech Acres representatives developed performance indicators. They included seven reimbursable performance indicators with correlating penalties. The total penalty amount was $100,500 in year one and increases each year to its maximum of $225,000 for years three and four. At the end of each contract year, the FCFC contract manager reviews Creative Connections' performance and determines and recommends to the Council agencies the penalty amount. The penalty amount is then deducted from the next quarterly payment to Creative Connections. In addition, Creative Connections prepares and furnishes Quality Assurance/ Improvement (QA/I) reports to FCFC on a quarterly basis. The QA/I reports are used to monitor Creative Connections' operational performance on the various performance indicators throughout the contract year. Examples of the general areas covered by the performance indicators include the following:

- Responsible fiscal management;
- Enrollees receive institutional treatment only when essential to decrease impairment;
- Appropriate services are available within region and County to meet enrollees' needs;
- Care management services are timely and responsive to needs of enrollees, providers, and Council agencies; and
- Services for enrollees are "high quality" and appropriately meet desired outcomes.

In addition to the QA/I reports, Creative Connections is responsible for producing annually QA/I and evaluation plans and an evaluation report. These reports are intended to assist Creative Connections, FCFC, and the Council agencies in evaluating program performance by identifying strengths, weaknesses, and areas for corrective actions.

As part of the CQMP, Creative Connections verifies the credentials, experience and licensure of those agencies and staff members responsible for the delivery of contracted services. In order to verify the credentials of service providers, Creative Connections performs annual site visits both to ensure that network providers meet minimum standards of care and to assist providers with the transition into a managed care environment. The credentialing process enables Creative Connections to identify the strengths and weaknesses of contracted providers compared to professional standards of care.

To enhance accountability and ensure protection of clients' rights, Creative Connections maintains a client rights and responsibilities doctrine which contains formal complaint and grievance

procedures. Creative Connections' clients are provided a copy of the client rights policy, and staff reviews the document with clients during initial meetings. Providing written information describing the client's rights increases Creative Connections accountability.

Technology Contractual Requirements

In June 1998, Beech Acres selected UNI/Care Systems as its major software vendor for all client services. The contract with FCFC contains little information about the technological resources needed to fulfill the agreement but indicates that technology should be capable of satisfying the contract's various reporting requirements. Although Beech Acres provided the Council agencies a plan for implementing information systems, the plan was incomplete and the Council agencies expressed concerns about the plan. Ultimately, Beech Acres chose to partially implement its long-term information systems plan for the contract and did not notify the Council agencies of key changes it made to that plan. For example, Beech Acres abandoned installation of the key UNI/Care systems module that would allow Beech Acres to fulfill its contractual reporting requirements regarding client outcomes. Financial software interfaces were also not implemented.

The installed UNI/Care modules do not facilitate automated sharing of diagnostic or treatment standards, such as the DMS IV to UNI/Care system input. The system does not allow comparison of the contract's key indicators or even any treatment outcome to any data in the UNI/Care system. Creative Connections does not use the UNI/Care system as a provider credentials database, although some basic information about providers can be maintained within the system. The version of UNI/Care currently in use does not integrate billing and clinical care modules.

Beech Acres' Information Systems Department supervises the use of information technology throughout the organization. Beech Acres has reasonable information systems policies and network, hardware, and software resources for its general office needs. However, it has not implemented a technology plan and does not have a disaster recovery plan. Also, electronic interfaces with computers outside of Beech Acres do not include security sufficient to ensure client confidentiality.

Child Welfare Managed Care Arrangements

Generally, public child welfare agencies plan and develop their managed care models to address specific needs which are unique to their community. In developing the overall design of their managed care arrangements, child welfare agencies must consider funding streams, target populations, available MSOs and level of community support. Generally, child welfare managed care initiatives can be classified under the four separate arrangements discussed below.

- *The public model* constitutes the lowest level of operational change from the traditional service delivery system generally used by public child welfare agencies. The public model presumes that service delivery and care coordination activities will remain the responsibility

of the public entity. However, managed care principals are incorporated into reimbursement procedures for contracted service providers. Additionally, the public model introduces performance measures into provider contracts to ensure high quality services. As of FY 1998, the public model was used in 10 child welfare managed care initiatives throughout the United States.

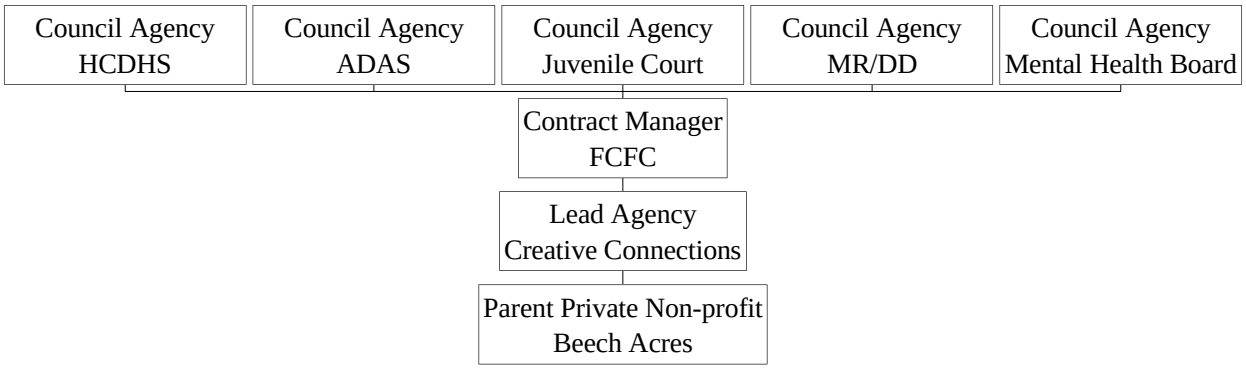
- *The lead agency model*, used in 19 state and local managed care initiatives by FY 1998, describes public child welfare agency operations where the agency contracts with a MSO to assume the responsibility for coordinating service delivery to a defined group of clients. The MSO becomes the lead agency in service delivery and its functions include: developing case plans, monitoring client progress and authorizing treatments. In this managed care arrangement, the lead agency provides all of the direct services or it may subcontract with a network of provider agencies.

- *The Administrative Services Organization (ASO) model* arrangement is typified by public child welfare agency contracting for the administrative and/or management services of a private entity. The private entity, or ASO, is responsible for a variety of administrative activities including billing, reimbursement, MIS network development, technical support and training. Direct service delivery, however, remains the responsibility of the public child welfare agency or becomes the responsibility of another contracted private agency. As of FY 1998, the ASO model was used in only three managed care arrangements nationwide.

- *The Managed Care Organization (MCO) model*, used in four child welfare managed care initiatives in FY 1998, requires a public child welfare agency to establish a contract with a MCO to administer service delivery through a panel or network of service providers. The MCO is responsible for developing the network of provider agencies and, in collaboration with the public child welfare agency, the MCO arranges, coordinates and authorizes services. As compared to the lead agency model, the MCO does not provide direct service delivery to children or families.

Creative Connections is operating in contract year three of its five-year contract with the Council agencies. **Chart 2-2** presents the managed care/child welfare relationship in Hamilton County between Creative Connections and the Council agencies as of January 2001, which is most similar to lead agency model arrangements in the health care industry.

Chart 2-2: Organizational Relationship, Creative Connections and Council Agencies (Lead Agency Model)



Managed Care versus Individualized Services

Nationally, the implementation of managed care in child welfare is a relatively new approach in serving the needs of identified abused and/or neglected children and their families. Likewise, the concept of individualized treatment plans, community-based care and wrap around services are relatively new developments in child welfare. Managed care has been implemented in several areas to reduce costs of care and/or improve service delivery to child welfare clients through greater coordination of care. The use of individualized and/or wrap around care has been implemented to improve outcomes in child welfare service delivery. Wrap around services in child welfare generally consist of rehabilitative and social support services which are critical to improving outcomes for abused and/or neglected children and their families. Examples of wrap around services include transportation, child care and employment-related services. Ensuring the availability of wrap around services is often challenging because several different government and non-profit agencies fund, manage and provide these services.

The two concepts, managed care and individualized treatment plans, are both components of the Creative Connections initiative. However, managed care and individualized treatment share deep philosophical divides regarding the role of care management and the expected outcomes of treatment.

A perceived philosophical divide between cost savings and improved outcomes provides a basis for some conflicts identified in the contract. The Council agencies have implemented the contract for a dual purpose: to improve service delivery coordination and to achieve cost containment. However, Creative Connections has focused exclusively on the concepts of individualized treatment and wrap around care while ignoring the objective of cost containment. Because Creative Connections has not implemented cost containment measures, scarce resources that may be needed by the Council agencies to serve additional clients are not necessarily available. Furthermore, such resources could be used to implement additional community based services, a goal articulated by the Council agencies and Beech Acres. The increased number of outliers (children with treatment costs above the capitated amount for more than three consecutive months) served through the contract and the large deficit incurred by Beech Acres during the first three years of the contract are indicative of the limited focus on costs. Although child outcomes have improved based on standardized psychological tests, Creative Connections is not able to show a correlation between types of treatment and expenditures, and the level of overall outcome improvement has not been quantified.

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Financial Management and Reporting

Performance Measurements

The following list of performance measures was used to conduct the review of the financial management and reporting component of the contract between Creative Connections, FCFC and HCDHS and the other Council agencies.

- Analyze the budgeting and expenditure reporting requirements in relation to Creative Connections' practices
- Assess line item billing amounts for administration, care management and overhead
- Review reconciliation process in relation to requirements and allowances of the contract
- Evaluate the maximization of funding
- Assess financial monitoring activities
- Examine the methodology used to determine funding percentages and the relationship between funding and clients served

Findings/Commendations/Recommendations

Budgeting, Expenditure Reporting and Deficit Usage

F3.1 Pursuant to the contract, Beech Acres prepares an annual project budget and provides the proposed budget to FCFC and the Council agencies for approval before the beginning of the contract year. The annual project budget includes the following information:

- Total estimated project revenue;
- Total budgeted project cost;
- Projected full service case rate;
- Projected County contribution;
- Projected individual outlier costs;
- Projected annual aggregate financial deficit/surplus; and
- Specification of salaries of Beech Acres' employees, including full time equivalents (FTEs) and care manager ratios.

The Council agencies have approved a consumer price index percentage increase for each year of the contract. In accordance with the contract, the annual project budget can be amended during the contract year with prior approval of FCFC and the Council agencies. However, the budget has not been amended during the first two contract years. **Table 3-1A** shows the budgeted and actual costs and **Table 3-1B** shows budgeted and actual revenues for each year of the contract.

Table 3-1A: Budgeted and Actual Costs, FY 1998-99 through FY 2000-01

	FY 1998-99 Budget Costs [1]	FY 1998-99 Actual Costs[1]	Variance[2]	FY 1999-00 Budget Costs	FY 1999-00 Actual Costs	Variance[2]	FY 2000-01 Budget Costs [1]	FY 1000-01 Actual Costs[1]	Variance[2]
Administrative Costs	$1,978,265	$1,792,553	9.4%	$2,252,764	$2,050,644	9.0%	$2,442,498	$2,069,794	15.3%
Care Management Costs	$1,268,138	$1,681,027	(32.6)%	$1,478,235	$2,155,738	(45.8)%	$1,843,256	$1,684,672	8.6%
Direct Service Costs	$11,054,472	$9,746,259	11.8%	$10,984,253	$11,276,311	(2.7)%	$10,928,675	$11,725,878	(7.3)%
Total	**$14,300,875**	**$13,219,839**	**7.6%**	**$14,715,252**	**$15,482,693**	**(5.2)%**	**$15,214,429**	**$15,480,344**	**(1.7)%**

Source: Beech Acres budget and year end statements FY 1998-99 and FY 1999-00
[1] First and third year costs have been annualized.
[2] Variance amounts are expressed as (unfavorable)/favorable.

As shown in **Table 3-1A**, Creative Connections posted a large variance between budgeted and actual expenditures during the second year of operations and will likely exceed budgeted expenditures in FY 2000-01, although the results of operations have not been finalized.

Exceeding budgeted expenditures has a direct effect on HCDHS and the Council agencies as it increases the cost of the contract beyond amounts budgeted by each County agency. When expenditures exceed budgeted amounts, the Council agencies must divert scarce resources from other programs to cover contract expenditures. Actual expenditures in excess of budgeted expenditures also contribute to the project deficit discussed in **F3.2**.

Table 3-1B shows budgeted and actual revenues. While FY 2000-01 is shown as having a positive variance in the table, the results of operations are not yet conclusive in the area of revenues received and recent information provided by the contract manager indicates that the variance may, in fact, be negative.

Table 3-1B: Budgeted and Actual Revenues, FY 1998-99 through FY 2000-01

	FY 1998-99 Budget Revenues [1]	FY 1998-99 Actual Revenues [1]	Variance [2]	FY 1999-00 Budget Revenues	FY 1999-00 Actual Revenues	Variance [2]	FY 2000-01 Budget Revenues [3]	FY 2000-01 Actual Revenues [3]	Variance [2]
County Contribution	$10,743,168	$10,325,327	(3.89)%	$10,910,749	$10,713,825	(1.80)%	$11,314,438	$11,314,438	0.00%
Non-County Funds	$2,290,671	$1,749,678	(23.62)%	$2,100,505	$2,677,750	27.48%	$1,935,086	$3,174,826	64.07%
Total	**$13,033,839**	**$12,075,005**	**(7.36)%**	**$13,013,253**	**$13,393,574**	**2.92%**	**$13,251,524**	**$14,491,264**	**9.36%**

Source: Beech Acres budget and year end statements FY 1998-99 and FY 1999-00
[1] First year costs have been annualized.
[2] Variance amounts are expressed as (unfavorable)/favorable.
[3] Based on the first 6 months of FY 3.

As shown in **Table 3-1B**, the large negative variance during the first contract year greatly impacted the ability of the Council agencies to afford the contract. . The most notable variance during the first contract year was in the area of non-County revenues, which has the potential to increase the County's liability by increasing the project deficit (see **F3.2** and **R3.1**) . The collection of non-county funds has improved in FYs 1999-00 and 2000-01; however, Creative Connections may not be maximizing these resources (see also **F3.19**).

F3.2 **Table 3-2** compares the budgeted expenses to budgeted revenues for each year of the contract.

Table 3-2: Comparison of Budgeted Expenses versus Revenues

	FY 1998-99	FY 1999-00	FY 2000-01
Budgeted Costs	$14,300,875	$14,715,252	$15,214,428
Budgeted Revenues	$12,853,839	$13,011,255	$13,649,523
Variance: Favorable (Unfavorable)	($1,447,036)	($1,703,997)	($1,564,905)
Percent Costs over Revenues	11.3%	13.1%	11.5%

Source: Beech Acres' Annual Budgets

As **Table 3-2** demonstrates, Beech Acres' budgeted expenditures in excess of revenues of over $1.4 million for each year of the contract. The practice of having planned expenditures exceed anticipated revenues is considered detrimental to the potential health of an organization. In accordance with the contract, Beech Acres' annual project budget includes a calculation of the projected annual aggregate financial deficit or surplus based on the calculations of total project cost and total project revenues. Budgeting for a net deficit each year indicates that Beech Acres has not implemented procedures to increase cost efficiencies or achieve cost containment in administering the program.

R3.1 The Council agencies should require Beech Acres to develop an appropriate budget reflecting the incorporation of managed care principles and the expenditures necessary to meet the requirements of the contract. Revenues should be projected on past year's receipts and Beech Acres should maximize Medicaid and first and third party insurance. The current deficit sharing methodology does not strongly encourage expenditure reduction and may lead to ongoing project deficits during the life of the contract. The deficit sharing methodology is particularly debatable when Beech Acres' billed amounts are not being correlated to actual expenditures (see also **F3.4**).

In future contract periods, the Council agencies should eliminate the deficit sharing methodology outlined in the contract. Deficits beyond budgeted amounts should be the responsibility of the vendor. However, the vendor must demonstrate utilization review (**R4.6**) and strategic planning (**R3.9**) as a component of budget development to ensure that any budget increases reflect necessary programmatic increases, not lenient expenditure planning. If the contracted entity fully implemented managed care cost containment practices, deficits could potentially be eliminated altogether.

Also, as contract provisions require FCFC and Beech Acres to share the burden for certain annual aggregate deficit amounts, FCFC and the Council agencies are paying additional unbudgeted amounts each year. These unbudgeted expenditures could negatively affect

Agency budgets and could potentially impact the Council agencies ability to provide other programs to residents of Hamilton County.

F3.3 Beech Acres financial practices may increase FCFC and the Council agencies program costs. Creative Connections delayed implementation of managed care principles has caused costs to run in excess of available revenues in each contract year. **Table 3-3** compares the actual costs and revenues, deficit amounts and financial responsibility for deficit amounts for each year of the contract.

Table 3-3: Comparison of Actual Costs versus Actual Revenues

	FY 1998-99	FY 1999-00	FY 2000-01 [1]
Actual Costs	$13,219,839	$15,482,693	$15,480,344
Actual Revenues	$12,091,603	$13,391,575	$14,581,664
Deficit	($1,128,236)	($2,091,118)	($898,680)
Percent Costs over Revenues	9.3%	15.6%	6.2%
Beech Acres Responsibility	$564,118	$1,141,118	$449,340
FCFC Responsibility	$564,118	$950,000	$449,340

Source: Beech Acres' Annual Budgets
1 FY 2000-01 figures are based on actual costs and revenues as of December 2000 and are annualized for the 12 month period.

Table 3-3 shows that the total program costs have exceeded revenues in the first two years of the contract and will exceed revenues again in FY 2000-01. Actual program costs are averaging 10.4 percent over the actual program revenues. The actual deficits may be even greater than shown because the Medicaid and provider revenues are estimated for the final aggregate report. Pursuant to the contract, responsibility for annual aggregate deficit amounts is defined according to the following apportionment:

- Beech Acres bears the entire amount if it is $333,333 or less in FY 1998-99 or $500,000 or less in FY 1999-00 and FY 2000-01.

- Beech Acres and FCFC equally share any amount between $333,334 and $1.9 million in FY 1998-99 or $500,001 and $1.9 million in FY 1999-00. According to the contract manager, this amount has been raised to $2.1 million for FY 2000-01.

Although the contract allows Beech Acres to include a deficit amount in its budget, the contract also requires that Creative Connections implement several managed care principles. Delayed managed care programmatic changes include:

- Network development;
- Longitudinal studies;
- Utilization reviews;
- Medicaid or third party funding maximization;
- Credentialing and provider profiling; and
- Coordinated case management. (see also **R3.18**, and ***performance measurement*** and ***technology*** sections).

Without the addition of managed care principles to the Creative Connections program, Beech Acres and Creative Connections will not be able to meet the Council agencies expectations of appropriate capitated amounts.

F3.4 Pursuant to the contract, Beech Acres provides FCFC with invoices specifying administrative costs, care management costs and direct care costs as aggregated cost categories. Beech Acres does not provide FCFC with detailed, line item expenditure information to support these costs. The contract does not require Beech Acres to provide a detailed breakdown of the costs for each category on invoices, budgets or year end reports. Furthermore, year end reports show only aggregate expenditures for each line item. Within this reporting format, the appropriateness of expenditures can not be verified by the contract manager or Council agency representatives. The Council agencies are not able to exercise oversight of public monies provided to Beech Acres in payment for services. Without detailed information on Beech Acres expenses, FCFC and the Council agencies have no way to verify the legitimacy of those expenditures.

R3.2 FCFC and the Council agencies should require Beech Acres to submit monthly detailed invoices to appropriately account for revenues and expenditures. Monthly invoices should include line-item accounting of accounts payable and payroll activities. Because public funds are used to fund the Creative Connections program, it is important that FCFC and the Council agencies implement adequate controls to reduce the potential for improper and over payment.

Without detailed invoices showing revenues and expenditures, the Council agencies are not able to adequately monitor expenditures or ensure that their Agency funds are appropriately employed for Creative Connections expenses. Detailed revenue and expenditure reports would allow the Council agencies to monitor the project expenditures at an appropriate level of control.

F3.5 Beech Acres does not submit its organization's budget. The Council agencies are only provided with the budgeted revenues and expenditures for Creative Connections. Likewise, year end reports do not show expenditures throughout Beech Acres' organization and programs but show only amounts attributed to Creative Connections.

A recent study on non-profit corporations and human services managed care by Wichita State University indicated that non-profit vendors should submit the entire organization budget and aggregate expenditures. Providing the contractor with a broader depiction of the non-profits financial position lets the government entity know what portion of the overall budget encompasses their program. Furthermore, examining the entire budget and aggregate expenditure records for the non-profit in comparison to specific programs under contract provides the contracting government entities with a better depiction of total organization costs and administrative overhead.

While the Council agencies are familiar with the overall Beech Acres endowment, their understanding of how the Creative Connections program relates to other Beech Acres programs is limited. As a component of the Creative Connections contract, Beech Acres can take referrals from Creative Connections and place the clients within other Beech Acres programs, thereby receiving a portion of direct care costs (see **F3.6**). A detailed explanation of how often or to what extent this occurs has not been available. The limited understanding of these financial interactions between the Beech Acres endowment and programs and Creative Connections and the governmental funds used to support the program reduces the Council agencies abilities to safeguard public funds.

R3.3 In future contracts, the Council agencies should require the non-profit organization, in this case Beech Acres, to submit the annual budget and actual expenditures in aggregate form for the entirety of the non-profit organization. Access to the non-profit's organization expenditures will afford the Council agencies a more in-depth understanding of the relationship between the contract program and the organization's overall financial position. The relationship between the program funded via government funds and those supported by the non-profit's endowment is an important indicator of the reliance on the government program by the non-profit. Over reliance on public funds could result in the inclusion of costs not applicable to the contracted program as a means to reduce usage of limited endowment resources.

F3.6 Creative Connections often refers children to residential foster care and therapeutic treatment programs managed by Beech Acres. **Table 3-4** shows the relationship between Beech Acres revenues and self referrals from Creative Connections for FY 1998.

Table 3-4: Beech Acres Revenues by Source for Foster Care Services

Agency	FY 1998 Revenues	Percent of Total
FCFM/Creative Connections	$3,301,683	30%
Investment Income	$2,672,818	24%
Talbert House	$1,865,733	16%
Hamilton County/ Magellan	$1,383,997	12%
Public Support (ie: bequests and funds raised)	$1,290,042	12%
Butler County	$404,099	4%
Other Service Reimbursements	$267,217	2%
Total Revenue by Source	**$11,185,589**	**100%**

Source: AOS Beech Acres Agreed Upon Procedure Report January 1, 1998 through December 31, 1998.

As shown in **Table 3-4**, self referrals to Beech Acres' programs from Creative Connections comprise a large percentage of revenues. Other Beech Acres publications indicate that 65 percent of FY 1999-00 revenues were derived from intensive programs which include Creative Connections. Furthermore, the FY 1998 Auditor of State Agreed Upon Procedures Report found that up to 47 percent of revenues derived from Beech Acres foster care services was used by Beech Acres for administrative expenses, maintenance costs or other program operating expenditures. Beech Acres' heavy usage of Creative Connections funds, of which as much as $1.5 million could have been directed to Beech Acres administrative expenses, calls into question the objectivity of utilization reviews and Creative Connections' ability to maintain an arms-length relationship with its parent organization.

R3.4 The Council agencies should closely monitor the usage of self-referrals by Beech Acres. Self-referrals should be detailed by client and by cost on a monthly basis and submitted to the contract manager. HCDHS should, during annual chart audits, assess the criteria used to determine that a self-referral best served the client's needs and compare the costs and outcomes of self-referrals to like services offered through other providers. The Council agencies should also monitor Creative Connections self-referrals as a percentage of Beech Acres' total revenues (see also **F3.6**). If HCDHS or the Council agencies determine that the usage of self-referrals is inappropriate or more costly than other alternatives, the usage of self-referrals should be removed from the contract. Future contracts should contain highly specific language governing the use of self-referrals as well as triggers that would precipitate a review of self-referral patterns or behaviors.

F3.7 As required by the contract, Creative Connections submitted the proposed budget to FCFC for FY 2000-01 prior to the start of the contract year. However, Creative Connections has made significant changes in staffing since submission of the budget without obtaining prior approval from FCFC and the Council agencies. **Table 3-9** shows the number of budgeted FTEs, as well as reported and vacant FTE positions as reported by Beech Acres for February 2001.

Table 3-5: Comparison of Budgeted and Reported Full Time Equivalents, FY 2000-01

Position	Budgeted FTEs [1]	Reported FTEs [2]	Vacant FTEs [3]
Beech Acres Staff Allocated to Creative Connections			
Quality Assurance/Program Evaluation	4.0	2.6	0.0
Financial Management	6.0	4.4	0.0
Information Systems	0.0	0.0	0.0
Total Beech Acres Staff	**10.0**	**7.0**	**0.0**
Creative Connections			
Administrative	3.0	2.0	1.0
Supervisor	2.3	5.0	2.0
Care Manager	16.0	29.0	1.0
Provider Representative	5.0	3.0	2.0
Liaison/Coordinator	0.0	4.3	0.0
Administrative Assistant	8.75	5.0	2.0
Records Clerk	2.0	1.9	2.0
Total Creative Connections Staff	**37.05**	**50.2**	**10.0**
Total FTEs Dedicated to Creative Connections	**47.05**	**57.2**	**10.0**

Source: Creative Connections FY 2000-01 Budget, Tables of Organization and interviews with executive director.

[1] Budgeted FTEs are those FTEs shown in the FY 2000-01 budget submitted to the Council agencies and approved by the System Refinance Committee.

[2] Reported FTEs are FTEs appearing on Beech Acres and Creative Connections payroll who billed hours to Creative Connections. Beech Acres provided a payroll report for February 2000.

[3] Vacant FTEs include employees listed on the new table of organization (February/March 2000) that were not included in the Budgeted or Reported FTEs.

The table indicates that Beech Acres may anticipate the need for 67.2 FTEs as opposed to the 47.05 FTEs included in the FY 2000-01 project budget. This would amount to a 43 percent increase in staffing levels since submission of the budget. Although the contract allows the budget to be amended during the contract year to include additional staff, Beech Acres did not submit a budget revision to FCFC for approval as required by the contract.

Also, the budget is not sufficiently specific or accurate when budgeted hours and reported work dedicated to Creative Connections is compared. In some cases, FTEs were shown as full-time Creative Connections employees or as Beech Acres staff dedicated to Creative Connections. However, when interviewed, some indicated that only a portion of their time was directed toward the contract program. These FTEs have not been adjusted in the table as the accuracy of payroll costs billed to Creative Connections could not be reconciled with budgeted amounts due to the absence of detailed expenditure reports (see **F3.4**).

F3.8 Increases in staffing result in increases in Creative Connections' payroll costs and increases in overall expenditures. **Table 3-6** shows the discrepancies between staffing levels shown in the budget and levels estimated by current employees and advertised vacancies for Creative Connections staff, the average salaries and estimated variances in costs.

Table 3-6: Costs of Increased Creative Connections Staffing

Position	Increase (Decrease) in Staffing	Average Salary	Increase (Decrease) in Costs
Administrative	0	N/A	$0
Supervisor	4.7	$ 42,381	$ 199,190
Care Manager	14	$ 28,702	$ 401,828
Provider Representative	0	N/A	$0
Liaison/Coordinator	4.3	$28,117 [1]	$ 120,903
Administrative Assistant	(1.75)	$ 20,319	$ (35,558)
Records Clerk	1.9	$ 20,779	$ 39,480
Total FTE Change from Budgeted to Reported plus Vacancies	23.15	N/A	**$ 725,843**

Source: Creative Connections FY 2000-01 Budget, Tables of Organization, payroll records and interviews with executive director.
[1] Average salary for Liaison/Coordinator positions was based on the average salary for Provider Representatives.

As shown in **Table 3-6**, the increases in Creative Connections staffing from the approved budgeted amounts to the reported FTEs and vacancies could result in a 27 percent increase in payroll costs for FY 2000-01. Creative Connections' marked increases in staffing have a direct impact on project deficits and may unfairly commit the Council agencies to unplanned expenditures. While staffing levels may occasionally need to be modified, the dramatic increase in staffing shown for the third year of the contract appears to be outside of normal staffing growth trends.

R3.5 Creative Connections should maintain staffing levels within budgeted levels. The costs for any unapproved changes in staffing levels should not be charged to the Council agencies. A staffing plan should be developed by Creative Connections on an annual basis indicating the staffing levels necessary to carry out the requirements of the contract. Job descriptions should

be developed for each position, and work and efficiency levels should be monitored for all FTEs. Because public funds are used to compensate Creative Connections employees, any amounts above the budgeted amounts should be approved prior to the expenditures being made. Furthermore, amounts allocated to temporary or contract employees should be accompanied by specific wage or expenditure schedules to demonstrate the intent of the expenditures.

Administrative, Care Management, and Direct Service Reported Costs

F3.9 Administrative costs are defined in the Beech Acres contract as costs associated with program support and management. These include the salaries and benefits of the following personnel:

- Administrators;
- Managers;
- Clerks;
- Supervisors; and
- Support Personnel.

Other costs in this category include facility expenditures, training, supplies, and equipment costs. For the purpose of this audit, administrative line item costs have been examined to consider the reasonableness of these expenses. **Table 3-7** displays administrative costs during the first three years of the contract.

Table 3-7: Administrative Costs FY 1998, FY 1999 and projected FY 2000

	Actual Administrative Costs FY 1998-99[1]	Actual Administrative Costs FY 1999-00	% Change	Projected Administrative Costs FY 2000-01[2]	% Change
Payroll	$700,928	$825,413	17.8%	$896,896	8.7%
Payroll Taxes and Benefits	$126,848	$167,979	32.4%	$197,718	17.7%
Professional Services	$297,572	$199,861	(32.8)%	$92,716	(53.6)%
Supplies	$5,793	$14,157	144.4%	$42,014	196.8%
Transportation and Training	$4,724	$24,929	427.8%	$36,808	47.7%
Membership and Dues	$90	$69	(23.3)%	$170	146.4%
Communication and Equipment	$18,399	$25,487	38.5%	$52,824	107.3%
Occupancy	$7,479	$10,078	34.8%	$33,268	230.1%
Insurance	$8,342	$4,895	(41.3)%	$12,752	160.5%
Other	$0	$0	-	$10,396	-
Depreciation	$38,678	$72,232	86.8%	$68,668	(4.9)%
Overhead	$583,703	$705,543	20.9%	$625,564	(11.3)%
Total Expenditures	**$1,792,553**	**$2,050,643**	14.4%	**$2,069,794**	**0.9%**

Source: Creative Connections

[1] The first contract year encompasses only an eight month period. Administrative costs have been annualized to reflect twelve months costs.

[2] Projected costs are based on mid-year FY 2000-01 actual figures and are annualized to reflect twelve months costs

An explanation for some of the more significant variances in **Table 3-7** are as follows:

- *An increase in payroll in FYs 1999-00 and 2000-01:* Beech Acres increased Creative Connections' resource managers by 2 FTEs, increased the evaluation staff by 1.5 FTEs, and added a new support staff supervisor position in FY 1998-99. In FY 1999-00, quality assurance and supervisor positions were added. Beech Acres' management stated that the new positions were necessary in order to meet the expansion of services that occurred under the contract.

- *A decrease in professional services in FY 1999-00 and FY 2000-01:* The decrease in professional services was caused by reducing the amount of professional services performed for Creative Connections by outside organizations. Services that were previously outsourced were performed in-house by employees of Creative Connections.

- *An increase in supplies, transportation and training, and communication and equipment in FYs 1999-00 and 2000-01:* The significant increase in these line items reflects the rise in support costs that occurred due to the expansion of the Creative Connections staff.

- *A decrease in insurance in FY 1999-00 and an increase in FY 2000-01:* The insurance line item represents expenditures incurred for liability insurance. Fluctuation in this line item was caused by the changing liability insurance needs of the Agency.

- *An increase in depreciation for FY 1999-00 and a decrease for FY 2000-01:* Depreciation is calculated on fixed assets for Creative Connections. Although a relatively detailed depreciation report was available, the report lacked the necessary information to verify the appropriateness of depreciation calculations and their inclusion in the Creative Connections administrative costs.

- *An increase in overhead during FY 1999-00 and a decrease in FY 2000-01:* As stipulated in the contract, overhead is calculated as 20 percent of the annual indirect costs. Creative Connection's chief financial officer (CFO) stated that no report is produced which identifies individual line items that are responsible for creating overhead expenses. Because overhead expenses cannot be traced directly to the responsible line items, the 20 percent estimate for overhead costs is a cost driver. The variance could not be explained by the CFO.

R3.6 The Council agencies should require all line items billed as administrative costs to be detailed by expenditure on a monthly basis. A detailed expenditure report should be provided to the contract manager (see also **R3.16**). As stated in the contract, overhead is calculated as 20 percent of the annual administrative and care management costs; direct expenditures related to the overhead line item are not available and the legitimacy of amounts billed through overhead are suspect. Also, the depreciation costs are not adequately detailed to ensure the correlation between depreciated amounts and actual Creative Connections fixed assets. If Creative Connections continues to include these amounts, a report tracing overhead and depreciation costs directly to individual expenditures must be produced and verified by the contract manager or Council Agency representatives. As of January 2001, overhead and depreciation costs totaled approximately $1.7 million over the life of the contract. These

costs represent approximately $0.7 million annually. If Creative Connections is unable to provide detailed cost accounting for these line items, the Council agencies should cease payment on these items.

Financial Implication: Unverified costs amounts for overhead and depreciation total approximately $700,000 annually. If detailed expenditure and depreciation reports are not provided, the Council agencies should discontinue payment on these amounts.

F3.10 Creative Connections's administrative costs may not exceed 14.0 percent of total project costs (administration cost cap) in any budget year, except by an amount equal to the cost cap plus an allowed variance of 5.0 percent of the budgeted cost (administration cost variance). The addition of the cost cap and the cost variance forms the administrative cost limit. A favorable variance occurs when Creative Connections' actual costs are lower than the cost limit. **Table 3-8** displays the cost limit in comparison to projected costs.

Table 3-8: Administrative Cost Activity FY's 1998,1999 and Projected FY 2000

	Administrative Cost Cap	Administrative Cost Variance	Administrative Cost Limit	Projected Administrative Costs[2]	Favorable (Unfavorable) Variance
FY 1998-99[1] Actual	$1,668,435	$83,422	$1,751,857	$1,792,553	($40,696) (2.3%)
FY 1999-00 Actual	$2,060,135	$103,007	$2,163,142	$2,050,643	$112,499 5.2%
FY 2000-01 Budgeted	$2,130,020	$106,501	$2,236,521	$2,069,794	$166,727 7.4%

Source: Creative Connections

[1] The first contract year encompassed eight months. FY 1998-99 administrative costs have been annualized to reflect twelve months costs.

[2] Projected costs for FY 2000-01 are based on mid-year actual figures and were annualized to reflect to twelve month costs.

In FY 1998-99, Creative Connections' actual costs exceeded the cost limit by 2.3 percent but were 5.2 percent lower than the limit in FY 1999-00 and 7.4 percent lower in FY 2000-01. As stated in the contract, administrative costs were not expected to decrease in proportion to direct service costs due to the fixed nature of these costs. Creative Connections is reimbursed for expenses up to the cost limit. Costs which exceed the prescribed limit, $40,696 in FY 1998-99, are not reimbursed to Beech Acres by the Council. However, by using the maximum cap levels, overhead costs are driven to maximum reimbursement levels.

F3.11 Creative Connections does not have a strategic plan to guide resource allocation. Likewise, the contract contains no guidance in this area. Strategic plans are highly recommended to guide short and long term programmatic and operational goals. Strategic plans should

encompass three to five years of operations and include goals, action steps to achieve goals, costs, time-lines and responsible individuals. Costs should be based on prior year expenditures and future planned actions and should include detailed descriptions of planned increases. Through careful strategic planning and by updating plans at least annually, an organization is able to better control costs and ensure judicious resource allocation. Because Creative Connections does not have a strategic plan to guide spending, annual variances may fluctuate widely and remain unexplained.

R3.7 The Council agencies should require Creative Connections to develop annual strategic planning documents for administrative costs which would correlate planned costs and activities with required resources. The plan should be used to develop the annual budget based on planned activities and the plan and budget should be amended as needed throughout the year. Developing a strategic plan will lend greater stability to the budgeting process and should reduce the level of variances experienced by Creative Connections.

F3.12 Care management costs are related to the provision of care management services by Creative Connections and the providers. Included in care management services are the following tasks:

- Developing and implementing plans of care for clients;
- Completing risk matrices;
- Monitoring the provision of direct services;
- Monitoring outcomes;
- Maintaining face to face contact with clients;
- Training other care managers and other provider personnel;
- Developing and maintaining a therapeutic relationship with an enrollee; and
- Preparing documentation and attending Semi-annual Administrative Reviews (SARs).

For the purpose of this audit, care management costs were examined to determine the reasonableness of these expenses. Care management costs for the first two contract years are displayed in **Table 3-9**.

Table 3-9: Care Management Costs FY's 1998, 1999, and projected FY 2000

	Actual Care Management Costs FY 1998-99[1]	Actual Care Management Costs FY 1999-00	% Change	Projected Care Management Costs FY 2000-01	% Change
Payroll	$616,026	$1,379,774	124.0%	$1,171,892	(15.1)%
Payroll Taxes and Benefits	$129,381	$298,477	130.7%	$191,862	(35.7)%
Professional Services	$493,194	$94,605	(80.8)%	$50,622	(46.5)%
Supplies	$19,358	$25,073	29.5%	$0	(100.0)%
Transportation and Training	$65,313	$133,687	104.7%	$118,500	(11.4)%
Membership and Dues	$953	$261	(72.6)%	$150	(42.5)%
Communication and Equipment	$71,609	$87,261	21.9%	$41,168	(52.8)%
Occupancy	$45,986	$36,236	(21.2)%	$29,384	(18.9)%
Insurance	$18,746	$18,018	(3.9)%	$11,262	(37.5)%
Other	$13,190	$16,546	25.4%	$9,180	(44.5)%
Depreciation	$207,273	$65,800	(68.3)%	$60,652	(7.8)%
Total Expenditures	**$1,681,027**	**$2,155,738**	**28.2%**	**$1,684,672**	**(21.9)%**

Source: Creative Connections

[1] The first contract year encompassed eight months. Care Management costs have been annualized to reflect twelve months costs.

[2] Projected FY 2000-01 costs are based on mid-year actual figures and are annualized to reflect twelve months costs.

An explanation for the more significant variances in **Table 3-9** are as follows:

- *An increase in payroll and payroll taxes and benefits in FY 1999-00 and a decrease in FY 2000-01*: Beech Acres increased Creative Connections' Care Managers by 6 FTEs and increased supervisors by 1 FTE in FY 1999-00. Payroll taxes and benefits also rose due to the additional positions. Beech Acres' management stated that additions to the staff were necessary to meet the expansion of services that occurred under the contract. In FY 2000-01, vacancies contributed to the reduced costs in both categories.

- *A decrease in professional services for FYs 1999-00 and 2000-01:* The decrease in professional services for FYs 1999-00 and 2000-01 are related to the decrease in outsourced functions.

- *An increase in supplies, transportation and training, communication and equipment, and other in FY 1999-00 and a decrease in FY 2000-01*: Additional spending was necessary to support the employees added after the first contract year. An increase in cell phone charges, data and telephone lines, and internet access were highlighted by Beech Acres' CFO as the primary reason for the rise in Creative Connections' communication costs. Costs decreased in FY 2000-01 as a result of the slight staffing decreases resulting from vacancies.

- *A decrease in membership and dues, and insurance in FY 1999-00 and 2000-01*: Property and professional insurance expenses decreased as a result of changes in staffing levels and the types of professional positions employed within Creative Connections (increased use of administrative assistants), as well as the increase in property and equipment.

- *A decrease in depreciation for FYs 1999-00 and 2000-01*: A depreciation schedule was made available, but did not contain sufficiently detailed information to attribute reported depreciation to Creative Connections (see also **F3.9**).

F3.13 A large portion of care management costs are payroll-related. Payroll constituted 36.6 percent of total care management costs in FY 1998-99, 64.0 percent in FY 1999-00, and is projected to increase to 69.5 percent of the total expenditures in FY 2000-01. Creative Connections' care management costs are not to exceed 8.0 percent of total project costs (care management cost cap) in any budget year, except by an amount equal to the cost cap plus an allowed variance of 10.0 percent of the budgeted cost (care management variance). Beech Acres' care management cost limit is displayed in **Table 3-10**. As displayed in the table, a favorable variance occurs when actual costs are lower than the cost limit. If the actual costs exceed the cost limit in any year (unfavorable variance), Beech Acres must provide the Council agencies with a detailed line item report indicating the reasons that the costs exceeded the prescribed percentage of total project costs.

Table 3-10: Care Management Cost Activity FY's 1998,1999 and projected FY 2000

	Care Management Cost Cap	Care Management Cost Variance	Care Management Cost Limit	Projected Care Management Costs[2]	Favorable (Unfavorable) Variance
FY 1998-99[1]	$953,391	$95,339	$1,048,730	$1,681,026	($632,296) (60.2%)
FY 1999-00	$1,177,220	$117,722	$1,294,942	$2,155,738	($860,796) (66.4%)
FY 2000-01	$1,217,154	$121,715	$1,338,869	$1,684,672	($345,803) (25.8%)

Source: Creative Connections

[1] The first contract year encompassed eight months. Care Management costs have been annualized to reflect twelve months costs.

[2] Actual FY 2000-01 costs are based on mid-year actual figures and are projected to reflect twelve months costs.

Beech Acres actual care management costs exceeded the cost limit by 60.2 percent in FY 1998-99, 66.4 percent in FY 1999-00, and 25.8 percent in FY 2000-01. This amounted to expenses of $632,296 in FY 1998-99, $860,769 in FY 1999-00, and $345,803 in FY 2000-01 that were not reimbursed by the Council agencies. Costs in excess of the 10.0 percent variance were not unexpected. The contract states that due to their fixed nature, care management costs may exceed the variance in contract years subsequent to contract year one.

R3.8 As with administrative expenses, the Council agencies should require Creative Connections to develop an annual strategic plan which would correlate care management costs and activities with required resources. By developing an annual plan that includes goals, steps to achieve the goals, and time-lines, Creative Connections should reduce the levels of care management cost variances experienced, and reduce the amount of costs not reimbursed. Also, correlating care management costs to utilization reviews would help Creative Connections better plan for care management resource needs.

F3.14 Direct Service Costs are those costs which are incurred in the provision of direct services to clients. These consist of the following services:

- Diagnostic and Evaluative Services;
- Medical/Somatic Services;
- Individual, Family, Group Psychotherapy;
- Home Based Intervention Services;
- Community Support Services;
- Out-Patient Partial Hospitalization Services;
- Foster Care Services;
- Group Care Services;
- Residential Care Services;
- Respite Services;
- Crisis Services; and
- Independent Living Services.

Direct Service Costs for the first three contract years are shown in **Table 3-11**.

Table 3-11: Direct Service Costs FY's 1998,1999 and projected FY 2000

	Total FY 1998-99[1]	Total FY 1999-00	% Change	Projected FY 2000-01[2]	% Change
Direct Service Cost	$9,746,259	$11,276,311	15.7%	$11,725,878	4.0%

Source: Creative Connections

[1] The first contract year encompassed eight months. Care Management costs have been annualized to reflect twelve months costs.

[2] Direct service costs for FY 2000-01 are based on mid-year actual figures and are projected to reflect twelve month costs.

The variation of 15.7 percent from FY 1998-99 to FY 1999-00 may be attributed to a lack of preparation on the part of Beech Acres for managing the true costs of service provision for the client population. The projected variance of 4.0 percent from FY 1999-00 to FY 2000-01 signifies a normalization of these costs consistent with the trend of rising medical costs and the medical Consumer Price Index for the Cincinnati region. However, Creative Connections has not performed utilization reviews or established network rates for service providers which, if used, could significantly reduce direct service costs (see the ***network management*** subsection in ***performance measurement***).

R3.9 The Council agencies should require Creative Connections to develop an annual strategic plan which would anticipate yearly Direct Service Costs. Indicators used to project costs should include:

- Medical CPI;
- Utilization reviews;
- Preliminary cost assessments of the client population;
- Network rates; and
- Other relevant variables.

Beech Acres should continue to closely monitor costs to avoid the wide variances experienced between the first two years of the contract. Direct service costs should not rise in proportions above medical services inflation.

Reconciliation and the Payment Process

F3.15 The Council agencies pay a capitated amount for each client served by Creative Connections. During the first contract year, the Council agencies reimbursed Beech Acres the county case rate of $3,130 per enrollee per month served. The first contract year encompassed an eight-month period. When annualized to reflect a full year, this amount would have been $4,695. The county case rate was determined by dividing the annualized County contribution by 3,432 (the maximum number of clients, 286, multiplied by 12 months). To determine this rate for subsequent contract years, the lesser of the following calculations was used:

- Increase the annualized actual project cost for the immediately preceding contract year by an amount corresponding to the increase in the Consumer Price Index, and subtract the projected cluster funds, Medicaid, interest, first and third party payments, Individual Outlier Reimbursement, and any other income.

- Increase the annualized county contribution for the immediately preceding contract year by an amount corresponding to the increase in the CPI.

During FY 1999-00, the County case rate was $4,288. This rate increased to $4,333 in FY 2000-01.

F3.16 Beech Acres sends a monthly detailed census report to FCFC for information purposes, and an annual census summary report is submitted within 30 days from the end of each contract year. Census reports are used to determine the number of children served each month based on the 286 available beds. The Council agencies transfer funds to FCFC for administrative, care management and direct service costs on a quarterly basis, no later than the first day of March, June, September, and December, pursuant to the contract. Total enrollee months are reconciled within 30 days of the end of each contract year to determine utilization and the amount owed to Creative Connections and Beech Acres. Beech Acres and the Council agencies review the difference between enrollee months paid in advance by the Council, and enrollee months utilized during that year. If Beech Acres did not have open enrollment and could not manage the current level of 286 clients, the Council agencies would receive a refund.

Direct service charges are billed in a bundled format and are based on the capitated amounts stipulated in the budget. Bundled charges may include Medicaid eligible services which, when not itemized, are often paid through local dollars. Also, non-itemized charges have limited utility in projecting costs, monitoring trends, and exercising financial oversight. The use of bundled charges coupled with the capitated rate structure prevents the Council agencies from capturing the true costs of services provided on a monthly basis. The bundled charges are not audited and are examined only in a cursory fashion by the contract manager. See also ***Hamilton County Managed Care, Magellan Behavioral Health*** report for additional information on the limitations of bundled rates.

R3.10 The Council agencies should discontinue bundling charges and require Creative Connections to itemize all invoices. The current method of bundling rates has been deemed by the Health Care Financing Administration (HCFA) as not producing "sufficient documentation of accurate and reasonable payments, and may result in higher payments than would be reasonable on a fee-for-service basis." Itemized invoices should be included for all financial reporting.

The Council agencies should review capitated payments in relation to actual costs. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), capitated payments are susceptible to "errors in judgement or erroneous assumptions ... [which can] cause an otherwise well designed program to fail due to insufficient capitation rate(s)." SAMHSA recommends three approaches to establishing capitation rates for a purchaser of behavioral health care services:

- **Specify in the RFP the exact capitation rate to be paid:** Though the RFP process was not used for this contract, this approach will narrow down the field of potential providers, while limiting the competition for the bid to performance outcomes and managerial efficiency. The importance of the RFP in the contractual process is underscored.

- **Specify the maximum capitation rate and allow bidders to bid this amount or a lower amount**: The purchaser (the Council agencies) sets a maximum capitation rate and allows for managed care organizations (MCO's) to bid at this rate or lower. This approach focuses on cost, with the intended result being lower prices overall.

- **Allow for MCO's to bid a rate of their own**: The purchaser would provide no guidance for a capitated rate in the RFP, allowing for full market competition. This approach would also ensure lower costs and higher levels of innovation with a possible risk of a decline in the quality of services.

Through an examination of actual itemized billing amounts and a longitudinal study of costs associated with the Creative Connections contract, HCDHS and the Council agencies should determine which of the above methods best ensures continued financial stability within the contract and contracted entity.

Claims Adjudication Process

F3.17 Beech Acres authorizes service units to be performed by selected providers for either Medicaid or non-Medicaid treatment as determined by providers' Medicaid eligibility. The authorization process includes the following provider guidelines:

- Providers have 30 to 60 days after the end of the month to bill Beech Acres for Medicaid and non-Medicaid services provided.

- Non-Medicaid claims billed to Beech Acres after the 60 day limit are permanently denied.

- Claims that are a combination of Medicaid and non-Medicaid reimbursable services may receive payment from Beech Acres for the Medicaid and non-Medicaid portion after the 60 day limit has expired, as long as Beech Acres was notified within 60 days after the date of service, that a Medicaid claim was pending for the service. This provision also allows for Beech Acres to gauge potential Medicaid claims before they are entered into MACSIS.

The claims adjudication process at Beech Acres has a series of checks that validate payment for the service. Claims received before the 60 day limit are checked against the number of hours billed for the service, and, if they match, they are entered into the Managed Care Module of UNI/Care. Claims that fail to match the number of hours billed are denied. More information on UNI/Care is provided in the ***technology*** section. In the UNI/Care software, the claim is matched against the more detailed explanation of benefits (EOB), which verifies the following information:

- Payee number and name;
- Client ID and name;
- Number of service units submitted pending payment;
- Dates of service;
- Allowable charges and insurance co-pay information; and
- Amount to be paid.

Claims that do not match the EOB are denied. Providers are given the reasons for denial within 45 days of Beech Acres' receipt of the original invoice, and the providers are afforded the opportunity to appeal the claim at their discretion. The intent to appeal a claim must be expressed in writing within 15 days of receipt of the denial letter. The Beech Acres Appeal Committee notifies the provider of its decision within 20 days after receipt of the request for appeal. The provider can resubmit the claim if granted the opportunity by the Beech Acres Appeal Committee, but, if the appeal is not granted, the claim is permanently denied.

C3.1 Beech Acres has developed a strict 60 day cutoff for reimbursement of non-Medicaid claims. The strict 60 day limit for providers to submit claims ensures timely submission of claims and provides Beech Acres with greater levels of control in projecting revenues and expenditures. Although Medicaid cases may be submitted to the Ohio Department of Mental Health (ODMH) up to 365 days from the date of service, Beech Acres' policy of denying any Medicaid claims not accepted by ODMH and not submitted within the 60 day billing window ensures that outdated claims do not linger in the payment process.

F3.18 Creative Connections is required to report the number of claims paid, pending and denied on a quarterly basis. The report was not provided to the FCFC contract manager during FYs 1998-99 and 1999-00. A paid, pending and denied report was submitted by Creative Connections for the first and second quarter of FY 2000-01. The amounts and percentages of paid pending and denied claims are shown in **Table 3-12**.

Table 3-12: Paid, Pending and Denied Claims, FY 2000-01 First and Second Quarters

Service Month	Claims Paid	Claims Pending	Claims Denied
FY 2000-01, 1st Quarter ($)	$1,743,789	$139,588	$621,655
FY 2000-01,1st Quarter (%)	56.35%	8.00%	35.65%
FY 2000-01, 2nd Quarter ($)	$1,395,245	$667,991	$142,226
FY 2000-01, 2nd Quarter (%)	41.93%	47.88%	10.19%
FY 2000-01, Year to Date Total ($)	$3,139,034	$807,579	$763,881
FY 2000-01, Year to Date Total (%)	49.94%	25.73%	24.33%

Source: Beech Acres/Creative Connections Paid, Pending and Denied Report July 1, 2000 to December 31, 2000.

Beech Acres pending and denied claims represent 25.73 percent and 24.33 percent of claims respectively. The Beech Acres CFO has not tracked the reasons for pending or denied status being applied to certain payments. Because the most common reasons for denials have not been ascertained, a procedure to reduce the amount of claims pending and denied has not been implemented. Also, the percentage of pending and denied claims has not been tracked over time and the average number of pending and denied claims can not be determined. Although provider complaints were not identified by Beech Acres or FCFC as resulting from denials, the high number of pending and denied claims indicate a communication barrier between Beech Acres and providers. The large dollar amounts remaining unpaid also may lead to reduced cooperation by providers.

R3.11 Beech Acres should implement a review process to identify the reasons why claims are labeled pending or denied. Once the reasons have been identified, Beech Acres should develop and implement a process to reduce the number of claims labeled as pending or denied. Magellan Behavioral Health (MBH) implemented a process called Concurrent Clinical Service Request (CCSR) for re-authorization of continuing services for existing clients. This process, designed by MBH, ensures that continued care is medically appropriate and approved by clinical staff at MBH. The CCSR process for re-authorization of services reduced the number of claims labeled as denied or pending by MBH by approximately 10 percent. A reduction in the number of claims in pending or denied status would not only improve provider relations, but it would likely result in a reduction in Beech Acres' processing costs.

F3.19 Medicaid services are processed through the MACSIS system and are documented by the Hamilton County Community Mental Health Board (Mental Health Board). Based on State law, providers have up to one year after the date of service to process Medicaid claims in MACSIS. Beech Acres tracks Medicaid claims and eligibility status for clients by receiving a downloaded copy of MACSIS information monthly from the Mental Health Board. The Mental Health Board estimates that, from the time a claim is filed to when it is reported in MACSIS as approved or denied may be between two to three months. For example, a claim

with a date of service on January 1, would be formally administered during the service month of January, billed to MACSIS in the February service month or at the latest mid-March, and finally realized two to three months later in either May or June.

According to the Mental Health Board, the submission of Medicaid claims within 30 days is a desirable and achievable benchmark, which between 90 and 95 percent of Medicaid eligible providers within Hamilton County currently observe. The Mental Health Board provides Beech Acres with information on the Medicaid eligibility of providers on a monthly basis. Based on year three, first quarter reports from Beech Acres, 39 of their providers or 71 percent were not Medicaid eligible. Non-Medicaid providers served 56.3 percent of the client population and encompassed 77.5 percent of aggregate service costs.

R3.12 Beech Acres should consult with Magellan Behavioral Health (MBH), or a reputable public consulting group with expertise in the health care field to assure that a majority of providers are Medicaid eligible. MBH ensures that close to 100 percent of its contracted providers are eligible to provide Medicaid eligible services and receive reimbursement for Medicaid services. By ensuring providers' Medicaid eligibility, the amount of local funds used for services will be reduced, thereby limiting local liability. Also, Medicaid reimbursements should be maximized. The limited attention to Medicaid revenue maximization may have increased the current deficit (see **F3.3**). An increase in Medicaid reimbursements would decrease the deficit amount incurred by the Council agencies.

Through increasing Medicaid eligibility among Beech Acres providers, a savings of up to 58 percent could be realized on Medicaid eligible services. However, several of the services provided through Beech Acres and Creative Connections are not Medicaid applicable. Current Medicaid services are anticipated at approximately 30 percent of quarterly direct care charges. Based on FY 1999-00 first quarter expenditures of $1,145,484, the anticipated Medicaid reimbursement was $343,400. Of this, $222,800 (64 percent) was realized.

If Creative Connections were able to maximize Medicaid reimbursements at the 30 percent used for formally planned Medicaid services, Creative Connections could realize approximately $350,000 in Medicaid off-sets per contract quarter. Over the life of the contract, the Medicaid off-set could have been as much as $6,283,000 above the Medicaid revenue shown in year end statements. Additional Medicaid revenue in amounts equal to 30 percent of direct care charges would not only have negated the project deficit but also would have created a year end revenue surplus.

Financial Implication: If Creative Connections were able to maximize Medicaid eligible providers, an annual cost savings of up to $1.4 million could be realized.

F3.20 Beech Acres invoices FCFC for the shared costs of clients classified as outliers (clients whose services cost are between $7,000 and $15,000 a month for three consecutive months). The outlier authorization process occurs when the Monthly Outlier Report is sent by Beech Acres to FCFC for outlier payments. The FCFC contract manager and each Council agency's service coordinator compare the Monthly Outlier Report to submitted invoices. If a client is absent from the Monthly Outlier Report, it indicates that Beech Acres did not notify FCFC of the client entering outlier status and Beech Acres receives no additional remuneration for services beyond the County case rate. During contract year three, there were several outliers that were not properly identified and, by the fifth month of the contract, Beech Acres had an unreimbursed outlier expenditure of approximately $400,000.

The contract specifies that FCFC must receive monthly notification of clients entering outlier status from Beech Acres. However, these reports were deemed impractical to produce on a monthly basis because of the need for three consecutive months of history. The reports were produced on a quarterly basis beginning in August 2000. FCFC is limited in obtaining this information because of the number of clients involved and the current 60 to 90 day time frame for billing. The result is an inaccurate portrait of clients entering this status for the referring agencies. Uncertainty regarding future expenditures for outliers directly impacts the ability of the Council agencies to budget for and forecast amounts for these clients's services. The inability to effectively monitor the outlier and budget costs has created a substantial deficit in year three of the contract.

According to HCDHS, Beech Acres clients enter the system at or near outlier status and improve as they progress through the care management program, leaving the system at a lower cost per month. Beech Acres has identified several children, though, who have remained at outlier status for several months and have shown no marked progress toward recovery. However, Creative Connections has not developed a utilization review process to increase oversight on Outlier cases. Without a method to ascertain the appropriateness of service, Creative Connections may allow clients to remain in settings that are more expensive than necessary. Furthermore, the poor implementation of managed care principles (see **F3.3**) may be directly responsible for high outlier costs.

R3.13 The Council agencies should require Beech Acres to provide a monthly report no later than 10 days after the close of the month detailing claims pending related to outlier status. In addition, all outlier treatment plans should undergo utilization review (see the ***performance measurement*** subsection) on a monthly basis to determine if the treatment is appropriate for the clinical needs of the child.

Also, the Council agencies should review the parameters of the outlier classification to determine the best method to manage extraordinarycare needs and costs within the same system. Because outliers require the provision of more complex and intensive services, the

Council agencies should consider adjusting the cost allocation for these clients contingent upon utilization reviews.

Revenue Maximization

F3.21 Beech Acres relies on six separate income sources for the payment of client claims. These sources include the following:

- **Medicaid Funding:** Medicaid pays approximately 58.0 percent of each claim for Medicaid eligible services. Beech Acres budgets and guarantees a specific amount at the beginning of each contract year which reflects the amount they expect to collect from Medicaid for the provision of direct services in accordance with local, State, and federal regulations.

- **County Contribution:** (Pooled Funding) These are the funds that each Council Agency contributes throughout the year for care of the clients that are referred to the program. The County contribution, as determined by the County case rate, is further discussed in **F3.15**. The funds from each of these agencies is provided to FCFC, who in turn, remits payment to Beech Acres. These funds cover the other approximate 42.0 percent of claims not covered by Medicaid and the vast majority of all non-Medicaid services. More information on this is provided in the ***Pooled Funding Agreement*** subsection.

- **First and Third party insurance:** Creative Connections collects first and third party reimbursements for direct services, excluding Medicaid revenue to providers. Beech Acres assesses fees based on a subsidy fee scale for direct payments from the client (1st party), or, if the client has health insurance (3rd party), from the insurance provider. The subsidy fee scale is provided by the Mental Health Board and indicates what percentage of the total fee the parent will be responsible for paying, based on income.

- **State Cluster Funds:** The State Cluster Fund is a block grant that is specified for multi-need clients, and is available on a "first come-first served" basis. Funding is available to capped amounts and more may be invoiced before the end of a year if the total amount of funds have not been expended. The contract guarantees Creative Connections will receive $500,000 in State Cluster Funds each year.

- **Outlier reimbursement:** Creative Connections invoices FCFC for 50.0% of the costs for clients with expenses between $7,000 and $15,000. For client expenses over $15,000, Beech Acres invoices the referring Council Agency for 100.0% of those costs.

- **Interest income:** Creative Connections is guaranteed a certain amount of interest income for each year as stipulated in the budget. For FY 1998-99, the amount of interest income was $112,500. The interest income is derived from the Beech Acres endowment.

F3.22 The contract mandates that Beech Acres maximize all possible funding from outside sources by executing the following actions:

- Delivering Medicaid eligible services;
- Monitoring service utilization, cost, and effectiveness;
- Exploring development of new and more cost-effective service deliveries; and
- Pursuing third party insurance.

First and third party payments are non-existent for most clients of Creative Connections. The clients are generally from adverse financial circumstances and lack the resources to either make payments or to acquire insurance coverage for services.

According to the contract, Beech Acres is to apply for grants germane to both the client population and the nature of the program. Beech Acres has received two small grants for Creative Connections-- the Greater Cincinnati Foundation ($30,000) for child assessments and Knowledge Works Foundation which provides funds for the educational needs of Creative Connections clients.

Beech Acres has not demonstrated a plan to maximize existing revenue sources, or to seek out other revenue streams. Because of the amount of Beech Acres' contractual risk (see **Table 3-14**), the need for alternative funding sources and strategies is paramount. Based on contract year three data for the period ending June 2000, Beech Acres formally planned to receive Medicaid reimbursements in the amount of $99,000. Medicaid was billed for claims amounting to $87,000 or 87.8 percent of the formally planned revenues. Beech Acres actually received only approximately $75,000 in Medicaid reimbursements after denials, or approximately 75.7 percent of planned Medicaid reimbursements. The low revenues derived from Medicaid and grants contributes to the project deficit and increases Council Agency costs beyond the capitated amount (see **F3.3**).

R3.14 Beech Acres should utilize existing personnel to aggressively pursue grants and Medicaid reimbursements. Current efforts to maximize third party funding include developing an internal grant writer function through the Beech Acres fund raiser position.

Also, Beech Acres should perform an internal review to determine the best methods foroptimizing its financial resources and integrating its operational and technological assets to increase program efficiency and effectiveness. The following assessments should be included in an internal review:

- Financial assessment and planning;
- Actuarial surveys for norms on capitated reimbursements;
- Sensitivity analyses of capitation and fee-for-service reimbursements;
- Case rate and capitation models;
- Risk sharing methodologies and models; and
- Capital reserve protocols and funds flow models for Medicaid managed care, and network reimbursements.

By exploring grant opportunities and Medicaid maximization, while simultaneously analyzing internal processes and resource allocation, Beech Acres can potentially reduce taxpayer cost, create cost savings and improve cost avoidances.

Contractual Reporting Requirements

F3.23 Beech Acres is required by the contract to develop and maintain a regular system of reporting in consultation with the Council agencies. The reports in **Table 3-13** have been established to present the financial position of Beech Acres:

Table 3-13: Required Fiscal Reporting

Required Reports	Contractual Reporting Timeframe (Current Reporting Schedule)	Produced *
Exhibit B		
Percentage and Total of Medicaid eligible services planned, billed and realized	Annually (Quarterly, Annually)	YES
Percentage and Total of Medicaid eligible services planned and not realized	Annually (Quarterly, Annually)	YES
Percentage and Total services by type and provider authorization on plan of care, paid, pending and denied	Annually (Quarterly, Annually)	YES
Full Service and County Case Rate	Annually (Quarterly, Annually)	YES
• Individual Outlier • Total Enrollee Costs • Cumulative Individual Outlier Reimbursement, planned and realized	Annually (Quarterly, Annually)	YES

Projected and Actual Annual Aggregate Financial Deficit or Surplus	Annually (Quarterly, Annually)	YES
Exhibit F		
Full Service and County Rate	Annually (Quarterly, Annually)	YES
Actual vs. Authorized or planned cost per Enrollee per month	Annually (Quarterly, Annually)	YES
Cost per month by Council Agency referral slot	Annually (Quarterly, Annually)	NO
Cost per month by Council Agency Service Utilization	Annually (Quarterly, Annually)	NO
Medicaid billed, received by Service type, Provider and number of clients served	Annually (Quarterly, Annually)	YES
Comparison of realized Medicaid to projected Medicaid	Annually (Quarterly, Annually)	YES
Compare monthly 3rd party revenue to budgeted projection	Annually (Quarterly, Annually)	NO
Compare actual Administrative Cost, Care Management Costs, and Direct Services Costs to approved and projected costs	Annually (Quarterly, Annually)	NO
Expenses authorized or formally planned but not reported monthly	Annually (Quarterly, Annually)	NO
Actual Outlier Costs vs. Projected amount	Annually (Quarterly, Annually)	NO
Actual Aggregate Financial Surplus/Deficit vs. Projected	Annually (Quarterly, Annually)	YES
Service type, unit, Provider, cost & Enrollee by planned, authorized, pending, delivered and denied	Year one 04/30 and 07/31	YES
Accounts aging data	Year one 04/30 and 07/31	NO
Proportion of bills submitted by Providers as required by Provider Contract	Year one 04/30 and 07/31	NO
Proportion of bills paid by Beech Acres w/in 120 days of Service delivery date	Year one 04/30 and 07/31	NO
Medicaid revenue authorized and realized in Monthly reports	Annually (Quarterly, Annually)	YES

Hamilton County Mental Health Board or Ohio Department of Mental Health Medicaid audit results	Within 7 days of an audit (Annually)	YES
Budget to authorized and budget to actual	Monthly (Within 25 days of month end) (Quarterly, Annually)	YES

Source: FCFC

* Beech Acres' CFO has stated that all reports have been submitted as required. However, **Table 3-13** shows the reports received and documented by the FCFC Contract Manager.

As shown by the varied reporting requirements, the Council agencies and contract manager do not have a consolidated means to examine the financial position of Creative Connections. Several of the reports listed in exhibit F are not complete. In addition, some of the reports have only recently been implemented. Beech Acres has attributed the limited reporting to the past CFO and staff. Only since the hiring of the current CFO have the majority of reports been produced at the contractually specified rate of frequency. However, a disconnect remains between the types of reports used by Council Agency fiscal personnel and the format of existing reports. Beech Acres financial personnel have not attempted to tailor financial reports to specific issues, aggregate data to show comprehensive statistics, or even combine reports required within the same reporting periods.

The variance in financial reporting requirements and outcomes may result from the absence of specific financial management and reporting requirements usually outlined in an RFP. By delineating what information would be required for the proper monitoring of contract costs, an RFP provides all parties involved in the pre-contract phase with a clear understanding of expected outputs and outcomes.

In addition to the reports in **Table 3-13**, financial information is also conveyed through exhibits L, M and N, through the Beech Acres' Continuous Quality Management Program (CQMP). Further analysis of the effectiveness of the Continuous Quality Management Program can be found in the ***performance measurement*** section of the report. In accordance with the CQMP program, financial incentives are tied to the observance of reporting deadlines. These exhibits contain information on the following performance indicators and standards:

- **Exhibit L:** Annual Project Budget
- **Exhibit M:** Calculation of Administrative Cost
- **Exhibit N:** Self Referral Standards

The exhibits produced through the CQMP are not correlated with financial reports in exhibits B and F. Also, personnel responsible for the compilation of CQMP reports do not consult with or provide draft reports to the Beech Acres financial department or Creative Connections management.

R3.15 Creative Connections should produce all contractually specified reports within the appropriate time frames as outlined in the contract. FCFC should serve as a vehicle to modify reports to Council Agency needs by communicating all reporting changes between the Council agencies and Creative Connections and Beech Acres. Each member of the Council Agency should also be informed of clinical and financial communication with Beech Acres by FCFC and records should be maintained to serve as a reference for future policy-making discussions.

In addition, all Beech Acres and Creative Connections departments should coordinate reporting efforts and develop a more comprehensive reporting structure. Current reporting methods limit the contract manager and Council agencies' ability to easily identify trends and potential problems. Limited analysis also precludes Creative Connections from highlighting important data. By coordinating and annotating reports, Creative Connections and Beech Acres would be able to provide the contract manager and Council agencies with a better portrayal of program achievements and shortcomings.

F3.24 The role of the FCFC contract manager is not defined in the contract. The contract manager currently reviews financial data and serves as an intermediary between Creative Connections and Beech Acres and the Council Agency representatives. In general, a contract manager should be provided specific job duties to fulfill on behalf of the contract holder(s). Neither the County agreement or the Beech Acres contract mention the role or specified function of the contract manager.

R3.16 The role of FCFC and the contract manager should be more clearly defined through an amendment to the current contract and the inclusion of such language in future contracts. The contract manager position should be provided a level of autonomy so that the management of the contract is coordinated through a single entity. The contract manager should also be provided with a greater ability to delegate some of the tasks executed by the current position, such as the detailed analysis of data. With a revised job function, the contract manager would be better able to serve as a conduit between the agencies and the contracted entity. Preliminary steps, such as creating a permanent fiscal subgroup and developing policies and procedures for the contract manager position would enhance the current role of the contract manager.

F3.25 County officials approached Beech Acres to take over care management from FCFM. Because the client population required immediate transition of services, the Council agencies did not use a formal RFP process. Instead, the contract with Beech Acres was developed over several months and was not signed by the contract parties until well into the first contract year.

The purpose of an RFP is to communicate the unique business requirements of an organization prior to formalization of a contacted relationship. The RFP should contain detailed criteria to identify vendors who are qualified to execute the requirements of the contracting organization. In addition, the RFP should clearly state the expected outputs and outcomes of the relationship so that interested parties can determine the feasibility of the relationship prior to entering into a formalized agreement.

As one of the three agencies which carried out Care Management functions for FCFM, Beech Acres was familiar with the vision of the Council agencies in serving the client population, and had the financial resources to ensure fiscal solvency for the continuation of services. However, the unpreparedness of Beech Acres to meet many of the contract stipulations, coupled with the vague and conflicting language included in the contract, has contributed to the ongoing noncompliance with contract requirements.

R3.17 In future contractual agreements between the Council agencies and an MCO, the requirements and expectations of the relationship should be detailed through a formal RFP. SAMHSA suggests that an RFP contain the following criteria:

- Federal, State and county insurance, and other financial reporting regulations;
- Deadlines and required format for financial reports;
- Requirements for reporting financial expenditures for both administrative and service costs;
- Reporting requirements for each of the applicable funding sources;
- Action plans for assuring fiscal solvency;
- Stipulations of the right of the purchaser to audit;
- Establishment of what degree financial and clinical risk may be transferred from the MCO to providers;
- Mandatory provision that in capitated subcontract arrangements, MCO's must receive detailed reports from providers enabling the MCO to provide adequate information to the purchaser; and
- Indication of processes used for reconciling costs at the end of a contract year.

During the RFP process, prospective MCOs should submit sample reports. By reviewing the sample reports, the Council agencies can determine if current reporting procedures provide adequate disclosure, and identify necessary modifications to either the format of reports or existing software. The above criteria can be expanded to include specific requirements for the contract manager and for financial links to utilization review and provider network management. More information on criteria for RFP's in the establishment of risk-sharing arrangements is available at www.samhsa.gov.

Pooled Funding Agreement

F3.26 After the 1997 bankruptcy of FCFM and the expansion of Creative Connections, the Council agencies implemented a new management structure with FCFC as the intermediary. The new structure included a designated contract manager and a new contract between FCFC and the Council agencies. The Council agencies, prior to contracting with FCFM, developed a shared funding agreement based on the number of children served by each agency that met specific criteria for critical needs. The Council agencies identified 286 children who would be appropriate for the program and divided the costs among the agencies based on their percentage of children out of all children served. The original shared cost percentages are shown in **Table 2-1**. FCFM developed a subsequent analyses of utilization by each agency and the associated cost but the percentage structure was not amended during the FCFM or Creative Connections' contract periods. Also, because Beech Acres was involved in the managed care system in a limited fashion, some of the financial costs and risks associated with the provision of care were shared between Beech Acres and the Council agencies, a common practice in MCO agreements. The structure of the shared risk environment is shown in **Table 3-14**.

Table 3-14: Shared Risk between Beech Acres and the Council Agencies

Contract Year	Amount of Risk	Cost Responsibility
Contract Year One[1]	$333,333 or less	Beech Acres
	$333,334 to $1,900,000	Shared equally between Beech Acres and Council Agencies
Contract Years Two through Four[1]	$500,000 or less	Beech Acres
	$500,001 to $1,900,000	Shared equally between Beech Acres and Council Agencies

[1] Contract Sec. 4.3.2

While the shared risk associated with the contract places a large financial encumbrance on Beech Acres, the use of managed care principles should reduce the associated risk. However, Beech Acres has not implemented several standard managed care practices thereby increasing the risk and pushing Beech Acres financial liability for the agreement beyond the parameters shown in **Table 3-14**.

C3.2 The current pooled funding agreement represents a delicate balance between what the Council agencies can afford, or elect to contribute, and their actual number of referred clients in the system. The level of coordination between the Council agencies and Beech Acres, coupled with the benefits received by the client population, outweigh the inequities of cost distribution or risk sharing.

As there is no existing, comparable program of this nature, the continued active participation of each of the Council agencies is crucial to the success of this program. The Council agencies have crafted a contract which maximizes each of the parties' strengths to the extent that the most problematic clients in the geographic area are able to receive high-level behavioral health care. However, this issue may need to be revisited if funding for any or all of the Council agencies is reduced.

R3.18 Costs for program services should be closely monitored by all parties to the contract and Beech Acres should immediately implement managed care principles within Creative Connections. The standard managed care principles, such as network development, longitudinal studies, utilization reviews, Medicaid maximization or third party funding, credentialing and provider profiling, and coordinated case management have not been implemented (see also ***performance measurement*** and ***technology*** sections). Although outlier costs have impacted the risk, the delayed implementation of cost controlling managed care techniques and the sporadic reporting of crucial information continue to place Beech Acres at an elevated financial risk.

Performance Measurement

Performance Measures

The following list of performance measures was used to conduct the review of the performance measurement and network management component of the contract between Creative Connections, FCFC and HCDHS and the other Council agencies.

- Assess the development and implementation of the Continuous Quality Management Program (CQMP) as required by the contract
- Assess the capturing and reporting capabilities of Creative Connections regarding performance measures and benchmarks as stated in the contract
- Analyze the application of financial penalties based on established performance indicators as stated in the contract
- Evaluate the FCFC and Council agencies' monitoring of Creative Connections
- Assess Creative Connections ability to coordinate and monitor the service provider network
- Assess the implementation of service provider profiles
- Review credentials, licensing and provider insurance based on contract provisions
- Assess client rights and confidentiality policies and procedures
- Review policies and procedures governing client complaints and grievances in relation to contract requirements

Findings / Commendations / Recommendations

Continuous Quality Management Program

F4.1 The Creative Connections Agreement requires Beech Acres to establish, coordinate, and maintain a Continuous Quality Management Program (CQMP) consistent with appropriate industry standards. The CQMP must comply with standards and reporting requirements described in Exhibits B through N of the contract. Although there are no specific standards for a managed care program identical to Creative Connections, a committee of representatives from HCDHS, FCFC, the Mental Health Board, and Beech Acres developed the performance indicators and standards in Exhibits B through N of the original agreement based on Child Protection Oversight and Evaluation (CPOE) outcome indicators, Medicaid standards, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. Beech Acres CQMP is a component of its accreditation by the Council on Accreditation for Children and Family Services (COA) and certification by the Ohio Department of Mental Health (ODMH).

COA accredits organizations based on two sets of standards, organizational and service specific. COA's organizational standards include the following:

- Organizational purpose and relationship to the community;
- Continuous Quality Improvement Process;
- Organization stability;
- Management of human resources;
- Quality of service environment;
- Financial and risk management;
- Professional practices;
- Person and family-centered assessment and planning; and
- Person and family-centered service delivery processes.

COA's service standards cover elements of practice that are unique to over 50 areas accredited by their organization. The two sets of standards together create a comprehensive picture of what is needed for sound organizational functioning. Beech Acres meets COA standards and is scheduled for COA re-accreditation in May 2001.

C4.1 Beech Acres has met the contract requirements for the CQMP through COA accreditation. COA accredits the organization as a whole versus accrediting specific agency programs. Beech Acres accreditation demonstrates that the organization meets the performance standards for quality child welfare services. In addition, the Council agencies may receive a higher level of assurance in the quality of services than may be the case with non-accredited organizations.

F4.2 The contract requires that Creative Connections establish a specific clinical Quality Improvement Program (QIP) as a component of the Beech Acres CQMP. Exhibit J of the contract outlines the goals and elements of the Quality Improvement Program. **Table 4-1** shows the contractual requirements and Creative Connections' compliance with each component of the QIP.

Table 4-1: Quality Improvement Program Requirements

Contract QIP Requirement	Achieved by Creative Connections	Comments
Written Quality Improvement/Evaluation Plan	Partially	As a component of the Beech Acres QA/I plan
Staff person responsible for overseeing the QIP	Partially	PIQA Director dedicates 25% of her time
Monthly QIP meetings with individuals responsible for monitoring and implementing services	Partially	CC Executive Director participates in monthly Beech Acres QA/I team meetings
Written documentation of all QIP meetings	Yes	Minutes maintained by PIQA
Regular review of performance data as described in the contract and in accordance with ODMH service standards	No	Performance review is incomplete.
Annual evaluation of the effectiveness, high quality, and responsiveness of services	No	Data reported but no analysis of information.
Information system support to monitor defined aspects of high quality, responsiveness and standards/indicators of services as stipulated in the exhibits and the contract	No	Implementation of information systems is incomplete.
Regular Quality Improvement reports as stipulated in the contract	No	Regular reports are provided, but do not provide information as stipulated in the contract.
At least one focus group annually with providers, clients, family members and custodians to assess impact and effectiveness of services	Yes	Focus groups are conducted at least annually.
Client satisfaction surveys for providers, Council agencies, clients, and family members to assess high quality and responsiveness of services	Yes	Client satisfaction surveys are used to assess services.
Written standards, methods, and processes to describe how Beech Acres shall deliver, evaluate, and monitor the performance, high quality and responsiveness of services	Partially	QA/I plan does not contain processes for analyzing captured data.

Source: Exhibit J of the Beech Acres' Contract and interviews with Beech Acres staff

As shown in **Table 4-1**, Creative Connections does not fully meet the contractual requirements for the QIP. As a Beech Acres' program, Creative Connections quality assurance and improvement (QA/I) activities are the responsibility of the Process Improvement and Quality Assurance Department (PIQA). Creative Connections' QA/I activities are addressed as a component of the overall Beech Acres QIP and do not adequately meet the requirements of the contract. Although a separate Quality Assurance Report is prepared for Creative Connections, the report is based on the Beech Acres QA/I plan and no references are made in the reports to delineate Creative Connections contract

requirements from other indicators. The FY 2000 Quality Assurance Report states that the "...sections are based on indicators in Exhibit B (partial), C (all), D (all), and G (all)." The report does not provide an explanation for excluding other indicators or make reference to other reports which may provide this information. Without appropriate data and explanations, the Council agencies ability to determine the program outcomes is compromised.

R4.1 Beech Acres should ensure that QA/I activities meet the requirements of the contract and the needs of the Council agencies, as well as adequately address the performance of Creative Connections as a managed care, contracted entity. Beech Acres can enhance the QA/I functions of Creative Connections by implementing the following:

- Designate a QA/I position within Creative Connections to be responsible for all contractually required QIP processes. Beech Acres should conduct a job audit to determine if current staff can be reallocated to the QA/I position.

- Ensure that Creative Connections QA/I plan and reports are aligned with the contract before incorporation into the agency-wide QA/I plan and reports.

- Ensure that Creative Connections QA/I staff coordinates with financial and information systems personnel to provide the best information for evaluating outcomes.

By dedicating a Creative Connection's staff member to QA/I activities, Creative Connections could ensure that these activities provide the contractually required information to evaluate the program's effectiveness, enhance cost efficiency, and develop improvement plans. Additionally, Creative Connection's will have more control over the information provided to the contract manager and will be able to ensure compliance with contract requirements.

F4.3 Beech Acres Program Evaluation Department is also involved in quality assurance and evaluation activities for Beech Acres and Creative Connections. For FY 2000, the Program Evaluation Department proposed a study of the effectiveness of the Creative Connections program through integration of data from Beech Acres' evaluation, quality assurance, and financial databases to identify the appropriate service mix and the cost of those services. However, the subsequent program evaluation report did not provide this analysis and provided little detail on evaluation of areas directly related to Exhibit B, reimbursable performance indicators. For example, the evaluation indicated that the number of children requiring residential treatment and /or hospitalization as well as the length of stay in each placement were increasing but provided limited information and/or interpretation of these results. A thorough understanding of this information is important because reimbursable

performance indicators in Exhibit B are subject to financial penalties (see the ***application of financial penalties*** subsection).

The FY 2000 Creative Connections Program Evaluation Report did provide detailed analyses of Exhibit G Quality of Care indicators to demonstrate the effectiveness of the program. Results from standardized psychological and behavioral tests indicated significant improvements in level of functioning for children enrolled in the Creative Connections program.

R4.2 The Program Evaluation Department should perform detailed analyses of performance deficiencies identified by Creative Connections QA/I staff, the Council agencies and the contract manager to determine the contributing factors and recommend possible solutions and action plans to improve performance. The Program Evaluation Department should also work closely with Beech Acres' financial management employees and Creative Connections staff to conduct the analyses of service mix and associated costs. The results of this analyses should be used by Creative Connections management in planning for service needs and reporting program costs to the Council agencies and contract manager.

F4.4 The contract does not contain a performance measurement exhibit. Instead, performance indicators are spread throughout 11 separate exhibits of the contract. **Table 4-2** provides an example of a performance indicator, measure, benchmark, and data/reporting requirements from Exhibit B of the contract.

Table 4-2: Performance Indicator Example

Indicator	Measure	Benchmark	Data/Reporting
Clients receive institutional treatment only when essential to decrease impairment - decreased average and median length of stay for Clients in institutional placements.	Demonstrated decrease in number of days clients stay in institutional placements.	A 10 percent decrease in the number of Clients in institutions at time of Enrollment and 4 months later.	Average Length of Stay "ALOS" & Median for Clients in institutions at time of enrollment and 4 months later. Monthly, quarterly, and year to date data.

Source: Beech Acres Contract, Exhibit B

As shown in **Table 4-2**, the indicator, measure, benchmark, and data/reporting requirements are not closely correlated. The indicator shown in the example requires an analysis of the placement needs of the client while the measure requires demonstration of a decrease in the number of days an client resides in an institutional placement. Also, the benchmark requires a decrease in the number of clients in institutions versus the number of days. These discrepancies are found in several of the contractually required performance measures and

may have increased the difficulty in establishing CQMP reporting in compliance with the requirements of the contract (see also **R4.3** and **C4.2**).

F4.5 To address ambiguity or conflicting nature of the original performance indicators (PI) and contract exhibits, Creative Connections management developed a proposal to amend the standards and streamline the contract exhibits. The proposal, with amendments from the Council agencies, was adopted by the Intersystem Oversight Committee and sent to the Hamilton County Prosecutor's Office for review. **Table 4-3** compares the original exhibits and performance indicators to the proposed exhibits and amended standards.

Table 4-3: Comparison of Original and Proposed Exhibits to the Agreement between FCFC and Beech Acres

Original Exhibits	Proposed Exhibits	Changes
A- Direct Services	A- Direct Services	None
B-Reimbursable PIs	B- Performance & Reimbursable PIs	• Combined PIs from B, C, F, G, and I. • Measures, benchmarks, and data requirements have been modified. • Measures/benchmarks are broken down into clinical and fiscal. • More outcome oriented measures/benchmarks. • Penalties are weighted, but still total the original contract maximums.
C- Care Mgmt. Indicators	C- Miscellaneous	Includes subsections: • Mandatory Corrective Action Plan (formerly K) • Annual Project Budget (formerly L) • Calculation of Administrative Cost (formerly M) • Care Mgmt. Standards & Responsibilities (formerly D) • Quality Improvement (formerly J) • Self Referral Standards (formerly N)
D-Care Mgmt. Standards & Responsibilities		In Proposed C, Section 4
E- Transitional Data Plan		Eliminated
F- Fiscal PIs		In Proposed B
G- Quality of Care Indicators		In Proposed B
H- Disenrollment & Flagged Cases Policy		Eliminated
I- Utilization Review & Indicators		In Proposed B
J- Quality Improvement		In Proposed C, section 5
K- Mandatory Corrective Action Plans		In Proposed C, section 1
L- Annual Project Budget		In Proposed C, section 2
M - Calculation of Administrative Cost		In Proposed C, section 3
N - Self Referral Standards		In Proposed C, section 6
O - Related Ohio Revised Code Statutes		Agreement, section 8.1.3.1
P - Policies		Eliminated

Source: Created by AOS staff from Beech Acres contract exhibits and proposed amendments to the exhibits.

The proposed changes to the performance indicators reduce duplication, consolidate similar measures, and revise measures and benchmarks to be more consistent with the indicator. The revised measures and benchmarks are more focused on outcomes and evaluation rather than on reporting outputs. Also, the revised measures and benchmarks integrate clinical and financial benchmarks within each indicator to show quality services within constrained costs. Amendments to the corresponding performance penalties are also more reflective of this programmatic goal (see **F4.16**) and should prove more utilitarian to the contract manager and Council agencies.

In general, the contract specified benchmarks should satisfy the following criteria:

- **Results** - Focusing primarily on outcomes and outputs;
- **Selectivity** - Concentrating on the most important indicators of performance;
- **Utility** - Providing information of value to the agency and decision-makers;
- **Accessibility** - Providing periodic information about results; and
- **Reliability** - Providing accurate, consistent information over time.

Original and revised measures satisfy only a portion of the above criteria and limit the Council agencies' ability to monitor the outcomes of the program. Beech Acres has not implemented adequate information systems or reporting procedures to provide consistent, accurate information that can be used for decision-making by FCFC and the Council agencies (see F4.10). By incorporating all aspects of the above criteria, Creative Connections, FCFC and the Council agencies can better evaluate the merits of the program.

C4.2 Creative Connections, FCFC and the Council agencies collaborated to streamline the contract exhibits and amend the performance indicators. The revisions reduced duplication, consolidated similar measures, and revised measures and benchmarks to be more consistent with the indicator. The revised benchmarks and measures better address the goal of achieving quality and containing costs by integrating clinical and financial measures within each indicator. The amendments should provide Creative Connections, FCFC, and the Council agencies with performance information that is meaningful and useful in making decisions and evaluating the program.

R4.3 Beech Acres should implement adequate information systems and reporting procedures to ensure that performance measurement information is accessible, reliable, and useful to FCFC and the Council agencies (see also ***technology*** section). The proposed standards provide the framework for an effective measurement system but viable information systems and timely and accurate reporting are necessary for monitoring program outcomes.

F4.6 Behavioral health managed care for special needs children is a relatively new area of health care operations. Few standards or outcomes exist specific to this population. However,

several organizations have made recommendations or developed standards based on experiences in managed health care and traditional behavioral health care. **Table 4-4** shows the performance measure categories identified by the Child Welfare League of America (CWLA) compared to the original and proposed performance indicators.

Table 4-4: Performance Measure Comparison

CWLA Performance Measure Categories	Original Performance Indicator	Proposed Performance Indicators
Cost of system performance	Responsible Fiscal Management.	Individual Plans of Care, ISPs, and quarterly individual client reports are responsive to needs of clients and Council agencies. (Fiscal Measures) Adequately monitor & track financial status, quality improvement, and aggregate reporting of contract requirements.
Appropriateness of services	Clients receive institutional treatment only when essential to decrease impairment. Placement services are stable and meeting treatment needs.	Clients receive residential treatment only when essential to decrease impairment. Placement services are stable and meeting treatment needs. Contractor will perform designated Council agencies functions.
Access to services	Appropriate services are available within region and county to meet clients' needs.	Appropriate services available within region and county.
Positive client outcomes	Clients receive direct services in the most family/community like placements.	Clients receive residential treatment only when essential to decrease impairment.
Quality of providers	Services are provided in a responsive and high quality manner. (Exhibit G)	Services for client are "high quality responsive," and appropriate in meeting desired outcomes.
Satisfaction	Clients, family members, custodians, Council agencies, and providers are satisfied with services. (Exhibit G)	Services for client are "high quality responsive," and appropriate in meeting desired outcomes.

Source: Created by AOS staff based on Beech Acres' contract exhibits and proposed amendments to the exhibits.

The original and proposed performance indicators included measures consistent with the categories recommended by CWLA and other national organizations. By meeting these reporting and measurement standards, Creative Connections should be able to better provide cost efficient services and quality care to the Council agencies and the program clients. However, Beech Acres has not demonstrated a concrete methodology for incorporating results into the decision making process. An effective performance measurement system also

should provide information that is meaningful and useful to decision-makers, well-supported by management and integral in an entity's daily operations. Because Beech Acres has not established a method for implementing the outcomes of performance measurement, the data remains largely unused.

C4.3 By implementing standards consistent with best practices, Creative Connections has the ability to effectively evaluate the quality of services provided and the cost effectiveness of those services. This information should help Creative Connections to determine the appropriate service mix and fiscally responsible cost for providing those services. The proposed changes should provide the Council with a better framework to monitor, evaluate and manage the Creative Connections program.

R4.4 Creative Connections, FCFC and the Council agencies should study the outcomes of performance measures over time. Outcomes should be used by the Council agencies and Creative Connections to determine the appropriate service mix and program costs. The Council agencies and Creative Connections should use this information in decision-making about daily operations as well as planning for future development of the program.

F4.7 Performance measurement requires the implementation of an information system capable of tracking and integrating data elements to support management's performance information reporting needs. Creative Connections has not completed implementation of its information system, UNI/Care, and management indicated that the system will not meet the data and reporting needs as required by the contract (see the ***technology*** section). Additionally, Creative Connections has not developed comprehensive procedures for capturing and reporting data. Care managers do not entered performance data into UNI/Care in a timely or consistent manner. This deficiency was noted by HCDHS auditors on several occasions.

Creative Connections recently implemented new procedures to address performance data entry deficiencies. The new procedures directed administrative assistants to enter the data collected in the field by the care managers. During the audit review process, though, Beech Acres management indicated that the procedure had been changed again and administrative assistants and care managers have joint responsibility for data entry. Creative Connections believes the change in procedures will result in more timely and accurate entry of information.

R4.5 Creative Connections should fulfill CQMP reporting as required by the contract. To implement the CQMP reporting, Creative Connections should ensure that adequate information systems, appropriate procedures and trained personnel are in place. Creative Connections should use the proposed performance indicators as a framework for developing the systems and procedures for monitoring, evaluating and improving quality, and reporting progress toward CQMP goals as required by the contract.

F4.8 Although performance indicators are consistent with recommended performance standards, some measures may be difficult to meet given provider conditions within Hamilton County. Performance measures require a decreased use of out-of-region institutional placements and out-of-county foster care placements as defined in the contract. According to Creative Connections management, these measures are difficult to achieve because of the limited number of institutional and foster care providers in Hamilton County and the region. Institutions may have waiting lists for several months even though clients require immediate placement. Additionally, local providers may not offer services to meet the specialized needs of Creative Connections' client population. According to Creative Connections staff, programs for sex offenders, autism and short-term stabilization are especially needed. **Table 4-5** shows the number of children by location and costs for the first quarter of FY 2000-2001.

Table 4-5: Clients by Location and Costs

Provider Location	Number of Providers	Distance from Cincinnati	Number of Children Served	Percent of children in location	Aggregate Costs	Percent of total costs	Costs per child
Cincinnati, OH	29	0 mi.	269	70.8 %	$558,277	32.0 %	$2,075
Indianapolis, IN	5	121 mi.	32	8.4 %	$370,898	21.3 %	$11,591
Louisville, KY	3	105 mi.	11	2.9 %	$365,813	21.0 %	$33,256
Columbus, IN	1	92 mi.	6	1.6 %	$107,074	6.1 %	$17,846
Dayton, OH	2	49 mi.	14	3.7 %	$61,467	3.5 %	$4,391
Bloomington, IN	1	141 mi.	5	1.3 %	$61,250	3.5 %	$12,250
S. Burrough, MA	1	819 mi.	1	0.3 %	$33,740	1.9 %	$33,740
W. Liberty, OH	1	98 mi.	5	1.3 %	$31,517	1.8 %	$6,303
Fairfield, OH	1	19 mi.	6	1.6 %	$28,151	1.6 %	$4,692
Grove City, OH	1	93 mi.	6	1.6 %	$25,347	1.5 %	$4,224
Toledo, OH	1	198 mi.	5	1.3 %	$21,420	1.2 %	$4,284
Pedro, OH	1	145 mi.	6	1.6 %	$16,030	0.9 %	$2,672
Ypsilanti, MI	1	242 mi.	1	0.3 %	$15,200	0.9 %	$15,200
Newark, OH	1	138 mi.	1	0.3 %	$13,268	0.8 %	$13,268
Smithville, OH	1	204 mi.	2	0.5 %	$8,714	0.5 %	$4,357
Delphos, OH	1	138 mi.	2	0.5 %	$8,140	0.5 %	$4,070
Lacross, WI	1	577 mi.	1	0.3 %	$6,922	0.4 %	$6,922
Worthington, OH	1	113 mi.	2	0.5 %	$5,022	0.3 %	$2,511
Trotwood, OH	1	55 mi.	1	0.3 %	$2,790	0.2 %	$2,790
Peebles, OH	1	65 mi.	4	1.1 %	$2,750	0.2 %	$688
Total/Average	**55**	**170.6 mi.**	**380** [1]	**100.0 %**	**$1,743,789**	**100.0 %**	**$4,589**

Source: Created by AOS Staff from Creative Connections Provider Information for FY 2000-2001, First Quarter

[1] The number reflects all children enrolled at any time during the first quarter of FY 2000-2001.

Table 4-5 shows that 269, approximately 71.0 percent, of the clients were served in the Cincinnati area, an additional 28.0 percent were served within the region and that less than 1.0 percent (3 children) were served outside of the region. Although the majority of the children were served locally, the majority of the costs were to providers outside of Hamilton County. Providers outside of Hamilton County are normally used for foster care and institutional placements which tend to have higher costs than community services. Creative Connections management stated that they are working on building informal partnerships with local providers to encourage the development of needed services while maintaining cost

efficiencies. However, these relationships are not formal partnerships guided by written agreements and Creative Connections is not guaranteed the beds for its clients.

According to studies by SAMHSA and the General Accounting Office (GAO), similar managed care entities in other states are developing partnerships or coalitions with service providers in order to meet the needs of their clients. By developing formal partnerships, Creative Connections could better ensure that service providers are committed to the program's mission of developing needed services in the community while maintaining cost efficiencies. Additionally, many managed care entities establish the provider network through a competitive bidding process (see **F4.18**). By using a competitive approach, Creative Connections could establish criteria in the RFP that require service providers to collaborate with Creative Connections in the development of services to fill the gaps identified by utilization reviews (see **R4.7**).

R4.6 The Council agencies should require Creative Connections to formalize partnerships with local providers. The formal partnerships should be used to develop services to meet client needs identified through utilization review processes. By developing formal partnerships, Creative Connections can ensure that service providers are committed to developing services to meet the needs of clients which will also aid Creative Connections in better controlling costs. Providing services locally is consistent with the philosophy that children are better served in their own communities because families and significant others can be more involved in the treatment.

Creative Connections should request the assistance of HCDHS and the Council agencies in developing the formal partnerships needed to fulfill client care needs. The Council agencies could potentially identify larger populations requiring scarce services or could increase Creative Connections' bargaining power through economies of scale.

F4.9 Clients referred to Creative Connections may be in an out-of-region placement at the time of referral. Following an assessment, care managers must decide the most appropriate placement to meet the identified needs. Accreditation organizations recommend that performance measures emphasize appropriateness of services (see **F4.6**). The original contract performance measures focused on the location of the placement without analysis of the appropriateness of the placement and Creative Connections may have been penalized for choosing the most appropriate treatment environment. However, because utilization review has not been implemented, Creative Connections cannot demonstrate the appropriateness of placements.

The proposed performance measures state that "100 percent of clients placed.... out-of-county and out-of-region are in clinically appropriate settings as identified by Quality Assurance/Utilization Review(QA/UR) policies and procedures." This measure focuses on

the appropriateness of the placement and the best fit with the child's needs. In order to meet this standard, Creative Connections must develop the corresponding QA/UR policies and procedures to ensure that the child is in the most clinically appropriate placement. Creative Connections has not been able to provide the data to substantiate clinical appropriateness of current out-of-region placements or to identify gaps in services locally. Creative Connections has not adequately tracked and assessed the number of children placed out-of-region in relation to the appropriateness of the placements.

R4.7 Creative Connections should develop and implement the necessary policies and procedures to ensure that clients are in clinically appropriate settings. Creative Connections should fully use its information systems to provide the information necessary to determine the appropriateness of placements out-of-county and out-of-region and to determine gaps in services locally. Creative Connections can then initiate partnerships with local providers to develop services to fill these gaps and meet the needs of the Council agencies clients (see **R4.6**).

Capturing and Reporting for Performance Measures

F4.10 The contract requires Creative Connections to provide certain performance measurement reports to FCFC. Creative Connections reports do not meet contractual requirements (see **F4.2**) and do not provide analysis of the captured data. On January 6, 2000, FCFC requested a Corrective Action Plan (CAP) from Creative Connections pursuant to Exhibit K of the contract to ameliorate reporting issues. FCFC requested that the CAP address deficits in core reporting requirements from Exhibit B, C, F and G. Creative Connection's executive director provided the CAP to FCFC on January 28, 2000. **Table 4-6** shows the referenced performance indicator, Creative Connections response, and FCFC's subsequent year-end evaluation.

Table 4-6: Corrective Action Plan Evaluation

Performance Indicator	Creative Connections' Response	FCFC Evaluation
B-1(a) Maximized Medicaid Revenue	• Insufficient staff & faulty communication • New CFO will analyze • POC database to be used • Pending Medicaid claims will be pulled from adjudication database • Need accurate ARA information from Mental Health Board	• New staff dedicated to financial reporting • New CFO hired 3/00 • Status of POC database unknown • Medicaid data reported after new CFO hired • No problems with ARA transfers after 4/00 • **Medicaid data not reliable due to lag time in provider submission of claims**
B-2(a) & (b) Institutional Length of Stay	• Delayed by unforseen problems with UNI/Care implementation • Staff to receive training on definitions that cause confusion	• Length of stay data has been reported in quarterly reports • **UNI/Care continues to be a problem**. • All staff undergoing UNI/Care training
B-3(a) & (b) Services in County & Region	• Delayed by unforseen problems with UNI/Care implementation • Multi-disciplinary effort to collect and report statistics beginning 2/15/00	• **Inconsistent information provided on clients location within the region** • Number of children outside of region provided consistently
B-4(b) Family/Community Placement	• Delayed by unforseen problems with UNI/Care implementation	• **No baseline data provided** • **No indication that a system exists to measure this indicator**
C-1(e) Face to Face Contact	• Delayed by unforseen problems with UNI/Care implementation	• **HCDHS Quarterly Chart Audits indicate this is still a problem** • **FCFC not advised that this documentation is affected by UNI/Care implementation**
F-1(b) Quarterly Fiscal Reports	• Realized Medicaid costs will be computed monthly • Projected and net costs per client are reported in the Outlier Report • Medicaid revenue authorized and realized to be computed • Budget to authorized and budget to actual will be reported beginning 2/15/00	• **Actual costs only reported at the time of Outlier invoicing** • **Monthly Medicaid updates have not been reported** • Projected costs submitted monthly • **Actual Outlier costs reported infrequently** • **Budget to actual updates reported infrequently**

G -1(a) & (b) Quality of Care	• No problems exist reporting MUI and restraint data • Identifying and tracking outlier population for Utilization Review has been difficult • Data for Utilization Review does not exist in a single database • Implementation of electronic ISP should facilitate • Delayed by unforseen problems with UNI/Care implementation	• MUI and restraint data consistently reported • **Sampling for Utilization Review continues to be below expectations**

Source: Created by AOS staff from information contained in the FCFC Annual Report, FY 1999-2000**.**
Note: Bolded text indicates problems highlighted in this performance audit.

As shown in **Table 4-6**, Creative Connections continued to be deficient in meeting many of the contractual reporting requirements six months after the CAP was developed. In the CAP, Creative Connections provided reasons for the deficiencies, but did not provide detailed plans for correcting these problems. As of the time of reporting, many of the cited deficiencies have not been resolved.

R4.8 The Council agencies and FCFC should determine the reporting format and frequency necessary to provide performance data to assist in evaluation and planning efforts. Creative Connections reports should include the information required in the contract as well as an analysis of the information to indicate its origin and impact on the program. Quarterly and annual reports should provide information about program successes and failures, obstacles and plans for improvement. This level of analysis should provide all parties with the information necessary to monitor, manage and evaluate the program. **Table 4-7** provides an example of a report format that contains the necessary components.

Table 4-7: Example Report Format

Performance Measure	Benchmark	Data Source	Explanation/ Analysis	Action
Clients receive residential treatment only when essential to decrease impairment	Percent of clients served through residential treatment for reasons other than those essential to decrease impairment Percent increase (decrease) from prior reporting period	Method used to identify and track data, source of data	Reasons for placement in treatment contrary to contract stipulations	Actions to resolve placement issues

F4.11 Creative Connections indicated its difficulties in reporting were related to problems with implementing UNI/Care. Over a year after the review, UNI/Care has not been fully implemented and Beech Acres and Creative Connections management have indicated that UNI/Care is not able to meet reporting requirements. Care managers and supervisors rely heavily on manual processes to track information rather than using the automation available

through UNI/Care. The decision not to purchase the Care Management module of UNI/Care may contribute to the reliance on manual processes and to the difficulty in providing comprehensive reporting on performance measures (see ***technology*** section). The Care Management Module contains automated process that would enable care managers to use automated rather than manual systems for recording client information almost exclusively as well as produce reports on clinical utilization and quality assurance and improvement information. Although Creative Connections is unable to produce required reports, UNI/Care representatives stated that the software is able to produce the types of management reports indicated in the contract.

R4.9 Beech Acres should complete implementation of its information systems to comply with reporting requirements. Creative Connections should acquire sufficient software and electronic system interface capabilities to ensure compliance with the original Contract requirements. The additional software, such as the Care Management module for UNI/Care, would allow Creative Connections to input all data related to client treatment plans, treatment plan goals, and treatment outcomes, along with Contract performance measures (see ***software subsection of technology*** section).

Also, Creative Connections should review its business process to ensure that process are engineered to be compatible with the new software. Employing processes based on past manual practices may compromise the efficiency of the automated systems. By re-engineering its business processes, Creative Connections can ensure that the maximum utility is derived form the UNI/Care system.

F4.12 Beech Acres provides FCFC with separate financial, quality assurance and program evaluation reports. Three separate Beech Acres' departments, all independent of Creative Connections, develop the reports without integrating information or coordinating report elements. Reports are sent to FCFC directly from each department without review by or input from Creative Connections. This process does not allow Creative Connections management to have input into contractually required reports about its performance or provide FCFC with sufficient information to conduct a comprehensive evaluation of Creative Connections' performance.

According to Beech Acres long-term implementation plan for technology, the information and accounting systems would interface to integrate quality and financial information. To date, the interface has not been implemented. Furthermore, Creative Connections maintains that the information is not available through the current software package (see **F4.11**) and, despite any planned upgrades, they will continue to be unable to meet reporting requirements. Beech Acres has not directed its Finance or Technology departments to work directly with Creative Connections to resolve these issues. While the Finance and Technology departments

provide liaisons to Creative Connections, the contractual reporting requirements are not an emphasis in either department.

R4.10 Beech Acres should integrate quality, program evaluation, and financial information to fulfill Creative Connections contractually indicated reporting requirements. The UNI/Care and Great Plains interface should be implemented as soon as possible and any additional modules that would assist in reporting should be implemented. In the interim, Creative Connections should make use of its Creative Connections Leadership Team to communicate program results from all departments and to develop reports integrating and analyzing the results of financial and care management information.

The contract manager should require Creative Connections to present the results of annual reports to the Council agencies. This forum could facilitate increased communication among the parties and enhance Creative Connections' understanding of the desired outcomes and the progress necessary to achieve those outcomes.

F4.13 The contract contains a large number of measures which are dispersed throughout the contract and exhibits. **Table 4-8** shows the number of reporting requirements and exhibits referenced by category as identified by the contract manager.

Table 4-8: Contract Reporting Requirements

	Financial	Quality	Other
# of Reporting Requirements	25	50	22
# of Exhibits Referenced	3	3	5

Source: Created by FCFC Contract manager based on Beech Acres Contract.

The number of reporting requirements and their placement throughout the contract make it difficult to determine if all information is being reported in compliance with the contract. Additionally, the priority or importance of the various reporting requirements in relation to one another is unclear. As stated in **F4.4**, data and reporting requirements may not correlate with the corresponding performance indicator, measures, and benchmarks stated in the contract. These factors increase the difficulty in creating meaningful reports that provide necessary management information while complying with the contract.

Recommended best practices for establishing a measurement program similar to Creative Connections suggest beginning with two or three performance measures during the first year and slowly adding standards over the following years of the contract. By initially limiting measures, providers and funders can ensure quality services while allowing time to implement the necessary systems to monitor and measure performance. Also, according to

the U.S. Department of Health and Human Services' *Contracting for Managed Substance Abuse and Mental Health Services, A Guide for Public Purchasers*, " the contract should clarify what information must be included and the time frames for submission of different types of reports."

Although the proposed contract performance indicators eliminate duplication and have streamlined the indicators into the seven reimbursable indicators (see **F4.5**), the proposed number of reporting requirements still remains high at approximately 35 data/reporting requirements. Also, although the current contract includes reporting requirements, there is a need to streamline and collapse reporting requirements to create more practical and functional management reports.

F4.14 Creative Connections' inability to collect and report performance and financial outcomes is mirrored in other managed care initiatives. Studies of similar managed behavioral health programs indicate that managed care providers, especially non-profit organizations, have not developed the data systems or the capacity to analyze performance and outcome information. The Annie E. Casey Foundation recommends in their *"Guide for Managed Care and Family and Children Services"* that data systems should be capable of the following:

- Collecting and analyzing common data across the CFSS (child and family service system)-provider system;
- Monitoring costs and service utilization and accurately projecting future resource commitments;
- Tracking clients and services;
- Providing real-time reports of operations; and
- Performing administrative functions.

Although UNI/care reportedly can provide these elements, Creative Connections and Beech Acres have been unable to fully implement a functional data system to meet contract requirements.

R4.11 In future contracts, the Council agencies and FCFC contract manager should examine contractually required performance indicators and corresponding reporting requirements to ensure that reports provide all parties with the information necessary to monitor and measure financial and quality performance. The Council agencies and contract manager should prioritize the performance indicators and corresponding reporting requirements and phase-in two or three performance indicators at a time. By initially focusing on a few performance standards, the Council agencies can ensure the quality of services while allowing the contracted entity the time to implement the necessary systems to monitor and evaluate performance.

Also, any future contract should contain a specific section devoted to operational reporting requirements. This reporting section should contain language which grants the contractor, in consultation with the contract manager, the latitude to reduce duplicate reports, and to modify the frequency of reporting to convey an exact snapshot of relevant data for a specific time frame.

Finally, the Council agencies and contract manager should ensure that performance measures are implemented and management reporting capabilities are developed upon acceptance of the contract by the contracted entity. Any critical reporting elements that remain unfulfilled by the contracted entity should be examined in relation to the needs of the contract. Continued non-compliance with reporting requirements should trigger a review of the agreement by the Council agencies. The Council agencies emphasis on both service delivery and cost containment requires management information for program decision making purposes. Noncompliance should not persist through the duration of the contract.

Application of Financial Penalties

F4.15 The contract provides for the application of performance indicator penalties if Beech Acres and Creative Connections "materially fail... to meet or adequately demonstrate" the various outcomes as described in Exhibit B of the agreement. FCFC conducts an annual evaluation of Creative Connections based on the seven reimbursable performance indicators in Exhibit B of the contract. Performance indicator penalties are deducted from the next quarterly payment made to Beech Acres by FCFC. **Table 4-9** shows the application of performance indicator penalties for the first two years of the contract.

Table 4-9: Application of Financial Penalties

Contract Indicator #	Max Penalty FY 1998-99	Assessed Penalty FY 1998-99	Percent of Max Assessed	Max Penalty FY 1999-2000	Assessed Penalty FY 1999-2000	Percent of Max Assessed	Percent Increase (Decrease) FY 1998-99 to FY 1999-2000
B1.	$14,355	$4,785	33.3%	$14,355	$9,570	66.7%	50.0%
B2.	$14,355	$14,354	100.0%	$14,354	$14,354	100.0%	0.0%
B3.	$14,355	$14,354	100.0%	$14,354	$7,177	50.0%	(50.0)%
B4.	$14,355	$14,354	100.0%	$14,354	$14,354	100.0%	0.0%
B5.	$14,355	$14,355	100.0%	$14,354	$14,354	100.0%	0.0%
B6.	$14,355	$14,354	100.0%	$14,354	$0	0.0%	(100.0)%
B7.	$14,370	$10,765	74.9%	$14,354	$14,354	100.0%	25.0%
Total	**$100,500**	**$87,321**	**86.9%**	**$100,479**	**$74,163**	**73.8%**	**(15.1)%**

Source: FCFC Annual Reports FY 1998-99 and FY 1999-2000

FCFC has assessed penalties on the majority of the reimbursable performance indicators in the first two years of the contract. In FY 1998-99, FCFC assessed 100 percent of the penalty on five of the seven indicators and approximately 87 percent of the maximum penalty stated in the contract. Although there was a 15 percent decrease in the total amount assessed in FY 1999-00, Beech Acres was still assessed the maximum penalty on four of the seven indicators. Reimbursable performance indicator #6, Plans of Care, was the only indicator on which no penalty was assessed.

The use of financial incentives and sanctions is a common practice in managed care arrangements. Incentives and sanctions are predetermined amounts that are tied to contract-specific performance measures. They may take the form of a flat dollar amount or a percentage of the organization's fee for service. SAMHSA recommends that amounts be large enough to influence behavior, but not so large as to be unfeasible. SAMHSA further advises that the contract must clearly define the performance standards, incentives or sanctions, and the party responsible for evaluating compliance with the performance standards.

The performance indicator penalties included in the contract are not effective in influencing Creative Connections' performance. Based on the application of penalties, it would appear that Creative Connections performance stayed the same or declined on five of the seven indicators from FY 1998-99 to FY 1999-2000. Beech Acres and Creative Connections' management indicated that the penalties do not impact their performance and are considered

more of an inconvenience than an incentive for improved performance. The penalty amounts as specified in the contract appear to have insufficient impact to effectively act as a disincentive for poor performance.

Beech Acres and Creative Connections staff members also are not aware of how their performance affects the application of financial penalties. Beech Acres and Creative Connections staff members exhibit a lack of ownership in reported results. The contract financial penalties will continue to have limited impact on Creative Connections and Beech Acres performance unless these organizations' management stresses the connection between staff performance and the loss of revenue to applied penalties.

R4.12 In future contracts, FCFC and the Council agencies should revise the performance penalties. The amount should be large enough to influence behavior, but not so large as to be detrimental to the provision of services. The penalty amounts for each performance indicator should be weighted according to its importance in achieving the overall goals of the program. Additionally, the contract should include the following standards for penalty assessment in accordance with generally accepted business practices:

- Clearly defined performance standards and corresponding penalties;
- Detailed annual evaluation of performance in accordance with performance indicators as stated in the contract;
- Mandatory Corrective Action Plans (CAP) for performance deficiencies;
- Specific time frames for submission and completion of CAP; and
- Provision for increasing penalties if time frames are not met.

Public sector highway and technology departments have effectively used these types of standards to influence contractor performance through the application of performance penalties. These practices clearly define performance expectations and provide meaningful sanctions for poor performance. Furthermore, the contractor is required to focus on correcting any deficiencies in performance and to make such corrections in a timely manner or face further penalties. By implementing these standards, FCFC and the Council agencies can better ensure that performance standards are met.

In addition, Beech Acres should dedicate staff and resources to Creative Connections QA/I activities to ensure that these activities provide the information necessary to evaluate the program's effectiveness, enhance cost efficiency, and develop improvement plans (see **R4.1**). Staff members must understand the ramifications of noncompliance with the contract. Beech Acres management should stress the importance of contract compliance in Creative Connections' operations. Performance penalties will have greater influence on Beech Acres and Creative Connections' behavior if management supports high performance and staff members are able to see the relationship between their performance and earned sanctions.

F4.16 When Creative Connections, FCFC and the Council agencies collaborated to streamline the contract exhibits and amend the performance indicators, the reimbursable performance indicator penalties were also amended. **Table 4-10** shows the proposed reimbursable performance indicators and the corresponding maximum penalty.

Table 4-10: Proposed Reimbursable Performance Indicators and Penalties

Proposed Reimbursable Performance Indicator		Maximum Penalty FY 2000-2001
B1.	Clients receive residential treatment only when essential to decrease impairment.	$20,000
B2.	Appropriate services available within region and county.	$25,000
B3.	Contractor will perform designated Council agencies' functions.	$30,000
B4.	Placement services are stable and meeting treatment needs.	$10,000
B5.	Individual plans of care, ISPs, and quarterly individual client progress reports are responsive to needs of clients and Council agencies.	$40,000
B6.	Services for clients are "high quality responsive" and appropriate in meeting desired outcomes.	$45,000
B7.	Adequately monitor and track financial status, quality improvement and aggregate reporting of contract requirements.	$55,000
Total		**$225,000**

Source: Proposed Contract Exhibits

Pursuant to the proposal, the maximum penalty amount for FY 2000-01 remained the same at $225,000 but each of the performance indicator amounts was revised. In contrast with the equal division of the original penalties, the revised penalty amounts for each indicator range from $10,000 to $55,000. Per the proposed amendments, each performance indicator is weighted according to its importance in relation to the overall program goals. The weighting of the performance indicators places more emphasis on monitoring, tracking and reporting quality and financial performance and on ensuring that services appropriately meet the needs of clients.

Although the amendments improve the utility of the performance penalties by clearly defining performance priorities, the amount or distribution of the penalties may not be large enough to influence Creative Connections performance (see **F4.15** and **R4.12**). In order for the performance penalties to be effective, Creative Connections must view the incentive/penalty amount as an important outcome of program performance.

R4.13 The Council agencies and FCFC should ensure that all financial incentives and penalties produce the desired outcomes from Beech Acres and Creative Connections. In instances where financial penalties are insufficient to ensure contract compliance, the Council agencies

should consider the legal options available to remedy noncompliance with contractual provisions. Beech Acres and Creative Connections should provide adequate and relevant reports on all performance indicators, particularly those with associated financial implications. Although the monetary incentive may be small in comparison to the contract, Beech Acres and Creative Connections should consider the short and long term implications of contract non-compliance.

F4.17 The annual evaluation of Creative Connections is conducted by FCFC with input from the Council agencies. According to the contract, the annual evaluation is based on performance indicators in Exhibits B through O (excluding H), provider feedback, and other aspects of quality care. The FCFC contract manager uses information from Creative Connections reports, HCDHS quarterly chart audits, and FCFC chart audits to conduct the annual evaluation. The FCFC contract manager is responsible for determining and recommending the performance indicator penalty amounts based on the evaluation.

The FCFC annual evaluation does not provide supporting information regarding why the penalty amounts were assessed or recommendations for improved performance. Also chart audits do not provide sufficient information to determine performance penalties because most of the items included in the chart audit do not directly correspond to the reimbursable performance indicators. The audits provide verification of State required documentation such as length of stay, type of placement, and number of moves. The audits do not evaluate the documentation for compliance with the reimbursable performance indicators related to this information. Although results from HCDHS chart audits during HCDHS FY 1999 indicated overall improvement by Creative Connections in the areas audited, the application of financial penalties for the same time period indicates that Creative Connections showed very little improvement in performance (see **F4.15**).

For FY 1999-00, FCFC assessed penalties of $21,531 (foster care placements and successful step down) for indicators that Creative Connections reported meeting in its quality and evaluation reports. The FCFC contract manager stated that the penalties were determined for the reimbursable performance indicators based on the parameters of the contract. Although a minimum standard is outlined in the contract, an unstated expectation articulated by the contract manager is for Creative Connections to perform above the minimum standard. The contract manager explained that in some instances contractually specified penalties were assessed when a minimum standard was met.

In addition, the contract manager made penalty assessments based on the information provided by Creative Connections and Beech Acres at the time of the evaluation. Beech Acres records, provided at a later date, indicated that those performance indicators were achieved, but Beech Acres did not contest the application of the financial penalties. Creative Connections and Beech Acres staff, including QA/I staff responsible for preparing reports

of Creative Connections performance, stated that they were unaware they had been penalized for indicators they had reported achieving. FCFC's annual evaluation is addressed to the executive director of Creative Connections and carbon copied to Beech Acres' CEO. Quality Assurance and Program Evaluation staff, who are responsible for reporting on indicators, had not seen the annual evaluation and were unaware of specifics regarding penalty assignments.

The discrepancy between the Beech Acres' assessment of performance and the contract manager's assessment of performance illustrates the need for improved communication between Beech Acres and FCFC. The issue is further exacerbated by the lack of integration and coordination within Beech Acres (see **F4.12**). According to the FCFC executive director, the penalty could have been waived, or the evaluation amended at any time with reasonable notice and sufficient evidence from Beech Acres of a mistake or miscalculation on the part of the Council in assessing the performance indicator penalties.

R4.14 The FCFC annual evaluation should be used by Creative Connections, Beech Acres and the Council agencies to assess contract compliance and program performance. The penalties should be assessed based on the standards indicated in the contract. If the Council agencies determine that higher performance is desired, future contracts should include scaled performance indicators that increase minimum performance standards over the life of the contract.

Beech Acres and Creative Connections' report submission to FCFC for the annual evaluation should contain measures to address each area indicated in the performance indicators. Areas that are not addressed should be highlighted and an explanation for the omission included. Furthermore, Creative Connections management and newly appointed QA/I staff (see **R4.1**) should review all indicators to determine which have been met and which indicators require further efforts. Action plans to remedy deficiencies should be included in the annual evaluation.

The FCFC evaluation report should include evidence provided by the contract manager to support the assessment of penalties. Recommendations for improved performance in areas where there are deficiencies should also be included and any suggested action plans provided by Beech Acres and Creative Connections should be assessed for viability. The additional information in the evaluation will help communicate to Creative Connections and Beech Acres the contract manager's assessment of their performance, as well as expectations for future performance. Creative Connections and the contract manager should use the evaluation as a starting point for action plans to target the direction of the program and methods of measurement to be used in upcoming reporting period

Provider Network Management

F4.18 Managed care programs rely on delivery of contracted services through networks of service providers. Pursuant to the contract, Creative Connections contracts with and manages a network of service providers in order to meet the clinical needs of its clients. Beech Acres also provides direct services to clients in accordance with the self referral guidelines established in the contract. Contract Exhibit N provides guidelines for Creative Connections to make referrals for service delivery to other programs managed by Beech Acres. For example, during the first quarter of FY 2000-01, Creative Connections referred 39 children to Beech Acres' Family Outreach program for community and foster care services.

Creative Connections did not use a request for proposal (RFP) process for selecting service providers for its network. Many providers became part of the network because they were providing services to a client at the time of the referral to Creative Connections. Other providers have joined the network because they offer a specialized service or have immediate openings for clients. Creative Connections' provider database lists approximately 250 providers as part of the network but only about 100 of these are actively used by Creative Connections.

According to the Substance Abuse and Mental Health Services Association (SAMHSA), selection and monitoring of the provider network is critical to ensuring the needs of clients and funders are adequately met. Usually the provider network is established by competitive bidding prior to the managed care contract being awarded. Although selection process vary among managed care programs, SAMHSA recommends that the contract specify whether the managed care organization (MCO) should use a competitive, noncompetitive, or mixed process to procure services. Competitive processes are generally used to lower costs and to limit the network of providers. MCOs usually choose a noncompetitive approach when services are limited due to capacity or the uniqueness of the service. The contract should also establish time lines for developing the network of service providers. Additionally, the contract should establish formal, objective, and documentable procedures and criteria for review of providers' proposals for network membership.

The contract with Creative Connections does not include SAMHSA recommended requirements for the development of the provider network. Also, Creative Connections has not negotiated rates with providers within its network in an effort to control costs. Because Creative Connections may place only a few children with a provider, negotiated rates are generally not available. Furthermore, Creative Connections has not used HCDHS or other Council agencies' buying power to reduce rates paid to providers or emphasize Medicaid eligibility as a component of network membership.

R4.15 The Council agencies should ensure that future contracts specify whether the MCO should use a competitive, noncompetitive, or mixed process to procure provider services. The contract should also establish time lines for the development of the network and detailed criteria for selection of providers into the network. Criteria should be used to evaluate all providers participating in the managed care program and exceptions should be made only in the most extreme cases. By providing specific criteria, FCFC and the Council agencies can better ensure that selected providers meet the needs of their clients.

In addition, the MCO and provider contracts should specify the rates that will be paid by HCDHS for client services purchased by the MCO. All network providers should be required to adhere to the County rates for services. HCDHS, because of its purchasing power, should set standard agreed upon rates for the most common types of care. Providers who are unwilling to match the County rates should be excluded from the network. By implementing a County rate for all contracts and providers serving HCDHS and other County agencies, the agencies will be able to use economies of scale to reduce their costs for services.

F4.19 Creative Connections has been slow to implement the policies and procedures to manage and monitor the network of service providers. During the first two years of the contract, Creative Connections did little to manage or monitor the service provider network. **Table 4-11** shows the list of initiatives Creative Connections developed over the last six months and its progress in implementing these initiatives as of January 2001.

Table 4-11: Creative Connections Provider Relations Initiatives

Provider Relations Initiative	Status
Develop and implement provider rating system to include quality outcomes, cost effectiveness and accessibility.	In process
Develop and implement a full credentialing and re-credentialing program to include a delegated oversight component	Complete
Organize quality/credentialing committee	Pending [1]
Enhance Standards of Care by Level of Care	In process
Comprehensive network analysis to include the following:	
1. Determine network capacity based upon service needs assessment	1. Complete
2. Identify service gaps	2. In process
3. Identify long-term partners	3. In process
4. Evaluate reimbursement methodologies	4. In process
5. Perform a comprehensive cost-comparison analysis by levels of care	5. Complete
6. Develop comprehensive fee schedule	6. Pending
7. Determine provider classification criteria	7. Pending
Develop and implement provider surveys and other quality assessment tools	In process
Develop and/or enhance provider educational/informational materials	In process
Develop and implement provider training programs	Complete
Organize provider council groups	Pending
Develop and implement collaborative contracting /re-contracting strategies	Pending
Determine appropriate skill level requirements for representatives within Network Operations	Complete
Define Network/Provider Relations requirements for UR Process Implementation	Pending
Develop Provider Profiling System	Pending
Develop and implement internal Provider Relations training sessions	Complete
Develop and implement formal provider appeal/grievance process	In process

Source: Creative Connections Director of Operations

[1] Pending indicates that the initiative has been planned but no action has been taken to implement.

Creative Connections has implemented 19.0 percent of the 21 initiatives and 48.0 percent are in the process of being implemented. The initiatives as shown in **Table 4-11** are comparable to SAMHSA recommendations for managing and monitoring the provider network.

In *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers*, SAMHSA outlines recommendations for development of the provider network. SAMHSA identifies the following aspects as important in the development of effective provider networks:

- Specifying the capacity and composition of the MCO's provider network;
- Selecting providers for the network;
- Ensuring clients' access to network services;
- Subcontracting with providers;
- Establishing qualification standards for provider staff; and;
- Monitoring providers' performance.

According to SAMHSA, the selection and monitoring of the provider network is critical to ensuring that the needs of clients and funders are adequately met.

While implementation of these initiatives will enable Creative Connections to effectively manage the service provider network, the delays in implementation may cause the initiatives to be unfulfilled during the current contract period. Effective management of the network is integral to ensuring that clients are receiving appropriate and adequate services. Creative Connections management had stated that the initiatives would be fully implemented by March 2001. However, as of the completion of this performance audit, full implementation has not been achieved.

R4.16 Creative Connections should immediately complete implementation of the provider relations initiatives. These initiatives will provide Creative Connections with the tools to improve provider/client matching based on provider profiles, monitor the quality of services through credentialing and provider ratings, and improve provider skills and services through training. More importantly, the initiatives will help Creative Connections meet contractual provisions for management of the provider network and may help reduce costs. Implementation of these initiatives should enable Creative Connections to better manage the service provider network and to ensure that client's have access to appropriate services to meet their needs.

F4.20 Pursuant to the contract, Beech Acres enters into agreements with each service provider in the managed care network. Beech Acres uses a standardized agreement with each provider, outlining responsibilities and defining covered services. However, provider agreements do not contain the credentialing requirements with which providers must comply as a condition to remaining in the managed care network or specific performance expectations by which they will be evaluated. According to SAMHSA, credentialing and performance criteria should be a part of provider contracts to ensure the qualifications of staff and the quality of services (see also **F4.22**).

R4.17 Beech Acres should include the credentialing requirements as addendums to provider agreements. By including these requirements, providers are immediately made aware of the criteria which must be met to remain in the provider network. In addition, providers should begin to implement the policies, procedures, or operational changes necessary to meet the credentialing requirements. Beech Acres should, on an ongoing basis, monitor providers compliance with credentialing standards.

Also, Beech Acres should include performance expectations as addendums to the provider agreements. Performance expectations should mirror those used to monitor Creative Connections' performance and should aid Beech Acres in meeting contract requirements. By including credentialing and performance criteria at the inception of the agreement, providers would be able to develop their own internal processes to meet client and funder expectations in a managed care environment.

F4.21 Creative Connections does not maintain service provider profiles. Service provider profiles are used to isolate each provider and highlight similarities to, and differences from, other providers and the provider network as a whole. The purpose of a service provider profile is to provide information to Creative Connections and FCFC about each service provider in the network, specifically addressing the following capabilities:

- Number and types of clients served by each service provider;
- Service provider performance on key quality indicators and outcomes; and
- Service provider's performance against the performance of the entire provider network as a whole.

Creative Connections management indicated that development of service provider profiles is desirable, and a committee has been formed to develop the appropriate standards to integrate cost, quality and services as part of their network operations-provider relations initiatives (see **F4.19**). Currently, Creative Connections uses service definitions of providers based on types and levels of services, medicaid eligibility, and rankings according to costs for non-medicaid providers. Care managers select providers based on these definitions. The current system does not integrate quality and financial information for service providers. Service definitions do not provide care managers with provider performance information which would allow them to choose providers with the best services at the best cost.

R4.18 Creative Connections should immediately begin the development of service provider profiles. The first step in creating provider profiles is to develop performance standards to be used in provider evaluations. The performance standards should be consistent with the standards required by the contract between Beech Acres, FCFC and the Council agencies. Service provider profiles should be used to achieve the following objectives:

- Comparing the performance of providers of similar services;
- Enhancing the design of the quality improvement program at Creative Connections;
- Distributing incentives or enacting sanctions;
- Establishing corrective action plans; and/or
- Providing the basis for continued participation in the network.

Developing and maintaining profiles for each of the service providers would assist Creative Connections in obtaining valuable information regarding the characteristics, abilities, and financial performance of each service provider. Furthermore, provider profiles will allow Creative Connections to evaluate provider performance over time and use the data to support management decisions regarding network inclusion.

F4.22 In order to determine if network providers continue to meet the criteria stipulated in the provider agreement, Creative Connections' provider relations staff credentials and re-credentials providers. The credentialing process is briefly described in Creative Connections' provider evaluation and application process operating draft dated February 9, 2001. According to this policy, Creative Connections verifies provider accreditations and/or certifications including licenses from ODHS, ODMH, COA, and JCAHO and determines the provider's capabilities for verifying staff credentials. Creative Connections may delegate credentialing and re-credentialing activities to nationally accredited providers and maintain oversight responsibilities of those providers credentialing processes (see **F4.24**). For all other providers, Creative Connections verifies the provider and staff credentials during an onsite visit. Items that require updates are entered into UNI/Care and provider relations staff correspond with the provider by mail to obtain updated documents.

According to SAMHSA, credentialing criteria should be based on specific standards and prerequisites and should be used to approve a provider or practitioner to provide services in the network. Examples of credentialing standards based on COA standards for Residential Group Home care include the following:

- **Administrative Functions**
  - The provider is established as a legally recognized entity in the State in which it is located and provides services.
  - The provider maintains the required licensure/certification as a residential group home facility.
  - The provider has written policies, procedures and plans for quality improvement and utilization review functions in place.

- **Clinical Functions**
  - The program is available to individuals and their families when it has been determined that group home is the level of care needed at the time of

admission and that other forms of assistance, which are less restrictive, have not been successful or have been determined to be inappropriate.

- The provider has written policies and procedures for medical records documentation, confidentiality of patient information, disclosure of patient information, and informed consent.

- **Clinical Human Resources**
  - The provider maintains written policies and procedures for staff selection and credentialing of all staff working in the group home.
  - The policies and procedures for hiring group home and clinical staff include primary source verification of licensure, certification, appropriate reference checks, and a background check.

- **Clinical Documentation**
  - Medical records include specific demographic information regarding the client, authorizations to disclose information, client's name and identification number, progress notes, and discharge information.

- **Physical Plant and Safety Issues**
  - The provider conducts and maintains documentation of monthly fire drills, fire extinguisher inspections and general physical plant inspections intended to identify any potentially hazardous conditions.
  - The provider has written policies and procedures governing proper medication administration and storage.

The credentialing process as outlined in the operating draft provides general information about the process, but does not contain the detail necessary to implement the procedure. Specifically, the policy does not provide the credentialing standards, the required documentation, the frequency of the credentialing and re-credentialing process, or time frames for correcting deficiencies.

R4.19 Creative Connections should implement formal credentialing policies and procedures and should include detailed standards for credentialing based on national standards. Credentialing procedures should be consistent with industry standards set by accrediting organizations such as COA, NCQA and JCAHO. Credentialing standards should go beyond verification of licensure and certification and should include clinical and safety measures. By establishing detailed criteria consistent with national standards, Creative Connections can ensure that clients are receiving services that meet the Council agencies expectations based on professional standards of care.

F4.23 According to Creative Connections management, Creative Connections completed credentialing and re-credentialing of their current provider network in January of 2001. Credentialing was not initiated when the contract was signed and the process did not begin until the third year of the contract. New providers are credentialed through the application process. During the initial credentialing process, Creative Connections verifies the experience and licensure of those provider agencies and staff members responsible for the delivery of contracted services.

During the initial site visit, Creative Connections' provider services representatives complete the Creative Connections' provider questionnaire. The questionnaire is a 23-item survey designed to gather information about the provider's ability to meet the needs of the client population. The information is entered into a database and a status screen is being developed to allow Creative Connections' staff to pull this information from UNI/Care. The information will be used to evaluate provider services against client needs.

During the initial site visit, provider relations staff also collects provider documentation of the following:

- Credentials;
- Contact names and phone numbers;
- Level System Policy;
- Program descriptions;
- Service descriptions and proposed rates;
- Seclusion and restraint policies;
- QA/I processes and tools used to measure effectiveness of treatment; and
- References.

Although the credentialing standards being used are comparable to national standards, the information is not currently used for management decision making or network management. Furthermore, providers were treating clients of Creative Connections without demonstrating their credentials to provide such services which had the potential to increase Creative Connections, and by extension the Council agencies', liability in serving the client population.

R4.20 Creative Connections should ensure that any provider who receives Creative Connections clients for treatment has up-to-date and complete credentials. Creative Connections should use the information collected during the application or credentialing process to select providers that best meet the needs of their clients. This information should also be used in evaluating providers on an ongoing basis (see also **F4.21**). Creative Connections should also establish specific standards for credentialing including provider/ practitioner qualifications and QA/I activities and outcomes. QA/I standards should be consistent with the performance

indicators and reporting requirements as stated in the Beech Acres, FCFC and Council agencies contract. Creative Connection's credentialing process should be used as a tool in evaluating providers to ensure that clients and their families are receiving high quality services.

F4.24 Creative Connections added a delegated oversight component to its credentialing program. This delegation gives accredited providers responsibility for ensuring the appropriate certification, licensure, and experience of their staff while Creative Connections maintains oversight responsibilities. The delegated credentialing agreement stipulates that Creative Connections will perform a site visit at least annually to evaluate the credentialing program and that re-credentialing activities will take place biennially.

To meet Creative Connections' delegated credentialing standards, each provider must keep the following documents on file for each practitioner employed by the provider:

- State license(s) or certification to practice in practitioner's specialty field;
- Drug Enforcement Agency (DEA) registration (unrestricted), if applicable;
- State Controlled Dangerous Substance Certificate, if applicable
- Professional liability insurance policy face sheet, showing expiration dates, limits (not less than $1 million per claim and $3 million aggregate) and practitioner's name;
- Board Certification Certificate, if applicable;
- Certificate of letter certifying formal post-graduate training, if applicable;
- Curricula vita/resume, include five-year work history;
- ECFMG Certificate, if applicable;
- W-9 form for each tax identification number used;
- CLIA certificate, if applicable;
- Certificates of Advanced Nurse Practitioners employed by the office, if applicable; and
- Clinical privileges in good standing at primary hospital and in accordance with Creative Connections credentialing requirements, if applicable.

Pursuant to the delegation agreement, providers must have established written policies and procedures for the suspension, reduction, or termination of practitioner's privileges based on the results of the credentialing process. Furthermore, providers are required to report changes in practitioner's privileges to the Creative Connections and the appropriate authorities. In accordance with the delegation agreement, providers' credentialing activities are coordinated with Beech Acres' PIQA department and monitoring activities developed by Creative Connections. However, the delegation agreement does not provide specific QA/I standards that will be monitored (see also **R4.20**).

C4.4 The delegated credentialing and re-credentialing agreement allows Creative Connections to delegate certain credentialing activities to accredited providers while maintaining oversight and monitoring of those activities. Through delegation, Creative Connections eliminates duplication of credentialing activities that have already been completed by the accrediting organization. This allows Creative Connections to focus its efforts on credentialing activities for providers who are not already involved in other credentialing organizations.

R4.21 Creative Connections should include detailed credentialing standards in its delegated credentialing and re-credentialing policy consistent with industry standards (see **F4.23** and **R4.20**). Credentialing standards should include administrative, clinical and safety measures to ensure that clients are receiving the highest level of professional care.

F4.25 All contracted providers are required to maintain a professional liability policy in the minimum amount of one million dollars per claim and three million dollars in the annual aggregate to cover any loss, liability or damage. Network providers are further required to provide Beech Acres a certificate of insurance certifying the type and amount of insurance and to notify Beech Acres at least 30 days in advance of cancellation of any insurance policy. The agreement, however, does not require providers to list Beech Acres as an additional insured party. As an additional insured, Beech Acres would be notified by the insurance company in the event of any changes in policy status. Without being listed on the provider's insurance policy, Beech Acres has no guarantee of notification if changes are made to the insurance policy.

R4.22 The Council agencies should ensure that Beech Acres amends its provider agreements to require that they are listed as an additional insured or certificate holder on providers' insurance policies. Although providers agree to notify Beech Acres in the event of cancellation, there is no guarantee that Beech Acres would be notified if changes in policy status were to occur. By ensuring that Beech Acres is listed as an additional insured or certificate holder, the Council agencies further safeguard themselves and Beech Acres from potential lawsuits and liabilities stemming from provider malpractice. Furthermore, clients and their family members receiving services would be financially protected in the case of accidents or damages committed during the course of service delivery.

F4.26 In accordance with the contract, Beech Acres warrants that all contracted providers are duly licensed and/or certified in accordance with the appropriate State laws. Beech Acres is responsible for regularly monitoring the licensure status of each contracted provider and its employees. In signing the provider agreements to join the network, providers warrant that all licenses will remain in effect and all employees will remain certified to deliver covered services.

Provider agency and staff licenses are also verified during credentialing site visits (see also **F4.23**). According to Creative Connections delegation of credentialing and re-credentialing agreement, in order to verify the existence and status of practitioners' licenses, Creative Connections review's 5.0 percent or 50 (whichever is less) of the provider's credentialing files. Creative Connections prepares a written report within 30 days of the evaluation. The report identifies deficiencies and areas in need of improvement. Although the policy states that providers are required to respond with a corrective action plan within 30 days, the agreement does not include provisions for further follow-up or sanctions for failure to comply.

Credentialing site visits enable Creative Connections to check the status of provider licenses and credentials. Additionally, if any problems exist with a provider's license, the provider is contractually obligated to report the issue to Creative Connections.

C4.5 Creative Connections verifies documentation and monitors the status of provider and staff licenses and certifications. By obtaining copies of provider licenses during the application process, Creative Connections verifies that services are delivered by certified provider agencies. The credentialing process enables Creative Connections to monitor the licensure status of providers as well as their staff members.

R4.23 Creative Connections should include provisions in the delegation of credentialing and re-credentialing policy to follow-up with providers when a corrective action for deficiencies is required. Creative Connections' should conduct mandatory follow-up site visits to ensure that corrective action plans are implemented for any deficiencies identified through the credentialing process. Additionally, Creative Connections should institute sanctions for provider's failure to comply with credentialing standards.

F4.27 Pursuant to the contract, Beech Acres maintains a grievance procedure for clients, families, custodians, and guardians that meets the requirements of the Council agencies. The contract does not further specify the responsibilities of Beech Acres regarding client complaints and grievances and does not require tracking or reporting of client complaints or grievances to FCFC or the Council agencies.

SAMHSA recommends that public purchasers of managed substance abuse and mental health care include the following regarding complaints and grievances in RFPs and contracts:

- Mandate the MCO to develop written policies and procedures to address complaint, grievance, and appeal processes for the system of care.

- Require the MCO to provide consumers and families with information at the time of admission on how to file a complaint, grievance or appeal.

- Require that the MCO monitor and log grievances and develop action plans based on recurring problems.

- Ensure that the consumer has representation rights in any complaint, grievance or appeal.

- Stipulate that the MCO has a formal process for review of all complaints and grievances concerning all administrative activities.

- Require the MCO to ensure that procedures for filing grievances and complaints are accessible and responsive.

- Require the MCO to establish procedures that are culturally appropriate and linguistically accessible.

- Require the MCO to establish reasonable time frames subject to purchaser approval for response and resolution of complaints and grievances.

- Require the MCO and its provider network to systematically record and report to the purchaser complaints and their resolution.

- Develop a monitoring plan for complaints and grievances that may include incentives or sanctions based on the MCO's performance in this area.

A well-functioning grievance process can provide the purchaser with quality of care information in addition to ensuring protection of client's rights. Because these requirements are not included in the contract, FCFC and the Council agencies cannot hold service providers accountable for achieving these standards. By including specific requirements in the contract, purchasers can have more control over issues that arise from the MCO's approach to problems in the service delivery.

R4.24 In future contracts, the Council agencies should include specific requirements for complaint and grievance procedures. The Council agencies should consider using SAMHSA recommendations to ensure that grievance procedures protect client's rights. The Bazelon Center for Mental Health Law further recommends that grievance procedures be effective, expeditious, accessible, fair, and uniform. By including these requirements in the contract, FCFC and the Council agencies will have more control over issues that arise over the MCO or its service providers' provision of care.

F4.28 The Beech Acres grievance procedures are contained in its clients' rights policy. All Beech Acres clients receive a copy of the client rights policy at the initial session (see **F4.32**).

Creative Connections uses Beech Acres grievance procedures. The grievance procedure identifies the staff person responsible for receiving, monitoring and reporting complaints and contact information for that individual. Clients may also contact the client rights officer who has the following responsibilities:

- Collect and log information in the grievance log;
- Oversee and ensure compliance with the grievance process;
- Represent the client at the provider agency hearing;
- Assist the client in contacting any resource upon request;
- Review all grievances filed to track trends and patterns; and
- Make recommendations for modifications in policies and procedures.

Before a formal grievance is filed, staff provides the client with a copy of the grievance policy and procedure. The client, staff member and the program director meet to identify concerns and attempt to resolve the complaint within five business days of receipt of the complaint. If there is no resolution, a formal grievance is filed. In accordance with established procedures, Beech Acres staff will conduct or arrange an investigation of the circumstances of the grievance. Upon resolution of the grievance, the client and program director will be provided with a written statement of the resolution. If the grievance remains unresolved, a hearing is held with the vice president of Beech Acres' Professional Services Department and the president of the Beech Acres Board within 20 business days of the filing of the grievance. The client may be represented by the client rights officer or another person of his/her choice. If the grievance still remains unresolved, Beech Acres will provide a written response referring the client to outside entities, such as the Mental Health Board, HCDHS, or the Ohio Attorney General's Office.

The Public Children's Services Association of Ohio (PCSAO) recommends including the following items with associated procedures in a formal written grievance policy:

- Identification of parties who may seek formal redress of grievances;
- Established process describing how grievances are received by the provider agency;
- Designated staff members responsible for conducting the grievance process or hearing;
- Established time frame for grievance process to be initiated and completed;
- Established process for providing written decisions to those involved in the grievance process; and
- Methodology for documenting, reporting, and maintaining documents associated with the grievance process.

Although Beech Acres maintains formal written grievance policies and procedures, some aspects of the policies and procedures are not clearly stated in writing. Furthermore, Beech

Acres' formal policy does not establish time frames for initiating or completing an investigation. Also, the policy requires a grievance be heard within 20 working days of the initial filing, but does not establish time frames for intermediary steps in the process. The PIQA Department has implemented time frames internally, but this criteria has not been formalized in the client rights policy. Without including the time frames in the formal policy, Beech Acres cannot ensure that clients are fully aware of their rights which include a timely resolution to their complaints.

C4.6 Beech Acres' grievance procedures are provided to clients at the time of intake and reviewed with staff. Beech Acres keeps a record of the client's review and receipt of this information. This information is provided in conjunction with Beech Acres client rights policy (see **F4.32**). Providing written information describing the client's right to complain increases Beech Acres accountability in providing efficient and effective services.

R4.25 Beech Acres should modify its grievance policy and procedures to require that staff investigate and respond to complaints and grievances within predetermined time frames. Time frames should allow for complaints and grievances to be handled expeditiously and effectively. Additionally, Beech Acres should identify the staff responsible for investigating complaints and preparing written statements of resolution. The written client rights policy provided to clients should include a full explanation of the duties of the client rights officer and the established time frames for response, investigation and resolution of their complaint.

F4.29 Beech Acres' provider agreements stipulate that complaints received by Beech Acres regarding services rendered by the provider will be resolved in accordance with Beech Acres grievance procedures. Pursuant to the provider agreement, the provider is required to provide timely information, attend hearings and cooperate in the resolution of the complaint. Additionally, the provider is required to notify the care manager of any complaints and their outcome filed with the provider. According to the Beech Acres' QA/I plan, the client rights officer may review any Creative Connection's network provider's client's rights policies to ensure they identify client's rights in much the same way as Beech Acres.

R4.26 When contracting with providers, Beech Acres should include specific requirements for the complaint and grievance procedures in the provider agreement. Beech Acres should consider using SAMHSA recommendations to ensure that grievance procedures are handled in a way that protects client's rights. By including these requirements in the contract, Beech Acres would be better able to monitor the quality of service delivery. Also, when grievances are received by Beech Acres, a Beech Acres representative should immediately notify the Creative Connections care manager so that, if necessary, alternative treatment or interventions may be arranged. Relying on providers to notify care managers presents the possibility that providers may not conduct such notification in a timely manner.

F4.30 The client rights officer reports all complaints and grievances to the QA/I team and a database is maintained to track complaints and grievances made against Beech Acres. Beech Acres reports this information annually to the Mental Health Board. Creative Connections does not report complaint and grievance information to FCFC, because this is not a contractual reporting requirement (see **F4.27**). However, this information would be beneficial to FCFC and the Council agencies in responding to external concerns and monitoring the quality of services. Also, because grievances can have legal implications at the State level, Council agencies should be immediately informed of any grievances related to their contract that progress beyond an informal resolution process.

R4.27 Although not currently required by the contract, Creative Connections should report complaints and grievances made against the program or its service providers to FCFC on a quarterly basis. FCFC and the Council agencies should also be notified of any grievances that progress beyond informal resolution at monthly committee meetings. Creative Connections should include the following detailed information on complaints and grievances in their quality reports:

- Name of provider (if applicable);
- Date complaint received by Creative Connections;
- Content and source of complaint;
- Date of Creative Connections' response;
- Urgency of complaint;
- Date of resolution; and
- Corrective action taken to resolve complaint.

FCFC and the Council agencies should use this information to monitor Creative Connections' performance as a network manager and to monitor the overall quality of the network of service providers.

F4.31 HCDHS contracts with two primary managed care entities as well as a number of service providers for behavioral health services for its clients. Currently, HCDHS does not have a centralized method for capturing complaint and grievance information from its contracted entities. Without a centralized complaint/grievance database, HCDHS is unable to identify trends in complaint and grievance information for individual service providers or its networks of providers. Information generated from a centralized complaint/grievance database would assist HCDHS in monitoring the quality of its providers and managed care entities and could be a basis for decision-making regarding the renewal of future contracts.

R4.28 HCDHS should develop a centralized database to capture complaint and grievance information from all of its contracted providers and managed care entities. Meaningful statistics concerning complaints can be generated from the database to identify trends among

the different providers and be used to monitor the quality of the contracted services. The information generated from the database would assist HCDHS in responding to external concerns and improving services to clients and their family members.

F4.32 Beech Acres has established a client rights policy. Beech Acres requires that all clients receive a copy of the client rights policy and that staff reviews the policy with each client. The client signs a statement acknowledging receipt and understanding of the policy and the signature page is maintained in the client's record. In accordance with established policy, all new staff members review the client rights policy with their immediate supervisor and sign a statement acknowledging review. The signed copy is maintained in the staff's personnel file. The client rights officer conducts a refresher course for all Beech Acres' employees annually.

In 1993, the Federal government passed the Model Managed Care Consumer Protection Act which established standards for client/consumer protection against MCOs whose policies and/or fiscal incentives led to inadequate care. Many advocacy and professional organizations have also established comprehensive patient/client bills of rights linked to the full spectrum of services used by clients of managed behavioral health care and their families. The Bazelon Center for Mental Health Law has developed a bill of rights to be used as a model for managed care entities. **Table 4-12** compares the bill of rights standards used by Beech Acres with those recommended by the Bazelon Center.

Table 4-12: Client Bill of Rights Comparison

Standard	Bazelon Recommendation	Beech Acres Inclusion
Non-discrimination	No managed care entity may discriminate on the basis of disability, race, religion, national origin, income, gender, or sexual orientation.	To not be discriminated against in the provision of service on the basis of religion, race, color, creed, gender, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay. To be treated with consideration and respect for personal dignity, autonomy, and privacy.
Client Inclusion in Treatment Decisions	Clients have the right to be fully involved in all treatment decisions and to participate in the development of their service plan.	To active and informed participation in the establishment, periodic review, and reassessment of the service plan.

Informed Consent	Clients have the right to give or withhold consent to their service plan and to amend their consent as their plan is modified.	To be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives. Access to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.
Interagency Plans	Children with a serious emotional disturbance should be in an interagency, interdisciplinary service plan developed with their family and approved by their parent or guardian.	Not Addressed
Service Setting	Treatment plans must respect the individual client's choice of service and service setting.	To receive service in a humane setting which is the least restrictive feasible as defined in the treatment plan.
Unnecessary and Hazardous Treatment, Observation Techniques	Not Addressed	To freedom from unnecessary or excessive medication; To freedom from unnecessary restraint or seclusion; To be informed of and refuse any unusual or hazardous treatment procedures; To be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies, or photographs.
Refusal of Treatment	Clients have the right to refuse treatment they do not feel is appropriate and may not be disenrolled because they have refused treatment.	To consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal.
Denials based on Refusal of Treatment	Clients may not be denied services that are appropriate to their needs because of their decision not to accept other services.	To participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies; or regardless of relapse from earlier treatment in that or another service; unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services.
Confidentiality	Managed care entities must ensure confidentiality of records, guarantee clients full access to their own records and protect individual privacy.	To confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, State or federal statutes, unless release of information is specifically authorized by the client, parent or legal guardian.
Records Access	Not Addressed	To have access to one's own psychiatric, medical or other treatment records, unless access to particular items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan.

Power of Attorney and Treatment Directives	Clients have the right to establish psychiatric advance directives or durable powers of attorney specifying how they wish to be treated in an emergency or if they are incapacitated. The managed care entity should be required to educate its providers on the use of advance directives.	Not Addressed
Legal Counsel	Not Addressed	To have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense.
Appeals	Clients have the right to appeal decisions about their treatment when they disagree. The managed care entity must have an effective, expeditious, accessible, fair, and uniform grievance procedure to allow clients to appeal decisions about care they receive or services they are denied.	To be fully informed of all rights; To exercise any and all rights without reprisal in any form, including continued and uncompromised access to service; To file a grievance; and To have oral and written instructions for filing a grievance.
Disenrollment	Clients have the right not to be disenrolled from the plan without just cause**.**	To be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event.
Denials	Not Addressed	To receive an explanation of the reasons for denial of service.
Costs	Not Addressed	To know the cost of services.

Source: Bazelon Center for Mental Health Law, Patient Bill of Rights recommendations; Beech Acres Patient Bill of Rights.

Beech Acres' clients rights statement contains many of the Bazelon recommendations for clients of managed behavioral health care. The Beech Acres statement does not address standards for interagency plans or power of attorney and treatment directives. Although Beech Acres and Creative Connections' treatment philosophy supports an interagency and family treatment planning approach as evidenced by the Child and Family Team, this philosophy is not formalized as part of the client's bill of rights. Including a statement on the client's right to interagency planning and family involvement would show Beech Acres' commitment to providing this type of treatment planning. Also, Beech Acres' clients could benefit from the right to establish psychiatric advance directives or durable powers of attorney. Beech Acres could ensure that it continued to protect its clients' rights even when they were incapacitated due to a psychiatric emergency.

The Beech Acres client rights policy meets Mental Health Board and ODMH requirements. The policy establishes standards to protect clients rights and to ensure accountability for the quality of service delivery.

C4.7 The Beech Acres Client rights policy meets Mental Health Board and ODMH approval and is consistent with Bazelon's recommendations for client's bill of rights. Beech Acres

informs clients of their rights both in writing and through a one-on-one review with staff. This process helps to ensure that clients are informed and have an understanding of their rights as a client. By maintaining a client rights policy and subsequent grievance procedures (see **F4.28**), Beech Acres provides safeguards which not only protect client's rights but also foster higher standards of care.

R4.29 Beech Acres should amend its client's bill of rights to include the right to interagency treatment planning and to establish advance directives and durable powers of attorney. The addition of these statements would further enhance Beech Acres policy and the protection it offers to its clients.

F4.33 Pursuant to the provider agreement, members of Creative Connections' service provider network are required to observe, protect and promote the rights of clients and comply with Beech Acres concerning complaints and grievances concerning services rendered by the provider . Provider agreements do not include Beech Acres' Client rights policy or provide direction to the provider regarding the development of a client's bill of rights. Beech Acres' client rights officer has the authority to review any Creative Connections network provider's client rights policy to ensure they identify client's rights in much the same way as Beech Acres,. This clause is not included in the provider agreement.

R4.30 Beech Acres should require service network providers to develop a client's rights policy in accordance with the principles of Beech Acres client rights policy. The provider agreements should also stipulate that the policy be provided to clients in writing and be reviewed with staff upon admission to the program. The client rights policy should include the grievance procedures that clients can follow should they have concerns about their care (see **R4.26**). Through the credentialing process, Creative Connections should verify that service providers maintain these policies and procedures and that clients are informed of their rights.

F4.34 Beech Acres maintains a policy which provides guidelines for safeguarding confidential client information. Pursuant to policy, each department in Beech Acres must include procedures that detail the following:

- Access to and content of records (open or closed);
- Guidelines for sharing and releasing information;
- Controls for overall record system, including person responsible for controls;
- Guidelines for retention and destruction of records; and
- Protection of records from damaging conditions.

The right to confidentiality is an essential component of the therapist-client relationship, and the risk of breaches in client confidentiality are significant in the context of managed care. The managed care system is not inherently conducive to protecting the confidentiality of

clients due to the passage of client information between different parties in the network. Furthermore, consumers of mental health services and their families are especially vulnerable because of information that may be disclosed when they seek authorization for treatment or are referred from one practitioner or provider to another. Therefore, it is necessary for a managed care entity to have comprehensive policies and procedures in place governing client confidentiality.

In accordance with Beech Acres' confidentiality policy, Creative Connections is required to develop procedures to safeguard confidential client information and include these procedures in their department manual. Creative Connections has not developed specific program procedures. Without specific procedures to ensure confidentiality, client information may be improperly disclosed as it is passed between different parties in the network.

R4.31 Creative Connections should develop and implement detailed procedures for safeguarding confidential client information that are specific to the situations encountered by Creative Connections and network personnel. The procedures should address applicable Federal and State confidentiality requirements and include examples of how guidelines on confidentiality apply to daily operations. By specifically identifying the various scenarios in which issues of confidentiality arise, Creative Connections can teach effective safeguards which will to protect clients from breaches in confidentiality. The need for detailed guidelines is increased by the complexities of the managed care environment.

F4.35 In accordance with the provider agreements, network service providers agree to comply with all applicable Federal, State and local laws regarding the confidentiality of medical/health records, mental health records, drug and alcohol addiction treatment records and confidential records kept by HCDHS. Pursuant to the delegation of credentialing and re-credentialing agreement, Creative Connections conducts a comprehensive review of medical record keeping practices during the initial site visit with a service provider. However, no procedures were provided for continued monitoring of provider compliance with confidentiality requirements.

R4.32 Creative Connections should verify provider procedures for the maintenance of client records and other measures instituted to assure client confidentiality through the service provider credentialing and re-credentialing process. Creative Connections should also develop and initiate periodic, mandatory training sessions on client confidentiality for its staff and service providers. HCDHS' confidentiality training for its Children's Services staff could be used a resource for in-house development of confidentiality training programs. In a managed care setting , client information is usually shared among a number of different parties to deliver the most appropriate services. Therefore, the likelihood of breaching a client's confidentiality becomes increasingly probable. As a result, Creative Connections should put more emphasis on safeguarding client confidentiality and privacy through increased monitoring and periodic

training. Periodic training sessions on client confidentiality should address a variety of topics including the following:

- Reviewing the techniques and methods used to inform clients of their right to confidentiality;
- Reviewing all standard confidentiality forms, including the Authorization for Release of Records or Information;
- Re-examining all applicable Federal and State confidentiality regulations, including: Part 2, Title 42 of the Code of Federal Regulations (CFR), Chapter 51 of the Ohio Revised Code (ORC) and the ODJFS *Public Records and Confidentiality Laws*, OAC §5105:2-34-38;
- Reviewing scenarios in which breaches in client confidentiality are most likely to occur;
- Reviewing all credentialing standards on confidentiality by which service providers are evaluated;
- Reviewing the crisis protocol for high profile cases that includes time frames, staff responsibilities and media relations; and
- Discussing issues pertaining to confidentiality and the managed care information system, including: firewall installations, security clearances, and client identifier codes.

These training sessions would prepare Creative Connections and service provider staff for making appropriate decisions involving client confidentiality. Informed decision-making on confidentiality issues enhances the safety and protection of children and their families while safeguarding employees from potential liability issues.

Communications Between the Contract Parties

F4.36 Since execution of the contract in November 1998, Creative Connections has not met expectations for implementing the multiple requirements of the contract. The CQMP has not been fully implemented (**F4.2**), reports are incomplete and do not provide analyses of results (**F4.3**), and policies and procedures to select and manage the service provider network have been lacking(**F4.19**).

However, the contract does not clearly communicate the expectations of the Council agencies in several areas including reporting and network management.

- The number of performance standards and their placement throughout the contract make it difficult to determine the priority or importance of the various standards in relation to one another.

- The performance indicators, measures, benchmarks, and data/reporting requirements as specified by the contract do not consistently correspond with each other or with the intended outcomes (see **F4.4**).

- The contract does not clearly define reporting formats (**F4.10**).

- The contract does not define selection procedures for the service provider network (**F4.18**).

SAMHSA's *Guide for Public Purchasers* recommends that purchasers use RFPs and contracts to clearly specify the expectations and requirements for the managed care entity. By being specific and detailed in the RFP or contract, the purchaser can ensure that all parties understand the expectations and can better hold the MCO accountable for implementing those requirements.

Although Creative Connections persists in noncompliance with the contract, FCFC and HCDHS have provided only limited assistance or direction to remedy noncompliance issues. Reasons behind the limited assistance and minimal efforts to clarify the policy appear to be numerous and based outside of the constraints of the contract. Also, because Creative Connections did not have an opportunity to agree to an RFP and ensure the requested tasks could be completed, continued noncompliance is aggravated by the contracted entity's inability to bring operations up to the level of contract expectations (see **F3.25** and **R3.17** in the ***financial management*** section).

F4.37 Because portions of the contract have been subjected to varying interpretations, communication of expectations to the contracted party is essential to ensure the contract is implemented in accordance with the expectations of the Council agencies. However, appropriate channels of communication have not been defined to ensure messages are consistent and clear. Although regular communication occurs between the parties, coordination of information is not addressed and Creative Connections may receive varying instructions from the contract manager and Council Agency representatives as issues are discussed with each independent party. Although the contract establishes three interagency committees for oversight and management of the contract, no committee currently fulfills this role and Beech Acres is only represented on the Mid-Level Managers Committee.

Although this committee has been used as a vehicle for resolving some concerns, its scope is limited to clinical operational issues and financial and administrative issues are not addressed.

The Intersystem Oversight Committee is comprised of high level fiscal and/or operations personnel from each of the Council agencies. This committee is charged with the responsibility for assisting the contract manager in evaluating performance and recommending corrective action for performance deficiencies. Pursuant to the contract, the Intersystem Oversight Committee may develop subcommittees as needed. A fiscal subcommittee has been established to monitor the deficit amount projected in the contract. Members of the subcommittee meet with the Beech Acres' chief fiscal officer to discuss deficit projections. However, Beech Acres and Creative Connections personnel are not regularly included in the Intersystem Oversight Committee or the System Refinance Committee. Avenues to discuss obstacles to contract compliance are severely limited.

R4.33 To facilitate clear communication to Beech Acres and Creative Connections, FCFC and the contract manager must be used to a greater extent as an intermediary between the Council agencies and the contracted entity. Dialogue between any Council Agency and Beech Acres/Creative Connections should be passed through FCFC in a manner which would serve to inform the entire Council Agency group. By ensuring that each member of the Council Agency is informed of clinical and financial communication with Beech Acres, records can be maintained to serve as a reference for future policy-making discussions. Each Council Agency should stridently adhere to this protocol so that all communicative efforts represent a shared vision (see ***financial*** section). Council Agency representatives should discuss planned communications prior to contacting FCFC or Creative Connections so that a unified course of action is represented. The contract manager and a designated Creative Connection employee should act as the gatekeepers for information sharing between the various entities.

Additionally, the Intersystem Oversight Committee should establish a quality assurance and improvement subcommittee and meet regularly to discuss issues related to performance standards and reporting requirements. The Creative Connections executive director (or her designee) and QA/I representative should be included in these subcommittee meetings and should regularly report on the progress of the CQMP (**R4.1**). The contract manager should send out a request for agenda items and develop a set agenda prior to each meeting. This would enable the committee to be prepared to discuss important items and help to keep the meeting focused.

Regular communication between the parties is integral to effective contract management. The Council agencies should meet regularly in order to clarify expectations, discuss successes and limitations, and to provide feedback. The conclusions reached by Council Agency representatives should be shared with the contract manager and Creative Connections

representative. This type of communication can enhance program outcomes by ensuring a comprehensive understanding of these issues.

Finally, in contrast to the current reporting relationships, a streamlined reporting structure with gatekeepers at each Council Agency will help reduce confusion and miscommunication with Creative Connections. During the course of this audit, miscommunication and an absence of feedback was frequently cited by Creative Connections as a reason for persistent noncompliance. Streamlined, documented communications through designated representatives would not only reduce the potential for misunderstandings, but would also eliminate the rationale for continued noncompliance.

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Technology

Performance Measures

The following performance measures were used to conduct the review of the technology component of the contract between Creative Connections, FCFC and HCDHS and the other Council agencies:

- Assess the completeness of management information systems (MIS)
- Evaluate technology policy training and operations manuals
- Evaluate existing hardware capabilities to determine if stated functionality exists
- Evaluate existing software/licensed program capabilities to determine if stated functionality exists
- Assess network connectivity and its impact on information systems utilization
- Review MIS support based on staffing, provider satisfaction and assistance wait time

Findings / Commendations / Recommendations

Management Information Systems Implementation

F5.1 The contract between the Council agencies, FCFC and Creative Connections does not contain detailed management information systems (MIS) specifications. The contract states that,

> Council Agencies shall collaborate with FCFC and Beech Acres to coordinate new data collection methods and plans with information systems as described in the Contract. Council Agencies shall work with FCFC and Beech Acres so that resources are not overburdened to the detriment of Beech Acres's ability to implement Long Term Implementation Plans.

The contract defines the Long Term IS Implementation Plan as "Beech Acres' plan to describe specific methods for capturing information related to all [social] services and all standards" listed in the contract exhibits. The contract does not specify required hardware or software or describe what is meant by collaboration and overburdening of resources.

The contract does contain a Transitional Data Plan which lists long term technology goals, particularly electronic transmission of appropriate client, clinical, and cost data to the Council agencies in usable formats. Beech Acres prepared a more specific written description of its long term plans for transforming its existing manual and automated systems but missed the contractually-required deadline for submission and was fined $14,370 during the first year of the contract. A detail of the Transitional Data Plan shows the software or manual system responsible for reporting information by key indicator. However, this plan indicates heavy reliance on Microsoft Excel spreadsheets. This requires individuals to redo the data entry, which increases inefficiency and the likelihood of mistakes.

F5.2 The contract does not identify the responsibilities of each of the parties to ensure sufficient fulfillment of the MIS requirements of the contract. An important component of a legal contract is the definition of the specific responsibilities and goals of the relationship. The contract describes the monetary and reporting relationships among the signers of these legal documents. However, exhibits to the contract do not define the primary computer systems, Information System Department (ISD) positions, or potential system links required to fulfil the contract requirements. Similarly, language pledging coordination and limiting of "undue burden" on resources lacks quantitative measurement. As a result, it cannot be determined which party was responsible for the identification of MIS requirements, the implementation of such systems or if the MIS aspects of the contract have been fulfilled.

R5.1 Any renegotiated agreement should specify the labor and technology resources pledged by each of the Council agencies, Beech Acres and FCFC. The Council agencies should identify the requirements of the MIS and the parties responsible for implementation. The resources should be associated with numerical measurements, such as man-hours and types of hardware and software, that can be assessed periodically. The current contract recognizes the need for performance measurement as a means for determining the results of the negotiated commitment of the parties. Technology costs are not identified separately in the Administrative or Care Management costs reported to FCFC (see **Table 3-1** and **Table 3-3** of the ***financial management and reporting*** section). Numerical performance measurements for technology requirements would enable reviewers to gather and analyze objective data about the technology challenges encountered in the renegotiated managed care relationship.

F5.3 In October, 1999, Beech Acres chose not to purchase the Care Management module of the UNI/Care system. Beech Acres included this module in February, April, and May, 1999 in documents to FCFC as part of what it would use in its Long Term Information Systems Implementation Plan. In December, 2000, the Beech Acres chief information officer explained that the decision not to purchase the Care Management module was made because it did not meet Beech Acres' needs. However, UNI/Care describes the Treatment Planner subset of this module as fulfilling many of the performance and outcome measures sought by the Beech Acres contract:

> The Care Management Module was developed with the help of various mental health experts to track and monitor standards for mental health care. It provides for the ability to define client problems, goals and objectives for treatment and to structure appropriate treatment plans for individual clients....The UNI/Care Treatment Planner is a subset of the Care Management Module....Treatment plans ... follow ...
>
> - Compliant DSM-IV diagnoses with ... list boxes which already contain DSM-IV and ICD-9 codes. ....
> - All treatment is captured as multiple 'threads' each comprised of a link between a Problem-Goal Objective-Intervention (PGOI).
> - Virtually an unlimited number of Problems, Goals, Objectives, and Interventions can be defined. ....
> - Multidisciplinary Assessments [can be processed through] assessment forms generation & narratives creation
> - Print and view multidisciplinary treatment plans.
>
> [The Utilization Review component of the Care Management Module does the following]:
> - Monitor productivity standards as defined by the facility
> - Monitor utilization review standards as defined by third party payors, funding sources, JCAHO, and CARF
> - Produce reports summarizing clinical utilization and quality assessment and improvement information.

Beech Acres chose not to purchase the key component of the UNI/Care system that had a high probability of helping it fulfil its reporting obligations under the contract. The Care Management Module would have enabled care managers to use automated rather than manual systems for recording client information almost exclusively. Instead, care managers use a mixture of manual and automated systems, and all parties to the Beech Acres contract express reluctance to rely on data entered into the automated system.

According to the chief information officer, the funds allocated for the purchase of the Care Management module have not been spent on additional technology for the Creative Connections program and has not been billed to the Council agencies as a part of administrative expenses. However, because Beech Acres does not provide detailed expenditure reports for Creative Connections to the contract manager, this information could not be verified.

R5.2 Creative Connections should purchase the UNI/Care Care Management module or a similar compatible software and implement the electronic system interface capabilities to ensure compliance with the original contract requirements. The additional software would allow Creative Connections to input all data related to client treatment plans, treatment plan goals, and treatment outcomes, along with contract performance measures. The electronic system interfaces would permit Creative Connections to exchange client and contract performance data securely to and from FCFC and the Council agencies as required by the Long Term Information Systems Plan. The Council agencies, FCFC and Creative Connections will need to provide each other sufficient information about their technology and communication systems in order for Creative Connections to select appropriate secure communications technology to fulfill the required electronic data interchange. If these MIS features are not incorporated, the ability of all parties to the contract to determine whether Creative Connections is performing as agreed will be at least delayed, if not prevented altogether.

F5.4 A committee of representatives from HCDHS and FCFC reviewed and approved Beech Acres' Long Term Information Systems Implementation Plan with reservations in May, 1999. An April, 1999 analysis of the proposed plan predicted many of the problems noted in this December, 2000 audit:

- The UNI/Care system was praised, but "the Plan did not actually demonstrate how data would be collected, entered, analyzed, tested for integrity, or reported" through UNI/Care.
- There was no evidence provided
  - That the client's treatment plans would be automated;
  - That billing information would be integrated with client care information; or
  - That the resulting system would interface with relevant Council and State Agency systems.

- The implementation time frame was considered overly ambitious in suggesting that completion would occur September, 1999.

Beech Acres responded incompletely to these concerns in May, 1999, and there is no documentation of further communications suggesting whether the Council agencies or FCFC formally approved the Plan. This incomplete documentation typifies the erratic communication among the parties to the Beech Acres contract. For example, Beech Acres did not notify FCFC or the Council agencies of its decision not to install the UNI/Care Care Management module (see also **R5.2**).

F5.5 The clinical software package, UNI/Care, was implemented by Beech Acres in July, 1999. The Plan of Care, Financial Manager, and Care Manager modules were not included in the July implementation. Three Beech Acres departments - Finance, Process Improvement and Quality Assurance (PIQA), and Information Systems (ISD) - accepted responsibility for integrating the automated systems and fulfilling contractual reporting requirements. The three systems requiring integration include UNI/Care, Great Plains Dynamics and Microsoft Office.

Creative Connections has a general description and contractual information suggesting that UNI/Care can meet all of the information requirements of the Council agencies. However, the Council agencies and FCFC stated that Creative Connections cannot adequately provide the reports required by the contract. None of the quarterly or annual reports given by Creative Connections to FCFC or the Council agencies indicate the source(s) of information for the reported findings. Consequently, there is no documentation clearly matching UNI/Care capabilities to fulfil contractual requirements.

R5.3 Creative Connections should clearly indicate and distribute information demonstrating how UNI/Care meets contract information requirements to FCFC and the Council agencies. Creative Connections should also cite the names and dates of system reports and the files or databases used as part of quarterly and annual reports. Such citations enable efficient research of any questions that arise from the findings. Readers of the quarterly and annual reports can research the assumptions and calculations used in the source data and determine the impact of those factors on the analyses and conclusions in the reports.

F5.6 The Council agencies, FCFC and Creative Connections renegotiated the contract performance indicators in December, 2000 (see also **Table 4-3** of the ***performance measurement*** section). The revised attachments to the contract extend the same technology obligations of the original contract and exhibits. The primary difference is language that suggests that all parties to the contract recognize that the Long Term Information Systems Plan is incomplete. It states, "Information System support - description of how information *will be* integrated into a tracking and monitoring system, coordination/integration of data

implementation plans as described...." The revised performance indicators no longer address progress on implementing the technology plan. Consequently, these revisions eliminate any incentive to maximizing the use of technology for the required reporting under the contract.

Information Technology Administration

F5.7 Throughout FY 1999-2000, the Beech Acres MIS consisted of the following:

- 5 MIS professionals responsible for MIS support functions;
- 264 personal computers;
- 12 servers; and
- 6 campus locations.

These served all Beech Acres personnel and functions, including the Creative Connections functions. Of the five employees in the organization chart, three (60 percent) have been employed by the ISD throughout FY 1999-2000, and two replacements were hired since September, 2000. In each of the preceding two years, one employee was replaced. The chief information officer (CIO) requested two additional positions of Beech Acres for fiscal year 2001, primarily because of the lower than expected computer knowledge of Beech Acres employees and planned Beech Acres Internet web site and telephone system projects.

Based on their resumes and recent training, all five employees have appropriate experience and skills for their jobs. All ISD employees have been cross-trained on all data processing activities. **Table 5-1** shows Beech Acres employees reported experience levels and recent technology training.

Table 5-1: Experience and Training of Beech Acres ISD Employees

Employee Title	# Years Technology Experience	# Years at Beech Acres	Recent Technology Courses
Chief Information Officer	16.0	4.0	Technology Project Management, NT 4.0 administration, UNI/Care system, Microsoft Exchange Server administration
Network Administrator	11.0	0.4	Certifications in Citrix, Computer and Network Technical Support, NT 4.0 administration
Database Administrator	6.0	1.1	UNI/Care report writing, A/R & Billing module
IT Technical Support	2.6	1.3	NT 4.0, Microsoft Exchange Server, Microsoft Excel, Microsoft Word
Training/Administration Coordinator	10.0	22.0	Front Page 2000, UNI/Care management, Advanced Internet, Microsoft PowerPoint, Microsoft Excel

Sources: Beech Acres Job Responsibility lists, individual resumes, Beech Acres training records

The ISD employees received training appropriate to their job assignments. Employees with the most technology experience have the most complex technology assignments.

F5.8 Beech Acres has approximately one ISD employee for every 53 workstations. This ratio of ISD employees to computer users comes close to the 1:50 ratio found by *ComputerWorld* in September, 1997 but is somewhat less than the 1:60-100 ratio found by the Gartner Group for experienced but unsophisticated computer users in 1999. After reviewing the nature of users' requests to the ISD help desk requests, Beech Acres developed and taught a mandatory basic computer technology class. The need for this class suggests that the current technology knowledge level of Beech Acres users is low. Consequently, the technology staffing level for the organization needs to be close to the 1:50 ratio for inexperienced users; ISD met that level as of December,2000.

R5.4 Beech Acres should reorganize the ISD to enable the full-time administrative assistant who currently divides her time between training and administrative tasks to work exclusively on training issues. In order to fully comply with the contract, many Beech Acres employees will need training on new systems and procedures designed to increase the use of well-integrated automation. Administrative tasks such as logging help desk requests and changing user access codes could be done primarily through automation.

F5.9 The FY 1999-2000 Beech Acres ISD turnover rate was 40 percent. This rate greatly exceeds the 18.3 percent average turnover found in a 1999 PriceWaterhouseCoopers survey. However, another survey of information technology workers revealed that "turnover is four times higher for IT employees with three years of service or less." (*IT Talent Survey Highlights*, Hewitt Associates LLC, published March, 2000) The Hewitt survey suggests that "on average, it takes 87 days to fill an IT job." Beech Acres has a policy of looking for employees internally at first, and considers employment in all cases to be conditional pending criminal offense record checks. Continued high turnover in any function of any organization can delay completion of scheduled projects and impede productivity.

R5.5 Beech Acres should do the following in order to reduce turnover in its technology staff:

- Raise salaries;
- Create career ladders; and
- Seek recruits both internally and externally.

The ISD experienced 40 percent turnover during FY 1999-2000. Reducing the turnover can decrease overhead to Beech Acres by as much as two or three times the retained employees' salaries. The chief information officer suggested a combination of factors contributed to this high percentage: low supply of skilled candidates, little or no room for advancement within the department, and salaries below regional medians. The number of qualified candidates for technical jobs is likely to remain low. However, Beech Acres can mitigate the other two factors.

Hewitt Associates noted that in 1999, the "average cost for an IT hire represents 100 percent to 250 percent of salary." Therefore, hiring two ISD employees within a year may have cost Beech Acres at least double the amount paid to the three people who left. In other words, if the departing employees each earned $25,000 per year, the cost of hiring the two replacements - the sum of advertising the job and the time and paperwork needed to evaluate the job candidates - may have ranged from $50,000 to as much as $125,000. Beech Acres should raise ISD beginning salaries to amounts as close to the regional median as its budget permits.

Changes in Beech Acres ISD structure and management will benefit the Council agencies by reducing MIS costs. In addition, reduced turnover and greater skill levels would assist Creative Connections in meeting Council agencies' performance expectations. As the Council agencies are dependent on the ISD to provide appropriate MIS to meet contract reporting requirements, any positive changes to the ISD will produce a benefit for the Council agencies

Technology Planning

F5.10 The MIS function has not been guided by a Technology Steering Committee or long term strategic plan. The chief information officer drafted recommendations for both and submitted them to the Beech Acres President & CEO in December, 2000. The draft Technology Plan dated December, 2000 includes the concept of a steering committee, called the planning team, that involves technology user departments and periodic meetings. Its goal is to match technology available at Beech Acres to that organization's mission. Because the proposed planning team has not met, the Technology Plan does not contain text mapping the logic from defining computer user needs to identifying and scheduling technology projects. Instead it includes a list of ISD projects planned and completed during FY 1999-2000, a few of which will be finished during FY 2000-2001, and some significant proposed projects. The name and status of projects with direct impact on the contract are presented in **Table 5-2**.

Table 5-2: Summary of 2000 and 2001 Technology Projects for Creative Connections

Project Name	Project Description	12/1/00 Project Status per Beech Acres IS Department	Per AOS Performance Audit
UNI/Care Implementation	Creative Connections and Beech Acres West	Complete	Excludes interface with accounting system - see **F5.27**and **R5.15** Excludes Care Management module - see **F5.3** and **R5.2**
UNI/Care - Family Care Module	Implementation	Carryover into 2001	Should facilitate monitoring of foster care service providers - see **F4.9, F4.21**, **R4.7, R4.18** of ***Performance Measurement*** section
Time Tracking Database	To track time and associated costs on various projects; produce invoices for inter-company transfers and statistical reports	Complete	Detailed information about costs by project not available to FCFC. See **F3.8** and **R3.5** of ***Financial Management and Reporting*** section.
Client Transportation System	Client scheduling and transportation tracking and reporting system, integrated into UNI/Care	Carryover into 2001	Should facilitate accurate monitoring of clients in outlier status - see **F3.20** and **R3.13** of ***Financial Management and Reporting*** section.
IT Key Performance Indicators Database	Integrate three related databases to create and process reports of these indicators	Incomplete; not listed with 2001 projects	Accurate, complete reports vital to success of contract - see ***Capturing and Reporting for Performance Measures*** within ***Performance Measurement*** section and ***Contractual Reporting Requirements*** within ***Financial Management and Reporting*** section.

Sources: Beech Acres Technology Plan 2001, 12/1/00; AOS performance audit sections indicated

R5.6 Beech Acres should create the Technology Steering Committee and the proposed Planning Team that includes users and external report recipients, as well as ISD management. A Planning Team was named in January, 2001, but has not met. Minutes of discussions and decisions occurring at these meetings should be kept by Beech Acres and any that pertain to Creative Connections or the contract should be shared with FCFC. Meetings should occur regularly to accomplish the following primary objectives:

- Developing and revising the technology plan;
- Setting technology project priorities;
- Evaluating technology initiatives according to the plan and previously defined priorities; and
- Reviewing progress of technology projects during implementation.

Such cross-functional representation ensures that technology decisions coordinate with overall organizational goals and community needs.

F5.11 The Technology Plan Draft from February 2001 partially describes the relationship between existing resources and required resources to better achieve organizational goals. It proposes strategy and knowledge audits costing $50,000 to help Beech Acres define this relationship fully. Effective technology planning can result in a computing environment that allows more efficient use of staff and management time across all organizational functions. The ISD can justify its budget requests and implement proposed technology projects with a defined direction. The Technology Plan should fulfill the following objectives:

- Evaluating how existing hardware and software applications support long-term objectives of Beech Acres;
- Defining significant industry trends in applicable social services fields; and
- Determining what technology and training is needed to help Beech Acres best fulfil its long-term objectives.

Without such stated analysis, the Technology Plan relies on its readers to agree or disagree and prioritze the technology projects listed.

R5.7 Beech Acres management must fully support the Technology Plan with adequate funding. Technology plans are more likely to receive this support when they include the following:

- An annual review and revision process that allows the plan to evolve with internal and external changes in technology and organizational objectives; and
- Detailed, measurable implementation plans for each technology project in the plan, including time, equipment and resources required, statement of expected benefits, and expected completion dates.

A formal information technology planning methodology will help Beech Acres implement the proposed technology projects with greater user acceptance and less risk.

The Technology Plan, along with the ISD budget, should also address the issue of related training for technology employees and users. Innovations in all areas of technology continue to occur so rapidly that older technologies cannot be supported or maintained after brief periods. The UNI/Care contract stipulated that the vendor cannot support any software more than 12 months old. Workstation prices have dropped to the point that replacement is a realistic alternative to repair. Beech Acres has the technology inventory and depreciation data needed to add this component to its Technology Plan.

Internal Policies and Procedures and Security Features

F5.12 The Beech Acres ISD revised its organization-wide technology use policies in June 2000. The policies cover the most basic security features needed for a network computer system. The Beech Acres Organization and Human Resource Department emails staff terminations on a timely basis to the IS administrator in order for the ISD to eliminate departing employees' system access. Key policies are shown in **Table 5-3.**

Table 5-3: System Policies and Security Features

Policy Area	Key Policy
Confidentiality of Computerized Information	- must have job-related reason to access sensitive data - computer access limited to authorized users - change passwords as needed - turn network access off whenever that access is not needed - limit visibility of computer monitor screen - limit visibility of reports containing sensitive information
Data Backup	- weekly offsite storage of entire system backups - daily online storage of entire system backups
E-Mail	- IS department reserves right to monitor for appropriate, business-related use - avoid using to transmit offensive material, solicitations, chain letters, messages to large numbers of recipients ("spam")
Help Desk	- describes scope of requests handled and procedures for prioritizing and resolving
Internet Use	- limited to business of Beech Acres - scan files for viruses before downloading - cannot use for purchases, downloads of copyrighted material
Purchasing Policy	- hardware and software purchasing should be done via the ISD - no department-specific software purchase should be made without prior discussion with the chief information officer - all registration material, licenses, media, and purchase invoice copy are sent to the ISD.
Software Policy	- software copyrights will be followed; ISD will register all software, maintain library of licenses - software shall be upgraded and changed at the discretion of the ISD in order to maintain current levels of compatibility and functionality" - only ISD employees, software vendors, or outside computer technicians may install software - software purchased for Beech Acres may not be used on employees' home computers - Beech Acres employees may not transfer software from their home computers to their Beech Acres computers - ISD will audit software on all Beech Acres computers annually
System Access Security	- Supervisors notify ISD of access needed - Passwords needed at the network level and software package level for department-specific software - Number of unsuccessful login attempts restricted - Initial default login password expires after one use.

Source: Beech Acres internal technology policies, 6/00

Beech Acres covers key information security techniques through a combination of hardware, software, internal policies and procedures. The policies emphasize the sensitivity of information maintained by Beech Acres. Its network equipment includes software containing firewalls and virus detection and elimination systems. The internal controls of the organization's network infrastructure require two levels of password access and authorization for access from supervisors of employees. The Beech Acres Human Resources Department notifies the ISD immediately upon receiving news of an employee's termination so that system access is also removed on a timely basis. All of these features promote a reasonably secure environment for use of computer technology.

R5.8 The ISD policies should be adjusted in order to enhance the compatibility of all technology components and increase the overall level of security. Recommended changes are shown below:

- Develop and promote standardization of hardware across the agency, including a systematic replacement policy to enable equipment uniformity and compatibility over a short period of time.

- Strengthen purchasing policy to mandate the involvement of the ISD prior to all purchases of hardware and software, and insist on appropriate documentation to demonstrate that involvement. The latest software audit, conducted September, 2000, resulted in some software identified and eliminated due to improper authorization. Encouraging ISD involvement and approval of all purchases would prevent some of the improper and incompatible hardware and software from appearing within Beech Acres.

- Implementing policies to force users to change passwords periodically. Many software packages include options to force users to change passwords after a set length of time, and system administrators should invoke those options whenever possible. Other password controls worth adding include forcing users to select passwords that are combinations of letters and numbers, avoiding easily identifiable passwords, such as family names or birthdays, and not repeating previously used passwords. All of these password controls may be audited periodically using password audit software.

This combination of changes will increase the levels of security and consistency among all Beech Acres workstations.

F5.13 Beech Acres does not have a formal disaster recovery plan for technology services. At present, the number of servers and locations for Beech Acres provides redundancy for most of the applications and connections used by Beech Acres. Also, the daily and weekly backups of data and files would facilitate quick resumption of automated activities in a disaster. However, the procedures needed to actually guide a disaster recovery are not written.

R5.9 Beech Acres should develop written disaster recovery procedures, and a policy that requires periodic updates to those procedures The written procedures should specify what tasks need to be performed, and who would be authorized to perform them in a disaster situation. The disaster recovery plan should contain the following features:

- A prioritized application recovery list;
- List of technical recovery procedures and configurations; and
- Schedule of disaster recovery training and testing.

Once implemented, Beech Acres should periodically test the disaster recovery plan and adequacy of the training of Beech Acres employees in order to revise the plan as needed.

Network and Hardware Analysis

F5.14 In order to accommodate its six campus locations, Beech Acres established a Wide Area Network (WAN). The Creative Connections network depends upon elements of the overall Beech Acres network in order to function.

The WAN is based on a Cisco 3600 Router that connects to an assortment of network hubs, switches, network servers and application servers through T-1 lines, ISDN lines, and 10-Base-T twisted pair cables. Each location operates a Local Area Network (LAN). The network at the main Beech Acres campus is connected with twisted pair cable while the other locations rely on fiber optic cables to access the switches and hubs of the main campus. The LANs access all of the servers through a 10- Base-T line that leads to a switch running on a 100-Base-T line. Beech Acres reports no decrease in system responsiveness related to having a slower connection preceding a faster communication line. The offsite LANs access the primary Cisco 3600 Router over T1 and ISDN lines; however, workstations at three of the five offsite locations first transmit through 10-Base-T hubs.

F5.15 The primary router connects to one of the main switches for the application servers via a 10-Base-T telephone line. One computer consulting firm, CTS, suggests that "the hub or the switch should match the throughput rating of the cable in order for the network to perform at maximum speed." The Beech Acres network does not have cable that matches the speed of its other network equipment. However, not maximizing data transmission speed has not

affected the perception of the network's effectiveness by its users. All but 1.6 percent of network users responding to an internal survey rated the "Quality of Service" of the Beech Acres ISD "satisfactory" or "excellent".

R5.10 Beech Acres should replace the 10-Base-T with faster fiber-optic cable. Creative Connections uses a series of hubs to transmit data to and from the rest of the WAN. Sequencing hubs enables computer networks to extend the distance between network workstations but can also slow the speed of data transmission within that network. This cascading of hubs, coupled with the primary 10-Base-T connection described in **F5.14** reduces the efficiency of the data transmission speed.

F5.16 For its 264 workstations, Beech Acres has 171 Hub ports, a router for each location off the main campus on Beechmont Avenue and one for the Internet connection. A separate Proxy Server provides firewall protection over data transmitted through a 10 Mbps (million bits per second) line that leads to the ISDN connection between the Internet and Beech Acres. Reports are sent from Creative Connections via email to all but one of the Council Agencies. A 56k modem connection to the Hamilton County Mental Health Board facilitates data transmission to that agency's Research, Operations, Program Evaluation Software (ROPES).

The hubs that serve the Creative Connections LAN were originally purchased for other Beech Acres functions. Beech Acres relies on 3COM brand hubs, a brand reputed to effectively serve mid-sized businesses. 3COM manufactured most of Beech Acres' network switches.

F5.17 All servers are onsite, in locked rooms only accessible by ISD staff. No logs of their access are kept. Servers are in rooms protected from potential water damage from flooding and plumbing because they are not on ground level and plumbing pipes are not above or below those rooms. Fire and smoke detectors are in or near all rooms with servers; halon fire extinguishers were installed early in 2001, and a monitored fire alarm system will be added soon. All software media and copies are in a locked file cabinet accessible only to ISD personnel. Weekly and monthly backup tapes are located in a fireproof safe offsite. This offsite location has no plumbing and no fire or smoke detector but does have fire extinguishers. Beech Acres did not indicate whether the addition of the halon fire extinguishers lowered its insurance premiums.

C5.1 Beech Acres generally meets current technology industry standards for safeguarding software source code and network hardware. Beech Acres employed simple, cost effective measures to limit access to these assets and to minimize potential damage from two significant factors, fire and water.

R5.11 Beech Acres should investigate whether the purchase of the halon fire extinguishers might lower its insurance premiums as halon fire extinguishers are less likely to damage computer equipment if used. The ISD should also establish a log of all individuals accessing the network facilities or software cabinet in order to establish accountability for any incidents related to the network or software source code. Beech Acres has some security over the physical assets of its network and software source code such as locks, fire and smoke detectors, and nearby fire extinguishers. Some backup tapes are offsite.

F5.18 During FY 1999-2000, the ISD implemented an organization-wide (within Beech Acres) Intranet to improve communications and cooperative activities between Beech Acres departments. It includes a staff directory, organization forms, policies, procedures, Personnel Manual, the organization newsletter, access to the IS Help Desk and a separate page for UNI/Care assistance. The ISD baseline survey of Beech Acres computer users revealed that over 80 percent of Beech Acres employees considered the ISD's overall conduct, service, training and assistance "satisfactory" or "excellent." This survey precipitated the development of performance indicators for ISD Help Desk response time, network availability, and project implementation assistance.

C5.2 The Intranet at Beech Acres is well-developed and highly complete. It contains information relevant to employees' daily functions and responsibilities. By providing fast, desktop access to this information as well as appropriate forms and policies, ISD has contributed to enhancing the overall efficiency of Beech Acres.

F5.19 Beech Acres has a variety of personal computers and laptops. Beech Acres assigned and purchased a total of 71 computers for the Creative Connections project. The UNI/Care contract required that Beech Acres provide the equipment shown in **Table 5-6**.

Table 5-6: UNI/Care Contractual Hardware Specifications

Purpose	Hardware	Operating System	In Use 12/00
Application Server	Compaq Proliant 1600	Windows NT 4.0	Compaq Proliant 1600
Communication Server	Multi-Processor Intel Machine	Citrix Win Frame	Citrix MetaFrame
User Workstations	Pentium 133 Mhz	Windows 95	less powerful personal computers offset by MetaFrame software in network servers
Report Writer Workstations	Pentium 166	Windows 95	less powerful personal computers offset by MetaFrame software in network servers
Remote Communications	56K Modems	Not Specified	56K Modem and Proxy Server to Internet via ISDN
Printers	Dot Matrix and Laser	Not Specified	Dot Matrix, Laser Jet and Inkjet

Source: 6/29/98 General Agreement between Beech Acres and UNI/Care Systems and 12/00 Creative Connections hardware inventory

Creative Connections network assets exceed UNI/Care contract requirements. The Beech Acres computer network handles MIS requirements for both Creative Connections and other Beech Acres programs. Although the UNI/Care server is distinctive, as required by the UNI/Care contract, the Beech Acres personal computers, communication lines and printers connect to other Beech Acres programs in addition to Creative Connections. The Beech Acres UNI/Care Application Server has a faster processing chip and more random access memory than the minimum required under the UNI/Care contract, and the communication servers and hubs also exceed UNI/Care contract requirements.

Some Beech Acres computers do not meet the UNI/Care contract specifications for user or Report Writer workstations and cannot easily access all of the necessary application software. To rectify this situation, Beech Acres acquired Metaframe network resource software. Metaframe allows individual users high speed access to all remote and network files and devices regardless of the memory, connectivity, and storage capabilities of the individual computer. Beech Acres effectively reduced its maintenance, labor, and hardware acquisition and upgrade costs by installing Metaframe.

F5.20 There is incomplete documentation of the total cost incurred by Beech Acres for the technology needed for the Creative Connections project. The Creative Connections hardware inventory includes costs only for equipment installed since July, 1999. The depreciation schedule lists the cost of the UNI/Care program but does not distinguish between equipment assigned to the Creative Connections and equipment assigned to other Beech Acres departments or programs. The cost accounting information provided by Beech Acres does not clearly define the nature of the expenses listed. Equipment assigned to Creative Connections includes all of the LAN hardware and related software. The chief information officer created a Microsoft Excel spreadsheet to track the invoices received for the UNI/Care installation. However, the spreadsheet does not account for any Beech Acres employee time spent on the project. Without this information, it is difficult to determine the costs incurred by Beech Acres (see also ***budgeting, expenditure reporting and deficit usage*** subsection in ***financial management***).

R5.12 Beech Acres should segregate the Creative Connections technology costs from Beech Acres technology costs. Creative Connections costs should be incorporated into the total administrative costs reported in the annual project budget. Beech Acres has a sophisticated accounting software program, Great Plains Dynamics, that has a project accounting module as well as financial and accrual accounting features. Implementing project accounting of the invoices paid to outside contractors and equipment manufacturers and the time spent by Beech Acres employees on the Creative Connections contract will give FCFC and the Council agencies a better understanding of the actual administrative costs of the managed care arrangement. Furthermore, this type of detailed information will fulfill the oversight needs of the Council agencies and contract manager.

Software

F5.21 Creative Connections relies on a combination of software to fulfill obligations under the Beech Acres contract and other services performed at the Beech Acres facilities. Microsoft Office 2000 Professional provides not only the general administrative programs but also maintains a number of databases necessary for the contract and the organization. Other well-known and well-established Microsoft products enable Beech Acres employees to use a variety of email and Internet research functions. All Creative Connections staff has access to UNI/Care and Microsoft Office. The UNI/Care Report Writer module interfaces with Microsoft SQL in order to enable users to manipulate data with Microsoft Office products.

The Beech Acres Finance Department uses Great Plains Dynamics software for its accounting and financial management. Great Plains accounting software has been rated within the information technology industry as one of the best accounting software packages available for mid-sized firms. Within Creative Connections and Beech Acres, accounting information can be and is sent from the Great Plains Dynamics financial software to the

Microsoft Office software so that users can reformat and analyze the data in spreadsheets, text, and/or database reports used to facilitate management decisions.

The software listed in **Table 5-7** was purchased from late 1996 through late FY 1999-2000. The table summarizes the software package name, manufacturer and basic purpose and use.

Table 5-7: Software Inventory for Creative Connections

Software	Manufacturer	Purpose and Use
Arcserv	Cheyenne	Network data protection - backup, storage, disaster recovery
Inoculan	Cheyenne	Virus Protection
Cisco	Cisco	Network software
MetaFrame	Citrix Systems	Application server enabling software access through Internet; also enables application access directly from server
WinFrame	Citrix Systems	Application server enabling software access through network; upgraded to MetaFrame
Paradox	Corel	Database software
Dynamics	Great Plains	Financial Management System
Microsoft Exchange Server	Microsoft	Facilitates network communications, email
Microsoft Terminal Server	Microsoft	Terminal emulation, Windows NT management
MS Office 2000	Microsoft	General office applications
MS Project 98	Microsoft	Business project management
MS Proxy Server	Microsoft	Firewall, content cache for Internet use
MS SQL Server	Microsoft	Database management via Internet with firewall; IS Department Help Desk
Windows NT	Microsoft	Operating system for network and Internet
Dial-a-Ropes	Minisoft	Facilitates connection with Hamilton County Mental Health Board
Visio	Microsoft	Flowcharts, diagraming software
SPSS for Windows	SPSS	Client and treatment utilization management
UNI/Care	UNI/Care	Managed care operations

Source: Beech Acres Software Inventory 12/14/00 and manufacturers' web sites.

The software listed in **Table 5-7** allows Beech Acres to run a widespread computer network effectively and to facilitate many of the tasks needed to fulfil its overall mission. These programs are also used by Creative Connections to monitor and track client progress, provider licensing, costs and other essential information. Each of the software programs used by Creative Connections has some level of utility to the Council agencies and the contract

manager as the software is used for program management and reporting. However, some of the programs may duplicate functions available through UNI/Care (see also **F5.4** and **F5.5**). Although the combination of the software shown in **Table 5-7** meets a majority of the Council agencies and contract manager's reporting needs, redundant software may increase technology costs.

F5.22 Because of their numerous reporting and management requirements, managed care organizations usually rely on industry-specific software to gather and summarize the wide variety of client, treatment, provider, and payer data available. After a lengthy request for proposal (RFP) process, Beech Acres selected UNI/Care software to facilitate its MIS requirements. Beech Acres management decided that UNI/Care could best meet the needs of the entire organization and signed a contract with UNI/Care in June, 1998. Beech Acres opted not to purchase the Scheduling or Care Management modules that UNI/Care normally includes for first-time customers.

UNI/Care agreed to develop an interface between the Great Plains accounting software used by Beech Acres and the UNI/Care modules. Final invoices for UNI/Care were paid in February or March, 2000. As of December, 2000, the interface between Great Plains and UNI/Care had not been implemented. Creative Connections reported the Long Term IS Implementation Plan complete in September, 2000 even though UNI/Care continues to work on the interface with Great Plains accounting software as of December, 2000 (see **R5.15**).

F5.23 The Substance Abuse Management Health Services Agency (SAMHSA) developed a Technical Assistance Guide for entities considering information systems contracts to track managed care services. **Tables 5-8, 5-9** and **5-10** summarize the ideal characteristics of the information system as a whole, regardless of the level of automation, the information system content, and the information system security standards respectively.

Table 5-8: Ideal Managed Care Management Information System Characteristics

Ideal Information System Characteristics	UNI/Care	Creative Connections
Has capacity for any organization to share information	Not answered in UNI/Care's sales literature	Yes, via electronic files
Integrates different types of information (clinical, social, financial, administrative)	Yes	Yes
Processes changes in data elements throughout all system modules	Yes	No
Allow users to view information, enter and edit data	Yes	Yes
Enforces cooperative relationships among medical care recipients, the Managed Care Organization, and medical care providers	Not answered in UNI/Care's sales literature	Not answered
Can track clients in and out of treatment, from program to program	Yes	Yes
Can capture all clinical, social, financial information about client	Yes	Yes
Can summarize client information by client, program, treatment, group, provider.	Yes	Yes
Creates comprehensive data set about clients, Managed Care Organization, providers, including clinical, demographic, financial, utilization management	Yes	About clients
Allows all users to view, sort, manipulate data as needed	Yes	Data manipulation through Microsoft Access
Has data available on real-time basis to all users.	Yes	Yes

Sources: UNI/Care's description of its system modules provided by Beech Acres to FCFC, and Creative Connections' responses to criteria listed in table

Creative Connections could not provide an explanation for the two differences in UNI/Care system functionality described in **Table 5-8**. The UNI/Care gathers a large number of data elements about client services and enables system users to revise and analyze that data as simply and efficiently as possible. Users should be able to change a client's address once and simultaneously affect all system databases that would need to know that address change. UNI/Care reportedly contains this feature; Creative Connections has not been able to operationalize the feature but can not provide specific examples of reduced functionality.

Creative Connections does not have or use sufficient UNI/Care modules to enable the capture of "comprehensive data set about...Managed Care Organization, providers, ...[and] financial [and] utilization management." Both of these differences suggest that the UNI/Care system originally purchased by Beech Acres could have fulfilled the above suggested characteristics.

R5.13 Creative Connections should immediately begin the implementation of the modules needed to fulfill contract requirements. An appropriate information system is essential to the contract reporting process and is necessary to track and analyze client data to implement cost containment programs. The ISD should determine which features of UNI/Care are not functional (in comparison to advertized benefits) and should first follow up with UNIC/Care on these issues.

Creative Connections should also ensure that its software heightens cooperation between clients, Creative Connections, providers and the Council agencies. The software and component modules should also create comprehensive data sets about the clients, Creative Connections and providers, including clinical, demographic, financial and utilization data. The ISD should not begin programming its own modules until a thorough investigation of UNI/Care software is performed to ensure that the desired features are unavailable through the current system.

F5.24 **Table 5-9** shows SAMHSA's recommended MIS characteristics for the management of health care service delivery.

Table 5-9: Ideal Managed Care Software Features

Ideal Automated Information System Features	UNI/Care	Creative Connections
Frequent Electronic Data Information updates to manage client insurance eligibility information	Outside scope of UNI/Care software package	No
Database of providers' credentials, including qualifications, demographics, locations, availability, services provided, insurance coverage and claims against	Does not include providers' insurance coverages or any claims made against them	Does not include providers' insurance coverages or any claims made against them
Electronic exchange of data between providers and the Managed Care Organization, including unique client identifier, client demographics, treatments, outcomes, and payments	Not answered in UNI/Care's sales literature	Yes
Standardization of clinical assessments sufficient to support placement, treatment continuity, outcomes	Yes per UNI/Care's sales literature	No

Outcome evaluation - standard analyses by money spent, clinical results, providers used, client perspective, including comparison to accepted baselines	Yes per UNI/Care's sales literature	Does not record clinical results or client perspectives
Utilization management and treatment authorization - linked to clinical data, baselines and reported in hard copy or electronically	Yes per UNI/Care's sales literature	Yes
Case management - by client, provider, treatment plan, benefits remaining - with frequent updates	Yes	Creative Connections does not have the treatment planner component
Service tracking - by client, provider, outcome, cost	Yes	By client, provider, and cost - not by outcome
Claims processing - client eligibility, provider eligibility, fee schedule, authorization, billing	Yes	Yes
Comparison of data with established performance criteria	Yes, with user-defined criteria, or JCAHO, GAF or CARF	Custom report by Creative Connections
Wide variety of reporting available, including customization by system users	Yes	Almost all reports have been custom-written. The Accounts Receivable standard reports are used by the Finance Department**.**
Software-driven triggers to improve quality assurance of services provided	Not within UNI/Care software; possible in combination with other software packages	No
Critical incident reporting	No	No

Sources: UNI/Care's description of its system modules provided by Beech Acres to FCFC, and Creative Connections' responses to criteria listed in table

The differences between the UNI/Care reported features and Creative Connections' experience with that software is directly related to Beech Acres' decision not to install the UNI/Care Care Management module (see **F5.3** and **R5.2**). Several of the modules may fulfill the characteristics not covered within the current UNI/Care package. Desirable characteristics that have not been addressed include using electronic data to update client eligibility (which is currently the responsibility of the Mental Health Board for Medicaid eligibility), maintaining a provider database, standardized clinical assessments (which may require user definitions), the use of outcome evaluation and service tracking by outcome,

automated quality triggers and critical incident reporting. Although several of these features are available through UNI/Care, Creative Connections and the ISD may not be able to purchase sufficient software to fulfill some critical managed care MIS aspects.

R5.14 In order to implement the managed care aspects of the contract, Creative Connections and the ISD should develop sufficient expertise in UNI/Care to implement the clinical assessment standardization feature of the MIS. Also, the outcome evaluation features should be more fully explored so that outcomes can be incorporated into contract reporting. Furthermore, the ISD should purchase and implement the treatment planner module to obtain case management capabilities not available through the current MIS, including management by client, provider, treatment plan and remaining benefits. Creative Connections should explore the potential to use some of the built in performance measurement capabilities of UNI/Care which filters variables to achieve standardized performance measures used by national accreditation organizations.

The ISD should begin examining the possibility of enhancing UNI/Care features to create quality triggers– automated features designed to improve quality assurance activities. Also, the development of a critical incident reporting module should be considered. However, the ISD should not undertake any programming efforts until the capabilities and limitations of the current MIS are fully understood by the organization.

F5.25 Recent Federal regulations and laws have highlighted the need to ensure the security of medical treatment information. The SAMHSA suggestions for automated system features to ensure client confidentiality are shown in **Table 5-10**.

Table 5-10: Ideal Managed Care Information System Features for Data Security

Technical Information System Features	UNI/Care	Creative Connections
Unique identifier for clients	Not answered in UNI/Care sales literature	Yes
Security levels to limit access to client identifying information	Yes	Yes
Encrypted electronic data exchange	Outside scope of UNI/Care software package	No
Firewalls and multiple security clearances to prevent breaches of system information to unauthorized persons or entities	Outside scope of UNI/Care software package	Yes, through Windows NT and application security
"Open architecture" of software programming to enable data transfer and security	Not answered in UNI/Care sales literature	Yes
Data access via direct access or standardized formats	Yes	Yes
Data storage online for a defined period, and retrievable data once archived	Yes	Yes, Creative Connections does not archive any records yet**.**
Backup data secured and offsite	Outside scope of UNI/Care software package	Yes
High speed data transmission lines	Outside scope of UNI/Care software package	Yes
Software licensing agreement specifying number of users or workstations, servers, system maintenance, documentation, written and electronic help systems and data integrity	Yes	Yes

Sources: UNI/Care's description of its system modules provided by Beech Acres to FCFC, and Creative Connections' responses to criteria listed in table

Table 5-10 suggests that most of the procedures needed to ensure data security fall outside of the functions available through the UNI/Care system. Instead, managed care entities are responsible for having sufficient technology policies, practices, and enforcement mechanisms in place to provide adequate security for data about their clients. The technology practices include a number of instructions to computer users and sufficient general computer hardware and software to identify unauthorized computer access and unauthorized data transmission.

F5.26 Creative Connections has system fragmentation problems experienced by many collaborative managed care efforts. In May, 2000, the Bazelon Center for Mental Health Law and the Milbank Memorial Fund published a study of 31 states' efforts to manage behavioral health care. The study's technology-related findings include the following:

- Most states have little comprehensive, complete, or current data on eligible patients.
- Patient registration processes, identifiers, and service/benefit coding may vary widely among agencies participating in collaborative agreements.
- Managed Care providers do not have data systems that can provide performance and outcome analyses.

Within Creative Connections' installed UNI/Care modules, there is no automated sharing of diagnostic or treatment standards such as the DMS IV to UNI/Care system input. The system does not allow comparison of the contract's key indicators or even any treatment outcome to any data in the UNI/Care system. Creative Connections does not use the UNI/Care system as a provider credentialing database, although some basic information about providers can be maintained in the MIS. The COBOL version of UNI/Care currently in use does not integrate billing and clinical care modules; however, a graphical user interface version is available and has greater functionality than the COBOL version. A comparison of the Transitional Data Plan written for the Beech Acres contract to the Long Term Information Systems Plan confirmed that the UNI/Care system installation did effectively replace several hard copy reports, and internally created spreadsheets and a plan of care database.

F5.27 UNI/Care has not developed procedures for integrating its system with the Great Plains accounting software used by Beech Acres. Beech Acres completed payments on its UNI/Care contract despite lack of fulfillment of this portion of the contract. Beech Acres demanded that UNI/Care provide a plan for integrating the two systems by December 21, 2000, and UNI/Care missed this deadline. As a result, Creative Connections develops its financial and client care management reports from separate computer systems operated by two different Beech Acres departments. The departments that generate these reports do not share them with each other or with anyone else in Beech Acres or Creative Connections senior management prior to forwarding them to FCFC for review.

R5.15 Beech Acres should integrate its care management and financial reporting systems so that MIS reports will provide the Council agencies with more holistic program measures. This integration project is not mentioned in the draft Technology Plan submitted to Beech Acres management in December, 2000 and it appears that Beech Acres views this project as a low priority. If UNI/Care cannot or will not do this project in a timely or cost-effective manner, Beech Acres should find resources inside or outside its organization that can. Such

integration will enable Creative Connections to fulfill many elements of the revised performance indicator reporting. Integrated reports of clinical and cost information should be reviewed by senior management at Beech Acres prior to forwarding to FCFC for further auditing and analysis. Other MIS goals should include the following:

- Developing individual reports that provide sufficient data for multiple management decisions;
- Developing reports that help Creative Connections audit contract compliance with the Beech Acres contract; and
- Reorganizing reported client information and results of activities by contract funding source in order to enable all parties to the Beech Acres contract to understand the structure of the arrangement.

Completion of these steps will maximize the efficient use of technology for this managed care contract.

F5.28 Creative Connections care managers record case information in redundant systems-- once manually on service tickets, then in automated form on UNI/Care. Beech Acres executive management has not required employee use of automated systems. Care managers report that they cannot use the UNI/Care system to access a full, rolling chart of clients; consequently, they maintain paper files of all clients. Instead of the UNI/Care Scheduling module, Beech Acres employees complete non-billable service ticket forms, enter their information into a Microsoft Access database, then analyze the data through a Microsoft Excel spreadsheet. Also, instead of the Care Management module, Beech Acres employees enter information into Microsoft Word and maintain the information in hard copy. The UNI/Care modules, in updated UNI/Care versions, are integrated. Manual forms mentioned in the UNI/Care training manual include the following:

- Face Sheet;
- On-call Book;
- Intake Packet;
- Med/ Ed/ Visitation Form;
- Notification of Change Form; and
- Beech Acres Interagency Transfer Form.

Beech Acres management reported that it has not determined the most efficient process for entering information into the automated system. Instead, various employees share, and occasionally duplicate, data entry responsibilities. The UNI/Care Training Manual customized for Creative Connections suggests that data technicians are largely responsible for data entry although care managers must authorize changes to client information.

The ISD trained care managers on UNI/Care in tracking referrals, and managing client cancellations and no-shows. UNI/Care commands for these activities could constitute some key components of client history. The ISD cannot explain why care managers are not using the installed UNI/Care system for this purpose. Beech Acres and ISD have not undertaken a realignment of business processes to fully utilize UNI/Care.

Other service providers under the Creative Connections contract report that the UNI/Care software is easier to use than previous systems. However, UNI/Care at Beech Acres was chosen and installed without any input from the large pool of Creative Connections users. Not using all available technology adversely affects the efficiency of the client management process.

R5.16 Beech Acres and Creative Connections should realign key business processes to take full advantage of UNI/Care automated features and reporting capabilities. Chart review worksheets should emphasize the importance and use of UNI/Care by including the accuracy and completeness of client information recorded in UNI/Care as a component of the review. Beech Acres should include complete and accurate use of UNI/Care in its annual performance evaluations of the care managers. These steps would encourage consistent use of available technology and help Beech Acres identify weaknesses in software programming for rapid resolution. Also, improving the level of documentation in UNI/Care would facilitate Council agencies chart reviews and unmet data needs.

F5.29 Users generate client clinical reports from the UNI/Care system through database queries. The ISD is unable to log reports requested but does maintain an online Intranet help desk function that can guide users through the report writing process. The goal of the help desk is to resolve inquiries within eight hours. ISD usually responds within two hours and provides answers usually within four hours. Users can also see the status of their inquiries online and ISD management receives reports of help desk activity.

F5.30 The ISD tracked the cost of implementing the UNI/Care software system. Between June, 1998 and December, 2000, the total cost was $271,000 against a project budget of $349,000, for a favorable variance of $78,000. These amounts do not match the sum of the amounts charged to the Council agencies for Communication and Equipment shown in **Table 3-1** and **Table 3-3** of the ***financial management and reporting*** section.

The ISD and Beech Acres executive management are reluctant to work further with the UNI/Care vendor and expect the favorable variance to remain. The annual project budget for July, 2000 through June, 2001 sent to FCFC does not indicate how any of these implementation costs are allocated to the Creative Connections project. Consequently, no one can determine the financial impact of installing the UNI/Care software on Creative Connections' overall performance on the Beech Acres contract.

Connectivity

F5.31 The Beech Acres contract calls for electronic transmission of contract data and performance measure reports whenever possible. **Table 5-11** lists the data Creative Connections receives electronically, and **Table 5-12** lists data sent by Creative Connections electronically.

Table 5-11: Examples of Data Transmitted Electronically to Creative Connections

Type of Information	Source	Frequency	Media	Method of Transmission
MACSIS (Medicaid claim information)	Hamilton County Mental Health Board	2 nd Wednesday of each month	3 diskettes	hand-delivered
Census Data	Family and Children First Council	weekly, monthly, year to date	email	Internet
Plan of Care	Family and Children First Council	weekly, monthly, year to date	email	Internet

Sources: Interviews with source agencies listed, and Creative Connections.

Table 5-12: Examples of Data Transmitted Electronically from Creative Connections

Type of Information	Destination	Frequency	Media	Method of Transmission
MACSIS (Medicaid claim information)	Hamilton County Mental Health Board	Monthly	Hardwire link	dial-up 56K modem using Dial-a-ROPES software
Census Data	Family and Children First Council	weekly, monthly, year to date	diskettes	hand-delivered
Plan of Care	Family and Children First Council	weekly, monthly, year to date	diskettes	hand-delivered
Billing and Claim Information	Hamilton County Department of Human Services	Monthly	hard copy or diskette	mail or hand-delivered

Sources: interviews with destination agencies listed, and Creative Connections

Transmission of confidential data through the use of diskettes contradicts the intentions of the contract in having data transmitted electronically. Any speed of transmission gained through the use of software is lost with the dependence on human labor for the transportation of the information.

Creative Connections has not received technical specifications from HCDHS to enable data transmission in any form other than email file attachments. With software provided by Magellan Behavioral Health, another HCDHS contractor, HCDHS can inquire directly onto Magellan Behavioral Health's service providers' software screens and authorize services instantly. That efficiency is not available to Creative Connections at the current level of UNI/Care implementation.

Beech Acres does not use encryption software to protect the data in confidential electronic transmission. Beech Acres' internal policies caution computer users against sending sensitive client data via email because of the unencrypted nature of the material. FCFC continues the email file transmission because of its speed and efficiency. Although Beech Acres' policies permit examination of email transmission if the ISD learns of a concern, there is no routine record keeping about files sent through email. The Mental Health Board indicated that it frequently received files containing unencrypted, confidential client information from Creative Connections via email transmissions.

There are no firewalls or other security protections on the Creative Connections end of the modem connection with the Mental Health Board, although there is a firewall for this modem in the Mental Health Board data facility. The Mental Health Board authorizes Medicaid claims information transmission with a password given to authorized positions at each service provider. The password is supposed to be changed quarterly, although it had not changed for three years prior to the fall of 2000.

Creative Connections and FCFC would like to incorporate either encryption into the email system or develop a virtual private network in order to ensure confidentiality of client information. They are aware of Federal regulations and mental health industry concerns about maintaining client confidentiality. However, either privacy technology would involve determining how to install and implement the system on the servers of all Council agencies and FCFC, a process made difficult because of the variety of computer systems involved. As of February, 2001, Beech Acres has installed, but not implemented, the components needed for a virtual private network.

R5.17 Beech Acres should investigate and install cost-effective methods to ensure the confidentiality of client data in electronic transmissions. Currently, there are several weaknesses in the security of electronic data transmission including:

- Use of unencrypted Internet email messages;
- Files attached to email messages include identifying individual client information;
- Insecure modem connection to the Medicaid claims system; and
- Weak password security authorizing access to the Medicaid claims system..

Beech Acres and FCFC understand the need for client information to remain confidential but prefer the speed and efficiency of the current communication methods. The 1999 US Surgeon General's Report on Mental Health summarized the conflict:

> On the one hand, new technologies can support, and in some cases makes possible, the changes that have transformed the health care industry....Yet much of the same technology raises concerns about privacy, because of its capacity to store and disseminate rapidly to multiple users personal information that many individuals would prefer to remain private.

The report also noted that ensuring patient confidentiality can reduce discrimination associated with seeking and receiving mental treatment and foster trust in the treatment relationship .**F4.34** and **R4.31** further discuss industry standards for client confidentiality.

There are three primary technologies available today that provide good security over data transmissions: network firewalls, email encryption, and virtual private networks. All can make sure that communications between networks occur between authorized or anticipated computer networks. Email encryption extends to the data transmitted because recipients cannot read the data without knowing a code, or public key. Virtual private networks combine access protection with data encryption. Installation would require all parties to share information about their network resources.

F5.32 Beech Acres personnel Internet access is determined by employee supervisors and set up by the ISD. Beech Acres internal policies govern the research and communication permitted to employees. Those policies permit the ISD to investigate inappropriate use of the Internet as needed. Technical access to the Internet occurs through a proxy server managed with software that includes firewall protections. A variety of cables ranging from 10-Base-T through ISDN facilitate the Internet connection. The 10-Base-T cable limits data transmission speed to 10 Mbps.

User Training

F5.33 The UNI/Care software interfaces with Microsoft Office products to enable data sorting and report generation. Consequently, Creative Connections employees need a good understanding of both UNI/Care and Microsoft Office. The ISD created and conducted several levels of training for Microsoft Word and Excel to fulfill this need. **Table 5-13** shows the number and names of classes and number of students attending during 1999 and 2000.

Table 5-13: Beech Acres Computer Training FY 1998-99 and FY 1999-00

Class Name	Total Number Attending	Percentage of Beech Acres Employees Attending
Mandatory or Basic Computer Training	52	72%
Microsoft Word (all levels)	16	22%
Microsoft Excel (all levels)	15	21%
Microsoft PowerPoint (all levels)	10	14%
Microsoft Outlook and Internet	9	12%

Source: Beech Acres ISD Statistics

The ISD created and conducted several basic computer technology courses once it realized that many employees needed such training. The basic computer training was made mandatory for all Beech Acres employees. Seventy percent of the organization's employees attended this training, including 71 percent of those assigned to the Creative Connections project.

In response to employee requests, the ISD trainer administrator of information systems developed and taught other courses on the use of the Internet and the Microsoft Outlook email software. During FY 1999-2000, Beech Acres completed a survey of employees who attended in-house computer training. All survey respondents, approximately 32 percent of survey recipients, rated the training "excellent" or "satisfactory". Beech Acres created a training facility with 12 workstations to enable hands-on activities during all computer classes.

F5.34 In the June, 1998 contract Draft Implementation Plan, Beech Acres and UNI/Care agreed that user training was an essential component of successful software installation. User training was to begin approximately three months after the contract date, and would continue as each module was installed. The majority of UNI/Care user training, however, did not occur until early in the third year of the contract between Beech Acres and FCFC. Initial training of service providers occurred early in 1999, before the Creative Connections UNI/Care system was operational.

UNI/Care classes were free during FY 1999-2000. UNI/Care created customized training manuals for Creative Connections and Family Care services effective July and August, 2000, respectively, and most of the related user training occurred during those months. The two-day training classes occurred during July, 2000; after that, one-day or individual sessions were held approximately monthly. Users received copies of these training manuals and a reference manual listing available UNI/Care reports. Initial and group training is conducted

in the training laboratory at Beech Acres; individualized training is done in the user's office. The manuals are also available online through the Creative Connections Intranet.

F5.35 UNI/Care is a menu-driven software system consisting of two types of modules: DOS-based and COBOL-based. Users must learn a number of four-letter acronyms, function keys, and commands in order to navigate the system. Some field names are abbreviated to the point that an inexperienced reader of the screen would have difficulty interpreting the information. Providers and payers of benefits have numeric codes designating type and more detailed information. Beech Acres estimated that it would take 16 man-hours of formal training to familiarize users with the system. The two-day training course includes several hands-on exercises but no testing at the end of the course. **Table 5-14** shows active Creative Connections employees who had received formal UNI/Care training as of mid-December, 2000.

Table 5-14: Creative Connections Training in UNI/Care

Job Title	# of Employees	# Receiving UNI/Care Training	Percent Receiving UNI/Care Training
Executive Positions (Exec. Dir., COO, CIO)	3	3	100%
Clinical Team Supervisors	5	5	100%
Care Managers	30	30	100%
Liaisons and Coordinators	3	3	100%
Provider Relations Representatives	4	4	100%
Records Clerks	2	1	50%
Administrative Assistants	6	6	100%

Source: Creative Connections Training Schedule and Organization Charts.

R5.18 The ISD should include pre- and post-testing for all of its computer training classes. Beech Acres could use employee time more productively by pre-testing employees to determine their training needs. Also, there are several web sites offering free training in basic personal computer use, Internet, and Microsoft Office application products. The ISD should determine if online courses would be a more cost-effective way of training employees in basic computer skills than in- house group classes. Follow-up training should include documented pre-testing and post-testing of students in order to verify that students learned the material taught during the class.

F5.36 Creative Connections employees in positions most likely to use the UNI/Care system frequently received training on the system. Most Creative Connections employees received formal training once during FY 1999-2000. Beech Acres employees in the ISD and Finance Department received UNI/Care training. While HCDHS did attend a demonstration of the UNI/Care system, there is no evidence that anyone outside of Beech Acres received any hands-on training on that system. Beech Acres stopped attending UNI/Care user group meetings after 1999. These meetings could have enabled Creative Connections management to assess the organization's progress in using the UNI/Care system, or determining if available enhancements to the UNI/Care system would be beneficial.

R5.19 Beech Acres should consider mandatory retraining of care managers annually because annual and quarterly reports from Creative Connections Quality Assurance continue to report data entry and verification problems. Having administrative assistants responsible for data entry allows the benefit of UNI/Care training received by the care managers to lapse. Since all Creative Connections employees have computer access, all levels of employees who need access to UNI/Care should have responsibility for data entry appropriate to their positions. Forcing increased online data entry may reduce the redundancy and time used for completing and printing hard copies.

Creative Connections should also invite representatives from FCFC and the Council agencies to attend formal UNI/Care system demonstrations or training sessions so that those organizations can achieve a better understanding of the system's capabilities and be prepared to use the system once better connectivity is implemented. FCFC and two of the Council agencies, HCDHS, the Mental Health Board, and ADAS, work closely with another managed care organization (MCO), Magellan Behavioral Health who has developed and implemented a highly functional MIS. Attending UNI/Care system classes or demonstrations would enable these agencies to compare the features of the two systems and develop plans to improve both.

F5.37 UNI/Care offers annual users group meetings and features extensive support and training services. ISD personnel attended user group meetings in 1998 and 1999 but not in 2000. A Cincinnati, Ohio users group disbanded. Consequently, Creative Connections has not taken full advantage of the UNI/Care customer service features by not sharing its experiences with other customers and the vendor. Missing these opportunities correlates with delayed system implementation and incomplete use of the system. For example, the UNI/Care Training Manual notes that no history of Care Managers assigned to clients can be kept. Another Hamilton County customer of UNI/Care reported that the UNI/Care vendor provided excellent customer service both online and by telephone.

R5.20 Beech Acres should attend all annual UNI/Care users group meetings and any other opportunities made available by the vendor to learn more about the system's capabilities. All software vendors constantly revise their products in order to resolve problems identified

by customers and programmers. Users group meetings are designed to enable the vendor and customers to exchange information about problems and solutions found with the software. Attending these meetings would enable Beech Acres to learn from the vendor or other customers how any has resolved various problems found with using UNI/Care.

EXECUTIVE SUMMARY

Project History and Objectives

At the request of the Hamilton County Department of Human Services (HCDHS), the Auditor of State's Office performed an examination of the cost impact of the Ohio Department of Job and Family Services and Ohio Department of Mental Health interpretation of the Any Willing Provider (AWP) issue, which allows unrestricted provider choice to the Department's clients, and the proposed changes in Federal legislation that would exempt the Department from participation in this issue and allow greater Departmental control over managed care costs and services. As a component of this assessment, a case study review was proposed to show the effect on costs of AWP. The assessment also included a review of the legislation and the interpretations of AWP, as well as the effect of interpretations on HCDHS costs for behavioral health managed care.

The request for the analysis was driven, in part, by ODJFS's unwillingness to support the implementation of a Federal 1915b waiver which would close the AWP loophole for Medicaid recipients. HCDHS requested the examination of the AWP issue to provide management information on the cost increase to the County caused by AWP out-of-network utilization.

Scope and Methodology

During the course of this study, HCDHS was to provide the information necessary for the analyses through an accounting of HCDHS clients who were referred through HCDHS' managed care organization (MCO) Magellan Behavioral Health (MBH) but had exercised their Freedom of Choice (FOC) and used out-of-network providers. However, the tracking system used to capture this information was not implemented. An alternative group was identified to be used solely for cost comparison purposes. The alternative group comprises clients from all Hamilton County human services agencies and the courts who were referred to out-of-network providers by the referring agency for a variety of reasons. Although not FOC driven, the out-of-network referrals potentially have the same cost impact on a per client basis as an individual client's use of FOC.

Because of the unavailability of critical County data, the original objectives of this review were not achieved. Only an approximation based on a non-AWP population could be ascertained. As the issue of AWP costs is central to County support of the 1915b waiver, the County should immediately begin tracking AWP incidence rates for all populations served in a discreet database separate from other tracking systems. This information should be captured and maintained by the County, and examined at periodic intervals to identify trends and potential areas for cost savings.

Furthermore, because the use of networks and the impact of AWP on Medicaid are central to the study, HCDHS' MCO Creative Connections was included in a limited review. The review shows the impact of Medicaid versus non-Medicaid providers and illustrates the magnitude of cost differences between a capitated amount (Medicaid) and a fee-for-service (non-Medicaid) environment. Medicaid has the effect of negotiated network rates as Medicaid reimbursements are capitated and considered 100 percent reimbursements, even though the County agencies are required to pay approximately 42 percent of costs for Medicaid reimbursed behavioral health services.

Although a definite numeric representation of AWP costs could not be achieved, the study highlighted the financial risk associated with AWP out-of-network utilization. Furthermore, the comparison of MBH and Creative Connections costs showed that HCDHS is much more at risk for greater cost exposure through the Creative Connections contract than through the MBH contract. The elevated cost exposure is a result of the manner in which Creative Connections functions and manages its referrals to Medicaid and non-Medicaid care.

Only behavioral health services have been included in this study. Because of the highly varied regulations surrounding Medicaid usage, AWP and FOC would have different cost impacts based on the subset of medical services examined. Also, the effects of Mandated Points of Service (MPOS) legislation have been excluded from the study as MPOS was determined to have negligible impact on HCDHS' managed care programs.

Any Willing Provider

The Origins of Any Willing Provider

The Any Willing Provider issue has its roots in the exclusionary effects of MCOs. Initially championed by pharmacists and chiropractors, AWP is a regulatory control on MCOs to ensure against exclusion from managed care networks and network eligibility. True AWP legislation stipulates that any provider must be admitted to the network if it fulfills two basic criteria: the provider is willing to accept the network rates and abide by the network's rules. However, AWP has become the term broadly applied to three distinct issues of managed care choice. These issues are as follows:

- **Any Willing Provider (AWP):** True AWP laws require a MCO to include in their network any provider who is willing to accept the conditions of the organization. The AWP issue is exclusively provider focused.

- **Freedom of Choice (FOC):** FOC laws focus on ensuring that enrollees/clients are able to seek out-of-network providers and have the services of these providers covered by their health plan. Pure FOC laws require the out-of-network provider to be reimbursed by the MCO even if they do not accept the conditions of the plan. FOC legislation is client or patient focused.

- **Mandated Points of Service (MPOS):** MPOS requires health plans to offer enrolles/clients an option that allows them to seek out-of-network care. Some states have limited MPOS by allowing MCOs to require referrals, charge higher co-pays, or limit the out-of-network providers eligible under a particular MCO's MPOS. MPOS is entirely MCO focused as it provides MCOs with greater control over out-of-network usage.

Each of these issues impacts HCDHS' ability to manage behavioral health care through its current MCOs. However, the impacts of each is distinctly different and may reduce or increase costs depending on the interpretation of the laws. Furthermore, the impacts of each vary between Medicaid and non-Medicaid clients and services, and HCDHS' role in the referral.

At the Federal level, AWP is outlined as a program with broad applicability. The Federal AWP is defined through the Social Security Act (SSA) of 1932 sections (b)(3) and (b)(7) and refined through the Balanced Budget Act of 1997 4704 (a). Some states have opted to develop more specific state laws that limit the applicability of AWP and what types of providers are covered under the law. Ohio has chosen to use the broad, Federal interpretation of AWP. The cost impact of AWP on a national scale remains indeterminate.

FOC is also broadly defined at the Federal level. The Health Care Financing Administration (HCFA) and other Federal human services agencies have provided limited interpretations. Some states have regulated FOC by creating more restrictive state laws. Ohio has chosen to use the Federal interpretation of FOC.

In the case of FOC and the application of legislation to Medicaid recipients (sometimes also called AWP), the Federal interpretation leaves Ohio county governments susceptible to uncontrolled costs. FOC protections stipulate that Medicaid eligible clients must be allowed unrestricted access to any provider who is Medicaid eligible and willing to accept the patient as a client. In such cases, the governmental entity may be responsible for a greater range of services (and costs) as the provider may prescribe additional, medically necessary services above those initially authorized by the referring agency. The use of out-of-network providers reduces the government entity's ability to monitor and control service authorizations and, by extension, medical care costs. The Federal government recently enacted waiver programs to assist counties in developing programs for Medicaid managed care. The waivers narrow the definition of FOC legislation as applied to Medicaid recipients and permits the use of closed networks for Medicaid eligible populations.

MPOS legislation in Ohio is also interpreted under the broad Federal guidelines. MPOS was developed to assist MCOs in maintaining some control over out-of-network usage through the implementation of gatekeepers. The gatekeeper methodology, widely used in Britain and Canada to reduce the cost of government funded health care, requires a patient to go through a network primary care physician prior to using specialists or out-of-network providers. Under some programs, the patient is at liberty to choose the out-of network provider; in other cases, the gatekeeper chooses the provider. If the patient does not use the MPOS, the MCO can refuse the claim. MPOS has been shown to be effective in controlling out-of-network provider utilization. In the case of HCDHS, the County Agency acts as the MPOS gatekeeper through client referrals.

Medicaid Waivers

Medicaid legislation is individualized by state and, within each state, Medicaid programs may be differentiated further based on the services encompassed under eligibility. While the Federal government mandates which services are commonly eligible and what clients may obtain Medicaid benefits, all states have discretion on how they implement their programs. State programs also vary on the percentage of Medicaid expenditures covered by the Federal government. The Federal contribution is determined based on a state's per capita income and can vary from 50 to 83 percent of program costs.

At the Federal level, Medicaid has been modified through the development of waiver programs managed by HCFA within the United States Department of Health and Human Services (HHS). Federal waivers (1115 and 1915b) allow states to develop Medicaid managed care programs with closed systems in an effort to control Medicaid spending. The waivers are explained below:

- The 1115 waiver program allows states to develop closed systems and extend Medicaid supported benefits to previously ineligible groups. The extension of benefits is to be covered through the savings gleaned through managed care. Oregon, Tennessee and Hawaii have implemented 1115 waiver demonstration projects but, according to Government Accounting Office (GAO) and Health Care Financing Administration (HCFA) reports, have not experienced the expected savings. In addition, states have been granted Costs Not Otherwise Matchable (CNOM) authority under section 1115(a)(2) as part of their demonstrations by both the Administration for Children and Families and HCFA. This authority allows states to receive Federal matching payments for specified expenditures that would not ordinarily be matchable. These expenditures are usually incurred as the result of eligibility liberalizations affecting the AFDC and/or Medicaid programs. The most common example of a CNOM allows for the extension of transitional Medicaid benefits beyond the 12 months provided for in CFR 42 § 1925.

- The 1915(b) waiver program allows state or county run MCOs that serve Medicaid recipients to mandate enrollment for clients in an MCO and/or mandate provider enrollment in a gatekeeper system where capitated rates or fee-for-service may be applied. The 1915(b) waiver overturns most FOC and MPOS protections for Medicaid recipients.

These mandatory systems limit a client's choice of physicians which, in turn, helps the government entity control utilization and service costs. Although Ohio was approved for a 1115 waiver, the legislature opted not to implement the demonstration program. At the time of writing, Ohio had 1915(b) legislation pending in House Bill 596

The Use of MCOs and Community Mental Health in Ohio

Select county human services agencies in Ohio have used MCOs since 1978. Currently, the Ohio Medicaid Managed Care Program (managed by ODJFS and implemented by county DJFSs) consists of 11 MCOs operating in 16 counties. Enrollment in the counties in which Ohio's Medicaid Managed Care Program operates is voluntary, meaning clients may chose to enroll or disenroll at will. Furthermore, clients may chose to attend physicians and/or providers that operate outside of the MCO's network - making it difficult to control services and costs. Because Ohio has not yet implemented a 1915(b) waiver, the counties cannot implement a closed, mandatory MCO. Instead, counties have relied on a more traditional Title IV-A waiver program.

IV-A waivers precede welfare reform and have been largely supplanted by the 1115 Federal waivers. However, some states still operate under IV-A waivers which allow states to derestrict Medicaid eligibility based on the following criteria:

- Income and resource standards and methodologies;
- The IV-A deprivation requirements; and/or
- The IV-A requirement that a child live with a specified relative.

The welfare reform demonstration projects approved under the authority of section 1115 primarily involve waivers of pre-welfare reform Title IV-A. Many of these projects also involve waivers of provisions of Title XIX and/or provisions of the Food Stamp Act of 1977. Hamilton County operates its Community Medicaid Behavioral Health Program under the IV-A waiver which derestricts Medicaid eligibility based on certain criteria specified by ODJFS and certain Federal agencies

Most of Ohio's Medicaid Managed Care programs are geared toward unique programs developed to use the Federal Community Mental Health Services Block Grant. Local provider agencies in Ohio (county mental health boards and non-governmental providers) submit project applications to the Ohio Department of Mental Health (ODMH) for approval. Community Medicaid may provide a number of behavioral health treatments including out-of-home care, psychological assessments and treatment, sex offender assessment and offender and victim treatment. An interagency agreement between ODJFS and the ODMH permits the provision of behavioral health services for Medicaid eligible clients. The agreement accomplishes this by:

- Providing access to Community-based Mental Health programs and psychiatric hospital services;
- Implementing a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of services and excess payments, assesses the quality of services and provides for the control and utilization of those services;
- Developing strategies for managing Medicaid behavioral health services; and
- Establishing and maintaining an eligibility verification system which will be part of the claims and encounter system for managing behavioral health care services.

This interagency agreement and the processes used to fulfill the agreement are applicable to those behavioral health services covered by the Medicaid program. The agreement authorizes the transfer of Federal funds and responsibilities from ODJFS to ODMH for these Community Medicaid services which are generally administered by county DJFSs.

The objective of the Community Mental Health Services Block Grant Program (CMHS) is to provide financial assistance to states to enable them to carry out their respective plans for providing comprehensive community-based mental health services to adults with a serious mental illness and to children with serious emotional disturbances. Local solutions are highly encouraged. The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division of HHS, administers the block grant program.

HCDHS' Community Medicaid operates voluntarily, meaning clients have the right to chose which service provider he or she wants to attend. Because Hamilton County still operates under a Title IV-

A waiver, Medicaid can be used for less traditional interventions requested by HCDHS, the Mental Health Board, the Hamilton County Alcohol and Drug Addiction Services Board (ADAS), the Hamilton County Board of Mental Retardation and Developmental Disabilities (MRDD) and the Hamilton County Juvenile Court.

AWP Impact on Magellan Behavioral Health and Creative Connections Contracts

The impact of true AWP legislation on HCDHS' behavioral health managed care programs is dependent on the development and implementation of provider networks. Currently, HCDHS's managed care programs maintain established networks of service providers, yet they operate with open systems. Service providers not within the established networks may enter the managed care systems to accept clients because of the AWP legislation, so long as they accept network rates and rules.

The debate on the implementation of AWP at the state level is fueled by concerns of providers and insurance companies. Providers maintain that AWP expands patient choice and reduces discrimination against certain types of practitioners. Insurance companies, on the other hand, cite potential cost increases and the fundamental right of the company to choose its business partners. Data on AWP costs has been used to support the arguments of both parties and no clear impacts have yet been identified.

Magellan Behavioral Health (MBH) operates one of two managed care programs examined in this audit. In association with HCDHS, MBH developed its provider network based on responses to a request for proposal, resulting in the establishment of a 27-member provider panel. Agreements were established with each service provider, detailing the agreed-upon terms and conditions of the managed care program. The provider agreements also include the types and costs of services available to clients. Although AWP prevents HCDHS and MBH from implementing a closed managed care network, providers willing to join MBH's network are subject to the same negotiated costs, terms and conditions as network providers. Since the implementation of the original network, other practitioners have been added to the network under the MCO's rates and regulations. Therefore, AWP does not significantly impact the costs associated with the MBH managed care program.

Beech Acres operates the other managed care program examined by the Auditor of State's Office. The program (Creative Connections) was created to facilitate the delivery of services to children formerly under the care of the Family and Children First Management Inc. (FCFM). At capacity, FCFM operated with a network of 22 service providers, 3 of which also served as care management agencies. When Beech Acres took over as the MCO replacing the defunct FCFM, a policy and subsequent set of procedures did not exist for the selection of network service providers. Generally, providers became part of the network because they were already rendering services to the client at the time of referral to the Creative Connections program. Other providers enter the network because

they offer unique or specialized services or because they have immediate availability. Many providers maintain waiting lists due to the high demand for specialized treatments and services in the program.

Pursuant to the contract with FCFC, Creative Connections must establish contracts with enough providers to meet the needs of clients. Creative Connections uses a database listing approximately 250 providers, however only about 110 providers render services for a population of 286 clients. Creative Connections is trying to implement a series of initiatives aimed at improving provider relations and better developing the network by eliminating inactive providers from its network and establishing comprehensive fee schedules with all providers. Although agreements have been established between Beech Acres and some providers, negotiated rates have not been put in place.

Cost issues associated with Creative Connections do not result from AWP (see ***Hamilton County Managed Care, Creative Connections, Financial Management and Reporting*** for additional information). Creative Connections has not sufficiently developed its provider network, especially with regards to fee structures and service rates, to be impacted by AWP. The Federal AWP legislation enables any provider to join the network as long as it abides by the terms and conditions of the contract with the public purchaser. Because Creative Connections has not established negotiated rates in exchange for rendered services, all referrals are essentially agency driven FOC which markedly increases costs.

FOC Impact on Magellan Behavioral Health and Creative Connections Contracts

FOC prevents HCDHS from developing a closed network (prohibiting the use of out-of-network providers) which could better control Medicaid and non-Medicaid expenditures. Under FOC legislation, HCDHS' clients have the freedom to choose any network or out-of-network provider for services, although Medicaid eligible clients must make their selection from the pool of Medicaid eligible providers (as detailed under Title XIX of the Social Security Act). In many respects, FOC legislation enables clients to choose the type and duration of Medicaid services (as well as the cost of service in the case of self-pay clients) rendered under HCDHS' MCOs. If the duration, type or cost of the medically necessary rendered service is beyond the scope of services desired by HCDHS, the County remains responsible for the local portion of the costs.

HCDHS began efforts to track the cost impact of Medicaid eligible FOC case referrals in FY 2000. At the time of this study, that data was still unavailable through the tracking program. However, HCDHS also tracked out-of-network case referrals by other County agencies, the reasons for the referral and the costs for services. A baseline for out-of-network usage as a percentage of referrals was not available from either County MCO. Furthermore, HHS, HCFA, SAMSHA, and the Ohio Department of Insurance do not have baseline data for out-of-network usage for private and public MCOs. Representatives of these regulatory agencies were unable to identify any studies tracking this information on a local, regional or national level. The private insurance companies contacted as a

component of this audit cited the proprietary nature of such information and would not divulge the information.

Table 2-1 shows the service categories, the number of referrals during the study period, the out-of-network and network cost and the cost increase/savings incurred for the County agency out-of-network service referrals tracked by HCDHS. The data included in the table is from the months of January through September 2000 and network rates reflect MBH's negotiated rates. The sample contains 128 separate service referrals, although some clients who received multiple services are shown in each applicable service category.

These cases do not reflect client/patient FOC. Instead, the data reflects the potential cost impact to County agencies for out-of-network referrals. Reasons for County agency out-of-network placement include the following:

- **Limited Provision of Services:** In some categories a very limited number of providers offer the indicated treatment. For example, the greatest variance between MBH and out-of-network costs is found in the area of sex abuse diagnostic assessment (SADA) because only one provider in Hamilton County performs SADA for non-standard cases (child and female clients).

- **Level of Care:** In other cases, the referring agency (the Court, HCDHS, or other County agency) directs MBH to place a child in a specific location because the agency may disagree with MBH's level of care (LOC) designation.

- **Placement Location:** The referring agency (the Court, HCDHS, or other County agencies) directs MBH to place a child in a specific location because the agency may disagree with MBH's placement location.

The reasons for out-of-network placement by County agencies do not reflect client/patient FOC and are only shown as an example of potential cost increases generated by out-of-network utilization.

Table 2-1: Service Categories, Out-of Network Usage and Cost

Category	Number of Referrals	Out-of-network Cost	Network Cost	Average Cost Increase (Savings) of Out-of-network Referrals
Individual Therapy	2	$55	$81	**($26)**
Family Therapy	2	$65 to $90	$81	**($4)**
Individual and Family Therapy	2	$55	$81	**($26)**
Diagnostic Assessment and Therapy	10	$80 to $425	$100 to $286	**$2**
Individual Aid	8	$20 to $107	$81 to $109	**($30)**
Psychological Testing/Assessment	6	$56 to $105	$105	**($18)**
GSDA [1]	1	$240	$100	**$140**
GSPT [2]	1	$112	$100	**$12**
NSDA [3]	1	$200	$100	**$100**
SADA [4]	23	$88 to $275	$92	**$183**
SAIF [5]	2	$60	$81	**($21)**
RGH [6]	13	$100 to $150	$124	**($10)**
RL1 [7]	8	$125 to $550	$210	**$4**
RL1AIR [8]	8	$154 to $300	$210	**$18**
RL2 [9]	23	$220 to $550	$286	**$34**
SIL [10]	5	$55 to $92	$59	**$18**
SIL2 [11]	2	$70 to $72	$72	**$0**
TFCT [12]	2	$45 to $47	$43	**$3**
TFC1 [13]	2	$65	$62	**$3**
TFC2 [14]	4	$76 to $95	$77	**$15**
TFC3 [15]	3	$90 to $110	$92	**$10**

Source: HCDHS Records

[1] GSDA: general serivces diagnostic assessment.

[2] GSPT: general services psychological testing.

[3] NSDA: neighborhood services diagnostic assessment.

[4] SADA: sex abuse diagnostic assessment; MBH and out-of-network providers serve both sex offenders and victims (approximately 50 percent each).

[5] SAIF: sex abuse individual and family therapy.

[6] RGH: residential group home.

[7] RL1: residential level 1; general open residential foster care unit.

[8] RL1AIR: residential level one, all inclusive rate; these foster care providers use the bundled rate which includes Medicaid billable charges.

[9] RL2: residential level 2; RL2 homes are secured facilities with either staff secure or locked facilities.

[10] SIL: semi-independent living; apartment living without direct supervision.

[11] SL2: semi-independent living level 2; supervised independent living.

[12] TFCT: therapeutic foster care, traditional; general foster care, children have few or no treatment needs.

[13] TFC1: therapeutic foster care level 1; children require case management but do not require medication, exhibit aggressive behaviors or have problems in school.

[14] TFC2: therapeutic foster care level 2; children require more intensive case management and may require medication, exhibit aggressive behaviors and/or have problems in school.

[15] TFC3: therapeutic foster care level 3; children require very intensive case management and generally require medication, exhibit aggressive behaviors and/or have problems in school.

Note: Out-of-network costs reflect both Medicaid and non-Medicaid rates. Network costs represent Medicaid rates only. When possible, MBH pays Non-Medicaid providers at a negotiated rate that is below the Medicaid rate.

As shown in **Table 2-1** the range of cost increase/savings incurred by out-of-network referral varies greatly by the type of treatment. In these cases, the referring County agency must reimburse the out-of-network provider for services which are not Medicaid reimbursable. Additionally, the out-of-network provider does not have to subscribe to the same negotiated rates as MBH's network providers. The increased costs caused by the use of out-of-network providers has the potential to be of similar magnitude if it was a result of FOC.

To show the aggregate impact of the County agency out-of-network referrals, the total cost per month for the sample cases was calculated. **Table 2-2** shows the monthly cost for out-of-network referrals for the months of January through September 2000 as recorded by HCDHS, as well as the annualized cost increase.

Table 2-2: Sample Monthly Out-of-network Referral Costs

Month	Number of Clients Served	Cost Increase (Decrease) of Out-of-Network Referrals	Cost Increase (Decrease) per Client
January	20	$755	$38
February	10	$87	$9
March	13	$281	$22
April	13	$75	$6
May	16	$1,121	$70
June	20	$135	$7
July	17	$437	$26
August	13	$62	$5
September	18	$1,478	$82
Approximate Annual Number Served/Cost [1]	**187**	**$5,908**	**$32**

Source: HCDHS Records

[1] Nine month cost was annualized to show the approximate FY 2000 costs for the sample group.

The sample population's increased costs, approximately $32 per client served in an out-of-network setting, appear to have a limited effect on costs. However, HCDHS should take into consideration several issues that, if applied to the general client population, could have substantial cost impact.

- MBH serves 1,400 clients each month. If a number of clients equal to those identified in a recent health care consumer survey for out-of-network usage (18 percent) were to choose FOC, the increased cost to HCDHS would be approximately $8,000 per month based on the per client cost increase shown in the sample.

- The cost difference between network and out-of-network services is proportional to the level of specialization and direct care. MBH clients are generally referred to less restrictive interventions. However, the impact of FOC could increase if clients or their out-of-network physician determined that more aggressive interventions were warranted.

- For each provider that is not registered and approved to provide Medicaid services, the FOC impact to HCDHS will be greater as Medicaid rates act as a cost control and offset a portion of the local cost.

The cost increases caused by FOC could potentially impact the overall utility of providing services through a managed care environment. However, HCDHS incurs annual direct care costs of approximately $12.8 million through the MBH program alone. The net cost increase caused by FOC may be immaterial in comparison to overall program costs.

Of the factors that most directly impact FOC costs, the ability to receive Medicaid reimbursement for eligible services is paramount. Most HCDHS cases that are placed outside of the MBH network are channeled through Creative Connections which relies predominantly on non-Medicaid providers. The usage of non-Medicaid providers negatively impacts HCDHS because the County Agency is responsible for the entirety of the costs. FOC issues are relatively uncommon within Creative Connections as most clients are referred into specific programs by Hamilton County human service agencies. However, the magnitude of cost differences between Medicaid and non-Medicaid services, as shown in **Table 2-3**, is an important consideration in assessing the potential impact of FOC.

Table 2-3: Creative Connections Medicaid/Non-Medicaid Costs, FY 1999-00 1st Quarter

Creative Connections Category	Aggregate Costs	Number Served	Average Cost per Child	Average Cost per Child per month
Medicaid Providers' Quarterly Totals/Averages	$392,881	166	$2,367	$789
Non-Medicaid Providers Quarterly Totals/Averages	$1,350,908	214	$6,313	$2,104
Non-Medicaid Usage Cost Increase (Decrease) per Quarter	N/A	N/A	**$3,946**	**$1,315**

Source: Creative Connections Records

As shown in the table, the use of non-Medicaid providers within Creative Connections increases monthly costs per child by an average of $1,315. Based on the 286 children served by Creative Connections at any given time and the approximately 56 percent that were referred to non-Medicaid providers, the use of non-Medicaid providers could increase costs by as much as $210,000 per month or $2.5 million per year. Furthermore, not only are Medicaid rates lower on a per child basis, but HCDHS and the other participating agencies are only liable for the local match portion of costs (about 42 percent). HCDHS and the other participating agencies pay the entirety of the claim in the case of non-reimbursable services.

Tables 2-2 and **2-3** provide an example based on a select population but the potential impacts of out-of-network utilization and the contributing factors to cost increases apply to all HCDHS clients. HCDHS could potentially expect minor cost increases when FOC is exercised by Medicaid eligible clients receiving Medicaid eligible services. However, the cost increases have the potential to be much more steep if non-Medicaid providers are used because HCDHS does not benefit from Medicaid rate caps or the Federal claims cost match.

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