# FY13 Provider Scorecard

## Technical Specifications

Department of Behavioral Health
Office of Accountability

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## Introduction

The Department of Behavioral Health (DBH) Provider Scorecard highlights Core Services Agencies (CSAs) that perform well through adherence to agency, District and federal standards, while also highlighting opportunities for provider and system improvement. It makes accessible valuable information for consumers of community mental health services in the District as they seek out helpful sources to make informed choices about where to get community mental health care that best meets their needs. More broadly, the document serves as a lens of scrutiny and transparency available to the general public and for the residents of the District of Columbia on CSA performance.

DBH works closely with CSAs to ensure that they are providing quality services to their consumers. As part of that effort, DBH assesses community mental health best practices, adherence to 22 DCMR A34, Mental Health Rehabilitation Services (MHRS) Provider Certification Standards and compliance with DBH policy requirements by the CSAs within our system. These data sources allow DBH to compile the Provider Scorecard. In compiling the Scorecard, DBH utilizes programmatic expertise and data collection and analysis techniques to create and present a useful process performance document, that includes the Overall Score and 'star rating' afforded to each CSA.

The balance of this document details the methodology and specifications for the different items that make up the Provider Scorecard.

## Provider Scorecard Overview:

The Provider Scorecard comprises two comprehensive sections plus a bonus section that awards points for evidence of National Certification or Accreditation in Healthcare Quality. The **Quality** section is worth 110 points, the **Financial** section is worth 90 points, and the **Accreditation/Certification** bonus section is worth an additional 5 points.

### Review Period:

The FY13 DBH Provider Scorecard is based on data elements from fiscal year 2013 (October 1, 2012 through September 30, 2013) except in the case of the MHRS Claims Audit results. Since claims audits are conducted retrospectively the claims audit results used for the Scorecard will be the most recent fiscal year audit completed. The FY12 MHRS Claims Audit results will be used for the FY13 Provider Scorecard.

## Quality Section

The Quality section consists of the following domains.

A. Quality Review Score:

Description: The final adult or child Quality Review score, or the mean average of the two scores for CSAs that serve both adults and children.

Scoring/Calculation: 0-80 points (please also see FY13 Quality Review - Technical Specifications).

B. Compliance with the LOCUS/CALOCUS policy

Description: DBH Policy 300.1D Level of Care Utilization System (LOCUS/CALOCUS) Evaluations sets forth procedures to ensure that the level of care (LOC) for all consumers who are enrolled in a CSA are appropriately determined and guidelines for the type of interventions are identified. Section 6a of the policy outlines the circumstances in which a CSA shall perform a LOCUS/CALOCUS. This indicator measures compliance with section 6a (2) for consumers in continuing treatment at a CSA. Section 6a(2) states "Consumers in a continuing treatment in a CSA shall have a LOCUS or CALOCUS evaluation completed by the CSA at a minimum of every 180 days (every 6 months) in concert with the IRP/IPC planning process and update of level of functioning.

Scoring: CSAs will receive a value between 0 and 5 points based on the CSA's LOCUS/CALOCUS compliance rate, where 0= 0% compliance and 5=100% compliant.

Calculation: This is determined by review of the each CSAs percentage of compliance with LOCUS/CALOCUS data entry for FY12 and multiplying that percentage by 5.

Example: A Compliance rate of 75% is equal to (.75) x 5 = 3.75
80% is equal to (.80) x 5 = 4
20% is equal to (.20) x 5 = 1

Data Source: - The DBH LOCUS/CALOCUS Summary Report for Active Consumers will be used to measure a CSAs compliance rate.

C. Compliance with the GAIN-SS policy

Description: In summary, DBH Policy 200.4A 'Screening for Co-occurring Substance Abuse Disorders', implemented November 2012, requires that all consumers aged 10 or above presenting for intake shall receive at minimum an initial mandatory screening for co-occurring substance abuse disorders using the GAIN-SS, administered by the clinical home CSA (unless ACT or CBI provider), and subsequently as part of the treatment planning process every 180 days, and at additional clinically determined junctures. Therefore, an updated GAIN-SS should be present at minimum every 180 days. The web-based screening tool is mandatory and a printed copy should be kept on the consumers' paper record.

**DBH is sensitive to implementation challenges facing the provider community around the transition to the use of the GAIN-SS in its inaugural year, so for the purposes of this Scorecard item, the evaluation standard has been relaxed to <u>any electronic GAIN-SS screening (initial or other) completed for each active consumer between January and September 2013.</u>**

**'Active consumer'** is a consumer assigned to the CSA with one or more services received each quarter between January and September 2013.

i.e. if at least one electronic GAIN-SS screening was completed for each active consumer between January and September 2013, the compliance rate would be 100%.

<u>Scoring/Calculation:</u>
CSAs will receive a value between 0 and 5 points. Points are awarded according to the following compliance rates.

| Pass Rate % | Points |
|---|---|
| 70> | 5 |
| 60-69 | 4 |
| 50-59 | 3 |
| 40-49 | 2 |
| 30-39 | 1 |
| <30 | 0 |

<u>Data Source:</u> The GAIN-SS Aggregate Report Versions 2.1 and 3.0

D. <u>Corrective Action Plans (CAPs)</u>

<u>Description</u>: DBH Office of Accountability (OA) issues Corrective Action Plans to CSAs where non-compliance has been identified. DBH expects a response to, and implementation of, a Corrective Action Plan within the time frame specified.

<u>Scoring:</u> CSAs will receive 0 or 7 points for this element, in two different areas worth 4 and 3 points respectively. Agencies with no CAPs will get 7 points for the combined elements.

1. <u>Corrective Actions given</u>: This item will be proportionally scored with a maximum of six points based on the number of CAPs given to an agency.

   <u>Calculation</u>:
   4 = No CAPs issued to Agency
   3 = One CAP issued to Agency
   2= Two CAPs issued to Agency
   0= Three or more CAPs issued to Agency

2. Implementation of Corrective Actions: This indicator measures whether a CAP has been implemented as described in the CAP.
   Calculation:
   3= CAP completely implemented or No CAPs issued
   2= CAP Partially implemented
   1= CAP not implemented or unacceptably implemented

E. Quality Improvement Initiative (QII) Participation – 3 points

Description: Submission of requested information about the peer review process at the CSA by the specified deadline of August 31, 2013.

Scoring/Calculation: CSAs will receive a value of 0 or 3 points. Points are awarded according to the following compliance criteria.

| | |
|---|---|
| Peer Review Process submitted by August 31, 2013 | 3 |
| Did not meet deadline | 0 |

F. Operational Quality Improvement Program:

Description: MHRS regulation 3410.27 calls for each provider to establish and adopt a Quality Improvement plan describing the objectives and scope of its QI program. The program is required to be operational and shall measure and ensure at least the following elements:

a. Access and availability of services
b. Treatment and prevention of acute and chronic conditions
c. High volume services , high risk conditions and services, especially children and youth services
d. Coordination of care across behavioral health treatment and primary care settings
e. Compliance with all MHRS certification standards
f. Adequacy, appropriateness and quality of care
g. Efficient utilization of resources; and
h. Consumer and family satisfaction with services

MHRS regulation 3411.6 further stipulates that the QI program must be directed by a committee comprised of qualified practitioners and staff directly involved in the provision of services and be:

a. Chaired by a QP with direct access to the CEO
b. Include consumers and family members
c. Review unusual incidents, deaths, and other sentinel events, monitor and review utilization patterns and track consumer complaints and grievances and
d. Conduct and annual evaluation of the QI program, periodically revised the QI program description and develop the annual QI plan

Scoring: CSAs will receive 0, 5, or 10 points for this element. A CSA that does not have an operational quality improvement program will get 0 points. A CSA that has a partially implemented quality improvement program will get 5 points, and a CSA that has a fully operational quality improvement program will receive a score of 10 points.

Data Source: Most recently completed Medicaid Integrity or recertification review results and/or results of Quarterly Reporting from the CSA.

Calculation: This is determined by review of the each CSAs recertification or Medicaid Integrity review or review of quarterly reports from the CSA.

**Total Quality Section Score**: This score is a sum total of each domain in the Quality Section, with a total of 110 points possible.

| Quality Section | Points |
|---|---|
| Overall Quality Review Score | 0-80 |
| LOCUS/CALOCUS COMPLIANCE | 0-5 |
| GAIN-SS Compliance | 0-5 |
| Corrective Actions | 0-4 |
| Corrective Actions Status | 0-3 |
| QII Participation | 0-3 |
| Operational QI Program | 0-10 |
| **Max. Points Possible** | **110** |

## Financial Section

This section incorporates the latest FY12 MHRS Claims Audit results, as well as the presence of an Operational Compliance Plan, CSA compliance with submitting required financial statements, CSA compliance with screening for third-party liability, and whether the CSA is conducting staff exclusion checks.

A. **Claims Audit Results**:

Description: DBH Policy 911.1C Claims Audits sets forth procedures for auditing the documentation of certified providers to determine the presence of required information that supports the billing for MHRS. The policy states that DBH shall perform regular audits of all certified providers to ensure compliance with MHRS standards and applicable District and federal regulations. DBH conducts claims audits of each provider with submitted claims during a fiscal year. The audit is conducted to determine whether the provider has sufficient and correct documentation to support payment of specific claims for the provision of services.

Scoring: This indicator measures a CSAs compliance with DBH documentation and billing procedures as determined by the claims audit process. The claims audits determine a pass rate for the CSA and a partial pass rate. These rates will be used to determine the points with a range possible of 0-50 points.

Calculation: (The CSA's FY12 claims audit pass rate) + (50% of The CSA's FY12 claims audit partial pass rate) X 50

Example pass rate is 75% and partial pass rate is 10%
.75 + (.10/2) x 50 = 40 points

Example pass rate is 35% and partial pass rate is 10%
.35 + (.10/2) X 50 = 20 point

## B. Operational Compliance Plan

**1.** Compliance Plan Description: Chapter 34 Subsection 3410.38 states that each MHRS provider shall establish and adhere to a Corporate Compliance Plan for ensuring compliance with applicable federal and District laws and regulations and that the CSA must submit the Corporate Compliance Plan to DMH OA for review and approval. According to the regulation, the Compliance Plan shall:

a. Designated an officer or director with responsibility and authority to implement and oversee the Corporate Compliance Plan
b. Require all officers, directors, managers and employees know and understand its provisions
c. Include procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of MHRS;
d. Include procedures for the confidential reporting of violation of the Corporate Compliance Plan to DMH, including procedures for the investigations and follow-up of any reported violations,
e. Ensure that the identities of individuals reporting suspected violations of the Corporate Compliance Plan are protected and that individuals reporting suspected violations, fraud, or abuse are not retaliated against.
f. Require that confirmed violations of the Corporate Compliance Plan be reported to DMH within twenty-four (24) hours confirmation and
g. Require any confirmed or suspected fraud and abuse under state or federal law or regulation be reported to DMH.

Scoring: This indicator measures the CSA's compliance with the required submission and implementation of and operationalization of a compliance program. CSA's will get 0, 10, or 20 points for this element. A CSA that does not have an operational Compliance program will get 0 points. A CSA that has a partially implemented Compliance program will get 10 points, and a CSA that has a fully operational Compliance program will receive a score of 20 points.

Data Source: Most recently completed Medicaid Integrity or recertification review results and/or submission of quarterly compliance committee minutes that shows evidence listed above or annual compliance report from the CSA that shows evidence of criteria listed above.

Calculation: CSAs that can show evidence of an operational Compliance Plan/program will get 20 points. Those CSAs that show a partially implemented program will get 10 points. Those CSAs that do not have an operational compliance plan/program will get 0 points.

**2. Exclusion Checks**: This element measures a CSA's compliance with Chapter 34 Subsection 3410.37 and DMH Policy 716.6A regarding screening staff for eligibility to participate in federal health care programs and to contract with the District of Columbia government.

Chapter 34 Subsection 3410.37 states each MHRS provider shall operate accordingly to all applicable federal and District laws and regulations relating to fraud and abuse in healthcare, the provision of mental health services, and the Medicaid program. Each MHRS provider shall:
(c) Ensure that none of its practitioners have been excluded from participation as a Medicaid or Medicare provider and, if a practitioner is determined to be excluded by the Center for Medicare and Medicaid Services (CMS), notify DMH immediately.

DMH Policy 716.6A, Screening for Eligibility to Participate in Federal health Care Programs and to Contract with the District of Columbia Government requires DMH contractors to screen all contractors, subcontractors, employees and covered persons for eligibility to participate in federal health care programs and to contract with the District of Columbia government. Subsection 4d of this policy refers to three exclusion lists that CSAs are required screen their staff against.

Scoring: Providers are required to check for staff members who are "excluded" from participation in a federal health care program as found on the Department of Health and Human Services "List of Excluded Individuals/Entities" (Chapter 34, 3410.37(c).

Data Source: Latest Medicaid Integrity, or recertification, review tool and process results and or quarterly report from the CSA.

Calculation: CSAs will receive 0 or 5 points for this element. CSAs that are determined by the Medicaid Integrity review or recertification to be fulfilling their requirement to check for excluded individuals will get 5 points. Agencies that fail to check for excluded individuals will get 0 points.

**3. Internal Auditing System:** Chapter 34 Subsection 3410.38 (c) states that each MHRS provider should have procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of MHRS.

Scoring: This indicator measures whether CSAs have an operational internal auditing system

Data Source: Latest Medicaid Integrity, or recertification, review tool and process results and/or quarterly report from the CSA.

Calculation: CSAs that are determined in the Medicaid Integrity or recertification review to have an operational internal auditing process will get 5 points. CSAs that are not found to have an internal auditing process will get 0 points.

C. **Submission of Annual Audit Report**:

Description: Chapter 34 Subsection 3411.9 states that each CSA shall have an annual audit by a certified public accounting firm, and a copy of the resulting audit report shall be submitted to DMH within 120 days after the close of the CSA's fiscal year.

Scoring: This indicator measures if the CSA is in compliance with Chapter 34 Subsection 3411.9.

Data Source: The data source is report from DMH finance office indicating whether a CSA has or has not submitted the required annual audit report.

Calculation: CSAs will receive 0 or 5 points for this element. Agencies who have submitted necessary documentation will get 5 points. Agencies who have not submitted necessary documentation will get 0 points.

**D. Third-Party Liability (TPL) screening:**

Description: By law, the Medicaid program is the payer of last resort. In general, if a potentially liable third party (insurance) exists, providers shall attempt to ensure that the mental health provider bills the third party first before submitting the claim for Medicaid reimbursement. DMH Policy 913.1 Third Party Liability (TPL) sets forth procedures to ensure billing of third policy insurance before using public funds in providing mental health services.

Scoring: This indicator measures whether CSAs are conducting third party liability (insurance coverage) screenings on enrolled consumers.

Data Source: Most recently completed Medicaid Integrity or recertification review results and/or quarterly report from the CSA.

Calculation
CSAs will receive 0 or 5 points for this element CSAs that are determined by the Medicaid Integrity review or recertification to be fulfilling the requirement to screen for TPL will get 5 points. Agencies that are not fulfilling the requirement to screen for TPL will get 0 points.

**Total Financial Section Score:** This score will be determined by adding all elements from the financial section with a total possible of 90 points for this section:

| Financial Section | Points |
|---|---|
| FY12 Audit Pass rate X 50 | 0-50 |
| Operational Compliance Plan | 0-20 |
| Exclusion Checks | 0-5 |
| Internal Audit Process | 0-5 |
| Submission of Annual Audit Report | 0-5 |
| Screening for Medi-Medi TPL | 0-5 |
| **Max. Points Possible** | **90** |

**National Accreditation/Certification Section:** DBH recognizes that agencies that have a national accreditation have made an organizational investment and commitment to meet high quality consumer service and business standards and practices.

Scoring/Calculation: 5 points will be awarded when a CSA demonstrated a current and valid national certification for their mental health program by a national organization such as the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

Data Source: Submission of documentary evidence.

## Overall Score

The formula for the Overall Score for the Provider Scorecard is calculated as follows.

(QD) + (FD) /2 + (Accred./Cert)

Example:

Quality Section score out of 110….....85
Financial Section score out of 90……..75
Accreditation/Certification Section……5

Overall Score……. ……..(85+75) /2 + 5 = 85

Overall Score Translation: Each CSA will be assigned a rating between 0 and 5 stars based on their overall score. Zero (0) stars will equate to an agency that is substantially underperforming by the Department's standards and in need of immediate corrective action. Five (5) stars will equate to an optimally performing agency. See legend for point and star values.

| Overall Score | Stars |
|---|---|
| 95 + | ☆☆☆☆☆ |
| 90 - 94 | ☆☆☆☆ |
| 85 – 89 | ☆☆☆ |
| 80 – 84 | ☆☆ |
| 75 – 79 | ☆ |
| <74 | No Stars Earned |

Note: Scores are rounded using basic rounding principles