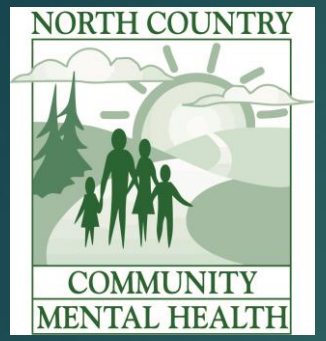

PROVIDER SCORECARD

NCCMH PROVIDER SCORECARD PROCEDURES – NOVEMBER 2018

Provider Scorecard

Learning Objectives:

A. Understanding regulatory reasons for implementing a provider risk assessment and 'scoring' procedure

B. Be aware of key considerations when developing and implementing the scoring process

C. Familiarize providers with the components of the process:
   - Policy and Procedures
   - Organizational Service Provider Scorecard: Domains, Criticality Scales
   - Service Provider Risk Assessment Scoring

D. Provider input on process and measurable/quantitative data

Provider Scorecard

Regulatory Requirement for Managed Care Rules
(Subpart D – MCO, PIHP and PAHP Standards)

438.206:

- Maintains and monitors a network of appropriate Providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.
- Meet and require its provider to meet State standards for care and services.
- Monitor providers regularly to determine compliance.

NCCMH Policy: It is the policy of North Country Community Mental Health that contracts be reviewed prior to renewal and annually for contracts that span more than one year.

Provider Scorecard

Purpose of a Scorecard

- To ensure that contract providers maintain and operate facilities and services according to the standards defined in licensing and other regulatory agencies
- To ensure services are delivered in accordance with the stipulations of the respective contract
- That documentation for service delivery meets Medicaid or other funding source requirements
- To foster a joint effort between NCCMH and provider in improving the quality of services
- To aid NCCMH in determining where and how to assist our provider network
- Open discussion at end of the presentation

Provider Scorecard

Risk Assessment Process Considerations:

- Public mental health serves higher risk populations using higher risk interventions than other behavioral health care populations
- Needs to avoid penalizing providers
- Reporting considerations
- Take into consideration provider response to incidents

Provider Scorecard

Risk Assessment Development Process:

- Modified a tool already in use in a Michigan CMH
- Tool developed with input from clinical and administrative departments of NCCMH
- Subject matter experts (assessors) were determined for each domain
- Assessor ratings are weighted, scored individually, and compiled with composite scores in 13 different domains, and a total score

Provider Scorecard

Risk Assessment Terminology

- Domain: Assessment Area
- Risk: Low, Moderate, or High, resulting in weighted scoring which allow emphasis to be placed on assessments that hold a higher level of risk
- Assessment Scoring Levels: Excellent, Good, Fair, or Poor with individual definitions of each for each Domain
- Data Source: Source of measurable information to back up the assessment scoring level given
- Provider Types: Phase 1 or Phase 2
- Assessor: Who performs the assessment by evaluating the data and formulates the score

Provider Scorecard

Risk Assessment Uses:

- Risk ratings, i.e. the Provider Scorecard, presented to the Risk Committee for evaluation
- Provider Risk Assessment, or "Provider Scorecard" will be:
  - Discussed with the provider after completion
  - Utilized in open discussion with the provider on ways to compliment or improve their practices
  - Utilized to develop achievable corrective action plans in the event of unsatisfactory ratings in any domain
  - Utilized to seek clinical supervisory approval for renewals of contracts

Provider Scorecard

Phases of Assessment Rollout:

PHASE 1: September 2018

All providers subject to contract renewal in September 2018 including: Crisis Residential, Autism Centers, Licensed Specialized Residential providers, Personal Residential Home CLS Providers, Case Management Companies, Day Programs, Professional (MD, OT, PT), Skill Development, Supported Employment

PHASE 2: 2019 Evaluations

Providers within the above classifications who were not subject to contract renewal in September 2018 plus also fiscal intermediaries, homes based services and wrap-around services.

Provider Scorecard:
Domain #1 – Administrative Effectiveness

Risk: Low

Assessment:

Excellent: Provider is exceptional relative to thoroughness, accuracy, and follow-through; no stakeholder complaints; all information is updated and submitted accurately and on time, including case mgmt. forms and backup, clinical documentation, credentialing and contracting documentation, plan of service updates and billing.
Good: Provider is unremarkable relative to thoroughness, accuracy, and follow-through; and/or few stakeholder complaints; all information is updated and submitted generally accurately and on time with minor exceptions.
Fair: Provider tends to be below average relative to thoroughness, accuracy, and follow through; and/or moderate stakeholder complaints; information is updated and submitted inaccurately and frequently late.
Poor: Significant concerns relative to thoroughness, accuracy, and follow-through; and/or significant stakeholder complaints; rarely is documentation updated and submitted accurately, completely or on time.

Data Source: Meeting notes, Emails, Community agency or other stakeholder complaints, Provider Contract Files (Disclosures/Accreditations/Certifications, Billing Submissions, Deadlines/ timeliness

Provider Types: All

Assessor(s): Program Director; Reimbursement Supervisor; Contract Manager; Customer Service; Recipient Rights Officer

Provider Scorecard: Domain #2 – Consumer Satisfaction Surveys

Risk: Low

Assessment:

Excellent: Exceeds satisfaction thresholds (minimum of 85%) across all survey questions (or on composite score)
Good: Meets or exceeds satisfaction thresholds (minimum of 85%) across most but not all survey questions (or on composite score)
Fair: Falls below satisfaction thresholds (minimum of 85%) across most but not all survey questions (or somewhat below on composite score)
Poor: Falls below satisfaction thresholds (minimum of 85%) across all survey questions (or well below on composite score)

Data Source: Direct from Providers who are requested to provide sample of survey, demographics and survey results report.

Provider Types: Large Residential Providers only

Assessor(s): NMRE does annual snapshot, evaluated by Contract Manager

Provider Scorecard:
**Domain #3 – Performance Indicators

Risk: Moderate

Assessment:

Excellent: Consistently exceeds all performance standards
Good: Provider meets most but not all performance standards on a consistent basis
Fair: Provider meets some but not most performance standards, or is inconsistent in performance
Poor: Provider does not meet most or all performance standards on a consistent basis

Data Source: Northstar

Provider Types: All

Assessor(s): Program Director, Contract Manager

****ON HOLD PENDING NORTHSTAR REPORTING MODIFICATIONS**

Provider Scorecard:
**Domain #4 – Clinical Outcomes

Risk: Moderate

Assessment:

Excellent: Provider exceeds expectations for positive outcomes
Good: Outcomes meet expectations for positive outcomes
Fair: Outcomes are inconsistent and/or less than CMHSP expectations (without appropriate clinical justification)
Poor: Outcomes appear uncontrolled and/or are significantly less than CMHSP expectations (without appropriate clinical justification)

Data Source: # moves between homes and providers; progress against goals and objectives in Northstar, which may be inaccurate at this time. Ask providers if they collect data on clinical outcomes, i.e. stage of change, % goals met, % dreams fulfilled. Ask providers how they report on goals and positive outcomes. The goals in Northstar are only completed or discontinued; we need partially completed and partial progress or satisfactory/unsatisfactory rating buttons in Northstar. Summary: there may be no real way to collect accurate clinical data at this time.

Provider Types: All

Assessor(s): Program Director, Chief Quality Officer

****ON HOLD PENDING DISCUSSION OF TRACKABLE ELEMENTS WITH PROVIDERS**

Provider Scorecard: Domain #5A – Substantiated Consumer Grievances (non-abuse/neglect)

Risk: Moderate

Assessment:

Excellent: No substantiated grievances; grievances properly reported.
Good: Substantiated grievance(s) are relatively 'minor', or 'moderate' but isolated in nature and being addressed effectively; grievances properly reported.
Fair: Substantiated grievance(s) are relatively 'moderate', or are 'significant' but isolated in nature and being addressed effectively, or are minor but occur repeatedly; grievances properly reported.
Poor: Substantiated grievance(s) are relatively 'significant' and not isolated in nature, or are 'moderate' but occur repeatedly; Grievances are not properly reported.

Data Source: Bi-Annual Data by Complaint from Recipient Rights Manager, who has appropriate data to indicate measurements as shown below and will use this data to determine rating from Poor – Excellent as shown above.

Provider Types: All

Assessor(s): Customer Service

Provider Scorecard: Domain #5B – Substantiated Consumer ORR Complaints (Abuse/Neglect)

Risk: Moderate

Assessment:

Excellent: No substantiated consumer complaints; complaints properly reported.
Good: Substantiated complaints are relatively 'minor', or 'moderate' but isolated in nature and being addressed effectively; complaints properly reported.
Fair: Substantiated complaints are relatively 'moderate', or are 'significant' but isolated in nature and being addressed effectively, or are minor but occur repeatedly; complaints properly reported.
Poor: Substantiated complaints are relatively 'significant' and not isolated in nature, or are 'moderate' but occur repeatedly; complaints are not properly reported.

Data Source: Bi-Annual Data by Complaint from ORR

Provider Types: All

Assessor(s): Recipient Rights Officer

Provider Scorecard: Domain #6 – Security/Privacy Violations

Risk: Moderate
Assessment:
- Excellent: None or unremarkable security/ privacy violations; Violations properly reported.
  - Violations are non-existent
  - Violations are identified, remediated and mitigated exceptionally well by the provider
  - Systemic improvements are consistently sustained
  - The rate of reporting is commensurate with other providers serving similar populations
- Good: Violations are relatively 'minor'; Violations properly reported.
  - Violations are identified, remediated and mitigated reasonably well by the provider
  - Systemic improvements are usually sustained
  - The rate of reporting is acceptably commensurate other providers serving similar populations
- Fair: Violations are moderate; Violations properly reported.
  - Violations are not consistently identified, remediated and mitigated effectively by the provider
  - Systemic improvements are not consistently sustained
  - The rate of reporting is somewhat disproportionate to other providers serving similar populations
- Poor: Violations are significant; Violations are not properly reported.
  - Violations are not identified, remediated and mitigated effectively by the provider
  - Systemic improvements are not sustained
  - The rate of reporting is highly disproportionate to other providers serving similar populations

Data Source: Reports of Security Breaches to HHS: HIPAA/ORR Logs
Provider Types: All
Assessor(s): Privacy Officer

Provider Scorecard: Domain #7 – ANNUAL AUDIT OR FINANCIAL STATEMENT REVIEW

Risk: Moderate

Assessments

Audit conducted by Certified Public Accountant (CPA): Providers Assessment > $500,000 in reimbursement from NCCMH
Excellent: Auditor's opinion is unqualified and outstanding or exceptional practices are noted
Good: Auditor's opinion is unqualified
Fair: Auditor's opinion is unqualified; some minor internal control weaknesses
Poor: Auditor's opinion is qualified or there are significant internal control weaknesses

Review conducted by CPA: Provider Assessment using Financial statements only > $250,000, < $500,000 in reimbursement from NCCMH
Good: (Rating of 4) CPA indicates Financial Statements are assembled in accordance with Generally Accepted Accounting Principles (GAAP)
Poor: (Rating of 1) CPA indicates that Financial Statements are not in accordance with GAAP

Assessment of Providers that do not have Audited or unaudited Financials or whose reimbursement is <$249,000 is generally not done.

Data Source: Submitted provider audited Financial Statements, latest Quarterly Financial Statements, Budgets and Expenditures against Budget for providers receiving >$500,000 annually – or - Financial Statements for providers receiving $250,000 - $499,999 annually if requested.

Provider Types: All – Phase 1

Assessor(s): Contract Manager calculates, Chief Financial Officer gives opinion

Provider Scorecard: Domain #7 – ANNUAL AUDIT OR FINANCIAL STATEMENT REVIEW

Financial Calculations:

Working Capital	**Current Assets - Current Liabilities**	**An indicator of whether the company will be able to meet its current obligations. The greater the amount of working capital the more likely it will be able to make its payments on time.**
Current Ratio	**Current Assets / Current Liabilities**	**This tells you the relationship of current assets to current liabilities. A ratio of 3:1 is better than 2:1. A 1:1 means there is no working capital**
Quick Ratio	**(Cash+Temp. Invest+Accts Rec)/ Current Liabilities**	**Excludes Inventory, Supplies and Prepaids. This indicates the relationship between the amount of assets that can be quickly turned into cash versus the amount of current liabilities.**
Debt to Equity Ratio	**Total Liabilities/ Stockholders' Equity**	**The proportion of a company's assets supplied by the company's creditors versus the amount supplied the owner or stockholders.**

Provider Scorecard: Domain #8 – SUBSTANTIATED ABUSE OR NEGLECT

Risk: High

Assessment:

Note: 'Minor', 'moderate' and 'significant' describe intensity and are not used to characterize or discount the nature of the event

Excellent: None or relatively unremarkable substantiated incidences of abuse or neglect; Incident reporting is provided as required.

- Incidents are non-existent or nearly non-existent in quantity
- Incidents are identified, remediated and mitigated exceptionally well by the provider
- Systemic improvements are consistently sustained
- The rate of reporting is commensurate with other providers serving similar populations

Good: Substantiated incidences of abuse or neglect are relatively 'minor'*; Incident reporting is provided as required.

- Incidents are minimal in quantity
- Incidents are identified, remediated and mitigated reasonably well by the provider
- Systemic improvements are usually sustained
- The rate of reporting is acceptably commensurate other providers serving similar populations

(Continued)

Provider Scorecard: Domain #8 – SUBSTANTIATED ABUSE OR NEGLECT

Assessment (Continued):

Fair: Substantiated incidences of abuse or neglect are relatively 'moderate'; Incident reporting is provided as required.

- Incidents are significant in quantity
- Incidents are not consistently identified, remediated and mitigated effectively by the provider
- Systemic improvements are not consistently sustained
- The rate of reporting is somewhat disproportionate to other providers serving similar populations

Poor: Single or multiple substantiated incidences of abuse or neglect is/are relatively 'significant'; Incident reporting is not provided as required.

- Incident quantity unacceptable
- Incidents are not identified, remediated and mitigated effectively by the provider □Systemic improvements are not sustained
- The rate of reporting is highly disproportionate to other providers serving similar populations

Data Source: Bi-Annual Report by Recipient Rights that takes into consideration swiftness of provider response and immediacy of correction action being taken.

Provider Types: All

Assessor(s): Recipient Rights Officer

Provider Scorecard:
Domain #9 – ADVERSE CLINICAL EVENTS

Risk: High

Assessment:

Excellent: No Events found to be attributable to provider actions, and events are properly reported.
- Incidents are non-existent
- Systemic process is consistently sustained
- The rate of reporting is commensurate with other providers serving similar populations

Good: Events found to be attributable to provider actions are relatively 'minor', including deaths that do not require root cause analysis, and events are properly reported.
- Events are identified, remediated and mitigated reasonably well by the provider
- Systemic process is usually sustained

Fair: Events found to be attributable to provider actions are relatively 'moderate', including deaths that do not require root cause analysis, and events are properly reported.
- Events are not consistently identified, remediated and mitigated effectively by the provider;
- Systemic process is not consistently sustained

Poor: Single or multiple event(s) found to be attributable to provider actions is/are relatively 'significant', including deaths that do not require root cause analysis, and events are not properly reported.
- Events are not identified, remediated and mitigated effectively by the provider
- Systemic process is not sustained

(Continued)

Provider Scorecard:
Domain #9 – ADVERSE CLINICAL EVENTS

Domain #9 Continued:

Data Source: CQI, Incident Reports, Sub-Committee Reports, RCAs

Considerations:

- Are complex care clients managed well?
- Is death or illness of clients managed well?
- How does provider respond to incidents and solve the problems with quality?
- Are med counts off? Did client refuse meds or did provider lose meds?
- Safety events

Provider Types: All

Assessor(s): Risk Officer, Risk Committee

Provider Scorecard:
Domain #10 – SUBSTANTIATED CORPORATE COMPLIANCE FINDINGS (COMPLIANCE WITH MEDICAID REGULATIONS)

Risk: High

Assessment:

Excellent: No substantiated compliance investigations;
- Exceeding minimum of 95% compliance for verification of service claims across all audit questions
- Events are identified, remediated and mitigated exceptionally well by the provider,
- Systemic improvements are consistently sustained,

Good: Substantiated compliance findings are relatively 'minor', or are 'moderate' but isolated in nature and being addressed effectively;
- Meeting/exceeding minimum of 95% compliance for verification of service claims across most but not all audit questions
- Events are identified, remediated and mitigated reasonably well by the provider
- Systemic improvements are usually sustained

Fair: Substantiated compliance findings are relatively 'moderate', or are significant but isolated in nature and being addressed effectively, or are relatively 'minor' but occur repeatedly;
- Falling below the minimum of 95% compliance for verification of claims across most but not all audit questions
- Events are not consistently identified, remediated and mitigated effectively by the provider;
- Systemic improvements are not consistently sustained

(Continued)

Provider Scorecard:
Domain #10 – SUBSTANTIATED CORPORATE COMPLIANCE FINDINGS (COMPLIANCE WITH MEDICAID REGULATIONS)

Assessment (Continued):

Poor: Single or multiple substantiated compliance findings are relatively 'significant' and not isolated in nature, or are moderate but occur repeatedly;

- Falling below the minimum of 95% compliance for verification of claims across for all audit questions
- Events are not identified, remediated and mitigated effectively by the provider
- Systemic improvements are not sustained

Data Source: Reports of Suspected Fraud and Abuse to MSHN/MDHHS; Corporate Compliance Activity Report; Medicaid Event Verification findings; NPI/CHAMPS Enrollment, Claims Verification, MDHHS Audit (RE: MDHHS Audit, please note that not every provider is tested during any one specific year.)

Provider Types: All

Assessor(s): COO/Compliance Officer; Reimbursement Supervisor;

Provider Scorecard:
Domain #11 – LICENSURE OR CERTIFICATION STATUS, HCBS, AND RELATED CAPS REQUIREMENTS

Risk: High

Assessment:

Excellent: Full or active licensure or certification with no corrective action plan required
Good: Full or active licensure or certification with corrective action plan required. For residential corporations, is true for all (contracted) homes, or any conditional or probationary licensure status is an isolated instance and being addressed effectively
Fair: Conditional or probationary licensure or certification. For residential, is true for all contracted homes, or any suspended or revoked licensure status is an isolated instance and addressed effectively
Poor: Suspended or revoked licensure or certification. For residential, not an isolated instance

Data Source: Licensing and Certifying body website; Contract management files: Provider Applications, Disclosures and renewal materials are up to date; Credentialing Records Up to date; NMRE provides written statement on who is on Heightened Scrutiny listings, who has a Corrective Action Plan and if those plans are being followed.

Provider Types: AFC Licensure: Residential Service Providers; Medicare 'Certification': Primary Service Providers; Direct operated programs; Day Programs which require Certifications (??)

Assessor(s): Contract Manager, or in some cases HR or Credentialing Committee; NMRE/Stewart Mills to validate in writing with regard to HCBS compliance.

Provider Scorecard:
Domain #12 – Accreditation Status

Risk: High

Assessment:

- Excellent: Full accreditation with no findings
- Good: Full accreditation with findings
- Fair: Partial accreditation
- Poor: Conditional or provisional accreditation

Data Source: Provider Application and contract renewal materials

Provider Types: All large specialized residential: Summertree, Listening Ear, ASI, GTI, Spectrum, CHHS, Beacon, Crossroads, Flatrock or >$500,000 in reimbursements, all Day Program providers

Assessor(s): Contract Manager

Provider Scorecard:
Domain #13 – Formal Site Reviews

Risk: High

Assessment:

Excellent: Composite score of 100% for Recipient Rights, Safety & Infection Control, and Training; location is not on HCBS Heightened Scrutiny Listing; Complies with all elements of HCBS
Good: Composite score between 95-99.9% for Recipient Rights, Safety & Infection Control, and Training; location is not on HCBS Heightened Scrutiny Listing; Complies with all elements of HCBS
Fair: Composite score between 90-94.99% for Recipient Rights, Safety & Infection Control, and Training; location is not on HCBS Heightened Scrutiny Listing; Complies with all elements of HCBS
Poor: Composite score 89.9% or below for Recipient Rights, Safety & Infection Control, and Training; location is on HCBS Heightened Scrutiny Listing and an HCBS related CAP is required or in place

Data Source: Site Visit Reports

Provider Types: All – Phase 1

Assessor(s): Safety Specialist, Recipient Rights Specialist

PROVIDER NAME --->		SAMPLE COMPANY					
PROVIDER TYPE --->		LARGE LIC RES, DAY PROGRAM, SUPP EMP					
	Score / Domain	Excellent	Good	Fair	Poor	Not Applicable	Total or Average
Low	**1. Administrative Effectiveness**	4	3	2	1	N/A	
	Program Director		3				3
	Reimbursement Supervisor			2			2
	Contract Manager		3				3
	Customer Service	4					4
	Recipient Rights Officer		3				3
	Average						3
	2. Consumer Satisfaction Surveys	4	3	2	1	NA	
	Contract Manager				1		1
	3. Performance Indicators - HOLD IF MEASURES ARE NOT AVAILABLE	5	4	3	2	NA	
	Program Director					NA	
	Contract Manager					NA	
	Average						
	4. Clinical Outcomes - HOLD AS MEASURES ARE NOT BE AVAILABLE	5	4	3	2	NA	

Provider Scorecard: Estimated Analysis of Risk Level

High Risk: Average score of "Poor" or (3) across ALL High Risk Domains (#8 - #13) or overall average score at or below 65%

Moderate Risk: Average score of "Poor" or (3) across 50% of the High Risk Domains (#8 - #13), or overall average score of 66% - 85%

Low Risk: Average Score of Good (5) or above across the High Risk Domains, or overall average score at 86% or higher

Provider Scorecard: Outcomes

Best Case Scenario:

- Improved levels of substantiated incidents while maintaining consistent reporting
- Greater awareness and attention to financial stability
- Creating opportunities for growth at the provider level through attention to analysis, site reviews, documentation, reporting, and improvements in specially identified areas of mutual concern between the provider and NCCMH
- Effective means of measuring clinical outcome achievement
- Effective means of measuring quality improvement overall
- Growth of the assessment program to aid long term growth of provider network through identified training, and needed support that may be provided by NCCMH
- Improvement in documentation and reporting processes between providers and NCCMH

Worst Case Scenario:

- Non-responsive providers may be placed on conditional status
- Adverse contract action or termination may be initiated

PROVIDER DISCUSSION

As providers, how do youcollect data on clinical outcomes?
ie: stage of change, % goals met, % dreams fulfilled.

How do providers report on client goals and positive outcomes?