Mental Health Services

Improve Business Operations to Measure Success

June 2003

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MEMORANDUM

Date: June 2, 2003

To: Diane Linn, Multnomah County Chair
Maria Rojo de Steffey, Commissioner, District 1
Serena Cruz, Commissioner, District 2
Lisa Naito, Commissioner, District 3
Lonnie Roberts, Commissioner, District 4

From: Suzanne Flynn, Multnomah County Auditor

Subject: Mental Health System Audit

The attached report covers our audit of the business processes in the County's Mental Health System. This audit was included in our FY02-03 Audit Schedule.

In response to major concerns with the County's delivery of mental health services, the system has been completely redesigned. Our objective in this audit was to provide analysis and recommendations that would strengthen and sustain the redesign.

The task that the County undertook was monumental. To attempt to completely change the approach of service delivery and build an insurance company is not easy in the best of times. And as we know, these have not been the best of times.

This was also not an easy audit for my Office as the effect of budget reductions quickly affected the systems that we were auditing. We found that the County has improved their ability to manage the business side of the mental health operation, but more improvements are needed.

We have discussed our findings and recommendations with the Chair's Office and management in the Department of County Human Services. A formal follow-up to this audit will be scheduled within 1-2 years.

We appreciate the cooperation and assistance extended to us by the management and staff in the Division of Mental Health and Addiction Services and the Department of County Human Services.

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Executive Summary

Over the past 20 years, the management of mental health services has become an integral part of the County's mission. As a result of the transfer of responsibility and funding from the state and federal governments, the County is the primary provider of mental health services for residents unable to afford these services.

From 1984 until recently, services were provided through contracts with community based agencies and the County's role was one of contract administrator. Because the eligible clients were not identified, agencies were not obligated to serve particular individuals. The County often could not determine how and to whom services were provided. With the advent of managed care and the Oregon Health Plan, the County began a new phase of managing the mental health system.

After problems surfaced with a first attempt to create a mental health managed care organization, the County formed Verity Integrated Behavioral Healthcare Systems (Verity). Located in the Mental Health and Addiction Services Division (MHAS), Verity became responsible for serving approximately 75,000 Oregon Health Plan members residing in Multnomah County.

The purpose of this audit was to determine if MHAS had the necessary business systems to effectively operate a managed care organization. We assessed whether the Division had the ability to collect, review, and analyze financial and client information that would allow it to control spending and provide for quality services. Overall, we found support for the managed care model enacted under Verity. We also saw a number of improvements in business processes.

While our audit concluded that the County has made progress towards creating effective business systems, there are gaps that should be addressed. The County has accurate up-to-date information about eligible clients and can ensure that providers know who should be served and prevent payments for those who are ineligible. However, the capability to manage the organization's finances and to effectively evaluate the managed care model could be improved.

Operating in a managed care environment requires up-to-date information about expenses and financial administrative personnel who are able to assist Verity in responding effectively. We found that a combination of inexperienced staff, incomplete data, and a fragmented organization has made this difficult.

Finally, the County is currently in a time of fiscal constraint. Successful operation of Verity requires increased control of expenditure such as inpatient treatment. This is an acceptable business practice, but it needs to be balanced with measures that ensure that clients receive services.

We recommend that the Department clarify the priorities and responsibilities of staff that are depended on for business services by Verity and shared with other functions in the Division or Department. We also recommend that the Department increase its ability to understand and interpret financial information by establishing a financial manager position with the authority to control the business operations and hire staff with experience in analyzing managed care operations.

Background

Mental health services expanded over the past two decades

Providing mental health programs has long been an important County function. Over the past two decades, management of these services has become integral to the County's role. During the 1980s and 1990s, program dollars and administrative responsibilities increased significantly as control of mental health programs shifted from the state and federal governments to counties.

In 1980, the County's primary mental health focus was treatment of those with substance abuse problems, care of clients with mental and emotional problems, and services for developmentally disabled residents. As mental health practices changed and funding for implementation of different programs became available, the range of County mental health services expanded. Major programs that were added or services that were increased included:

- Community mental health centers funded by Federal Block Grant dollars
- Residential care for the chronically mentally ill
- 24-hour mental health crisis services
- Mental health services, crisis intervention, and outreach to the homeless and indigent
- Intervention, screening, diagnosis, and treatment for children and youth
- School-based mental health services
- Specialized treatment for severely disturbed children
- Culturally-specific mental health and treatment programs
- Substance abuse intervention services
- Care for those transitioned from state mental institutions

Beginning in 1984, most direct services were contracted out to community-based mental health providers. The County designed and managed the system, purchased services, administered and monitored contracts, and evaluated the quality of care. The array of programs and their varied funding requirements increased the complexity of administering the system and the need to manage more effectively. By the mid-1990s, the County began looking for ways to gain flexibility, save money, and serve more people. They saw managed care as a means of achieving those outcomes.

The County had already experimented with managed care for medical and dental services offered through the Health Department. These physical health services were funded by the Oregon Health Plan which was created in 1989 to better manage federal Medicaid monies flowing to the state. By 1997, the Oregon Health Plan expanded its coverage to include mental health care for its members,

and the County received funding for a managed care organization (MCO) for mental health services. This initial MCO, called CAAPCare, brought significant changes to the County's approach to mental health care.

County organization affected by introduction of managed care

The County's traditional role had primarily been to oversee the grants and programs that together made up the system of mental health services. In that capacity, the County contracted with agencies to provide particular programs. Because the eligible client pool was not identified, agencies were not obligated to serve particular individuals, and the County often could not determine how and to whom services were delivered. When managed care was introduced, the County began acting as an insurance company whose primary purpose was management of a business function. Although the larger goal of the MCO was the delivery of effective mental health care, the operational goal was the efficient use of limited resources.

The County also entered into two separate contracts with the state. Under the first contract, the County received state funds for those traditional services administered by the County. The second contract for operation of the County's MCO was primarily funded by federal Medicaid dollars administered through the Oregon Health Plan. Both contracts had separate, although related purposes and were carried out by the same department. The various administrative and program functions specified in each state contract were dispersed throughout the department.

In 1998, the County's MCO implemented risk-sharing agreements with community-based outpatient provider networks. In exchange for a guaranteed amount of money each month, agencies agreed to make mental health services available to nearly 50,000 of the county Oregon Health Plan members. Providers contracting with the MCO became responsible for the mental health care needs of all clients who were assigned to or who chose their agency for services. In return, the agencies received a fixed payment. This required agencies to accept some of the financial risk of providing services, something they had not experienced in previous contracting relationships with the County.

Program reorganized after concerns about system

The adjustment to managed mental health care was difficult for the County, providers, and hospitals. Services were more costly than expected and important MCO business functions were unsuccessful. Some agencies reduced service because of financial management concerns. At the same time, a number of incidents occurred that pointed to weaknesses in the system that left clients vulnerable. Ultimately, County leaders, mental health care advocates, and community members became very concerned about the stability and quality of the mental health system.

Within two years of the implementation of the MCO contracts, a task force was appointed by the Board of County Commissioners to review the County's mental health care services. The task force declared the County's mental health system a "mess" and listed several areas of concern, including inaccurate, incomplete management information. Their recommendations for improvement were adopted, and a design team was appointed to work with consultants from the Technical Assistance Collaborative on identified problems. Based on the design team's findings, CAAPCare was dismantled, and the County's mental health care system was redesigned.

As part of the redesign, Verity Integrated Behavioral Healthcare Systems became the County's new MCO for mental health services. Under Verity, risk-sharing agreements with providers distributed more of the financial responsibility to the pool of contracting agencies. The model of service delivery was also restructured.

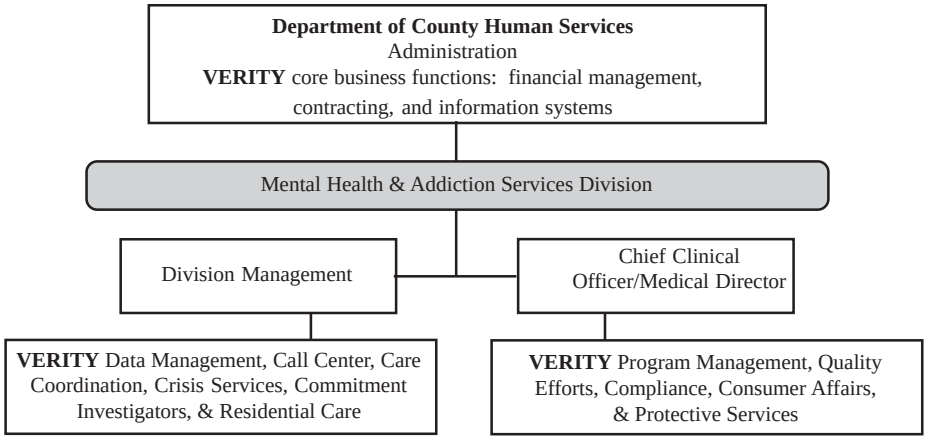
During the period of MCO redesign, the only other organization offering mental health care to Oregon Health Plan recipients in the county cancelled their contract with the state. As a result, Verity became responsible for serving 75,000 members residing in Multnomah County.

Overview of the Verity Managed Care Organization

Verity functions were dispersed throughout the Department of County Human Services (CHS). Administration, including quality assurance and compliance, was primarily under the direction of the Chief Clinical Officer and Medical Director in the Mental Health and Addiction Services Division (MHAS). Other units in the Division handled care coordination, crisis services, and data management. Some core business functions such as finance and information system management were carried out by the Department's central business unit outside of the Division. The chart below shows the dispersal of Verity operations.

Exhibit 1

Structure of Verity operations



Community-based agencies provided most Verity outpatient services

Most Verity outpatient services were provided by contracting agencies participating in the Verity network. The focus of these services was on intensive outpatient care and case management. Contracted crisis intervention activities, such as walk-in clinics, mobile crisis units, and active follow-up after hospitalization also connected individuals with outpatient services. In addition to these activities, the County operated a 24-hour crisis line and call center within MHAS. The primary purpose of the Verity service system was to provide proactive mental health care and to reduce the need for costly hospitalizations.

Verity members seeking mental health care could enter outpatient services in a variety of ways:

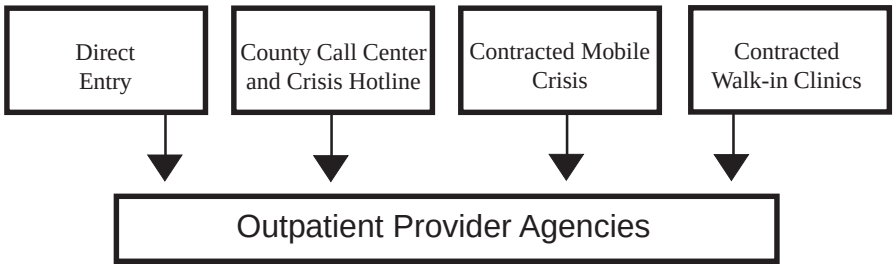
- Direct contact with contracting outpatient provider agencies
- Referral from the Call Center or the Crisis Hotline located at MHAS

- Referral from Mobile Crisis teams dispatched from agency offices
- Referral from Walk-in Clinics out in the community

The following chart depicts the Verity outpatient system.

Exhibit 2

Verity outpatient service system



About 70% of the Verity members signed up with an outpatient provider were served by Cascadia Behavioral Healthcare. This organization also operated the Mobile Crisis Teams and most of the Walk-in Clinics. Morrison Center served the majority of children enrolled with Verity, and other contracting agencies worked with a limited number of Verity clients or provided specialized services. In some instances, Verity members received mental health care on a fee-for-service basis from providers who were not among the agencies in the Verity network.

Although 75,000 county residents had a claim on Verity mental health services, most never used those services. This was typical of managed mental health care insurance plans. An average of 7,663 adults and 3,333 children were signed up with Verity outpatient providers each month during the first half of FY03, approximately 15% of the total members.

Hospitalization was the most costly service, usually $700 a day for every day authorized by the County. Under Verity, the financial responsibility for inpatient care was shared with outpatient providers. The more dollars spent on inpatient care, the less was available for outpatient care. The County implemented this risk-sharing model to create more incentive for agencies to reduce the need for hospitalizations through focused, supportive, and shorter-term outpatient services.

In cases where hospitalized Verity members were not signed up with any outpatient provider agency, County acute care coordinators and staff from outpatient agencies followed-up with these individuals to coordinate their outpatient care and reduce the need for a return to the hospital.

Verity impacted by budget cuts

The FY02-03 budget for the Division of Mental Health and Addiction Services was initially set at $81.5 million, with the largest portion of funding coming from federal and state program dollars. Cuts in state programs combined with lower than expected County revenues forced the Division to lay off staff and eliminate some services. Analysis provided by Division staff indicated that expected FY02-03 revenues were reduced to $69 million, but it was unclear

whether that figure captured the full impact of state budget cuts. The anticipated budget for next fiscal year will likely be closer to $60 million unless the Legislature eliminates mental health care coverage from the Oregon Health Plan. If that occurs, the Division's budget for FY03-04 will be reduced by another $29 million.

Scope and methodology

The purpose of the audit was to determine whether the Mental Health and Addiction Services Division (MHAS) had the necessary information systems and analysis for effective management of Verity, the County's managed mental health care organization. In particular, our goal was to evaluate the County's use of enrollment, utilization, and financial information. We did not assess the appropriateness of the clinical service model the Division was in the process of implementing or evaluate the impact of recent cuts in state funding. However, there were aspects of the model, particularly as they related to anticipated savings resulting from decreased hospitalization costs, that we did explore.

During the audit, activities we conducted included the following:

- Interviewed County budget staff and analyzed budget data for both MHAS as a whole and for the Verity enterprise fund
- Discussed Division-wide data analysis and performance measurement capabilities with Division program evaluation staff
- Reviewed agreements between the County and state regarding financial assistance (state mental health grants) and Oregon Health Plan participation
- Reviewed program materials prepared for the state mental health authority audit
- Reviewed the Verity provider manual and clinical accountability handbook
- Interviewed staff from the civil commitment, residential treatment, contract management, crisis call center, member services, children's services, and the compliance and quality management units of MHAS
- Interviewed information technology and finance staff from the central business office of the Department of County Human Services
- Interviewed administrators from CareOregon, the managed health organization that serves most of Oregon Health Plan recipients of medical care in Multnomah County
- Interviewed the Portland Police Department's crisis team lead
- Interviewed administrators from the State of Oregon Mental Health and Addiction Services Division.

In addition, we studied best practice literature and research articles to identify the possible financial risks of operating a managed mental health care organization and to determine the most effective way to avoid those risks. We examined financial data, membership data, and claims information, tested some of those systems, and analyzed trends.

This audit was conducted in accordance with generally accepted government auditing standards.

Audit Results

Operating a managed care organization (MCO) is different from the typical County human service model. Traditionally, the County and its contractors provided a particular level of services, but the number of clients to be served was not specified and the amount of services was limited by the budget. Verity, the County's MCO, received a fixed amount of money, but had to provide the covered services to all eligible individuals seeking care, regardless of the eventual cost. In this environment, it was critical that resources were managed closely. Like any managed care health insurance company, Verity faced financial risk. In order to manage that risk effectively, the County needed a strong system of care as well as strong business controls.

Overall, we found support for the managed care model enacted under Verity, particularly those changes aimed at strengthening the adult system of mental health care. We also saw a number of improvements in business processes, such as the development of a client database and the implementation of utilization review practices. Over the course of the audit, Verity staff worked to build timely, accurate, and reliable encounter and financial information systems. Verity began with the remnants of a system that had been characterized in the 2000 Mental Health Task Force Report as a "mess." Despite this and the upheaval that accompanied the transition to a different organization, some positive improvements occurred.

How managed care systems are design

Managed care models are essentially made up of a series of tradeoffs and balancing acts. For example, one of the County's goals was to give clients flexibility in choosing providers and obtaining services, while still retaining a firm grip on the utilization of these services. Decisions, such as how much financial responsibility to pass on to providers, the amount of control to exercise over payments (utilization review), and the number of providers affected the range of options available to members. But these decisions also helped to control costs and focused resources on areas with the highest likelihood of success.

Paying an MCO or provider a fixed (capitated) rate in advance of providing clients a set of services creates an incentive to improve efficiency by eliminating unnecessary services. However, it also carries financial risks and some negative incentives. The MCO or provider always runs the risk of running out of money before meeting its contractual obligations to clients. MCOs may face financial pressure from actual or potential losses from serving clients with extreme needs. This creates the incentive to either avoid these clients or to minimally serve less needy clients in order to concentrate resources on the extreme cases. When MCOs pass some or all of this financial risk on to providers, they also pass along these negative incentives.

Components of traditional managed care organizations

MCOs use membership, utilization, and financial data and analysis systems as well as the managed care model itself to manage the financial risk and to minimize the effect of the negative incentives inherent in managed care. These systems are also necessary to be accountable to its customers and clients. For an Oregon Health Plan-based MCO like Verity, the State of Oregon is the customer and health plan members are its clients.

Enrollment/Membership systems keep track of clients and help to ensure that members receive the services to which they are entitled. In Medicaid-based programs (like the Oregon Health Plan), eligibility can change frequently, and these changes need to be reflected in the eligibility records. Enrollment data direct payments to the primary providers and can be used to gauge the satisfaction with individual providers and groups by showing how many clients are leaving particular providers.

Utilization information systems are essential if MCOs are to capture information on the provision of services to eligible enrollees and to be accountable to their customers and clients. Utilization information systems commonly include automated encounter data; these data include diagnoses, type and duration of treatments, and prescriptions. Through analysis of these data and other utilization information, an MCO can identify the services individual members are receiving, review patterns of treatment by different providers, support quality assurance efforts, and fulfill reporting responsibilities.

Financial systems keep track of revenue and expenses as well as take in both enrollment and utilization data to ensure that proper payments are made, proper rates are set, and appropriate utilization controls are in place to protect resources. It is important that these financial systems be able to report the financial condition of the organization in real time. Without real time information, the MCO cannot make adjustments to account for unexpected costs or changes in the managed care model. And, without a good connection between utilization and financial data, it is very difficult to estimate how much it will cost to pay for all the required services – the premium the MCO must charge its customers. This ability to establish an appropriate premium not only makes it possible to stay afloat financially, it also protects clients from MCOs that would otherwise have to cut corners in treatment in order to stay in business.

Verity made progress, but gaps will need to be bridged

The County made significant progress toward implementing effective control of the financial risk and treatment quality required in a successful managed mental health care organization. Under Verity, the County developed a new managed care model and built many of the necessary data systems from scratch. The data systems appeared to be capable of providing the information needed to manage the operation, and the managed care model was evolving and improving. In order to take the next step in improving the operational capacity of the organization, gaps that impacted management's ability to ensure both accountability and service quality will need to be bridged.

County information about eligible clients appeared accurate

Verity developed a membership system and seemed to be able to accurately account for the fluctuating enrollment in the Oregon Health Plan. As a result, Verity had the capability to reconcile the premium payment it received from the state with the list of enrolled clients it was expected to serve. Verity was also able to identify the primary provider assigned to each client to ensure proper payments. And, providers could get up-to-date information on client

eligibility status, reducing the likelihood that an individual would be inappropriately denied service.

Verity downloaded Oregon Health Plan eligibility data from the state every week. In this download, the County got information on all health plan members that were assigned to Verity. We compared the Verity membership to state data for the same time period and found them to be consistent.

Verity faced challenges in accounting for services and measuring managed care model success

The redesign of the mental health system in Multnomah County and the creation of Verity brought with it a fundamental change in the approach to serving residents needing mental health services. With this change in serving its clients, Verity was challenged to find a new way to provide accountability for the money it spent on services and to measure the effectiveness of its managed care model. Verity had struggled with obtaining traditional automated utilization data from providers. Partly because of this difficulty in obtaining these data and partly due to their view of the limited usefulness of these data in providing a complete picture of Verity client service utilization, Verity management instead relied on a less formal system of aggregating and analyzing utilization information. However, the informal nature of Verity's utilization information system may have made it difficult to obtain a comprehensive evaluation of client utilization.

Verity developed an automated encounter system internally after CAAPCare failed to successfully contract out for this service. Encounter data collection was required in the County's contract with the state, and these data could have been a valuable resource for Verity management in obtaining a complete picture of service utilization by Verity clients. The automated system was in place to collect and organize the data, but until recently technological difficulties and miscommunication prevented Verity from collecting these data from providers.

Verity providers were slow in submitting utilization data for a variety of reasons. First, in order to be able to submit automated utilization data, provider data systems often needed to be upgraded, and community providers frequently needed assistance in adopting the technology necessary for appropriate reporting. Verity information technology staff said that some providers (including the largest provider) had a great deal of difficulty making their systems separate good utilization records from records with errors; consequently, their data were rejected.

Second, Verity contracts required primary providers to submit utilization data, but, providers were not penalized for failing to comply. Without the threat of a penalty, the providers had little incentive to make the investment necessary to upgrade their systems. Recently, Verity informed providers that they would be penalized for failure to submit utilization data.

Finally, Verity did not communicate effectively either internally or with its providers to facilitate the collection of the data. The way personnel who perform Verity functions were dispersed throughout the Department and Division contributed to problems with communications. Verity management were working to clear up some of the organizational barriers that impeded progress on data collection.

It was not clear that sufficient staff resources existed at Verity or within the Division to conduct a comprehensive utilization analysis once the encounter data were collected. Over the past two fiscal years, the number of full-time equivalent positions within the Mental Health and Addiction Services Division

had fallen from about 190 to what is expected to be about 120 at the end of the current fiscal year. Few, if any of the remaining staff were experienced in the rigorous analysis of managed care data, although they were gaining familiarity with the data.

Service accountability

Encounter data is the traditional way of determining that members are being served appropriately. A managed care model like Verity's, where providers bear substantial financial risk, can create an incentive for these providers to concentrate their resources on the neediest clients, with the intent of reducing the need for hospitalization – the most expensive treatment option. Such a concentration of resources is appropriate so long as it is not done to the detriment of clients with real, but less severe needs. The greater the financial pressure facing the provider, the greater the incentive to minimally serve these clients.

Verity management agreed that encounter data could be a valuable piece of the utilization picture, but had some concerns about focusing only on these traditional utilization data. They stated that part of the strength of their model was in the wrap-around support services necessary to keep clients out of high cost treatment, but that these services did not necessarily show up in traditional utilization data. They told us that these types of services, which ranged from structured services such as housing assistance to less formalized services like support from friends and family members, could be hard to capature. We would like management to institutionalize what has been an informal process to account for and analyze these services.

Verity managers believed their informal utilization information system combined with strict contract compliance monitoring had prevented providers from avoiding needy clients. However, identifying instances where less needy clients are being underserved is more difficult, and Verity's ability to monitor underservice would be improved with the addition of automated encounter data to the utilization information system.

Evaluation of the clinical model

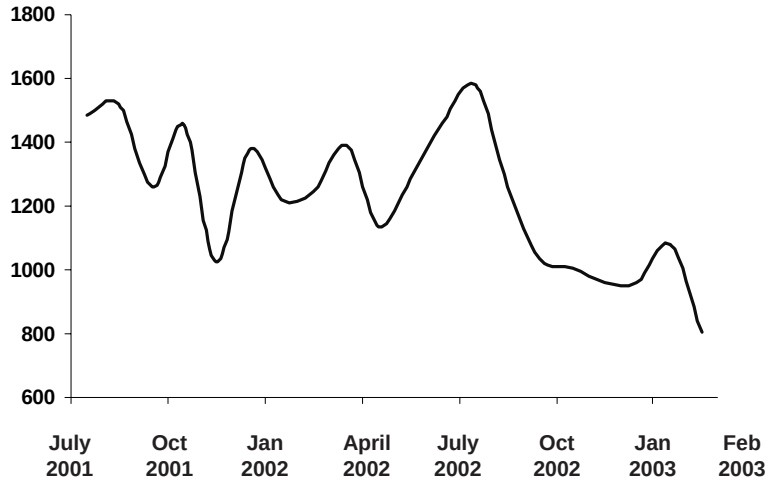
Verity collected data on outcome measures, such as the number of inpatient days, to gauge the success of its clinical model, which was based on outpatient treatment reducing the need for hospital admissions. Authorized hospitalizations per month fluctuated since July 2001, but experienced a significant decline between July 2002 and February 2003, going from 1,581 in July to 804 in February (see chart below). We believe that without outpatient utilization data, it is difficult to understand the relative strengths and weaknesses of the treatment model design or to evaluate alternative hypotheses for the improved outcomes.

For example, Verity staff suggested that the authorization process, which was part of Verity's utilization review, may also have been contributing to the reduction in the inpatient days paid by Verity. It was possible that a variety of factors in the design of the Verity model contributed to the decrease in authorized hospitalizations. It would be good to be able to determine which system components are having the greatest impact.

The following chart shows the total authorized bed days per month from July 2001 through February 2003.

Total Verity authorized hospital days

Exhibit 3



Financial management capacity was limited

Verity had few of the necessary building blocks for sound managed care financial management. Finance personnel had little or no experience with managed care, important data were either unavailable or slow to become available, and critical components of the financial management system were dispersed throughout the Department and the Division. As a result, it was difficult for Verity management to obtain accurate and timely financial information and for them to establish appropriate premiums and reimbursement rates.

While finance staff may have understood County financial operations, they were not adequately prepared to conduct the unique financial analysis required, nor were sound financial data available when Verity began operation. We were also told that some of the staff responsible for financial management information lacked knowledge of programs, limiting their ability to understand the significance of some financial data. Although some finance staff had started gaining a reasonable understanding of Verity financial information and had established some good processes, the lack of insurance company and managed care expertise or leadership with this sort of experience was a significant weakness.

Financial reporting

Like any insurance company, Verity needs to have finance personnel and systems that could accurately report the organization's financial condition in real-time. Without knowing how much money was being spent and how much was available, it was nearly impossible to make appropriate adjustments to account for unexpected costs or savings. A combination of inexperienced personnel, incomplete data, and fragmented organization made this task very difficult. Although this situation improved over the course of the audit, further improvement will be needed.

Managed care organizations typically use historical claims to estimate the cost of inpatient services that have been delivered, but have not been billed. Correctly estimating the Incurred But Not Reported (IBNR) charges is critical for understanding how much money will actually be available for services once these bills come due. When Verity began operations, there were no historical claims data available. So, Verity and Department staffs were forced to develop

an ad hoc method for estimating inpatient IBNR by using the number of authorized hospital days as a proxy for actual claims (bills). This method was not consistent with similar types of estimates made within the Division. And, even though IT and Finance staff expressed reservations about the accuracy of this ad-hoc method, nobody tested it. As more historical claims information became available, the IBNR methodology improved to the point that it was reviewed and approved during the County-wide financial audit.

Verity also struggled with obtaining important financial data from providers, as was required by the Oregon Health Plan contract. The provider contracts did not initially contain penalty provisions for Verity to enforce in the event the providers did not comply, and providers had only recently begun to consistently submit financial data. Without these data, Verity was essentially in the dark regarding the financial health of its provider network, leaving it vulnerable either to providers folding or cutting corners in service delivery in order to keep operating.

The Oregon Health Plan contract also required the County to submit an annual financial report on Verity operations to the state. It required that this report be audited by a qualified actuary or certified public accountant. As it was a test of the accuracy of the organization's financial data and the systems and processes used to aggregate the data into financial statements, such an audit was an integral part of the organization's financial controls. Verity managers and County-wide finance personnel we interviewed were either unaware of the requirement or did not know of any plans to comply. While the department submitted the County-wide financial audit results to the state, we do not believe this met the specific requirements of the contract. Moreover, we believe Verity would have benefitted from an individual financial audit.

Premiums and rates

Managed care organizations rely on historical claims, utilization and financial data, and analysis to establish the amount of money they need to receive in premiums in order to cover the cost of the claims they expect to receive. These data also allow the MCO to set reimbursement rates for providers that are sufficient to provide necessary services. The analysis required to establish premiums and set reimbursement rates is sophisticated. Nobody at Verity, the Division, or Department level had any experience performing this sort of analysis.

While the County could have contracted out for the expertise necessary to perform this analysis, the sort of data that is traditionally used for this purpose was simply not available. That made the task of estimating the amount of money that would be needed to provide the services required under the Oregon Health Plan contract very difficult. The County needed to know if the state revenues were adequate to provide the services required by the contract.

Balance between the treatment system and business needed to be monitored

Over the last two years, mental health system funding has shrunk. Consequently, Verity needed to strengthen its utilization review processes and make some adjustments to make more efficient use of resources. These changes reduced the ability of clients to protect themselves from poor quality or minimal service. While they may have been appropriate, the changes meant that Verity needed to be more aggressive in protecting its clients and making sure they were getting the services they needed by properly monitoring service utilization.

Verity closed its list of participating providers to reduce the administrative costs associated with credentialing new providers and to help control its exposure to outpatient fee-for-service costs. Prior to the change, clients had the freedom to choose essentially any provider outside the Verity network that would submit an acceptable treatment plan and accept payment according to the state fee schedule. This sort of option is very attractive to clients, but can be very expensive for managed care plans like Verity, as Verity needed to ensure that providers were qualified and treatment plans were appropriate. Individual private treatment can also be less effective and more costly.

Verity stopped accepting new non-participating providers in March 2003 and limited access to these providers unless the service being provided fit a particular need, such as culturally-specific services. This change restricted clients' ability to opt out of the primary provider system. The ability to opt out of a system is often seen as being a safety valve for people that believe they are being underserved. Without the safety valve, it was more important that Verity was able to detect underservice, via utilization data analysis.

Recommendations

1. To improve the effectiveness of the dispersed nature of Verity's vital business functions, Department management should:

   a. Clarify the priorities and responsibilities of Department-wide staff resources, relative to the individual Divisions in which they work.
   b. Ensure that there are sufficient resources within the Department to satisfy the differing demands placed on Department-wide staff by the various Divisions.
   c. Work to improve the lines of communication between Department and Division staffs.

2. To improve Verity's financial reporting and management capacity, Department management should establish and fill a financial manager position. A successful financial manager should have:

   a. Experience in financial reporting and rate setting analysis for a managed care organization.
   b. A position within the management structure that allows sufficient control over financial and utilization data so that accurate and timely financial reports can be produced and appropriate rates can be set.
   c. Authority to hire staff as needed to adequately manage Verity finances.

3. To improve Verity's utilization data analysis capacity, Division management should:

   a. Hire staff with experience in analyzing managed care utilization data or
   b. Reallocate existing Department staff and facilitate their training in managed care utilization analysis.

4. To maintain the balance between the treatment system and the business system, the Division should continue to monitor the quality of care.

Responses to the Audit