

MHSIP Policy Group  
Meeting Agenda  
September 7-8, 2000

Participants: Cecil Wurster, Ron Manderscheid, Randy Koch, Neal Adams, Olinda Gonzalez, David Brown, Ron Tremper, Mary Smith, Vijay Ganju, Steve Davis, Peter Steinmann (via phone). Meeting coordinator: Pat Smith. Marilyn Henderson and Sarah Minden attended the Friday session.

Thursday, September 7

1. The meeting opened with updates from participants on activities in their respective areas, including notes from the recent Western States Decision Support group meeting.
2. Next Ron M and Olinda discussed CMHS initiatives and issues. RM passed around a new book: *Cybercounseling and Cyberlearning: Strategies and Resources for the Millenium*, edited by Bloom and Walz; a CMHS publication by Mary Graham: *A Purchaser's Introductory Guide to Private Sector Managed Care*; and another on *Cultural Competence Standards in Managed Mental Health Services*. The latest survey of clients in treatment at service providers was discussed and request was made for MHSIP Policy Group members to be given the opportunity to review the instrument.

**TASK: CMHS will distribute the survey instrument to MPG members for review.**

The survey is the first done since 1986. It will oversample children and minorities, looking at admissions and person in treatment, and will include level of functioning and insurance coverage data. The first wave of analyses will be published in *Mental Health, US, 2000*; Annie E. Casey Foundation may fund additional child data analyses. A question was raised about how the survey fits into the Decision Support 2000+ (DS2K+) typology of organizations and financing--they will converge in the future.

OMB approval was received last week for the first self-help group survey. Kessler's phase 2 national co-morbidity survey (NCS2) sampling units will be used to identify areas to survey and every self-help group in an area will be identified and surveyed. The instrument is to be piloted in the Baltimore area. One aim is to link results to NCS2 results.

The KEN website has a mental health services locator application.

Ingrid Goldstrom is present results of the first Survey of Juvenile Justice Mental Health Services to the CMHS Advisory Council's new consumer-survivor group today and results will be published in MH, US, 2000. Ted Lutterman is preparing the end-of-year-2 16-state project report. Olinda noted that one of the successes of the 16-state project has been the participation of national experts: Ruth Ralph (recovery), Bruce Dembling (mortality), Molly Brunk (child/parent survey), and John McGrew (PACT).

**TASK: Non-16-state project states need to be informed of the technical work being done on the 16-state project, through the MHSIP website, the national mental health statistics conference, and by incorporation in MHSIP Report Card, version 2 (MRCv2)--no specific assignment.**

Results of the 16-state project have not been interpreted yet, e.g., no state-to-state comparisons on indicators. Data need to be put in one place to allow access for analysis, so the project does not end with comparisons and other analyses being tested and completed. The next State Profile System award from CMHS will require compiling indicators from states. In the children's arena, implementation of Children's Outcomes Roundtable/Len Bickman data model, including 16-state child and parent surveys, will be tested in New York with funding from CMHS (Gary deCarolis' unit).

A consumer-survivor sub-group of the SAMHSA Advisory Council has been established. Paolo del Vecchio was the primary organizer. Laura Van Tosh will present the group a report on consumer-related data projects.

**TASK: MPG will ask for time with the new group to discuss consumer concerns regarding data as one source of consumer input into MPG projects.**

The SAMHSA Advisory Council will be meeting next week. They have established a data sub-committee, but currently have no mental health representatives. Ron M will present information to the group on September 14 re: DS2K+.

HCFA has published a 153-page document on individual and group provider identifiers.

3. Discussion of membership referenced recommendations from the focus groups held last year re: a coordinating group that would help insure joint activities with multiple stakeholders (see task assignment on Friday). Qualifications and expectations of consumer and state representatives were discussed. Qualifications of consumers included (1) key advocacy role re: data, and (2) substantive responsibility in data from research, state, self-help organization, etc. perspective. Qualifications, as well as expectations re: number of annual meetings, participation on workgroups, task forces and conferences,

will be clarified in a request-for-nominees letter to be distributed using Paolo del Vecchio's contact lists, MHSIP website and others (e.g., Sylvia Caras, MHAmerica), MHSIP Updates newsletter, RUGs, MH Planning Councils, past MPG consumer members, Consumer Affairs organizations, etc. An introduction will make identify current members and activities, who votes and how, and make clear the MPG chair and task force chairs are drawn from MPG membership.

A similar letter will be distributed to solicit nominees for the state representative vacancies for the northeast, west, and a "general" slot. The letter will make clear representation is of regions, not RUGs. MPG members may nominate and NASMHPD members will be invited to nominate.

**TASK: Draft letters to be distributed to solicit nominations--Steve to complete and distribute to MPG for review by Sept. 15.**

**TASK: Ron M, Olinda and David compile consumer, RUG and state contact e-mail lists; Vijay to get e-mail and fax lists for NASMHPD members.**

Mary Smith, IL, was elected chair of the MHSIP Policy Group to replace Steve Davis, OK, whose term had expired.

4. The SAMHSA-NASMHPD State Uniform Reporting System documentation now references MHSIP and DS2K+. Areas of measurement have been narrowed to need, outcome, performance indicators, financial, and utilization, and the number of data tables planned has been reduced to less than 20. In addition, plans for county-level data collection have been dropped. An OMB clearance request for 2002 must now be submitted. There is disagreement over whether reporting should be mandatory.

5. The National Conference on Mental Health Statistics planning meeting is to be held September 11. Mary will be the MPG representative; Dorothy Webman, Workgroup for a Computerized BH and Welfare Record, will also attend to discuss vendor fair. The 2001 meeting marks the 25th anniversary of MHSIP and the 50th anniversary of the conference. No other federal conference has such longevity, so it is a cause for celebration and opportunity to publicize mental health data needs.

The group agreed the vendor display needs to be well-integrated. Vendors may also make technical reports, but must submit proposals like other potential presenters. As MPG works with Dorothy on the vendor fair, roles and sharing of risks and proceeds should be made clear. Time needs to be built into the conference schedule to visit the vendor exhibits, perhaps around lunch on days 2 and 3. It might also be beneficial to have technology presentation sessions in the conference immediately prior to vendor exhibits opening.

Peter Steinmann and John Pandiani have offered to manage a poster session. It was recommended that a historical overview of MHSIP be a part of the poster session.

6. Vijay reviewed the MHSIP Report Card, version 2 (MRCv2) workgroup report and proposed charge. Three potentially conflicting areas of work were mentioned: developing more specificity, e.g., indicators for children or for specific settings, perhaps through modularity; addressing implementation issues; and simplification. Addressing implementation may include synthesizing "lessons learned," incorporating new development, adapting to the outcome of the Performance Measures Summit, and including the consumer survey work. The point was made that, without technical work on instruments, toolkits, etc., the results will lack impact, so we need to make use of analyses of 16-state data and other work to inform MRCv2 development.

Discussion led to suggestions for additions or changes to the report and charge: include more information about the impact of MRCv1; consider the ACMHA vetting process with consumers as a model for grassroots involvement; insure more consumer inclusion in all steps of MRCv2 process; survey consumers re: what is still a priority among MRCv1, 16-state, NASMHPD and other initiatives; get input from people already funded on related projects; distribute press release re: MRCv2 project and describe in MHSIP Updates newsletter; balance a broad proposal with feasibility considerations.

7. The aim of the Performance Measures 2000 Summit is to reach consensus on a small number of performance measures that can be used in common across the behavioral healthcare field. If consensus can be reached on a few, then implementation issues can be addressed and development, revision and inclusion can be pursued for "parking lot" issues on which consensus cannot be immediately reached. CMHS has sponsored the planning with representation from AMBHA, NAMI, NAPHS, MHSIP, NASMHPD, Federation of Families, accrediting organizations, etc. The meeting is to be held in Atlanta, October 30-31, 2000, at the Carter Center. Concerns that may be obstacles to consensus include fear that measurement leads to a de facto practice standard, or that common measurement will lead to common expectations across diverse providers.

8. The Experience of Care and Health Outcomes (ECHO) survey is a combination of MHSIP and CABHS surveys with additional items to address Summit and other concerns. The survey is being developed and tested by Paul Cleary and staff at Harvard with input from MHSIP, NASMHPD, Washington Circle, accreditors and others. The survey now has about 85 items and needs to be shortened to be practical. Testing with AMBHA members is to be done this Fall. Questions remain about the unit of measurement--a health plan, as is the case with CAHPS/CABHS, or an individual provider (which would make it more appealing to accreditors other than NCQA). NCQA is considering a web-based

version of the survey and has recommended it to organizations it accredits. Quality and outcome domains of ECHO come from MHSIP, but have been re-formatted to match the CAHPS/CABHS model, with filtering questions. The continued development of this survey has implications for MRCv2, the child/parent surveys being tested, and other MHSIP-related activities.

FRIDAY AM

9. To follow-up on unresolved issues related to MHSIP organization and membership, a Guidelines review committee was appointed: Neal (chair), Randy, Cindy, and Leslie.

**TASK: The guidelines review committee will meet via conference call(s) prior to the December MHSIP Policy Group meeting, review MHSIP Policy Group Guidelines, and last year's focus group reports to make recommendations to the larger group re: MPG organization and membership.**

10. Ron M provided background re: the development of the Decision Support 2000+ project: focus groups were held and policy issues identified and published under phase 1 of the project; requirements analyses for model components were performed under phase 2; and phase 3 aims to establish a typology of financing and organization of behavioral health care, and develop core datasets to implement the requirements analyses that match the typology. Discussion of how DS2K+ might be implemented and MHSIP's role and influence followed. MHSIP might be a voice among partners or serve as an organizer of partners. Questions were raised about labeling products, since much of the initial enrollment/encounter requirements in DS2K+ were taken from previous MHSIP work. How to involve public, private and consumer stakeholders was discussed.

**TASK: Cecil and Sarah will draft a proposal for MHSIP participation in the DS2K+ development process and send it to Mary for distribution to MPG members to review for action at next MPG meeting.**

11. A recovery measurement meeting was held last spring in Texas with consumer experts who discussed and identified 26-27 key aspects of recovery. Ruth Ralph had previously been funded by CMHS to review literature, compile instruments, and recommend next steps. The Texas meeting group developed items for an instrument, some of which came from existing instruments that follow two typologies. The first asks about individual recovery, the second asks what the service system does to support a person in recovery. About 40 items were identified with parallel items in two instruments following the two typologies. A conference call of participants was held last week and many expressed concerns CMHS and the 16-state project were taking control of the recovery measurement process. Some consumers recommended each state develop its own recovery instrument with consumers in the state. An alternative proposal

was to build on previous accomplishments to produce a broadly applicable instrument.

12. Walter Suarez, MD, Director of the MN Health Data Institute, addressed the group via speaker phone to discuss HIPAA and its implications for behavioral health data. He started with an overview of the four major areas to which HIPAA applies: (a) standardization of administrative transactions for providers, payors, clearinghouses and others involved in electronic billing, eligibility checking, etc.; (b) privacy; (c) security; and (d) standardization of the electronic medical record.

a. Final rules eliminated exceptions for use within a corporate boundary. Business associates or partners who do business with providers will be covered. Local codes are eliminated; only national codes will be accepted, and some specific codes, e.g., some dental codes were eliminated. Rules on unique provider identifiers are to be out later this year. These rules will require a new enumeration process which has not yet been developed. In addition, new regulations are to be released re: a national payer ID, rules about claims attachments, enforcement and compliance monitoring (likely early next year).

b. Privacy rules are to be out in the next few months and will affect state health departments, collectors of health statistics, in addition to providers, payers and clearinghouses. Some issues remain re: which activities will be exempt from individual permission to release. There will be no unique client ID before privacy standards have been put in place.

c. Technology security rules and policies and procedures related to security are to be put in place. Those rules may not include digital signatures, since a new law recently signed covers this issue. One issue to resolve is how to specify rules without prescribing a specific technology to implement them.

d. A report from the National Committee on Vital and Health Statistics is due to be released on electronic medical records.

October 2002 is the deadline for the August 2000 rule implementation--Congress has a two-month comment period that ends October 16, 2000.

The "transaction standardization process" is the only way for behavioral health to see that our "business needs" are met. HIPAA has identified several existing entities as Data Standard Maintenance Organizations (DSMOs). Those concerned with data format are the American National Standards Institute (ANSI) X12 subcommittee for payers and submission of claims; the national pharmacy committee for pharmacy standards; and Health Level 7 (HL7) for clinical data, e.g., immunizations, vital statistics, lab results. The committees concerned with data content are the National Uniform Claims Committee (NUCC), that has responsibility for the HCFA 1500 form; the National Uniform Billing Committee (NUBC), that covers the billing form for institutional care (UB92); and the Dental

Content Committee. Memorandums of understanding (MOUs) have been shared among the six entities to provide rules for deciding which will act on what topic, how soon responses must be prepared, and for resolving inconsistent conclusions among the six groups. Other groups have educational or advocacy roles, e.g., the Medicaid agency directors; the Workgroup on Electronic Data Interchange (WEDI), which was named in HIPAA to monitor and coordinate the National Implementation Process (NIP) for sequencing standards implementation; and the Public Health Data Standards Consortium (PHDSC), supported by NCHS to bring the business needs of public health (including behavioral health--represented by CMHS and MHSIP) and health services research to the standards process. There is a strong statement in the latest rules mandating USDHHS to attend to the interests of public health, population health, and by inference according to Suarez, behavioral health.

The cost investment for larger organizations (e.g., Mayo Clinic has 40 staff working on claims processing) is expected to pay off in 10 years. Smaller organizations are likely to transfer their data to someone else to transform and process by the new standards. The penalties for non-compliance could be steep--up to \$25,000 per penalty, up to \$250,000--but large companies may decide it is worth that cost not to comply. There are also criminal penalties for intentional misuses of data, including up to 10 years in prison.

When asked how mental health might best address HIPAA, Suarez recommended identifying items that may be affected on a day-to-day basis in a mental health treatment organization; create a list of data elements, code sets, etc., e.g., DSM-IV conditions not in ICD-9; then go to one of the six committees, e.g., HL7 or X12, to ask for adoption of prioritized items. The PHDSC has representatives on the NUCC and NUBC, so it may be helpful to create a mental health special interest group within PHDSC. Suarez suggested including local people working with data that understand the problems that are likely to arise if the prioritized data elements are not added to the HIPAA standards. The X12 and HL7 committees hold quarterly meetings and Suarez estimated it would take one year of attending to "learn the landscape" and determine how best to justify a change request. Major payers, e.g., Signa in MN, has five people in mental health working on HIPAA standards.

**TASK: Vijay will talk with Ted and others at NASMHPD to determine how that group is responding to HIPAA. Ron T will contact the person in RI who is compiling local codes to submit for consideration in the national code set. Contact large states where impact may be large to learn what they are doing, to identify needed data elements, and go to PHDSC for assistance.**

It was noted that Suarez emphasized the need to make a "business case" for any changes and to justify change in terms of "business needs." Reviewing the process and documentation used by PHDSC members to get a race/ethnicity data element approved may help mental health develop a model strategy.

Ron M is meeting with software vendors September 25 to discuss with them their plans for adapting to or working to change HIPAA standards. This may lead to a meeting that could involve MHSIP, with support from vendors for work with the standards committees.

13. After a discussion about possibly meeting in conjunction with the NASMHPD meeting in AZ December 5-6, it was agreed it was important to have CMHS staff present, so the decision was made to hold the next meeting in the Washington, D.C., area December 11-12.

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Ron Tremper's notes:

Reported by Ron Manderscheid

- 1) Nelba Chaves is gone no matter who wins election.
- 2) Bernie Aarons is gone if Bush wins.
- 3) 1998 Survey of Mental Health Organizations is almost done. First attempt at a sample rather than a universal tally.
- 4) Survey of Mental Health Organizations 2000 moving through OMB. To be sent to Advisory group within a week for review.
- 5) Completing 1998 client patient survey of 25,000 cases in inpatient, residential and ambulatory care.
- 6) OMB clearance just received for 1st national self-help survey. Will look at how organized, who serves, etc. Much of the work to be done by primary consumers. Will use the same primary survey units as Kessler's study so that CMHC can link results up to the National Co-Morbidity II Survey.
- 7) The National Juvenile Justice Survey has also been cleared for release.

General Committee:

- 1) The 16 State Project is moving well. Have at least a plan to get full implementation of all measures by the end of 3rd year.

2) The Child Outcome Round Table has decided to attempt to test Len Bickman's proposed instrument in one state, possibly New York.

3) Mental Health Summit planning moving along. To be held October 30 & 31 at the Carter Center in Atlanta. The goal is to work with all stakeholders (MHSIP, NASMHPD President's Task Force, AMBHA, ACAMA, SA, Consumers, private providers) to:

Goal 1: define a small common set of Performance Indicators that should be collected in all mental Health agencies. This might be as few as 2-3 indicators to start with

Goal 2: Initiate a process through which we can agree on common indicators for the future.

4) HIPAA- Walter Suarez will be presenting to the group tomorrow.. Basically, all specialty fields (MH, SA, Maternal & Child Health, etc.) will lose greatly with HIPPA implementation if it stays in its current form. Also, the final regulations on the National Provider ID are either out or imminent. Regs for the 8 electronic transactions have been out since mid-August.

5) Uniform Data System: CMHS/NASMHPD (Joyce Berry). Has settled into domains of Need; utilization, outcomes; performance indicators; and financial.

Needs assessment - will rely primarily on SMI/SPMI rates from SAMHSA studies and walking down to local levels. The Fiscal section will rely on the NASMHPD Revenue and Expenditure Report; Performance indicators will closely parallel those used in the 16-state study. Overall, Joyce Berry's initial request is cut far back and reduced to where there are now only approximately 20 tables required. However, there is still considerable infrastructure behind this which no one seems to have taken into account.

Nelba Chavez wants mandatory reporting of this while the SAMHSA data committee says no to mandatory report. Rather than fight the issue internally, SAMHSA will ask for permission to require mandatory reporting from OMB in anticipation of being turned down.

6) This is the 25th anniversary of MSHIP plus the 50th of National Conference. Appropriate additional activities will be planned.

7) HIPAA presented by Walter Suarez.

Several areas covered:

1. Transactions X Code sets and unique IDS.
2. Data Privacy
3. Security Standards
4. Standardization of Election & Medical Record.

a) Transaction and Code Sets: within the next two years everyone will have to use code sets if doing business electronically. Of significance is that the exception for use of code sets within corporate boundaries is removed; that entities that providers and health plans are doing business with all are subject to the same regulations; and that the HCPC codes for drugs and dental care have been eliminated.

b) Privacy - Regulations due out in next several months. Health Statistics Systems (state health depts., dmhrh, etc) will be affected here in addition to plans and providers.

c) Security - more technical in nature and not likely to have tremendous effect on data systems collect.

d) UIDS: Proposed national payor ID and claims attachment regulations due before January 1, 2001. Proposed enforcement guidelines will be out early next year.