



**Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance
Abuse Services**

**2014 External Quality Review Report
Value Behavioral Health
FINAL REPORT**

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GLOSSARY OF TERMS

Average (i.e., arithmetic mean or mean)	The sum of all items divided by the number of items in the list. All items have an equal contribution to the calculation; therefore, this is un-weighted.
Confidence Interval	Confidence interval (CI) is a range of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% CI indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would be within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the CI 95 times, or 95% of the time.
HealthChoices Aggregate Rate	The sum of all behavioral health (BH) managed care organization (MCO) numerators divided by the sum of all BH-MCO denominators.
HealthChoices BH-MCO Average	The sum of the individual BH-MCO rates divided by the total number of BH-MCOs (five BH-MCOs). Each BH-MCO has an equal contribution to the HealthChoices BH-MCO Average value.
HealthChoices HC BH Contractor Average	The sum of the individual HC BH Contractor rates divided by the total number of HC BH Contractors (34). Each HC BH Contractor has an equal contribution to the HC BH Contractor Average value.
Rate	A proportion indicated as a percentage of members who received services out of the total population of identified eligible members.
Percentage Point Difference	The arithmetic difference between two rates.
Weighted Average	Similar to an arithmetic mean (the most common type of average), where instead of each of the data points contributing equally to the final average, some data points contribute more than others.
Statistical Significance	A result that is unlikely to have occurred by chance. The use of the word significance in statistics is different from the standard one, which suggests that something is important or meaningful.
Z-ratio	How far and in what direction the calculated rate diverged from the most probable result (i.e., the distribution's mean). Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.



INTRODUCTION

Purpose and Background

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that a MCO furnishes to Medicaid recipients.

The EQR-related activities that must be included in the detailed technical reports are as follows:

- review to determine plan compliance with structure and operations standards established by the State (42 CFR §438.358),
- validation of performance improvement projects, and
- validation of MCO performance measures.

HealthChoices Behavioral Health is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2014 EQRs for the HealthChoices Behavioral Health (BH) MCOs and to prepare the technical reports. This technical report includes seven core sections.

- I: Structure and Operations Standards
- II: Performance Improvement Projects
- III: Performance Measures
- IV: Quality Study
- V: 2013 Opportunities for Improvement - MCO Response
- VI: 2014 Strengths and Opportunities for Improvement
- VII: Summary of Activities

For the HealthChoices BH-MCOs, the information for the compliance with the Structure and Operations Standards section of the report is derived from monitoring and reviews conducted by OMHSAS of the BH-MCOs, as well as the oversight functions of the County or contracted entity when applicable, against the Commonwealth's Program Evaluation Performance Summary (PEPS) review tools and/or Readiness Assessment Instrument (RAI), as applicable.

Information for Sections II and III of this report is derived from IPRO's validation of each BH-MCO's performance improvement projects (PIPs) and performance measure submissions. The Performance Measure validation as conducted by IPRO included a repeated measurement of two Performance Measures – Follow-up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. For the first year, IPRO produced a third Performance Measure, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. The results of this measure are being studied by PA DHS/OMHSAS, and the data presentation will be included in the 2015 EQR BBA Technical Report.

Section IV contains the results of a Quality Study conducted by OMHSAS and IPRO that examines the HealthChoices Behavioral Health readmission rate, and conducts analysis to determine what factors correlate with an increased 30, 60, or 90 day readmission rate.

Section V, 2013 Opportunities for Improvement – MCO Response, includes the BH-MCO's responses to opportunities for improvement noted in the 2013 EQR Technical Report, and presents the degree to which the BH-MCO addressed each opportunity for improvement.



Section VI has a summary of the BH-MCO's strengths and opportunities for improvement for this review period (2014) as determined by IPRO, and a "report card" of the BH-MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HealthChoices Behavioral Health Managed Care Organization.

Section VII provides a summary of EQR activities for the BH-MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA Regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.



I: STRUCTURE AND OPERATIONS STANDARDS

This section of the EQR report presents a review by IPRO of the BH-MCO Value Behavioral Health's (VBH's) compliance with the structure and operations standards. In Review Year (RY) 2013, 63 PA Counties participated in this compliance evaluation.

Organization of the HealthChoices Behavioral Health Program

OMHSAS determined that the County governments would be offered the right-of-first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program; the mandatory managed care program that provides Medical Assistance recipients with services to treat mental health and/or substance abuse diagnoses/disorders. Forty-three of the 67 counties have signed agreements using the right of first opportunity and have sub-contracted with a private sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four counties have elected not to enter into a capitated agreement and as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties. For economy of scale, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the HC BH Contractors while providing an oversight function of the BH-MCOs. During RY 2011, one HealthChoices Oversight Entity, Erie County, held a contract with VBH through June 30, 2011 and contracted with another BH-MCO as of July 1, 2011.

Beaver, Fayette and the Southwest Six counties comprised of Armstrong, Butler, Indiana, Lawrence, Washington and Westmoreland Counties hold contracts with VBH. The Oversight Entity for the Southwest Six counties is Southwest Behavioral Health Management, Inc. Two other Oversight Entities, Behavioral Health of Cambria County (BHoCC) and Northwest Behavioral Health Partnership, Inc. (NWBHP) comprised of Cambria, Crawford, Mercer and Venango counties hold contracts with VBH. The Department contracts directly with VBH to manage the HC BH program for Greene County.

In some cases the HealthChoices Oversight Entity is the HealthChoices Behavioral Health (HC BH) Contractor, and in other cases multiple HC BH Contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. Operational reviews are completed for each HealthChoices Oversight Entity. The Department holds the HC BH Program Standards & Requirement (PS&R) Agreement with the HC BH Contractor who in turn, contracts with a private sector BH-MCO. The HC BH Contractor is responsible for their regulatory compliance to federal and state regulations, and the HC BH Program Standards & Requirement (PS&R) Agreement compliance. The HC BH PS&R Agreement includes the HC BH Contractor's responsibility for the oversight of the BH-MCO's compliance. The table below shows the name of the HealthChoices Oversight Entity, the associated HealthChoices HC BH Contractor(s), and the county(ies) encompassed by each HC BH Contractor.



Table 1.0 HealthChoices Oversight Entities, HC BH Contractors, and Counties.

HealthChoices Oversight Entity	HC BH Contractor(s)	County(ies)
Beaver County	Beaver County	Beaver County
Behavioral Health of Cambria County (BHoCC)	Cambria County	Cambria County
Northwest Behavioral Health Partnership, Inc. (NWBHP)	Northwest Behavioral Health Partnership, Inc. (NWBHP)	Crawford County
		Mercer County
		Venango County
Fayette County Behavioral Health Administration (FCBHA)	Fayette County	Fayette County
PA Department of Human Services	Value Behavioral Health of Pennsylvania Otherwise known as Greene County for this review	Greene County
Southwest Behavioral Health Management, Inc. (Southwest 6)	Armstrong-Indiana Behavioral & Developmental Health Program	Armstrong County
		Indiana County
	Butler County	Butler County
	Lawrence County	Lawrence County
	Westmoreland County	Westmoreland County
	Washington County	Washington County

Methodology

The findings in this section of the report are based on IPRO’s assessment of data provided by OMHSAS resulting from the evaluation of VBH by OMHSAS monitoring staff within the past three Review Years (RYs 2013, 2012, 2011). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS’ PEPS review tools for Review Year (RY) 2013. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year timeframe under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review Substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program’s Program Standards and Requirements (PS&R) are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2014 and entered into the PEPS tools as of October 2014 for RY 2013. Information captured within the PEPS tools informs this report. The PEPS tools are a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each HealthChoices Oversight Entity/BH-MCO. Within each standard, the tool specifies the sub-standards or Items for review,



the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional reviewer comments. Based on the tools, a HealthChoices Oversight Entity/BH-MCO is evaluated against sub-standards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS' more rigorous monitoring criteria.

At the implementation of the PEPS tools in 2004, IPRO evaluated the standards in the tools and created a crosswalk to pertinent BBA regulations. For standards with substandards, all of the substandards within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the substandards required for fulfilling BBA requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS' ongoing monitoring. In the amended crosswalk, the supplemental substandards no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Substandards concerning first level complaints and grievances inform the compliance determination of the BBA categories relating to Federal & State Grievance Systems Standards. All of the PEPS Substandards concerning second level complaints and grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category. As was done for the prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The RY 2013 crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in Appendix A and B, respectively. The review findings for selected OMHSAS-specific Substandards are reported in Appendix C.

Because OMHSAS' review of the HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS Substandards from RY 2013, RY 2012, and RY 2011 provided the information necessary for the 2014 assessment. Those standards not reviewed through the PEPS system in RY 2013 were evaluated on their performance based on RY 2012 and/or RY 2011 decisions, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed. Since Erie, Blair, Clinton, and Lycoming Counties contracted with two BH-MCOs in the review period, and because all applicable standards were reviewed for both BH-MCOs within the three-year time frame, these HealthChoices Oversight Entity review findings were not included in the assessment of compliance for either BH-MCO.

For VBH, this year a total of 163 Items were identified as being required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations. In addition, 11 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Substandards were relevant to more than one BBA regulation or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS Item may contribute more than once to the total number of Items required and/or reviewed. Table 1.1 provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of VBH against the Structure and Operations Standards for this report. In Appendix C, Table C.1 provides a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH-MCO and associated HealthChoices Oversight Entity against other state-specific Structure and Operations Standards.



Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for VBH's HealthChoices Oversight Entities

Table 1.1 Substandards Pertinent to BBA Regulations Reviewed for VBH

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2013	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	Not Reviewed*
Enrollee Rights	12	2	7	3	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	24	9	13	2	0
Coordination and Continuity of Care	2	0	0	2	0
Coverage and Authorization of Services	4	1	0	2	1
Provider Selection	3	0	3	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	8	0	0	0
Practice Guidelines	6	4	0	2	0
Quality Assessment and Performance Improvement Program	23	23	0	0	0
Health Information Systems	1	1	0	0	0
Statutory Basis and Definitions	11	1	0	9	1
General Requirements	14	1	0	12	1
Notice of Action	13	6	6	0	1
Handling of Grievances and Appeals	11	1	0	9	1
Resolution and Notification: Grievances and Appeals	11	1	0	9	1
Expedited Appeals Process	6	1	0	4	1
Information to Providers and Subcontractors	2	0	0	2	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	1	0	4	1
Effectuation of Reversed Resolutions	6	1	0	4	1

* Items "Not Reviewed" were not scheduled or not applicable for evaluation. "Not Reviewed" Items, including those that are Not Applicable, do not substantially affect the findings for any category if other Items within the category are reviewed.

For RY 2013, nine categories, 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements were not directly addressed by the PEPS Substandards reviewed. As per OMHSAS' judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health Program's PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH-MCOs. The category of Marketing Activities is Not Applicable because as a result of the Centers for Medicare and Medicaid Services (CMS) HealthChoices waiver, DHS has been granted an allowance to offer only one



BH-MCO per County. Compliance for the Cost Sharing category is not assessed by PEPS Substandards, as any cost sharing imposed on Medicaid enrollees is in accordance with CMS regulation 42 CFR 447.50-447.60.

In evaluations prior to the 2008 report, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all HC BH Contractors and BH-MCOs based only on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. Beginning with the 2008 report and the 2014 report, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories by OMHSAS. Hence, Solvency Requirement tracking reports and the quarterly reporting of Complaint and Grievances data were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

Determination of Compliance

To evaluate HealthChoices Oversight Entity/BH-MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring substandards by provision, and evaluated the HC BH Contractors' and BH-MCO's compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of met, partially met or not met in the PEPS tools submitted by the Commonwealth. If a substandard was not evaluated for a particular HealthChoices Oversight Entity/BH-MCO, it was assigned a value of Not Determined. Compliance with the BBA provisions was then determined based on the aggregate results across the three-year period of the PEPS Items linked to each provision. If all Items were met, the HealthChoices Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as partially compliant. If all Items were not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as non-compliant. If no crosswalked Items were evaluated for a given provision, and no other source of information was available to determine compliance, a value of Not Applicable ('N/A') was assigned for that provision. A value of Null was assigned to a provision when none of the existing PEPS Substandards directly covered the Items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results for all provisions within a given category were aggregated to arrive at a summary compliance status for the category. For example, all provisions relating to enrollee rights are summarized under Enrollee Rights - 438.100.

Format

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol*. Under each general subpart heading are the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a manner consistent with the three subparts in the BBA regulations explained in the Protocol i.e., Enrollee Rights and Protections, Quality Assessment and Performance Improvement (including access, structure and operation and measurement and improvement standards), and Federal and State Grievance System Standards.

This format reflects the goal of the review, which is to gather sufficient foundation for IPRO's required assessment of the HealthChoices Oversight Entity/BH-MCO's compliance with BBA regulations as an element of the analysis of their strengths and weaknesses. In addition, this level of analysis avoids any redundancy with the detailed level of review found in the PEPS documents.

Findings

For VBH and the 10 HC BH Contractors associated with the BH-MCO included in the structure and operations standards for RY 2013, 163 PEPS Items were identified as required to fulfill BBA regulations. The 10 HC BH Contractors were evaluated on 153 PEPS Items during the review cycle. There were 10 Items that were not scheduled or not applicable for evaluation for RY 2013. Since Erie contracted with two BH-MCOs in MY 2011, and because all applicable standards were reviewed for both BH-MCOs within



the three-year time frame, review findings for this HC BH Contractor are not included in the assessment of compliance for either BH-MCO.

Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this subpart is to ensure that the HC BH Contractors/BH-MCO has written policies regarding enrollee rights, complies with applicable Federal and State laws that pertain to enrollee rights, and that the HC BH Contractors/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees [42 C.F.R. § 438.100 (a), (b)].

Table 1.2 Compliance with Enrollee Rights and Protections Regulations

Enrollee Rights and Protections				
Subpart C: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Partial	Beaver, Fayette, Greene	Cambria, NWBHP,, Armstrong- Indiana, Butler, Lawrence, Washington, Westmoreland	12 substandards were crosswalked to this category. Beaver, Greene, and Fayette HC BH Contractors were evaluated on 12 substandards and compliant on 12 substandards. Cambria was evaluated on 12 substandards, compliant on 11 substandards and partially compliant on 1 substandard. Armstrong-Indiana, Butler, Lawrence, Washington, and Westmoreland) were evaluated on 12 substandards, compliant on 10 substandards and partially compliant on 2 substandards. NWBHP was evaluated on 12 substandards, compliant on 9 substandards and partially compliant on 3 substandards.
Provider-Enrollee Communications 438.102	Compliant	All VBH HC BH Contractors		Compliant as per PS&R sections E.4 (p.52) and A.3.a (p.20).
Marketing Activities 438.104	N/A	N/A	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH-MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	All VBH HC BH Contractors		Compliant as per PS&R sections A.9 (p.64) and C.2 (p.32).



Enrollee Rights and Protections				
Subpart C: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Cost Sharing 438.108	Compliant	All VBH HC BH Contractors		Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	All VBH HC BH Contractors		Compliant as per PS&R section 3 (p.37).
Solvency Standards 438.116	Compliant	All VBH Counties		Compliant as per PS&R sections A.3 (p.64) and A.9 (p.69), and 2013-2014 Solvency Requirements tracking report.

There are seven categories within Enrollee Rights and Protections Standards. VBH was compliant on five categories and partially compliant on one category. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50-447.60. The category Solvency Standards was compliant based on the 2013-2014 Solvency Requirement tracking report.

Beaver, Fayette, and Greene were compliant on six categories of the Enrollee Rights and Protections Standards. The remaining HC BH Contractors (Cambria, NWBHP, Armstrong- Indiana, Butler, Lawrence, Washington, and Westmoreland) were compliant on five categories.

Of the 12 PEPS substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated for NWBHP and they were compliant on 9 substandards and partially compliant on 3 substandards. Cambria was evaluated on all 12 substandards, compliant on 11 substandards and partially compliant on 1 substandard. Beaver, Fayette and Greene were evaluated on all 12 substandards and compliant on 12 substandards. Armstrong-Indiana, Butler, Lawrence, Washington, Westmoreland were evaluated on 12 substandards, compliant on 10 substandards and partially compliant on 2 substandards. Some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Enrollee Rights

NWBHP was partially compliant with Enrollee Rights due to partial compliance with three substandards within PEPS Standard 108.

PEPS Standard 108: Consumer / Family Satisfaction. The County Contractor/BH-MCO: a) incorporates consumer satisfaction information in provider profiling and quality improvement process; b) collaborates with consumers and family members in the development of an annual satisfaction survey that meets the requirements of Appendix L; c) provides the department with quarterly and annual summaries of consumer satisfaction activities, consumer issues identified and resolution to problems, and d) provides an effective problem identification and resolution process.

NWBHP was partially compliant on three substandards of Standard 108: Substandards 1, 2, and 10 (RY 2012).

Substandard 1: County/BH-MCO oversight of C/FST Program ensures HealthChoices contractual requirements are met.



Substandard 2: C/FST budget is sufficient to: hire staff proportionate to HC covered lives, has adequate office space, purchase equipment, travel and attend on-going training.

Substandard 10: The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.

Cambria was partially compliant with Enrollee Rights due to partial compliance with one substandard of Standard 108: Substandard 5 (RY 2012).

Substandard 5: The C/FST has access to providers and HealthChoices members to conduct surveys, and employs a variety of survey mechanisms to determine member satisfaction; e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.

Armstrong-Indiana, Butler, Lawrence, Washington, and Westmoreland were partially compliant with Enrollee Rights due to partial compliance with two substandards of Standard 108: Substandards 1 and 2 (RY 2012).

Substandard 1: County/BH-MCO oversight of C/FST Program ensures HealthChoices contractual requirements are met.

Substandard 2: C/FST budget is sufficient to: hire staff proportionate to HC covered lives, has adequate office space, purchase equipment, travel and attend on-going training.



Subpart D: Quality Assessment and Performance Improvement Regulations

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's Medicaid managed care program, the HealthChoices Program, are available and accessible to MCO enrollees [42 C.F.R. § 438.206 (a)].

The PEPS documents for each HC BH Contractor include an assessment of the HC BH Contractor/BH-MCO's compliance with regulations found in Subpart D. Table 1.3 presents the findings by categories consistent with the regulations.

Table 1.3 Compliance with Quality Assessment and Performance Improvement Regulations

Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Elements of State Quality Strategies 438.204	Compliant	All VBH HC BH Contractors		Compliant as per PS&R section G.3 (p.57).
Availability of Services (Access to Care) 438.206	Partial		All VBH HC BH Contractors	24 substandards were crosswalked to this category NWBHP, Cambria, Beaver, Greene, and Fayette were evaluated on 24 substandards, compliant on 22 substandards, partially compliant on 1 substandard and non-compliant on 1 substandard. Armstrong-Indiana, Butler, Lawrence, Washington, and Westmoreland were evaluated on 24 substandards, compliant on 21 substandards, partially compliant on 2 substandards and non-compliant on 1 substandard.
Coordination and Continuity of Care 438.208	Partial		All VBH HC BH Contractors	2 substandards were crosswalked to this category Each HC BH Contractor was evaluated on 2 substandards, partially compliant on 1 substandard and non-compliant on 1 substandard.
Coverage and Authorization of Services 438.210	Partial		All VBH HC BH Contractors	4 substandards were crosswalked to this category Each HC BH Contractor was evaluated on 3 substandards, partially compliant on 1 substandard and non-compliant on 2 substandards.
Provider Selection 438.214	Compliant	All VBH HC BH Contractors		3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards and compliant on 3 substandards.



Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Confidentiality 438.224	Compliant	All VBH HC BH Contractors		Compliant as per PS&R sections D.2 (p.49), G.4 (p.59) and C.6.c (p.47).
Subcontractual Relationships and Delegation 438.230	Compliant	All VBH HC BH Contractors		8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards and compliant on 8 substandards.
Practice Guidelines 438.236	Partial		All VBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant on 4 substandards, partially compliant on 1 substandard and non-compliant on 1 substandard.
Quality Assessment and Performance Improvement Program 438.240	Partial		All VBH HC BH Contractors	23 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards, compliant on 22 substandards and partially compliant on 1 substandard.
Health Information Systems 438.242	Compliant	All VBH HC BH Contractors		1 substandard was crosswalked to this category. Each HC BH Contractor was evaluated on 1 substandard and compliant on this substandard.

There are 10 categories in the Quality Assessment and Performance Improvement Regulations Standards. VBH was compliant on five categories and partially compliant on five categories. Two of the five categories that VBH was compliant on – Elements of State Quality Strategies and Confidentiality – were not directly addressed by any PEPS substandards, but were determined to be compliant as per the HealthChoices PS&R.

For this review, 71 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations for all 10 HC BH Contractors associated with VBH, and each HC BH Contractor was evaluated on 70 Items. There was one Item that was not scheduled or not applicable for evaluation for RY 2013. NWBHP and Armstrong-Indiana, Butler, Lawrence, Washington, and Westmoreland were evaluated on 70 Items, compliant on 59 Items, partially compliant on 6 Items and non-compliant on 5 Items. Fayette, Beaver, Greene, and Cambria were evaluated on 70 Items, compliant on 60 Items, partially compliant on 5 substandards and non-compliant on 5 Items. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

The 10 HC BH Contractors associated with VBH were partially compliant with Availability of Services due to partial or non-compliance with substandards of PEPS Standards 1 and 28.



PEPS Standard 1: Geographical Accessibility. The Program must include a full array of in-plan services available to adults and children. Provider contracts are in place.

Armstrong-Indiana, Butler, Lawrence, Washington, and Westmoreland were partially compliant on one substandard of Standard 1: Substandard 2 (RY 2012).

Substandard 2: 100% of members are given a choice of 2 providers at each level of care within 30/60 urban/rural met

PEPS Standard 28: Longitudinal Care Management (and Care Management Record Review). The BH-MCO has a comprehensive, defined program of care that incorporates longitudinal disease management.

All of the HC BH Contractors were non-compliant on one substandard of Standard 28: Substandard 1 (RY 2011).

Substandard 1: Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.

All of the HC BH Contractors were partially compliant on one substandard of Standard 28: Substandard 2 (RY 2011).

Substandard 2: The medical necessity decision made by the BH-MCO physician/psychologist advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.

Coordination and Continuity of Care

All of the HC BH Contractors associated with VBH were partially compliant with Coordination and Continuity of Care due to partial or non-compliance with two substandards of PEPS Standard 28.

PEPS Standard 28: See standard description, and partially and non-compliant substandard determinations under Availability of Services (Access to Care) on Page 15 of this report.

Coverage and Authorization of Services

All 10 HC BH Contractors associated with VBH were partially compliant with Coverage and Authorization of Services due to partial or non-compliance with substandards of PEPS Standards 28 and 72.

PEPS Standard 28: See standard description, and partially and non-compliant substandard determinations under Availability of Services (Access to Care) on Page 15 of this report.

PEPS Standard 72: Denials or reduction of services are provided, in writing, to the member, parent/custodian of a child/adolescent, and/or County Child and Youth agency for children in substitute care. The denial note includes: a) Specific reason for denial, b) Service approved at a lesser rate, c) Service approved for a lesser amount than requested, d) Service approved for shorter duration than requested, e) Service approved using a different service or Item than requested and description of the alternate service, if given, f) Date decision will take effect, g) Name of contact person, h) Notification that member may file a grievance and/or request a DHS Fair Hearing and I) If currently receiving services, the right to continue to receive services during the grievance and/or DHS Fair Hearing process.

All of the VBH HC BH Contractors were non-compliant on one substandard of Standard 72: Substandard 1 (RY 2013).



Substandard 1: Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

Practice Guidelines

All of the VBH HC BH Contractors were partially compliant with Practice Guidelines due to partial or non-compliance with two substandards of PEPS Standard 28.

PEPS Standard 28: See description and partially and non-compliant substandard determinations under Availability of Services (Access to Care) on page 15 of this report.

Quality Assessment and Performance Improvement Program

All 10 HC BH Contractors associated with VBH were partially compliant with Quality Assessment and Performance Improvement Program due to partial compliance with one substandard within PEPS Standard 91.

PEPS Standard 91: The BH-MCO has a quality management program that includes a plan for ongoing quality assessment and performance improvement. The BH-MCO conducts performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The QM plans emphasize High volume and High-risk services and treatment and BHRS.

All of the VBH HC BH Contractors were partially compliant on one substandard of Standard 91: Substandard 12 (RY 2013).

Substandard 12: The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.



Subpart F: Federal and State Grievance System Standards

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances.

The PEPS documents include an assessment of the HC BH Contractors/BH-MCO's compliance with regulations found in Subpart F. Table 1.4 presents the findings by categories consistent with the regulations.

Table 1.4 Compliance with Federal and State Grievance System Standards

Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All VBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 10 substandards, compliant on 2 substandards, partially compliant on 3 substandards and non-compliant on 5 substandards.
General Requirements 438.402	Partial		All VBH HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards, compliant on 5 substandards, partially compliant on 3 substandards and non-compliant on 5 substandards.
Notice of Action 438.404	Partial		All VBH HC BH Contractors	13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 12 substandards, compliant on 1 substandard, and non-compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All VBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 10 substandards, compliant on 2 substandards, partially compliant on 3 substandards and non-compliant on 5 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All VBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 10 substandards, compliant on 2 substandards, partially compliant on 3 substandards and non-compliant on 5 substandards.
Expedited Appeals Process 438.410	Partial		All VBH HC BH Contractors	6 substandards were crosswalked to this category.



Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		MCO Compliance Status
		Fully Compliant	Partially Compliant	
				Each HC BH Contractor was evaluated on 5 substandards, compliant on 1 substandard, partially compliant on 1 substandard and non-compliant on 3 substandards.
Information to Providers & Subcontractors 438.414	Partial		All VBH HC BH Contractors	2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards, partially compliant on 1 substandard and non-compliant on 1 substandard.
Recordkeeping and Recording Requirements 438.416	Compliant	All VBH HC BH Contractors		Compliant as per the 2013 quarterly Complaints and Grievance tracking reports.
Continuation of Benefits 438.420	Partial		All VBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5 substandards, compliant on 1 substandard, partially compliant on 1 substandard and non-compliant on 3 substandards.
Effectuation of Reversed Resolutions 438.424	Partial		All VBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5 substandards, compliant on 1 substandard, partially compliant on 1 substandard and non-compliant on 3 substandards.

There are 10 categories in the Federal and State Grievance System Standards. VBH was compliant on one category and partially compliant on nine categories. The category Recordkeeping and Recording Requirements was compliant as per the quarterly reporting of Complaint and Grievances data.

For this review, 80 substandards were crosswalked to Federal and State Grievance System Standards for all 13 Counties associated with VBH. Each HC BH Contractor was evaluated on 72 substandards, compliant on 25 substandards, partially compliant on 16 substandards and non-compliant on 31 substandards. Eight substandards were not scheduled or not applicable for evaluation for RY 2013. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

The 10 HC BH Contractors associated with VBH were partially compliant with nine of the 10 categories (all but Recordkeeping and Recording Requirements) pertaining to Federal State and Grievance System Standards due to partial or non-compliance with substandards within PEPS Standards 68, 71 and 72.



Statutory Basis and Definitions

All HC BH Contractors associated with VBH were partially compliant with Statutory Basis and Definitions due to partial or noncompliance with substandards of PEPS Standards 68, 71 and 72.

PEPS Standard 68: Complaints. Complaint (and BBA Fair Hearing) rights and procedures are made known to Independent Enrollment Assistance Program (IEAP), members, BH-MCO staff, and the provider network through manuals, training, handbooks, etc.

All of the VBH HC BH Contractors were partially compliant on two substandards of Standards 68: Substandards 1 and 5 (RY 2011).

Substandard 1: Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how the compliant rights and procedures are made known to members, BH-MCO staff and the provider network. BBA Fair Hearing 1st level 2nd level External.

Substandard 5: Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.

All of the VBH HC BH Contractors were non-compliant on two substandards of Standards 68: Substandards 3 and 4 (RY 2011).

Substandard 3: Complaint decision letters must be written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).

Substandard 4: The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.

PEPS Standard 71: Grievances and State Fair Hearings. Grievance and DHS Fair Hearing rights and procedures are made known to Enrollment Assistance Program (EAP), members, BH-MCO Staff and the provider network through manuals, training, handbooks, etc.

All of the VBH HC BH Contractors were non-compliant on two substandards of Standards 71: Substandards 1 and 3 (RY 2011).

Substandard 1: Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: BBA Fair Hearing, 1st level, second level, External, Expedited.

Substandard 3: Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.

All of the VBH HC BH Contractors were partially compliant on one substandard of Standard 71: Substandard 4 (RY 2011).

Substandard 4: Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either



by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.

PEPS Standard 72: See standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

All of the VBH HC BH Contractors were non-compliant on one substandard of Standard 72: Substandard 1 (RY 2013).

General Requirements

All HC BH Contractors associated with VBH were partially compliant with General Requirements due to partial or non-compliance with substandards of Standards 68, 71 and 72.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.

PEPS Standard 71: See standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.

PEPS Standard 72: See Standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

Notice of Action

All HC BH Contractors associated with VBH were partially compliant with Notice of Action due to non-compliance with Substandard 1 of Standard 72.

PEPS Standard 72: See Standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

Handling of Grievances and Appeals

All HC BH Contractors associated with VBH were partially compliant with Handling of Grievances and Appeals due to partial or non-compliance with substandards of Standards 68, 71 and 72.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.

PEPS Standard 71: See standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.

PEPS Standard 72: See standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

Resolution and Notification: Grievances and Appeals

All HC BH Contractors associated with VBH were partially compliant with Resolution and Notification due to partial or non-compliance with substandards of Standards 68, 71 and 72.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.



PEPS Standard 71: See standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.

PEPS Standard 72: See standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

Expedited Appeals Process

All HC BH Contractors associated with VBH were partially compliant with Expedited Appeals Process due to partial or non-compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.

PEPS Standard 72: See standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

Information to Providers & Subcontractors

All HC BH Contractors associated with VBH were partially compliant with Information to Providers & Subcontractors due to partial compliance with Substandard 1 of Standard 68 and non-compliance with Substandard 1 of Standard 71.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 19 of this report.

PEPS Standard 71: See standard description and determination of compliance under Statutory Basis and Definitions on page 19 of this report.

Continuation of Benefits

All HC BH Contractors associated with VBH were partially compliant with Continuation of Benefits due to partial or non-compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See standard description and determination of compliance under Statutory Basis and Definitions on page 19 of this report.

PEPS Standard 72: See Standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 16 of this report

Effectuation of Reversed Resolutions

All HC BH Contractors associated with VBH were partially compliant with Effectuation of Reversed Resolutions due to partial or non-compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See standard description and determination of compliance under Statutory Basis and Definitions on page 19 of this report.

PEPS Standard 72: See Standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 16 of this report



II: PERFORMANCE IMPROVEMENT PROJECTS

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH-MCO. Under the existing HealthChoices Behavioral Health agreement with OMHSAS, HC BH Contractors along with the responsible subcontracted entities (i.e., BH-MCOs), are required to conduct a minimum of two focused studies per year. The HC BH Contractors and BH-MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, BH-MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2014 for 2013 activities.

A new EQR PIP cycle began for BH-MCOs and HC BH Contractors in 2014. For this PIP cycle, OMHSAS selected the topic, “Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis” as the topic for this PIP. The topic was selected because the Aggregate HealthChoices 30-day Readmission Rate has consistently not met the OMHSAS goal of a rate of 10% or less. In addition, all HealthChoices BH-MCOs continue to remain below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS) Follow-Up After Hospitalization (FUH) metrics.

The Aim Statement for this PIP is “Successful transition from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices members hospitalized with a mental health or a substance abuse diagnosis.” OMHSAS selected three common objectives for all BH-MCOs:

1. Reduce behavioral health and substance abuse readmissions post-inpatient discharge.
2. Increase kept ambulatory follow-up appointments post-inpatient discharge.
3. Improve medication adherence post-inpatient discharge.

Additionally, OMHSAS is requiring all BH-MCOs to submit the following core performance measures on an annual basis:

- 1. Readmission within 30 Days of Inpatient Psychiatric Discharge (Mental Health Discharges)**
The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days without a substance abuse diagnosis during the initial stay.
- 2. Readmission within 30 Days of Inpatient Psychiatric Discharge (Substance Abuse Discharges)**
The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days with a substance abuse diagnosis (primary or secondary) during the initial stay.
- 3. Adherence to Antipsychotic Medications for Individuals with Schizophrenia**
The percentage of members diagnosed with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. This measure is based on the HEDIS measure of the same name.
- 4. Components of Discharge Management Planning**
This measure is based on review of facility discharge management plans, and assesses the following:
 - a. The percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses and provider phone numbers.
 - b. The percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses and provider phone numbers where at least one of the scheduled appointments occurred.



This PIP project will extend from January 2014 through December 2017, with initial PIP proposals submitted in 2014 and a final report due in June 2018. The non-intervention baseline period will be January 2014 to December 2014. BH-MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. BH-MCOs will be required to submit interim reports in June 2016 and June 2017, as well as a final report in June 2018. BH-MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH Contractor-level and BH-MCO-level data, including clinical history and pharmacy data. This PIP is designed to be a collaboration between the HC BH Contractors and BH-MCOs. The BH-MCOs and each of their HC BH Contractors are required to collaboratively develop a root-cause/barrier analysis that identifies potential barriers at the BH-MCO level of analysis. Each of the barriers identified should include the contributing HC BH Contract level data and illustrate how HC BH Contractor knowledge of their high risk populations contributes to the barriers within their specific service areas. Each BH-MCO will submit the single root-cause/barrier analysis according to the PIP schedule.

This PIP was formally introduced to the BH-MCOs and HC BH Contractors during a Quality Management Directors meeting on June 4th 2014. During the latter half of 2014, OMHSAS and IPRO conducted follow-up calls with the BH-MCOs and HC BH Contractors as needed.

The 2014 EQR is the 11th review to include validation of PIPs. With this PIP cycle, all BH-MCOs/HC BH Contractors share the same baseline period and timeline. To initiate the PIP cycle in 2014, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, remeasurement, and sustained improvement. Direction was given to the BH-MCOs/HC BH Contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness.

The BH-MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with the CMS protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

- Activity Selection and Methodology
- Data/Results
- Analysis Cycle
- Interventions

Validation Methodology

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (*Validating Performance Improvement Projects, Final Protocol, Version 1.0, May 1, 2002*) and meets the requirements of the final rule on the EQR of Medicaid MCOs issued on January 24, 2003. IPRO's review evaluates each project against ten review elements:

1. Project Topic And Topic Relevance
2. Study Question (Aim Statement)
3. Study Variables (Performance Indicators)
4. Identified Study Population
5. Sampling Methods
6. Data Collection Procedures
7. Improvement Strategies (Interventions)
8. Interpretation Of Study Results (Demonstrable Improvement)
9. Validity Of Reported Improvement
10. Sustainability Of Documented Improvement

The first nine elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points are



awarded for the two phases of the project noted above, and are combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance.

Review Element Designation/Weighting

As 2014 is the baseline year, no scoring for the current PIP can occur for this review year. This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods.

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Table 2.1 presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 2.1 Review Element Scoring Designations and Definitions

Element Designation	Definition	Weight
Full	Met or exceeded the element requirements	100%
Partial	Met essential requirements but is deficient in some areas	50%
Non-compliant	Has not met the essential requirements of the element	0%

Overall Project Performance Score

The total points earned for each review element are weighted to determine the BH-MCO's overall performance score for a PIP. The seven review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all seven demonstrable improvement elements is 80 points (80% x 100 points for Full Compliance).

PIPs are also reviewed for the achievement of sustained improvement. This has a weight of 20%, for a possible maximum total of 20 points. The BH-MCO must sustain improvement relative to the baseline after achieving demonstrable improvement. The evaluation of the sustained improvement area has two review elements.

Scoring Matrix

When the PIPs are reviewed, all projects will be evaluated for the same elements. The scoring matrix is completed for those elements that have been completed during the review year. At the time of the review, a project is reviewed for only the elements that are due, according to the PIP submission schedule. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule. At the time each element is reviewed, a finding is given of "Met", "Partially Met", or "Not Met". Elements receiving a "Met" will receive 100% of the points assigned to the element, "Partially Met" elements will receive 50% of the assigned points, and "Not Met" elements will receive 0%.



Table 2.2 Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Topic And Topic Relevance	5%
2	Study Question (Aim Statement)	5%
3	Study Variables (Performance Indicators)	15%
4 / 5	Identified Study Population And Sampling Methods	10%
6	Data Collection Procedures	10%
7	Improvement Strategies (Interventions)	15%
8 / 9	Interpretation Of Study Results (Demonstrable Improvement) and Validity Of Reported Improvement	20%
Total Demonstrable Improvement Score		80%
10	Sustainability Of Documented Improvement	20%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

Findings

As per the timeline distributed by OMHSAS for this review period, BH-MCOs were required to submit an initial proposal on November 2014. The initial proposal was reviewed by OMHSAS and IPRO and recommendations were provided to VBH. VBH was given the opportunity to schedule a technical assistance meeting to review their changes based on the initial review. VBH assistance call occurred on February 2015.

VBH submitted their PIP proposal document for review in November 2014. As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care.

VBH's proposal included a rationale for conducting the PIP based on member surveys, appointment availability data, and an encounter data analysis of readmission rates and follow-up visit rates of their population. VBH also included a discussion of high volume diagnosis within their membership. As the proposal was submitted prior to the end of the baseline year (2014) no baseline data was included in the proposal, nor were final goals set for improvement in subsequent years. These elements will be required for future PIP submissions.

VBH provided a barrier analysis which primarily consisted of a matrix of potential barriers identified via focus groups of VBH staff, providers, and HC BH Contractor staff. The barriers identified included lack of access to outpatient providers, a lack of services available on the weekend, and transportation barriers. There was a lack of data analysis to validate the existence and magnitude of the barriers. VBH also included a root cause analysis previously completed for the HEDIS and PA-Specific Follow-up After Hospitalization measures, which identified access to outpatient providers as a barrier to meeting follow-up rate goals.

VBH proposed a number of interventions for the PIP, including provider training on discharge management, the creation of an intensive care management program for high-risk members, and the creation of an Aftercare Coordinator position to provide support to members post-discharge. Most interventions were scheduled to begin within the first six months of 2015. There was a lack of discussion of how VBH is planning on monitoring the effectiveness of their interventions.

IPRO and OMHSAS met with VBH to review their PIP in December 2014. VBH is required to revise and submit a final proposal in early 2015. No elements were scored for this review period.



III: PERFORMANCE MEASURES

In 2014, OMHSAS and IPRO conducted three EQR studies. Both the Follow-up After Hospitalization for Mental Illness (FUH) and Readmission within 30 Days of Inpatient Psychiatric Discharge studies were re-measured. OMHSAS also elected to implement a statewide measure that focuses on substance abuse services, the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) HEDIS measure. The results of this measure will be reported in the 2015 BBA Technical Report .

Follow-up After Hospitalization for Mental Illness

This performance measure assessed the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider on the date of discharge up to seven and 30 days after hospital discharge. The measure continued to be of interest to OMHSAS for the purposes of comparing County, HC BH Contractor, and BH-MCO rates to available national benchmarks and to prior years' rates.

MY 2002 was the first year follow-up rates were reported. QI 1 and QI 2 utilize the HEDIS methodology for this measure. The PA-specific follow-up indicators were added to include services with high utilization in the HealthChoices BH Program that could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits. Each year the QI 1 and QI 2 specifications are aligned with the HEDIS Follow-up after Mental Health Hospitalization measure. The PA-specific codes that are not included in the HEDIS measure are also reviewed for accuracy on an annual basis.

The last major change to the PA-specific measures was in MY 2006. Codes added to the measures as per suggestions from OMHSAS, the Counties, and BH-MCOs changed the measures substantially, and rates for these indicators were no longer comparable to those from preceding measurement years. Consequently, these indicators were renamed to QI A and QI B, respectively. As these indicators represented a significant deviation from HEDIS measure specifications, comparisons to HEDIS rates were not made. In addition, for MY 2006 the follow-up measure was collected for the newly implemented HealthChoices Northeast Counties, and these Counties were asked to collect data for the six-month time frame that they were in service for 2006.

For MY 2007, all PA local codes previously mapped to standard CPT and HCPCS codes as per HIPAA requirements were retired and removed. Additionally, the measure was initiated for the 23 North/Central State Option Counties implemented in January 2007. As with the Northeast Counties for MY 2006, the North/Central County Option Counties were asked to collect data for the six-month time frame that they were in service for 2007.

For MY 2008, two procedure codes to identify eligible follow-up visits were added to the PA-specific measures per suggestions from OMHSAS, the Counties, and the BH-MCOs. Additionally, as requested by OMHSAS, the MY 2008 findings by age were presented as three cohorts: Ages 6-20 years, Ages 21-64 years, and Ages 65 years and over. The Ages 21-64 years cohort was reported as two age ranges (Ages 21-59 years and Ages 60-64 years) in prior measurements.

For MY 2009, indicators in the study had few changes. As requested by OMHSAS, all data analyses by region were removed, since the regional characteristics had become increasingly geographically diverse and the associated Counties are non-contiguous as the HealthChoices BH Program expanded beyond the initial legacy regions over the years of re-measurement.

For MY 2010, indicators had very few changes based on the HEDIS 2011 Volume 2: Technical Specifications. One revenue code was removed from the criteria to identify non-acute care exclusions.



For MY 2011, there was one minor change to the HEDIS specifications. An additional place of service code was added to the numerator specifications. There was no narrative report produced for MY 2011; however, aggregate and demographic rates were provided, and recommendations were submitted to OMHSAS.

For MY 2012, indicators again had minor changes based on the HEDIS 2013 Volume 2: Technical Specifications. A clarification was added to only use facility claims, not professional claims, to identify discharges. As requested by OMHSAS, analysis by HC BH Contractor was added.

For MY 2013, three clarifications were made to the specifications, and two changes were made to the Performance Measure reporting.

The measure clarifications are: if a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim.

The first reporting change is that the performance measure results are aggregated at the HC BH Contractor level instead of at the County level as in previous years. The second reporting change is the addition of HEDIS 7 and 30 day rates for ages 6 to 64 years old as of the date of discharge. This age cohort is presented to align with OMHSAS performance measure goals for this measure.

Measure Selection and Description

In accordance with DHS guidelines, IPRO created the indicator specifications to resemble HEDIS specifications. For each indicator, the criteria specified to identify the eligible population were: product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications as needed. Indicator rates were calculated using only the BH-MCO's data systems to identify numerator positives (i.e., administratively).

This performance measure assessed the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider on the date of discharge up to seven and 30 days after hospital discharge.

There were four separate measurements related to Follow-up After Hospitalization. All utilized the same denominator, but had different numerators.

Eligible Population

The entire eligible population was used for all 34 HC BH Contractors participating in the MY 2013 study.

Eligible cases were defined as those members in the HealthChoices program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a discharge date occurring between January 1 and December 1, 2013;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Six years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.



Members with multiple discharges on or before December 1, 2013, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified, are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 1, 2013. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2014 methodology for the Follow-up After Hospitalization for Mental Illness measure.

I: HEDIS Follow-up Indicators

Quality Indicator 1 (QI 1): Follow-up After Hospitalization for Mental Illness within Seven Days after Discharge (Calculation based on Industry Standard codes used in HEDIS):

Numerator: An ambulatory visit with a mental health practitioner on the date of discharge up to seven days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator 2 (QI 2): Follow-up After Hospitalization for Mental Illness within 30 Days after Discharge (Calculation based on Industry Standard codes used in HEDIS):

Numerator: An ambulatory visit with a mental health practitioner on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

II: PA-Specific Follow-up Indicators

Quality Indicator A (QI A): Follow-up After Hospitalization for Mental Illness within Seven Days after Discharge (Calculation based on Numerator 1 codes and additional PA-specific codes not used in HEDIS):

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to seven days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator B (QI B): Follow-up After Hospitalization for Mental Illness within 30 Days after Discharge (Calculation based on Numerator 1 codes and additional PA-specific codes not used in HEDIS):

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator Significance

According to the *Global Burden of Disease: 2004 Update* released by the World Health Organization (WHO) in 2008, mental illnesses and mental disorders represent six of the 20 leading causes of disability worldwide. Among developed nations, depression is the leading cause of disability for people ages 0-59 years, followed by drug and alcohol use disorders and psychoses (e.g., bipolar disorder and schizophrenia)¹. Mental disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. Additionally, patients with schizophrenia or bipolar



disorder have elevated rates of preventable medical co-morbidities^{ii,iii} such as obesity, cardiovascular diseases and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns^{iv,v}, reduced use of preventive services^{vi} and substandard medical care that they receive^{vii,viii,ix}. Moreover, these patients are five times more likely to become homeless than those without these disorders^x. On the whole, serious mental illnesses account for more than 15 percent of overall disease burden in the U.S.^{xi}, and they incur a growing estimate of \$317 billion in economic burden through direct (e.g. medication, clinic visits, or hospitalization) and indirect (e.g., reduced productivity and income) channels^{xii}. For these reasons, timely and appropriate treatment for mental illnesses is essential.

It has long been recognized that continuity of care is critical to positive outcome and to prevent long-term deterioration in people with severe and persistent mental illness^{xiii}. As noted in its 2007 *The State of Health Care Quality* report by the NCQA, appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses, and the likelihood of recurrence^{xiv}. An outpatient visit within at least 30 days (ideally seven days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance, and identify complications early on to avoid more inappropriate and costly use of hospitals and emergency departments^{xv}. With the expansion of evidence-based practice in the recent decade, continuity has become a core principle in care delivery and in performance measurement for mental health services^{xvi}. And one way to improve continuity of care is to provide greater readiness of aftercare by shortening the time between discharge from the hospital and the first day of outpatient contact^{xvii}.

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a longstanding concern of behavioral health care systems, with some researchers having estimated that 40 to 60 percent of patients fail to connect with an outpatient clinician^{xviii}. Research has demonstrated that patients who do not have an outpatient appointment after discharge were two times more likely to be re-hospitalized in the same year than patients who kept at least one outpatient appointment^{xix}. Over the course of a year, patients who have kept appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow-up with outpatient care^{xx}. Patients who received follow-up care were also found to have experienced better quality of life at endpoint, better community function, lower severity of symptoms, and greater service satisfaction^{xxi}. Patients with higher functioning in turn had significantly lower community costs, and improved provider continuity was associated with lower hospital^{xxii} and Medicaid costs^{xxiii}.

There are various measures of treatment efficacy, such as service satisfaction, functional status and health outcomes. Among them, re-hospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment^{xxiv}. Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care, and is an effective means to control the cost and maximize the quality of mental health services.

As noted, this measure and the issue of follow-up have been and remain of interest to OMHSAS, and results are reviewed for potential trends each year. While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs for each HC BH Contractor participating in the current study. The source for all administrative data was the BH-MCOs' transactional claims systems. Each BH-MCO was also required to submit the follow-up rates calculated for the four indicators along with their data files for validation purposes. The BH-MCOs were given the opportunity for resubmission, as necessary.



Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. The 3-year OMHSAS goal is to achieve the 75th percentile for ages 6-64, based on the annual HEDIS published percentiles for 7-day and 30-day FUH by Measurement Year 2016. For Measurement Years 2013 and 2015 BH-MCOs will be given interim goals for the next Measurement Year for both the 7 and 30 day follow-up rates based on their previous years' results.

The interim goals are defined as follows:

1. If a BH-MCO achieves a rate greater than or equal to the NCQA 75th percentile, the goal for the next Measurement Year is to maintain or improve the rate above the 75th percentile.
2. If a BH-MCO's rate is within 2% of the 75th percentile and above the 50th percentile, their goal for the next Measurement Year is to meet or exceed the 75th percentile.
3. If a BH-MCO's rate is more than 2% below the 75th percentile and above the 50th percentile, their goal for the next Measurement Year is to increase their current year's rate by 2%
4. If a BH-MCO's rate is within 2% of the 50th percentile, their goal for the next Measurement Year is to increase their rate by 2%
5. If a BH-MCO's rate is between 2% and 5% below the 50th percentile, their goal for the next Measurement Year is to increase their current year's rate by the difference between their current year's rate and the 50th percentile.
6. If a BH-MCO's rate is greater than 5% below the 50th percentile, their goal for the next Measurement Year is to increase their current year's rate by 5%.

Interim goals were provided to the BH-MCOs after the MY 2012 rates were received. The interim goals will be updated from MY 2013 to MY 2015. The interim goals are used the BH-MCOs progress in achieving the OMHSAS goal of the 75th percentile.

HEDIS percentiles for the 7- and 30-day FUH indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis for these indicators. As noted in Section V of this report, beginning with MY 2012 performance, and continuing for MY 2013, rates for the HEDIS FUH 7- and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request for a root cause analysis.

Data Analysis

The quality indicators were defined as rates, based on a numerator and a denominator. The denominator equaled the number of discharges eligible for the quality indicator, while the numerator was the total number of members for which the particular event occurred. The HealthChoices Aggregate for each indicator was the total numerator divided by the total denominator, which represented the rate derived from the total population of discharges that qualified for the indicator. The aggregate rate represented the rate derived from the total population of members that qualified for the indicator (i.e., the aggregate value). Year-to-year comparisons to MY 2012 data were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

HC BH Contractors With Small Denominators

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for all HC BH Contractors. Caution should be exercised when interpreting results for small



denominators, as they produce rates that are less stable. Rates produced from small denominators are subject to greater variability, or greater margin of error.

Findings

BH-MCO and HC BH Contractor Results

The HEDIS follow-up indicators are presented for three age groups: Ages 6-64 years old, 6 years and older and ages 6-20 years old. The results for the 6-64 years old age group are presented to compare the BH-MCOs and HC BH Contractor results to the OMHSAS interim and final goals for the age group. The 6+ years old results are presented to show the follow-up rates for the HEDIS population, and the 6-20 year old age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old.

The results are presented at the BH-MCO and HC BH Contractor level when multiple HC BH Contractors are represented by a single BH-MCO. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (i.e., across HC BH Contractors with the same contracted BH-MCO). The HC BH Contractor's-specific rates were calculated using the numerator and denominator for that particular HC BH Contractors. For each of these rates, the 95% Confidence Interval (CI) was reported. Both the HealthChoices BH-MCO Average and HealthChoices HC BH Contractors Average rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HealthChoices BH-MCO Average to determine if they were statistically significantly above or below that value. Whether or not a BH-MCO performed statistically significantly above or below the average was determined by whether or not that BH-MCO's 95% CI included the HealthChoices BH-MCO Average for the indicator. Statistically significant BH-MCO differences are noted.

HC BH Contractor-specific rates were compared to the HealthChoices HC BH Contractor Average to determine if they were statistically significantly above or below that value. Whether or not a HC BH Contractor performed statistically significantly above or below the average was determined by whether or not that HC BH Contractor 95% CI included the HealthChoices HC BH Contractor Average for the indicator. Statistically significant HC BH Contractor-specific differences are noted.

The HEDIS follow-up results for the 6-64 year old age group and the 6+ year old age groups are also compared to the MY 2013 HEDIS national percentiles. The HEDIS percentiles are based on results for the 6+ years old population. The percentile comparison for the ages 6-64 year old age group is presented to show BH-MCO and HC BH Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile by MY 2016. HEDIS percentile comparisons for the ages 6+ years old age group are presented for illustrative purposes only.

I: HEDIS Follow-up Indicators

(a) Age Group: 6-64 Years Old

As noted above, OMHSAS has elected to set a three year goal for both the HEDIS 7-day and 30-day follow-up measures for members ages 6 to 64 years old. The goal is for all HC BH Contractors and the BH-MCO rate to meet or exceed the HEDIS 75th percentile by Measurement Year 2015. For Measurement Years 2013 to 2015 BH-MCOs will be given interim goals for the next Measurement Year for both the 7 and 30 day follow-up rates based on their previous years' results. Table 3.1 below shows the Measurement Year 2013 results as compared to their Measurement Year 2013 goals and HEDIS percentiles.



Table 3.1 MY 2013 HEDIS Follow-up Indicator Rates: 6-64 years old

	MY 2013							MY 2012	RATE COMPARISON: MY 13 against MY 12			
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2013 Goal	2013 Goal Met?	%	PPD	Percent Change: MY 12 to MY 13*	SSD	HEDIS MY 2013 Medicaid Percentile
Q1 1 – HEDIS 7 Day Follow-up for Ages 6-64 Years Old												
HealthChoices Aggregate	16,035	34,026	47.1%	46.6%	47.6%	48.5%	NO	47.5%	-0.4	-0.9%	NO	Below 75th, at or above 50th percentile
VBH	2,577	5,509	46.8%	45.5%	48.1%	46.4%	YES	45.5%	1.3	2.86%	NO	Below 75th, at or above 50th percentile
Armstrong-Indiana	241	455	53.0%	48.3%	57.7%	47.8%	YES	46.9%	6.1	12.99%	NO	Below 75th, at or above 50th percentile
Beaver	274	539	50.8%	46.5%	55.1%	54.8%	NO	55.3%	-4.5	-8.15%	NO	Below 75th, at or above 50th percentile
Butler	192	424	45.3%	40.4%	50.2%	49.5%	NO	48.6%	-3.3	-6.77%	NO	Below 75th, at or above 50th percentile
Cambria	260	645	40.3%	36.4%	44.2%	38.4%	YES	36.6%	3.7	10.29%	NO	Below 50th, at or above 25th percentile
Fayette	225	482	46.7%	42.1%	51.3%	50.1%	NO	49.1%	-2.4	-4.99%	NO	Below 75th, at or above 50th percentile
Greene	77	142	54.2%	45.7%	62.7%	48.9%	YES	47.9%	6.3	13.10%	NO	Below 75th, at or above 50th percentile
Lawrence	152	333	45.6%	40.1%	51.1%	45.6%	YES	44.7%	0.9	2.13%	NO	Below 75th, at or above 50th percentile
NWBHP	380	873	43.5%	40.2%	46.8%	44.9%	NO	44.0%	-0.5	-1.02%	NO	Below 75th, at or above 50th percentile
Washington	316	614	51.5%	47.5%	55.5%	45.9%	YES	45.0%	6.5	14.30%	YES	Below 75th, at or above 50th percentile
Westmoreland	460	1,002	45.9%	42.8%	49.0%	44.7%	YES	43.3%	2.6	5.98%	NO	Below 75th, at or above 50th percentile
Q1 2 – HEDIS 30 Day Follow-up for Ages 6-64 Years Old												
HealthChoices Aggregate	23,081	34,026	67.8%	67.3%	68.3%	69.5%	NO	68.1%	-0.3	-0.5%	NO	Below 75th, at or above 50th percentile
VBH	3,889	5,509	70.6%	69.4%	71.8%	71.3%	NO	69.9%	0.7	0.97%	NO	Below 75th, at or above 50th percentile
Armstrong-Indiana	343	455	75.4%	71.3%	79.5%	75.7%	NO	76.6%	-1.2	-1.54%	NO	At or above 75th Percentile
Beaver	403	539	74.8%	71.0%	78.6%	75.7%	NO	76.3%	-1.5	-1.98%	NO	At or above 75th Percentile
Butler	293	424	69.1%	64.6%	73.6%	74.1%	NO	72.6%	-3.5	-4.85%	NO	Below 75th, at or above 50th percentile
Cambria	440	645	68.2%	64.5%	71.9%	68.6%	NO	67.2%	1.0	1.46%	NO	Below 75th, at or above 50th percentile
Fayette	332	482	68.9%	64.7%	73.1%	72.5%	NO	71.1%	-2.2	-3.12%	NO	Below 75th, at or above 50th percentile
Greene	109	142	76.8%	69.5%	84.1%	74.1%	YES	72.6%	4.2	5.73%	NO	At or above 75th Percentile
Lawrence	230	333	69.1%	64.0%	74.2%	70.6%	NO	69.2%	-0.1	-0.20%	NO	Below 75th, at or



	MY 2013							MY 2012	RATE COMPARISON: MY 13 against MY 12			
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2013 Goal	2013 Goal Met?	%	PPD	Percent Change: MY 12 to MY 13*	SSD	HEDIS MY 2013 Medicaid Percentile
												above 50th percentile
NWBHP	614	873	70.3%	67.2%	73.4%	68.9%	YES	67.6%	2.7	4.10%	NO	Below 75th, at or above 50th percentile
Washington	437	614	71.2%	67.5%	74.9%	66.0%	YES	64.7%	6.5	9.93%	YES	Below 75th, at or above 50th percentile
Westmoreland	688	1,002	68.7%	65.8%	71.6%	70.0%	NO	68.6%	0.1	0.12%	NO	Below 75th, at or above 50th percentile

* Percentage change is the percentage increase or decrease of the MY 2013 rate when compared to the MY 2012 rate. The formula is: (MY 2013 Rate - MY 2012 Rate) / MY 2012 Rate

The MY 2013 HealthChoices Aggregate rates in the 6-64 year age group were 47.1% for QI 1 and 67.8% for QI 2. These rates were comparable to the MY 2012 HealthChoices Aggregate rates for this age cohort of 47.5% and 68.1%, respectively. The HealthChoices Aggregate HEDIS rates were below the MY 2013 interim goals of 48.5% for QI 1 and 69.5% for QI 2, therefore both interim goals were not met in MY 2013. The MY 2013 QI 1 and QI 2 rates both fell between the HEDIS percentiles for the 50th and 75th percentile, therefore the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2013 for either rate.

The VBH MY 2013 6-64 year old QI 1 rate of 46.8% and QI 2 rate of 70.6% did not change statistically significantly from their MY 2012 rates. The VBH QI 1 rate of 46.8% was not statistically significantly different from the QI 1 HealthChoices BH-MCO average of 46.2% for this age group. The VBH QI 2 rate of 70.6% was statistically significantly higher than the QI 2 HealthChoices BH-MCO average of 66.8%. VBH exceeded their MY 2013 QI 1 interim goal of 46.4% for QI 1, but did not meet the MY 2013 QI 2 interim goal of 71.3%. Both VBH HEDIS rates were between the HEDIS MY 2013 50th and 75th percentiles, therefore the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by VBH in MY 2013 for either rate.

As presented in Table 3.1, the 6-64 year old QI 1 and QI 2 rates for Washington were statistically significantly higher than their MY 2012 rates by 6.5 percentage points each. HEDIS rates for the remaining HC BH Contractors did not change significantly from the prior year. Six out of the ten HC BH Contractors associated with VBH met their MY 2013 interim goals for QI 1: Armstrong-Indiana, Cambria, Greene, Lawrence, Washington and Westmoreland. None of the VBH HC BH Contractors had a QI 1 rate over the HEDIS 75th percentile. For QI 2, Greene, NWBHP and Washington met their MY 2013 interim goals for QI 2. Three HC BH Contractors, Armstrong-Indiana, Beaver and Greene, met the OMHSAS goal of meeting or exceeding the 75th percentile for QI 2.

Figure 3.2 is a graphical representation of the 6-64 year old MY 2013 HEDIS follow-up rates for VBH and its associated HC BH Contractors. Figure 3.3 shows the HealthChoices HC BH Contractor Average rates and the individual VBH HC BH Contractor rates that were statistically significantly higher or lower than the HealthChoices HC BH Contractor Average. The QI 1 rates for Greene, Armstrong-Indiana, Washington and Beaver were statistically significantly higher than the MY 2013 QI 1 HC BH Contractor Average of 45.5% by at least 5.3 percentage points, while the QI 1 rate for Cambria was statistically significantly lower than the HC BH Contractor Average by 5.2 percentage points. The QI 2 rates for Greene, Armstrong-Indiana and Beaver were statistically significantly higher than the QI 2 HC BH Contractor Average of 68.0% by at least 6.8 percentage points. HEDIS rates for the remaining VBH HC BH Contractors were not statistically significantly different from the respective HC BH Contractor Averages.

Figure 3.2: MY 2013 HEDIS Follow-up Indicator Rates: 6-64 Years Old

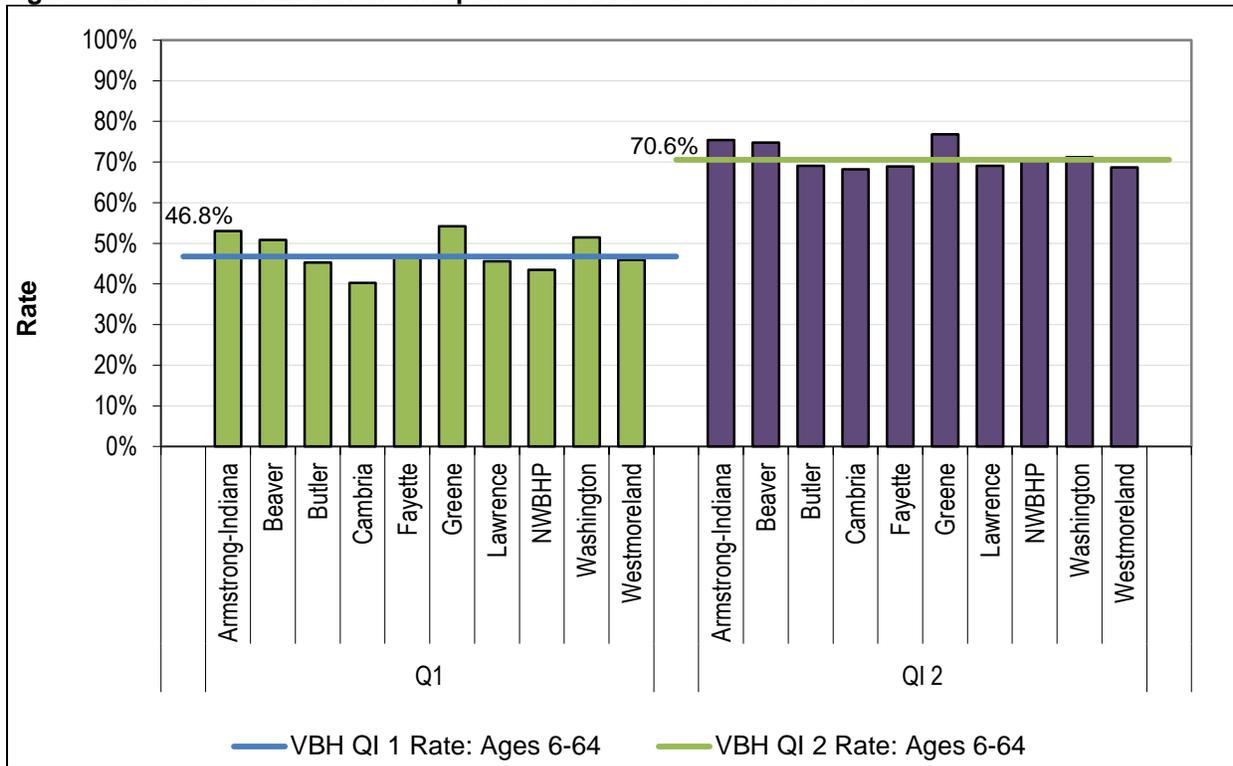
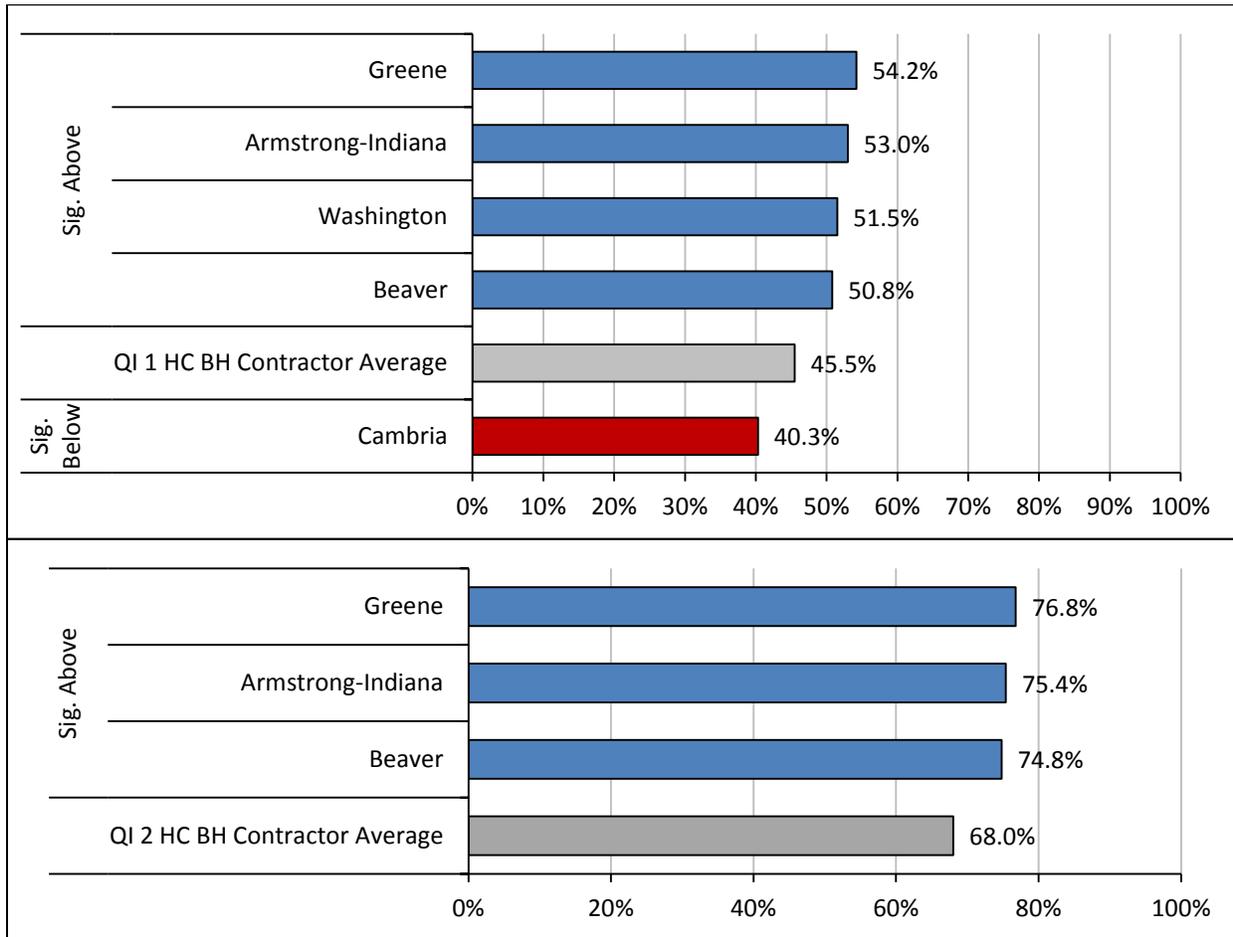


Figure 3.3: HEDIS Follow-up Rates Compared to MY 2013 HealthChoices HC BH Contractor Average: 6-64 years old





(b) Overall Population: 6+ years old

Table 3.4 MY 2013 HEDIS Follow-up Indicator Rates: Overall Population

	MY 2013							MY 2012	RATE COMPARISON of MY 2013 against :		
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	%	MY 2012		HEDIS MY 2013
									PPD	SSD	
Q1 – HEDIS 7 Day Follow-up for Ages 6+ Years Old											
HealthChoices Aggregate	16,196	34,564	46.9%	46.4%	47.4%	45.9%	45.2%	47.2%	-0.3	NO	Below 75th, at or above 50th percentile
VBH	2,608	5,608	46.5%	45.2%	47.8%			45.0%	1.5	NO	Below 75th, at or above 50th percentile
Armstrong-Indiana	244	466	52.4%	47.8%	57.0%			46.0%	6.4	NO	Below 75th, at or above 50th percentile
Beaver	276	543	50.8%	46.5%	55.1%			55.4%	-4.6	NO	Below 75th, at or above 50th percentile
Butler	193	434	44.5%	39.7%	49.3%			47.5%	-3.0	NO	Below 75th, at or above 50th percentile
Cambria	268	665	40.3%	36.5%	44.1%			36.1%	4.2	NO	Below 50th, at or above 25th percentile
Fayette	229	492	46.5%	42.0%	51.0%			48.5%	-2.0	NO	Below 75th, at or above 50th percentile
Greene	78	146	53.4%	45.0%	61.8%			46.4%	7.0	NO	Below 75th, at or above 50th percentile
Lawrence	155	337	46.0%	40.5%	51.5%			45.1%	0.9	NO	Below 75th, at or above 50th percentile
NWBHP	382	884	43.2%	39.9%	46.5%			43.6%	-0.4	NO	Below 75th, at or above 50th percentile
Washington	319	623	51.2%	47.2%	55.2%			44.2%	7.0	YES	Below 75th, at or above 50th percentile
Westmoreland	464	1,018	45.6%	42.5%	48.7%			43.1%	2.5	NO	Below 75th, at or above 50th percentile
Q1 – HEDIS 30 Day Follow-up for Ages 6+ Years Old											
HealthChoices Aggregate	23,332	34,564	67.5%	67.0%	68.0%	66.5%	67.7%	67.8%	-0.3	NO	Below 75th, at or above 50th percentile
VBH	3,940	5,608	70.3%	69.1%	71.5%			69.4%	0.9	NO	Below 75th, at or above 50th percentile
Armstrong-Indiana	348	466	74.7%	70.6%	78.8%			75.7%	-1.0	NO	At or above 75th Percentile
Beaver	406	543	74.8%	71.1%	78.5%			76.2%	-1.4	NO	At or above 75th Percentile
Butler	295	434	68.0%	63.5%	72.5%			71.3%	-3.3	NO	Below 75th, at or above 50th



	MY 2013						MY 2012	RATE COMPARISON of MY 2013 against :			
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	%	MY 2012		HEDIS MY 2013 percentile
									PPD	SSD	
Cambria	453	665	68.1%	64.5%	71.7%			66.6%	1.5	NO	Below 75th, at or above 50th percentile
Fayette	338	492	68.7%	64.5%	72.9%			70.5%	-1.8	NO	Below 75th, at or above 50th percentile
Greene	110	146	75.3%	68.0%	82.6%			70.2%	5.1	NO	At or above 75th Percentile
Lawrence	233	337	69.1%	64.0%	74.2%			69.3%	-0.2	NO	Below 75th, at or above 50th percentile
NWBHP	619	884	70.0%	66.9%	73.1%			67.7%	2.3	NO	Below 75th, at or above 50th percentile
Washington	442	623	70.9%	67.3%	74.5%			63.6%	7.3	YES	Below 75th, at or above 50th percentile
Westmoreland	696	1,018	68.4%	65.5%	71.3%			68.5%	-0.1	NO	Below 75th, at or above 50th percentile

The MY 2013 HealthChoices Aggregate rates were 46.9% for QI 1 and 67.5% for QI 2. These rates were not statistically significantly different from the MY 2012 HealthChoices Aggregate rates of 47.2% and 67.8%, respectively. The VBH MY 2013 QI 1 rate was 46.5% and QI 2 rate was 70.3%. Neither rate was statistically significantly different from the prior year. The VBH MY 2013 QI 1 rate of 46.5% was not statistically significantly different than the QI 1 HealthChoices BH-MCO average of 45.9%. The VBH QI 2 rate of 70.3% was statistically significantly higher than the QI 2 HealthChoices BH-MCO Average of 66.5% by 3.8 percentage points. Overall, VBH had the highest QI 2 rate of the five BH-MCOs evaluated in MY 2013.

As presented in Table 3.4, the MY 2013 QI 1 and QI 2 rates for Washington had statistically significant increases from MY 2012 to MY 2013, with a 7.0 percentage point increase in its QI 1 rate, and a 7.3 percentage point increase in its QI 2 rate. The MY 2013 HEDIS rates for the remaining HC BH Contractors were not statistically significant from their rates in MY 2012.

Figure 3.5 is a graphical representation of the MY 2013 HEDIS follow-up rates for VBH and its associated HC BH Contractors. Figure 3.6 shows the HealthChoices HC BH Contractor Average rates and individual VBH HC BH Contractor rates that were statistically significantly higher or lower than the MY 2013 HealthChoices HC BH Contractor Average. The QI 1 rates for Armstrong-Indiana, Washington and Beaver were statistically significantly higher than the QI 1 HealthChoices HC BH Contractor Average of 45.2% by at least 5.6 percentage points, while the QI 1 rate for Cambria was statistically significantly lower than the HC BH Contractor Average by 4.9 percentage points. The QI 2 rates for Greene, Beaver and Armstrong-Indiana were statistically significantly higher than the QI 2 HealthChoices HC BH Contractor Average of 67.7% by at least 7.0 percentage points. HEDIS rates for the remaining VBH HC BH Contractors were not statistically significantly different from the HC BH Contractor Average, therefore they are not included in Figure 3.6.

Figure 3.5 MY 2013 HEDIS Follow-up Indicator Rates – Overall Population

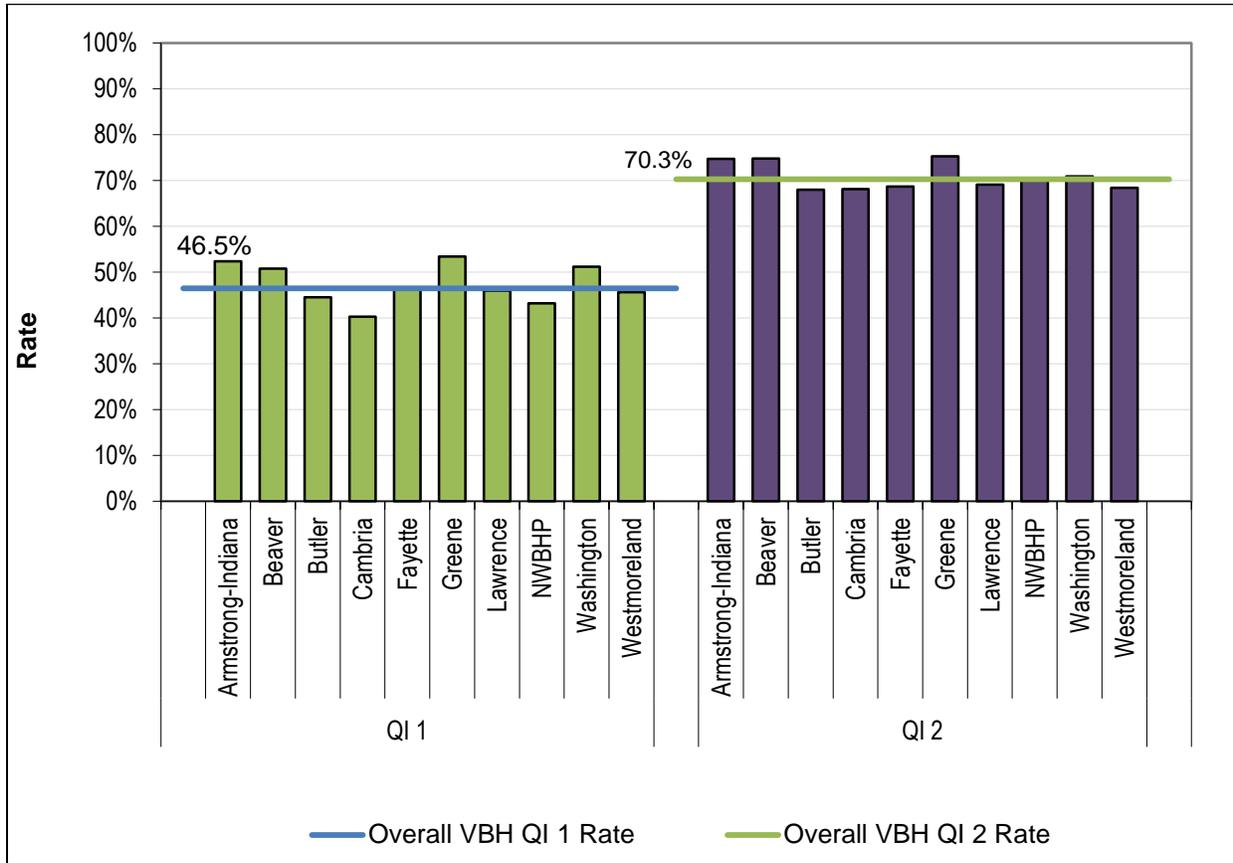
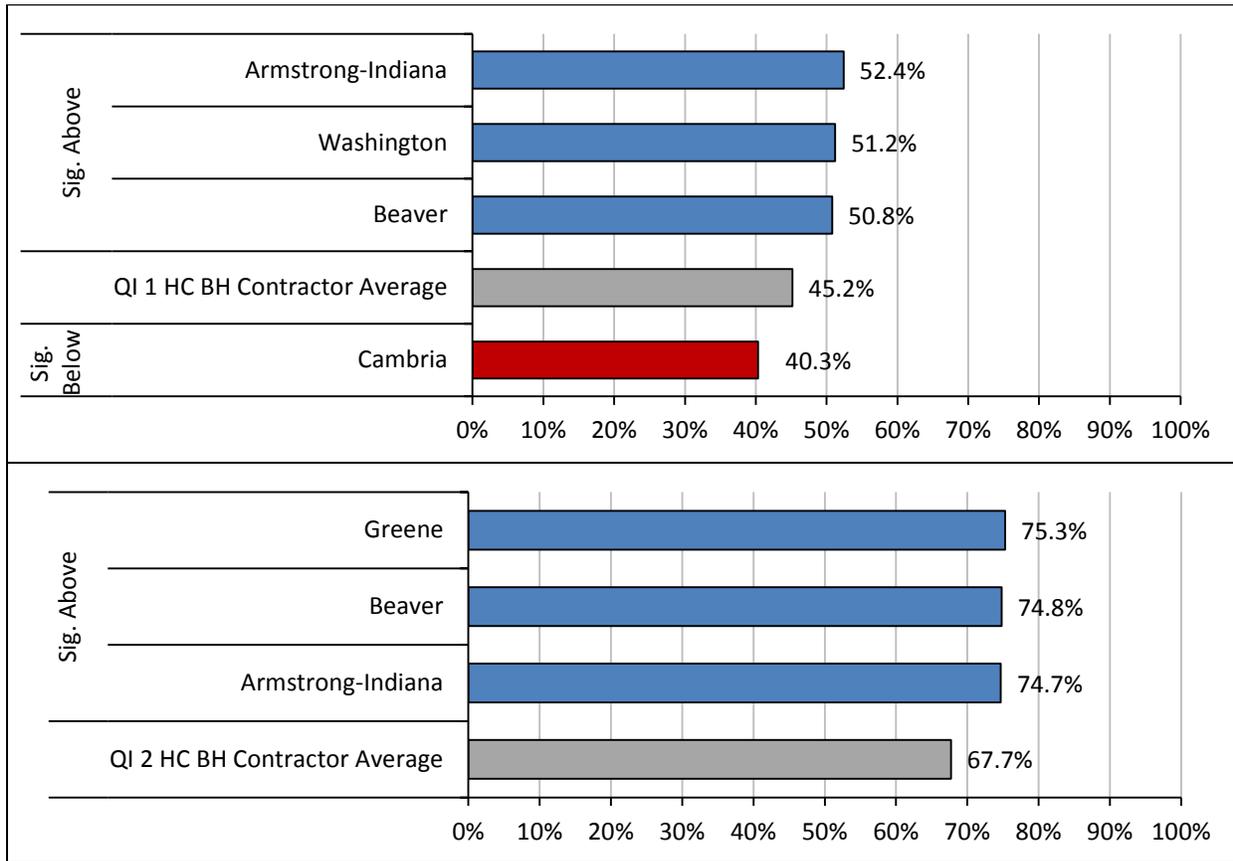




Figure 3.6 HEDIS Follow-up Indicator Rates Compared to MY 2013 HealthChoices HC BH Contractor Average – Overall Population





b) Age Group: 6-20 Years Old

Table 3.7 MY 2013 HEDIS Follow-up Indicator Rates: 6-20 Years Old

	MY 2013							MY 2012		
	(N)	(D)	MY 2013 %	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2012 %	RATE COMPARISON of MY 13 against MY 12	
									PPD	SSD
Q1 1 – HEDIS 7 Day Follow-up for Ages 6-20 Years Old										
HealthChoices Aggregate	5,382	9,604	56.0%	55.0%	57.0%	55.1%	55.2%	55.7%	0.3	NO
VBH	920	1,599	57.5%	55.0%	60.0%			53.7%	3.8	YES
Armstrong-Indiana	72	117	61.5%	52.3%	70.7%			64.1%	-2.6	NO
Beaver	90	146	61.6%	53.4%	69.8%			59.8%	1.8	NO
Butler	62	134	46.3%	37.5%	55.1%			58.4%	-12.1	NO
Cambria	86	148	58.1%	49.8%	66.4%			52.9%	5.2	NO
Fayette	71	129	55.0%	46.0%	64.0%			51.7%	3.3	NO
Greene	28	44	63.6%	48.2%	79.0%			50.0%	13.6	NO
Lawrence	43	78	55.1%	43.4%	66.8%			48.5%	6.6	NO
NWBHP	158	289	54.7%	48.8%	60.6%			53.8%	0.9	NO
Washington	124	192	64.6%	57.6%	71.6%			54.0%	10.6	YES
Westmoreland	186	322	57.8%	52.3%	63.3%			46.3%	11.5	YES
Q1 2 – HEDIS 30 Day Follow-up for Ages 6-20 Years Old										
HealthChoices Aggregate	7,374	9,604	76.8%	76.0%	77.6%	75.9%	77.4%	76.8%	0.0	NO
VBH	1,307	1,599	81.7%	79.8%	83.6%			78.7%	3.0	YES
Armstrong-Indiana	105	117	89.7%	83.8%	95.6%			85.2%	4.5	NO
Beaver	125	146	85.6%	79.6%	91.6%			84.1%	1.5	NO
Butler	100	134	74.6%	66.9%	82.3%			79.2%	-4.6	NO
Cambria	129	148	87.2%	81.5%	92.9%			81.2%	6.0	NO
Fayette	97	129	75.2%	67.4%	83.0%			77.5%	-2.3	NO
Greene	40	44	90.9%	81.3%	100.0%			80.0%	10.9	NO
Lawrence	59	78	75.6%	65.4%	85.8%			72.7%	2.9	NO
NWBHP	231	289	79.9%	75.1%	84.7%			75.2%	4.7	NO
Washington	163	192	84.9%	79.6%	90.2%			77.3%	7.6	NO
Westmoreland	258	322	80.1%	75.6%	84.6%			78.4%	1.7	NO

The MY 2013 HealthChoices Aggregate rates in the 6-20 year old age group were 56.0% for Q1 1 and 76.8% for Q1 2. These rates were comparable to (i.e. not statistically significantly different from) the MY 2012 HealthChoices Aggregate rates for this age group, which were 55.7% and 76.8%, respectively. The VBH Q1 1 rate of 57.5% and Q1 2 rate of 81.7% in the 6-20 year old age cohort were statistically significantly higher than the VBH MY 2012 rates by 3.8 and 3.0 percentage points, respectively.

For MY 2013, the VBH Q1 1 rate of 57.5% in the 6-20 year old age group was not statistically significantly different from the MY 2013 Q1 1 HealthChoices BH-MCO average of 55.1%. The VBH Q1 2 rate of 81.7% in the 6-20 year old age cohort was statistically significantly higher than the Q1 2 HealthChoices BH-MCO average of 75.9% by 5.8 percentage points.

As presented in Table 3.7, the 6-20 year old QI 1 rates for Washington and Westmoreland statistically significantly increased from their MY 2012 rates by 10.6 and 11.5 percentage points, respectively. The remaining HC BH Contractors did not have statistically significant QI 1 changes from the prior year, and none of the HC BH Contractors associated with VBH had statistically significant QI 2 rate changes from MY 2012 to MY 2013 in this age cohort.

Figure 3.8 is a graphical representation of the MY 2013 HEDIS 6-20 year old follow-up rates for VBH and its associated HC BH Contractors. Figure 3.9 shows the HealthChoices HC BH Contractor Average rates and the individual VBH HC BH Contractor rates that were statistically significantly higher or lower than the HC BH Contractor Average. The QI 1 rate for Washington was statistically significantly higher than QI 1 HC BH Contractor Average of 55.2% by 9.4 percentage points, while the rate for Butler was statistically significantly lower than the HC BH Contractor Average by 8.9 percentage points. The QI 2 rates for Greene, Armstrong-Indiana, Cambria, Beaver and Washington were statistically significantly higher than the QI 2 HC BH Contractor Average of 77.4% by at least 7.5 percentage points. QI 2 rates for the remaining VBH HC BH Contractors were not statistically significantly different from the HC BH Contractor Averages for this age group.

Figure 3.8 MY 2013 HEDIS Follow-up Indicator Rates: 6-20 years old

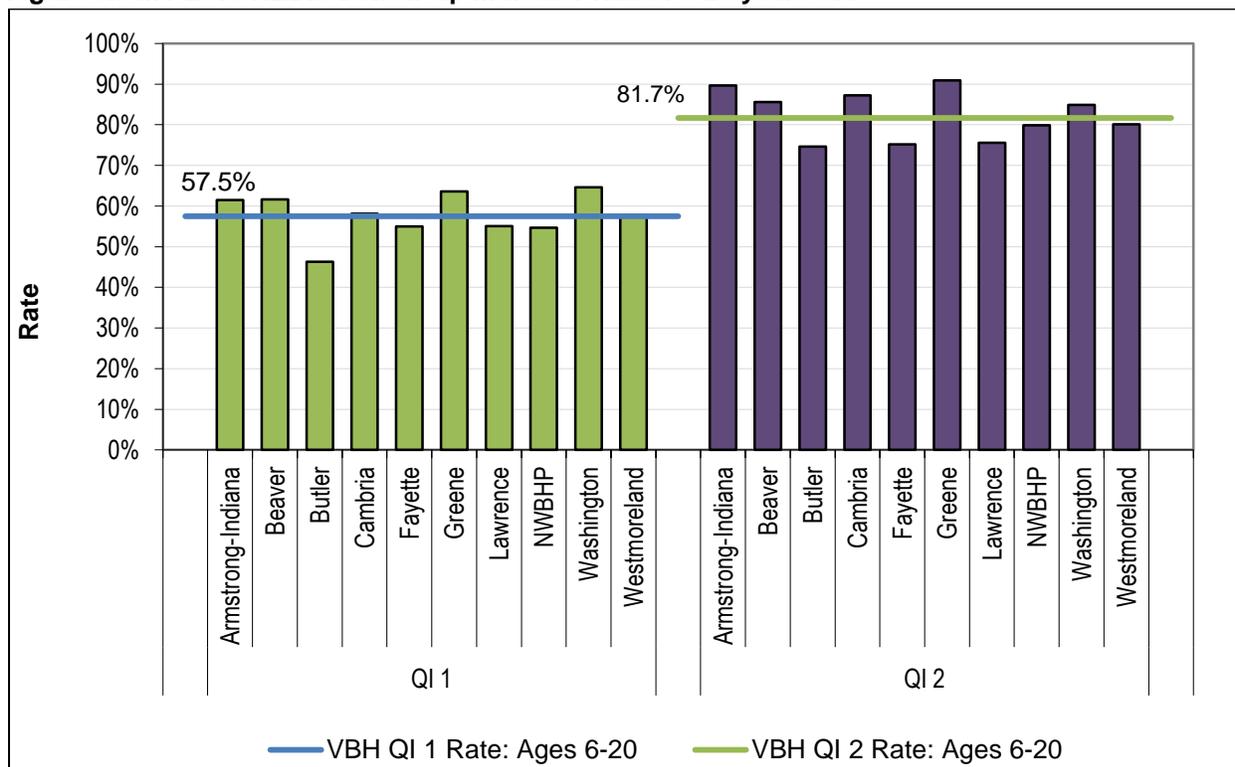
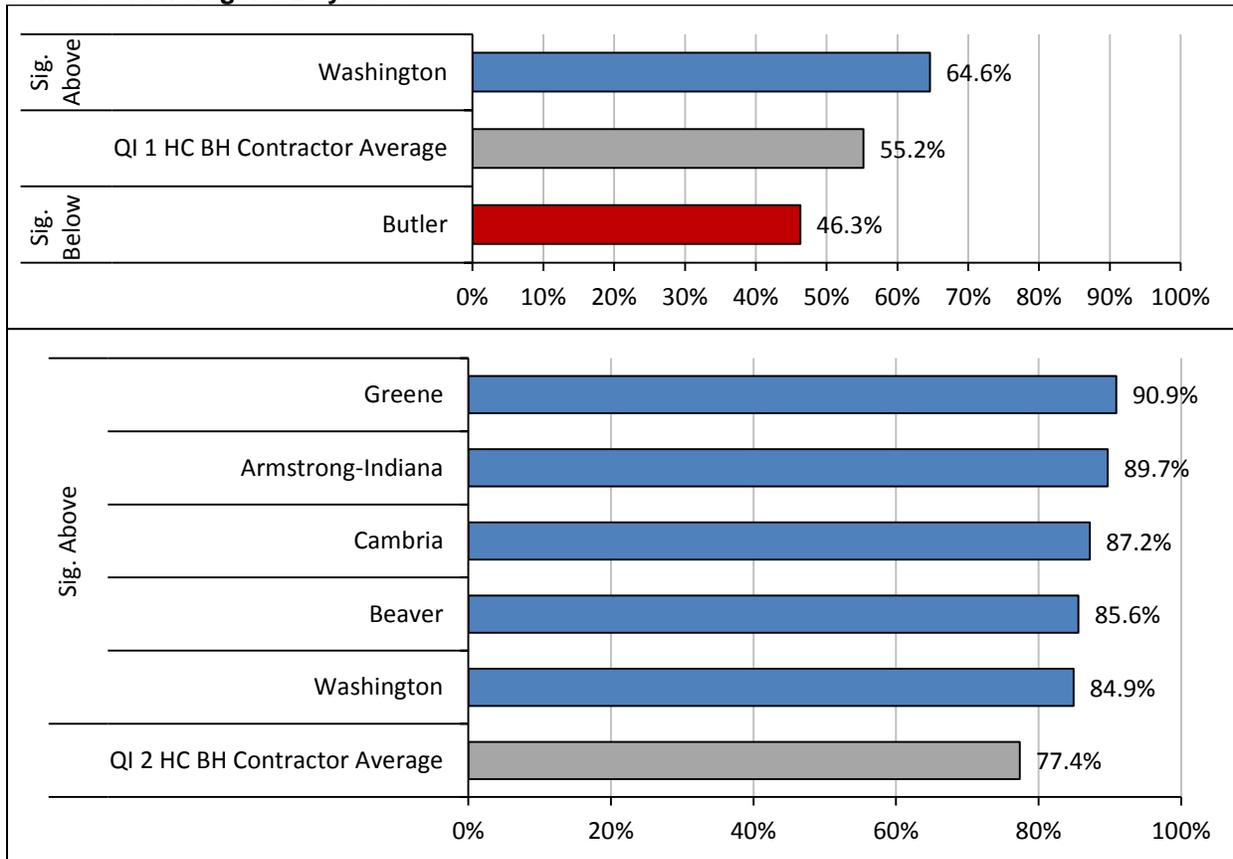




Figure 3.9 HEDIS Rates Follow-up Indicator Compared to MY 2013 HealthChoices HC BH Contractor Average: 6-20 years old





II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ years old

Table 3.10 MY 2013 PA-Specific Follow-up Indicator Rates with Year-to-Year Comparisons – Overall Population

	MY 2013							MY 2012		
	(N)	(D)	MY 2013 %	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2012 %	RATE COMPARISON of MY 13 against MY 12	
									PPD	SSD
QI A – PA Specific 7 Day Follow-up for Ages 6+ Years Old										
HealthChoices	19,687	34,564	57.0%	56.5%	57.5%	55.7%	55.7%	58.6%	-1.6	YES
VBH	3,162	5,608	56.4%	55.1%	57.7%			55.5%	0.9	NO
Armstrong-Indiana	293	466	62.9%	58.4%	67.4%			57.9%	5.0	NO
Beaver	317	543	58.4%	54.2%	62.6%			62.7%	-4.3	NO
Butler	241	434	55.5%	50.7%	60.3%			56.3%	-0.7	NO
Cambria	353	665	53.1%	49.2%	57.0%			49.4%	3.7	NO
Fayette	251	492	51.0%	46.5%	55.5%			55.3%	-4.3	NO
Greene	96	146	65.8%	57.8%	73.8%			67.5%	-1.7	NO
Lawrence	190	337	56.4%	51.0%	61.8%			55.9%	0.5	NO
NWBHP	463	884	52.4%	49.1%	55.7%			52.3%	0.1	NO
Washington	361	623	57.9%	53.9%	61.9%			54.1%	3.8	NO
Westmoreland	597	1,018	58.6%	55.5%	61.7%			56.4%	2.2	NO
QI B – PA Specific 30 Day Follow-up for Ages 6+ Years Old										
HealthChoices	25,381	34,564	73.4%	72.9%	73.9%	72.3%	74.1%	75.0%	-1.6	YES
VBH	4,259	5,608	75.9%	74.8%	77.0%			75.3%	0.6	NO
Armstrong-Indiana	370	466	79.4%	75.6%	83.2%			80.6%	-1.2	NO
Beaver	426	543	78.5%	75.0%	82.0%			79.8%	-1.3	NO
Butler	320	434	73.7%	69.4%	78.0%			75.9%	-2.2	NO
Cambria	501	665	75.3%	71.9%	78.7%			72.0%	3.3	NO
Fayette	354	492	72.0%	67.9%	76.1%			74.5%	-2.5	NO
Greene	121	146	82.9%	76.5%	89.3%			82.1%	0.8	NO
Lawrence	248	337	73.6%	68.7%	78.5%			73.2%	0.4	NO
NWBHP	663	884	75.0%	72.1%	77.9%			73.9%	1.1	NO
Washington	466	623	74.8%	71.3%	78.3%			70.8%	4.0	NO
Westmoreland	790	1,018	77.6%	75.0%	80.2%			76.2%	1.4	NO

The MY 2013 HealthChoices Aggregate rates were 57.0% for QI A and 73.4% for QI B. These rates were statistically significantly lower than the MY 2012 HealthChoices Aggregate rates of 58.6% (QI A) and 75.0% (QI B) by 1.6 percentage points each. The VBH MY 2013 QI A rate of 56.4% and QI B rate of 75.9% were not statistically significantly different from the VBH MY 2012 rates.

The MY 2013 VBH QI A rate of 56.4% did not differ statistically significantly from the MY 2013 QI A HealthChoices BH-MCO average of 55.7%. The VBH QI B rate of 75.9% was statistically significantly higher than the QI B HealthChoices BH-MCO average of 72.3% by 3.7 percentage points. As shown in Table 3.10, none of the HC BH Contractors associated with VBH had statistically significant increases in their PA-Specific rates from MY 2012 to MY 2013.

Figure 3.11 is a graphical representation of the MY 2013 PA-Specific follow-up rates for VBH and its associated HC BH Contractors. Figure 3.12 shows the HealthChoices HC BH Contractor Average rates and the individual VBH HC BH Contractor rates that were statistically significantly higher or lower than the HC BH Contractor Averages. The QI A rates for Armstrong-Indiana and Greene were statistically significantly higher than the QI A HC BH Contractor Average of 55.7% by 7.2 and 10.1 percentage points, respectively, while the QI A rate for Fayette was statistically significantly lower than the average by 4.7 percentage points. The QI B rates for Greene, Armstrong-Indiana, Beaver and Westmoreland were statistically significantly higher than the QI B HC BH Contractor Average of 74.1% by at least 3.5 percentage points. QI B rates for the remaining VBH HC BH Contractors were not statistically significantly different from the HC BH Contractor Averages.

Figure 3.11 MY 2013 PA-Specific Follow-up Indicator Rates – Overall Population

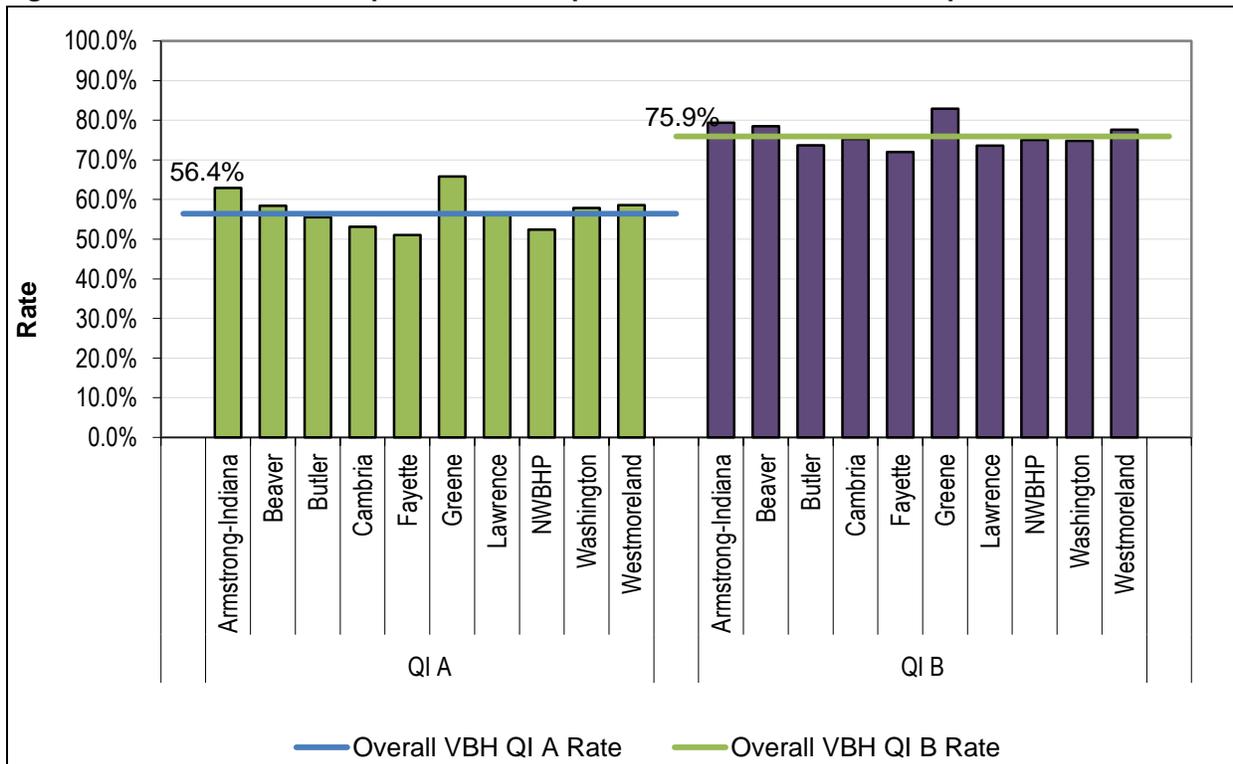
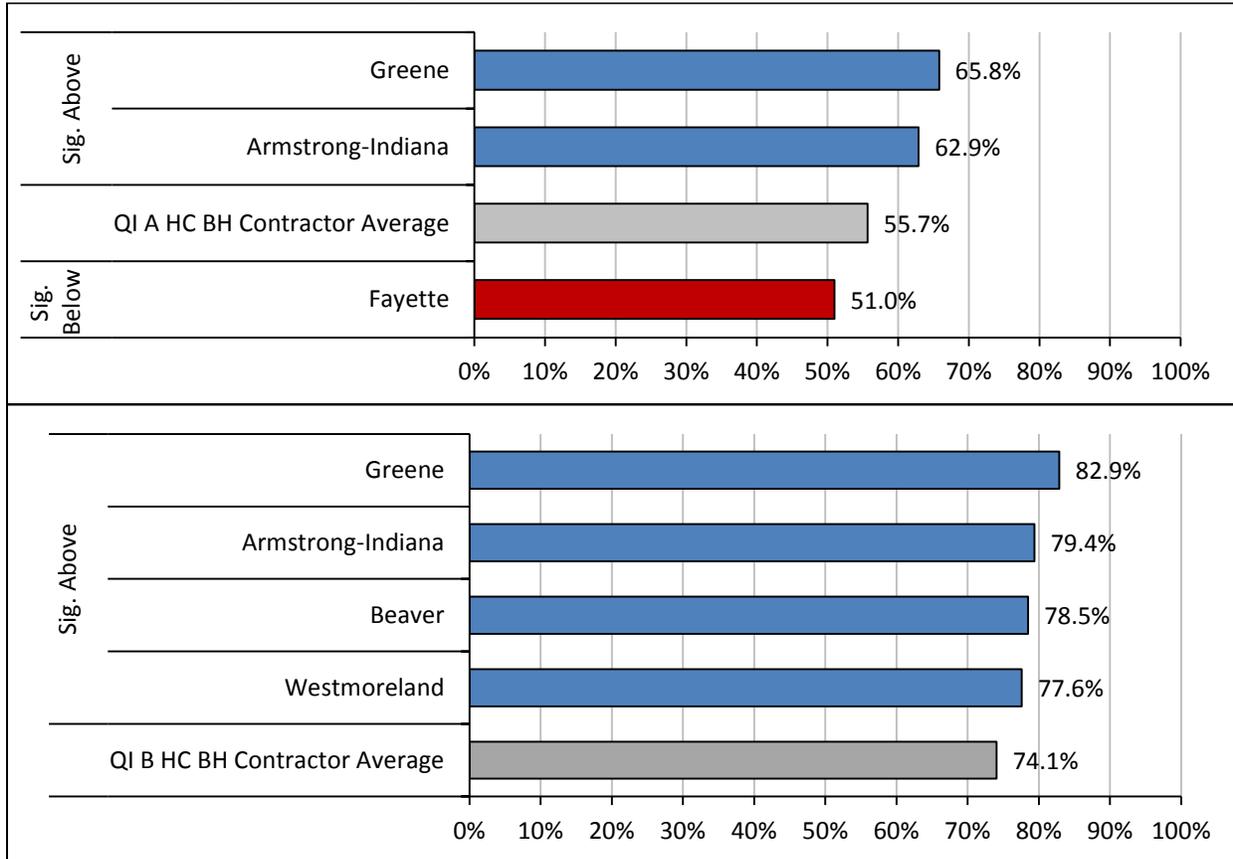


Figure 3.12 PA-Specific Follow-up Indicator Rates Compared to MY 2013 HealthChoices HC BH Contractor Average – Overall Population



III: Conclusion and Recommendations

The study concluded that efforts should continue to be made to improve performance with regard to Follow-up After Hospitalization for Mental Illness particularly for those BH-MCOs that performed below the HealthChoices BH-MCO Average.

In response to the 2014 study, which included results for MY 2012 and MY 2013, the following general recommendations were made to all five participating BH-MCOs:

- Despite a number of years of data collection and interventions, historically FUH rates have not increased meaningfully; in fact FUH rates show a general decline from MY 2012 to MY 2013. FUH for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted, the following recommendations may assist in future discussions.
- The purpose of this re-measurement study is to inform OMHSAS, the HC BH Contractors and the BH-MCOs of the effectiveness of the interventions implemented during 2011, 2012 and 2013 to promote continuous quality improvement with regard to follow-up care after psychiatric hospitalization. The information contained within this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. The HC BH Contractors and BH-MCOs participating in this study should continue to evaluate the current interventions in place with respect to their follow-up rates to assess how these interventions affected change in follow-up rates from the prior measurement years MY 2012 and MY 2013. The HC BH



Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care and then implement action and monitoring plans to further increase their rates.

- The findings of this re-measurement indicate that disparities in rates between racial and ethnic groups persist. There were several cases in MY 2013 where improvements or decreases in performance from MY 2012 affected certain racial or ethnic groups disproportionately within BH-MCOs or HC BH Contractors. It is important for these entities to analyze performance rates by racial and ethnic categories and continue to target the demographic populations that do not perform as well as their counterparts. It is recommended that BH-MCOs and HC BH Contractors continue to focus interventions on populations that continue to exhibit lower follow-up rates (e.g., Black/African American population). Possible reasons for these rate disparities include access, cultural differences and financial factors, which should all be considered and evaluated to determine their potential impact on performance. BH-MCOs should be encouraged to initiate targeted interventions to address disparate rates between study populations.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. For instance, the apparent decrease in gender disparity from MY 2012 to MY 2013 is a consequence of a decline in female performance rates rather than a reflection of sustained and equitable improvements. Historically performance rates in female populations have been prone to some fluctuation relative to male populations. BH-MCOs should investigate root causes for populations where rates demonstrate inconsistent trends.
- BH-MCOs and HC BH Contractors are encouraged to review the findings of the follow-up study in conjunction with inpatient psychiatric readmission rates. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either had or did not have evidence of ambulatory follow-up/aftercare visit(s) during the interim period.



Readmission within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow up After Hospitalization for Mental Illness, OMHSAS elected to retain and re-measure the Readmission within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Re-measurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2013 study conducted in 2014 was the seventh re-measurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish a same day readmission from a transfer to another acute facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH Contractor level for MY 2013.

This measure continued to be of interest to OMHSAS for the purposes of comparing HC BH Contractor, and BH-MCO rates to the OMHSAS performance goal and to prior rates.

This study examined behavioral health services provided to members participating in the HealthChoices Behavioral Health Program. For the indicator, the criteria specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications as needed. This measure's calculation was based on administrative data only.

This performance measure assessed the percentage of discharges for enrollees from inpatient acute psychiatric care that were subsequently followed by an inpatient acute psychiatric care readmission within 30 days of the previous discharge.

Eligible Population

The entire eligible population was used for all 67 Counties and 34 HC BH Contractors participating in the MY 2013 study.

Eligible cases were defined as those members in the HealthChoices Behavioral Health Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2013;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim must be clearly identified as a discharge.

The numerator was comprised of members who were readmitted to inpatient acute psychiatric care within 30 days of the previous inpatient psychiatric discharge.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs. The source for all administrative data was the BH-MCOs' transactional claims systems. The BH-MCOs were given the opportunity for resubmission, as necessary.



Performance Goals

OMHSAS designated the performance measure goal as better than (i.e. less than) or equal to 10.0% for the participating BH-MCOs and Counties. **This measure is an inverted rate, in that lower rates are preferable.**

HC BH Contractors With Small Denominators

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for all HC BH Contractors. Caution should be exercised when interpreting results for small denominators, as they produce rates that are less stable. Rates produced from small denominators are subject to greater variability, or greater margin of error.

Findings

BH-MCO and HC BH Contractor Results

The results are presented at the BH-MCO and then HC BH Contractor level. Year-to-year comparisons of MY 2013 to MY 2012 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

Individual rates are also compared to the categorical average. Rates statistically significantly above and/or below the average are indicated. Whether or not an individual rate performed statistically significantly above or below average was determined by whether or not that rate's 95% CI included the average for the indicator.

Lastly, aggregate rates are compared to the OMHSAS-designated performance measure goal of 10.0%. Individual BH-MCO and HC BH Contractor rates are *not* required to be statistically significantly below 10.0% in order to meet the performance measure goal.

Table 3.13 MY 2013 Readmission Rates with Year-to-Year Comparisons

	MY 2013								MY 2012
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	BH-MCO Average	HC BH Contractor Average	2013 Goal Met?	%
INPATIENT READMISSION									
HealthChoices Aggregate	5,925	43,604	13.6%	13.3%	13.9%	13.5%	13.7%	NO	12.7%
VBH	764	6,697	11.4%	10.6%	12.2%			NO	9.9%
Armstrong-Indiana	37	530	7.0%	4.7%	9.3%			YES	11.6%
Beaver	80	674	11.9%	9.4%	14.4%			NO	10.2%
Butler	81	582	13.9%	11.0%	16.8%			NO	11.4%
Cambria	121	815	14.8%	12.3%	17.3%			NO	12.3%
Fayette	71	593	12.0%	9.3%	14.7%			NO	7.5%
Greene	21	177	11.9%	6.8%	17.0%			NO	18.4%
Lawrence	31	384	8.1%	5.2%	11.0%			YES	8.9%
NWBHP	78	973	8.0%	6.2%	9.8%			YES	7.2%
Washington	82	734	11.2%	8.9%	13.5%			NO	11.5%
Westmoreland	162	1,235	13.1%	11.2%	15.0%			NO	8.1%

The MY 2013 HealthChoices Aggregate readmission rate was 13.6%, statistically significantly higher than the MY 2012 HealthChoices Aggregate rate of 12.7% by 0.9 percentage points. The VBH MY 2013 readmission rate of 11.4% is a statistically significant increase over the VBH MY 2012 rate of 9.9% by 1.5 percentage points. Note that this measure is an inverted rate, in that the lower rates indicate better performance. The VBH MY 2013 readmission rate of 11.4% is statistically significantly lower than the HealthChoices BH-MCO Average of 13.5% by 2.2 percentage points. VBH did not meet the performance goal of a readmission rate below 10.0% in MY 2013.

The readmission rate for one VBH HC BH Contractor, Armstrong-Indiana, decreased from 11.6% in MY 2012 to 7.0% in MY 2013, a statistically significant decrease of 4.6 percentage points. Two HC BH Contractors associated with VBH, Fayette and Westmoreland, had statistically significant readmission rate increases from the prior year by 4.5 and 5.0 percentage points, respectively. As presented in Table 3.13, Armstrong-Indiana, Lawrence, and NWBHP met the performance goal of a readmission rate below 10.0% in MY 2013.

Figure 3.14 is a graphical representation of the MY 2013 readmission rates for VBH HC BH Contractors compared to the performance measure goal of 10.0%. Figure 3.15 shows the Health Choices HC BH Contractor Average readmission rates and the individual VBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Averages. Four HC BH Contractors (Washington, Lawrence, NWBHP and Armstrong-Indiana) had readmission rates that were statistically significantly lower (better) than the HealthChoices HC BH Contractor Average of 13.7% by at least 2.5 percentage points. None of the HC BH Contractors associated with VBH had readmission rates above the HC BH Contractor Average.

Figure 3.14 MY 2013 Readmission Rates

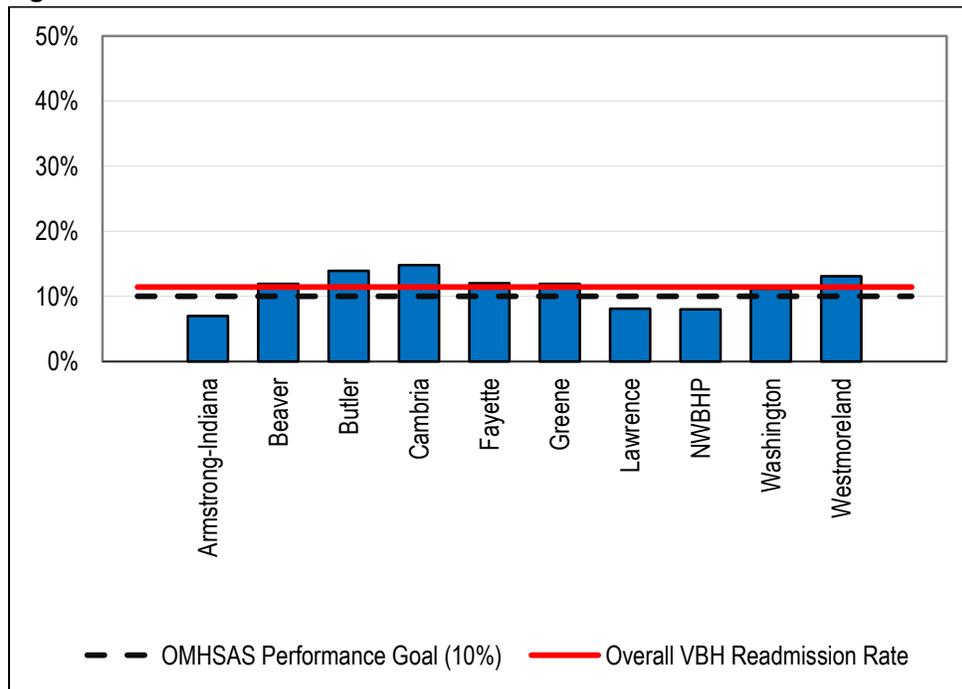
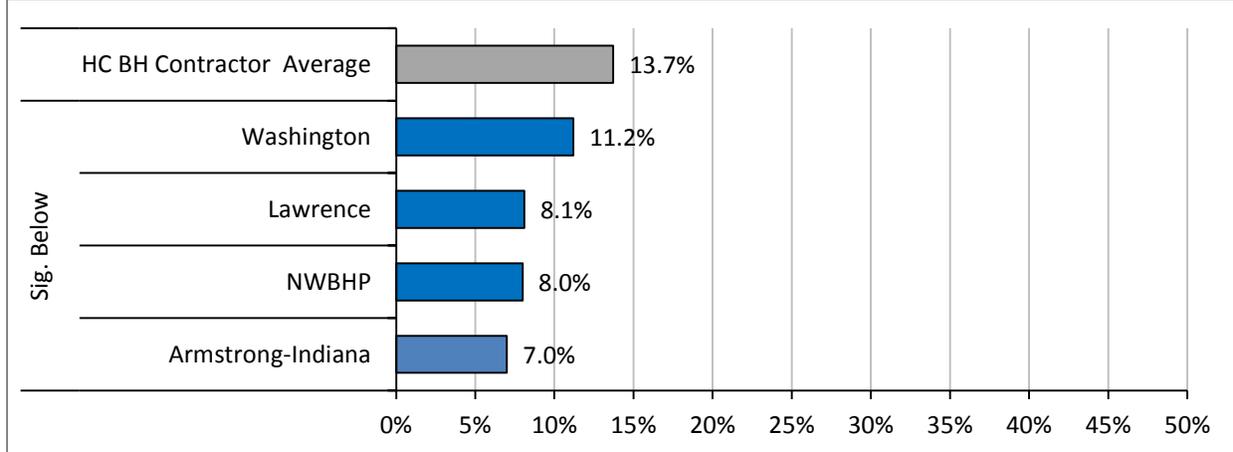




Figure 3.15 MY 2013 Readmission Rates Compared to HealthChoices HC BH Contractor Average*



*This measure is an inverted rate, meaning that rates statistically significantly below the HC BH Contractor Average indicate good performance, and rates statistically significantly above the HC BH Contractor Average indicate poor performance.

III: Conclusion and Recommendations

Continued efforts should be made to improve performance with regard to Readmission within 30 Days of Inpatient Psychiatric Discharge, particularly for those BH-MCOs that did not meet the performance goal, and/or performed below the HealthChoices BH-MCO Average.

BH-MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the 2014 (MY 2013) Readmission within 30 Days of Inpatient Psychiatric Discharge data tables.

In response to the 2014 study, the following general recommendations are applicable to all five participating BH-MCOs:

- Compared to MY 2012, there was a 0.9 percentage point increase in the HealthChoices Aggregate rate. Additionally, three of the five BH-MCOs had rate increases of 1.4 to 2.2 percentage points. HC BH Contractors and BH-MCOs participating in this study conduct root cause analyses to help determine what factors are negatively impacting readmission rates, and develop interventions that target specific barriers to improving the readmission rates.
- Each BH-MCO should conduct additional analyses of the data in order to determine if any other trends are noted. For example, higher readmission rates may be associated with those individuals with particular diagnoses or co-occurring conditions such as substance abuse and/or addiction. Targeted analyses such as these should be evaluated as part of any root cause analysis. In addition, BH-MCOs and HC BH Contractors are encouraged to review the findings of the readmission study in conjunction with follow-up after hospitalization rates.
- As with the MY 2012 study, readmission rates observed for Black/African American and the White populations were not statistically significantly different. The percentage point difference between the White and Black/African American populations was -0.3 (White – 13.7% Black/African American – 13.4%) for MY 2013 compared to 1.0 in MY 2012 (White – 12.5% Black/African American – 13.5%). The decrease in the disparity is due to an increase in the readmission rate for the White population, and the Black/African American rate remaining relatively stable. Within BH-MCOs, there is significant variation between race cohorts. This finding may suggest further study across BH-MCOs to explore the potential for further improvements that can be sustained.
- IPRO recommends continued annual evaluation of Inpatient Readmission after Psychiatric Discharge rates for OMHSAS contracted HC BH Contractors and their subcontracted BH-MCOs.
- Case management consideration should be given to those individuals who appear to be the highest utilizers of inpatient acute psychiatric care and have shown to be at risk for frequent readmission.



- As with MY 2012, considerable variation by county/HC BH Contractor was again observed for all of the BH-MCOs for MY 2013. BH-MCOs should further evaluate individual County/HC BH Contractor rates, explore the underlying causes of variance, and identify those practices or systems that may contribute to lower readmission rates.



Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

As part of the Center for Medicaid and Medicare Services' (CMS) Adult Quality Measure (AQM) Grant Program, DHS is required to report the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measure. This measure was reported initially by one county for MY 2012 and expanded to the HealthChoices population for MY 2013. Due to several implementation issues identified with BH-MCO access to all applicable data and at DHS' request, this measure was produced by IPRO. IPRO began development of this measure in 2014 for MY 2013. The measure was produced using HEDIS 2014 specifications, and included encounter data that were submitted to DHS by the BH-MCOs and the Physical Health MCOs. As directed by OMHSAS, IPRO produced rates for this measure for the HealthChoices population, by BH-MCO, and by HC BH Contractor. The results were presented to the BH-MCOs and HC BH Contractors in December 2014, and the BH-MCOs and HC BH Contractors were given the opportunity to review and respond to the results. After the results were reviewed and approved, the rates were provided to CMS. As MY 2013 was the first year this measure was produced, no comparison is available for previous years and it is being studied by DHS/OMHSAS. The results for the MY 2014 compared to the MY 2013 will be included in the 2015 BBA Technical Reports.



IV: QUALITY STUDY

The purpose of this section is to describe a quality study performed in 2013 for the HealthChoices population. The study is included in this report as an optional EQR activity which occurred during the Review Year (42 CFR §438.358 (c)(5)).

Overview / Study Objective

OMHSAS commissioned IPRO to conduct a study to identify risk factors for Behavioral Health acute inpatient readmissions among members enrolled in the Pennsylvania Medicaid Behavioral Health HealthChoices program. IPRO and OMHSAS developed a claims based study to determine what demographic and clinical factors are correlated with increased readmission rates. The objective of this study was to provide data to guide targeted BH quality improvement interventions by identifying subpopulations with high readmission rates.

Data Collection and Analysis

This study was a claims based analysis of acute inpatient behavioral health admissions between 12/2/2010 and 12/1/2011. The primary source of data was BH-MCO claims that were submitted to and accepted by the DHS PROMISE encounter system. One BH-MCO had significant data loss during the study period. For this BH-MCO, the Person Level Event (PLE) files that the BH-MCO submitted to OMHSAS for rate setting purposes were used in place of PROMISE data for this BH-MCO. Any claims not submitted to or not accepted by PROMISE are not included in this study. For the BH-MCO with data loss, any encounters not included in their PLE files are not included in this study. The analysis consisted of comparisons of 30, 60, and 90 day readmission rates for various subpopulations. Subpopulations were distinguished by member demographics, diagnosis prior to and during the admission, and the number and type of encounters before and after the inpatient stay. Finally, a regression analysis was done to identify what factors or combinations of factors correlate with a high readmission rate.

Results / Conclusions

There were a total of 25,792 admissions included in this study. The 30 day readmission rate for the HealthChoices population was 8.5% which is a lower rate than reported for the Readmission within 30 Days of Inpatient Psychiatric Discharge Performance Measure due to the study requirements. The study was completed in April of 2014, and presented to the BH-MCOs and HC BH contractors in June 2014.

There were a number of demographic factors that were statistically significantly correlated with an increased 30 day readmission rate. Males had a higher readmission rate than females, and African American members had a higher readmission rate than White members. Members residing in urban counties had higher readmission rates than members residing in rural counties. Members aged 6-20 years old had the highest readmission rate when the population was stratified into age cohorts. Members who were in an aid category of "Aged/Blind/Disabled" had a higher readmission rate than members in other aid categories. There were also statistically significant differences in readmission rates between the BH-MCOs.

Additionally, there were a number of variables related to the admission that were also correlated to an increased 30 day readmission rate. Admissions with a primary admitting diagnosis of: Schizophrenic Psychoses, Other Nonorganic Psychoses, or Transient Organic Psychotic Conditions had readmission rates more than two percentage points higher than the HealthChoices average. Members who had a history of behavioral health encounters prior to the admission had a higher readmission rate than members with no behavioral health history. The study also showed that members who had a follow-up visit within 30 days of discharge had a lower readmission rate than members who did not have a follow-up visit.



Other factors found that correlated to higher readmission rates were a history of behavioral health inpatient admissions and prescriptions for multiple psychotropic drugs. Members' behavioral health service history also correlated to statistically significant differences in readmission rates. Members with no behavioral health services within 12 months prior to the admission had a 30 day readmission rate of 4.4%, members with only mental health or substance abuse services prior to the admission had readmission rates of 8.7% and 7.3% respectively. Members with both mental health and substance abuse services prior to the admission had the highest readmission rate of 11.1%.

The results of the study were presented to the BH-MCOs and HC BH Contractors in June 2014. The findings of the study assisted in the development of the current Behavioral Health PIP (See Section II). For example, due to the high readmission rate of members with a diagnosis of Schizophrenia, BH-MCOs will be required to report on medication adherence for members with a Schizophrenia diagnosis.



V: 2013 OPPORTUNITIES FOR IMPROVEMENT MCO RESPONSE

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each BH-MCO has effectively addressed the opportunities for improvement cited by IPRO in the 2013 EQR Technical Reports, which were distributed in April 2014. The 2014 EQR Technical Report is the seventh report to include descriptions of current and proposed interventions from each BH-MCO that address the 2013 recommendations.

The BH-MCOs are required by OMHSAS to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the Pennsylvania Medicaid BH-MCOs. These activities follow a longitudinal format, and are designed to capture information relating to:

- Follow-up actions that the BH-MCO has taken through September 30, 2014 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken; and
- The BH-MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of the end of 2014, as well as any additional relevant documentation provided by VBH.

Table 4.1 Current and Proposed Interventions: Opportunities for Improvement

Reference Number	Opportunity for Improvement	Follow-up Actions Taken and Future Actions Planned
VBH 2013.01	Within Subpart C: Enrollee Rights and Protections Regulations, VBH was partially compliant on one out of seven categories – Enrollee Rights.	<p>Follow-up Actions Taken and Planned Through 9/30/14</p> <p>NWBHP Standard 108</p>  <p>NW3 PEPS 2012 CAP DPW Letter_01-16-14.</p> <p>SBHM- Standard 108</p>  <p>SW6 2012 PEPS Review_07-26-13.pdf</p> <p>Future Actions Planned Counties, VBH-PA, and CFST have implemented recommendations per the PEPS RY2012 and subsequent follow up review in September 2013. 10/1/14-Ongoing monitoring will be maintained to approved interventions.</p>

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found VBH to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Future Actions Planned
VBH 2013.02	VBH was partially compliant on five out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: <ol style="list-style-type: none"> 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Practice Guidelines, 5) Quality Assessment and Performance Improvement Program. 	<p>Standard 28:</p>  <p>PEPS Standard 28 CAP Completed.docx</p> <p>Standard 93:</p>  <p>POMS CR Form_rev0107.doc</p>  <p>POMS QTR Form_rev0107.doc</p> <ul style="list-style-type: none"> • POMS data addressing changes in employment, education, vocational and living status are submitted quarterly to OMHSAS. • Aggregate reporting of the changes in employment, education, vocational and living status of members has been implemented and annual reporting process is ongoing.  <p>POMS 2013.pdf</p> <p>Future Actions Planned 10/1/14 Ongoing monitoring will be maintained for the approved interventions.</p> <p>POMS aggregate reporting will occur in the 2014 Annual Evaluation</p> <p>Standard 72:</p>  <p>PEPS2013 VBH CAP_STD 72.docx</p>  <p>Denial Monitoring</p>

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found VBH to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Future Actions Planned
VBH 2013.03	VBH was partially compliant on nine out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: <ol style="list-style-type: none"> 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers and Subcontractors, 8) Continuation of Benefits, 9) Effectuation of Reversed Resolutions. 	Follow-up Actions Taken and Planned Through 9/30/14  PEPS Standard 68 CAP Completed.docx  PEPS Standard 71 CAP Completed.docx  PEPS2013 VBH CAP_STD 72.docx Future Actions Planned 10/1/14.VBH-PA will continue to follow all approved protocols and will continue to follow the described interventions.

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found VBH to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Future Actions Planned
VBH 2013.04	VBH's rate for the MY 2012 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 1 rate was statistically significantly lower than the QI 1 Health Choices BH-MCO Average by 1.7 percentage points.	<p>Follow-up Actions Taken and Planned Through 9/30/14</p>  <p>2013 BH FUH RCA VBH-PA.pdf</p> <p>Response for QI 1/ 7day FUH</p> <p>Future Actions Planned Future Actions are detailed in the PDF attachment. -Identification of barriers for Tele psychiatry -Communication with hospital staff regarding expectations for discharge processes and discharge resources. -Improvement in provider notifications for FUH -Tiered care management system</p>
VBH 2013.05	VBH's rate for the MY 2012 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI A rate was statistically significantly lower than the QI A HealthChoices BH-MCO Average by 2.7 percentage points. Overall, VBH observed the lowest rate for QI A among the five BH-MCOs evaluated in MY 2012.	<p>Follow-up Actions Taken and Planned Through 9/30/14</p>  <p>2013 BH FUH RCA VBH-PA.pdf</p> <p>Response for QI A/7 day FUH</p> <p>Future Actions Planned Future Actions are detailed in the PDF attachment -Will continue Single Point of contact to providers by VBH-PA</p>

Corrective Action Plan for Partial and Non Compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2012, VBH began to address opportunities for improvement related to Standards 72, 91, and 108. Proposed actions and evidence of actions taken by VBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring VBH into compliance with the relevant Standards.



Root Cause Analysis and Action Plan

The 2014 EQR is the sixth for which BH-MCOs were required to prepare a Root Cause Analysis and Action Plan for performance measures performing statistically significantly poorer than the BH-MCO average and/or as compared to the prior measurement year. The performance measures that were noted as opportunities for improvement in the 2013 EQR Technical Report required that the MCO submit:

- A goal statement;
- Root cause analysis and analysis findings;
- Action plan to address findings;
- Implementation dates; and
- A monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

IPRO reviewed each submission, and offered technical assistance to BH-MCO staff. The BH-MCOs were given the opportunity to revise and re-submit response forms as needed and as time permitted. For the 2014 EQR, VBH was required to prepare a Root Cause Analysis and Action Plan for the following performance measures and quality indicators:

- Follow-Up After Mental Health Hospitalization (HEDIS 7 and 30 Day)
- Follow-Up After Mental Health Hospitalization (PA Specific 7 Day)

VBH submitted a Root Cause Analysis and Action Plan as required in October 2014



Table 4.2 Root Cause Analysis

<p><u>Managed Care Organization (MCO):</u> Value Behavioral Health (VBH)</p>	<p><u>Measure:</u> Follow-up After Hospitalization(FUH) for Mental Illness QI 1 (HEDIS 7 Day)</p>	<p><u>Response Date:</u> October 6,2014</p>
<p><u>Goal Statement:</u> (Please specify individual goals for each measure):</p> <p>Short term goal: Improve the 7 day FUH rate 2.0 percent to 46.39% by next measurement year.</p> <p>Long term goal: Improve the 7 day FUH rate above the 75th percentile >54.80%</p>		
<p><u>Analysis:</u> What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.</p>	<p><u>Findings</u></p>	
<p><u>Policies</u> (e.g., data systems, delivery systems, provider facilities)</p>	<p><u>Initial Response- Barriers</u></p> <ul style="list-style-type: none"> Members, providers and counties report the need for better access to psychiatrists for medication management, particularly after discharge from an inpatient setting within 7 and 30 day timeframes. (known shortage of psychiatrists for non-urban areas). Some providers limit medication services to members receiving outpatient services at their facility due to limited Psychiatric time available. As a result, Health Choices members may rely on Primary Care Physicians to get medication management after discharge (follow up claim cannot be captured). Members report difficulty keeping an appointment in rural areas where Medical Assistance Transportation (MATP) requires several hours to get to the appointment and then return home. A trip that should take a reasonable amount of travel time forces consumers to waste a large portion of the day waiting to get a ride back home. Rural consumers report waiting many hours for a return trip home. This barrier can impact timely follow up. <p><u>Follow-up Status Response</u> <insert follow-up response here; leave blank for initial response submission></p>	
<p><u>Procedures</u> (e.g., payment/reimbursement, credentialing/collaboration)</p>	<p><u>Initial Response</u></p> <ul style="list-style-type: none"> PA Medicaid does not pay for the Mental Health nurse's time for injection of Long Acting Injectable medications. Provider is unable to be reimbursed for the injection. <p><u>Follow-up Status Response</u></p>	
<p><u>People</u> (e.g., personnel, provider network, patients)</p>	<p><u>Initial Response</u></p> <ul style="list-style-type: none"> Inpatient providers may not be aware of services available for an out of county member and the hospital does not initiate proper collaboration to ensure follow up appointments resulting in an inadequate linkage after discharge. 	



Fishbone for low FUH
2014.doc

- Timely follow up appointments may not be scheduled. The hospital may take the first available appointment instead of calling another provider to meet 7 day access standard.
- Some members feel family is not included in aftercare planning process so consumer feel that natural supports could be improved.
- Outpatient Provider, OP Therapist, Blended Case Manager (BCM) or other provider isn't notified of member's hospitalization
- Member not given a substance abuse (S/A) follow up appointment when there is a substance abuse diagnosis or positive Urinary Drug Screen (UDS) at admission. Has only MH follow up appointment or only a PCP appointment.
- Member discharged on medications not on their formulary which may prevent member access to their medications in a timely fashion after discharge.
- Outpatient Substance Abuse (SA) Providers are reluctant to treat co-occurring seriously mentally ill (SMI).

Follow-up Status Response

Provisions

(e.g., screening tools, medical record forms, provider and enrollee educational materials)

Initial Response

- Inpatient providers report that they are not aware of the array of services available in some less populated areas of a county.

Follow-up Status Response

Other (specify)

Initial Response

Follow-up Status Response

Measure: *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)*

For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2013. Documentation of actions should be continued on additional pages as needed.



<p>Action</p> <p>Include those planned as well as already implemented.</p>	<p>Implementation Date</p> <p>Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)</p>	<p>Monitoring Plan</p> <p>How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.</p>
<p>Members, providers and counties report the need for better access to psychiatrists</p> <p>-VBH-PA county partners, and oversight entities have collaborated to implement telepsychiatry programs to increase access for members to receive services from a psychiatrist. These programs are located from remote clinical locations in an underserved rural setting, Currently services available in Cambria, Greene, Butler, Fayette, Indiana and Westmoreland Counties. Re-emphasize those programs that have remained viable. Determine additional barriers that prevent higher utilization. Cambria County is planning to partner with Physical Health clinic to address access issues in the northern portion of the county.</p>	<p>Baseline data FY 2013-14</p> <p>Measurement in 2nd Q 2015 for CY 2014</p>	<p>Initial Response</p> <ul style="list-style-type: none"> Measure member utilization (distinct members, avg units /member, and cost.) of telepsychiatry by county. New base line will be FY 2013-14. Reports will be monitored in six month cycles for increases. Determine current utilization and discuss the barriers in the six counties with appropriate county stakeholders and current service providers. <p>Follow-up Status Response</p> <p><insert follow-up response here; leave blank for initial response submission></p>
<p>Inpatient providers may not be aware of services available for an out of county member or far distances from the hospital.</p> <p>An informational letter with resource materials will be sent to all MH Inpatient facilities regarding HEDIS/ FUH rates and the importance of appropriate discharge planning in order to improve follow up within 7 days. The letter will include findings from the root cause analysis regarding:</p> <ul style="list-style-type: none"> Discharge planning (importance of family education and input, involvement of natural supports, member awareness of support services in the community) Ensuring that the patient will get the 7 day appointment, and a listing of some of the HEDIS acceptable services. Medications at discharge-formulary issues <p>Resources will include a copy of the VBH-PA county specific directories so hospital staff can be aware of all available OP providers that provide the various services, as well as county directories for adjacent counties. Social workers and BHU directors will be targeted for the 30 MH inpatient units that serve primarily VBH-PA members.</p>	<p>Mailing in 4th Q 2014</p> <p>Call to sample of providers will follow after 4 weeks.</p> <p>Ongoing Monitoring of CFST satisfaction questions</p>	<p>Initial Response</p> <ul style="list-style-type: none"> 2013 Consumer Family Satisfaction Team (CFST) data for inpatient level of care is below 85% in Butler, Cambria and Westmoreland Counties for the question “Has your provider made you aware of the support services available in your community?” Monitor these three counties for improvements. 2013 Consumer Family Satisfaction Team (CFST) data for inpatient level of care is below 85% for the question, “Does your family get the education or support they need to be helpful to you?” For the seven counties that have been surveyed for this level of care in 2013, five counties below the 85% standard. These five counties will be monitored for improvement. Bring attention to these two questions at the CFST trainings scheduled in October 2014 for monitoring. Ask CFST surveyors to attempt to increase consumer surveys for inpatient satisfaction, if possible. After the letter is mailed, VBH-PA will call hospitals serving these five counties to confirm receipt and ask if information is helpful to understand available services/providers for aftercare. The provider will be reminded of the importance to understand available aftercare services available and also to involve and educate family members or / natural supports about their roles after discharge.



<p>appointment when there was a substance abuse diagnosis or positive UDS at admission.</p> <p>In several counties the community liaisons /program specialists collaborate with IP social worker to monitor follow up appointment and in Lawrence County the liaison will open the case with the county for SA case management while member is on the unit if patient is new to the county. Westmoreland and other counties will refer to rehabilitation treatment from the IP unit. The SA Case manager and Crisis worker will target the members who have overdosed and contact the member on the unit to link with other services. SA Case management makes referrals to outpatient counseling and linkage with other providers.</p>	<p>Educational letter to be mailed 4th Q 2014</p> <p>2013/ ongoing</p>	<p>This issue will be included as an identified barrier to follow up in the letter to the Inpatient providers during the 4th quarter 2014</p> <p>Follow-up Status Response</p>
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<p>Managed Care Organization (MCO): Value Behavioral Health (VBH)</p>	<p>Measure: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)</p>	<p>Response Date: 10/6/14</p>
<p>Goal Statement: (Please specify individual goals for each measure):</p> <p>Short term goal: Improve the 30 day FUH rate 2.0 percent by next measurement year. (from 69.91% to 71.31%) .</p> <p>Long term goal: Improve the 30 day FUH rate above the 75th percentile (>75.68%)</p>		
<p>Analysis: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.</p>	<p>Findings</p>	
<p>Policies (e.g., data systems, delivery systems, provider facilities)</p>	<p>Initial Response</p> <p>Follow-up Status Response <insert follow-up response here; leave blank for initial response submission></p>	
<p>Procedures (e.g., payment/reimbursement, credentialing/collaboration)</p>	<p>Initial Response</p> <p>Follow-up Status Response</p>	
<p>People (e.g., personnel, provider network, patients)</p>	<p>Initial Response</p> <ul style="list-style-type: none"> Member misses or forgets appointment and doesn't reschedule in a timely manner, 	



	missing the 7 day window for follow up. Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)	Initial Response <ul style="list-style-type: none"> Current electronic records at the Inpatient Providers may not be fully set up to prompt or alert staff to make follow up appointments in a timely manner. Follow-up Status Response
Other (specify)	Initial Response Follow-up Status Response

Measure: <i>Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)</i>		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2013. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	Implementation Date Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	Monitoring Plan How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
Member misses or forgets appointment and doesn't reschedule in a timely manner, missing the 7 day window for follow up. VBH-PA has always had a policy to engage the member with 24-72 hours from discharge to remind the member of their follow up appointment or to link the member to the provider if the appointment was already missed. At least 2 attempts are made to reach the member and a follow up letter is sent if the aftercare coordinator is unable to contact the member. Ongoing barriers have members who do not provide correct phone number or address at discharge. Member's demographic data in eligibility files from the state can be outdated as members don't notify the local MA office of changes. VBH-PA has gradually implemented a new tiered care	Ongoing March 2014	Initial Response <ul style="list-style-type: none"> VBH-PA is currently flagging the members in Care Connect System who have been identified to receive Intensive Care Management (ICM). These flags identify to any VBH-PA care manager the higher level of touch required and refer any information to the designated ICM at VBH. As the program matures, a member's utilization and all levels of care will be tracked before ICM services, during enrollment in ICM, and after if the member is discharged from the program. Utilization should decrease for higher levels of care with the length of time a member is enrolled in Intensive care management services through VBH-PA. Stabilization can be seen as the member adheres to ongoing treatment. Follow up rates for these flagged members will be monitored. Follow-up Status Response



<p>management system in Beaver, Cambria, Washington and Greene Counties since March 2014. One of several interventions involves the intensive care management (ICM) team stays in more frequent contact with members that have been identified as needing a higher level of care management. An important aspect of this program is assisting the member to keep appointments, particularly after discharge or other routine MH or SA treatment. If the member misses the 7 day appointment after discharge, the ICM at VBH-PA will contact other resources (such as BCM) if they are unable to connect with the member. The BCM or SA Case manager will assist with addressing the follow up barrier.</p>	<p>Beginning October 1, 2014, members discharge with SA diagnosis will be considered for inclusion in the tiered care management program.</p> <p>Program to be extended to other counties in 2015.</p>	<p><insert follow-up response here; leave blank for initial response submission></p>
<p>Member misses or forgets appointment and doesn't reschedule in a timely manner, missing the 7 day window for follow up. The VBH-PA ICM uses the Health Alert system to automatically remind the member of upcoming appointments. This free service can also be used by any MH or substance abuse provider to remind their patients of future appointments. VBH-PA will continue to remind providers of this free service that can improve the 'no show' rates that providers experience.</p>	<p>In place since 2013. Ongoing education of the provider network of the free reminder service.</p>	<p>Initial Response Monitor and report the rate of provider use of the Health Alert System Set goal to increase provider use of the appointment system.</p> <p>Follow-up Status Response</p>
<p>Current electronic records VBH-PA will explore additional data collection surveys to gather additional information related to electronic medical records use and possible options to enhance data collection that will improve FUH rates.</p>	<p>2nd Q 2015</p>	<p>Initial Response Initiate data collection for use of EMR that can impact FUH rates.</p> <p>Follow-up Status Response</p>
		<p>Initial Response</p> <p>Follow-up Status Response</p>

<p><u>Managed Care Organization (MCO):</u> Value Behavioral Health (VBH)</p>	<p><u>Measure:</u> Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)</p>	<p><u>Response Date:</u></p>
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Goal Statement: (Please specify individual goals for each measure):

Short term goal: Improve the 7 day FUH (PA Specific) rate 2.0 percent from 56.4 % to 57.53% by next measurement year.

Long term goal: Improve the 7 day FUH (PA Specific) rate above the Health Choices average.

<p>Analysis: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.</p>	<p>Findings</p>
<p>Policies (e.g., data systems, delivery systems, provider facilities)</p>	<p>Initial Response <insert initial response here></p> <p>Follow-up Status Response <insert follow-up response here; leave blank for initial response submission></p>
<p>Procedures (e.g., payment/reimbursement, credentialing/collaboration)</p>	<p>Initial Response</p> <p>Follow-up Status Response</p>
<p>People (e.g., personnel, provider network, patients)</p>	<p>Initial Response</p> <ul style="list-style-type: none"> • Member not given an S/A follow up appointment when there is a substance abuse diagnosis or positive Urine drug screen(UDS) at admission • Outpatient Provider, Therapist, BCM, Peer support or Certified Recovery Specialist are not notified of member's hospitalization <p>Follow-up Status Response</p>
<p>Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)</p>	<p>Initial Response</p> <p>Follow-up Status Response</p>
<p>Other (specify)</p>	<p>Initial Response</p> <p>Follow-up Status Response</p>

Measure: Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)



For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2013. Documentation of actions should be continued on additional pages as needed.

<p>Action Include those planned as well as already implemented.</p>	<p>Implementation Date Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)</p>	<p>Monitoring Plan How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.</p>
<p>Member not given an S/A follow up appointment when there is a substance abuse diagnosis or positive UDS at admission</p> <p>In some counties the community liaison /program specialist collaborates with the IP social worker to monitor follow up appointments. In Lawrence County, the liaison will open the case with the county for SA case management while member is on the unit if patient is new to the county. The patient is referred to a Certified Recovery Specialist(CRS) for support post discharge.</p> <p>Westmoreland and other counties will refer to rehab or other services such as methadone administration, Intensive outpatient or other SA treatment from the IP unit.</p> <p>SA Case management and Crisis services target member who have overdosed and contact members on the unit to link with other services. Case management makes referrals to outpatient counseling and linkage with other providers.</p>	<p>Ongoing</p> <p>CRS starting in Cambria County in 2015.</p> <p>Ongoing</p> <p>2013</p>	<p>Initial Response</p> <ul style="list-style-type: none"> Letter to inpatient providers scheduled for 4th Q 2014.Reinforce the expectation of 7 day follow up for both MH (and/or SA) follow up when identified during IP treatment. Continue to monitor reports and analyze improvements for Certified Recovery Specialist utilization data through Quality Management Committee for VBH-PA network, review trends with County representative/D&A provider representative. CRS not available in all counties. <p>Follow-up Status Response <insert follow-up response here; leave blank for initial response submission></p>
<p>Outpatient Provider, Therapist, BCM Peer support or Certified Recovery Specialist (CRS) isn't notified of member's hospitalization</p> <p>Each county is notified by VBH-PA of their daily inpatient census of Health Choices members. The counties in turn depending on their internal process notify the case management supervisor, community liaison, ACT Team of recent admissions.</p> <p>It is the expectation of VBH-PA that members with BCM services are contacted by the BCM after admission or on day of discharge to assist with collaboration with outpatient services, such as Peer</p>	<p>Certified Recovery Specialist (CRS) program(like peer support) to begin in Cambria county in 2015.</p> <p>BCM baseline 2014, and quarterly thereafter.</p>	<p>Initial Response Measure the following indicators: Baseline data 2014 DM/ cases with BCM that had one or more inpatient stays in a quarter Cases with BCM claim while inpatient Cases with BCM claim within 7 days after discharge (0-7) Cases with BCM claim within 30 days after discharge (0-30) Review these outcomes with Quality Management Committees and seek recommendations from QMC</p> <p>Follow-up Status Response</p>



<p>Support, certified recovery specialist, or intensive outpatient substance abuse providers. With appropriate ROI, the BCM can notify other providers of the admission. This expectation has been clearly communicated to all BCM providers through the CM workgroup in 2013.</p>	<p>ongoing</p>	
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VI: 2013 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of VBH's 2014 (MY 2013) performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH-MCO. As the Initiation and Engagement of Alcohol or Other Drug Dependence Treatment (IET) measure was produced for the first time in MY 2013, BH-MCOs are not expected to respond to opportunities for improvement for this measure for this review year. BH-MCOs will be expected to address opportunities for improvement regarding the IET measure in subsequent review years.

Strengths

- VBH's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness - HEDIS follow-up indicator (QI 2) was statistically significantly higher than the BH-MCO average by 3.8 percentage points. VBH had the highest QI 2 rate of all the BH-MCOs.
- VBH's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness 30 day – PA Specific follow-up indicator (QI B) was statistically significantly higher the BH-MCO average by 3.7 percentage points.
- VBH met the OMHSAS MY 2013 interim goal for Follow-up After Hospitalization for Mental Illness - QI 1 for ages 6-64.
- VBH's rate for the MY 2013 Readmission within 30 Days of Inpatient Psychiatric Discharge indicator was statistically significantly lower (better) than BH-MCO average by 2.1 percentage points.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2011, RY 2012, and RY 2013 found VBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
 - VBH was partially compliant on one out of seven categories within Subpart C: Enrollee Rights and Protections. The partially compliant category is Enrollee Rights.
 - VBH was partially compliant on five out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care) 2) Coordination and Continuity of Care 3) Coverage and Authorization of Services 4) Quality Assessment and Performance Improvement Program and 5) Practice Guidelines
 - VBH was partially compliant on nine out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.
- VBH's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness HEDIS performance measures did not meet the OMHSAS designated performance goal the HEDIS 75th percentile for ages 6-64.
- VBH's rate for the MY 2013 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.



Additional strengths and targeted opportunities for improvement can be found in the BH-MCO-specific 2014 (MY 2013) Performance Measure Matrices that follow.

PERFORMANCE MEASURE MATRICES

The Performance Measure (PM) Matrices provide a comparative look at quality indicators (QIs) included in the External Quality Review (EQR) evaluation for Quality Performance of the HealthChoices BH-MCO.

The first matrix and table (Figures 1.1 – 1.2):

- Compares the BH-MCO's own measure performance over the two most recent reporting years (Measurement Year (MY) 2013 and MY 2012); and
- Compares the BH-MCO's MY 2013 performance measure rates to the MY 2013 HealthChoices BH-MCO Average.

Figure 1.1 is a three-by-three matrix. The horizontal comparison represents the BH-MCO's performance as compared to the applicable HealthChoices BH-MCO Average. When comparing a BH-MCO's rate to the HealthChoices BH-MCO Average for each indicator, the BH-MCO rate can be above average, equal to the average or below average. Whether or not a BH-MCO performed statistically significantly above or below average is determined by whether or not that BH-MCO's 95% confidence interval for the rate included the HealthChoices BH-MCO Average for the specific indicator.

Figure 1.2 represents the BH-MCO's performance for each measure in relation to its prior year's rates for the same indicator. The BH-MCO's rate can trend up (▲), have no change, or trend down (▼). For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

The second matrix and table (Figures 2.1 – 2.2):

- Compares the BH-MCO's MY 2013 performance to the HEDIS 90th, 75th, 50th and 25th percentiles for applicable measures (FUH QIs 1 and 2, the HEDIS 7- and 30-day indicators).

Figure 2.1 is a four-by-one matrix. This represents the BH-MCO's performance as compared to the HEDIS 90th, 75th, 50th and 25th percentiles for the Follow-Up After Hospitalization 7-day/30-day metrics (FUH7/FUH30). A root cause analysis and plan of action is required for items that fall below the 75th percentile.

Figure 2.2 illustrates the rates achieved compared to the HEDIS 75th percentile goal. Results are not compared to the prior year's rates.

The matrices are color-coded to indicate when the findings for these measures are notable and whether there is cause for action:



	<p>PA-specific Follow-Up After Hospitalization Measures: Indicates that the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012.</p> <p>Readmission within 30 Days of Inpatient Psychiatric Discharge: Indicates that the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012.</p> <p>HEDIS Follow-Up After Hospitalization Measures: At or above 90th percentile.</p> <p><i>BH-MCOs may have internal goals to improve.</i></p>
	<p>PA-specific Follow-Up After Hospitalization Measures: Either the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012 <u>or</u> that the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average but there is no change from MY 2012.</p> <p>Readmission within 30 Days of Inpatient Psychiatric Discharge: Either the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012 <u>or</u> that the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average but there is no change from MY 2012.</p> <p>HEDIS Follow-Up After Hospitalization Measures: At or above 75th and below 90th percentile.</p> <p><i>BH-MCOs may identify continued opportunities for improvement.</i></p>
	<p>PA-specific Follow-Up After Hospitalization Measures: The BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012 <u>or</u> the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and there is no change from MY 2012 <u>or</u> the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average but trends down from MY 2012.</p> <p>Readmission within 30 Days of Inpatient Psychiatric Discharge: The BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012 <u>or</u> the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and there is no change from MY 2012 <u>or</u> the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average but trends up from MY 2012.</p> <p>HEDIS Follow-Up After Hospitalization Measures: N/A</p> <p><i>No action is required although MCOs should identify continued opportunities for improvement.</i></p>
	<p>PA-specific Follow-Up After Hospitalization Measures: Either the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average and there is no change from MY 2012 <u>or</u> that the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012.</p> <p>Readmission within 30 Days of Inpatient Psychiatric Discharge: Either the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average and there is no change from MY 2012 <u>or</u> that the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012.</p> <p>HEDIS Follow-Up After Hospitalization Measures: At or above 50th and below 75th percentile.</p> <p><i>A root cause analysis and plan of action is required.</i></p>
	<p>PA-specific Follow-Up After Hospitalization Measures: the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012.</p> <p>Readmission within 30 Days of Inpatient Psychiatric Discharge: the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012.</p> <p>HEDIS Follow-Up After Hospitalization Measures: At or below the 50th percentile.</p> <p><i>A root cause analysis and plan of action is required.</i></p>



Value Behavioral Health (VBH)

Figure 1.1: Performance Measure Matrix – VBH

		<i>HealthChoices BH-MCO Average Statistical Significance Comparison</i>		
Year to Year Statistical Significance Comparison	Trend	Below / Poorer than Average	Average	Above / Better than Average
	▲	C	B	A
	No Change	D	C FUH QI A	B FUH QI B
	▼	F	D	C REA ¹

Key to the Performance Measure Matrix Comparison

- A: Performance is notable. No action required. BH-MCOs may have internal goals to improve.
- B: No action required. BH-MCOs may identify continued opportunities for improvement.
- C: No action required although BH-MCOs should identify continued opportunities for improvement.
- D: Root cause analysis and plan of action required.
- F: Root cause analysis and plan of action required.

Performance measure rates for MY 2010 to MY 2013 are displayed in Figure 1.2. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

- ▲ Statistically significantly higher than the prior year,
- ▼ Statistically significantly lower than the prior year, or
- = No change from the prior year.

Figure 1.2: Performance Measure Rates – VBH

Quality Performance Measure	MY 2010 Rate	MY 2011 Rate	MY 2012 Rate	MY 2013 Rate	MY 2013 HC BH-MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	56.9% =	57.0% =	55.5% =	56.4% =	55.7%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	76.3% =	76.3% =	75.3% =	75.9% =	72.3%
Readmission within 30 Days of Inpatient Psychiatric Discharge ¹	10.5% =	9.4% =	9.9% =	11.4% ▲	13.5%

¹ Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



Value Behavioral Health (VBH)

Figure 2.1: HEDIS Follow-Up After Hospitalization (FUH) 7-day/30-day (Ages 6-64) Performance Measure Matrix – VBH

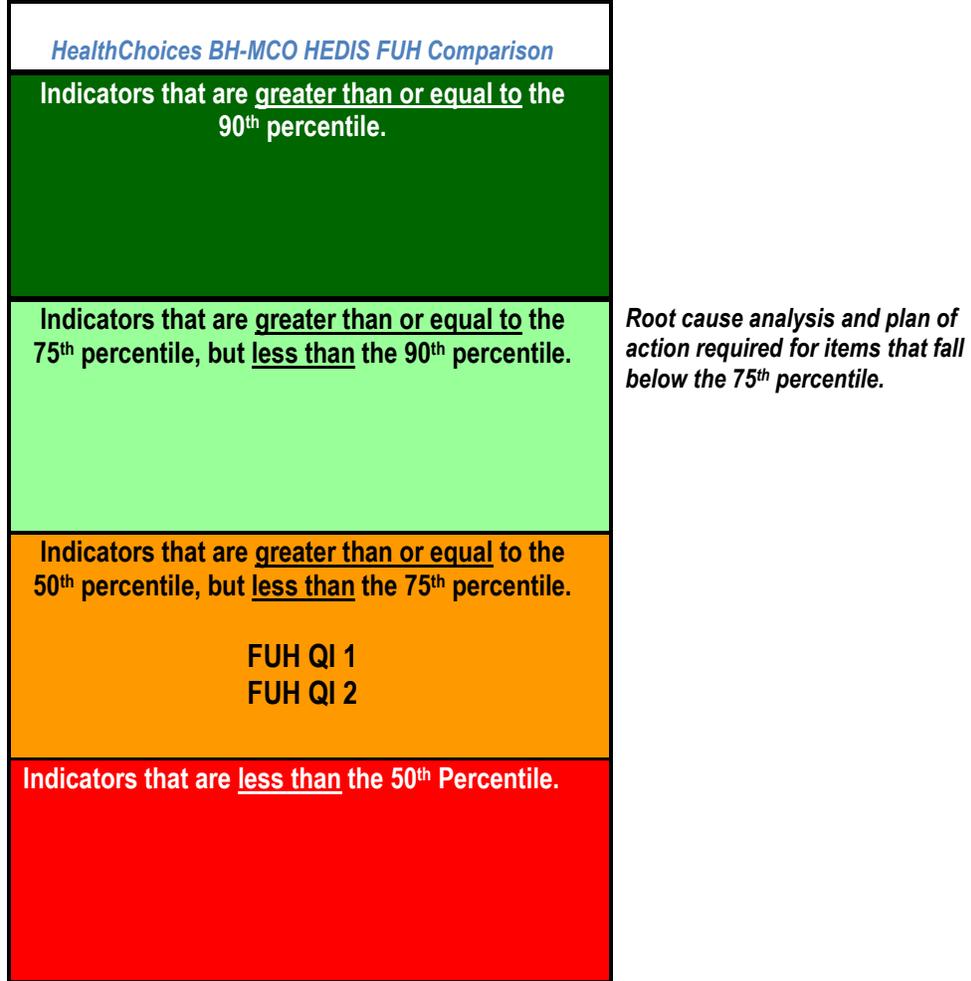


Figure 2.2: HEDIS Follow-Up After Hospitalization (FUH) 7-day/30-day Performance Measure Rates – VBH

Quality Performance Measure	MY 2012 Rate	HEDIS 2013 75 th ile
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day) - Ages 6-64	46.8% <i>Not Met</i>	<i>Below 75th, at or above 50th percentile</i>
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day) - Ages 6-64	70.6% <i>Not Met</i>	<i>Below 75th, at or above 50th percentile</i>



Value Behavioral Health (VBH)

KEY POINTS

▪ **A - Performance is notable. No action required. BH-MCOs may have internal goals to improve.**

- No VBH performance measure rate fell into this comparison category.

▪ **B - No action required. BH-MCO may identify continued opportunities for improvement.**

- Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)

▪ **C - No action required although BH-MCO should identify continued opportunities for improvement.**

- Readmission within 30 Days of Inpatient Psychiatric Discharge¹
- Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)

▪ **D - Root cause analysis and plan of action required.**

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day – 6 to 64 years)
- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day – 6 to 64 years)

• **F - Root cause analysis and plan of action required.**

- No VBH performance measure rate fell into this comparison category.

¹ Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



VII: SUMMARY OF ACTIVITIES

Structure and Operations Standards

- VBH was partially compliant on Subparts C, D and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2013, RY 2012, and RY 2011 were used to make the determinations.

Performance Improvement Projects

- VBH submitted one PIP proposal in 2014

Performance Measures

- VBH reported all performance measures and applicable quality indicators in 2014.

2013 Opportunities for Improvement MCO Response

- VBH provided a response to the opportunities for improvement issued in 2013, and submitted a root cause analysis and action plan response in 2014.

2014 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for VBH in 2014. The BH-MCO will be required to prepare a response for the noted opportunities for improvement in 2015.



APPENDIX

Appendix A: Crosswalk of Required PEPS Substandards to Pertinent BBA Regulations

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Standard 108.2	C/FST budget is sufficient to: hire staff proportionate to HC covered lives, has adequate office space, purchase equipment, travel and attend on-going training.
	Standard 108.5	The C/FST has access to providers and HC members to conduct surveys and employs of a variety of survey mechanisms to determine member satisfaction e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Standard 108.6	The problem resolution process specifies the role of the County, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
	Standard 108.7	The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
§438.206 Availability of Service	Standard 108.8	The Annual Mailed/Telephonic survey results are representative of HC membership, identify systemic trends and actions have been taken to address areas found deficient, as applicable.
	Standard 108.10	The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.
	Standard 1.1	<ul style="list-style-type: none"> • A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages. • Excel or Access data base with the following information: Name of Agency (include satellite sites). Address of Agency (and satellite sites) with zip codes. Level of Care (e.g. Partial Hospitalization, D&A Outpatient, etc). Population served (adult, child & adolescent). Priority Population. Special Population.
	Standard 1.2	100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met.



BBA Category	PEPS Reference	PEPS Language
	Standard 1.3	Provider Exception report submitted & approved when choice of two providers is not given.
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).
	Standard 1.5	BH-MCO has notified DPW of any drop in provider network. <ul style="list-style-type: none"> • Monitor provider turnover. • Network remains open where needed.
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.208 Coordination and Continuity of Care	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.210 Coverage and authorization of	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is



BBA Category	PEPS Reference	PEPS Language
services		supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.2104 Provider Selection	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as, other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.240 Quality assessment and performance improvement program	Standard 91.1	QM program description outlines the ongoing quality assessment and performance improvement activities, Continuous Quality Improvement process and places emphasis on, but not limited to High volume/high-risk services and treatment and Behavioral Health Rehabilitation services.
	Standard 91.2	QM work plan includes goal, aspect of care/ service, scope of activity, frequency, data source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.

BBA Category	PEPS Reference	PEPS Language
	Standard 91.4	QM work plan outlines, the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services, provider network adequacy, penetration rates, appropriateness of service authorizations, inter-rater reliability, complaint, grievance and appeal process, denial rates, grievance upheld and overturn rates and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other HV/HR services).
	Standard 91.8	The QM work plan includes monitoring activities conducted to evaluate the quality and performance of the provider network (quality of individualized service plans and treatment planning, adverse incidents, collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance).
	Standard 91.9	The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	The QM work plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator for : ---Mental Health ---Substance Abuse External Quality Review: ---Follow up After Mental Health Hospitalization QM Annual Summary Report
	Standard 91.11	The identified Performance Improvement Projects must include the following: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality. 3. Evaluation of the effectiveness of the interventions. 4. Planning and initiation of activities for increasing or sustaining improvement. 5. Timeline for reporting status and results of each project to DPW. 6. Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year.
	Standard 91.12	The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.
	Standard 91.13	The BH-MCO has a process for its own evaluation of the impact and effectiveness of its quality management program annually. A report of this evaluation will be submitted to DPW by April 15 th .
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30



BBA Category	PEPS Reference	PEPS Language
		seconds
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH-MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for Coordination with Other Service Agencies and School.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
§438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO

BBA Category	PEPS Reference	PEPS Language
		committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.



BBA Category	PEPS Reference	PEPS Language
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to



BBA Category	PEPS Reference	PEPS Language
		investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.408 Resolution and notification: Grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.



BBA Category	PEPS Reference	PEPS Language
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.410 Expedited resolution of appeals	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.414 Information about the grievance system to	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level



BBA Category	PEPS Reference	PEPS Language
providers and subcontractors		<ul style="list-style-type: none"> • 2nd Level • External
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
§438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.424 Effectuation of reversed appeal resolutions	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.



BBA Category	PEPS Reference	PEPS Language
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

Appendix B: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Second Level Complaints and Grievances		
Complaints	Standard 68.6	The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 68.9	Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.
Grievances and State Fair Hearings	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 71.8	Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.
Enrollee Satisfaction		
Consumer / Family Satisfaction	Standard 108.3	County/BH-MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.
	Standard 108.4	The C/FST Director is responsible for setting program direction consistent with County direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority and directing staff to perform high quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.

Appendix C: Program Evaluation Performance Summary OMHSAS-Specific Substandards for VBH HC BH Contractors

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2013, 11 substandards were considered OMHSAS-specific monitoring standards. Of the 11 OMHSAS-specific PEPS Substandards, all were evaluated for VBH and the six HC BH Contractors subcontracting with VBH. Table C.1 provides a count of these items, along with the relevant categories.

Table 1.5 OMHSAS-Specific Substandards Reviewed for VBH



Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2013	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	Not Reviewed
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	0	0	4	0
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	3	0	0

Format

This document groups the monitoring standards under the subject headings Second Level Complaints and Grievances, and Enrollee Satisfaction. The status of each Substandard is presented as it appears in the PEPS tools (i.e., met, partially met, not met) and/or applicable RAI tools (i.e., complete, pending) submitted by OMHSAS. This format reflects the goal of this supplemental review, which is to assess the HC BH Contractor/BH-MCO's compliance on selected ongoing OMHSAS-specific monitoring standards.

Findings

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards². Of the eight substandards evaluated, VBH met one substandard, partially met four standards, and did not meet two substandards, as indicated in Table C.2.

Table C.2 OMHSAS-Specific Requirements Relating to Second Level Complaints and Grievances

Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
Complaints	Standard 68.6	RY 2011	Not Met
	Standard 68.7	RY 2011	Partial
	Standard 68.8	RY 2011	Partial
	Standard 68.1	RY 2011	Partial
Grievances and State Fair Hearings	Standard 71.5	RY 2011	Not Met
	Standard 71.6	RY 2011	Met
	Standard 71.7	RY 2011	Not Met
	Standard 71.8	RY 2011	Partial

PEPS Standard 68: Complaints. Complaint (and BBA Fair Hearing) rights and procedures are made known to IEAP, members, BH-MCO staff, and the provider network through manuals, training, handbooks, etc.

The HC BH Contractors Associated with VBH did not meet the criteria for compliance for Substandard 68.6:

Substandard 68.6: The second level complaint case file includes documentation that the member was contacted about the second level complaint meeting and offered a convenient time

² Beginning with RY 2012, MCO-specific substandards 68.9 and 71.8 were changed to County-specific substandards and renumbered to 68.1 and 78.1 respectively under the County-specific standard set.



and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.

The HC BH Contractors Associated with VBH partially met the criteria for compliance for Substandards 68.7, 68.8, and 68.9:

Substandard 68.7: Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.

Substandard 68.8: A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

Substandard 68.9: Where applicable there is evidence of County oversight and involvement in the second level complaint process.

PEPS Standard 71: Grievances and State Fair Hearings. Grievance and DHS Fair Hearing rights and procedures are made known to Enrollment Assistance Program (EAP), members, BH-MCO Staff and the provider network through manuals, training, handbooks, etc.

The HC BH Contractors Associated with VBH did not meet the criteria for compliance for Substandards 71.5 and 71.7:

Substandard 71.5: The second level grievance case file includes documentation that the member was contacted about the second level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.

Substandard 71.7: A transcript and/or tape recording of the second level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

The HC BH Contractors Associated with VBH partially met the criteria for compliance for Substandard 71.1:

Substandard 71.8: Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are HC BH Contractor-specific review standards. All three substandards crosswalked to this category were evaluated for the six VBH HC BH Contractors. VBH was compliant on one substandard and partially compliant on two substandards. The status by HC BH Contractor for these is presented in Table C.3 below.

Table C.3 OMHSAS-Specific Requirements Relating to Enrollee Satisfaction

Category	PEPS Item	Review Year	MCO Compliance	By HC BH Contractor	
				Met	Partially met
Enrollee Satisfaction					
Consumer/Family Satisfaction	Standard 108.3	RY 2012	Partial	Beaver, Cambria, Fayette, Greene and the Southwest Six	Crawford-Mercer-Venango



Category	PEPS Item	Review Year	MCO Compliance	By HC BH Contractor	
				Met	Partially met
	Standard 108.4	RY 2012	Partial	Beaver, Cambria, Fayette, Greene and the Southwest Six	Crawford-Mercer-Venango
	Standard 108.9	RY 2012	Met	All VBH HC BH Contractors	

PEPS Standard 108: Consumer / Family Satisfaction. The County Contractor/BH-MCO: a) incorporates consumer satisfaction information in provider profiling and quality improvement process; b) collaborates with consumers and family members in the development of an annual satisfaction survey that meets the requirements of Appendix L; c) provides the department with quarterly and annual summaries of consumer satisfaction activities, consumer issues identified and resolution to problems, and d) provides an effective problem identification and resolution process.

Crawford, Mercer, and Venango was partially on Substandards 108.3 and 108.4 due to partial compliance with standards 108.3 and 108.4.

Substandard 108.3: County/BH-MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.

Substandard 108.4: County/BH-MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.

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