



Commonwealth of Pennsylvania  
Department of Public Welfare  
Office of Mental Health and Substance  
Abuse Services

2011 External Quality Review Report  
Value Behavioral Health  
**FINAL REPORT**

Completed on: April 6, 2012



## REPORT CONTENT

---

<b>Glossary of Terms.....</b>	<b>p. 3</b>
<b>Introduction.....</b>	<b>p. 4</b>
<b>I: Structure and Operations Standards.....</b>	<b>p. 5</b>
Program Evaluation Performance Summary Items Pertinent to BBA Regulations	p. 7
Program Evaluation Performance Summary OMHSAS-Specific Items	p. 18
<b>II: Performance Improvement Projects.....</b>	<b>p. 22</b>
<b>III: Performance Measures.....</b>	<b>p. 28</b>
Follow-up After Hospitalization for Mental Illness	p. 28
Readmission within 30 Days of Inpatient Psychiatric Discharge	p. 41
<b>IV: 2010 Opportunities for Improvement - MCO Response.....</b>	<b>p. 45</b>
Current and Proposed Interventions	p. 45
Corrective Action Plan	p. 51
Root Cause Analysis and Action Plan	p. 52
<b>V: 2011 Strengths and Opportunities for Improvement.....</b>	<b>p. 53</b>
Performance Measure Matrix	p. 54
<b>VI: Summary of Activities.....</b>	<b>p. 58</b>
<b>Appendix.....</b>	<b>p. 59</b>
Appendix A: Crosswalk of Required PEPS Items to Pertinent BBA Regulations	p. 59
Appendix B: OMHSAS-Specific PEPS Items	p. 68
<b>References.....</b>	<b>p. 70</b>



## GLOSSARY OF TERMS

---

<b>Average</b> (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.
<b>Confidence Interval</b>	Confidence intervals (CIs) are ranges 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.
<b>HealthChoices Aggregate Rate</b>	The sum of all behavioral health (BH) managed care organization (MCO) numerators divided by the sum of all BH MCO denominators.
<b>HealthChoices BH MCO Average</b>	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.
<b>HealthChoices County Average</b>	The sum of the individual County rates divided by the total number of Counties (67 Counties). Each County has an equal contribution to the HealthChoices County Average value.
<b>Rate</b>	A proportion indicated as a percentage.
<b>Percentage Point Difference</b>	The arithmetic difference between two rates.
<b>Weighted Average</b>	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.
<b>Statistical Significance</b>	In statistics, a result is described as statistically significant if it 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.
<b>Z-ratio</b>	The z-ratio expresses 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.

The Commonwealth of Pennsylvania (PA) Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2011 EQRs for the HealthChoices Medicaid MCOs and to prepare the technical reports. This technical report includes six core sections:

- I: Structure and Operations Standards
- II: Performance Improvement Projects
- III: Performance Measures
- IV: 2010 Opportunities for Improvement - MCO Response
- V: 2011 Strengths and Opportunities for Improvement
- VI: Summary of Activities

For the Behavioral Health (BH) Medicaid MCOs, the information for the compliance with the Structure and Operations Standards section of the report is derived from monitoring conducted by OMHSAS of the BH MCOs 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. Performance measure validation as conducted by IPRO includes two performance measures – Follow-up After Hospitalization for Mental Illness and Readmission Within 30 Days of Inpatient Psychiatric Discharge.

Section IV, Opportunities for Improvement – MCO Response, includes the BH MCO's responses to opportunities for improvement noted in the 2010 EQR Technical Report and presents the degree to which the BH MCO addressed each opportunity for improvement.

Section V has a summary of the BH MCO's strengths and opportunities for improvement for this review period (2010) as determined by IPRO, and a "report card" of the BH MCO's performance as related to the Pay for Performance (P4P) measures.

Section VI provides a summary of EQR activities for the BH MCO for this review period, followed by an appendix that crosswalks PEPS standards to pertinent BBA Regulations and to OMHSAS-specific PEPS Items, and 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 Value Behavioral Health's (VBH's) compliance with the structure and operations standards. In Review Year (RY) 2010, all 67 PA Counties participated in this compliance evaluation.

### **Organization of HealthChoices Behavioral Health Program**

OMHSAS determined that the County governments would be offered the right-of-first opportunity to enter into capitated contracts with the Commonwealth with regard to the administration of Medicaid managed care behavioral health and substance abuse services. Forty-three of the 67 Counties subcontract directly with BH MCOs to administer behavioral health services. These 43 Counties provide monitoring and oversight of the BH MCOs. The remaining 24 County contracts are managed directly by OMHSAS since the Counties elected not to bid on the HealthChoices contract directly. Each County subsequently chose a BH MCO subcontractor, which operates under the authority of that County, to administer behavioral health and substance abuse services.

Beaver, Fayette, Greene, and an alliance of Armstrong, Butler, Indiana, Lawrence, Washington and Westmoreland Counties called the Southwest Behavioral Health Management, Inc. hold contracts with VBH. The North/Central County Option (NC/CO) Counties – Cambria, Crawford, Erie, Mercer and Venango – also hold contracts with VBH. While Medicaid managed care members may choose a Physical Health (PH) MCO for physical health care services, each HealthChoices enrollee is assigned a BH MCO based on his or her County of residence. IPRO's EQR is based on OMHSAS' reviews of VBH and the 14 Counties associated with the BH MCO.

### **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 years. These evaluations are performed at the BH MCO and County levels, and the findings are reported in OMHSAS' PEPS review tools for Review Year (RY) 2010. 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 Items are considered Readiness Review Items only. Items reviewed at the time of the Readiness Review upon initiation of the HealthChoices 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 Counties and BH MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review Items were deemed as complete. As necessary, the HealthChoices Behavioral Health 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 as of October 2011 for RY 2010. 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 County/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 County/BH MCO is evaluated against Items that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Items 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 multiple review Items, all of the Items 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 review Items 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 Items no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Items 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 Items concerning second level complaints and grievances are considered OMHSAS-specific Items, 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 the first section of this chapter. The review findings for selected OMHSAS-specific Items are reported in the second section of this chapter. The RY 2010 crosswalk of PEPS Items to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Items can be found in this report's Appendices.

Because OMHSAS reviews the Counties and their subcontracted BH MCOs on 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 Items from RY 2010, RY 2009, and RY 2008 provided the information necessary for the 2011 assessment. Those standards not reviewed through the PEPS system in RY 2010 were evaluated on their performance based on RY 2009 and/or RY 2008 decisions, or other supporting documentation, if necessary. For those Counties that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Items were evaluated when none of the PEPS Items crosswalked to a particular BBA category were reviewed.

For VBH, this year a total of 137 Items were identified as being required for the evaluation of County/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 Items 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. Tables 1.1a and 1.1b provide a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of the VBH Counties against the Structure and Operations Standards for this report. Tables 1.5a and 1.5b provide 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 Counties against other state-specific Structure and Operations Standards.



## Program Evaluation Performance Summary Items Pertinent to BBA Regulations for VBH Counties

**Table 1.1a Items Pertinent to BBA Regulations Reviewed for Beaver, Fayette, Greene, and the Southwest Six (Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland) Counties**

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	Not Reviewed*
<b>Subpart C: Enrollee Rights and Protections</b>					
Enrollee Rights	12	2	0	10	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
<b>Subpart D: Quality Assessment and Performance Improvement</b>					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	4	18	0	0
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	1	2	0	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	2	0	0
Quality Assessment and Performance Improvement Program	23	23	0	0	0
Health Information Systems	1	1	0	0	0
<b>Subpart F: Federal &amp; State Grievance Systems Standards</b>					
Statutory Basis and Definitions	7	1	0	5	1
General Requirements	10	1	0	8	1
Notice of Action	11	1	9	0	1
Handling of Grievances and Appeals	7	1	0	5	1
Resolution and Notification: Grievances and Appeals	7	1	0	5	1
Expedited Appeals Process	4	1	0	2	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	4	1	0	2	1
Effectuation of Reversed Resolutions	4	1	0	2	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



**Table 1.1b Items Pertinent to BBA Regulations Reviewed for the NC/CO Counties (Cambria, Crawford, Erie, Mercer, and Venango)**

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	Not Reviewed*
<b>Subpart C: Enrollee Rights and Protections</b>					
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
<b>Subpart D: Quality Assessment and Performance Improvement</b>					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	4	18	0	0
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	1	2	0	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	2	0	0
Quality Assessment and Performance Improvement Program	23	23	0	0	0
Health Information Systems	1	1	0	0	0
<b>Subpart F: Federal &amp; State Grievance Systems Standards</b>					
Statutory Basis and Definitions	7	1	0	5	1
General Requirements	10	1	0	8	1
Notice of Action	11	1	9	0	1
Handling of Grievances and Appeals	7	1	0	5	1
Resolution and Notification: Grievances and Appeals	7	1	0	5	1
Expedited Appeals Process	4	1	0	2	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	4	1	0	2	1
Effectuation of Reversed Resolutions	4	1	0	2	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 2010, 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 Items reviewed. As per OMHSAS' judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health 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, DPW has been granted an allowance to offer only one BH MCO per County.



In evaluations prior to the 2008 report, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all Counties and BH MCOs based only on the HealthChoices Behavioral Health PS&R and Readiness Review assessments, respectively. Beginning with the 2008 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, Encounter Monthly Aggregate Complaint/Grievance records (EMG) and Encounter Monthly Complaint/Grievance Synopsis records (MCG) were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

### **Determination of Compliance**

To evaluate County/BH MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring Items by provision and evaluated the Counties and BH MCO's compliance status with regard to the PEPS Items. Each Item was assigned a value of met, partially met or not met in the PEPS tools submitted by the Commonwealth. If an Item was not evaluated for a particular County/BH MCO, it was assigned a value of Not Determined. Compliance with the BBA provisions was then determined based on the aggregate results of the PEPS Items linked to each provision. If all Items were met, the County/BH MCO was evaluated as compliant; if some were met and some were partially met or not met, the County/BH MCO was evaluated as partially compliant. If all Items were not met, the County/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 Items 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 County/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 14 Counties associated with the BH MCO, 137 PEPS Items were identified as required to fulfill BBA regulations. The 14 Counties were evaluated on 128 PEPS Items during the review cycle. There were nine Items that were not scheduled or not applicable for evaluation for RY 2010



## Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this subpart is to ensure that each County/BH MCO has written policies regarding enrollee rights and complies with applicable Federal and State laws that pertain to enrollee rights, and that the County/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 County		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Partial	Beaver, Erie, Greene, Venango	Cambria, Crawford, Fayette, Mercer, Southwest Six	12 Items were crosswalked to this category.  Each County was evaluated on 12 Items.  Beaver, Greene, Erie, and Venango Counties were compliant on 12 Items. Armstrong and Indiana Counties were compliant on 6 Items and partially compliant on 6 Items. Butler and Crawford Counties were compliant on 10 Items and partially compliant on 2 Items. Cambria and Mercer Counties were compliant on 9 Items and partially compliant on 3 Items. Fayette, Washington, and Westmoreland Counties were compliant on 11 Items and partially compliant on 1 Item. Lawrence County was compliant on 7 Items and partially compliant on 5 Items.
Provider-Enrollee Communications 438.102	Compliant	All VBH Counties		Compliant as per PS&R sections E.4 (p.50) and A.3.a (p.24).
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 Counties		Compliant as per PS&R sections A.9 (p.63) and C.2 (p.34).
Cost Sharing 438.108	Compliant	All VBH Counties		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 Counties		Compliant as per PS&R section 3.d (p.31).
Solvency Standards 438.116	Compliant	All VBH Counties		Compliant as per PS&R sections A.3 (p.60) and A.9 (p.63), and 2010-2011 Solvency Requirements tracking report.



There are seven categories within Enrollee Rights and Protections Standards. VBH was compliant on five categories, partially compliant on one category, and received a waiver for one 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 2010-2011 Solvency Requirement tracking report, and the category Marketing Activities was waived and deemed Not Applicable.

Beaver, Erie and Greene Counties were compliant on six categories of the Enrollee Rights and Protections Standards. The remaining 11 Counties (Cambria, Crawford, Fayette, Mercer, Venango, and the Southwest Six) were compliant on five categories.

Of the 12 PEPS Items that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated for each County. Beaver, Greene, Erie, and Venango Counties were compliant on 12 Items. Armstrong and Indiana Counties were compliant on six Items and partially compliant on six Items. Butler and Crawford Counties were compliant on 10 Items and partially compliant on two Items. Cambria and Mercer Counties were compliant on nine Items and partially compliant on three Items. Fayette, Washington, and Westmoreland Counties were compliant on 11 Items and partially compliant on one Item. Lawrence County was compliant on seven Items and partially compliant on five Items. Those Items deemed partially compliant may correlate to a fewer number of PEPS substandards deemed partially compliant. Some PEPS standards are crosswalked to more than one category.

### **Enrollee Rights**

Cambria, Crawford, Fayette, Mercer, and the Southwest Six Counties were partially compliant with Enrollee Rights due to partial compliance with substandards within PEPS Standard 108.

**PEPS Standard 108:** 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.

***Armstrong and Indiana Counties*** were partially compliant on six substandards of Standard 108: Substandards 1, 2, 5, 6, 7, and 10 (RY 2008).

**Substandard 1:** County/BH MCO oversight of Consumer/Family Satisfaction Team (C/FST) Program ensures HealthChoices (HC) 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 5:** The C/FST has access to providers and HC 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.

**Substandard 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.

**Substandard 7:** The C/FST quarterly reports are 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.

**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.



**Butler County** was partially compliant on two substandards of Standard 108: Substandards 5 and 7 (RY 2008).

**Substandard 5:** The C/FST has access to providers and HC 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.

**Substandard 7:** The C/FST quarterly reports are 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.

**Cambria County** was partially compliant on three substandards of Standard 108: Substandards 2, 5, and 10 (RY 2009).

**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 5:** The C/FST has access to providers and HC 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.

**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.

**Mercer County** was partially compliant on three substandards of Standard 108: Substandards 2, 6, and 10 (RY 2009).

**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 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.

**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.

**Crawford County** was partially compliant on two substandards of Standard 108: Substandards 2 and 10 (RY 2009).

**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.

**Fayette County** was partially compliant on one substandard of Standard 108: Substandard 1 (RY 2008).

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

**Lawrence County** was partially compliant on five substandards of Standard 108: Substandards 1, 2, 5, 6, and 7 (RY 2008).



**Substandard 1:** County/BH MCO oversight of C/FST Program ensures HC 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 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.

**Substandard 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.

**Substandard 7:** The C/FST quarterly reports are 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 ad systemic issues as applicable.

**Washington and Westmoreland Counties** were partially compliant on one substandard of Standard 108: Substandard 7 (RY 2008).

**Substandard 7:** The C/FST quarterly reports are 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 ad systemic issues as applicable.

## Subpart D: Quality Assessment and Performance Improvement Regulations

The PEPS documents for each County include an assessment of the County/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 County		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Elements of State Quality Strategies 438.204	Compliant	All VBH Counties		Compliant as per PS&R section G.3 (p.55).
Availability of Services (Access to Care) 438.206	Partial		All VBH Counties	22 Items were crosswalked to this category Each County was evaluated on 22 Items, compliant on 19 Items, and partially compliant on 3 Items.
Coordination and Continuity of Care 438.208	Partial		All VBH Counties	2 Items were crosswalked to this category Each County was evaluated on 2 Items and partially compliant on both.



Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	MCO Compliance Status	By County		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Coverage and Authorization of Services 438.210	Partial		All VBH Counties	4 Items were crosswalked to this category Each County was evaluated on 4 Items and partially compliant on 3 Items.
Provider Selection 438.214	Compliant	All VBH Counties		3 Items were crosswalked to this category. Each County was evaluated on 3 Items and compliant on 3 Items.
Confidentiality 438.224	Compliant	All VBH Counties		Compliant as per PS&R sections D.2 (p.47), G.4 (p.55-56) and C.7.c (p.46).
Subcontractual Relationships and Delegation 438.230	Compliant	All VBH Counties		8 Items were crosswalked to this category. Each County was evaluated on 8 Items and compliant on 8 Items.
Practice Guidelines 438.236	Partial		All VBH Counties	6 Items were crosswalked to this category. Each County was evaluated on 6 Items, compliant on 3 Items, and partially compliant on 3 Items.
Quality Assessment and Performance Improvement Program 438.240	Partial		All VBH Counties	23 Items were crosswalked to this category. Each County was evaluated on 23 Items, compliant on 22 Items and partially compliant on 1 Item.
Health Information Systems 438.242	Compliant	All VBH Counties		1 Item was crosswalked to this category. Each County was evaluated on 1 Item and compliant on this Item.

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 Items, but were determined to be compliant as per the HealthChoices PS&R.

For this review, 69 Items were crosswalked to Quality Assessment and Performance Improvement Regulations for all 14 Counties associated with VBH, and each County was evaluated on 68 Items. There was one Item that was not scheduled or not applicable for evaluation for RY 2010. Each County was compliant on 56 Items and partially compliant on 12 Items. Those Items deemed partially compliant may correlate to a fewer number of PEPS substandards deemed partially compliant. As stated previously, some PEPS standards are crosswalked to more than one category.

**Availability of Services (Access to Care)**

All 14 Counties associated with VBH were partially compliant with Availability of Services due to partial compliance with substandards of PEPS Standards 28 and 93.



**PEPS Standard 28:** The BH MCO has a comprehensive, defined program of care that incorporates longitudinal disease management.

**All of the VBH Counties** were partially compliant on two substandards of Standard 28: Substandards 1 and 2 (RY 2009).

**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.

**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.

**PEPS Standard 93:** The BH MCO evaluates the effectiveness of services received by Members. Evaluate effectiveness of the services received by members and changes made when necessary to access services, provider network adequacy, appropriateness of service authorization, inter-rater reliability, complaint, grievance and appeal process, and treatment outcomes.

**All of the VBH Counties** were partially compliant on one substandard of Standard 93: Substandard 4 (RY 2010).

**Substandard 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.

### **Coordination and Continuity of Care**

All 14 Counties associated with VBH were partially compliant with Coordination and Continuity of Care due to partial compliance with two substandards of PEPS Standard 28. See Standard description and partially compliant substandard determination under Availability of Services (Access to Care) on page 14 of this report.

### **Coverage and Authorization of Services**

All 14 Counties associated with VBH were partially compliant with Coverage and Authorization of Services due to partial compliance with substandards of PEPS Standards 28 and 72.

**PEPS Standard 28:** See Standard description and partially compliant substandard determination under Availability of Services (Access to Care) on page 14 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 DPW Fair Hearing and i) If currently receiving services, the right to continue to receive services during the grievance and/or DPW Fair Hearing process.

**All of the VBH Counties** were partially compliant on one substandard of Standard 72: Substandard 1 (RY 2010).

**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 14 Counties associated with VBH were partially compliant with Practice Guidelines due to partial compliance with two substandards of PEPS Standard 28. See Standard 28’s description and partially compliant substandard determination under Availability of Services (Access to Care) on page 14 of this report.

**Quality Assessment and Performance Improvement Program**

All 14 Counties associated with VBH were partially compliant with Quality Assessment and Performance Improvement Program due to partial compliance with one substandard within PEPS Standard 93. See Standard 93’s description and partially compliant substandard determination under Availability of Service (Access to Care) on page 14 of this report.

**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 for each County include an assessment of the County/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 County		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All VBH Counties	7 Items were crosswalked to this category. Each County was evaluated on 6 Items, compliant on 2 Items, and partially compliant on 4 Items.
General Requirements 438.402	Partial		All VBH Counties	10 Items were crosswalked to this category. Each County was evaluated on 9 Items, compliant on 5 Items, and partially compliant on 4 Items.
Notice of Action 438.404	Partial		All VBH Counties	11 Items were crosswalked to this category. Each County was evaluated on 10 Items, compliant on 9 Items, and partially compliant on 1 Item.
Handling of Grievances and Appeals 438.406	Partial		All VBH Counties	7 Items were crosswalked to this category. Each County was evaluated on 6 Items, compliant on 2 Items, and partially compliant on 4 Items.



Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By County		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Resolution and Notification: Grievances and Appeals 438.408	Partial		All VBH Counties	7 Items were crosswalked to this category. Each County was evaluated on 6 Items, compliant on 2 Items, and partially compliant on 4 Items.
Expedited Appeals Process 438.410	Partial		All VBH Counties	4 Items were crosswalked to this category. Each County was evaluated on 3 Items, compliant on 1 Item, and partially compliant on 2 Items.
Information to Providers & Subcontractors 438.414	Partial		All VBH Counties	2 Items were crosswalked to this category. Each County was evaluated on 2 Items, compliant on 1 Item, and partially compliant on 1 Item.
Recordkeeping and Recording Requirements 438.416	Compliant	All VBH Counties		Compliant as per 2010 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.
Continuation of Benefits 438.420	Partial		All VBH Counties	4 Items were crosswalked to this category. Each County was evaluated on 3 Items, compliant on 1 Item, and partially compliant on 2 Items.
Effectuation of Reversed Resolutions 438.424	Partial		All VBH Counties	4 Items were crosswalked to this category. Each County was evaluated on 3 Items, compliant on 1 Item, and partially compliant on 2 Items.

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 2010 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.

For this review, 56 Items were crosswalked to Federal and State Grievance System Standards for all 14 Counties associated with VBH. Each County was evaluated on 48 Items, compliant on 24 Items, and partially compliant on 24 Items. Eight Items were not scheduled or not applicable for evaluation for RY 2010. Those Items deemed partially compliant may correlate to a fewer number of PEPS substandards deemed partially compliant. As stated previously, some PEPS standards are crosswalked to more than one category.

The 14 Counties 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 compliance with substandards within PEPS Standards 68, 71 and 72.



**PEPS Standard 68:** 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 Counties** were partially compliant on two substandards of Standards 68: Substandards 2 and 3 (RY 2008).

**Substandard 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.

**Substandard 3:** 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:** Grievance and DPW 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 Counties** were partially compliant on one substandard of Standard 71: Substandard 1 (RY 2008).

**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, 1<sup>st</sup> level, second level, External, Expedited.

**PEPS Standard 72:** See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 15 of this report.

## Program Evaluation Performance Summary OMHSAS-Specific Items for VBH Counties

In RY 2009, 11 Items were considered OMHSAS-specific monitoring standards, and were reviewed although not required to fulfill BBA requirements. Tables 1.5a and 1.5b provide a count of these Items, along with the relevant categories. All 11 OMHSAS-specific PEPS Items were evaluated for each VBH County.

**Table 1.5a OMHSAS-Specific Items Reviewed for Beaver, Fayette, Greene, and the Southwest Six Counties**

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	Not Reviewed
<b>Second Level Complaints and Grievances</b>					
Complaints (Standard 68)	4	0	0	4	0
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	0
<b>Enrollee Satisfaction</b>					
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0



**Table 1.5b OMHSAS-Specific Items Reviewed for the NC/CO Counties**

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	Not Reviewed
<b>Second Level Complaints and Grievances</b>					
Complaints (Standard 68)	4	0	0	4	0
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	0
<b>Enrollee Satisfaction</b>					
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 Item is presented as it appears in the PEPS tools submitted by the Commonwealth (i.e., met, partially met, or not met). This format reflects the goal of this supplemental review, which is to assess the County/BH MCO's compliance on selected ongoing OMHSAS-specific monitoring standards.

**Findings**

The OMHSAS-specific PEPS Items relating to second level complaints and grievances are MCO-specific review standards, and all eight Items were evaluated for VBH. VBH met four Items, partially met two Items, and did not meet two Items as seen in Table 1.6.

**Table 1.6 OMHSAS-Specific Requirements Relating to Second Level Complaints and Grievances for all VBH Counties**

Category	PEPS Item	Review Year	Status
<b>Second Level Complaints and Grievances</b>			
Complaints	Substandard 68.4	RY 2008	Partially Met
	Substandard 68.5	RY 2008	Met
	Substandard 68.6	RY 2008	Not Met
	Substandard 68.7	RY 2008	Met
Grievances and State Fair Hearings	Substandard 71.3	RY 2008	Partially Met
	Substandard 71.4	RY 2008	Met
	Substandard 71.5	RY 2008	Not Met
	Substandard 71.6	RY 2008	Met

Note: Substandards 68.4, 68.5, 68.6, and 68.7 from RY 2007 and RY 2008 were re-numbered as Substandards 68.6, 68.7, 68.8, and 68.9, respectively, in the RY 2009 PEPS tool.

Substandards 71.3, 71.4, 71.5, and 71.6 from RY 2007 and RY 2008 were re-numbered as Substandards 71.5, 71.6, 71.7, and 71.8, respectively, in the RY 2009 PEPS tool.

**PEPS Standard 68:** 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.

**VBH** was “partially met” on Substandard 68.4 (RY 2008; numbered as Substandard 68.6 in RY 2009):

**Substandard 68.4:** The second level complaint case file includes documentation that the member was contacted about the second 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.



**VBH** was “not met” on Substandard 68.6 (RY 2008; numbered as Substandard 68.8 in RY 2009):

**Substandard 68.6:** 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.

**PEPS Standard 71:** Grievance and Fair Hearing rights and procedures are made known to EAP, members, BH MCO Staff and the provider network through manuals, training, handbooks, etc.

**VBH** was “partially met” on Substandard 71.3 (RY 2008):

**Substandard 71.3:** 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.

**VBH** was “not met” on Substandard 71.5 (RY 2008):

**Substandard 71.5:** 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 OMHSAS-specific Items relating to Enrollee Satisfaction are County-specific review standards. All three Items crosswalked to this category were evaluated for the 14 VBH Counties, and their statuses are presented in Tables 1.7a and 1.7b. Beaver, Fayette, Greene, and the Southwest Six Counties met all three Items. The NC/CO Counties had varying compliance.

**Table 1.7a OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for Beaver, Fayette, Greene, and the Southwest Six Counties**

Category	PEPS Item	Review Year	Status
<b>Enrollee Satisfaction</b>			
Consumer/Family Satisfaction	Standard 108.3	RY 2008	Met
	Standard 108.4	RY 2008	Met
	Standard 108.9	RY 2008	Met

**Table 1.7b OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for the NC/CO Counties**

Category	PEPS Item	Review Year	Status by County		
			Met	Partially Met	Not Met
<b>Enrollee Satisfaction</b>					
Consumer/Family Satisfaction	Standard 108.3	RY 2008	Crawford, Erie, Venango	Cambria, Mercer	
	Standard 108.4	RY 2008	Erie	Cambria, Crawford, Venango	Mercer
	Standard 108.9	RY 2008	Cambria, Erie	Crawford, Mercer, Venango	



**PEPS Standard 108:** 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.

***Cambria and Mercer Counties*** were “partially met” on Substandard 108.3:

**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.

***Cambria, Crawford, and Venango Counties*** were “partially met” on Substandard 108.4:

**Substandard 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.

***Crawford, Mercer and Venango Counties*** were “partially met” on Substandard 108.9:

**Substandard 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.



## 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 behavioral health agreement with OMHSAS, primary contractors (i.e., the Counties), along with the responsible subcontracted entities (i.e., BH MCOs) are required to conduct a minimum of two focused studies per year. The Counties 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 2011 for 2010 activities.

A new EQR PIP cycle began for BH MCOs and Counties in 2008. For this PIP cycle, OMHSAS again selected Follow-Up After Hospitalization for Mental Illness (FUH) as the PIP study topic to meet the EQR requirement. OMHSAS indicated that while some improvements were noted in the previous cycle, aggregate FUH rates have remained below the OMHSAS-established benchmark of 90%. FUH for the Medicaid Managed Care (MMC) population continues to be an area of interest for OMHSAS.

The 2011 EQR is the eighth review to include validation of PIPs. With this PIP cycle, all BH MCOs/Counties share the same baseline period and timeline. To initiate the PIP cycle in 2008, 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 with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness.

The BH MCOs are required by OMHSAS to submit their projects using the National Committee for Quality Assurance (NCQA™) Quality Improvement Activity (QIA) 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 nine review elements:

1. Project Topic, Type, Focus Area
2. Topic Relevance
3. Quality Indicators
4. Baseline Study Design and Analysis
5. Baseline Study Population
6. Interventions Aimed at Achieving Demonstrable Improvement
7. Demonstrable Improvement
- 1S. Subsequent or Modified Interventions
- 2S. Sustained Improvement

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last two relate 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

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 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 are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred through 2010. 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.

Point score allocation was modified for this PIP from the CMS protocol suggested points. Review Elements 1 (Project Title, Type, Focus Area) and 3 (Quality Indicators) were pre-determined by OMHSAS. Points for Element 1 were awarded based on BH MCO attendance on the Technical Assistance webinar conducted in October 2009 to discuss the new PIP cycle and the submission instructions for the project. Points will not be awarded for Element 3 because the indicators have been defined for the BH MCOs. These points have been reallocated to Elements 4 and 6. The point score reallocation for the FUH PIP is outlined in the scoring matrix in Table 2.2.

**Table 2.2 Review Element Scoring Weights**

Review Element	Standard	Scoring Weight
1	Project Title, Type, Focus Area	5%
2	Topic Relevance	5%
3	Quality Indicators	0%
4	Baseline Study and Analysis	20%
5	Baseline Study Population and Baseline Measurement Performance	10%
6	Interventions Aimed at Achieving Demonstrable Improvement	20%
7	Demonstrable Improvement	20%
<b>Total Demonstrable Improvement Score</b>		<b>80%</b>



Review Element	Standard	Scoring Weight
1S	Subsequent or modified Interventions Aimed at Achieving Sustained Improvement	5%
2S	Sustained Improvement	15%
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 information for review element six: Interventions Aimed at Achieving Demonstrable Improvement. VBH submitted the required element of the FUH PIP for review.

The project had previously received full credit for all elements through Baseline Study Population and Baseline Measurement Performance. Of these, Topic Selection had been pre-determined by OMHSAS and pre-populated by IPRO into QIA forms that were sent to the BH MCOs in August 2009. As outlined in the PIP submission guidelines, VBH received credit for Topic Selection by attending IPRO's Technical Assistance webinar held on October 5, 2009.

### Follow-up After Hospitalization for Mental Illness

OMHSAS selected Follow-up After Hospitalization for Mental Illness as the topic for the PIP for all BH MCOs and Counties. OMHSAS again prioritized this as an area in need of improvement based on cumulative findings from multiple performance measure and data collection activities. In addition to defining the topic, OMHSAS defined the study indicator based on the Healthcare Effectiveness Data Information Set (HEDIS<sup>®</sup>) Follow-up After Hospitalization measure, for both the seven and 30-day rates. The study indicator utilizes HEDIS specifications to measure the percentage of discharges for members six years and older who were hospitalized for treatment of selected mental health disorders, and who were seen on an ambulatory basis or were in day/night treatment with a mental health provider on the date of discharge up to seven days (Quality Indicator (QI) 1) and 30 days (QI 2) after hospital discharge. Two additional indicators are also calculated, which utilize the HEDIS specifications outlined above, and include additional Pennsylvania service codes to define ambulatory or day/night treatment for both the seven and 30-day rates (called QIs A and B, respectively). All indicators are updated annually as necessary to reflect any changes to HEDIS technical specifications. In addition, the PA-specific indicators (QIs A and B) are reviewed on an annual basis by OMHSAS, the Counties and BH MCOs for consideration of inclusion of additional codes. OMHSAS has determined that the rates calculated for Measurement Year (MY) 2008 using these four indicators are to be used as baseline measurements for all Counties/BH MCOs for the current PIP study cycle.

The rationale provided for this activity selection included discussion of the population's characteristics, the benefits of follow-up, BH MCO costs, the BH MCO's root cause analysis, and the BH MCO's literature review. VBH noted that MMC members who are hospitalized with a mental health diagnosis are a high-risk population. They represent the most seriously mentally ill patients and have high likelihood of re-hospitalization without proper follow-up. VBH listed factors associated with the diagnoses, some of which include impaired self-care, impaired judgment, high-risk behaviors and difficulty with compliance and structure. The MCO noted that during hospitalization symptoms are stabilized, and a plan for continuing care becomes a vital step towards recovery. VBH asserted that ambulatory follow-up is essential to ensure that progress made during hospitalization is not lost, and that it serves a number of functions: 1) promoting progress towards treatment goals, 2) facilitating continuity of care, and 3) helping to reduce the incidence of relapse.

VBH also discussed the BH MCO's increased costs associated with psychiatric hospitalization, noting an increase of 6% from Fiscal Year (FY) 2007/2008 to FY 2008/2009. VBH further indicated that for several Counties, inpatient readmission rates were inversely associated with seven- and 30-day follow-up rates;



high inpatient readmission rates were associated with lower rates of follow-up, while low readmission rates appeared to be associated with higher follow-up rates.

VBH cited that the recovery model embraced in PA, particularly in terms of involvement from consumers of mental health services, guided their activities. According to VBH, consumers are invested in their own health and recovery, and empowering them to care for themselves by following up with scheduled appointments helps to promote their recovery. VBH discussed the root cause analysis they conducted, which used a focus group format with consumers, family members, and County representatives at Consumer/Family Satisfaction Team (C/FST) trainings. This analysis led to the identification of three overall system areas having problems. The three system areas were identified as consumer/family issues, outpatient provider issues, and hospital/inpatient issues. Possible causes under each of these three overall system areas were also discussed during the C/FST trainings.

In conducting the literature review, VBH noted that support for ambulatory follow-up after an acute episode of care as an important quality of care issue. VBH indicated that the link from psychiatric inpatient treatment to outpatient aftercare treatment is a key component of their treatment recommendations, and an area of concern is assuring ongoing stability for those experiencing mental illness. VBH outlined some of the risks of not following up after discharge, noting that members may be: 1) more likely to be readmitted, 2) more likely to attempt or complete suicide, or endanger themselves or others, 3) more likely to be non-adherent to prescribed medications, 4) more likely to have the clinical gains made during inpatient treatment be undermined. Additionally, VBH listed some factors related to people being less likely to attend and/or engage in follow-up treatment after discharge, including: 1) being admitted to the hospital involuntarily or leaving the hospital against medical advice, 2) poor family and/or social support system, 3) co-occurring mental health and substance abuse diagnoses, 4) not being involved in outpatient services before the inpatient hospitalization, 5) having severe and persistent mental illness.

Baseline results were calculated in 2009 for the period January 1, 2008 through December 31, 2008 and were presented along with analysis that led to interventions initiated in late 2009. The baseline results indicated a rate of 40.6% for QI 1 (HEDIS – seven days), 65.8% for QI 2 (HEDIS – 30 days), 53.2% for QI A (PA-Specific – seven days), and 73.6% for QI B (PA-Specific – 30 days). VBH adopted the 2008 NCQA HEDIS follow-up measure means for seven and 30 days as the goals for the project indicators. For the HEDIS indicators, VBH's rate for QI 2 exceeded the goal. Although not directly comparable to HEDIS, rates for the two PA QIs (A and B) exceeded the goals. All four rates fell below the 90% benchmark. Following review of baseline data, and as part of the BH MCO's barrier analysis, VBH indicated that the root cause analysis/fishbone diagram was presented and discussed at all of VBH's County Quality Management (QM) Committees. Their QM Committee included representatives from the Counties, consumers, family members, providers, and staff from VBH's Quality, Clinical, and Networks departments, as well as associated Account Executives. FUH rates from MY 2008 (baseline) were presented and discussed. From these discussions, additional causes/barriers were identified, as well as possible interventions to improve future FUH rates. VBH also discussed individual County trends, particularly because the BH MCO's FUH rates had either remained steady or decreased from MY 2007 to MY 2008. Because fewer increases were found in the BH MCO's "newer" five Counties, VBH proposed that the lack of increase could possibly be attributed to the inclusion of these Counties in the overall rates. The BH MCO noted that, in these Counties, discussions of County-specific barriers to FUH were not completed prior to mid-2007 and, consequently, no corresponding interventions to improve FUH rates had been formally undertaken prior to then. Additionally, VBH used the combined root cause and barrier analyses to outline reasons why people do not follow up after discharge, or are not able or willing to attend their follow-up appointments. VBH observed that many of these factors are also supported in the literature.

Interventions Aimed at Achieving Demonstrable Improvement began in 2009 and continued into 2010. VBH conducted and utilized a number of analyses in addition to the combined root cause and barrier analyses in development of interventions to address barriers. VBH conducted an expanded root cause analysis (RCA) in July 2010 to help determine reasons why members may not be following up in a timely manner after discharge from an inpatient hospitalization. Additionally, VBH observed some differences among Counties regarding types of services and most common services utilized. VBH used these



results, the expanded RCA, and other analyses conducted throughout 2010 to develop action plans for the MCO and to address county differences. The MCO turned these action plans into interventions, which included: 1) improving access to psychiatrists through the implementation of telepsychiatry programs, particularly for more rural counties, 2) notification to outpatient providers that their patients have been hospitalized, 3) increasing utilization of peer support services and blended case management, and 4) improving provider awareness of the importance of follow-up after hospitalization and appropriate discharge planning via informational packets containing follow-up after hospitalization rates and available resource materials. For a number of these interventions, VBH also presented County-specific intervention activities. VBH indicated that new interventions implemented by the Counties would be added to the action plan and continue to be monitored by the MCO, as well as expanded to other Counties as applicable.

VBH received full credit for the element of the study evaluated that reflected activities in 2010 (Interventions Aimed at Achieving Demonstrable Improvement). Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement will be evaluated in 2012, based on activities conducted in late 2010 through mid-2011.

**Table 2.3 PIP Scoring Matrix:  
Follow-up After Hospitalization for Mental Illness**

Review Element	Compliance Level	Scoring Weight	Final Points Score
1. Project Title, Type, Focus Area	Full	5%	5
2. Topic Relevance	Full	5%	5
3. Quality Indicators	Full	0%	0
4. Baseline Study and Analysis (Calendar Year (CY) 2008, reported in CY 2009)	Full	20%	20
5. Baseline Study Population and Baseline Measurement Performance (CY 2008)	Full	10%	10
6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010)	Full	20%	20
7. Demonstrable Improvement (CY 2010, reported in 2011)	Not Determined	20%	TBD
<b>Total Demonstrable Improvement Score</b>			<b>TBD</b>
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Not Determined	5%	TBD
2S. Sustained Improvement (CY 2011, reported in 2012)	Not Determined	15%	TBD
<b>Total Sustained Improvement Score</b>			<b>TBD</b>
<b>Overall Project Performance Score</b>			<b>TBD</b>

**Table 2.4 PIP Year Over Year Results:  
Follow-up After Hospitalization for Mental Illness**

Project	2008	2009/2010	2010	2010/2011	Comparison Benchmark for Review Year
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge (Q1 1)	40.6%	NA	TBD	TBD	90%



Project	2008	2009/2010	2010	2010/2011	Comparison Benchmark for Review Year
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	65.8%	NA	TBD	TBD	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge. (Standard HEDIS Codes and PA codes) (QI A)	53.2%	NA	TBD	TBD	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge. (Standard HEDIS Codes and PA codes) (QI B)	73.6%	NA	TBD	TBD	90%
Project Status	Baseline Study	Interventions	Remeasurement #1	Remeasurement #2	

Note: Table remains unchanged from 2009 Review Year, as no rates were evaluated for the 2010 Review Year.



### III: PERFORMANCE MEASURES

---

In 2011, OMHSAS and IPRO conducted two EQR studies. Both the Follow-up After Hospitalization for Mental Illness and Readmission within 30 Days of Inpatient Psychiatric Discharge studies were re-measured.

#### **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 and BH MCO rates to available national benchmarks and to prior years' rates.

In MY 2002, the initial measurement year, IPRO and OMHSAS worked together to adapt the measures from the HEDIS methodology, allowing for a significant reduction in the time period needed for indicator development. Senior medical staff at IPRO reviewed the adapted methodology in detail to ensure consistency was maintained with regard to the specifications. Project management staff at both IPRO and OMHSAS also collaborated extensively during the indicator development phase, especially with regard to which local PA codes were considered for inclusion in the list of qualifying procedure codes, while still maintaining consistency with the HEDIS measure specifications. In addition to the adapted indicators, OMHSAS expanded the measures to include services with high utilization in the HealthChoices Behavioral Health Program. For MY 2002, since two codes of interest could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits, QI 3 and QI 4 were developed to capture these codes, while still generating rates for measures (i.e., QIs 1 and 2) that could be compared to national benchmarks. For the second re-measure in MY 2004, the indicator specifications were updated to reflect changes in the HEDIS 2005 Volume 2, Technical Specifications and four more local codes were added – to bring the total to six – to QIs 3 and 4. OMHSAS staff provided IPRO with a PA local code to national code mapping document to assist in this regard. The MY 2005 re-measure saw very few changes to the measure specifications, of which the main change to the methodology involved the exclusion of an expired PA local code. The MY 2006 re-measure, however, saw significant changes to QI 3 and QI 4 from prior years. 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 updated 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 – Lackawanna, Luzerne, Susquehanna, and Wyoming. These Counties were asked to collect data for the six-month time frame that they were in service for 2006 (July to December). In effect, MY 2006 was a baseline measurement year for collection of QIs A and B, and for the Northeast region across all indicators.

For MY 2007, the indicator specifications were updated to reflect changes in the HEDIS 2008 Volume 2, Technical Specifications. The primary change was the addition of a Place of Service (POS) code requirement to select Current Procedural Terminology (CPT) codes in the HEDIS and PA-specific measure specifications. In addition, all PA local codes previously mapped to standard CPT and Healthcare Common Procedure Coding System (HCPCS) codes as per HIPAA requirements were retired and removed. For the study, the follow-up measure was implemented for the 23 North/Central State Option Counties implemented in January 2007, and the 15 North/Central County Option Counties implemented in July 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 (July to December).

For MY 2008, indicator specifications were again aligned to the HEDIS 2009 Volume 2, Technical Specifications. Two Diagnosis Related Group (DRG) codes were removed, and one Universal/Uniform Billing (UB) type of bill code was added to the criteria to identify non-acute care exclusions. Additionally, five POS codes were added to select CPT codes. Two procedure codes (one CPT and one HCPCS code) to identify eligible follow-up visits were added to the PA-specific measures per suggestions from OMHSAS, the Counties, and the BH MCOs. These codes were added to the existing 17 PA-specific codes, totaling 19 additional service codes that distinguish the PA-specific measure from the HEDIS measure in the MY 2008 study. Furthermore, as requested by OMHSAS, the MY 2008 findings by age are 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 studies including MY 2007. As a result, the population previously reported as two cohorts are combined for comparative purposes.

For MY 2009, indicators in the study had few changes based on the HEDIS 2010 Volume 2: Technical Specifications. The primary change was the removal of CPT codes that were no longer valid, and the addition of several HCPCS codes. As requested by OMHSAS, all data analyses by region were removed, since the regional characteristics have become increasingly geographically diverse and the associated Counties are non-contiguous as the HealthChoices program has expanded beyond the initial legacy regions (Leigh/Capital, Southeast, and Southwest) over the years of re-measuring this performance indicator.

For the current study, indicators again 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. In all, MY 2010 is the fourth re-measurement for QIs A and B, and is the third re-measurement for the Counties in the North/Central County and State Options regions across all indicators.

### **Measure Selection and Description**

In accordance with DPW 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 67 Counties participating in the MY 2010 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, 2010;
- 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.

## I: HEDIS 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 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)<sup>i</sup>. 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<sup>ii,iii</sup> such as obesity, cardiovascular



diseases and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns<sup>iv,v</sup>, reduced use of preventive services<sup>vi</sup> and substandard medical care that they receive<sup>vii,viii,ix</sup>. Moreover, these patients are five times more likely to become homeless than those without these disorders<sup>x</sup>. On the whole, serious mental illnesses account for more than 15 percent of overall disease burden in the U.S.<sup>xi</sup>, 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<sup>xii</sup>. 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<sup>xiii</sup>. 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<sup>xiv</sup>. 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<sup>xv</sup>. 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<sup>xvi</sup>. 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<sup>xvii</sup>.

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long standing 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<sup>xviii</sup>. 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<sup>xix</sup>. 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<sup>xx</sup>. 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<sup>xxi</sup>. Patients with higher functioning in turn had significantly lower community costs, and improved provider continuity was associated with lower hospital<sup>xxii</sup> and Medicaid costs<sup>xxiii</sup>.

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<sup>xxiv</sup>. 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.

## **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 County 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**

Performance goals were set for this review year at the OMHSAS designated gold standard of 90% for all measures. In addition, the HEDIS measures were compared to industry benchmarks, in that the aggregate and BH MCO indicator rates were compared to the *HEDIS 2010 Audit Means, Percentiles and Ratios*. These benchmarks contained means, 10<sup>th</sup>, 25<sup>th</sup>, 50<sup>th</sup> (median), 75<sup>th</sup> and 90<sup>th</sup> percentiles, and the enrollment ratios for nearly all HEDIS measures. There were tables published by product line (i.e., Commercial, Medicaid, and Medicare). The appropriate Medicaid benchmarks available for the



measurement year were used for comparison. As indicated previously, the PA-specific measures were not comparable to these industry benchmarks.

### 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 overall, or aggregate, performance rate for each indicator was the total numerator divided by the total denominator. 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 2009 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.

### Findings

#### BH MCO and County Results

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

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

**Table 3.1 MY 2010 HEDIS Indicator Rates with Year-to-Year Comparisons**

	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI 1										
HealthChoices	17,109	37,093	46.1%	45.6%	46.6%	45.4%	48.9%	45.6%	0.5	NO
VBH	3,083	6,949	44.4%	43.2%	45.5%			44.4%	0.0	NO
Armstrong	109	223	48.9%	42.1%	55.7%			50.9%	-2.0	NO
Beaver	275	539	51.0%	46.7%	55.3%			55.0%	-4.0	NO
Butler	189	383	49.4%	44.2%	54.5%			55.0%	-5.6	NO



	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
Cambria	146	513	28.5%	24.5%	32.5%			30.7%	-2.2	NO
Crawford	188	398	47.2%	42.2%	52.3%			49.2%	-2.0	NO
Erie	519	1,259	41.2%	38.5%	44.0%			35.0%	6.2	YES
Fayette	260	592	43.9%	39.8%	48.0%			46.0%	-2.1	NO
Greene	84	210	40.0%	33.1%	46.9%			43.0%	-3.0	NO
Indiana	118	212	55.7%	48.7%	62.6%			55.1%	0.6	NO
Lawrence	153	308	49.7%	43.9%	55.4%			48.6%	1.1	NO
Mercer	190	459	41.4%	36.8%	46.0%			44.7%	-3.3	NO
Venango	90	213	42.3%	35.4%	49.1%			40.2%	2.1	NO
Washington	253	594	42.6%	38.5%	46.7%			43.7%	-1.1	NO
Westmoreland	509	1,046	48.7%	45.6%	51.7%			44.6%	4.1	NO
QI 2										
HealthChoices	24,820	37,093	66.9%	66.4%	67.4%	66.2%	72.5%	65.6%	1.3	YES
VBH	4,750	6,949	68.4%	67.3%	69.5%			68.5%	-0.1	NO
Armstrong	175	223	78.5%	72.9%	84.1%			75.2%	3.3	NO
Beaver	388	539	72.0%	68.1%	75.9%			72.7%	-0.7	NO
Butler	266	383	69.5%	64.7%	74.2%			74.8%	-5.3	NO
Cambria	264	513	51.5%	47.0%	55.9%			55.8%	-4.3	NO
Crawford	284	398	71.4%	66.8%	75.9%			72.8%	-1.4	NO
Erie	831	1,259	66.0%	63.3%	68.7%			62.8%	3.2	NO
Fayette	389	592	65.7%	61.8%	69.6%			70.3%	-4.6	NO
Greene	136	210	64.8%	58.1%	71.5%			67.2%	-2.4	NO
Indiana	162	212	76.4%	70.5%	82.4%			75.2%	1.2	NO
Lawrence	240	308	77.9%	73.1%	82.7%			75.3%	2.6	NO
Mercer	321	459	69.9%	65.6%	74.2%			70.5%	-0.6	NO
Venango	151	213	70.9%	64.6%	77.2%			70.1%	0.8	NO
Washington	407	594	68.5%	64.7%	72.3%			67.5%	1.0	NO
Westmoreland	736	1,046	70.4%	67.5%	73.2%			68.4%	2.0	NO

The MY 2010 HealthChoices behavioral health rates were 46.1% for QI 1 and 66.9% for QI 2. The QI 2 rate was statistically significantly higher than MY 2009. VBH's MY 2010 QI 1 rate was 44.4% and QI 2 rate was 68.4%. Neither rate statistically significantly differed from the prior year.

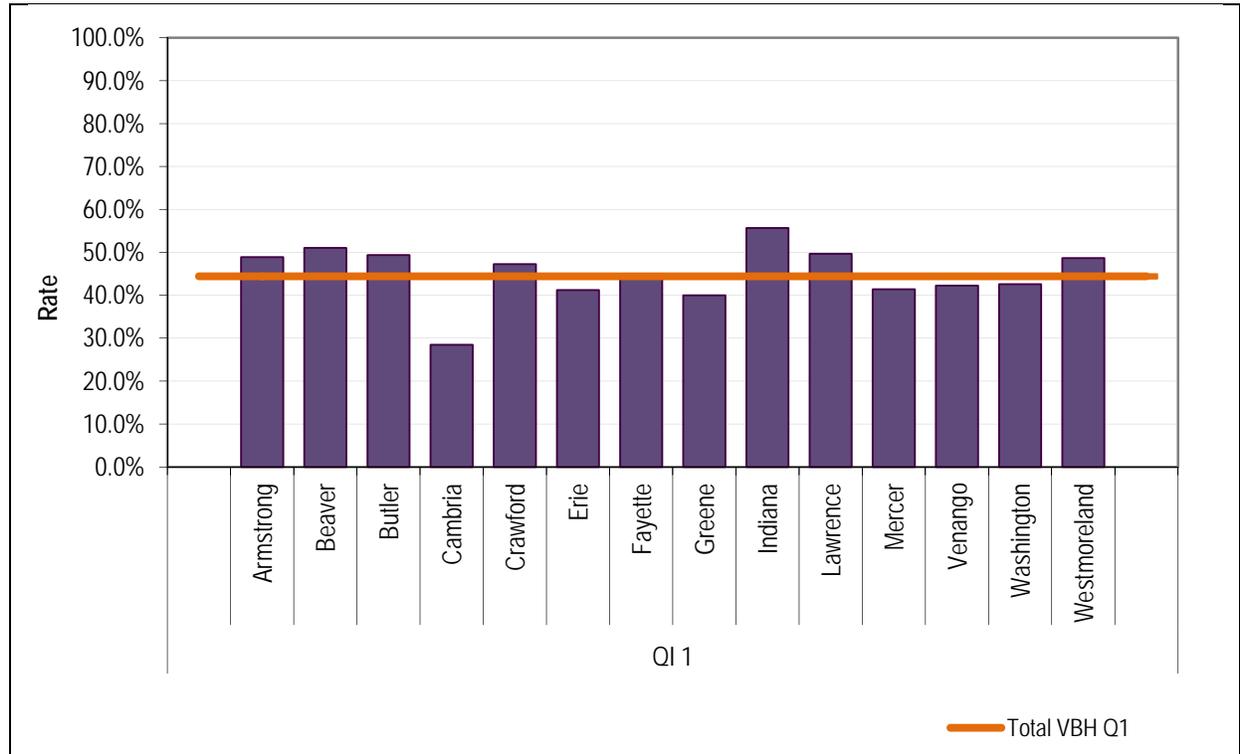
For MY 2010, VBH's QI 1 rate of 44.4% was comparable to (i.e., not statistically significantly different from) the MY 2010 QI 1 HealthChoices BH MCO Average of 45.4%. The MY 2010 QI 2 rate of 68.4%, on the other hand, was statistically significantly higher than the MY 2010 QI 2 HealthChoices BH MCO Average of 66.2% by 2.2 percentage points.

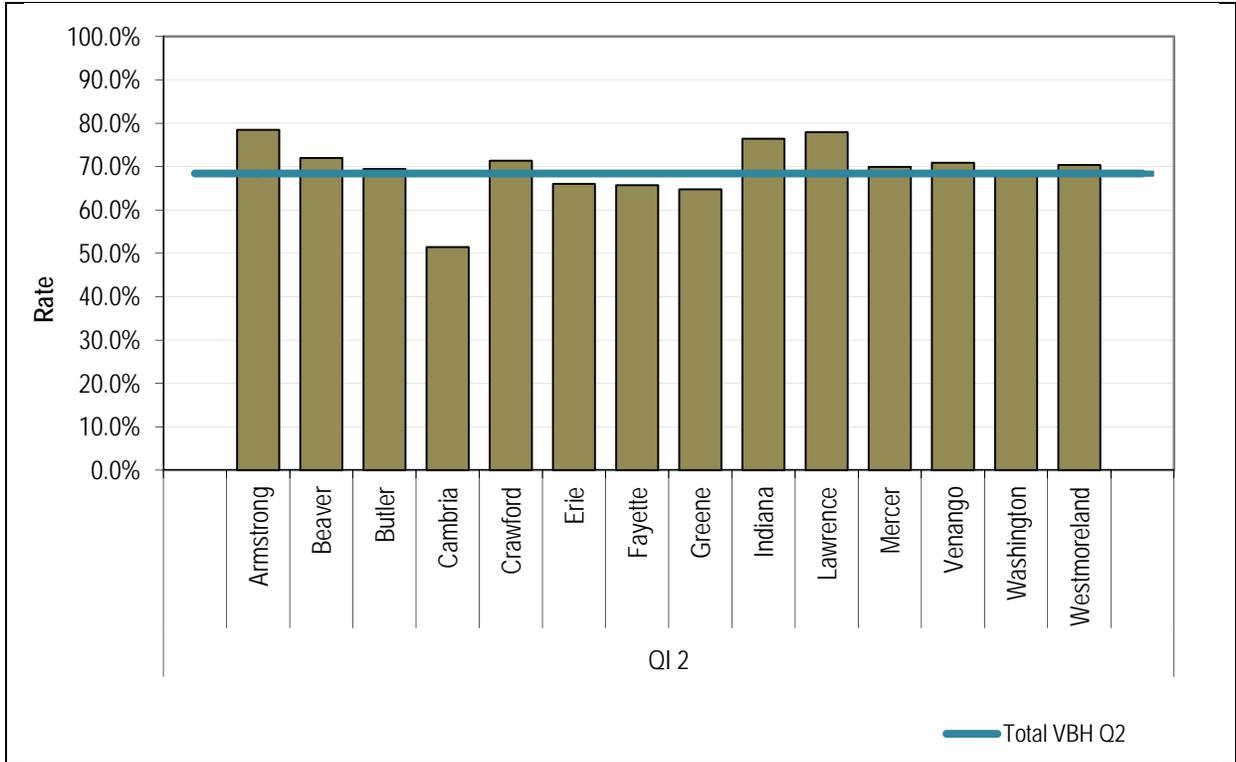


As presented in Table 3.1, the QI 1 rate for Erie County statistically significantly increased between MY 2009 and MY 2010. All other County rate changes for QI 1 and QI 2 were not statistically significant.

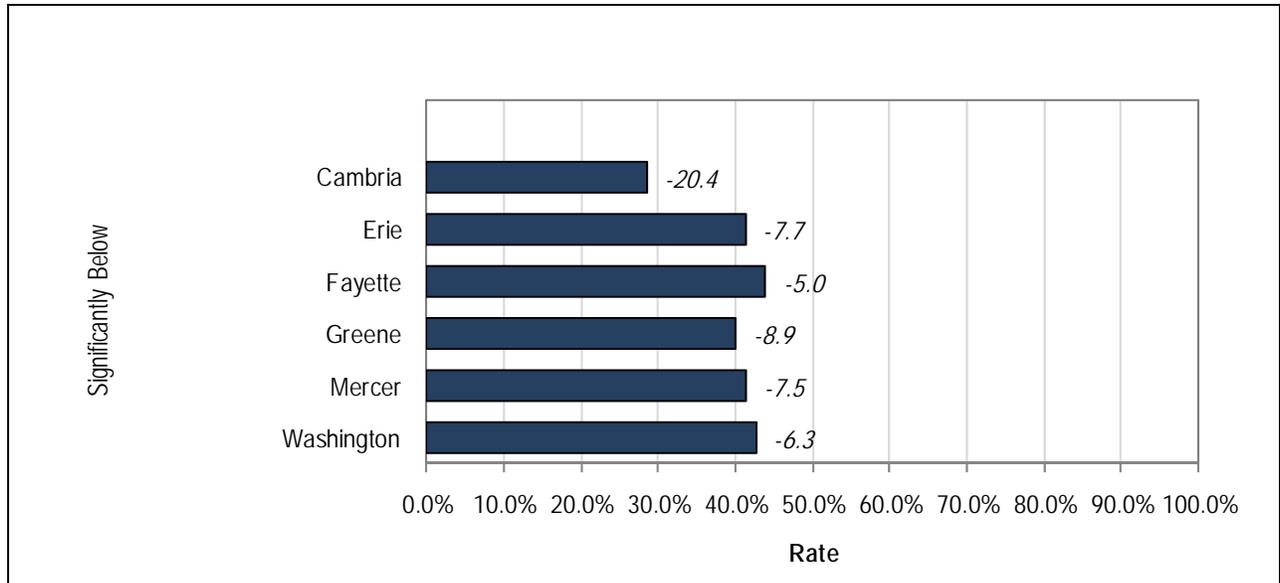
Figure 3.1 displays a graphical representation of the MY 2010 HEDIS follow-up rates for VBH and its respective Counties. Figure 3.2 presents the individual VBH Counties that performed statistically significantly above or below the MY 2010 QI 1 and QI 2 HealthChoices County Averages.

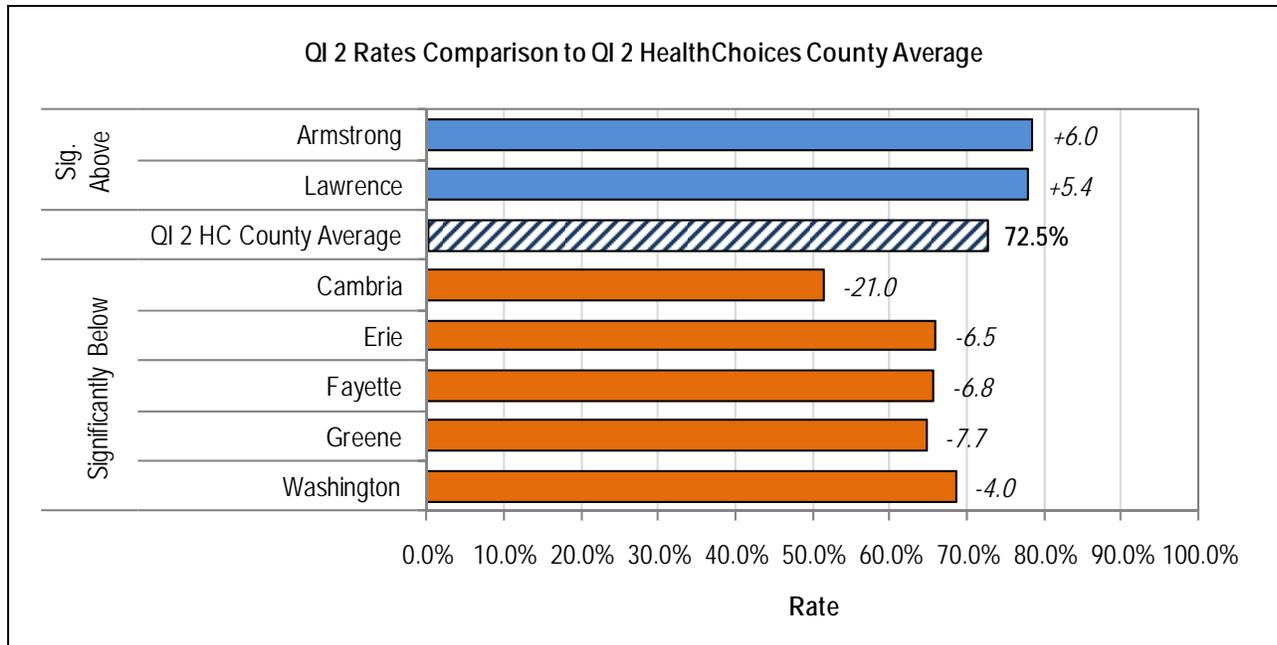
**Figure 3.1 MY 2010 HEDIS Indicator Rates**





**Figure 3.2 MY 2010 HEDIS County Rates Compared to HealthChoices County Average**





In MY 2010, six VBH Counties (Cambria, Erie, Fayette, Greene, Mercer, and Washington) performed statistically significantly below the MY 2010 QI 1 HealthChoices County Average of 48.9%. For QI 2, two Counties (Armstrong and Lawrence) performed statistically significantly above, while five Counties (Cambria, Erie, Fayette, Greene, and Washington) had rates statistically significantly lower than the MY 2010 QI 2 HealthChoices County Average of 72.5%.

**Table 3.2 MY 2010 PA-Specific Indicator Rates with Year-to-Year Comparisons**

	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI A										
HealthChoices	21,551	37,093	58.1%	57.6%	58.6%	57.5%	60.6%	58.9%	-0.8	YES
VBH	3,951	6,949	56.9%	55.7%	58.0%			57.5%	-0.6	NO
Armstrong	134	223	60.1%	53.4%	66.7%			61.9%	-1.8	NO
Beaver	308	539	57.1%	52.9%	61.4%			62.1%	-5.0	NO
Butler	249	383	65.0%	60.1%	69.9%			69.4%	-4.4	NO
Cambria	203	513	39.6%	35.2%	43.9%			42.1%	-2.5	NO
Crawford	212	398	53.3%	48.2%	58.3%			56.1%	-2.8	NO
Erie	755	1,259	60.0%	57.2%	62.7%			57.5%	2.5	NO
Fayette	307	592	51.9%	47.8%	56.0%			54.9%	-3.0	NO
Greene	134	210	63.8%	57.1%	70.5%			64.5%	-0.7	NO
Indiana	133	212	62.7%	56.0%	69.5%			72.0%	-9.3	NO
Lawrence	194	308	63.0%	57.4%	68.5%			61.0%	2.0	NO



	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
Mercer	239	459	52.1%	47.4%	56.7%			52.9%	-0.8	NO
Venango	99	213	46.5%	39.5%	53.4%			45.6%	0.9	NO
Washington	338	594	56.9%	52.8%	61.0%			56.5%	0.4	NO
Westmoreland	646	1,046	61.8%	58.8%	64.8%			58.4%	3.4	NO
<b>QI B</b>										
<b>HealthChoices</b>	27,679	37,093	74.6%	74.2%	75.1%	74.1%	78.9%	75.0%	-0.4	NO
<b>VBH</b>	5,299	6,949	76.3%	75.3%	77.3%			76.3%	0.0	NO
Armstrong	184	223	82.5%	77.3%	87.7%			80.7%	1.8	NO
Beaver	414	539	76.8%	73.2%	80.5%			78.5%	-1.7	NO
Butler	303	383	79.1%	74.9%	83.3%			81.3%	-2.2	NO
Cambria	326	513	63.6%	59.3%	67.8%			63.8%	-0.2	NO
Crawford	299	398	75.1%	70.8%	79.5%			75.1%	0.0	NO
Erie	984	1,259	78.2%	75.8%	80.5%			78.1%	0.1	NO
Fayette	430	592	72.6%	69.0%	76.3%			76.2%	-3.6	NO
Greene	168	210	80.0%	74.4%	85.6%			79.0%	1.0	NO
Indiana	168	212	79.3%	73.6%	84.9%			84.4%	-5.1	NO
Lawrence	253	308	82.1%	77.7%	86.6%			79.1%	3.0	NO
Mercer	347	459	75.6%	71.6%	79.6%			73.6%	2.0	NO
Venango	154	213	72.3%	66.1%	78.5%			71.6%	0.7	NO
Washington	450	594	75.8%	72.2%	79.3%			73.4%	2.4	NO
Westmoreland	819	1,046	78.3%	75.8%	80.8%			76.9%	1.4	NO

The MY 2010 HealthChoices behavioral health rates were 58.1% for QI A and 74.6% for QI B. The year-to-year decrease from MY 2009 was statistically significant for QI A. VBH's MY 2010 QI A rate of 56.9% and QI B rate of 76.3% were comparable to (i.e., not statistically significantly different from) MY 2009 rates.

For MY 2010, VBH's QI A rate (56.9%) was not statistically significantly different from the QI A HealthChoices BH MCO Average of 57.5%, but the QI B rate (76.3%) was statistically significantly higher than the QI B HealthChoices BH MCO Average of 74.1% by 2.2 percentage points. As presented in Table 3.2, none of the year-to-year County rate changes were statistically significant.

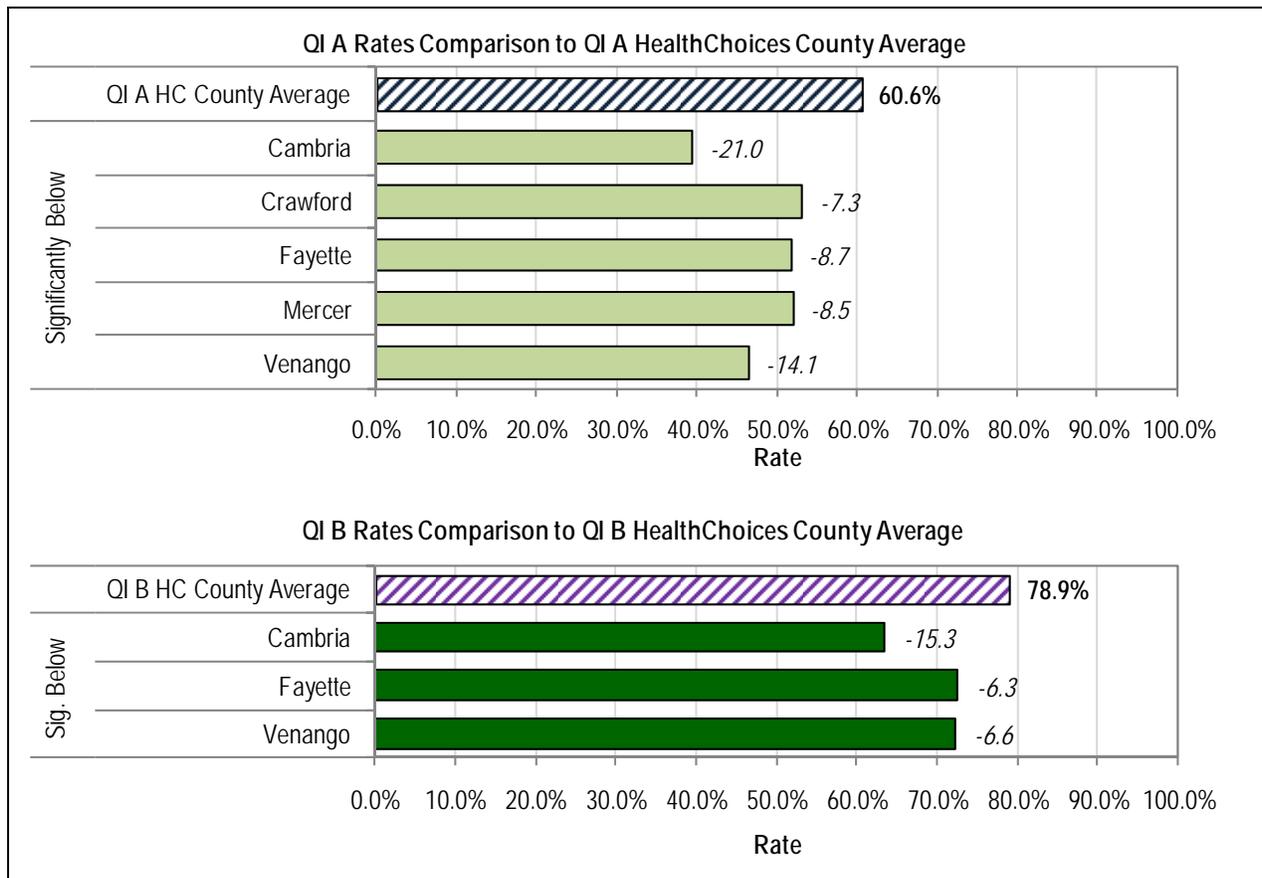
Figure 3.3 displays a graphical representation of the MY 2010 PA-specific follow-up rates for VBH and its associated Counties. Figure 3.4 presents the individual VBH Counties that performed statistically significantly above or below the MY 2010 QI A and QI B HealthChoices County Averages. In MY 2010, the QI A rates for five VBH Counties (Cambria, Crawford, Fayette, Mercer, and Venango) were statistically significantly below the MY 2010 QI A HealthChoices County Average of 60.6%. For QI B, the MY 2010 rate for Cambria, Fayette, and Venango Counties were statistically significantly below the MY 2010 QI B HealthChoices County Average of 78.9%. Rates for the remaining Counties did not differ statistically significantly from the respective HealthChoices behavioral health averages.

**Figure 3.3 MY 2010 PA-Specific Indicator Rates**





**Figure 3.4 MY 2010 PA-Specific County Rates Compared to HealthChoices County Average**



**Comparison to HEDIS® Medicaid Benchmarks**

The HealthChoices HEDIS indicator rates and BH MCO rates were compared to the *HEDIS 2010 Audit Means, Percentiles and Ratios* published by NCQA. The reference rates for national normative data contain means, 10<sup>th</sup>, 25<sup>th</sup>, 50<sup>th</sup>, 75<sup>th</sup> and 90<sup>th</sup> percentiles, and the enrollment ratios for nearly all HEDIS measures. There are tables by product lines (i.e., Commercial, Medicaid, and Medicare), so that the appropriate Medicaid benchmarks were used for comparison. NCQA’s means and percentiles for each product line are generated annually using HMO, POS, and HMO/POS combined products from BH MCOs that underwent a HEDIS Compliance Audit™. Data were included from BH MCOs, regardless of whether the BH MCO did or did not report individual HEDIS rates publicly. The means and percentiles displayed in the *HEDIS 2010 Audit Means, Percentiles and Ratios* tables are based on data from the 2009 measurement year. The benchmark values are presented in Table 3.3.

**Table 3.3 HEDIS 2010 Medicaid Benchmarks**

MEDICAID	SUMMARY STATISTICS FOR RATES ACROSS MCOS					
	MEAN	10TH %ILE	25TH %ILE	MEDIAN	75TH %ILE	90TH %ILE
Follow-up After Hospitalization for Mental Illness – 7 Days	42.9	18.2	29.6	43.5	59.1	64.3
Follow-up After Hospitalization for Mental Illness – 30 Days	60.2	31.8	49.0	62.6	74.3	83.6



For MY 2010, the HealthChoices behavioral health rates were 46.1% for QI 1 and 66.9% for QI 2. As compared to the HEDIS 2010 Medicaid benchmarks, the rates for both QI 1 and QI 2 fell between the 50<sup>th</sup> and 75<sup>th</sup> percentiles. In MY 2009, the QI 1 rate of 45.6% and QI 2 rate of 65.6% also fell between the 50<sup>th</sup> and 75<sup>th</sup> percentiles of the HEDIS 2009 Medicaid benchmarks.

When comparing the MY 2010 VBH rates to the HEDIS 2010 benchmarks, the QI 1 rate of 44.4% and QI 2 rate of 68.4% fell between the 50<sup>th</sup> and 75<sup>th</sup> percentiles. In MY 2009, VBH's QI 1 rate of 44.4% fell between the 25<sup>th</sup> and 50<sup>th</sup> percentiles, while the QI 2 rate of 68.5% fell between the 50<sup>th</sup> and 75<sup>th</sup> percentile ranges of the HEDIS 2009 benchmarks.

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the Follow-up After Hospitalization for Mental Illness EQR final report.

### **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 2011 study, which represented results for MY 2010, the following general recommendations were made to all five participating BH MCOs:

**Recommendation 1:** The purpose of this re-measurement study is to inform OMHSAS, the Counties and the BH MCOs of the effectiveness of the interventions implemented between MY 2009 and MY 2010 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 Counties 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 2009 and MY 2008. The Counties 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.

**Recommendation 2:** The findings of this re-measurement indicate that disparities in rates between demographic populations continue to persist as seen in prior studies. It is clear that the OMHSAS contracted Counties and their subcontracted BH MCOs are working to improve their overall follow-up rates, but it is important for these entities to continue to target the demographic populations that do not perform as well as their counterparts. Furthermore, it is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. It is recommended that BH MCOs and Counties 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. Additionally, the BH MCOs should be encouraged to initiate targeted interventions to address disparate rates between study populations.

**Recommendation 3:** BH MCO and Counties are encouraged to review the findings of the follow-up study in conjunction with inpatient psychiatric readmission rates, as professional literature consistently indicate a high correlation between these measures. 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.

**Recommendation 4:** Additional analyses of each BH MCO's data should be conducted in order to determine if any other trends are noted. For example, lower follow-up rates may be associated with individuals with particular diagnoses, or with co-occurring conditions such as substance abuse and/or



addiction. After evaluating the BH MCO data for trends, subject-specific findings should be transmitted to BH MCO and/or County care managers for implementation of appropriate action.

Additional recommendations for the 67 Counties and their subcontracted MCOs can be found in the 2011 Follow-up After Hospitalization for Mental Illness EQR final report.

## **Readmission within 30 Days of Inpatient Psychiatric Discharge**

In addition to Follow up After Hospitalization for Mental Illness, OMHSAS elected to 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. Similarly, in 2010, a re-measurement study was conducted on MY 2009 data. The MY 2010 study conducted in 2011 was the fourth re-measurement of this indicator, and the indicator specification had no significant changes as compared to MY 2009. This measure continued to be of interest to OMHSAS for the purposes of comparing County and BH MCO rates to the OMHSAS performance goal and to baseline 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 participating in the MY 2010 study.

Eligible cases were defined as those members in the HealthChoices 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, 2010;
- 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.



## 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.**

## Findings

### BH MCO and County Results

The results are presented at the BH MCO and then County level when multiple Counties contract with a single BH MCO. Year-to-year comparisons of MY 2010 to MY 2009 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 below the average are indicated. The average takes the sum of the individual rates and divides the sum by the total number of sub-groups within the category. Therefore, all averages presented in this study are *not* weighted. 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, County, and region rates are *not* required to be statistically significantly below 10.0% in order to meet the performance measure goal.

**Table 3.4 MY 2010 Readmission Rates with Year-to-Year Comparisons**

	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
HealthChoices	5,957	48,884	12.2%	11.9%	12.5%	12.4%	10.3%	12.1%	0.1	NO
VBH	878	8,342	10.5%	9.9%	11.2%			11.2%	-0.7	NO
Armstrong	34	272	12.5%	8.4%	16.6%			12.8%	-0.3	NO
Beaver	50	652	7.7%	5.6%	9.8%			9.0%	-1.3	NO
Butler	54	485	11.1%	8.2%	14.0%			10.6%	0.5	NO
Cambria	74	638	11.6%	9.0%	14.2%			13.7%	-2.1	NO
Crawford	38	466	8.2%	5.6%	10.7%			10.7%	-2.5	NO
Erie	201	1,476	13.6%	11.8%	15.4%			12.2%	1.4	NO
Fayette	54	671	8.1%	5.9%	10.2%			8.3%	-0.2	NO
Greene	22	237	9.3%	5.4%	13.2%			13.7%	-4.4	NO
Indiana	26	252	10.3%	6.4%	14.3%			12.1%	-1.8	NO
Lawrence	49	398	12.3%	9.0%	15.7%			10.9%	1.4	NO
Mercer	33	510	6.5%	4.2%	8.7%			9.2%	-2.7	NO
Venango	39	288	13.5%	9.4%	17.7%			11.7%	1.8	NO
Washington	81	760	10.7%	8.4%	12.9%			11.7%	-1.0	NO
Westmoreland	123	1,237	9.9%	8.2%	11.6%			12.0%	-2.1	NO



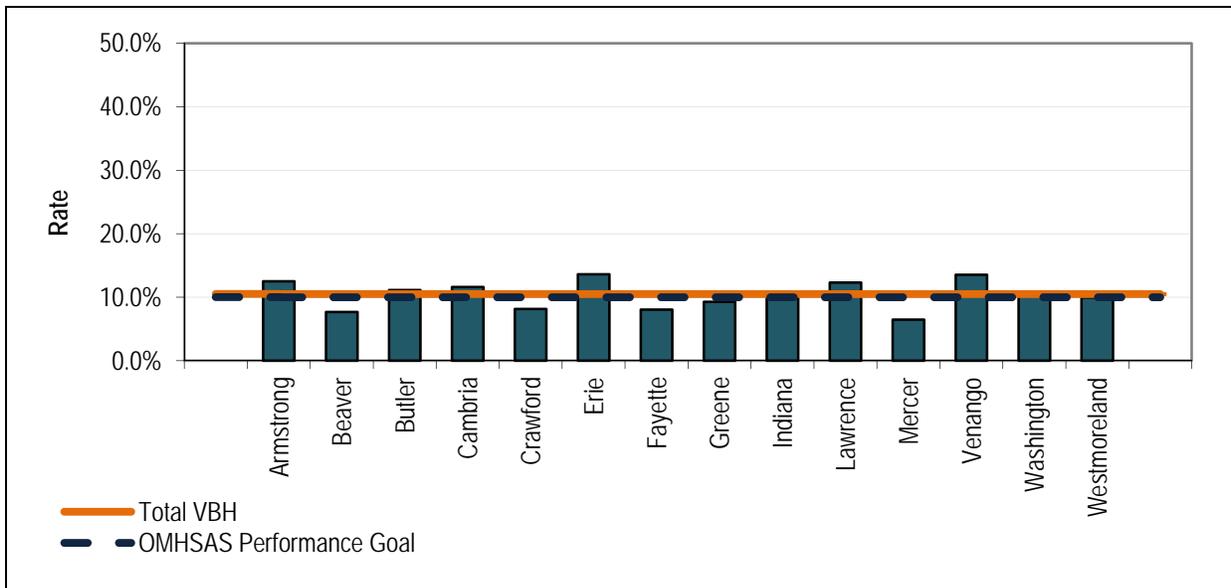
The aggregate MY 2010 HealthChoices readmission rate was 12.2%. VBH's MY 2010 rate of 10.5% did not differ from the MY 2009 rate, but was statistically significantly below (better than) the MY 2010 HealthChoices BH MCO Average of 12.4% by 1.9 percentage points. The rate did not meet the designated performance goal. Note that this measure is an inverted rate, in that lower rates are preferable.

As presented in Table 3.4, year-to-year County rate changes were not statistically significant. For MY 2010, rates for six VBH Counties (Beaver, Crawford, Fayette, Greene, Mercer, and Westmoreland) met the performance goal of 10.0%.

In MY 2010, the rates for Beaver, Fayette, and Mercer Counties were statistically significantly lower (better), while the rate for Erie County was statistically significantly higher (poorer) than the MY 2010 HealthChoices County Average of 10.3%. Note that this measure is an inverted rate, in that lower rates are preferable. The readmission rates for the remaining 10 VBH Counties did not statistically significantly differ from the MY 2010 HealthChoices County Average.

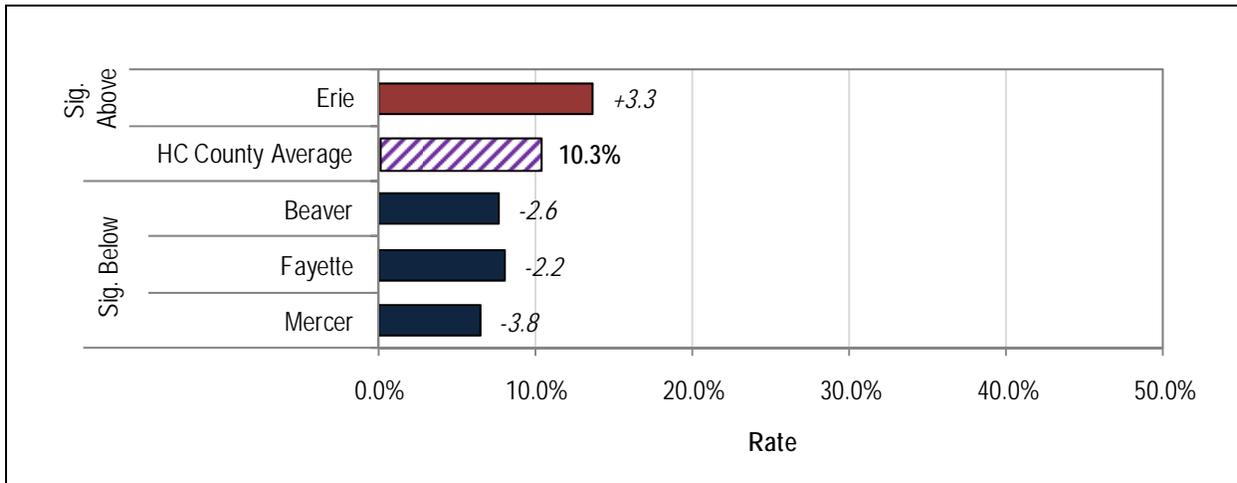
Figure 3.5 provides a graphical presentation of the MY 2010 readmission rates for VBH and its associated counties. Figure 3.6 displays percentage point differences for the individual VBH Counties that performed statistically significantly higher or lower than the MY 2010 HealthChoices County Average.

**Figure 3.5 MY 2010 Readmission Rates**





**Figure 3.6 MY 2010 Readmission Rates Compared to HealthChoices County Average**



### Conclusion and Recommendations

The study concluded that continued efforts should be made to improve performance with regard to Readmission within 30 Days of Inpatient Psychiatric Discharge, particularly for those BH MCOs such as VBH 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 Readmission within 30 Days of Inpatient Psychiatric Discharge final report.

In response to the MY 2010 study, the following general recommendations were made to all five participating BH MCOs:

- Given that no significant improvement was noted for any of the BH MCOs, IPRO recommends that the Counties 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 Counties are encouraged to review the findings of the readmission study in conjunction with follow-up after hospitalization rates.
- Given the statistically different readmission rates observed for Black/African American and the White populations, which is driven by the Philadelphia County population, IPRO recommends that a performance improvement project that focuses on Disparities in Healthcare, with a focus on Philadelphia County, be undertaken. Fifty-six percent of all African American discharges occur in Philadelphia County.
- IPRO recommends continued annual evaluation of Inpatient Readmission after Psychiatric Discharge rates for OMHSAS contracted Counties 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.
- Considerable variation by county was observed for all of the BH MCOs. BH MCOs should evaluate individual County rates, explore the underlying causes of variance by County, and identify those County practices or systems that may contribute to lower readmission rates.

## IV: 2010 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 2010 EQR Technical Reports, which were distributed in March 2011. The 2011 EQR Technical Report is the fourth report to include descriptions of current and proposed interventions from each BH MCO that address the 2010 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, 2011 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 October 2011, 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	MCO Response	
<b>Structure and Operations Standards</b>			
VBH 1	Within Subpart C: Enrollee Rights and Protections Regulations, VBH was partially compliant on one of seven categories – Enrollee Rights.	<p>a) quarterly submission to OMHSAS: 1<sup>st</sup> Quarter May 15<sup>th</sup> 2<sup>nd</sup> Quarter August 15<sup>th</sup> 3<sup>rd</sup> Quarter November 15<sup>th</sup> 4<sup>th</sup> Quarter February 15<sup>th</sup> Annual Review March 1<sup>st</sup></p> <p>b) training and business meetings June and July 2011, new survey began July 1, 2011</p>	<p><u>Files and attachments submitted by VBH</u></p>  <p>VBH Attachments</p> <p><u>Follow Up Actions Taken Through 09/30/11</u> <u>PEPS Standard 108:</u></p> <p>a) Consumer/Family Satisfaction Team (CFST) quarterly reports compiled by VBH-PA are submitted to Office of Mental Health and Substance Abuse (OMHSAS). The reports are reviewed by each of the County Quality Management Committees and included in the Annual Summary Review.</p> <p>b) As a response to the proposed revisions of Appendix L, VBH-PA worked with their counties' CFSTs to revise their survey items and database to reflect the recovery orientation of the proposed Appendix L revisions. The C/FST Training &amp; Business Meetings were held June 9, 2011 in New Castle and June 17, 2011 in Trafford. During the business portion of the meeting, the</p>



Reference Number	Opportunity for Improvement	MCO Response	
		<p>c) PEPS submitted to OMHSAS Lawrence 09/09/09 Armstrong Indiana July 2009 Mercer 5/10/2010</p> <p>a) 2011 Annual HealthChoices review to be scheduled by OMHSAS before 5/31/12</p>	<p>new C/FST survey was reviewed. The new survey began July 1, 2011.</p> <p>c) A review of sub standards by county determined to be in partial compliance are summarized in <b>Attachment (7)</b>. There are a total of 23 occurrences of a substandard listed as partially met. Of these, 7 required corrective action plans (CAPS) as a result of the DPW HealthChoices Annual Review; sixteen did not require corrective action plans.</p> <p><b>Attachments (2) (3) (4) for CAPS submitted</b></p> <hr/> <p><b>Future Actions Planned</b> 2011 Annual HealthChoices review to be scheduled by OMHSAS before 5/31/12</p> <p>a) PEPS 108 Substandard 7 was listed as partially compliant for Armstrong/Indiana, Butler, Lawrence, Washington and Westmoreland Counties. The quarterly reports to OMHSAS include numeric results by level of care, and narrative information about trends and actions taken on behalf of individual consumers. Beginning in 4<sup>th</sup> quarter 2011 the reports will also include numeric surveys by provider.</p> <p>b) Continue monthly, quarterly, and annual data reporting with new survey to Quality Management Committees (QMCs), and OMHSAS. <b>Attachments (5) (6) for QMC example schedules</b></p> <p>c) CAPS for Armstrong/Indiana CFST, Lawrence County CFST, and Mercer County CFST have been submitted to OMHSAS and will be monitored in the 2011 onsite Annual HealthChoices Review.</p>
VBH 2	<p>VBH was partially compliant on five of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were:</p> <ol style="list-style-type: none"> <li>1) Availability of Services (Access to Care),</li> <li>2) Coordination and Continuity of Care,</li> <li>3) Coverage and Authorization of Services,</li> <li>4) Practice Guidelines, and</li> <li>5) Quality Assessment and Performance Improvement Program.</li> </ol>	<p><b>28 Substandard 1:</b></p> <p>a) All action plan steps are ongoing and documented daily in Care Connect.</p> <p>b) Trainings are ongoing and provided 2<sup>nd</sup> Thursday of every monthly after Clinical Advisory Committee meetings</p> <p>c) Quality of Care referrals are taken from clinical staff on an ongoing basis and appropriate investigation and follow up occurs through the Quality of Care</p>	<p><b>Follow Up Actions Taken Through 09/30/11</b></p> <p><b>1) Access to Care</b> <b>PEPS 28</b></p> <p><b>Substandard 1:</b> CAP to address appropriate consistent application of medical necessity criteria and care management to address quality of care concerns was submitted to and approved by OMHSAS, completion date 7/9/10. <b>Attachment (7) CAP Standard 28</b></p> <p>a) Documentation guideline forms were updated to include member's history, <b>Attachments (8 a,b,c)</b>. Cases where Care managers and CAFS Coordinators' request physician consult for quality of care issues are documented in Care Connect. Start date 1/1/10.</p>



Reference Number	Opportunity for Improvement	MCO Response	
		<p>Committee on the 2<sup>nd</sup> Monday of every month. Both Quality and Clinical Directors participate and the committee is chaired by the Medical Director</p> <p><b>28 Substandard 2:</b> Random chart audits by Medical Director began 8/08 and are ongoing monthly Other action items listed started 2/09 and are ongoing</p> <p><b>PEPS 93</b> Reporting Treatment outcomes, and Readmissions at least bimonthly and annually FUH quarterly and annually Consumer Satisfaction at least bi-monthly and annually POMS data is submitted quarterly and is ongoing</p> <p><b>Substandard 28</b> (see above)</p> <p><b>72 Substandard 1</b> a) audit letters will continue to be submitted to SBHM</p>	<p>b) Care managers and CAFs coordinators continue to receive training in evidence based treatments via Grand Rounds <i>Attachments ( 9 a,b,c,d,e) for examples</i></p> <p>c) Quality of care Concerns are addressed jointly between Clinical and Quality departments <i>Attachments (10a 10b) 2010 &amp; 2011 QM/UM work plans and ( 11) 2010 QOCC summary</i></p> <p><b>Substandard 2: No CAP was required in RY 2009.</b></p> <p>However, action plans put in place as a result of OMHSAS Review of Denial notices 2008 are ongoing including: Medical Director does monthly chart audit review of 6-10 Peer Advisor charts to assure compliance with documentation of appropriately applied medical necessity criteria, Peer Advisor training, and use of Revised Peer Advisor Form for documenting medical necessity. CAPS covered all VBH-PA counties.</p> <p><i>Attachments</i> <i>(12)Example Denial Review CAP 2008</i> <i>(13) Minutes (see highlights)</i> <i>(14) Revised Peer Review Form</i></p> <p><b>PEPS 93: 4</b> Monitoring results for a)Treatment outcomes: b) readmissions, c) follow up after hospitalization (FUH) &amp; d) consumer satisfaction is presented at QMCs and in the Annual QM/UM Summary <i>Attachments (10 a, 10b) work plans</i></p> <p>Changes in employment/education/vocational status and living status is reported through POMS data, submitted by providers to VBH and reported to OMHSAS on a schedule to comply with Appendix M of the state RFP. <i>Attachments (17) POMS reporting</i> <i>(18) POMS coding</i></p> <p><b>Coordination of Care</b> PEPS 28 – see Access to Care</p> <p><b>Coverage and Authorization of Services</b> PEPS 28 – see Access to Care</p> <p><b>PEPS 72 .1</b> a) CAPs to address adequate explanation for service denial in letters were submitted for Beaver,</p>



Reference Number	Opportunity for Improvement	MCO Response	
	<p>and OMHSAS and the process evaluated in Annual HealthChoices Review in 2012</p> <p>* updated checklists are currently in use and ongoing</p> <p>b) OMHSAS will reply with written confirmation to verify logic before next year's submissions</p>	<p>Cambria, Northwest 3, and Southwest 6 counties. <b>Attachments (19, 20, 21)</b></p> <ul style="list-style-type: none"> <li>• Trainings for all VBH-PA clinical staff regarding Writing Denial and Grievance Letters, and Writing Denial and Grievance Letters for MH Inpatient and D&amp;A levels of care were conducted in July. <b>Attachments(22,23) PowerPoints (24) Sign in sheets</b></li> <li>• CAPS were reviewed in clinical staffing <b>Attachment (25) Staffing minutes</b></li> <li>• Clinical symptoms of member referenced in explanatory paragraph along with justification related to symptoms when another service is approved was added to the Denial Review Checklist 10/26/09 and updated on 8/1/11 <b>Attachment (26) updated checklist BHRS RTF (27) updated checklist IP and HLCO</b></li> <li>• Targeted audits of letters are conducted monthly and submitted to OMHSAS using audit tool with special focus on explanation of denied services. (10 IP and 25 BHRS letters) Submissions began August 2011 <b>Attachment (28) VBH-PA audit tool</b></li> <li>• Random sample of 10 denial letters across all levels of care are submitted bimonthly to Southwest Behavioral Health Management (SBHM) and OMHSAS for feedback.</li> </ul> <p>b) CAP for number of denial notices received versus number of denials in log was submitted to OMHSAS by NW3 and SW6 counties <b>(see CAPS Attachments 19, 20 above for Southwest 6 and Northwest Three)</b></p> <p>4) Practice Guidelines PEPS 28- see Access to Care</p> <p>5) Quality Assessment and Performance PEPS 91:10 Beaver County No CAP was required from the Annual Review 2009 <b>Attachment (29) Beaver PEPS CAP</b> <b>Attachment (30, 31) update for Beaver PIPS</b> PEPS 93 – See Access to Care</p>	<p><b>Future Actions Planned</b> None</p>
VBH 3	VBH was partially compliant on nine of 10 categories	68.2 Additional check	<b>Follow Up Actions Taken Through 09/30/11</b> <b>PEPS 68</b>



Reference Number	Opportunity for Improvement	MCO Response	
	<p>within <b>Subpart F</b>: Federal and State Grievance System Standards Regulations. The partially compliant categories were:</p> <ol style="list-style-type: none"> <li>1) Statutory Basis and Definitions,</li> <li>2) General Requirements,</li> <li>3) Notice of Action,</li> <li>4) Handling of Grievances and Appeals,</li> <li>5) Resolution and Notification: Grievances and Appeals,</li> <li>6) Expedited Appeals Process,</li> <li>7) Information to Providers and Subcontractors,</li> <li>8) Continuation of Benefits, and</li> <li>9) Effectuation of Reversed Resolutions.</li> </ol>	<p>boxes were added to checklists to review that every part of the complaint is addressed in both acknowledgement and resolution letters- 6/1/10 and ongoing.</p> <p>68.3 – approved workflow as response to Mercer audit 2009 is ongoing.</p> <p>68.6 Counties tape all Level II Complaints</p> <p>PEPS 71.3 Updates were implemented 5/10 and are ongoing.</p> <p>71.5 ongoing</p>	<p><b>Attachment (32, 33) PEPS Review &amp; CAP 2008 approved 8/3/2009</b></p> <p><b>Substandard 2:</b> The checklists were updated based on approved feedback from the DOH in 2009. Policies and Procedures were updated to close CAPS for 2008 and 2010. <b>Attachment (34) Example checklist (35) OMHSAS approved updated language for Policy and Procedure</b></p> <p><b>Substandard 3</b> Please see attachment documenting the complaint resolution workflow <b>Attachment (36) Complaint Workflow</b></p> <p>Substandard 4: No CAP was required on 2008 PEPS Substandard 6: CAP required Counties transcribe and or tape meetings as they are the facilitators, the instances where VBH is facilitating meetings are taped.</p> <p><b>PEPS 71.3</b> The VBH-PA and county specific second level grievance scheduling forms were updated to document that the member was offered a convenient time and place and asked if they need assistance to attend the meeting. <b>Attachment (37) Scheduling Form (38) Grievance letter (39) Contact sheet</b></p> <p>Related Policies and Procedures are updated to reflect the same. <b>Attachment (40) P&amp;P SW6 (41) P&amp;P Greene County</b></p> <p><b>PEPS 71.5</b> Tapes and/or transcripts of second level committee meetings are recorded and kept by the County who facilitates the meetings. If VBH-PA is the facilitator VBH-PA maintains these records. P&amp;Ps and meeting attendance have been updated to reflect comments from the PEP review 2008 (<i>see corrective action plan narrative Attachment 33 and Attachment (42) Facilitator Script</i>)</p> <p><b>PEPS 72</b> see response to 3) Coverage and Authorization of Services</p> <hr/> <p><b>Future Actions Planned</b> None</p>
<b>Performance Measures</b>			
VBH 4	VBH's rate for the MY 2009 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated		<p><b>Follow Up Actions Taken Through 09/30/11</b> VBH-PA reports on readmission rates monthly or bimonthly to all counties at the regularly scheduled QMCs. Annual rates are reviewed by calendar years. Overall readmission rates are also reported by age and gender.</p>



Reference Number	Opportunity for Improvement	MCO Response	
	<p>performance goal of 10.0%.</p>	<p>Cambria - Individuals identified through the RAFT database are referred to the VBH-PA clinical department for assessment for Complex Care Management.</p> <p>CCM- Individuals from all counties who meet hospitalization criteria for Complex Care management are referred on an ongoing basis.</p> <p>See NW3 attachment – interventions listed are ongoing</p> <p>VSP providers are reviewed monthly and reports on ongoing.</p>	<p>Cambria County A cohort of 21 frequently readmitted individuals has been identified through the Readmission Follow Up Tracking Data based, designed and implemented 2010. <b>Attachment (43) Cambria RAFT</b></p> <p>Complex Care Management (CCM) services are provided for individuals in high risk groups and with a history of frequent hospitalizations within a 12 month period. Interventions coordinated by VBH CCM have been shown to decrease hospitalizations. <b>Attachment (44) for CCM</b></p> <p>In the NW3 counties (Crawford, Mercer, and Venango) a targeted initiative to reduce readmission rates was implemented in 2010, though expanding the continuum of care in community services to include Mobile Psych Nursing, increasing the capacity for BCM, and using web based census reports to alert the County BCM to hospitalizations, thus allowing for timely intervention. Venango county readmission rates were primarily driven by youth under 17 and the county added 3 child specific BCMs. <b>Attachment (45)</b></p> <p>VSP – The Value Select Provider (VSP) program is a relatively new program that Value Behavioral Health of Pennsylvania (VBH-PA) started in 2008. The VSP program monitors the performance of Inpatient facilities for average length of stay and readmissions. Several parameters need to be met for the facility to be granted a 5 day pre-authorization review. Several monthly reports are shared with the facility in order for them to self monitor. Examples of the monitoring reports that are shared are the monthly “Readmission Rate Report” and the “Consumer Detail Readmission Report” that is reviewed by the hospital behavioral health clinical team and also by the County over-sight team to insure that all consumers have appropriate follow-up. It is a collaborative effort by both parties to make sure that community support services are in place at the time of the consumer’s discharge. Current participants are Highlands hospital in Fayette County, Jameson Hospital in Lawrence County (also used regularly by Butler and Beaver counties). <b>Attachment (46) for example VSP report</b></p> <p>Certified Peer Specialist – multiple counties have included in their QM work plan for 2010 to link peer specialists with access to the Inpatient Unit to engage a</p>



Reference Number	Opportunity for Improvement	MCO Response	
	<p>Lawrence County workgroup and action planning is ongoing.</p> <p>Beaver CCISC and SPA are ongoing</p>	<p>hospitalized person in follow up support. (Greene, Cambria, Crawford, Venango Washington and Westmoreland counties,)</p> <p>Outreach to Hospitals to improve discharge planning for follow up services in the community – as part of a FUH action plan VBH-PA prepared a report and information packet that was mailed to all hospitals in the VBH Network. It included a description of HEDIS approved follow up services (including Peer Support) a Provider Directory and Resource Guide and list of contacts for Peer Specialist by county. <b>Attachment (47) letter to hospitals</b></p> <p>Lawrence county along with SBHM and VBH-PA have a formed a workgroup to strategize action plans to reduce hospitalization rates in Lawrence.</p> <p>Beaver County has developed CCISC- The Comprehensive Continuous Integrated System of Care and SPA – Single Point of Accountability for consumers most in need of support. <b>Attachment (48)</b></p>	<p><b>Future Actions Planned</b></p> <p>Cambria - VBH-PA will partner with Access Plus to identify any individuals within the high readmit population who have concurrent medical conditions that can be managed through Access Plus services and PH/BH care coordinated. Planning meeting to be held 10/11.</p> <p>Continue to expand the use of Peer Specialist in outreach.</p> <p>VBH-PA , Venango County, and UPMC are collaborating on implementing Peer Specialist and CM in hospital during discharge October 2011</p> <p>Beaver County CCISC was renamed They System Transformation Initiative in early 2001, new target populations include need for supported housing, employment and trauma-informed care with PH/BH coordination – to continue through 2011</p>

**Corrective Action Plan**

When deficiencies were noted during the PEPS reviews, a Corrective Action Plan response was required from the BH MCO addressing those issues requiring follow-up action. VBH was not required to implement a corrective action plan in calendar year 2010.



## **Root Cause Analysis and Action Plan**

The 2011 EQR is the third 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 2010 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. VBH was not required to submit a root cause analysis and action plan in 2011 based on 2010 Performance.



## V: 2011 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

---

The review of VBH's 2011 (MY 2010) 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.

### **Strengths**

- VBH submitted one PIP for validation in 2011 and received full credit for the element of the study evaluated that reflected activities in 2010 (Interventions Aimed at Achieving Demonstrable Improvement).
- VBH's rate for the MY 2010 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 2 was statistically significantly higher than the QI 2 HealthChoices BH MCO Average by 2.2 percentage points.
- VBH's rate for the MY 2010 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI B was statistically significantly higher than the QI B HealthChoices BH MCO Average by 2.2 percentage points.
- VBH's rate for the MY 2010 Readmission within 30 Days of Inpatient Psychiatric Discharge measure was statistically significantly below (better than) the MY 2010 HealthChoices BH MCO Average by 1.9 percentage points.

### **Opportunities for Improvement**

- Review of compliance with standards conducted by the Commonwealth in RY 2008, RY 2009, and RY 2010 found VBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.
  - Within Subpart C: Enrollee Rights and Protections Regulations, VBH was partially compliant on one out of seven categories – 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 were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Practice Guidelines, and 5) Quality Assessment and Performance Improvement Program.
  - 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 and Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.
- VBH's rate for the MY 2010 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 2011 (MY 2010) Performance Measure Matrix that follows.



## PERFORMANCE MEASURE MATRIX

The Performance Measure (PM) Matrix provides a comparative look at quality indicators (QIs) included in the External Quality Review (EQR) evaluation for Quality Performance of the HealthChoices Behavioral Health Managed Care Organization. The matrix:

- Compares the Behavioral Health Managed Care Organization's (BH MCO's) own measure performance over the two most recent reporting years (Measurement Year (MY) 2010 and MY 2009); and
- Compares the BH MCO's MY 2010 performance measure rates to the MY 2010 HealthChoices BH MCO Average.

The table 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.

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

-  The green box (A) indicates that performance is notable. The BH MCO's MY 2010 rate is statistically significantly above the MY 2010 HealthChoices BH MCO Average and trends up from MY 2009.
-  The light green boxes (B) indicate either that the BH MCO's MY 2010 rate is equal to the MY 2010 HealthChoices BH MCO Average and trends up from MY 2009 or that the BH MCO's MY 2010 rate is statistically significantly above the MY 2010 HealthChoices BH MCO Average but there is no change from MY 2009.
-  The yellow boxes (C) indicate that the BH MCO's MY 2010 rate is statistically significantly below the MY 2010 HealthChoices BH MCO Average and trends up from MY 2009 or that the BH MCO's MY 2010 rate is equal to the MY 2010 HealthChoices BH MCO Average and there is no change from MY 2009 or that the BH MCO's MY 2010 rate is statistically significantly above the MY 2010 HealthChoices BH MCO Average but trends down from MY 2009. *No action is required although MCOs should identify continued opportunities for improvement.*
-  The orange boxes (D) indicate either that the BH MCO's MY 2010 rate is statistically significantly below the MY 2010 HealthChoices BH MCO Average and there is no change from MY 2009 or that the BH MCO's MY 2010 rate is equal to the MY 2010 HealthChoices BH MCO Average and trends down from MY 2009. *A root cause analysis and plan of action is required.*
-  The red box (F) indicates that the BH MCO's MY 2010 rate is statistically significantly below the MY 2010 HealthChoices BH MCO Average and trends down from MY 2009. *A root cause analysis and plan of action is required.*



## Value Behavioral Health (VBH)

---

### KEY POINTS

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

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

Measures that had no statistically significant change from MY 2009 to MY 2010 but were statistically significantly above/better than the MY 2010 HealthChoices BH MCO Averages are:

- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)
- Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)
- Readmission within 30 Days of Inpatient Psychiatric Discharge<sup>1</sup>

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

Measures that had no statistically significant changes from MY 2009 to MY 2010 and were not statistically significantly different from the MY 2010 HealthChoices BH MCO Averages are:

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
- Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 30 Day)

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

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

---

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



**Figure 1: Performance Measure Matrix – VBH**

		HealthChoices BH MCO Average Statistical Significance Comparison		
Trend		Below / Poorer than Average	Average	Above / Better than Average
Year to Year Statistical Significance Comparison	↑	C	B	A
	No Change	D	C Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day) Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	B Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day) Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day) Readmission within 30 Days of Inpatient Psychiatric Discharge <sup>2</sup>
	↓	F	D	C

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.

<sup>2</sup> Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



Performance measure rates for MY 2008, MY 2009, and MY 2010 are displayed in Figure 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 2: Performance Measure Rates – VBH**

Quality Performance Measure	MY 2008 Rate	MY 2009 Rate	MY 2010 Rate	MY 2010 HC BH MCO Average
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	40.6%	44.4% ▲	44.4% =	45.4%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	65.8%	68.5% ▲	68.4% =	66.2%
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	53.2%	57.5% ▲	56.9% =	57.5%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	73.6%	76.3% ▲	76.3% =	74.1%
Readmission within 30 Days of Inpatient Psychiatric Discharge <sup>3</sup>	11.5%	11.2% =	10.5% =	12.4%

<sup>3</sup> Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



## VI: SUMMARY OF ACTIVITIES

---

### **Structure and Operations Standards**

- VBH was partially compliant on Subparts C, D, and F. As applicable, compliance review findings from RY 2010, RY 2009, and RY 2008 were used to make the determinations.

### **Performance Improvement Projects**

- VBH submitted one PIP for validation in 2011 and received full credit for the element of the study evaluated that reflected activities in 2010 (Interventions Aimed at Achieving Demonstrable Improvement).

### **Performance Measures**

- VBH reported all performance measures and applicable quality indicators in 2011.

### **2010 Opportunities for Improvement MCO Response**

- VBH provided a response to the opportunities for improvement issued in 2010.

### **2011 Strengths and Opportunities for Improvement**

- Both strengths and opportunities for improvement were noted for VBH in 2011. The BH MCO will be required to prepare a response for the noted opportunities for improvement in 2012.



## APPENDIX

### Appendix A: Crosswalk of Required PEPS Items 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.
	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.	
§438.206 Availability of Service	Standard 1.1	<ul style="list-style-type: none"> <li>• A complete listing of all contracted and credentialed providers.</li> <li>• 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.</li> <li>• Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages.</li> <li>• 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&amp;A Outpatient, etc). Population served (adult, child &amp; adolescent). Priority Population. Special Population.</li> </ul>
	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. • 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 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 services	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 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	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law,



BBA Category	PEPS Reference	PEPS Language
Provider Selection		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.
	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).

BBA Category	PEPS Reference	PEPS Language
	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 <sup>th</sup> .
	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 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



BBA Category	PEPS Reference	PEPS Language
		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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> </ul>
	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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	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	



BBA Category	PEPS Reference	PEPS Language
		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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> </ul>
	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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	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
§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 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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> </ul>
	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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	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

BBA Category	PEPS Reference	PEPS Language
		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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> </ul>
	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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	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



BBA Category	PEPS Reference	PEPS Language
		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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	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 providers and subcontractors	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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> </ul>
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
§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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	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



BBA Category	PEPS Reference	PEPS Language
		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"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	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.

### Appendix B: OMHSAS-Specific PEPS Items

Category	PEPS Reference	PEPS Language
<b>Second Level Complaints and Grievances</b>		
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	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



Category	PEPS Reference	PEPS Language
Hearings		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.
<b>Enrollee Satisfaction</b>		
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.

## REFERENCES

---

- i World Health Organization. (2008) WHO Global Burden of Disease: 2004 Update. Available from: [www.who.int/healthinfo/global\\_burden\\_disease/2004\\_report\\_update/en/index.html](http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html)
- ii Dombrovski A, Rosenstock J (2004) Bridging General Medicine and Psychiatry: Providing General Medical and Preventive Care for the Severely Mentally Ill. *Current Opinion in Psychiatry*, 17(6):523-529
- iii Moran M. (2009) Schizophrenia Patients Show High Rates of Comorbid Illness. *Psychiatric News*, 44(18):22.
- iv Gill SS. (2005). Stable Monotherapy with Clozapine or Olanzapine Increases the Incidence of Diabetes Mellitus in People with Schizophrenia. *Evid Based Ment Health*, 8(1):24.
- v Leslie DL, Rosenheck RA. (2004) Incidence of Newly Diagnosed Diabetes Attributable to Atypical Antipsychotic Medications. *Am J Psychiatry*, 161:1709–11.
- vi Druss BG, Rosenheck, RA, Desai MM, & Perlin, J. B. (2002). Quality of Preventive Medical Care for Patients with Mental Disorders. *Medical Care*, 40(2):129–136.
- vii Desai M, Rosenheck RA, Druss BG, Perlin J.B. (2002) Mental Disorders and Quality of Diabetes Care in Veterans Health Administration. *Am J Psychiatry*, 159:1584-1590
- viii Frayne SM., Halanych JH., Miller D.R., et al. (2005) Disparities in Diabetes Care: Impact of Mental Illness. *Arch Intern Med*, 165(22):2631-8.
- ix Druss BG, Bradford DW, Rosenheck RA et al. (2000) Mental Disorders and Use of Cardiovascular Procedures After Myocardial Infarction *JAMA*, 283(4):506-11.
- x Averyt JM, Kuno E, Rothbard AB, Culhane DP. (1997) Impact of Continuity of Care on Recurrence of Homelessness Following an Acute Psychiatric Episode. *Continuum* 4.3
- xi National Institute of Mental Health — Statistics. <http://www.nimh.nih.gov/health/topics/statistics/index.shtml>. updated Mar 31,2009. Accessed May 20, 2009.
- xii Insel TR. (2008) Assessing the Economic Costs of Serious Mental Illness. *Am J Psychiatry*, 165:663-65.
- xiii D’Mello DA, Boltz MK, Msibi B. (1995) Relationship between Concurrent Substance Abuse in Psychiatric Patients and Neuroleptic Dosage. *Am J Drug Alcohol Abuse*, 2:257-65.
- xiv National Committee for Quality Assurance (NCQA, 2007). *The State of Health Care Quality 2007*. Washington, DC: National Committee for Quality Assurance. Available at [http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC\\_2007.pdf](http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_2007.pdf) (Accessed July 12, 2010).
- xv van Walraven C, Mamdani M, Fang J, Austin PC. (2004) Continuity of Care and Patient Outcomes After Discharge. *J Gen Intern Med*, 19:624-31
- xvi Hermann RC. (2000) Quality measures for mental health care: results from a National Inventory. *Medical Care Research and Review*, 57:136-54

---

xvii Ibid.

xviii Cuffel BJ, Held M, Goldman W. (2002) Predictive Models and the Effectiveness of Strategies for Improving Outpatient Follow-up Under Managed Care. *Psychiatric Services* 53:1438-43.

xix Nelson EA, Maruish ME, Axler JL. (2000) Effects of Discharge Planning and Compliance with Outpatient Appointments on Readmission Rates. *Psychiatric Services*, 51:885-889.

xx Ibid.

xxi Adair CE, McDougall GM, Mitton CR. (2005) Continuity of Care and Health Outcomes Among Persons with Severe Mental Illness. *Psychiatric Services*, 56(9):1061-69.

xxii Mitton CR, Adair CE, McDougall GM, Marcoux G. (2005) Continuity of Care and Health Care Costs Among Persons with Severe Mental Illness. *Psychiatric Services*, 56(9):1070-6.

xxiii Chien C, Steinwachs DM, Lehman AF, et al. (2000) Provider Continuity and Outcomes of Care for Persons with Schizophrenia. *Mental Health Services Research*, 2:201-11.

xxiv Ibid.