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

2018 External Quality Review Report
Value Behavioral Health

FINAL
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Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

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.

Overview

HealthChoices (HC) Behavioral Health (BH) is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO (Island Peer Review Organization) as its EQRO to conduct the 2018 EQRs for HC BH MCOs and to prepare the technical reports. The subject of this report is one HC BH-MCO, Value Behavioral Health (VBH). Subsequent references to MCO in this report refer specifically to this HC BH-MCO.

Objectives

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.

Report Structure

This technical report includes seven core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures
IV. Quality Study
V. 2017 Opportunities for Improvement - MCO Response
VI. 2018 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the MCO, the information for compliance with the Structure and Operations Standards section of the report is derived from monitoring and reviews conducted by OMHSAS, as well as the oversight functions of the county or contracted entity when applicable, against the Commonwealth's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable. Information for Sections II and III of this report is derived from IPRO's validation of the MCO's performance improvement projects (PIPs) and performance measure submissions. The Performance Measure validation, as conducted by IPRO, included a repeated measurement of three Performance Measures: Follow-up After Hospitalization for Mental Illness, Readmission Within 30 Days of Inpatient Psychiatric Discharge, and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. Section V, 2017 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2017 EQR Technical Report and presents the degree to which the MCO addressed each opportunity for improvement. Section VI has a summary of the MCO's strengths and opportunities for improvement for this review period (2018), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH Quality Performance of the MCO. Lastly, Section VII provides a summary of EQR activities for the MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA Regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

Supplemental Materials

Upon request, the following supplemental materials can be made available:

- The MCO's BBA Report for RY 2017, and
- The MCO's Annual PIP Review for RY 2018.

I: Structure and Operations Standards

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the structure and operations standards. In RY 2017, 67 Pennsylvania counties participated in this compliance evaluation.

Organization of the HealthChoices Behavioral Health Program

OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program, the mandatory managed care program that provides Medical Assistance recipients with services to treat mental health and/or substance abuse diagnoses/disorders. Forty-three (43) of the 67 counties have signed agreements using the right of first opportunity and have subcontracted with a private-sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four counties (24) have elected not to enter into a capitated agreement and, as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties. In the interest of operational efficiency, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the HC BH Contractors while providing an oversight function of the BH-MCOs.

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

Beaver, Fayette, and the Southwest Six counties (comprised of Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland Counties) hold contracts with Value Behavioral Health (VBH). The Oversight Entity for the Southwest Six counties is Southwest Behavioral Health Management, Inc. Two other Oversight Entities – Behavioral Health of Cambria County (BHoCC) and Northwest Behavioral Health Partnership, Inc. ([NWBHP] comprised of Crawford, Mercer, and Venango Counties) hold contracts with VBH. The Department contracts directly with VBH to manage the HC BH program for Greene County. In Calendar Year 2017, Cambria County moved from VBH to Magellan Behavioral Health (MBH). If a county is contracted with more than one BH-MCO in the review period, compliance findings for that county are not included in the PEPS section for either BH-MCO for a three-year period. **Table 1.1** shows the name of the HealthChoices Oversight Entity, the associated HealthChoices HC BH Contractor(s), and the county(ies) encompassed by each HC BH Contractor.

Table 1.1: HealthChoices Oversight Entities, HC BH Contractors and Counties

HealthChoices Oversight Entity	HC BH Contractor	County
Beaver County Behavioral Health	Beaver County Behavioral Health	Beaver County
Northwest Behavioral Health Partnership, Inc. (NWBHP)	Northwest Behavioral Health Partnership, Inc. (NWBHP)	Crawford County
		Mercer County
		Venango County
Fayette County Behavioral Health Administration (FmbhA)	Fayette County Behavioral Health Administration	Fayette County
PA Department of Human Services	Value Behavioral Health of Pennsylvania, otherwise known as Greene County for this review	Greene County
Southwest Behavioral Health Management, Inc. (Southwest Six)	Southwest Behavioral Health Management, Inc. (Southwest Six)	Armstrong County
		Indiana County
		Butler County
		Lawrence County
	Westmoreland County	Westmoreland County
	Washington County	Washington County

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of VBH by OMHSAS monitoring staff within the past three RYs (2017, 2016, and 2015). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for RY 2017. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year timeframe under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year time frame, the Readiness Review substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's Program Standards and Requirements (PS&R) are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2018 and entered into the PEPS Application as of October 2018 for RY 2017. Information captured within the PEPS Application informs this report. The PEPS Application is a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each HealthChoices Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the substandards 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 PEPS Application, a HealthChoices Oversight Entity/BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS's more rigorous monitoring criteria.

At the implementation of the PEPS Application in 2004, IPRO evaluated the standards in the Application and created a crosswalk to pertinent BBA regulations. For standards with substandards, all of the substandards within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the substandards required for fulfilling BBA requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS's ongoing monitoring. In the amended crosswalk, the supplemental substandards no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Substandards concerning first-level complaints and grievances inform the compliance determination of the BBA categories relating to Federal & State Grievance Systems Standards. All of the PEPS Substandards concerning second-level complaints and grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category. Substandards are sometimes added or otherwise changed on the crosswalk which may change the category-tally of standards from year to year. As was done for prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The review findings for selected OMHSAS-specific Substandards are reported in **Appendix C**. The RY 2017 crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in **Appendix A** and **Appendix B**, respectively.

Because OMHSAS's review of the HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS Substandards from RY 2017, RY 2016, and RY 2015 provided the information necessary for the 2018 assessment. Those standards not reviewed through the PEPS system in RY 2017 were evaluated on their performance based on RY 2016 or RY 2015 decisions, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year time frame under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed.

For VBH, a total of 167 substandards were applicable for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2015–2017). In addition, 16 OMHSAS-specific Substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. It should

be noted that some PEPS Substandards were relevant to more than one BBA regulation or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS substandard may contribute more than once to the total number of BBA categories required and/or reviewed. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific items that are not required as part of BBA regulations but are reviewed within the three-year cycle to evaluate the BH-MCO and associated HealthChoices Oversight Entities against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for VBH

Table 1.1 tallies the PEPs substandards used to evaluate the HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2015–2017). Because compliance categories (first column) may contain substandards that are reviewed either annually or triennially, the total number of PEPS substandards applicable to this year's (RY 2017) evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations for any given category may not equal the sum of those substandard counts.

Table 1.2: Tally of Substandards Pertinent to BBA Regulations Reviewed for VBH

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
	Total	NR	RY 2017	RY 2016	RY 2015
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	14	0	7	0	7
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	N/A	N/A	N/A	N/A	N/A
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
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	25	0	3	9	13
Coordination and Continuity of Care	3	0	3	0	0
Coverage and Authorization of Services	5	0	5	0	0
Provider Selection	3	0	0	0	3
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	8	0
Practice Guidelines	7	0	32	4	0
Quality Assessment and Performance Improvement Program	25	0	18	7	0
Health Information Systems	1	0	0	1	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	0	11	0	0
General Requirements	14	0	14	0	0
Notice of Action	13	0	2	5	6
Handling of Grievances and Appeals	11	0	11	0	0
Resolution and Notification: Grievances and Appeals	11	0	11	0	0
Expedited Appeals Process	6	0	6	0	0
Information to Providers and Subcontractors	2	0	2	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	0	6	0	0
Effectuation of Reversed Resolutions	6	0	6	0	0
Total	**171**	**0**	**137**	**34**	**29**

[1] The total number of required substandards required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations. Any PEPS substandards not reviewed indicate retired substandards previously used to evaluate the BH-MCO.
[2] The number of substandards that came under active review during the cycle specific to the review year. Due to substandards coming under active review both annually and triennially for each review year, the sum of the substandards that came under review in RY 2017, 2016, and 2015 may not equate to the total number of applicable PEPS substandards for evaluation of the BH-MCO (167 in RY 2017).
RY: Review Year.
NR: Not reviewed.
N/A: Not applicable.

For RY 2017, nine categories – 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements – were not directly addressed by the PEPS Substandards reviewed. As per OMHSAS's judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health Program's PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH-MCOs. The category of Marketing Activities is Not Applicable because, as a result of the Centers for Medicare and Medicaid Services (CMS) HealthChoices waiver, DHS has been granted an allowance to offer only one BH-MCO per county. Compliance for the Cost Sharing category is not assessed by PEPS Substandards, as any cost sharing imposed on Medicaid enrollees is in accordance with CMS regulation 42 CFR 447.50–447.60.

Before 2008, the categories of Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all HC BH Contractors and BH-MCOs based on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. In 2008, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories. In this 2018 report, the Solvency tracking reports and the quarterly reporting of Complaint and Grievances data were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

Determination of Compliance

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

In MY 2017, PEPS Standards 91 and 104 changed from County-Specific Standards to BH-MCO-Specific Standards.

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 *CMS EQR Protocol #1: Assessment of Compliance with Medicaid Managed Care Regulations* ("Quality of Care External Quality Review," 2012). Under each general subpart heading are the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a

manner consistent with the three subparts in the BBA regulations explained in the Protocol (i.e., Enrollee Rights and Protections, Quality Assessment, and Performance Improvement [including access, structure and operation, and measurement and improvement standards]), and Federal and State Grievance System Standards.

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

Findings

Of the 167 PEPS substandards that were used to evaluate VBH and the five HealthChoices Oversight Entities associated with VBH, 104 substandards were under active review in RY 2017.

Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this subpart is to ensure that each HC BH Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable Federal and State laws that pertain to enrollee rights, and that the HC BH Contractor/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees (42 CFR 438.100 [a], [b]). **Table 1.3** presents the findings by categories consistent with the regulations.

Table 1.3: Compliance with Enrollee Rights and Protections Regulations

Subpart C: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Partial		All VBH HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was compliant with 11 substandards, partially compliant with 2 substandards, and non-compliant with 1 substandard.
Provider-Enrollee Communications 438.102	Compliant	All VBH HC BH Contractors		Compliant as per PS&R sections E.4 (p. 55) and A.4.a (p. 21).
Marketing Activities 438.104	N/A	N/A	N/A	Not applicable due to CMS HealthChoices waiver. Consumers are assigned to BH-MCOs based on their county of residence.
Liability for Payment 438.106	Compliant	All VBH HC BH Contractors		Compliant as per PS&R sections A.9 (p. 73) and C.2 (p. 28).
Cost Sharing 438.108	Compliant	All VBH HC BH Contractors		Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50–447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	All VBH HC BH Contractors		Compliant as per PS&R section 4 (p. 30).
Solvency Standards 438.116	Compliant	All VBH HC BH Contractors		Compliant as per PS&R sections A.3 (p. 68) and A.9 (p. 73), and 2016–2017 Solvency Requirements tracking report.

N/A: not applicable.

There are seven categories within Enrollee Rights and Protections Standards. VBH was compliant with five categories and partially compliant with one category. The remaining category was considered not applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were compliant as per the

HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50–447.60. The category Solvency Standards was compliant based on the 2017–2018 Solvency Requirement tracking report. Of the 14 PEPS substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 14 were evaluated. Each HC BH Contractor was evaluated on 14 substandards, compliant with 11 substandards, partially compliant with 2 substandards, and non-compliant with 1 substandard.

Enrollee Rights

All HC BH Contractors were partially compliant with Enrollee Rights due to non-compliance with one substandard within PEPS Standard 60 (RY 2017).

PEPS Standard 60: Complaint/Grievance Staffing:

- The BH-MCO shall identify a lead person responsible for overall coordination of the complaint and grievance process, including the provision of information and instructions to members. (Responsibility includes Health Insurance Portability and Accountability Act of 1996 [HIPAA] Privacy duties related to complaints and mechanisms for tracking and reporting of HIPAA related complaints.)
- The BH-MCO shall designate and train sufficient staff responsible for receiving, processing and responding to member complaints and grievances in accordance with the requirements contained in Appendix H [Appendix H, A., 8., p. 1].
- All BH-MCO staff shall be educated concerning member rights and the procedure for filing complaints and grievances [C.4., p. 44].

All HC BH Contractors were non-compliant with one substandard of Standard 60: Substandard 2 (RY 2017).

> **PEPS Standard 60, Substandard 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.

Subpart D: Quality Assessment and Performance Improvement Regulations

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's Medicaid managed care program, the HealthChoices Program, are available and accessible to MCO enrollees [42 CFR 438.206 (a)]. The PEPS documents for each HC BH Contractor include an assessment of the HC BH Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 1.4** presents the findings by categories consistent with the regulations.

Table 1.4: Compliance with Quality Assessment and Performance Improvement Regulations

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Elements of State Quality Strategies 438.204	Compliant	All VBH HC BH Contractors		Compliant as per PS&R section G.3 (p. 61).
Availability of Services (Access to Care) 438.206	Partial		All VBH HC BH Contractors	25 substandards were crosswalked to this category. Each HC BH Contractor was compliant with 24 substandards and non-compliant with 1 substandard.
Coordination and Continuity of Care 438.208	Partial		All VBH HC BH Contractors	3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards, partially compliant with 2 substandard, and non-compliant with 1 substandard.
Coverage and Authorization	Partial		All VBH HC BH Contractors	5 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
of Services 438.210				substandards, compliant with 3 substandards, partially compliant with 1 substandard, and non-compliant with 1 substandard.
Provider Selection 438.214	Compliant	All VBH HC BH Contractors		3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards and compliant with 3 substandards.
Confidentiality 438.224	Compliant	All VBH HC BH Contractors		Compliant as per PS&R sections D.2 (p. 50), G.4 (p. 62), and C.6.c (p. 48).
Subcontractual Relationships and Delegation 438.230	Partial		All VBH HC BH Contractors	8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards, compliant with 7 substandards, and partially compliant with 1 substandard.
Practice Guidelines 438.236	Partial		All VBH HC BH Contractors	7 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 7 substandards, compliant with 6 substandards, and non-compliant with 1 substandard.
Quality Assessment and Performance Improvement Program 438.240	Partial		All VBH HC BH Contractors	25 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 25 substandards, compliant with 23 substandards, and partially compliant with 2 substandards.
Health Information Systems 438.242	Compliant	All VBH HC BH Contractors		1 substandard was crosswalked to this category. Each HC BH Contractor was evaluated on 1 substandard and compliant with this substandard.

There are 10 categories in the Quality Assessment and Performance Improvement Regulations Standards. VBH was compliant with 4 categories and partially compliant with 6 categories. Two (2) of the 4 categories with which VBH was compliant—Elements of State Quality Strategies and Confidentiality—were not directly addressed by any PEPS substandards, but were determined to be compliant, as per the HealthChoices PS&R.

For this review, 73 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations for all HC BH Contractors associated with VBH, and each HC BH Contractor was evaluated on 73 substandards. Each HC BH Contractor was compliant with 65 substandards, partially compliant with 4 substandards, and non-compliant with 4 substandards. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating with an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

All HC BH Contractors associated with VBH were partially compliant with Availability of Services (Access to Care) due to partial and non-compliance with substandards of PEPS Standard 28.

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

All HC BH Contractors were non-compliant with one substandard of Standard 28: Substandard 1 (RY 2017).

PEPS Standard 28, Substandard 1: Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.

All of the HC BH Contractors were compliant with one substandard of Standard 28: Substandard 2 (RY 2017).

PEPS Standard 28, 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 28, Substandard 3: Other: Significant onsite review findings related to Standard 28.

Coordination and Continuity of Care

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

PEPS Standard 28: See descriptions of Standard, partially compliant substandard, and non-compliant substandard under Availability of Services (Access to Care). All HC BH Contractors were non-compliant with one substandard of Standard 28: Substandard 1 (RY 2017). All of the HC BH Contractors were compliant with two substandards of Standard 28: Substandard 2, Substandard 3 (RY 2017).

Coverage and Authorization of Services

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

PEPS Standard 28: See descriptions of Standard, partially compliant substandard, and non-compliant substandard under Availability of Services (Access to Care). All HC BH Contractors were non-compliant with one substandard of Standard 28: Substandard 1 (RY 2017). All of the HC BH Contractors were compliant with two substandards of Standard 28: Substandard 2, Substandard 3 (RY 2017).

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

All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2017).

PEPS Standard 72, Substandard 2: The content of the notices adheres to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DHS Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services, if applicable; and contains date denial decision will take effect).

Practice Guidelines

All VBH HC BH Contractors were partially compliant with Practice Guidelines due to non-compliance with one substandard of PEPS Standard 28.

PEPS Standard 28: See descriptions of Standard, partially compliant substandard, and non-compliant substandard under Availability of Services (Access to Care). All HC BH Contractors were non-compliant with one substandard of Standard 28:

Substandard 1 (RY 2017). All of the HC BH Contractors were compliant with two substandards of Standard 28: Substandard 2, Substandard 3 (RY 2017).

Quality Assessment and Performance Improvement

All HC BH Contractors associated with VBH were partially compliant with Quality Assessment and Performance Improvement Program due to partial compliance with two substandards of PEPS Standard 91.

PEPS Standard 91: Quality Management (QM) Program Description, QM Work Plan, and PIPs. The BH-MCO has a quality management program that includes a plan for ongoing quality assessment and performance improvement. The BH-MCO conducts performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The QM plans emphasize high-volume and high-risk services and treatment, including Behavioral Health and Rehabilitation Services (BHRS).

All HC BH Contractors were partially compliant with two substandards of Standard 91: Substandards 4 and 13 (RY 2017).

PEPS Standard 91, Substandard 4: The QM Work Plan includes:

- Objective
- Aspect of care/service
- Scope of activity
- Frequency
- Data source
- Sample size
- Responsible person
- Specific, measurable, attainable, realistic and timely performance goals, as applicable.

PEPS Standard 91, Substandard 13: The identified performance improvement projects must include the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement;
- Timeline for reporting status and results of each project to the Department of Human Services (DHS); and
- 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.

Subpart F: Federal and State Grievance System Standards

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances. The PEPS documents include an assessment of the HC BH Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 1.5** presents the findings by categories consistent with the regulations.

Table 1.5: Compliance with Federal and State Grievance System Standards

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All VBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 3 substandards, partially compliant with 4 substandard, and non-compliant with 4 substandards.
General Requirements 438.402	Partial		All VBH HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards, compliant with 3 substandards, partially compliant with 6 substandard, and non-compliant with 5 substandards.
Notice of Action 438.404	Partial		All VBH HC BH Contractors	13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards, compliant with 12 substandards, and partially compliant with 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All VBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 3 substandards, partially compliant with 4 substandard, and non-compliant with 4 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All VBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 3 substandards, partially compliant with 4 substandard, and non-compliant with 4 substandards.
Expedited Appeals Process 438.410	Partial		All VBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 2 substandard, partially compliant with 1 substandard, and non-compliant with 3 substandard.
Information to Providers & Subcontractors 438.414	Partial		All VBH HC BH Contractors	2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards, compliant with 1 substandard, and non-compliant with 1 substandard.
Recordkeeping and Recording Requirements 438.416	Compliant	All VBH HC BH Contractors		Compliant as per the 2017 quarterly Complaints and Grievance tracking reports.
Continuation of Benefits 438.420	Partial		All VBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 2 substandards, partially compliant with 1 substandard, and non-compliant with 3 substandard.

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Effectuation of Reversed Resolutions 438.424	Partial		All VBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 2 substandards, partially compliant with 1 substandard, and non-compliant with 3 substandard.

There are 10 categories in the Federal and State Grievance System Standards. VBH was partially compliant with all categories. For this review, 80 substandards were crosswalked to Federal and State Grievance System Standards for all HC BH Contractors associated with VBH. Each HC BH Contractor was evaluated on 80 substandards, compliant with 31 substandards, partially compliant with 22 substandards, and non-compliant with 27 substandards. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating with an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

The HC BH Contractors associated with VBH were partially compliant with 9 of the 10 categories (all but Recordkeeping and Recording Requirements) pertaining to Federal State and Grievance System Standards due to partial and non-compliance with substandards within PEPS Standards 60, 68, 71, and 72.

Statutory Basis and Definitions

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

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

All VBH HC BH Contractors were partially compliant with one substandards of Substandards 68: Substandards 3, 4, and 5 (RY 2017), and non-compliant with one substandard of Standards 68: Substandard 2 (RY 2017).

PEPS Standard 68, Substandard 1: Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process, including how the compliant rights and procedures are made known to members, BH-MCO staff, and the provider network: 1. BBA fair hearing, 2. 1st level, 3. 2nd level, 4. External, 5. Expedited.

PEPS Standard 68, Substandard 3: Complaint decision letters must be written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).

PEPS Standard 68, Substandard 4: 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 68, Substandard 5: Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff, either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.

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

All HC BH Contractors were non-compliant with three substandards of Standards 71: Substandard 1, 3, and 4 (RY 2017).

PEPS Standard 71, Substandard 1: Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff, and the provider network:

- BBA fair hearing
- 1st level
- 2nd level
- External
- Expedited

PEPS Standard 71, Substandard 3:
Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision, including the medical necessity criteria utilized.

PEPS Standard 71, Substandard 4: Grievance case files must include documentation of any referrals to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff, either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.

PEPS Standard 72: See Standard and partially compliant substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2017).

General Requirements
All HC BH Contractors associated with VBH were partially compliant with General Requirements due to partial and non-compliance with substandards of Standards 60, 68, 71, and 72.

PEPS Standard 60: See Standard and non-compliant substandard descriptions under Enrollee Rights. All HC BH Contractors were non-compliant with one substandard of Standard 60: Substandard 2 (RY 2017).

PEPS Standard 68: See Standard and non-compliant substandard descriptions under Statutory Basis and Definitions. All VBH HC BH Contractors were non-compliant with one substandard of Standards 68: Substandard 2 (RY 2017).

PEPS Standard 71: See Standard and non-compliant substandard descriptions under Statutory Basis and Definitions. All HC BH Contractors were non-compliant with three substandards of Standards 71: Substandards 1, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2017).

Notice of Action
All HC BH Contractors associated with VBH were partially compliant with Notice of Action due to partial compliance with Substandard 2 of Standard 72.

PEPS Standard 72: See Standard and partially compliant substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2017).

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

PEPS Standard 68: See Standard partially compliant and non-compliant substandard descriptions under Statutory Basis and Definitions. All VBH HC BH Contractors were partially compliant with three substandards of Standards 68: Substandards 3, 4, and 5 (RY 2017), and non-compliant with one substandard of Standard 69: Substandard 2 (RY 2017).

PEPS Standard 71: See Standard and non-compliant substandard descriptions under Statutory Basis and Definitions. All HC BH Contractors were non-compliant with three substandards of Standards 71: Substandards 1, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2017).

Resolution and Notification: Grievances and Appeals

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

PEPS Standard 68: See Standard partially compliant and non-compliant substandard descriptions under Statutory Basis and Definitions. All VBH HC BH Contractors were partially compliant with three substandards of Standards 68: Substandards 3, 4, and 5 (RY 2017), and non-compliant with one substandard of Standard 68: Substandards 2(RY 2017).

PEPS Standard 71: See Standard and non-compliant substandard descriptions under Statutory Basis and Definitions. All HC BH Contractors were non-compliant with three substandards of Standards 71: Substandards 1, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2017).

Expedited Appeals Process

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

PEPS Standard 71: See Standard and non-compliant substandard descriptions under Statutory Basis and Definitions. All HC BH Contractors were non-compliant with three substandards of Standards 71: Substandards 1, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2017).

Information to Providers & Subcontractors

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

PEPS Standard 71: See Standard and non-compliant substandard descriptions under Statutory Basis and Definitions. All VBH HC BH Contractors were non-compliant with one substandard of Standard 71: Substandards 1 (RY 2017).

Continuation of Benefits

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

PEPS Standard 71: See Standard and non-compliant substandard descriptions under Statutory Basis and Definitions. All HC BH Contractors were non-compliant with three substandards of Standards 71: Substandards 1, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2017).

Effectuation of Reversed Resolutions

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

PEPS Standard 71: See Standard and non-compliant substandard descriptions under Statutory Basis and Definitions. All HC BH Contractors were non-compliant with three substandards of Standards 71: Substandards 1, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2017).

II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for the MCO. Under the existing HC BH agreement with OMHSAS, HC BH Contractors, along with the responsible subcontracted entities (i.e., MCOs), are required to conduct a minimum of two focused studies per year. The HC BH Contractors and MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or re-measurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2018 for 2017 activities.

Background

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

The Aim Statement for this PIP is "Successful transition from inpatient care to ambulatory care for Pennsylvania HealthChoices members hospitalized with a mental health or a substance abuse diagnosis." OMHSAS selected three common objectives for all MCOs:

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

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

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

This PIP project extended from January 2014 through December 2018, with initial PIP proposals submitted in 2014 and a final report due in June 2019. In 2016, OMHSAS elected to add an additional intervention year to the PIP cycle to allow sufficient time for the demonstration of outcomes. The non-intervention baseline period was from January 2014 to December 2014. MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. MCOs were required to submit interim reports in 2016 and 2017. MCOs will be required to submit an additional interim report in 2018, as well as a final report in 2019. MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH Contractor-level and MCO-level data, including clinical history and pharmacy data. This PIP is a collaboration between the HC BH Contractors and MCOs. The MCOs and each of

their HC BH Contractors are required to collaboratively develop a root cause/barrier analysis that identifies potential barriers at the MCO level of analysis. Each of the barriers identified should include the contributing HC BH Contract level data and illustrate how HC BH Contractor knowledge of their high-risk populations contributes to addressing the barriers within their specific service areas. Each MCO will submit the single root cause/barrier analysis according to the PIP schedule. This PIP was formally introduced to the MCOs and HC BH Contractors during a Quality Management Directors meeting on June 4, 2014. During the latter half of 2014, OMHSAS and IPRO conducted follow-up calls with the MCOs and HC BH Contractors, as needed.

The 2018 EQR is the 15th review to include validation of PIPs. With this PIP cycle, all MCOs/HC BH Contractors share the same baseline period and timeline. To initiate the PIP cycle in 2014, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given to the MCOs/HC BH Contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness. The MCOs were expected to implement the interventions that were planned in 2014, monitor the effectiveness of their interventions, and to improve their interventions based on their monitoring results.

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

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

In 2016, OMHSAS elected to begin conducting quarterly PIP review calls with each MCO. The purpose of these calls was to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance, as necessary. Plans were asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, MCOs were asked to submit only one PIP interim report in starting in 2016, rather than two semiannual submissions.

Validation Methodology

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (*EQR Protocol 3: Validating Performance Improvement Projects [PIPs], Version 2.0, September 2012*) and meets the requirements of the final rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 10 review elements listed below:

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

The first 9 elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for each element is based on full, partial, and non-compliance. As calendar year 2017 was an intervention year for all MCOs

(which was then extended into 2018, as well), IPRO reviewed elements 1 through 9 for each MCO and provided preliminary feedback and guidance pertaining to sustainability.

Review Element Designation/Weighting

Calendar year 2017 was the second year of the Demonstrable Improvement stage. This section describes the scoring elements and methodology for reviewing the demonstrable improvement of the PIPs.

For each review element, the assessment of compliance is determined through the weighted responses to each review item. 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. **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
Met	Met or exceeded the element requirements	100%
Partially met	Met essential requirements, but is deficient in some areas	50%
Not met	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 MCO's overall performance score for a PIP. Review elements 1 through 9 are for demonstrable improvement and have a total weight of 80% (**Table 2.2**). The highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for full compliance). The MCO must sustain improvement relative to the baseline after achieving demonstrable improvement.

Table 2.2: Review Element Scoring Weights

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

*At the time of this report, this standard was not yet reportable, in accordance with the PIP implementation schedule.

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements that have been completed during the review year. At the time of the review, a project is reviewed only for elements that are due according to the PIP submission schedule. The project will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule. At the time each PIP element is reviewed, a finding is

given of "met," "partially met," or "not met." Elements receiving a "met" will receive 100% of the points assigned to the element, "partially met" elements will receive 50% of the assigned points, and "not met" elements will receive 0%.

Findings

MCO submitted their Year 3 PIP Update document for review in August 2018. IPRO provided feedback and comments to MCO on this submission. **Table 2.3** presents the PIP scoring matrix for this August 2018 Submission, which corresponds to the key findings of the review described in the following paragraphs. VBH received a total demonstrable improvement score of 47.5 out of 80 points (59.4%). Overall, this PIP was non-compliant for demonstrable improvement.

Table 2.3: PIP Scoring Matrix: Successful Transition from Inpatient to Ambulatory Care

Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 – Project Topic and Relevance	PM	50	5%	2.5
Review Element 2 –- Study Question (AIM Statement)	M	100	5%	5
Review Element 3 – Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 – Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 – Data Collection Procedures	PM	50	10%	5
Review Element 7 – Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 – Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**47.5**
Review Element 10 – Sustainability of Documented Improvement*	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			**20%**	**N/A**
OVERALL PROJECT PERFORMANCE SCORE			**100%**	**N/A**

M: met (100 points); PM: partially met (50 points); NM: not met (0 points); N/A: not applicable.
*At the time of this report, this standard was not yet reportable in accordance with the PIP implementation schedule.

As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. The MCO was partially compliant with review element 1, specifically in regard to the project identifiers. Under the Section 1 header (starting on page 2 of the PIP update submitted by the MCO), there were significant formatting issues and errors that impact clarity of changes reported and extent of project implementation. The MCO indicated that this submission was the final report; however, this submission was for the demonstrable improvement phase of the PIP. The brief description in the overview of changes (i.e., item 6d on page 3 of the MCO's submission) were not well organized; there was no indicator for the corresponding changed area (i.e., Project Topic, Methodology, Barrier Analysis/Intervention, or Other). The description contained only two points: 1) the MCO was undergoing a name change to Beacon Health Options (and at the time of this 2018 submission, the final legal entity had not been finalized, and therefore VBH-PA was referenced throughout the submission); and 2) for the 2017 DMP reviews, the BH-MCO utilized a combination of on-site and desktop reviews for the completion of the record review component of the DMP at the four pilot facilities. The two points do not sufficiently encompass an overview of all areas and dates of change. Furthermore, for the attestation on page 5 of the MCO's submission, there were no undersigned approvals of the project following the changes described in the submitted report. Recommendations to the MCO were to appropriately categorize changes into separate dates/areas of change, to reflect information regarding the change in the narrative with appropriate prefacing within the submission's Update section as well, and to ensure that any proposed or reported methodological changes are accompanied with updated attestations, reflecting sufficient approval and assurance of involvement of requisite MCO staff throughout the course of the project. There were no other issues or concerns with the requirements for the PIP topic and relevance; the PIP incorporated comprehensive data collection and analysis of aspects of enrollee needs, care and services, and addressed a broad spectrum of these appropriately.

The MCO had no issues or concerns with requirements for the aim statement. For the performance indicators that were being studied in the PIP, the MCO used objective, clearly defined, measureable, time-specific indicators to track outcomes (including the capacity to assess change and strengths of association); the MCO generally implemented

measurement methodology that was consistent with clinical standards, developed relevant process measures for each intervention, and demonstrated successful intervention tracking through the proposed process measures with quarterly reporting. However, for outcomes, not all metrics were sufficiently timed to meet the comprehensive and dynamic measurement needs of the PIP, resulting in gaps in ability to sufficiently interpret key performance indicators strongly associated with improved outcomes. This limited the MCO's ability to demonstrate improvement and validate reported improvement, and the MCO was recommended to recalibrate the measurement methodology to mitigate any gaps in reporting.

There were no issues or concerns with requirements for identification of study populations and methodology for sampling. The MCO was also compliant with the study design specifying the data sources and the data collection processes in terms of automated versus manual mechanisms. However, there were several issues with data collection procedures, resulting in partial compliance with associated requirements. For specification of a study design that used a systematic method of data collection that ensured validity and reliability for appropriate representation of the target population, the MCO was partially compliant: although the MCO had demonstrated some consideration to reliability and validity, there were flaws in the study design, which resulted in downstream implications for PIP reporting capabilities, and the MCO was unable to produce all required data needed to demonstrate improvement and validate reported improvement. For prospective specification of a data analysis plan, the MCO provided a generally clear data analysis plan (DAP). The DAP listed data collection and definitions of the denominators/numerators for After-Care Program (ACP) measures, and the MCO also provided detailed information on the performance indicators of the Provider Education intervention, on the analysis of FUH and BHRS rates for the members in the ACP, and stratifications in the analysis (by county, HC BH contractor, gender, race, age, and diagnosis) for the majority of the measures; however, the MCO insufficiently recalibrated the DAP upon identification of flaws in study design, which also contributed to downstream implications for PIP reporting capabilities, contributing to the inability to produce all required data needed to demonstrate improvement and validate reported improvement. To address these deficiencies, the MCO was recommended to address organizational barriers as part of the barrier analysis component of the PIP, and to recalibrate the data collection methodology accordingly. The time line for data collection, analysis, and reporting did not meet the requirement: the MCO was unable to produce all required data needed to demonstrate improvement and validate reported improvement; therefore, the time line failed to accommodate requisite data procurement parameters. The MCO was recommended to review and adjust the time line to reflect feasible and appropriate data collection, analysis, and reporting activities of the PIP.

There were also issues and concerns with the improvement strategies (i.e., interventions) for the PIP. For several interventions, ongoing barrier analyses were incomplete or missing. Of greater significance to this PIP, the MCO identified what appeared to be an organizational barrier, described by the MCO as the "inability to regularly obtain data for additional drill-down analyses of barriers and impacts of interventions on outcome metrics due to competing priorities and staff turnover from VBH-PA data analytics team." This statement from the MCO's submission identifies an apparent barrier that impacted the structure and implementation of the PIP. Methodological flaws impaired the MCO's ability to demonstrate improvement and validate reported improvement, and the MCO was recommended to focus on addressing organizational barriers by further studying the issue and then recalibrating the PIP, as appropriate. Processes of interventions were able to be reported through the quarterly updates provided by the MCO and, to this extent, reasonable interventions were undertaken to address identified causes and/or barriers identified. However, organization-level barriers led to significant analytical constraints; this was insufficiently addressed through any recalibration of the PIP methodology. The MCO did not provide timely clarification of the extent of organization-level barriers to meet outcome reporting requirements, which may have informed earlier guidance from OMHSAS or IPRO. As a result, the submission was found to insufficiently reconcile the reporting gaps. The MCO was recommended to identify, evaluate, and mitigate organizational barriers related to data access and downstream methodological impacts, and to recalibrate the PIP methodology to ensure compliance with reporting requirements.

In regard to the MCO interpreting and reporting the demonstrability and validity of improvement, issues and concerns were also identified for every requirement of the associated element. The submission was found to insufficiently reconcile the reporting gaps. The MCO was unable to produce all required data needed to demonstrate improvement and validate reported improvement; therefore, the analysis was incomplete and did not adhere to the statistical analysis techniques defined in the data analysis plan. Furthermore, the narrative used confusing tenses and lacked sufficient

organization; tables and charts from previous submissions are not appropriately contextualized and/or lack clarity in regard to the analysis. The MCO was recommended to: identify, evaluate, and mitigate organizational barriers and recalibrate the PIP methodology to ensure a robust analysis; to improve clarity, organization, and context for this section's narrative and visual graphics (i.e., consistent and thorough use of technical writing conventions and objective language); and to consider moving outdated graphics into the appendix.

Furthermore, in regard to demonstrability and validity of improvement, because the MCO was unable to produce all required data needed to demonstrate improvement and validate reported improvement, the analysis was incomplete and did not adequately adhere to the statistical analysis techniques defined in the data analysis plan; initial and repeat measurements were not clearly identified, making it difficult to assess changes in performance over time. The discussion did not address threats to internal and external validity (among them, factors complicating comparison of repeated measurements), nor did the discussion sufficiently address requisite analytical outcomes with context from the background literature review, previous analyses, methodological constraints and limitations, and decision-making processes related to barrier analyses. As a result, there was insufficient basis to interpret the extent to which the PIP was successful and to plan for follow-up activities. The discussion insufficiently synthesized requisite analytical outcomes with context from the background literature review, previous analyses, methodological constraints and limitations, and decision-making processes related to barrier analyses. The partial results, lack of clarity, and insufficient organization of findings do not provide sufficient basis for assessing either change in performance from baseline or subsequent improvement. The partial results, lack of clarity, and insufficient organization of findings do not provide sufficient basis to assess improvement. In particular, the causal links between the interventions and outcomes remain obscured; therefore, where improvements were noted, such claims generally lacked face validity. The MCO was recommended to ensure all requisite analytical outcomes (for both the subject submission and prior submissions) are appropriately and comprehensively integrated into the discussion section, and are appropriately framed by the background literature review, critical interpretation of findings in regard to intervention-level details, and consideration of revised methodological constraints and limitations (with clear justification of any recalibration of the PIP), as well as previous analyses, methodological constraints and limitations, and decision-making processes related to barrier analyses to support demonstration of meaningful change.

III: Performance Measures

In 2018, OMHSAS and IPRO conducted three EQR studies. Both the Follow-up After Hospitalization for Mental Illness (FUH) and Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were re-measured in 2017. OMHSAS also elected to implement a statewide measure that focuses on substance abuse services, based on the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) HEDIS measure.

Follow-up After Hospitalization for Mental Illness

This performance measure assessed the percentage of discharges for members 6 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 7 and 30 days after hospital discharge. The measure continues to be of interest to OMHSAS for the purpose of comparing County, HC BH Contractor, and BH-MCO rates to available national benchmarks and to prior years' rates.

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

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

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

For MY 2008 to MY 2012, and in MY 2014, there were only minor changes made to the specifications. The specifications were modified each year to align with the HEDIS measure.

In July 2013, after the BH-MCOs submitted their MY 2012 results, IPRO and OMHSAS conducted an encounter data validation of each BH-MCO. Part of this validation was a complete review of how each MCO produced and validated its performance measures. Based on these reviews, minor inconsistencies were found in how each BH-MCO produces its PM results. It was found that not all BH-MCOs include denied claims in their submission, and there are differences in how BH-MCOs identify transfers. Based on the results of these validations, the following changes were made to the specifications for subsequent years: If a member was known to have multiple member IDs in the MY, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim.

On January 1, 2013, a number of CPT codes for psychiatry and psychotherapy services were retired and replaced with new codes. The HEDIS follow-up measures for MY 2013 included retired codes in the follow-up specifications, but for MY 2014, the retired CPT codes were removed from all follow-up specifications.

Measure Selection and Description

In accordance with DHS guidelines, IPRO created the indicator specifications to resemble HEDIS specifications. For each indicator, the criteria specified to identify the eligible population were: product line, age, enrollment, anchor date, and

event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications, as needed. Indicator rates were calculated using only the BH-MCO's data systems to identify numerator positives (i.e., administratively).

This performance measure assessed the percentage of discharges for members 6 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 7 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 29 HC BH Contractors participating in the MY 2017 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, 2017;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Six years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2017, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified, are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 1, 2017. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2018 methodology for the Follow-up After Hospitalization for Mental Illness measure.

HEDIS Follow-up Indicators

Quality Indicator 1 (QI 1): Follow-up After Hospitalization for Mental Illness Within 7 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 7 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.

PA-Specific Follow-up Indicators

Quality Indicator A (QI A): Follow-up After Hospitalization for Mental Illness Within 7 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 7 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 in 2008, mental illnesses and mental disorders represent 6 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; World Health Organization, 2008). 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 (Dombrovski & Rosenstock, 2004; Moran, 2009) such as obesity, cardiovascular diseases, and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns (Gill, 2005; Leslie & Rosenheck, 2004), reduced use of preventive services (Druss et al., 2002), and substandard medical care that they receive (Desai et al., 2002; Frayne et al., 2005; Druss et al., 2000). Moreover, these patients are five times more likely to become homeless than those without these disorders (Averyt et al., 1997). On the whole, serious mental illnesses account for more than 15% of overall disease burden in the United States (National Institute of Mental Health, 2009), 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 (Insel, 2008). 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 (D'Mello et al., 1995). 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. An outpatient visit within at least 30 days (ideally, 7 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 to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments (van Walraven et al., 2004). 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 (Hermann, 2000). 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 (Hermann, 2000).

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% of patients fail to connect with an outpatient clinician (Cuffel et al., 2002). 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 (Nelson et al., 2000). 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 (Nelson et al., 2000). 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 (Adair et al., 2005). Patients with higher functioning, in turn, had significantly lower community costs, and improved provider continuity was associated with lower hospital (Mitton et al., 2005) and Medicaid costs (Chien et al., 2000).

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 (Chien et al., 2000). Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care and is an effective means to control the cost and maximize the quality of mental health services.

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

Methodology

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

Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. The three-year OMHSAS goal was to achieve the 75th percentile for ages 6 to 64, based on the annual HEDIS published percentiles for 7-day and 30-day FUH by MY 2017. For MY 2013 through MY 2017, BH-MCOs were given interim goals for the next MY for both the 7-day and 30-day follow-up rates based on their previous years' results. The interim goals are defined as follows (Note: If any of the following rules generate a goal lower than the previous year's goal, then the new goal = last year's goal, even if this amounts to a greater than 5% improvement):

1. If the yearly rate is below the NCQA Quality Compass® 50th percentile, then:
    a. If rate ≥ 5 percentage points (PPs) below the Quality Compass 50th percentile, then new goal = last year's rate + 5% improvement over last year's rate.
    b. If rate ≥ 2 PPs and < 5 PPs below the Quality Compass 50th percentile, then new goal = last year's rate + 5% improvement over last year's rate, or the Quality Compass 50th percentile, whichever is less.
    c. If rate < 2 PPs below the Quality Compass 50th percentile, then new goal = the Quality Compass 50th percentile.
2. If the yearly rate is rate is above or equal to the Quality Compass 50th percentile and below the 75th percentile, then:
    a. If rate ≥ 2 PPs below the Quality Compass 75th percentile, then new goal = last year's rate + 2% improvement over last year's rate.
    b. If rate < 2 PPs below the Quality Compass 75th percentile, then new goal = last year's rate + 2% improvement over last year's rate, or the Quality Compass 75th percentile, whichever is less.
3. If rate is above or equal to the Quality Compass 75th percentile, then new goal = last year's goal.

Interim goals were provided to the BH-MCOs after the MY 2016 rates were received. The interim goals were updated from MY 2013 to MY 2017. The interim goals are used the BH-MCOs progress in achieving the OMHSAS goal of the 75th percentile.

HEDIS percentiles for the 7-day and 30-day FUH indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis for these indicators. As noted in **Section V** of this report, beginning with MY 2012 performance, and continuing through MY 2017, rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request for a root cause analysis.

Data Analysis

The quality indicators were defined as rates, based on a numerator of qualifying events or members and a denominator of qualifying events or members, defined according to the specifications of the measure. The HealthChoices Aggregate (Statewide) for each indicator was the total numerator divided by the total denominator, which represented the rate derived for the Statewide population of denominator-qualifying events or members. Year-to-year comparisons to MY 2016 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *z* statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

$$\hat{p} = \frac{N1 \ + \ N2}{D1 \ + \ D2}$$

Where:

*N*1 = Current year (MY 2017) numerator
*N*2 = Prior year (MY 2016) numerator
*D*1 = Current year (MY 2017) denominator
*D*2 = Prior year (MY 2016) denominator

The single proportion estimate was then used for estimating the standard error (SE).

Z-test-statistic was obtained by dividing the difference between the proportions by the standard error of the difference. Analysis that uses the *z* test assumes that the data and their test statistics approximate a normal distribution. To correct for approximation error, the Yates correction for continuity was applied:

$$z - statistic = \frac{ABS(p1 - p2) - 0.5(\frac{1}{D1} + \frac{1}{D2})}{\sqrt{\hat{p}(1 - \hat{p})[\frac{1}{D1} + \frac{1}{D2}]}}$$

Where:

*p*1 = Current year (MY 2017) quality indicator rate
*p*2 = Prior year (MY 2016) quality indicator rate

Two-tailed statistical significant tests were conducted at *p* value = 0.05 to test the null hypothesis of:

$$H_0: p1 = p2$$

Percentage point difference (PPD) as well as 95% confidence intervals for difference between the two proportions were also calculated. Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

It should be noted that Pennsylvania continued its Medicaid expansion under the Affordable Care Act in 2017. Due to data quality concerns with identifying the Medicaid expansion subpopulation; however, the decision was made not to compare rates for this subpopulation; thus, any potential impacts on rates from the Medicaid expansion were not evaluated for MY 2017. The plan is to incorporate this analysis in next year's BBA report.

Finally, the Southwest Behavioral Health Management, Inc., which was formed on January 1, 2017, was treated as one Contractor in this analysis, and none of the related comparisons were made.

Limitations

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for HC BH Contractors. Caution should be exercised when interpreting results for small denominators. A denominator of 100 or greater is preferred for drawing conclusions from Z-score tests of the performance measure results. In addition, the above analysis assumes that the proportions being compared come from independent samples. To the extent that this is not the case, the findings should be interpreted with caution.

Findings

BH-MCO and HC BH Contractor Results

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

The results are presented at the BH-MCO- and HC BH-Contractor level when multiple HC BH Contractors are represented by a single BH-MCO. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (i.e., across HC BH Contractors with the same contracted BH-MCO). The HC BH Contractor-specific rates were calculated using the numerators and denominators for that particular HC BH Contractor. For each of these rates, the 95% confidence interval (CI) is reported. The HealthChoices BH Aggregate (Statewide) rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HealthChoices BH Statewide rates 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 Statewide rate for the indicator. Statistically significant BH-MCO differences are noted.

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

The HEDIS follow-up results for the 6 to 64 years old age group and the 6+ years old age groups are compared to the MY 2017 HEDIS national percentiles. NCQA produces annual HEDIS Follow-up After Mental Health benchmarks for the 6+ years old age band only; therefore results for the 6 to 64 year old age group are compared to percentiles for the 6+ years old age bands. The percentile comparison for the ages 6 to 64 years old age group is presented to show BH-MCO and HC BH Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile by MY 2017. HEDIS percentile comparisons for the ages 6+ years old age group are presented for illustrative purposes only. The HEDIS follow-up results for the 6 to 20 years old age group are not compared to HEDIS benchmarks for the 6+ years old age band.

I: HEDIS Follow-up Indicators

(a) Age Group: 6–64 Years Old

As noted in the Performance Goal section, OMHSAS has elected to set a three-year goal for both the HEDIS 7-day and 30-day follow-up measures for members ages 6 to 64 years old. The goal was for all HC BH Contractor and BH-MCO rates to meet or exceed the HEDIS 75th percentile by MY 2017. For MYs 2013 through 2017, BH-MCOs were given interim goals for the next MY for both the 7-day and 30-day follow-up rates based on their previous years' results. **Table 3.1** shows the MY 2017 results compared to their MY 2017 goals and HEDIS percentiles, as well as to MY 2016.

Table 3.1: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Indicators (6–64 Years)

MY 2017								MY 2016	MY 2017 Rate Comparison		
				95% CI		Goal			To MY 2016		To MY 2017 HEDIS
Measure	(N)	(D)	%	Lower	Upper	%	Met?	%	PPD	SSD	Medicaid Percentiles
QI1 – HEDIS 7-Day Follow-up (6–64 Years)											
HealthChoices (Statewide)	16,420	41,778	**39.3%**	38.8%	39.8%	48.5%	No	43.7%	-4.4	Yes	Below 75th percentile, above 50th percentile
VBHPA	2,975	7,539	**39.5%**	38.4%	40.6%	48.6%	No	44.1%	-4.6	Yes	Below 75th percentile, above 50th percentile
Beaver	308	863	**35.7%**	32.4%	38.9%	48.1%	No	45.2%	-9.5	Yes	Below 50th percentile, above 25th percentile
Cambria*	153	367	**41.7%**	36.5%	46.9%	44.9%	No	43.3%	-1.6	No	Below 75th percentile, above 50th percentile
NWBHP	494	1,217	**40.6%**	37.8%	43.4%	45.6%	No	43.8%	-3.2	No	Below 75th percentile, above 50th percentile
Fayette	299	804	**37.2%**	33.8%	40.6%	51.5%	No	43.2%	-6.0	No	Below 75th percentile, above 50th percentile
Greene	87	232	**37.5%**	31.1%	43.9%	50.6%	No	40.0%	-2.5	No	Below 75th percentile, above 50th percentile
SWBHM	1,634	4,056	**40.3%**	38.8%	41.8%	46.0%	No	44.4%	-4.1	Yes	Below 75th percentile, above 50th percentile
QI2 - HEDIS 30-Day Follow-up (6-64 Years)											
HealthChoices (Statewide)	25,425	41,778	**60.9%**	60.4%	61.3%	69.2%	No	63.5%	-2.6	Yes	Below 75th percentile, above 50th percentile
VBHPA	4883	7,539	**64.8%**	63.7%	65.9%	73.2%	No	68.3%	-3.5	Yes	Below 75th percentile, above 50th percentile
Beaver	519	863	**60.1%**	56.8%	63.5%	72.3%	No	70.8%	-10.7	Yes	Below 75th percentile, above 50th percentile
Cambria*	261	367	**71.1%**	66.3%	75.9%	72.3%	No	70.0%	1.1	No	At or above 75th percentile
NWBHP	798	1,217	**65.6%**	62.9%	68.3%	73.5%	No	67.5%	-1.9	No	Below 75th Percentile, Above 50th Percentile
Fayette	519	804	**64.6%**	61.2%	67.9%	72.8%	No	70.5%	-5.9	No	Below 75th percentile, above 50th percentile
Greene	145	232	**62.5%**	56.1%	68.9%	74.0%	No	73.3%	-10.8	No	Below 75th percentile, above 50th percentile
SWBHM	2,641	4,056	**65.1%**	63.6%	66.6%	68.8%	No	67.8%	-2.7	Yes	Below 75th percentile, above 50th percentile

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; VBHPA: Value Behavioral Health of Pennsylvania; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.
Note: Cambria moved its HC BH Contract from VBH to MBH, effective July 1, 2017.

The MY 2017 HealthChoices Aggregate (Statewide) HEDIS follow-up rates in the 6 to 64 years age group were 39.3% for QI 1 and 60.9% for QI 2 (**Table 3.1**). These rates were statistically significantly lower than the HealthChoices Aggregate rates for this age group in MY 2016, which were 43.7% and 63.5%, respectively. The HealthChoices Aggregate rates were below the MY 2017 interim goals of 48.5% for QI 1 and 69.2% for QI 2; therefore, neither of the interim goals were met in MY 2017. Both HealthChoices Aggregate rates were between the NCQA 50th and 75th percentile; therefore, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2017 for either rate.

The MY 2017 VBH QI 1 rate for members ages 6 to 64 years was 39.5%, a 4.6 percentage point decrease from the MY 2016 rate of 44.1% (**Table 3.1**). VBH's corresponding QI 2 rate was 64.8%, a 3.5 percentage point decrease from the MY 2016 rate of 68.3%. Both rates were statistically significantly lower than the prior year. VBH's rates were below its target goals of 48.6% for QI 1 and 73.2% for QI 2; therefore, neither of the interim follow-up goals was met in MY 2017. VBH'S QI 1 and QI 2 rates were between the HEDIS 50th and 75th percentiles. Therefore, the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by VBH in MY 2017 for either rate.

From MY 2016 to MY 2017, Beaver and SWBHM rates dropped statistically significantly for both QI 1 and QI 2 (**Table 3.1**). None of the VBH Contractors met their MY 2017 interim goals for the two measures. Only the QI 2 rate of Cambria met the OMHSAS goal of meeting the corresponding HEDIS 75th percentile.

Figure 3.1 is a graphical representation of MY 2017 HEDIS FUH 7- and 30-Day follow-up rates in the 6 to 64 years old population for VBH and its associated HC BH Contractors.

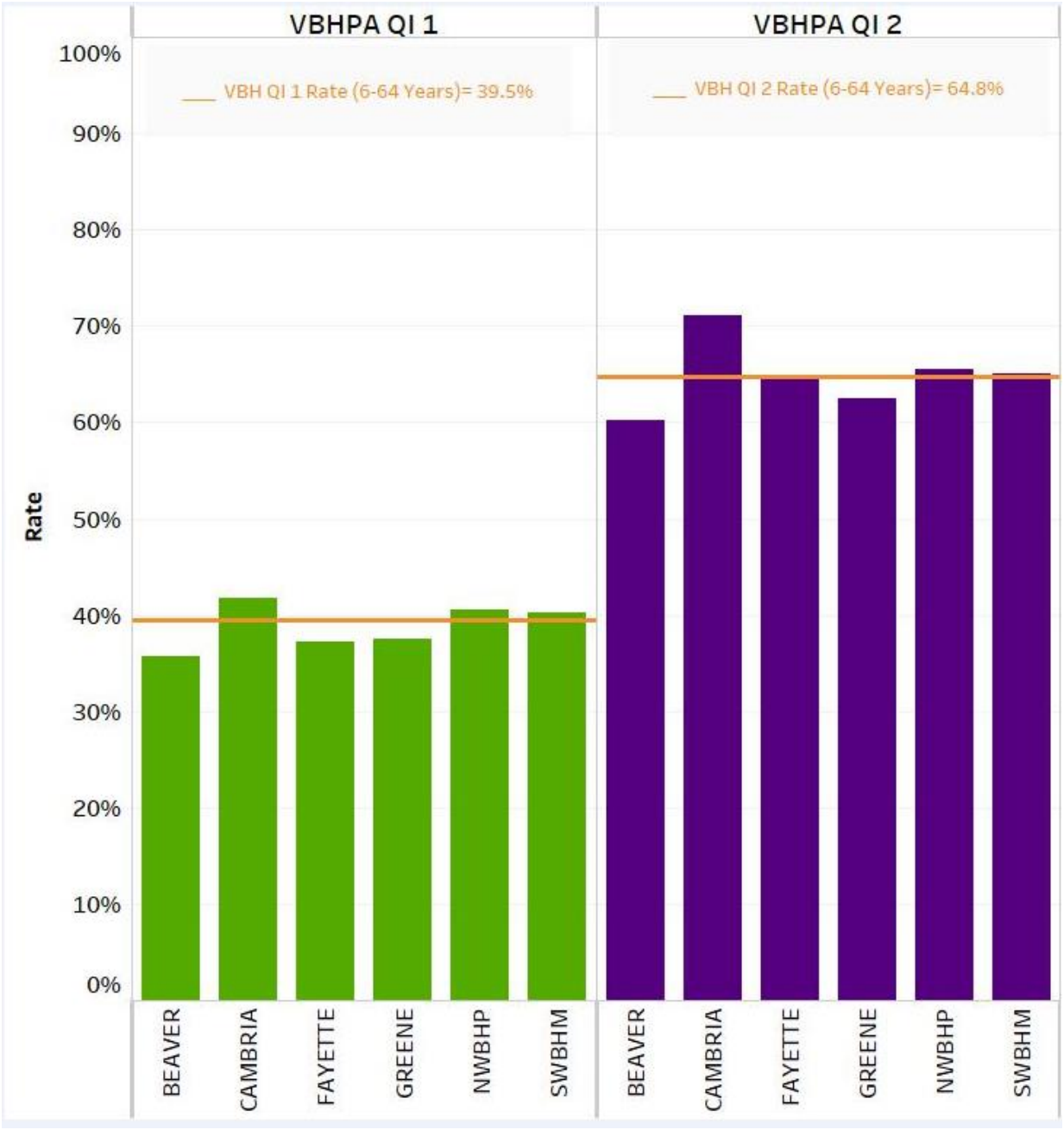

Figure 3.1: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (6–64 Years).

Figure 3.2 shows the HC BH (Statewide) rates for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the HC BH (Statewide) rate. Of all the contractors, the QI 1 rate for Beaver was statistically significantly below the MY 2017 QI 1 HC BH rate of 39.3% by 3.6 percentage points. Fayette, SWBHM, NWBHP, and Cambria produced QI 2 rates significantly above the QI 2 HC BH rate of 60.9%, surpassing that benchmark by between 3.7 and 10.2 percentage points.

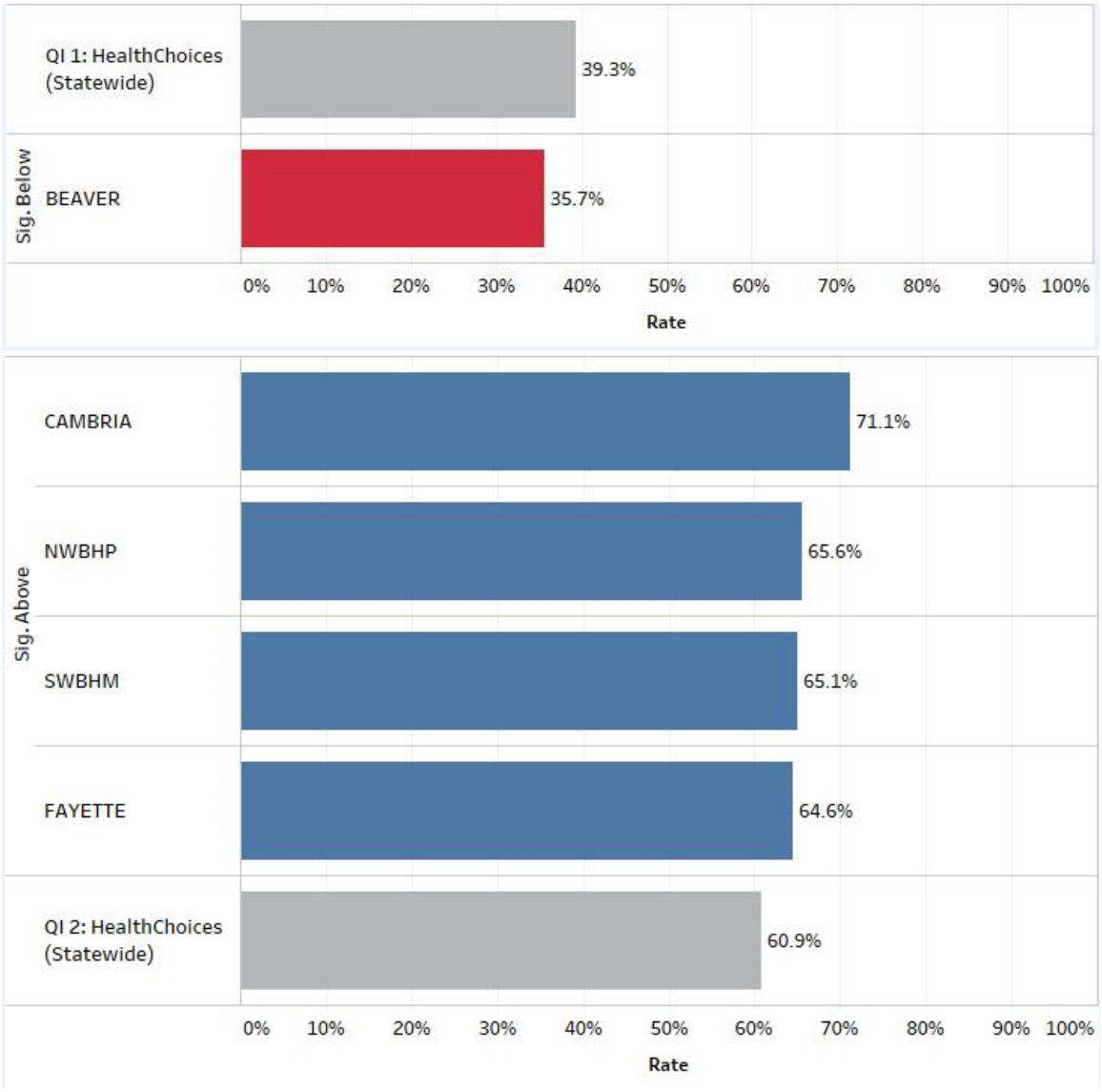

Figure 3.2: Comparison of VBH Contractor MY 2017 HEDIS FUH Follow-up Rates (6–64 Years) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (6–64 Years).

(b) Overall Population: 6+ Years Old

The MY 2017 HealthChoices Aggregate HEDIS follow-up rates were 39.1% for QI 1 and 60.6% for QI 2 (**Table 3.2**). These rates were statistically significantly lower than the HealthChoices Aggregate rates in MY 2016, which were 43.5% and 63.2%, respectively. For VBH, the MY 2017 QI 1 rate was 39.4%, a statistically significant decrease of 4.4 percentage points from the prior year. The VBH QI 2 rate was 64.6%, a statistically significant decrease of 3.5 percentage points from the MY 2016 QI 2 rate. Once again, the only notable changes from MY 2016 to MY 2017 among the VBH HC BH Contractors were Beaver and SWBHM, which decreased statistically significantly for both QI 1 and QI2 rates. None of the Contractors met the HEDIS goal of meeting or exceeding 75th percentile except Cambria for its QI 2 rate (**Table 3.2**).

Table 3.2: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Indicators (Overall)

MY 2017						MY 2016	MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD	
QI – HEDIS 7-Day Follow-up (Overall)									
Statewide	16,536	42,283	**39.1%**	38.6%	39.6%	43.5%	-4.4	Yes	Below 75th percentile, above 50th percentile
VBHPA	2,992	7,601	**39.4%**	38.3%	40.5%	43.8%	-4.4	Yes	Below 75th percentile, above 50th percentile
Beaver	308	868	**35.5%**	32.2%	38.7%	45.3%	-9.8	Yes	Below 50th percentile, above 25th percentile
Cambria*	156	373	**41.8%**	36.7%	47.0%	42.8%	-1.0	No	Below 75th percentile, above 50th percentile
NWBHP	494	1,221	**40.5%**	37.7%	43.3%	43.4%	-2.9	No	Below 75th percentile, above 50th percentile
Fayette	304	817	**37.2%**	33.8%	40.6%	42.8%	-5.6	No	Below 75th percentile, above 50th percentile
Greene	87	233	**37.3%**	30.9%	43.8%	40.0%	-2.7	No	Below 75th percentile, above 50th percentile
SWBHM	1,643	4,089	**40.2%**	38.7%	41.7%	44.1%	-3.9	Yes	Below 75th percentile, above 50th percentile
QI2 – HEDIS 30-Day Follow-up (Overall)									
Statewide	25,630	42,283	**60.6%**	60.1%	61.1%	63.2%	-2.6	Yes	Below 75th percentile, above 50th percentile
VBHPA	4,914	7,601	**64.6%**	63.6%	65.7%	68.1%	-3.5	Yes	Below 75th percentile, above 50th percentile
Beaver	521	868	**60.0%**	56.7%	63.3%	70.9%	-10.9	Yes	Below 75th percentile, above 50th percentile
Cambria*	265	373	**71.0%**	66.3%	75.8%	69.5%	1.5	No	At or above 75th percentile
NWBHP	798	1,221	**65.4%**	62.6%	68.1%	67.4%	-2.0	No	Below 75th percentile, above 50th percentile
Fayette	527	817	**64.5%**	61.2%	67.8%	70.1%	-5.6	No	Below 75th percentile, above 50th percentile
Greene	145	233	**62.2%**	55.8%	68.7%	73.3%	-11.1	No	Below 75th percentile, above 50th percentile
SWBHM	2,658	4,089	**65.0%**	63.5%	66.5%	67.5%	-2.5	Yes	Below 75th percentile, above 50th percentile

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; VBHPA: Value Behavioral Health of Pennsylvania; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.
Note: Cambria moved its HC BH Contract from VBH to MBH, effective July 1, 2017.

Figure 3.3 is a graphical representation of the MY 2017 HEDIS follow-up rates for VBH and its associated HC BH Contractors.

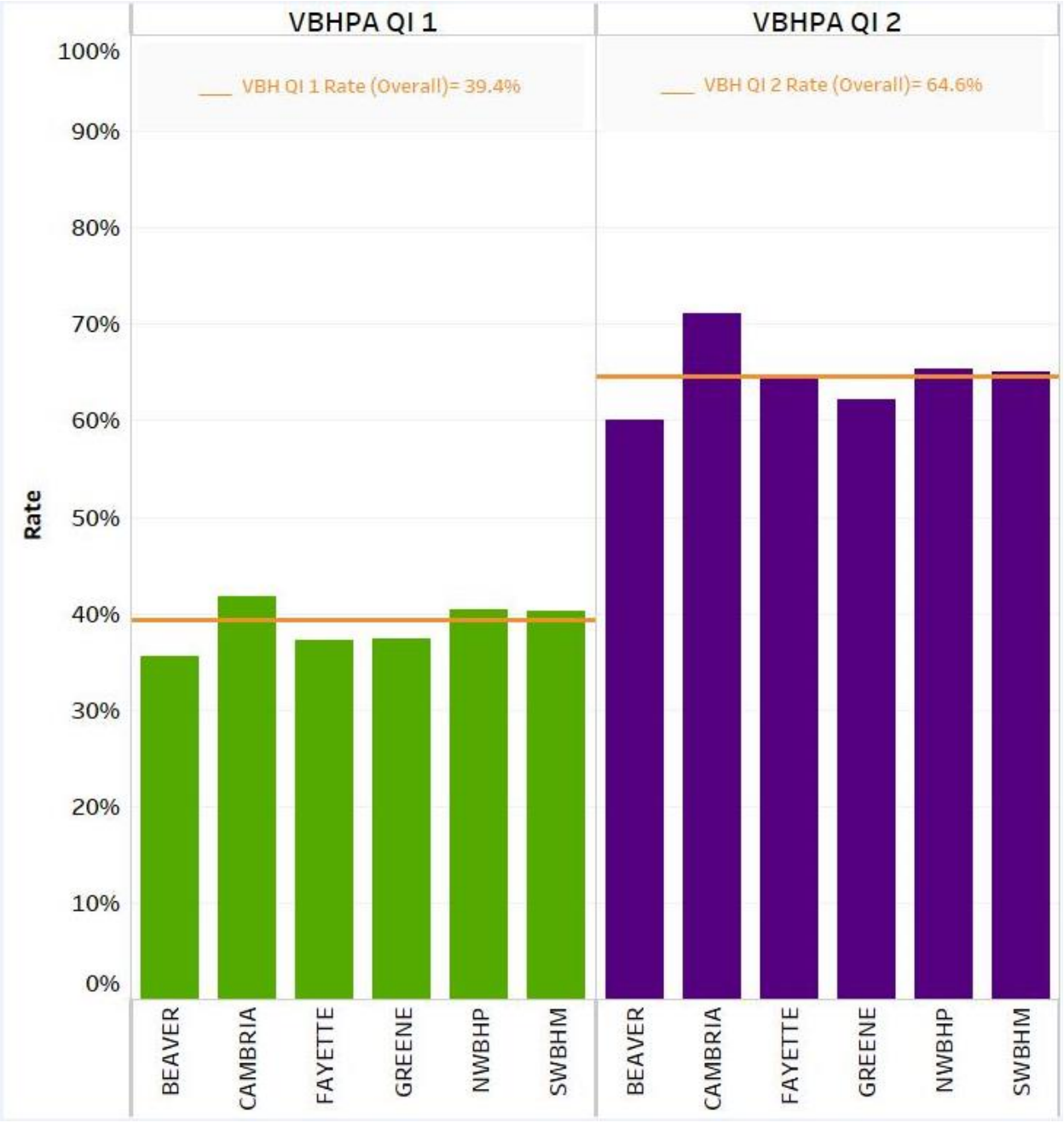

Figure 3.3: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (Overall).

Figure 3.4 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than its statewide benchmark. Of all the contractors, the QI 1 rate for Beaver was statistically significantly below the MY 2017 QI 1 HC BH rate of 39.1% by 3.6 percentage points. Fayette, SWBHM, NWBHP, and Cambria produced QI 2 rates significantly above the QI 2 HC BH rate of 60.6%, surpassing that benchmark by between 3.9 and 10.4 percentage points.

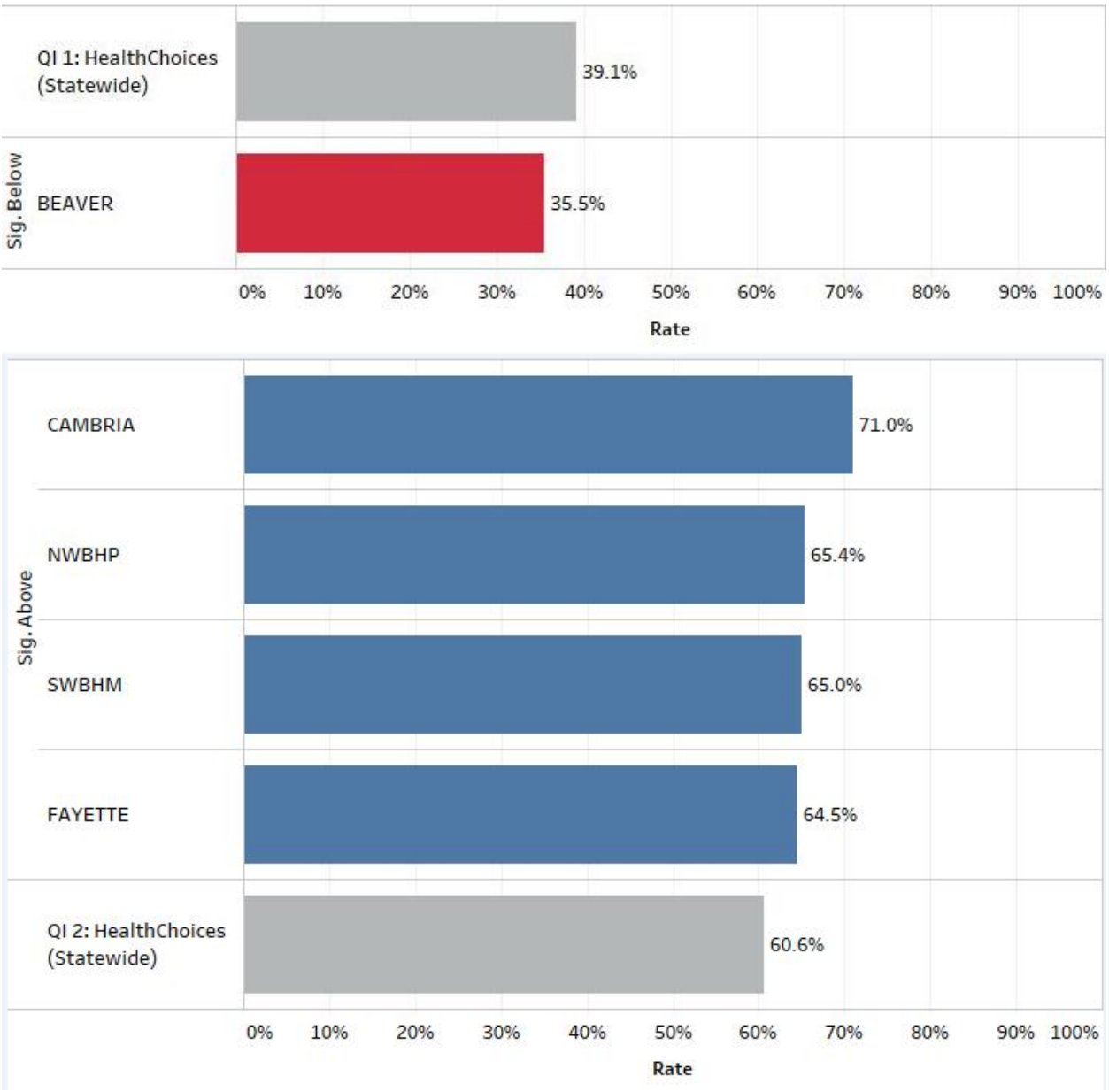

Figure 3.4: Comparison of VBH Contractor MY 2017 HEDIS FUH Follow-up Rates (Overall) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (Overall).

(c) Age Group: 6–20 Years Old

The MY 2017 HealthChoices Aggregate rates in the 6 to 20 years age group were 51.1% for QI 1 and 74.0% for QI 2 (**Table 3.3**).These rates were statistically significantly lower than the MY 2016 HealthChoices Aggregate rates for the 6 to 20 years age cohort, which were 56.1% and 77.4%, respectively. The VBH MY 2017 HEDIS rates for members ages 6 to 20 years were 49.3% for QI 1 and 76.5% for QI 2; the QI 1 rate was statistically significantly lower than the prior year rate by 5 percentage points, but the QI 2 rate was comparable (**Table 3.3**). Of the VBH Contractors with sufficiently large denominators to compare, the only notable change was the QI 1 rate for SWBHM Contractor, which dropped statistically significantly by 4.9 percentage points from 54.7% in MY 2016 to 49.8% in MY 2017.

Table 3.3: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Indicators (6–20 Years)

MY 2017						MY 2016	MY 2017 Rate Comparison to MY 2016	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI1 – HEDIS 7-Day Follow-up (6–20 Years)								
Statewide	5,792	11,325	**51.1%**	50.2%	52.1%	56.1%	-5.0	YES
VBHPA	1,055	2,140	**49.3%**	47.2%	51.4%	54.3%	-5.0	YES
Beaver	89	187	**47.6%**	40.2%	55.0%	54.6%	-7.0	NO
Cambria*	48	91	**52.7%**	N/A	N/A	62.1%	-9.4	N/A
NWBHP	197	408	**48.3%**	43.3%	53.3%	50.2%	-1.9	NO
Fayette	129	250	**51.6%**	45.2%	58.0%	54.5%	-2.9	NO
Greene	32	80	**40.0%**	N/A	N/A	44.8%	-4.8	N/A
SWBHM	560	1,124	**49.8%**	46.9%	52.8%	54.7%	-4.9	YES
QI2 – HEDIS 30-Day Follow-up (6–20 Years)								
Statewide	8,380	11,325	**74.0%**	73.2%	74.8%	77.4%	-3.4	YES
VBHPA	1,637	2,140	**76.5%**	74.7%	78.3%	79.4%	-2.9	NO
Beaver	141	187	**75.4%**	69.0%	81.8%	82.4%	-7.0	NO
Cambria*	73	91	**80.2%**	N/A	N/A	84.1%	-3.9	N/A
NWBHP	306	408	**75.0%**	70.7%	79.3%	76.2%	-1.2	NO
Fayette	201	250	**80.4%**	75.3%	85.5%	77.3%	3.1	NO
Greene	54	80	**67.5%**	N/A	N/A	75.9%	-8.4	N/A
SWBHM	862	1,124	**76.7%**	74.2%	79.2%	79.6%	-2.9	NO

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; VBHPA: Value Behavioral Health of Pennsylvania; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

N/A: Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

Note: Cambria moved its HC BH Contract from VBH to MBH, effective July 1, 2017.

Figure 3.5 is a graphical representation of the MY 2017 HEDIS follow-up rates in the 6 to 20 years old population for VBH and its associated HC BH Contractors.

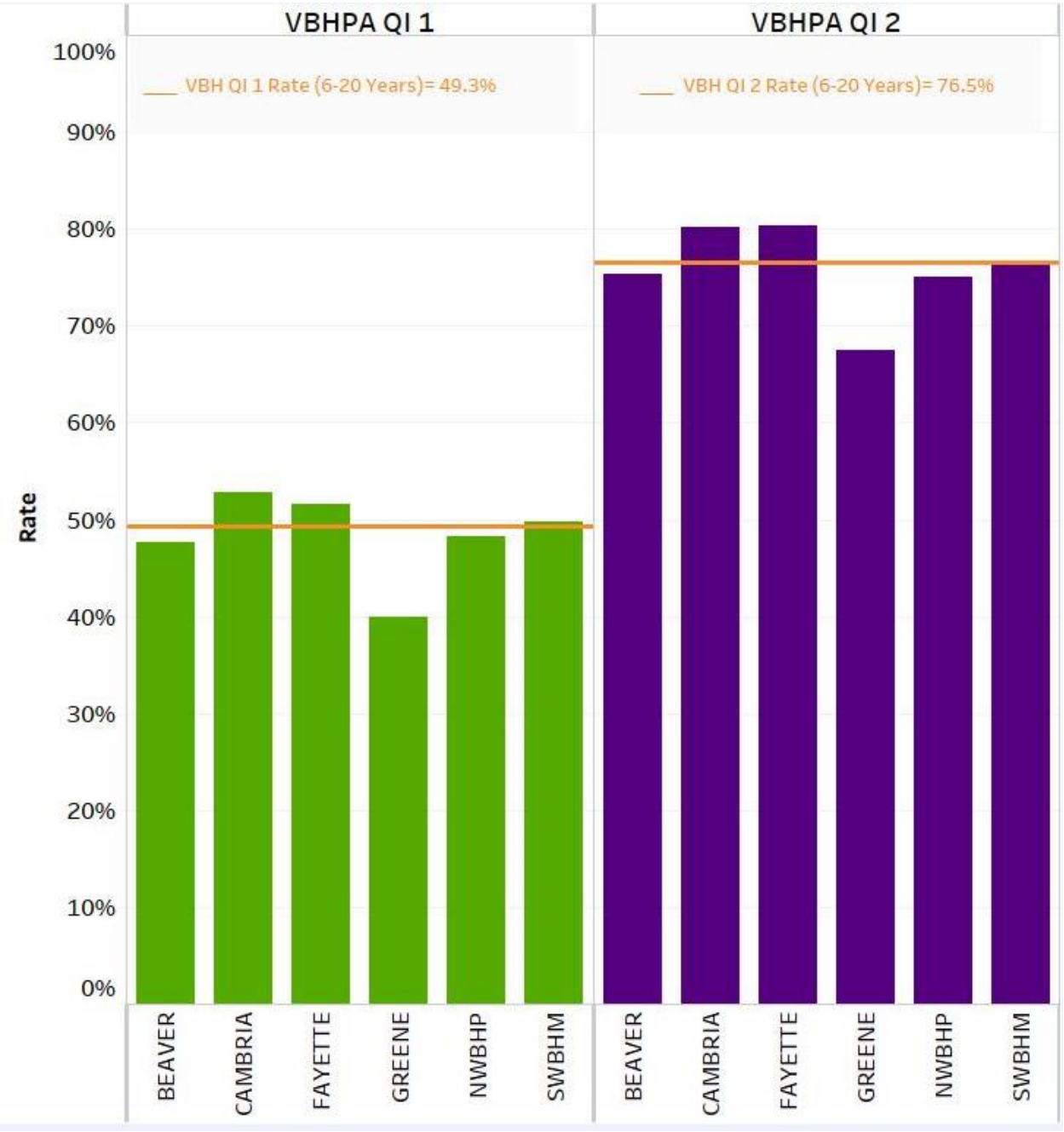

Figure 3.5: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (6–20 Years).

Figure 3.6 shows the HC BH (Statewide) rates for this age cohort and the individual HC BH Contractor rates that would have been statistically significantly higher or lower than the statewide rates. None of the Contractors turned in rates that deviated significantly from the HC BH QI 1 rate of 51.1%. Fayette did, however, turn in a QI 2 rate that was statistically significantly above the HC BH QI 2 rate of 74.0% by 6.4 percentage points.

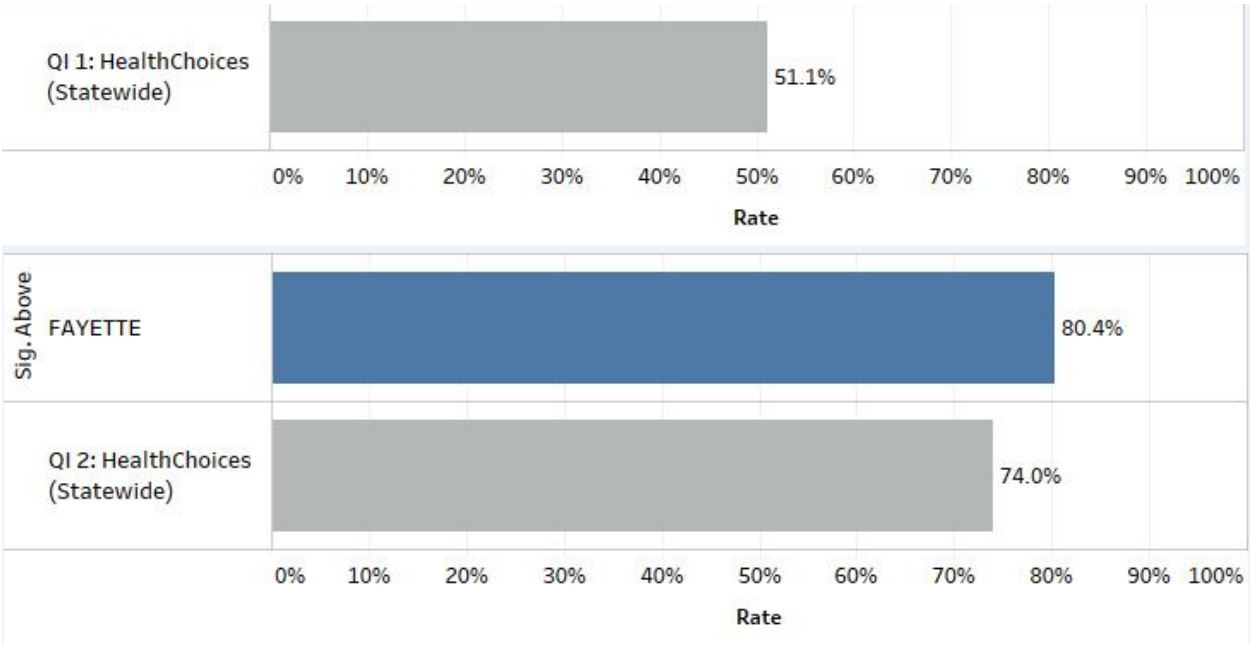

Figure 3.6: Comparison of VBH Contractor MY 2017 HEDIS FUH Follow-up Rates (6–20 Years) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (6-20 Years).

II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

The MY 2017 HealthChoices Aggregate rates were 52.2% for QI A and 69.6% for QI B (**Table 3.4**). Both rates demonstrated statistically significant decreases from the MY 2016 PA-specific follow-up rates: the QI A rate decreased from the MY 2016 rate of 53.8% by 1.6 percentage points, while the QI B rate decreased from the MY 2016 rate of 70.4% percentage points by 0.8 percentage points. The MY 2017 VBH QI A rate was 49.6%, which represents a 5.0 percentage point decrease from the prior year, and the VBH QI B rate was 72.0%, which represents a 3.2 percentage point decrease from the prior year. These year-to-year decreases were statistically significant.

Of all the VBH HC BH contractors, QI A and QI B both decreased significantly from MY 2016 to MY 2017 for Beaver and SWBHM. For NWBHP, the QI A rate dropped statistically significantly from 55.9% in MY 2016 to 51.5 % in MY 2017, but the QI B rate did not change significantly for this HC BH contractor (**Table 3.4**).

Table 3.4: MY 2017 PA-Specific FUH 7- and 30-Day Follow-up Indicators (Overall)

MY 2017						MY 2016	MY 2017 Rate Comparison to MY 2016	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI A – PA-Specific 7-Day Follow-up (Overall)								
Statewide	22,071	42,280	**52.2%**	51.7%	52.7%	53.8%	-1.6	Yes
VBHPA	3,771	7,598	**49.6%**	48.5%	50.8%	54.6%	-5.0	Yes
Beaver	392	868	**45.2%**	41.8%	48.5%	56.3%	-11.1	Yes
Cambria	185	373	**49.6%**	44.4%	54.8%	51.0%	-1.4	No
NWBHP	628	1,220	**51.5%**	48.6%	54.3%	55.9%	-4.4	Yes
Fayette	353	819	**43.1%**	39.6%	46.6%	49.7%	-6.6	No
Greene	109	233	**46.8%**	40.2%	53.4%	51.1%	-4.3	No
SWBHM	2,104	4,085	**51.5%**	50.0%	53.1%	55.1%	-3.6	Yes

MY 2017						MY 2016	MY 2017 Rate Comparison to MY 2016	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI B - PA-Specific 30-Day Follow-up (Overall)								
Statewide	29,440	42,280	**69.6%**	69.2%	70.1%	70.4%	-0.8	Yes
VBHPA	5,473	7,598	**72.0%**	71.0%	73.0%	75.2%	-3.2	Yes
Beaver	576	868	**66.4%**	63.2%	69.6%	76.8%	-10.4	Yes
Cambria	279	373	**74.8%**	70.3%	79.3%	74.3%	0.5	No
NWBHP	899	1,220	**73.7%**	71.2%	76.2%	74.8%	-1.1	No
Fayette	574	819	**70.1%**	66.9%	73.3%	75.9%	-5.8	No
Greene	164	233	**70.4%**	64.3%	76.5%	75.6%	-5.2	No
SWBHM	2,981	4,085	**73.0%**	71.6%	74.3%	75.4%	-2.4	Yes

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; VBHPA: Value Behavioral Health of Pennsylvania; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.
Note: Cambria moved its HC BH Contract from VBH to MBH, effective July 1, 2017.

Figure 3.7 is a graphical representation of the MY 2017 PA-specific follow-up rates for VBH and its associated HC BH Contractors.

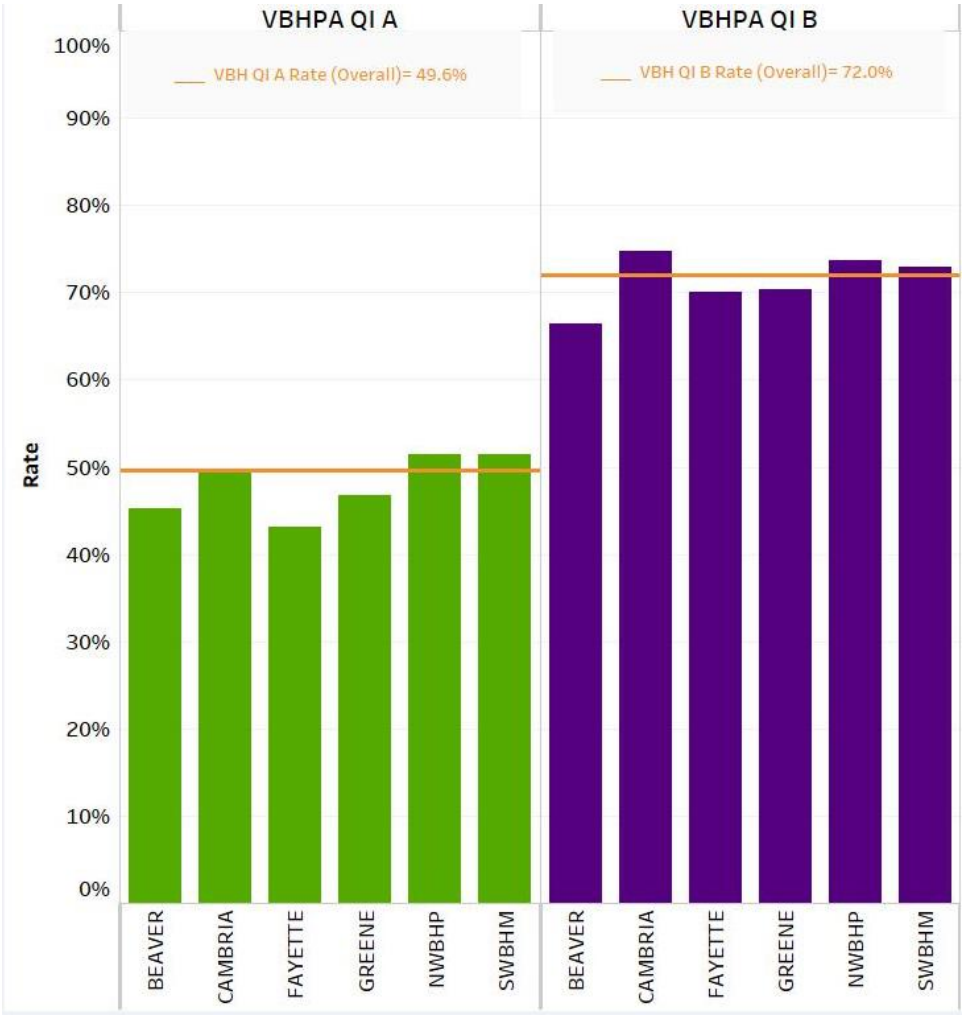

Figure 3.7: MY 2017 PA-Specific FUH 7- and 30-Day Follow-up Rates (Overall).

Figure 3.8 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. For QI A, Beaver and Fayette fell statistically significantly below the Statewide QI A rate of 52.2% by 7.0 and 9.1 percentage points, respectively. Cambria, NWBHP, and SWBHM produced QI B rates that were significantly above the QI B HC BH rate of 69.6%, surpassing that benchmark by between 5.2, 4.1, and 3.4 percentage points, respectively. The QI B rate for Beaver fell statistically significantly below the Statewide rate by 3.4 percentage points.

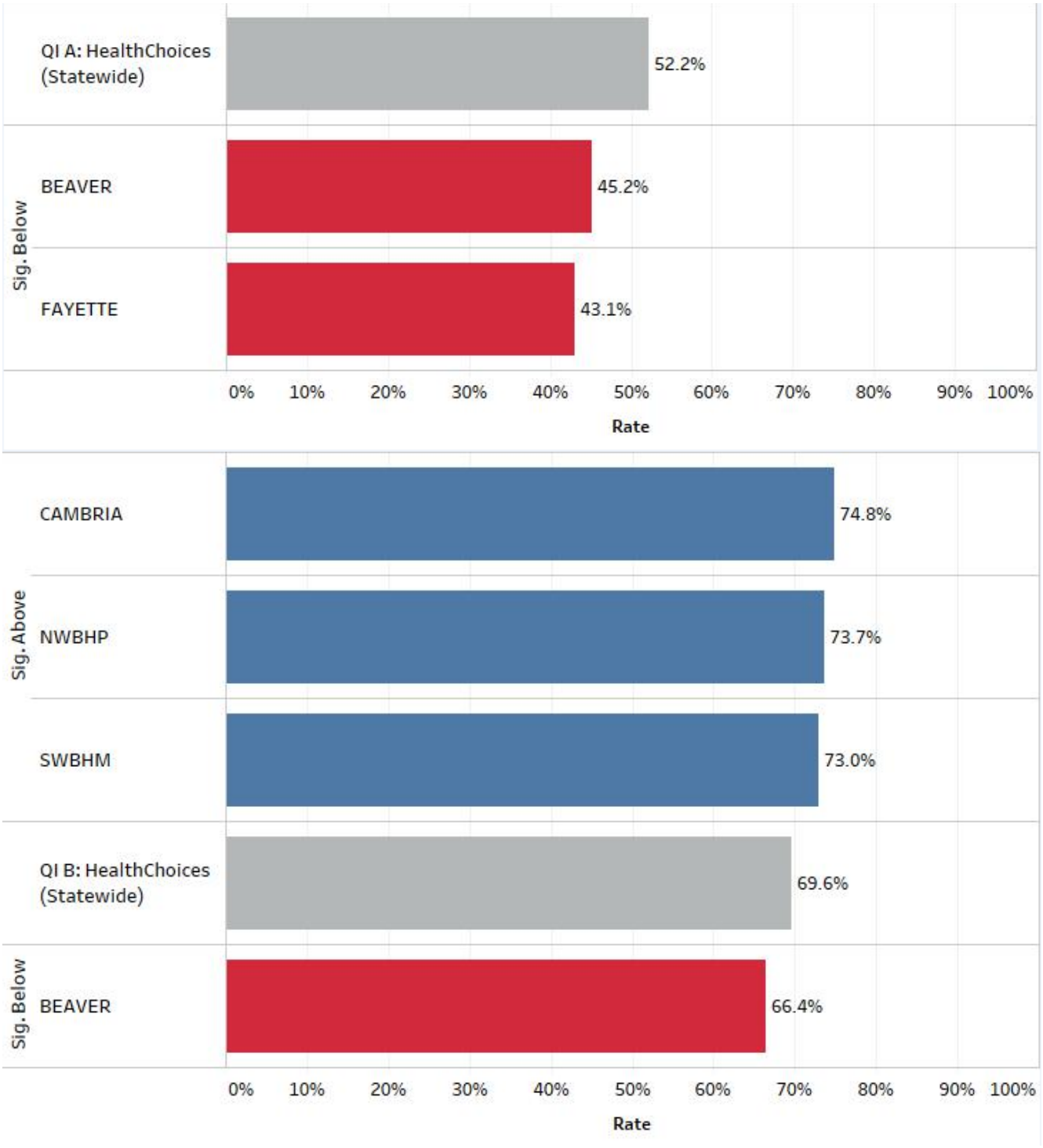

Figure 3.8: Comparison of VBH Contractor MY 2017 PA-Specific FUH Follow-up Rates (Overall) versus HealthChoices (Statewide) MY 2017 PA-Specific FUH Follow-up Rates (Overall).

Conclusion and Recommendations

As with most reporting years, it is important to note that there were some changes to the HEDIS 2018 specifications, including the numerator exclusion of visits that occur on the date of discharge (although this exclusion did not extend to the PA-specific measure). That said, efforts should continue to be made to improve Follow-up After Hospitalization for Mental Illness performance, particularly for those BH-MCOs that performed below the HealthChoices Statewide rate. Following are recommendations that are informed by both the MY 2017 review as well as by the 2015 follow-up (care) study, which included results for MY 2014 and MY 2015:

- The purpose of this re-measurement study is to inform OMHSAS, the HC BH Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2017 which included the third year of the current PIP cycle, to promote continuous quality improvement with regard to timely 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. BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in the next few years as a result of their interventions. To that end, the HC BH Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving behavioral health care follow-up. The HC BH Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care and then implement action and monitoring plans to further increase their rates. OMHSAS's shift in 2017 to a prospective RCA and CAP process should assist with this effort.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. This year's findings indicate that, with some notable HC BH Contractor exceptions, FUH rates have, for the most part decreased (worsened), both for the State and for the BH-MCO. In some cases, the change was a continuation or even acceleration of existing trends. As previously noted, this analysis was not able to carry out more detailed examination of rates associated with the Medicaid expansion subpopulation. The potential impact on rates from the Medicaid expansion in 2017 could not be evaluated in this report. However, BH-MCOs and HC BH Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For one, it is important for BH-MCOs and HC BH Contractors to analyze performance rates by racial and ethnic categories and to target the demographic populations that do not perform as well as their counterparts. It is recommended that BH-MCOs and HC BH Contractors continue to focus interventions on populations that exhibit lower follow-up rates. Further, it is important to examine regional trends in disparities. For instance, previous studies indicate that African Americans in rural areas have disproportionately low follow-up rates, which stands in contrast to the finding that overall follow-up rates are generally higher in rural areas than in urban areas. Possible reasons for racial-ethnic disparities include access, cultural competency, and community factors; these and other drivers should be evaluated to determine their potential impact on performance.
- BH-MCOs and HC BH Contractors are encouraged to review the findings of the follow-up study in conjunction with inpatient psychiatric readmission rates. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-up After Hospitalization for Mental Illness, OMHSAS elected to retain and re-measure the Readmission Within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Re-measurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2017 study conducted in 2018 was the ninth re-measurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish a same-day readmission from a transfer to another acute facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH (Statewide) level for MY 2017. This measure continued to be of interest to

OMHSAS for the purposes of comparing HC BH Contractor and BH-MCO rates to the OMHSAS performance goal and to prior rates.

This study examined behavioral health services provided to members participating in the HealthChoices Behavioral Health Program. For the indicator, the criteria specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. In order to identify the administrative numerator-positives, date-of-service, and diagnosis/procedure code criteria were outlined, as well as were 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 followed by an inpatient acute psychiatric care readmission within 30 days of the previous discharge.

Eligible Population

The entire eligible population was used for all 67 counties and 29 HC BH Contractors participating in the MY 2017 study. Eligible cases were defined as those members in the HealthChoices Behavioral Health Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2017;
- A principal ICD-9- or ICD-10-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 that was clearly identified as a discharge.

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

Methodology

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

Performance Goals

OMHSAS designated the performance measure goal as better than (i.e., less than) or equal to 10.0% for the participating BH-MCOs and counties. **For this measure, lower rates indicate better performance.**

Findings

BH-MCO and HC BH Contractor Results

The results are presented at the BH-MCO and then HC BH Contractor level. Year-to-year comparisons of MY 2017 to MY 2016 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* score. Statistically significant difference (SSD) at the $p = 0.05$ level between groups is noted, as well as the PPD between the rates.

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

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

The MY 2017 HealthChoices Aggregate (Statewide) readmission rate was 13.4%, which represents a statistically significantly decrease from the MY 2016 HealthChoices Aggregate rate of 13.9% by 0.5 percentage points (**Table 3.5**).

The VBH MY 2017 readmission rate was 13.1%, which was increased (worsened) significantly from MY 2016 rate of 11.7% by 1.4 percentage points. VBH did not meet the performance goal of a readmission rate at or below 10.0% in MY 2017.

From MY 2016 to MY 2017, the psychiatric readmission rate for Cambria, NWBHP, and SWBHM increased (worsened) significantly by 5.2, 3.4, and 1.5 percentage points, respectively. Although REA rates for Beaver decreased (improved) by 0.7 percentage points, this decrease was not statistically significant. None of the VBH contractors met or surpassed the OMHSAS performance goal of 10%.

Table 3.5: MY 2017 REA Readmission Indicators

MY 2017							MY 2016 %	MY 2017 Rate Comparison to MY 2016	
				95% CI					
Measure	(N)	(D)	%	Lower	Upper	Goal Met?[1]		PPD	SSD
Inpatient Readmission									
Statewide	7,121	52,977	**13.4%**	13.2%	13.7%	No	13.9%	-0.5	Yes
VBHPA	1,030	7,842	**13.1%**	12.4%	13.9%	No	11.7%	1.4	Yes
Beaver	95	846	**11.2%**	9.0%	13.4%	No	11.9%	-0.7	No
Cambria*	79	401	**19.7%**	15.7%	23.7%	No	14.5%	5.2	Yes
NWBHP	146	1,304	**11.2%**	9.4%	12.9%	No	7.8%	3.4	Yes
Fayette	115	857	**13.4%**	11.1%	15.8%	No	13.3%	0.1	No
Greene	31	229	**13.5%**	8.9%	18.2%	No	13.1%	0.4	No
SWBHM	564	4,205	**13.4%**	12.4%	14.5%	No	11.9%	1.5	Yes

[1]The OMHSAS-designated performance measure goal is a readmission rate at or below 10%.
MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; VBHPA: Value Behavioral Health of Pennsylvania; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.
Note: Cambria moved its HC BH Contract from VBH to MBH, effective July 1, 2017.

Figure 3.9 is a graphical representation of the MY 2017 readmission rates for VBH HC BH Contractors compared to the OMHSAS performance goal of 10.0%.

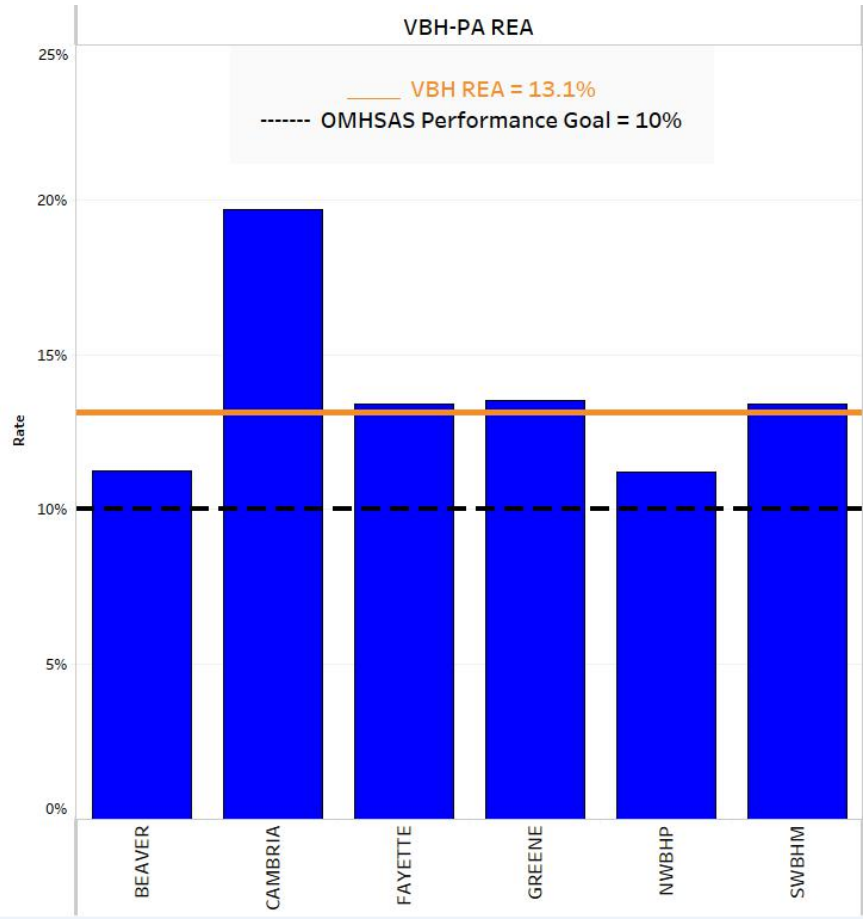

Figure 3.9: MY 2017 REA Readmission Rates.

Figure 3.10 shows the HealthChoices BH (Statewide) readmission rate and the individual VBH HC BH Contractors that performed statistically significantly higher (red) or lower (blue) than the Statewide rate. Cambria's rate was statistically significantly higher (worse) than the Statewide rate of 13.4% by 4.3 percentage points, while NWBHP's rate was significantly better (lower) that the HealthChoices REA rate in MY 2017.

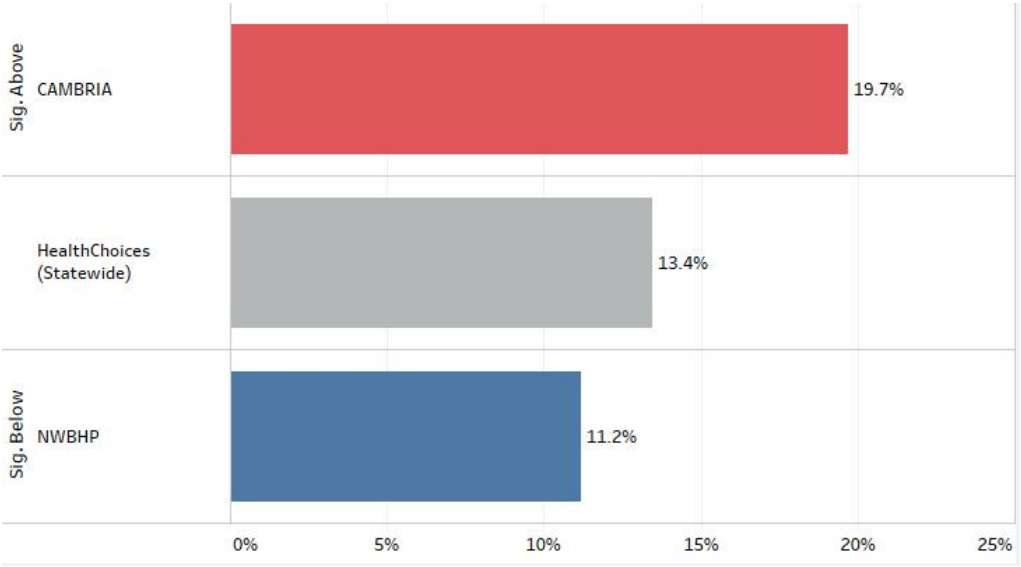

Figure 3.10: Comparison of VBH Contractor MY 2017 REA Readmission Rates (Overall) versus HealthChoices (Statewide) MY 2017 REA Readmission Rates (Overall).

Conclusion and Recommendations

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

Despite a number of years of data collection and interventions, readmission rates after psychiatric discharge have, for the most part, not improved and, for some BH-MCOs and their Contractors, rates have worsened (increased). The HC BH Statewide rate showed a statistically significant decrease of 0.5 percentage points in 2017. Readmission for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the current performance improvement project cycle, the recommendations may assist in future discussions.

In response to the 2018 study, the following general recommendations are applicable to all five participating BH-MCOs:

- The purpose of this re-measurement study is to inform OMHSAS, the HC BH Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2017 to promote continuous quality improvement with regard to mental health discharges that result in a readmission. The information contained within this study should be used to further develop strategies for decreasing the likelihood that at-risk members will be readmitted. Building on the current cycle of performance improvement projects, which entered its first (non-baseline) year in 2017, BH-MCOs are expected to demonstrate meaningful improvement in behavioral health readmission rates in the next few years as a result of the newly implemented interventions. To that end, the HC BH Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing behavioral health readmissions. The HC BH Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. It is important for BH-MCOs and HC BH Contractors to target the demographic populations that do not perform as well as their counterparts. It is recommended that the BH-MCOs and HC BH Contractors continue to focus interventions on populations that exhibit higher readmission rates (e.g., urban populations).
- BH-MCOs and HC BH Contractors are encouraged to review the findings of the behavioral health readmission study in conjunction with follow-up after hospitalization rates. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

As part of the CMS's Adult Quality Measure Grant Program, the DHS was required to report the Initiation and Engagement of Alcohol and Other Drug Dependence (IET) measure. Although the grant ended in December 2014, DHS will continue reporting the IET measure as part of CMS's Adult Quality Core Measure set. This measure was reported initially by one county for MY 2012 and expanded to the HealthChoices population in MY 2013. Due to several implementation issues identified with BH-MCO access to all applicable data and at DHS's request, this measure was produced by IPRO. IPRO began development of this measure in 2014 for MY 2013 and continued to produce the measure in 2017 and 2018. The measure was produced according to HEDIS 2018 specifications. The data source was encounter data submitted to DHS by the BH-MCOs and the Physical Health MCOs (PH-MCOs). As directed by OMHSAS, IPRO produced rates for this measure for the HealthChoices population, by BH-MCO, and by HC BH Contractor.

This study examined substance abuse services provided to members participating in the HealthChoices Behavioral Health and Physical Health Programs. For the indicator, the criteria used to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. Date-of-service and diagnosis/procedure codes were used to identify the administrative numerator-positives. The denominator and numerator criteria were identical to the HEDIS 2018 specifications, with one modification: members must be enrolled in the same PH-MCO and BH-MCO during the continuous enrollment period (60 days prior to the index event, to 48 days after the index event). This performance

measure assessed the percentage of members who had a qualifying encounter with a diagnosis of alcohol or other drug dependence (AOD) who had an initiation visit within 14 days of the initial encounter, and the percentage of members who also had 2 visits within 34 days after the initiation visit.

Quality Indicator Significance

Substance abuse is a major health issue in the United States. According to the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), 8.5% of adults had an alcohol use disorder problem, 2% met the criteria for a drug use disorder, and 1.1% met the criteria for both (U.S. Department of Health & Human Services, 2008). Research shows that people who are dependent on alcohol are much more likely than the general population to use drugs, and vice versa. Patients with co-occurring alcohol and other drug use disorders are more likely to have psychiatric disorders, such as personality, mood, and anxiety disorders, and they are also more likely to attempt suicide and to suffer health problems (Arnaout & Petrakis, 2008). The opioid crisis has only added to the urgency. Deaths from opioid overdoses alone reached 28,647 in 2014 (The Surgeon General's Report on Alcohol, Drugs, and Health, 2017).

With appropriate intervention for AOD dependence, the physical and behavioral health conditions of patients can be improved and the use of health care services, such as the emergency departments (ED), will be decreased. In 2009 alone, there were nearly 4.6 million drug-related ED visits nationwide (National Institute on Drug Abuse, 2011). Social determinants of health are also themselves impacted by AOD. Improvement in the socioeconomic situation of patients and lower crime rates will follow if suitable treatments are implemented.

Eligible Population[1]

The entire eligible population was used for all 29 HC BH Contractors participating in the MY 2017 study. Eligible cases were defined as those members in the HealthChoices Behavioral Health and Physical Health Programs who met the following criteria:

- Members who had an encounter with a primary or secondary AOD diagnosis between January 1 and November 15, 2017;
- Continuously enrolled in both HealthChoices Behavioral Health and Physical Health from 60 days prior to the AOD diagnosis to 48 days after the AOD diagnosis with no gaps in enrollment;
- No encounters with an AOD diagnosis in the 60 days prior to the initial encounter;
- If a member has multiple encounters in the measurement year that meet the criteria, only the first encounter is used in the measure.

This measure is reported for three age cohorts: ages 13 to 17 years old, ages 18+ years old, and ages 13+ years old.

Numerators

This measure has two numerators:

Numerator 1 – Initiation of AOD Treatment: Members who initiate treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization with a primary or secondary AOD diagnosis within 14 days of the diagnosis.

Numerator 2 – Engagement of AOD Treatment: Members who initiated treatment and who had two or more additional inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with a primary or secondary diagnosis of AOD within 34 days of the initiation visit. The engagement numerator was only evaluated for members who passed the initiation numerator.

Methodology

As this measure requires the use of both Physical Health and Behavioral Health encounters, only members who were enrolled in both Behavioral Health and Physical Health HealthChoices were included in this measure. The source for all information was administrative data provided to IPRO by the BH-MCOs and PH MCOs. The source for all administrative data was the MCOs' transactional claims systems. As administrative data from multiple sources was needed to produce

[1] HEDIS 2018 Volume 2 Technical Specifications for Health Plans (2018).

this measure, the measure was programmed and reported by IPRO. The results of the measure were presented to representatives of each BH-MCO, and the BH-MCOs were given an opportunity to respond to the results of the measure.

Limitations

As physical health encounters with an AOD diagnosis are used in this measure, a BH-MCO does not have complete information on all encounters used in this measure. This incomplete information will limit the BH-MCOs' ability to independently calculate their performance of this measure, and determine the effectiveness of interventions.

Findings

BH-MCO and HC BH Contractor Results

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

BH-MCO-specific rates were compared to the HealthChoices Statewide rate 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 differences in BH-MCO rates are noted.

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

The performance measure results for the three age cohorts (13 to 17 years old, ages 18+ years, and ages 13+ years) are compared to HEDIS national percentiles. NCQA produces annual HEDIS IET benchmarks for these three age bands; therefore, results for each age group are compared to national percentiles for the corresponding age bands.

(a) Age Group: 13–17 Years Old

The MY 2017 HealthChoices Aggregate (Statewide) rates in the 13–17 years age group were 46.3% for Initiation and 34.6% for Engagement (**Table 3.6**). These rates were statistically significantly increased compared to the MY 2016 13–17 years HealthChoices Aggregate rates of 38.5% and 26.0%, respectively. In MY 2017, the HealthChoices Aggregate rate for Initiation was between the HEDIS 50th and 75th percentiles, while the HealthChoices Aggregate rate for Engagement was above the 75th percentile. The VBH MY 2017 13-17 years Initiation rate was 46.1%, which was significantly higher than the MY 2016 VBH rate of 29.8% (**Table 3.6**). Similarly, the VBH MY 2017 13–17 years Engagement rate was 36.1%, which was statistically significantly increased compared to the MY 2016 rate of 21.3%. VBH's Initiation rate for MY 2017 was between the HEDIS 50th and 75th percentiles, while the BH-MCO's Engagement rate was at or above the 75th percentile.

None of the HC BH Contractors had sufficiently large denominators to test for year-over-year change, except for SWBHM, which significantly increased for both rates. For the Initiation sub-measure, of all VBH's contractors, one met the HEDIS goal of meeting or exceeding 75th percentile (Cambria), three performed between the 50th and 75th percentiles (Beaver, Fayette, and SWBHM), one performed between the 25th and 50th percentiles (NWBHP), and Greene fell below the 25th percentile. The Contractors generally performed better on the Engagement rate, and all of the Contractors met the OMHSAS goal of meeting or surpassing the HEDIS 75th percentile.

Table 3.6: MY 2017 IET Initiation and Engagement Indicators (13–17 Years)

MY 2017						MY 2016	MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (13–17) Years									
Statewide	1,316	2,843	**46.3%**	44.4%	48.1%	38.5%	7.8	Yes	Below 75th percentile, above 50th percentile
VBHPA	203	440	**46.1%**	41.4%	50.9%	29.8%	16.3	Yes	Below 75th percentile, above 50th percentile
Beaver	27	63	**42.9%**	N/A	N/A	38.5%	4.4	N/A	Below 75th percentile, above 50th percentile
Cambria*	5	9	**55.6%**	N/A	N/A	13.6%	42.0	N/A	At or above 75th percentile
Fayette	17	37	**45.9%**	N/A	N/A	9.1%	36.8	N/A	Below 75th percentile, above 50th percentile
Greene	3	10	**30.0%**	N/A	N/A	N/A	N/A	N/A	Below 25th percentile
NWBHP	22	53	**41.5%**	N/A	N/A	39.7%	1.8	N/A	Below 50th percentile, above 25th percentile
SWBHM	129	268	**48.1%**	42.0%	54.3%	29.1%	19.0	Yes	Below 75th percentile, above 50th percentile
Numerator 2: Engagement of AOD Treatment (13–17) Years									
Statewide	984	2,843	**34.6%**	32.8%	36.4%	26.0%	8.6	Yes	At or above 75th percentile
VBHPA	159	440	**36.1%**	31.5%	40.7%	21.3%	14.8	Yes	At or above 75th percentile
Beaver	22	63	**34.9%**	N/A	N/A	25.0%	9.9	N/A	At or above 75th percentile
Cambria*	3	9	**33.3%**	N/A	N/A	13.6%	19.7	N/A	At or above 75th percentile
Fayette	11	37	**29.7%**	N/A	N/A	9.1%	20.6	N/A	At or above 75th percentile
Greene	3	10	**30.0%**	N/A	N/A	N/A	N/A	N/A	At or above 75th percentile
NWBHP	18	53	**34.0%**	N/A	N/A	27.6%	6.4	N/A	At or above 75th percentile
SWBHM	102	268	**38.1%**	32.1%	44.1%	20.9%	17.2	Yes	At or above 75th percentile

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; VBHPA: Value Behavioral Health of Pennsylvania; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

N/A: Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

Note: Cambria moved its HC BH Contract from VBH to MBH, effective July 1, 2017. IET takes the earliest IESD for denominator eligibility.

Figure 3.11 is a graphical representation of the 13–17 years MY 2017 HEDIS Initiation and Engagement rates for VBH and its associated HC BH Contractors.

Figure 3.11: MY 2017 IET Initiation and Engagement Rates (13–17 Years).

Figure 3.12 shows the HealthChoices Contractor Average rates for this age cohort and the individual VBH HC BH Contractor rates that were statistically significantly higher or lower than the HealthChoices HC BH Statewide rate. In MY 2017, only SWBHM had sufficient denominators for Initiation and Engagement rates to be compared to the Statewide rates; however, SWBHM's Initiation and Engagement rates were not statistically significantly different compared to the Statewide rates of 46.3 % for Initiation and 34.6% for Engagement.

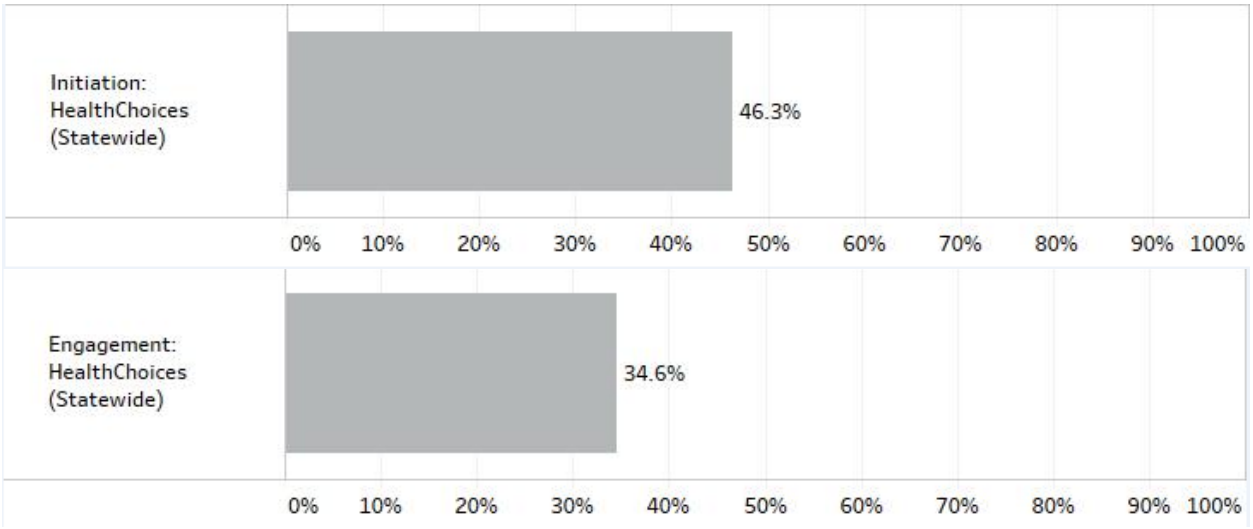

Figure 3.12: Comparison of VBH Contractor MY 2017 IET Rates (13–17 Years) versus HealthChoices (Statewide) MY 2017 IET Rates (13–17 Years).

(b) Age Group: 18+ Years Old

The MY 2017 HealthChoices Aggregate rates in the 18+ years age group were 41.1% for Initiation and 33.7% for Engagement (**Table 3.7**). Both rates were statistically significantly higher than the corresponding MY 2016 rates: the HealthChoices Aggregate Initiation rate increased by 15.5 percentage points and the Engagement rate increased by 16.9 percentage points from the prior year. The MY 2017 HealthChoices Aggregate Initiation rate in this age cohort was between the HEDIS 25th and 50th percentiles for 2018, while the Engagement rate met HEDIS goal of at or above the 75th percentile.

The VBH MY 2017 Initiation rate for the 18+ years population was 48.1% (**Table 3.7**). This rate was at or above the HEDIS 75th percentile for 2018 and significantly higher than the MY 2016 rate. The VBH MY 2017 Engagement rate for this age cohort was 42.0% and was at or above the HEDIS 75th percentile for 2018. This rate was also statistically significantly higher than the prior year's rate.

As presented in **Table 3.7**, all Initiation and Engagement rates of VBH's Contractors increased significantly, except for Greene's Initiation rate between MY 2016 and MY 2017. Relative to national performance, all VBH Contractors' performance for the Initiation sub-measure was at or above the 75th percentile, except for Fayette, which performed between the 25th and 50th percentiles, and Greene, which performed below the 25th percentile. Overall, the VBH Contractors performed better on the Engagement submeasure, and all met the OMHSAS goal of achieving the HEDIS 75th percentile.

Table 3.7: MY 2017 IET Initiation and Engagement Indicators (18+ Years)

MY 2017						MY 2016	MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (18+ Years)									
Statewide	27,307	66,505	**41.1%**	40.7%	41.4%	25.6%	15.5	Yes	Below 50th percentile, above 25th percentile
VBHPA	6,373	13,246	**48.1%**	47.3%	49.0%	28.9%	19.2	Yes	At or above 75th percentile
Beaver	643	1,246	**51.6%**	48.8%	54.4%	30.3%	21.3	Yes	At or above 75th percentile
Cambria*	328	568	**57.7%**	53.6%	61.9%	29.2%	28.5	Yes	At or above 75th percentile
Fayette	851	2,140	**39.8%**	37.7%	41.9%	28.9%	10.9	Yes	Below 50th percentile, above 25th percentile
Greene	135	363	**37.2%**	32.1%	42.3%	30.9%	6.3	No	Below 25th percentile

MY 2017						MY 2016	MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
NWBHP	602	1,232	**48.9%**	46.0%	51.7%	28.4%	20.5	Yes	At or above 75th percentile
SWBHM	3,814	7,697	**49.6%**	48.4%	50.7%	28.6%	21.0	Yes	At or above 75th percentile
Numerator 2: Engagement of AOD Treatment (18+ Years)									
Statewide	22,379	66,505	**33.7%**	33.3%	34.0%	16.8%	16.9	Yes	At or above 75th percentile
VBHPA	5,565	13,246	**42.0%**	41.2%	42.9%	20.8%	21.2	Yes	At or above 75th percentile
Beaver	540	1,246	**43.3%**	40.5%	46.1%	21.4%	21.9	Yes	At or above 75th percentile
Cambria*	301	568	**53.0%**	48.8%	57.2%	22.3%	30.7	Yes	At or above 75th percentile
Fayette	740	2,140	**34.6%**	32.5%	36.6%	20.7%	13.9	Yes	At or above 75th percentile
Greene	105	363	**28.9%**	24.1%	33.7%	19.1%	9.8	Yes	At or above 75th percentile
NWBHP	510	1,232	**41.4%**	38.6%	44.2%	19.7%	21.7	Yes	At or above 75th percentile
SWBHM	3,369	7,697	**43.8%**	42.7%	44.9%	20.7%	23.1	Yes	At or above 75th percentile

MY: Measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval VBHPA: Value Behavioral Health of Pennsylvania; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Note: Cambria moved its HC BH Contract from VBH to MBH, effective July 1, 2017. IET takes the earliest IESD for denominator eligibility.

Figure 3.13 is a graphical representation MY 2017 IET rates for VBH and its associated HC BH Contractors for the 18+ years age group.

Figure 3.13: MY 2017 IET Initiation and Engagement Rates (18+ Years).

Figure 3.14 shows the HealthChoices BH Statewide rates and individual VBH HC BH Contractors that performed statistically significantly higher or lower than the Statewide rate. NWBHP, SWBHM, Beaver, and Cambria all produced Initiation rates statistically significantly higher than the Statewide rate of 41.1% by between 7.8 and 16.6 percentage points. The same four Contractors also achieved Engagement rates that were statistically significantly higher than the Statewide rate of 33.7% by between 7.7 and 19.3 percentage points.

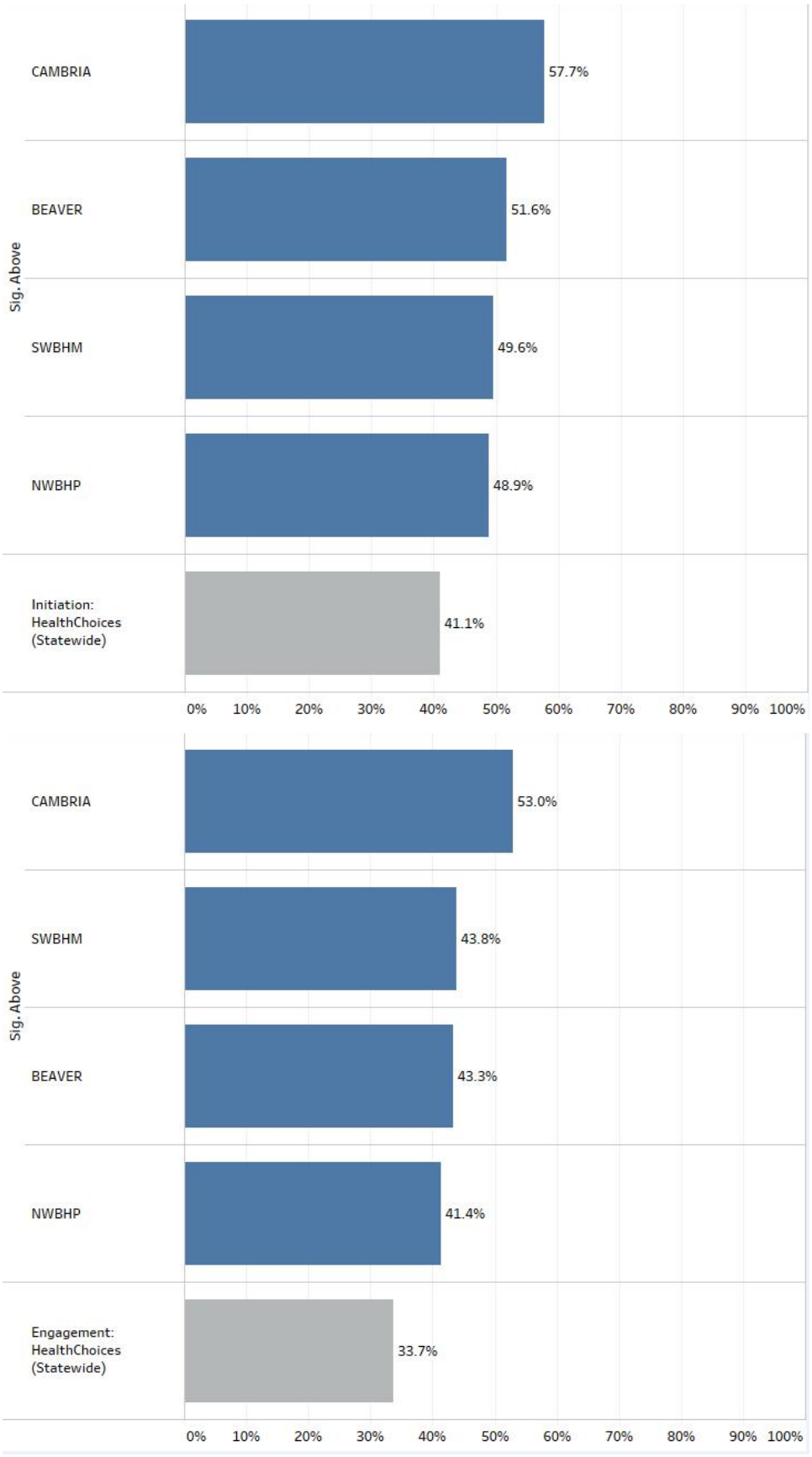

Figure 3.14: Comparison of VBH Contractor MY 2017 IET Rates (18+ Years) versus HealthChoices (Statewide) MY 2017 IET Rates (18+ Years).

(c) Age Group: 13+ Years Old

The MY 2017 HealthChoices Aggregate rates in the 13+ years age group were 41.3% for Initiation and 33.7% for Engagement (**Table 3.8**). The Initiation rate was statistically significantly higher than the MY 2016 Initiation rate by 15.1 percentage points, and the Engagement rate was statistically significantly higher than the MY 2016 Engagement rate by 16.5 percentage points. The MY 2017 HealthChoices Aggregate Initiation rate was between the HEDIS 25th and 50th percentiles for 2018, while the Engagement rate was at or above the 75th percentile.

The VBH MY 2017 Initiation rate for the 13+ years population was 48.0% (**Table 3.8**). This rate was at or above the HEDIS 75th percentile for 2018 and significantly higher than the MY 2016. The VBH MY 2017 Engagement rate was 41.8%, which was significantly higher than MY 2016 rate and met the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile for this measure. As shown in **Table 3.8**, all Initiation and Engagement rates of VBH's Contractors increased significantly, except for Greene's Initiation rate between MY 2016 and MY 2017. Relative to national performance, VBH Contractors' performance for the Initiation submeasure was at or above the 75th percentile for all Contractors, except for Fayette, which performed between the 25th and 50th percentiles, and Greene, which performed below the 25th percentile. Overall, the VBH Contractors performed better on the Engagement submeasure, and all VBH Contractors met the OMHSAS goal of achieving the HEDIS 75th percentile.

Table 3.8: MY 2017 IET Initiation and Engagement Indicators (Overall)

MY 2017						MY 2016	MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (Overall)									
Statewide	28,623	69,348	**41.3%**	40.9%	41.6%	26.2%	15.1	Yes	Below 50th percentile, above 25th percentile
VBHPA	6,576	13,686	**48.0%**	47.2%	48.9%	28.9%	19.1	Yes	At or above 75th percentile
Beaver	670	1,309	**51.2%**	48.4%	53.9%	30.8%	20.4	Yes	At or above 75th percentile
Cambria*	333	577	**57.7%**	53.6%	61.8%	28.8%	28.9	Yes	At or above 75th percentile
Fayette	868	2,177	**39.9%**	37.8%	42.0%	28.5%	11.4	Yes	Below 50th percentile, above 25th percentile
Greene	138	373	**37.0%**	32.0%	42.0%	30.5%	6.5	No	Below 25th percentile
NWBHP	624	1,285	**48.6%**	45.8%	51.3%	28.8%	19.8	Yes	At or above 75th percentile
SWBHM	3,943	7,965	**49.5%**	48.4%	50.6%	28.6%	20.9	Yes	At or above 75th percentile
Numerator 2: Engagement of AOD Treatment (Overall)									
Statewide	23,363	69,348	**33.7%**	33.3%	34.0%	17.2%	16.5	Yes	At or above 75th percentile
VBHPA	5,724	13,686	**41.8%**	41.0%	42.7%	20.8%	21.0	Yes	At or above 75th percentile
Beaver	562	1,309	**42.9%**	40.2%	45.7%	21.6%	21.3	Yes	At or above 75th percentile
Cambria*	304	577	**52.7%**	48.5%	56.8%	22.1%	30.6	Yes	At or above 75th percentile
Fayette	751	2,177	**34.5%**	32.5%	36.5%	20.5%	14.0	Yes	At or above 75th percentile
Greene	108	373	**29.0%**	24.2%	33.7%	18.9%	10.1	Yes	At or above 75th percentile
NWBHP	528	1,285	**41.1%**	38.4%	43.8%	20.1%	21.0	Yes	At or above 75th percentile
SWBHM	3,471	7,965	**43.6%**	42.5%	44.7%	20.8%	22.8	Yes	At or above 75th percentile

MY: Measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; VBHPA: Value Behavioral Health of Pennsylvania; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Note: Cambria moved its HC BH Contract from VBH to MBH, effective July 1, 2017. IET takes the earliest IESD for denominator eligibility.

Figure 3.15 is a graphical representation MY 2017 IET rates for VBH and its associated HC BH Contractors for the 18+ years age group.

Figure 3.15: MY 2017 IET Initiation and Engagement Rates (Overall).

Figure 3.16 shows the HealthChoices HC BH Contractor Average rates and individual VBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. NWBHP, SWBHM, Beaver, and Cambria all produced Initiation rates statistically significantly higher than the Statewide rate of 41.3% by between 7.3 and 16.4 percentage points. The same four Contractors also produced Engagement rates that were statistically significantly higher than the Statewide rate of 33.7% by between 7.4 and 19.0 percentage points.

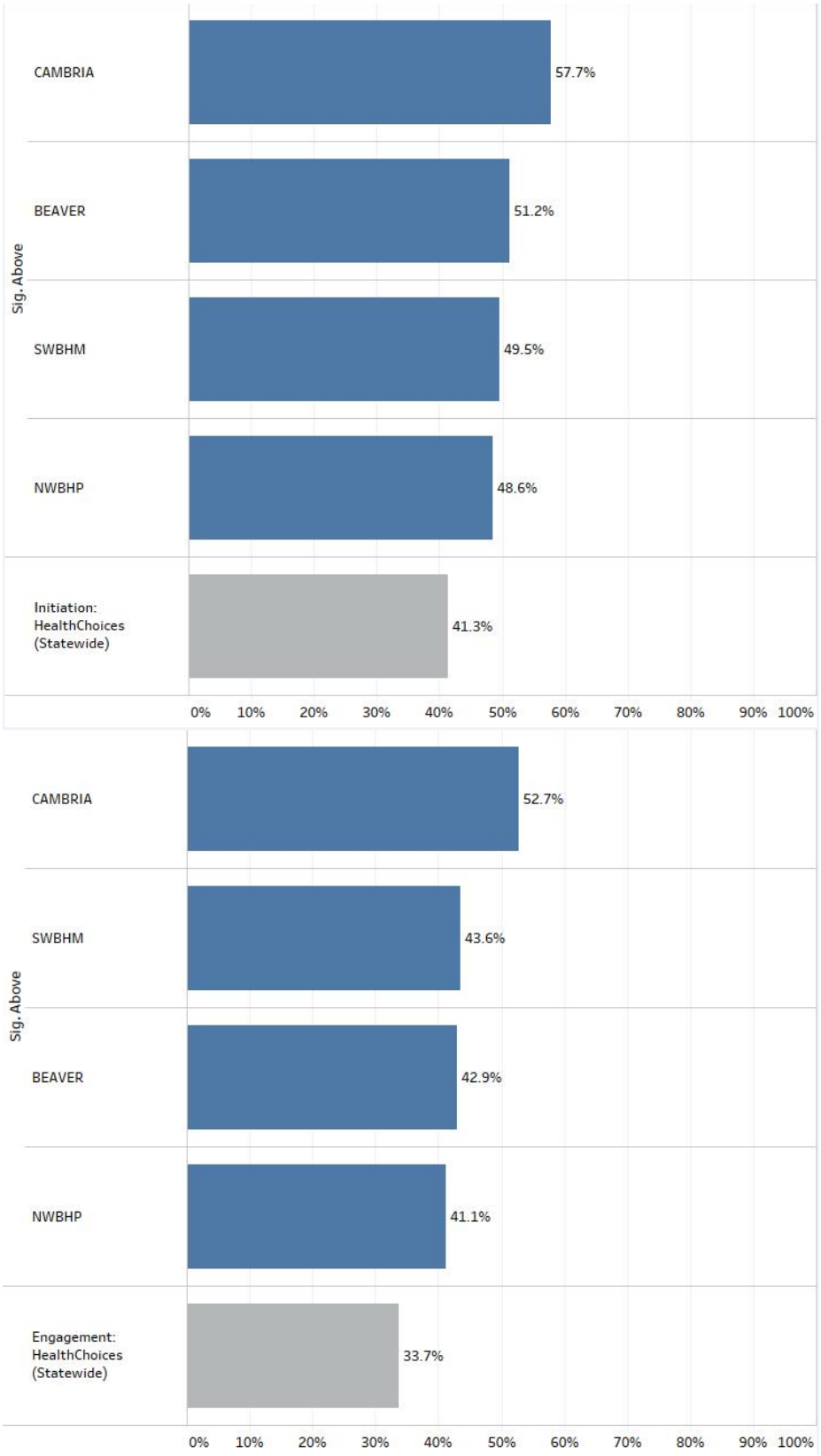

Figure 3.16: Comparison of VBH Contractor MY 2017 IET Rates (Overall) versus HealthChoices (Statewide) MY 2017 IET Rates (Overall).

Conclusion and Recommendations

For MY 2017, the Aggregate HealthChoices rate in the 13+ years population (Overall population) was 41.3% for the Initiation rate and 33.7% for the Engagement rate. The Initiation rate was between the HEDIS 25th and 50th percentiles, while the Engagement rate was above the 75th percentile. For VBH, however, the performance compared to MY 2016 in the Initiation and the Engagement rates was remarkable, with VBH in some cases seeing percentage point (PP) increases of around 20 or more, depending on the age group; many of its Contractors experienced increases of over 30 or even 40 percentage points. As seen in other performance measures, there is significant variation between the HC BH Contractors. Overall, VBH BH HC contractors performed better in Engagement rates, with all Contractors meeting or exceeding the HEDIS goal of 75th percentile (except for Cambria, which was switched to MBH on July 1, 2017). As with most reporting years, it is important to note that there were some changes to the HEDIS 2018 specifications, including the extension of the Engagement of AOD Treatment time frame to 34 days from 30 days and the addition of Medication Assisted Treatment. Even so, VBH's results stand out from the other BH-MCOs. It should be noted that some anomalies in VBH encounter claims volume were addressed only after these results were compiled.

The following general recommendations are applicable to all five participating BH-MCOs:

- BH-MCOs should further develop programs to report this measure for their population on a regular basis. This will allow BH-MCOs to identify specific subpopulations with low performance for future interventions.
- BH-MCOs should identify high-performing subpopulations to determine if any best practices exist for increasing the Initiation and Engagement rates.

IV: Quality Studies

The purpose of this section is to describe quality studies performed in 2017 for the HealthChoices population. The studies are included in this report as optional EQR activities that occurred during the Review Year (42 CFR 438.358 (c)(5)).

Certified Community Behavioral Health Clinics

On July 1 2017, Pennsylvania launched its SAMHSA-funded Certified Community Behavioral Health Clinics (CCBHCs) Demonstration Project ("Demonstration"), to run through June 30, 2019. The purpose of the Demonstration is to develop and test an all-inclusive (and all-payer) prospective payment system model for community clinics to integrate behavioral and physical health care services in a more seamless manner. The model is centered on the provision of nine core services. Crisis services, screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services are provided directly by the CCBHCs. The other services may be provided through a contract with a Designated Collaborating Organization (DCO). To receive CCBHC certification, clinics also had to provide a minimum set of Evidence Based Practices (EBP), which was selected based on community needs assessments and centered on recovery-oriented care and support for children, youth, and adults. Seven clinics were eventually certified and participated: Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA). In several cases, CCBHC-certified clinics share agreements with one or more DCOs to supplement the core services provided at the clinic. The counties covered by these clinics span three BH-MCOs: CBH, CCBH, and MBH.

In 2017, activities focused on implementing and scaling up the CCBHC model within the seven clinic sites. Data collection and reporting is a centerpiece of this quality initiative in two important ways. First, the CCBHC Demonstration in Pennsylvania features a process measure Dashboard, hosted by the EQRO through REDCap, whereby clinics are able to monitor progress on the implementation of their CCBHC model. From July through December 2017—the Dashboard was operational in October 2017—clinics tracked and reported on clinical activities in a range of quality domains reflecting the priorities of the initiative: clinic membership, process, access and availability, engagement, evidence-based practices, and satisfaction. The dashboard provides for each clinic a year-to-date (YTD) comparative display that shows clinic and statewide results on each process measure, as well as average scores for three domains of the satisfaction surveys: convenience of provider location, satisfaction with provider services, and timeliness and availability of appointments. In support of this, and to ensure alignment with SAMHSA reporting requirements, a data dictionary (and spreadsheet template) was developed for the clinics to use in reporting their monthly, quarterly, and YTD results in the Dashboard. These Dashboard results were reported out to a CCBHC Stakeholder Committee at the end of the two quarters.

A second important feature of the Demonstration is an assessment, to be completed at its conclusion by the EQRO, to test whether the CCBHC clinics perform significantly better over the demonstration period compared to a control group of clinics located under the same HC BH contractors as the CCBHC clinics. Measurement of performance, in terms of both quality as well as overall cost, will span multiple areas and scales, involving a variety of administrative sources, medical records, and other sources. Several measures in the CCBHC measure set, including those reported directly by clinics (primarily medical record-based), are placed in a Quality Bonus Payment (QBP) program. To support this reporting, clinics in 2017 collected and reported baseline data on quality measures. The EQRO also used SurveyMonkey to support the administration and collecting of person-experience-of-care surveys for adults (PEC) as well as for children and youth (Y/FEC). Finally, in the latter half of 2017, clinics began to collect and report, on a quarterly basis, consumer level files documenting various relevant characteristics of their CCBHC consumers, including housing, veteran, and insurance statuses. Throughout the process, OMHSAS and EQRO provided technical assistance focused on data collection, management, and reporting, where much of the focus was on walking through the quality and process measures and their operationalization using the clinics' data plans. In this respect, 2017 was a period of building up the capacity of the clinics to bring the vision of the CCBHC Demonstration to its full fruition. Results from demonstration year (DY) 1 will be reported in next year's BBA report.

V: 2017 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 2017 EQR Technical Reports, which were distributed in April 2017. The 2017 EQR Technical Report is the 11th report to include descriptions of current and proposed interventions from each BH-MCO that address the (2017) 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 June 30, 2017, to address each recommendation;
- future actions that are planned to address each recommendation;
- when and how future actions will be accomplished;
- the expected outcome or goals of the actions that were taken or will be taken; and
- the BH-MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of the end of 2017, as well as any additional relevant documentation provided by the BH-MCO. **Table 5.1** presents VBH's responses to opportunities of improvement cited by IPRO in the 2017 EQR Technical Report, detailing current and proposed interventions.

Table 5.1: VBH's Responses to Opportunities for Improvement Cited by IPRO in the 2017 EQR Technical Report

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2014, RY 2015, and RY 2016 found VBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/18 /Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
VBH 2017.01	Within Subpart C: Enrollee Rights and Protections Regulations, VBH was partially compliant on one out of seven categories – Enrollee Rights.	Third Quarter 2018 and On-going (refer to details below)	**Enrollee Rights and Protections: PEPS Standard 60:** Complaint/Grievance Staffing. The BH-MCO shall identify a lead person responsible for overall coordination of the complaint/grievance process, including the provision of information and instructions to members. (Responsibility includes HIPAA Privacy duties related to complaints and mechanisms for tracking and reporting of HIPAA related complaints.) The BH-MCO shall designate and train sufficient staff responsible for receiving, processing and responding to member complaints and grievances in accordance with the requirements contained in Appendix H. All BH-MCO staff shall be educated concerning member rights and the procedure for filing complaints and grievances.
		September 5, 2018 with expectation of	**Enrollee Rights and Protections: PEPS Standard 60, Substandard 1:** Table of organization identifies lead person responsible for overall coordination of

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		review for staffing by Beacon National by November 1, 2018	complaint and grievance process and adequate staff to receive, process and respond to member complaints and grievances. **VBH Response:** Attached please find a copy of the Table of Organization (TO) for VBH which delineates that Mark Fuller, M.D. in his role as CEO, oversees as direct reports to him the VP of Clinical Services and the Director Of Quality Management**.** These two positions report directly to the CEO and are responsible for overseeing, leading and directing the functions for coordinating the complaint and grievance processes and all policies and procedures related to these processes. In addition, the TO outlines the staff dedicated to these functions and reflects that the staffing remains adequate to meet the needs of member complaints and grievances.  10_OCT2018_VBH-PA Org Chart.pptx  60_Org_Tbl_Complaint_Updated 9-26-18  2018_Grievance Org. Chart.ppt A proposal for a re-organization of the complaint and grievance coordination has been submitted to Beacon National for approval in centralizing these related administrative functions. This includes the proposed addition of 2.25 FTE's to support these functions.
		October 1, 2018 through December 1, 2018	Review of existing complaint and grievance related policies and procedures to ensure fluid coordination of the complaint and grievance processes and alignment with the recent changes to Appendix H.
VBH 2017.02	VBH was partially compliant with five out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care), 2) Coordination and	August 23, 2018 through October 31, 2018	**Availability of Services (Access to Care): PEPS Standard 28: 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. **VBH Response:** VBH/Beacon will be updating the clinical documentation templates to ensure that the following elements are included: 1. Discharge Plan: Level of care that the individual

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
	Continuity of Care, 3) Coverage and Authorization of Services, 4) Practice Guidelines, 5) Quality Assessment and Performance Improvement Program.		will be discharged to; natural supports and stabilization resources to facilitate and support stepdown; access and transportation to stepdown; barriers to discharge plan; and steps employed to overcome barriers 2. Treatment Plan Review: How does the treatment plan link to admission issue; describe the appropriateness of the treatment plan; and what feedback/recommendations does the Care Manager (CM) have for the providers on the treatment plan 3. Evidence Based Practices: Describe which Evidence Based Practices (EBPs) may be relevant and recommended for this Member 4. Substance Use Template Only: Describe which alternatives to 24 hour treatment were explored; why 24 hour care is the most appropriate and least restrictive choice; and the results of discussion of potential use of medication assisted therapies (MAT)
		October 31, 2018	Training for all staff annually on treatment plan adequacy and how to discern treatment plan quality and documentation of this activity when discussing with provider
		October 31, 2018	Training for all staff annually on active care management and following up with providers on recommendations, along with identification and documentation of progress and/or lack of progress
		August 23, 2018	Use of readmission rounds and complex case calls with contractors and oversight partners; and documentation of these activities to support progress in those individuals with multiple admissions to higher levels of care or lack of treatment progress
		October 31, 2018	A new "Quality of Care Concern" checklist will be developed and included as part of the review for each case sent for consultation, peer review, and/or grievance (including Fair Hearing and Expedited and External Review)
		October 1, 2018 and On-going	**PEPS Standard 28: 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. **VBH Response:** The VBH/Beacon Medical Director utilizes an audit tool to review the denials. These audits will be conducted on a regular basis and the

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			results will be shared for feedback and on-going re-education of the important aspects of  Audit Tool Denial.xlsx documentation.
		Refer to previous response	**Coordination and Continuity of Care: PEPS Standard 28: 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. **VBH Response:** Refer to response above for Availability of Services (Access to Care) Substandard 1
		Refer to previous response	**PEPS Standard 28: 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. **VBH Response:** Refer to response above for Availability of Services (Access to Care) Substandard 2
		Refer to previous response	**Coverage and Authorization of Services: PEPS Standard 28: 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. **VBH Response:** Refer to response above for Availability of Services (Access to Care) Substandard 1.
		Refer to previous response	**PEPS Standard 28: 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. **VBH Response:** Refer to response above for Availability of Services (Access to Care) Substandard 2.
		Submitted August 23, 2018 to OMHSAS	**Coverage and Authorizations of Services: PEPS Standard 72: Substandard 2*:*** The content of the notices adhere to OMHSAS requirements (e.g.,

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect): **VBH Response:** All notices have been reviewed by OMHSAS for conformance following the conversion to the 2018 updated Appendix H and AA requirements.
		September 2018 and On-going	Training for Peer Advisors on the development of the 'member statement' and contents of the denial letter regarding rationale and description of denied services.
		August 23, 2018 through October 31, 2018	**Practice Guidelines: PEPS Standard 28:** **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. **VBH Response:** VBH/Beacon is updating our clinical documentation templates to ensure the following are included: 1. Discharge Plan: Level of care that member will be discharged to; natural supports and stabilization resources to facilitate and support stepdown; access and transportation to stepdown; barriers to discharge plan; steps employed to overcome barriers 2. Treatment Plan Review: How does treatment plan link to admission issue; describe the appropriateness of the treatment plan; what feedback/recommendations does the Care Manager (CM) have for the providers on the treatment plan 3. Evidence Based Practices: Describe which evidence –based practices (EBPs) may be relevant and recommended for this Member 4. Substance Use Template Only: describe which alternatives to 24 hour treatment were explored; why 24 hour care is the most appropriate and least restrictive choice; results of discussion of potential use of medication assisted therapies (MAT)
		Refer to previous	**PEPS Standard 28: Substandard 2:** The medical

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		response	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. **VBH Response:** Refer to response above for Availability of Services (Access to Care) Substandard 2.
		First Quarter 2018 and On-going	**Quality Assessment and Performance Improvement:** **PEPS Standard 91:** **Substandard 10:** The QM work plan outlines the specific performance improvements projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator: Mental Health; and, Substance Abuse External Quality Review: Follow up After Mental Health Hospitalization QM Annual Summary Report. **VBH Response:** The VBH/Beacon Quality Management/Utilization Management Work Plan is updated annually and was revised to incorporate feedback from OMHSAS as to the format and content. In 2018 it was expanded to include additional elements related to the UM program and the re-organized corporate regional structure. This document is presented and reviewed in detail by the five local QM Committees (QMCs) and submitted to OMHSAS as required by the annual deadline. Specifically the 2018 QM/UM Work Plan includes Goal 4.2: Improve the following Integrated Care Plan (Pay for Performance) Metrics, which contains five (5) separate metrics for performance based indicators. Also, Goal 10.1: Continue IPRO Root Cause Analysis (RCA)" addresses the FUH metric, as well as Goal 11.5: Complete IPRO HEDIS for the FUH measure. In addition, with regard to performance based contracting, VBH currently partners on a number of alternative payment arrangements with our Primary Contractors in addition to launching a value based purchasing model for inpatient mental health in 2018. Outline of the model and the APA's were submitted to OMHSAS in January of 2018 along with a 3 year plan for increasing the

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			number and complexity of models to meet the requirements of 5% of claims being paid under value based contracts in 2018. [The 2018 QM/UM Work Plan for VBH/Beacon is on file for reference with OMHSAS as part of the 2018 submission requirements]
		Second Quarter 2018	**PEPS Standard 91: Substandard 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 DHS by April 15th. **VBH Response:** The VBH/Beacon Quality Management/Utilization Management Program Evaluation is completed each year and updated to reflect the accomplishments and activities of the QM/UM Program over the prior year. This evaluation incudes an assessment of the impact of these programs and the overall effectiveness of these activities. This summary report is presented and reviewed each year to the five local QMCs for approval. It is then submitted to OMHSAS by the annual due date (April 15th) in compliance with the established deadline.
VBH 2017.03	VBH was partially compliant on nine out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions	2nd Quarter 2017 and On-going Third Quarter 2018 and On-going	**Statutory Basis and Definitions: PEPS Standard 68:** **Substandard 1:** Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how the complaint rights and procedures are made known to members, BH-MCO staff and the provider network. 1. BBA Fair Hearing 2. 1st level 3. 2nd level 4. External 5. Expedited **VBH Response:** All of the VBH/Beacon Complaint Investigators (CIs) undergo a common customized on-boarding process, including one-on –one training and mentoring with an existing and experienced CI. The complaint related Policies and Procedures are reviewed and discussed in detail. These materials address the rights and procedures for members, along with the various levels of hearings. A new desk top procedure will be finalized outlining additional detail for the education of the CIs to this process. Any future new CIs joining the QM team will receive this reference, as well as

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			other related training materials, as part of the on-boarding and orientation process. Staff training materials were updated in 2018 following the revisions to Appendix H and these will be utilized for future trainings, once approved by OMHSAS. New educational materials were developed to educate network providers as to the new changes to Appendix H and the CI staff were part of developing these materials. An educational article was also placed in the VBH/Beacon newsletter for reinforcement.
		Third Quarter 2018 and On-going	**PEPS Standard 68: Substandard 3:** Complaint decision letters must be written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s). **VBH Response:** The complaint resolution letters are modeled after the guidelines in Appendix H. They were all revised and updated in the Second Quarter 2018 to align with the new templates from OMHSAS. All staff were educated on these new templates and they will be fully implemented with the rollout of these new processes.
		Second Quarter 2017 and On-going	**PEPS Standard 68: Substandard 4:** The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file. **VBH Response:** The complaint investigation process has been fully re-designed from a paper driven process to a paperless process. As part of this change, all of the tools used to document a complaint have been revised and updated. This process change enables the Complaint Investigator to focus more time on the investigation and follow up with the member /provider rather than duplicative documentation on paper and in the on-line system. The on-line process also enables greater ability to track and trend issues and compile reports to oversee the process and update our oversight committees. The paperless process also adds efficiencies with the quality control audits that are performed regularly on member complaint cases to ensure on-going compliance and adherence to timeliness

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			standards. A new Quality Control (QC) process has also been designed and implemented to conduct 100% retrospective reviews of all complaint cases to ensure that the checklists are complete and the files contain all of the necessary documentation. This is conducted by an independent analyst from the QM Department who is not directly involved in the investigations or the complaint resolutions and remains objective in the completion of the audits. A report is produced regularly for the QM leadership to review and address any findings. The QM Manager also conducts random audits of CI cases and incorporates this feedback into supervision meetings with the CI team for re-education, as needed. These reviews are documented for reference.
		Second Quarter 2017 and On-going	**PEPS Standard 68: Substandard 5:** Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review. **VBH Response:** All complaints are referred to County oversight partners at the time of resolution to notify them of the recommendations for follow-up to be completed by the provider or BH-MCO. Documentation of this notification is saved in the Complaint File under Section 10. "Email to County." County oversight may take this information and conduct further follow-up actions, if indicated. If a potential Quality of Care issue is identified in the complaint investigation process, a referral is made to the Quality of Care Committee (QOCC) through the Care Concern process. Care Concerns are reviewed and a form is completed and reviewed by the Care Concern Triage group, who submit documentation of follow-up actions and recommendations to the Complaint Investigator. These completed Care Concern forms are saved in the Complaint File under Section 11. "Follow Up

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			Documentation." The VBH Complaint Investigator will request the completed Care Concern Form for any follow up referrals made to the QOCC Committee and save in the follow up section of the member's complaint record. The VBH Complaint Investigator will request the completed audit report for any follow up referrals made to the Program Integrity Department and save in the follow up section of the member's complaint record. The VBH Complaint Investigator will request documentation form the county representative for any follow up referrals to the County and save in the follow up section of the member's complaint record
		October 2018 and On-going	**PEPS Standard 71: Substandard 4:** Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BHMCO 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. **VBH Response:** The applicable staff will be re-educated about the importance that the grievance case files will include documentation of any referrals to County/BH-MCO committees for further review and to be addressed. Any needed retrospective audits that are determined to be needed will also be coordinated and addressed.

Corrective Action Plan for Partial and Non-compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2016, VBH began to address opportunities for improvement related to compliance categories within Subparts: C (Enrollee Rights), D (Access to Care, Coordination and Continuity of Care, Coverage and Authorization of Services, Practice Guidelines, and Quality Assessment and Performance Improvement Program), and F(Federal and State Grievance System Standards Regulations). The partially compliant categories within Subpart F were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions. Proposed actions and evidence of actions taken by VBH were monitored through action plans,

technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring VBH into compliance with the relevant Standards.

Root Cause Analysis and Action Plan

The 2017 EQR would have been the 10th year for which BH-MCOs would have been required to prepare a Root Cause Analysis and Action Plan for performance measures that were performing statistically significantly poorer than the BH-MCO Average and/or as compared to the prior measurement year. For performance measures that are noted as opportunities for improvement in the EQR Technical Report, BH-MCOs are required to 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.

Following several years of underperformance in the key quality indicator areas, however, OMHSAS deemed in 2017 that it was necessary to change the EQR process from a retrospective to more of a prospective process. This change meant, among other things, eliminating the requirement to complete root cause analyses (RCAs) and corresponding action plans (CAPs) responding to MY 2015. Instead, BH-MCOs were required to submit member-level files for MY 2016 in the summer of 2017, from which rates were calculated and validated by IPRO. MY 2016 Results of HEDIS Follow-up after Hospitalization for Mental Illness (7- and 30-day) were then used to determine RCA and CAP assignments. The change coincided with the coming phase-in of Value-Based Payment (VBP) at the HC BH Contractor level in January 2018. Thus, for the first time, RCA and CAP assignments were made at the Contractor level as well as at the BH-MCO level. Contractors receiving assignments completed their RCAs and CAPs in November 2017, while BH-MCOs completed their RCAs and CAPs by December 31, 2017. In 2018, coinciding with the carve-in of long-term care, OMHSAS directed BH-MCOs to begin focusing their RCA and CAP work on the HEDIS FUH All Ages measure and implemented a new goal-setting logic to spur performance improvement in the measure. Based on the MY2017 performance, all five BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and CAPs to achieve their MY 2019 goals. HC BH Contractors that scored below the 75th NCQA Quality Compass Percentile were also asked to submit RCAs and CAPs. All five BH-MCOs submitted their RCAs and CAPs on April 1, 2019. HC BH Contractors will be submitting their RCAs and CAPs by April 30, 2019.

MY 2016 RCAs and CAPs, already completed last year, are included in this 2018 BBA report. **Table 5.2** presents VBH's submission of its RCA and CAP for the FUH 6-64 years 7- and 30-day measures.

Table 5.2: VBH RCA and CAP for the FUH 7- and 30-Day Measures (6–64 Years)

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	**Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)**	**Response Date: 12/29/2017**
Goal Statement: (Please specify individual goals for each measure): The following goals were identified by OMHSAS/IPRO and adopted by Value Behavioral Health (VBH)/Beacon Health Options as part of the Root Cause Analyses (RCAs) conducted by the five (5) individual BH HC contractors in 2017. This RCA summary is based on the most current BH HC contractor and BH MCO specific data available for the MY 2016 HEDIS rates for 7- Day and 30-Day Follow-Up After Hospitalization (FUH) for Mental Illness of 43.95% and 67.85%, respectively, at the time of the RCA sessions. The following are the goals for these two metrics: • **7-Day FUH Goal:** The percent of members across the twelve county service area who attended a follow up visit within 7 days after a mental health inpatient admission did not consistently achieve the MY 2016 goal of 48.59%. The new goal established for MY 2017 remains at 48.59%.		

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)	Response Date: 12/29/2017
• **30-Day FUH Goal:** The percent of members across the twelve county service area who attended a follow up visit within 30 days after a mental health inpatient admission did not consistently achieve the MY 2016 goal of 73.17%. The new goal established for MY 2017 remains at 73.17%.		
Analysis: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.	**Findings**	
People (1) **1.Key Stakeholders Root Cause:** Key stakeholders and subject matter experts from the 12 county systems of care (inpatient/outpatient/ administrative) have varying levels of understanding and engagement about the 7 and 30 day HEDIS FUH measures and the goals set forth by OMHSA/IPRO for the conduction of the RCA. This negatively impacts goal achievement and the establishment of system-wide collective approaches and plans of action to address the potential opportunities to improve the rates. This includes: • Historical County/ HC BH contractor level approaches to addressing improvement opportunities may have impacted system of care approaches across	**Initial Response:** • Individuals involved with the behavioral health care system at various levels and settings (inpatient/outpatient/administrative/oversight) may operate day to day in more siloed systems. • The current needs and demands on the behavioral health care system and the individuals supporting it does not readily lend itself to dedicated time to interact collectively across the continuum of care to problem solve and generate ideas for continuous improvements. • Key stakeholders may benefit from additional opportunities and forums to explore system-wide approaches to problem identification and solution generation. • Data driven solutions to improving the FUH rates will help to ensure that the true root causes are selected as the areas of focus for improvement efforts. **Follow-up Status Response:** • Root Cause: The preliminary root causes noted above have been considered and at this time it has been determined that a multi-disciplinary approach to improving the FUH rates is desirable and that the BH HC contractors will work to establish mechanisms to regularly bring together the key stakeholders from their respective systems of care to collaborate on this effort. It has been determined that this root cause is actionable and attainable (Action 1).	

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)	Response Date: 12/29/2017
the service area . • Forums for promoting best practice sharing across providers /facilities have been limited and improvement efforts more largely focused on local impacts. • Shared learning opportunities have been more focused locally versus regionally, thereby potentially limiting knowledge transfers of successful interventions.		
People (2) **1.Clients/members/patients** **Root Cause:** Members may not have a full understanding of the importance of follow up appointments with a behavioral health provider and the need for ongoing care following an inpatient discharge due to a variety of reasons, including: • Members may feel better, are out of crisis and lack understanding and insights into the need for an outpatient visit for	**Initial Response:** • Individuals with dual diagnoses and/or complex needs with chronic medical and substance use issues often require more coordination across the continuum of care and they may not feel the need to follow up with a psychiatrist or therapist. • Individuals often lack family support with treatment (such as parents not bringing their child to follow up appointments, no family involvement in discharge planning, parents unwillingness to sign releases to coordinate care, family not accepting appropriate level of care for the child, patient /family dynamic). • Members may have their first experience with the BH care system and feel their needs can be met by their PCP. • A member focus group (NW3/SW6) indicated that one reason for lack of follow up was the perception that follow up was not needed. • Individuals may be reluctant to seek treatment and continue with follow up care due to mental health stigma. • Individuals are non-adherent with follow up appointments. Based on county specific HEDIS data from MY 2016, only 43.95% of members were adherent for the 7 day FUH visits and only 67.85% of members were adherent for the 30 day FUH visits. • Individuals often have misconceptions about the treatment process (such as expectations of the provider as a “miracle worker” and a lack of understanding of their diagnosis/illness). • Members may lack an investment in his/her own recovery. • Individuals may perceive a “lack of fit” with the provider due to personalities,	

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<tr><th>HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response</th><th><u>Measure:</u> Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)</th><th><u>Response Date: 12/29/2017</u></th></tr>
<tr><td>follow up treatment to continue their recovery.
• Members may schedule the follow up visit with their PCP due potentially to established relationships and easier/more timely access and a perceived lack of connectedness with an outpatient BH provider.
• Some members may be at higher risk based on their clinical presentations and there is a lack of tracking of these high risks and the need for additional supports and services.</td><td colspan="2">incompatibility, and a sense of poor performance/unsatisfactory outcomes of treatment.

Root Cause (Preliminary):
• Members may have an incomplete and/or unrealistic understanding of the achievable outcomes of their care based on the nature of their individual cases and the available treatment options.

Root Cause (Preliminary):
• Members often lack available natural supports in the community (such as family, friends, etc.) which does not help to promote their on-going adherence to treatment recommendations and maintenance of follow up for outpatient visits.

Follow-up Status Response:
• Root Cause: Members do not have a full understanding of the importance of follow up appointments with behavioral health care providers and therefore do not consistently make or keep scheduled follow up visits at 7 and 30 days.

It has been determined that this root cause is actionable and attainable (Action 2).</td></tr>
<tr><td>Providers (1)
(e.g. provider facilities, provider network)

1.Outpatient Providers
Root Cause: The twelve county service area is experiencing a lack of available outpatient appointments within the 7 and 30 day timeframes for a variety of reasons, including the following:
• There is a lack of</td><td colspan="2">Initial Response:
• Outpatient provider access is often limited to be able to accommodate the members in a timely manner (within 7 and 30 days) who are being discharged following an inpatient stay for various reasons (including members lack of initial choice of available providers and/or options to change if members desire a new provider, limited psychiatrist time, extended wait times for psychiatrist appointments, limited provider choices, lack of availability to take on new clients, and rural settings experience greater challenges with provider retention). A fishbone diagram was completed following a RCA session with the Value Behavioral Health (VBH) Provider Advisory Committee (PAC) in March 2017 and participating providers noted that provider availability and a lack of psychiatrist time was a key contributing factor to FUH visit non-adherence.
• Lack of clear understanding by the provider of the patients' needs.
• Inadequate communication between the hospital and the follow up provider/PCP for continuity of care.
• Scheduling barriers and reluctance to overbook due to staffing issues.

Root Cause (Preliminary):
• Members do not consistently have access to outpatient providers following an inpatient</td></tr>
</table>

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)	Response Date: 12/29/2017
psychiatrists and psychiatric time in the region due in part to a lack of psychiatrists entering the field and thereby creating a national/local shortage and career pursuits in a non-public sector setting. • Budgets and incentives are limited to attract new psychiatrists to the region/field in order to increase availability. • Scheduling outpatient appointments is impacted by the lack of availability and provider choice if there is not a fit with the member/provider interaction. • Lack of tenured support staff due to turnover and unfamiliarity with BH needs and the systems and processes of care.	stay due to limited choices in behavioral health providers who are available to provide appointments to meet the 7 and 30 day standards. **Follow-up Status Response:** • Root Cause: The lack of an adequate number of trained psychiatrists/other behavioral health providers and available psychiatric time leads to missed opportunities for timely follow up visits and members often seeking care via their PCP or choosing not to follow up at all. It has been determined that select aspects of this root cause are actionable and attainable (Action 3).	
Providers (2) (e.g. provider facilities, provider network) **1.Inpatient Providers: Inadequate Discharge Planning** **Root Causes:**	**Initial Response:** • Inadequate discharge planning (including lack of education provided to patients by the provider to stress the importance of follow up outpatient care to aid in recovery) and overall lack of emphasis on discharge planning. • Unclear discharge instructions. Recent reviews of a random sample of treatment records at the four pilot facilities that were selected for the "Successful Transitions from Inpatient to Ambulatory Care" PIP (Performance Improvement Project) supports the twelve county service area for VBH members. The 2016 results identified slower than	

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)	Response Date: 12/29/2017
• Members may return back to the hospital (inpatient setting) following a recent discharge which may be linked to insufficient supports in place to assist the members with attending F/U appointments. • Members are not consistently linked to the appropriate level of care (LOC), transportation options, and/or proper medication reconciliation interventions prior to discharge. • Inpatient providers are not proactively planning for the members' discharge through the consistent completion of an outpatient needs assessments at the time of intake/admission (such as requesting ROIs for ensuring complete data sets for the providers). • Inpatient staff (Social Workers) are often addressing the presenting higher acuity needs of the member upon admission, rather	expected progress towards the stated goals, with opportunities for improvement related to documented medication reconciliation. Also, FUH visits scheduled and kept were lower than the stated goals. The goal was 40% for medication reconciliation and follow up scheduled within 0-14 days. • Poor communication/lack of knowledge of available services and agencies to patients to be referred to for follow up care. Inpatient profiles developed by VBH are produced annually and shared with contracted network facilities with 50+ discharges in the previous year. In 2016, facilities with 50+ admissions that serve VBH members were included in these profiles and had rates for 7 and 30 day FUH visits that were noted in the profiles. The VBH average of 57% identified overall opportunities for improvement. Interviews by the VBH Medical Director with representative from the four pilot facilities identified that they have been moving to electronic medical records in an effort to standardize the forms and discharge instructions, but the ability to change/update/modify the EHRs is often delayed and costly if not compatible with other changes occurring within the overall hospital system. This can create delays and may result in converting back to supplemental paper processes and forms to meet external expectations. • Inadequate communication between the hospital and the follow up provider for continuity of care. A barrier analysis session was held in 2016 with VBH care coordinators, management staff and Value Recovery Coordinators. A six sigma SIPOC (Supplier, Input, process, Output and Customer) diagram (high level process flow) was completed and this revealed barriers and hand-offs across the systems of care that were determined to be contributory factors to non-adherence to FUH visits. **Root Cause:** • Based on annual chart abstractions conducted by a team from VBH, the discharge management planning (DMP) efforts at network participating inpatient facilities do not consistently meet the goals established as part of the PIP project for the four core metrics related to medication reconciliation and FUH appointments. • Based on the MY 2016 HEDIS measure for 7 and 30 day FUH visits, VBH is not achieving the overall stated goals.	
	Follow-up Status Response: • **Root Cause:** There is a perceived lack of coordinated and well established processes and communication channels across the continuum of care (inpatient to outpatient) to adequately address the continuity of care needs of the members upon admission through discharge, leading to missed opportunities to meet two of the core metrics of the PIP project related to FUH appointments and DMP. It has been determined that this root cause is impactful and attainable (Action 4).	

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)	Response Date: 12/29/2017
than additionally focusing on their discharge needs. **2. Inpatient Providers: Lack of Consistent Communication Between the Hospital and the Follow up Provider for Continuity of Care** **Root Causes:** • Families may not make the hospital staff aware of any current services/hospital staff are not soliciting for complete information of any current services being provided in order to connect with the follow up outpatient provider. • Initial intake is often completed by hospital administrative/ED staff vs. social workers, as such there may be a gap in the language utilized with members/family. • Lack of awareness of hospital staff and current culture surrounding behavioral health (BH) services leading to the members/family		

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having a lack of understanding and engagement in follow up. • Lack of coordinated processes/formalized communications between the inpatient and outpatient staff related to the members and their ongoing needs.		
Policies / Procedures (1) (e.g., data systems, delivery systems, payment/reimbursement) **Refer to "Provider" section above which also addresses policies/procedures related issues as crossover root causes.**	**Initial Response:** • N/A **Follow-up Status Response:** • N/A	
Provisions (1) (e.g., screening tools, medical record forms, transportation) **Lack of Transportation Options** **Root Causes:** Members are often faced with significant challenges to secure transportation to and from their behavioral health provider visits that directly impact their ability to consistently attend these appointments	**Initial Response:** • Members do not have consistently have access to reliable, dependable and easy to access transportation to/from their follow up appointments due to a variety of factors. Based on a barrier analysis session conducted in March 2017 with the VBH Provider Advisory Committee (PAC) one of the most common barriers identified was the lack of transportation for members to keep compliant with their recommended follow up visits. • Transportation providers may not be fully aware or understanding of the demographic they are dealing with (such as consumers with MH (mental health) illness or IDD (intellectual developmental disability) consumers, many of whom may appear "normal" from the outside even though they may be in crisis in their mind, though this may not be understood and things may be said when they are late or call and cancel). ***Root Cause:*** • Members who may lack personal transportation that is reliable and dependable are not able to consistently adhere to their follow up visits due to a lack of alternative transportation options that have the flexibility to meet their individual needs and schedules.	

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)	Response Date: 12/29/2017
for 7 and 30 day follow up due to: • Lack of transportation resources before/after the select time of the day for the available appointment. • Ensuring that providers and members are fully aware and educated/informed on the transportation services available and some of the limitations that may need to be addressed when scheduling these services. • Transportation times, including early drop off and late pick up, which may cause a patient to spend half a day at the providers setting for a 45 minute to an hour appointment. • Lack of transportation resources in the county. • Inability for individuals to access the transportation that the whole family may be eligible for	**Follow-up Status Response:** **Root Cause:** Members may have limited access to reliable, affordable and easy to access transportation options (such as public transportation, personal vehicles, community supports, etc.) to assist them in ensuring they can consistently access their providers in a timely manner to meet the scheduled follow up appointments. It has been determined that aspects of this root cause are actionable and attainable (Action 5).	

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)	Response Date: 12/29/2017
(such as single parents needing to find resources for their children when scheduling follow up appointments).		
Provisions (2) (e.g., screening tools, medical record forms, transportation) N/A	**Initial Response:** N/A	
	Follow-up Status Response: N/A	
Other (specify)	**Initial Response:**	
	Follow-up Status Response:	

Corresponding Action Plan		
Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day) for MY 2016		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2016. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	**Implementation Date** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
Action (1) ***Root Cause: Key stakeholders and subject matter experts from the 12 county systems of care (inpatient/outpatient /administrative) have varying levels of understanding and engagement about the 7 and 30 day HEDIS FUH measures and the goals set forth by OMHSA/IPRO for the conduction of the RCA and establishing a plan of action to address the***	1.) October 2017: Kick off sessions 2.) Individual BH HC contractor specific meetings (on-going into 2018 as needed/deter-mined by each individual contractor)	**Initial Response:** • The VBH QM Director developed a set of orientation materials (attached) to introduce the key stakeholders and county liaisons as to the current levels of performance for the 7 and 30 day FUH rates, as well as the background of the measure, the elements of the measure, the county specific rates for 2014-2015, along with drill down data and other introductory information. This information was made available to each contractor for use, as applicable, in their stakeholder respective sessions. Upon invitation, the VBH QM Director participated in/led several of the initial kick off sessions to provide the overview.  RCA Update 10.17.2017.pptx • **COMPLETED: October 2017.** • Face to face sessions were coordinated at the BH HC contractor level with key stakeholders/SMEs to review introductory materials, introduce the concepts of a root

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)	Response Date: 12/29/2017
potential opportunities to improve the rates. Address the need for a common set of goals and a level setting of the current FUH rates, a common understanding of the elements of the measure and begin to engage the county level key stakeholders in a collective approach across the continuum of care for improving the FUH rates for all counties. 1.) VBH Quality Management (QM) Director developed an introductory set of presentation materials to be used, as needed by each HC BH contractor, to provide an overview for the participants in the RCA session. 2.) Held "kick-off' sessions with the key stakeholders and subject matter experts (SMEs) at the BH HC contractor level to initiate a dialogue about the problem and begin to develop potential root causes.		cause analysis and conduct the first facilitated session of the RCA. • **COMPLETED: October 2017.** • Developed and administered an on-line survey (in select counties) or other mechanisms for summarizing the RCA "kick-off" sessions to gather feedback from the groups of the priority areas of interest/future focus, the main root causes and input on future meetings and on-going dialogue**.** • **COMPLETED: October 2017** • On-line survey results/summaries and fishbone diagrams were developed as determined by each county, as needed**.** <insert initial response here> **Follow-up Status Response:** These action steps, as outlined above, were all completed in 2017 and tailored by each BH HC contractor to meet the individual needs/preferences of their respective counties and their participants and the desired approaches of the county leads. This information will be updated on an "as needed" basis as the project progresses. Each of the BH HC contractors have established forums for their respective systems of care to bring together the key stakeholders and SMEs to work collectively on improving FUH rates at the local level. Throughout 2018 ongoing dialogue will be taking place regularly through face to face sessions, meetings/teleconferences, and/or on site visits, etc. to maintain communication and continue the open exchanges of ideas and information. On a quarterly basis during 2018 VBH will gather with the key representative from all the HC BH contractors to monitor progress on the established goals and exchange feedback on individual and collective efforts. VBH/Beacon Health Options will sponsor the Third Annual "Best Practice Forum' in the Fall of 2018 to again bring together inpatient providers to exchange best practices and success/barriers to improving the FUH rates. The agenda and the speakers for the forum will begin to be developed in the Spring of 2018 and will include a topic related to activities impacting the FUH rates.	

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3.) VBH QM Director completed a draft fishbone diagram template as part of the overview materials for review by the participants for prioritization. This was intended as a guide to note the four P's selected by IPRO/OMHSAS for the areas of focus. 4.) Conducted an on-line survey of participants (in select counties) for feedback and insights into next steps for planning future sessions and root cause selection. 5.) BH HC contractors used the information from the initial sessions to determine follow up action steps based on face to face feedback and/or survey findings.		
Action (2) ***Root Cause: Members do not have a full understanding of the importance of follow up appointments with behavioral health care providers and therefore do not consistently make or keep***	1.) **October 2017:** Kick off Sessions 2.) **January 2018-Summer 2018:** Refer to Individual HC BH contractors individual RCA plans for	**Initial Response:** • Develop/support data collection plans with the HC BH contractors (as applicable) to ascertain feedback from consumers related to their experiences and perceptions about their treatment. • Gather input from inpatient providers related to tracking systems for identifying members who are high risk for follow up • Explore data collection and possible tracking of FUH visits at 7 and 30 days for members with their PCP versus a BH provider to ascertain the degree to which the follow up visits

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)	Response Date: 12/29/2017
scheduled follow up visits at 7 and 30 days. Address the need to better understand the perspective of the members related to their recovery and the need for follow up visits with BH outpatient providers: 1.) VBH to collaborate with the HC BH contractors to address potential methods for data collection and/or member/provider feedback (such as focus group, survey data, family member input, etc.). 2.) HC BH contractors to develop the data collection tools/processes and timelines for completion and data analysis for this action step. 3.) Integrated Care Planning collaborations between VBH and the PH MCOs have been initiated and options will be explored to utilize these new existing vehicles of communication to promote F/U visits.	additional details	a e occurring in the primary care setting • Consider use of the Integrated Care Planning communication channels to address need for follow up visits with BH provider rather than the PCP **Follow-up Status Response:** • To be added in the future, as needed.

HealthChoices BH MCO: Value Behavioral Health of Pennsylvania (VBH)/Beacon Health Options: All County RCA Response	Measure: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)	Response Date: 12/29/2017
Action (3) ***Root Cause: Members do not consistently have access to outpatient providers following an inpatient stay due to limited choices in providers who are available to provide appointments to meet the 7 and 30 day standards*** Address the need to better understand alternative solutions to increasing psychiatric time that may not have been explored sufficiently in the past. Outpatient providers may not have access to appointments to meet the HEDIS requirements.	1.) **October 2017:** Kick off sessions 2.) **January 2018-Summer 2018:** Refer to individual HC BH contractor plans for additional details.	**Initial Response:** • Explore options to establish "discharge clinics" (in select counties) with interested inpatient/outpatient providers for individuals being discharged from an inpatient setting that meet the 7 and 30 FUH day timeframes. • Explore the potential use of alternate staff (county, etc.) to be available in the ED for individuals who present (in select counties) • Utilize care managers (in select counties) to interact with members during follow up calls to ascertain whether their follow up appointments were with a PCP and if this was their choice. Provide education, as needed, on the importance of follow up with a BH provider and offer to assist with scheduling an appointment if the member is interested. • Ensure local providers are aware (via joint provider meetings/ discussions) of initiatives/resources/services taking place in their area that may assist with increasing member awareness and understanding of the importance of follow up visits. **Follow-up Status Response:** • To be added in the future, as needed.
Action (4) ***Root Cause: Based on annual chart abstractions conducted by a team from VBH, discharge management planning (DMP) efforts at network participating inpatient facilities do not consistently meet the goals established as part of the PIP project for one of the four core metrics related to medication reconciliation and FUH appointments.***	1.) **October 2017:** Kick off sessions 3.) **January 2018-Summer 2018:** Refer to individual HC BH contractor plans for additional details	**Initial Response:** • Measure indicator: Discharge Management Planning (DMP) measure (Numerators 4 and 5: Follow-up visit scheduled within 7 and 30 days of discharge). • Monitoring will be based on the results of the annual DMP audits as part of the PIP • Baseline: DMP results for MY 2015 • Re-measure # 2 and #3 and #4: DMP results for MY 2016 and MY 2017and MY 2018 • Begin to coordinate the Q2 2018 DMP reviews and include the county level liaisons who were trained in 2017 for insights and engagement • Coordinate follow up with four pilot facilities for DMP feedback • Target: FUH rates of 48.59% and 73.17% for the 7 and 30 day FUH HEDIS measures, respectively. • **Follow-up Status Response:**

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Address the following: • There is a current initiative related to the PIP that assesses the four pilot facilities on an annual basis for the DMP core metric and assesses for all of the related elements of the discharge plan. The HC BH contractors will further review the DMP elements and the current processes to determine if additional actions steps and/or interventions can be developed and implemented to address this measure (such as training, more frequent audits, self-audits for monitoring by the facilities, review of the electronic health records for compliance and potential modifications, assess whether the treatment records can be accessed via provider portals to perform desk top reviews more frequently, etc.)	1.) **October 2017:** Kick off sessions 2.) **January 2018-Summer 2018:** Refer to individual HC BH contractor plans for additional details	• To be added in the future, as needed. **Initial Response:** • Members may benefit (in select counties) from training related to feedback on effective budgeting in making decision regarding transportation options. • Rural county members may have added transportation constraints without access to public services. When public transportation is available, the times/locations for pick up/drop off are not always convenient and scheduling presents concerns with lack of flexibility to accommodate individual needs • Efforts will be explored (in select counties) to partner with the local county specific transportation providers for exploring new solutions/options. • Explore options (in select counties) to assess current transportation materials for members to determine usability/ease of understanding, potentially develop new materials that are ADA sensitive, and encourage use by inpatient facilities at the time of discharge planning to ensure this is adequately address before the individual leaves the inpatient setting.	

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• The VBH QM Director and County liaisons will have additional discussions to explore possible short and long-term solutions and barriers. • The Quality teams will develop data analysis with the hospitals on a regular basis to review progress towards the goals and the data collection. **Action (5)** ***Root Cause: Members may have limited access to reliable, affordable and easy to access transportation options (such as public transportation, personal vehicles, community supports, etc.) to assist them in ensuring they can consistently access their providers in a timely manner to meet the scheduled follow up appointments.***			

VI: 2018 Strengths and Opportunities for Improvement

The review of VBH's 2018 (MY 2017) performance against structure and operations standards, performance improvement projects, and performance measures identified strengths and opportunities for improvement in the quality outcomes, and in the timeliness of and access to services for Medicaid members served by this BH-MCO.

Strengths

- VBH's MY 2017 PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness rate (QI B) for the overall population was statistically significantly higher (better) compared to the MY 2017 HC BH (Statewide) rate by 2.4 percentage points.
- VBH's MY 2017 HEDIS 30-Day Follow-up After Hospitalization for Mental Illness was statistically significantly higher better) than the Statewide rate by 3.9 percentage points.
- Both VBH's MY 2017 Initiation and Engagement of AOD Treatment rates for ages 13+ years achieved the goal of meeting or exceeding the 75th percentile for the corresponding measure.
- Both VBH's MY 2017 Initiation and Engagement of AOD Treatment rates for ages 13+ years were statistically significantly higher (better) than the Statewide rates by 6.7 and 8.1 percentage points, respectively.
- Both VBH's MY 2017 Initiation and Engagement of AOD Treatment rates for ages 13+ years were statistically significantly higher (improved) compared to the prior year rates by 19.1 and 21.0 percentage points, respectively.

Opportunities for Improvement

- VBH was partially compliant with the following five elements under review for Year 3 of the Performance Improvement Project:
    - Review Element 1 – Project Topic and Relevance
    - Review Element 3 – Study Variables (Performance Indicators)
    - Review Element 6 – Data Collection Procedures
    - Review Element 7 – Improvement Strategies (Interventions)
    - Review Elements 8/9 – Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement.

- Review of compliance with standards conducted by the Commonwealth in RY 2015, RY 2016, and RY 2017 found VBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
    - VBH was partially compliant with 1 out of 7 categories within Subpart C: Enrollee Rights and Protections Regulations. The partially compliant category is Enrollee Rights.
    - VBH was partially compliant with 6 out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Subcontractual Relationships and Delegation, 5) Practice Guidelines, and 6) Quality Assessment and Performance Improvement Program.
    - VBH was partially compliant with 9 out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.
- VBH's MY 2017 Readmission within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.
- VBH's MY 2017 Readmission within 30 Days of Inpatient Psychiatric Discharge rate increased (worsened) significantly compared to the prior year rate by 1.4 percentage points.
- VBH's MY 2017 PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness rate (QI B) for the overall population was statistically significantly lower (worsened) compared to the MY 2017 HC BH (Statewide) rate by 2.6 percentage points.
- VBH's MY 2017 PA-Specific 7-Day and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI A and QI B) were both statistically significantly lower (worsened) compared to the prior year by 5.0 and 3.2 percentage points, respectively.

- VBH's MY 2017 HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for ages 6–64 years did not meet the OMHSAS interim goals for MY 2017, nor did they achieve the goal of meeting or exceeding the HEDIS 75th percentile. VBH's MY 2017 HEDIS 7-Day and 30-Day Follow-up After Hospitalization for Mental Illness rates(QI 1 and QI 2) were both statistically significantly lower (worsened) compared to the prior year by 4.6 and 3.5 percentage points, respectively.
- VBH's MY 2017 HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness rates for ages 6+ years (Overall) did not meet the OMHSAS interim goals for MY 2017, nor did they achieve the goal of meeting or exceeding the HEDIS 75th percentile. Both rates were statistically significantly lower (worsened) compared to the prior year by 4.4 and 3.5 percentage points, respectively.

Performance Measure Matrices

The Performance Measure (PM) Matrices provide a comparative look at quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HealthChoices BH-MCO. The comparisons are presented in matrices that are color-coded to indicate when the findings for these measures are notable and whether there is cause for action.

Table 6.1 is a three-by-three matrix depicting the horizontal same-year comparison between the BH-MCO's performance and the applicable HC BH (Statewide) rate and the vertical comparison of the BH-MCO's MY 2017 performance to its prior year performance. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly: above (▲), below (▼), or no difference (═). This comparison is determined by whether or not the 95% CI for the BH-MCO rate included the benchmark rate. However, the qualitative placement of the performance in the matrix depends on the measure. For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) measure, lower rates reflect better performance.

Table 6.1: BH-MCO Performance Matrix for MY 2017 PA-Specific 7- and 30-Day Follow-up After Hospitalization and MY 2017 Readmission Within 30 Days of Inpatient Psychiatric Discharge (Overall)

BH-MCO Year to Year Statistical Significance Comparison	Trend	BH-MCO versus HealthChoices Rate Statistical Significance Comparison		
		Poorer	No difference	Better
	Improved	C	B	A
	No Change	D	C	B
	Worsened	F FUH QI A	D REA[1]	C FUH QI B

[1] For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.
Letter Key: Performance is notable. BH-MCOs may have internal goals to improve. B: BH-MCOs may identify continued opportunities for improvement. C-F: Recommend BH-MCOs identify continued opportunities for improvement.
FUH QI A: PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness (Overall).
FUH QI B: PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall).
REA: Readmission Within 30 Days of Inpatient Psychiatric Discharge.

Table 6.2 quantifies the performance information contained in **Table 6.1**. It compares the BH-MCO's MY 2017 7- and 30-Day Follow-up After Hospitalization and Readmission Within 30 Days of Inpatient Psychiatric Discharge rates to prior years' rates for the same indicator for measurement years 2013 through 2017. The last column compares the BH-MCO's MY 2017 rates to the corresponding MY 2017 HC BH (Statewide) rates. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly: above (▲), below (▼), or no difference (═). This comparison is determined by whether or not the 95% CI for the BH-MCO rate included the benchmark rate.

Table 6.2: MY 2017 PA-Specific 7- and 30-Day Follow-up After Hospitalization and MY 2017 Readmission Within 30 Days of Inpatient Psychiatric Discharge Rates, Compared Year-over-Year and to HC BH Statewide (Overall)

Quality Performance Measure	MY 2013 Rate	MY 2015 Rate	MY 2015 Rate	MY 2016 Rate	MY 2017 Rate	MY 2017 HC BH (Statewide) Rate
QI A – PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness (Overall)	56.4% ═	57.6% ═	55.7% ▼	54.6%═	49.6%▼	52.2%▼
QI B – PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall)	75.9% ═	76.6% ═	75.2% ═	75.2%═	72.0%▼	69.6%▲
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	11.4% ═	12.1% ═	11.7% ═	11.7% ═	13.1%▼	13.4%=

[1] For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.

Table 6.3 is a four-by-one matrix that represents the BH-MCO's MY 2017 performance as compared to the HEDIS 90th, 75th, 50th, and 25th percentiles for the MY 2017 HEDIS FUH 7-Day (QI 1) and 30-Day Follow-up (QI 2) After Hospitalization metrics. A root cause analysis and plan of action is required for rates that fall below the 75th percentile.

Table 6.3: BH-MCO Performance Matrix for MY 2017 HEDIS FUH 7- and 30-Day Follow-up After Hospitalization (6–64 Years)

HealthChoices BH-MCO HEDIS FUH Comparison[1]
Indicators that are greater than or equal to the 90th percentile.
Indicators that are greater than or equal to the 75th percentile, but less than the 90th percentile. (*Root cause analysis and plan of action required for items that fall below the 75th percentile.)*
Indicators that are greater than or equal to the 50th percentile, but less than the 75th percentile. **FUH QI 1** **FUH QI 2**
Indicators that are less than the 50th percentile.

[1] Rates shown are for ages 6–64 years.
FUH QI 1: HEDIS 7-Day Follow-up After Hospitalization for Mental Illness (6–64 Years).
FUH QI 2: HEDIS 30-Day Follow-up After Hospitalization for Mental Illness (6–64 Years).

Table 6.4 shows the BH-MCO's MY 2017 performance for HEDIS (FUH) 7- and 30-day Follow-up After Hospitalization for Mental Illness (6–64 Years) relative to the corresponding HEDIS MY 2017 NCQA Quality Compass percentiles.

Table 6.4: BH-MCO's MY 2017 FUH Rates Compared to the Corresponding MY 2017 HEDIS 75th Percentiles (6–64 Years)

Quality Performance Measure	MY 2017		HEDIS MY 2017 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-up After Hospitalization for Mental Illness (6–64 Years)	**39.5%**	Not met	Below 75th and at or above 50th percentile
QI 2 – HEDIS 30-Day Follow-up After Hospitalization for Mental Illness (6–64 Years)	**64.8%**	Not met	Below 75th and at or above 50th percentile

[1] Rates shown are for ages 6–64 years.

VII: Summary of Activities

Structure and Operations Standards

- VBH was partially compliant with Subparts C, D, and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2017, RY 2016, and RY 2015 were used to make the determinations.

Performance Improvement Projects

- VBH submitted a Year 3 PIP Update in 2018. VBH participated in quarterly meetings with OMHSAS and IPRO throughout 2018 to discuss ongoing PIP activities.

Performance Measures

- VBH reported all performance measures and applicable quality indicators in 2018.

2017 Opportunities for Improvement MCO Response

- VBH provided a response to the opportunities for improvement issued in 2017.

2018 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for VBH in 2018. The BH-MCO will be required to prepare a response in 2019 for the noted opportunities for improvement.

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Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for Required PEPS Substandards pertinent to BBA Regulations.

Table A.1: Required PEPS Substandards Pertinent to 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 DHS.
	Standard 104.2	The BH-MCO must submit to the DHS data specified by the DHS 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 DHS.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
	Standard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly PEPS Reports
	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, have 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. 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	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages. • Excel or Access data base with the following information: Name of Agency (include satellite sites). Address of Agency (and satellite sites) with zip codes. Level of Care (e.g. Partial Hospitalization, D&A Outpatient, etc.). Population served (adult, child & adolescent). Priority Population. Special Population.
	Standard 1.2	100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met.
	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).

BBA Category	PEPS Reference	PEPS Language
	Standard 1.5	BH-MCO has notified the Department 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 provide instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of oral interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Standard 24.2	Provider network database 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 28.3	Other: Significant onsite review findings related to Standard 28.
	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: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, and Consumer satisfaction.
§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.
	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
§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 28.3	Other: Significant onsite review findings related to Standard 28.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free

BBA Category	PEPS Reference	PEPS Language
		from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.2104 Provider Selection	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as, other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
	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: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, and Consumer satisfaction.
§438.240 Quality assessment and performance improvement program	Standard 91.1	QM program description outlines ongoing quality assessment, performance improvement activities, a 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 processes; denial rates; upheld and overturned grievance 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

BBA Category	PEPS Reference	PEPS Language
		utilization patterns and trends including BHRS and other high volume/high risk services).
	Standard 91.8	The QM work plan includes monitoring activities conducted to evaluate the quality and performance of the provider network (quality of individualized service plans and treatment planning, adverse incidents, collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance).
	Standard 91.9	The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	The QM work plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator: Mental Health; and, 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 DHS. 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 DHS by April 15th.
	Standard 91.14	The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the Annual Evaluation and any Corrective Actions required from previous reviews.
	Standard 91.15	The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outline in the program description and the work plan.
	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: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, and Consumer satisfaction.
	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 schools.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DHS.
	Standard 104.2	The BH-MCO must submit to the DHS data specified by the DHS 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 DHS.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.

BBA Category	PEPS Reference	PEPS Language
	Standard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly PEPS Reports
§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. ● BBA Fair Hearing ● 1st Level ● 2nd Level ● External ● Expedited
	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 decision letters must be written in clear, simple language that includes each issue identified in the member 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 must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§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.

BBA Category	PEPS Reference	PEPS Language
	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. ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	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 decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must 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 must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.404 Notice of	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5%

BBA Category	PEPS Reference	PEPS Language
action		requirement is met.
	Standard 23.3	List of oral interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Standard 24.2	Provider network database 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 according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§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. ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	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 decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must 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 must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established

BBA Category	PEPS Reference	PEPS Language
		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 according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§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. ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	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 decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must 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 must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the

BBA Category	PEPS Reference	PEPS Language
		documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.410 Expedited resolution of appeals	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§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. ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
§438.420 Continuation of benefits while the MCO or PIHP appeal	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level

BBA Category	PEPS Reference	PEPS Language
and the State fair hearing are pending		• 2nd level • External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.424 Effectuation of reversed appeal resolutions	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: • BBA Fair Hearing • 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-Specific PEPS Substandards.

Table B.1: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Care Management		
Care Management (CM) Staffing	Standard 27.7	Other: Significant onsite review findings related to Standard 27.
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
Second Level Complaints and Grievances		
Complaints	Standard 68.6	The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 68.9	Where applicable there is evidence of county oversight and involvement in the 2nd level complaint process.
Grievances and State Fair Hearings	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 71.8	Where applicable there is evidence of county oversight and involvement in the 2nd level grievance process.
Denials		
Denials	Standard 72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to requirements.
Executive Management		
County Executive Management	Standard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Standard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		

Category	PEPS Reference	PEPS Language
Consumer/ Family Satisfaction	Standard 108.3	County/BH-MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.
	Standard 108.4	The C/FST Director is responsible for setting program direction consistent with county direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority and directing staff to perform high quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.

Appendix C. Program Evaluation Performance Summary: OMHSAS-Specific Substandards for VBH Counties

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2017, 16 substandards were considered OMHSAS-specific monitoring standards. Of the 16 OMHSAS-specific PEPS Substandards, all were evaluated for VBH and the HC BH Contractors subcontracting with VBH. **Table C.1** provides a count of these substandards, along with the relevant categories. Because compliance categories (first column) may contain substandards that are either annually or triennially reviewed, the total number of PEPS substandards applicable to this year's (RY 2017) evaluation of HealthChoices Oversight Entity/BH-MCO compliance for any given category may not equal the sum of those substandard counts.

Table C.1: Tally of OMHSAS-Specific Substandards Reviewed for VBH

Category (PEPS Standard)	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
	Total	NR	RY 2017	RY 2016	RY 2015
Care Management					
Care Management (CM) Staffing (Standard 27)	1	0	1	0	0
Longitudinal Care Management (and Care Management Record Review) (Standard 28)	1	0	1	0	0
Second Level Complaints and Grievances					
Complaints (Standard 68)	5	0	5	0	0
Grievances and State Fair Hearings (Standard 71)	5	0	5	0	0
Denials					
Denials (Standard 72)	1	0	1	0	0
Executive Management					
County Executive Management (Standard 78)	1	0	1	0	0
BH-MCO Executive Management (Standard 86)	1	0	1	0	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	3	0	0
Total	18	0	18	0	0

[1] The total number of OMHSAS-Specific substandards required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with OMHSAS standards. Any PEPS substandards not reviewed indicate retired substandards previously used to evaluate the BH-MCO.

[2] The number of OMHSAS-Specific substandards that came under active review during the cycle specific to the review year. Because compliance categories (first column) may contain substandards that are either annually or triennially reviewed, the total number of PEPS substandards applicable to this year's (RY 2017) evaluation of HealthChoices Oversight Entity/BH-MCO compliance with any given category may not equal the sum of those substandard counts.

RY: Review Year.

NR: Not reviewed.

Format

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

Findings

Care Management

The OMHSAS-specific PEPS Substandards relating to Care Management are MCO-specific review standards. These two substandards were added to the PEPS Application for RY 2015. VBH partially met the criteria for compliance with these two substandards. The status for these substandards is presented in **Table C.2**.

Table C.2: OMHSAS-Specific Requirements Relating to Care Management

Category	PEPS Item	Review Year (RY)	Status by HC BH Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Standard 27.7	2017	All HC BH Contractors		
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	2017	All HC BH Contractors		

VBH met the criteria for compliance with PEPS Standard 27 and Standard 28.

Second-Level Complaints and Grievances

The OMHSAS-specific PEPS Substandards relating to second-level complaints and grievances are MCO and HC BH Contractor-specific review standards. Ten (10) substandards were evaluated for all HC BH Contractors during RY 2017. All of VBH's HC BH Contractors met 7 substandards and partially met 3 substandards. Findings are presented in **Table C.3**.

Table C.3: OMHSAS-Specific Requirements Relating to Second-Level Complaints and Grievances

Category	PEPS Item	Review Year (RY)	Status by HC BH Contractor			
			Met	Partially Met	Not Met	Not Reviewed
Second Level Complaints and Grievances						
Complaints	Standard 68.1	2017	All HC BH Contractors			
	Standard 68.6	2017	All HC BH Contractors			
	Standard 68.7	2017	All HC BH Contractors			
	Standard 68.8	2017	All HC BH Contractors			
	Standard 68.9	2017		All HC BH Contractors		
Grievances and State Fair Hearings	Standard 71.1	2017	All HC BH Contractors			
	Standard 71.5	2017	All HC BH Contractors			
	Standard 71.6	2017		All HC BH Contractors		
	Standard 71.7	2017		All HC BH Contractors		
	Standard 71.8	2017	All HC BH Contractors			

All of the HC BH Contractors partially met county-specific PEPS Standard 68, Substandard 9 (RY 2017).

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. [Appendix H, A., 4 and 5] [E.2.a, b, f, pp.38] [IV-5, C.4., p. 44].

> **PEPS Standard 68, Substandard 9:** Where applicable, there is evidence of County oversight and involvement in the second-level complaint process.

The HC BH Contractors partially met County-specific PEPS Standard 71, Substandards 6 and 7 (RY 2017).
PEPS Standard 71: Grievance and the Department's fair hearing rights and procedures are made known to EAP members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

> **PEPS Standard 71, Substandard 6:** Training rosters identify that all second-level panel members have been trained. Include a copy of the training curriculum.

> **PEPS Standard 71, Substandard 7:** A transcript and/or tape recording of the second-level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed, and that the decision was based on input from all panel members.

Denials

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2016. VBH was evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

Table C.4: OMHSAS-Specific Requirements Relating to Denials

Category	PEPS Item	Review Year (RY)	Status
Denials			
Denials	Standard 72.3	2017	Met

Executive Management

There are two OMHSAS-specific PEPS substandards relating to Executive Management. The County Executive Management substandard is a County-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. These substandards were added to the PEPS Application during RY 2015. With the exception of Crawford/Mercer and Beaver, all of the HC BH Contractors met the compliance standards for both Substandards. Crawford/Mercer was partially compliant, while Beaver was found non-compliant with PEPS Standard 78, Substandard 5. VBH was found compliant with the BH-MCO Executive Management substandard (Standard 86, Substandard 3). The status for the Executive Management substandards is presented in **Table C.5**.

Table C.5: OMHSAS-Specific Requirements Relating to Executive Management

Category	PEPS Item	Review Year (RY)	Status By HC BH Contractor			
			Met	Partially Met	Not Met	Not Reviewed
Executive Management						
County Executive Management	Standard 78.5	2017	Fayette, Green, Southwest Six	Crawford/Mercer	Beaver	
BH-MCO Executive Management	Standard 86.3	2017	All HC BH Contractors			

Enrollee Satisfaction

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are County-specific review standards. All three substandards crosswalked to this category were evaluated for the VBH HC BH Contractors, and all contractors were compliant with all three substandards. The status for these substandards is presented in **Table C.6**.

Table C.6: OMHSAS-Specific Requirements Relating to Enrollee Satisfaction

Category	PEPS Item	Review Year (RY)	Status by HC BH Contractor	
			Met	Partially Met
Enrollee Satisfaction				
Consumer/Family Satisfaction	Standard 108.3	2015	All VBH HC BH Contractors	
	Standard 108.4	2015	All VBH HC BH Contractors	
	Standard 108.9	2015	All VBH HC BH Contractors	