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

2016 External Quality Review Report
Value Behavioral Health

FINAL
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IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org

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Glossary of Terms

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

Introduction

Purpose and Background

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

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

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

HealthChoices Behavioral Health is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2016 EQRs for the HealthChoices Behavioral Health (BH) MCOs and to prepare the technical reports. This technical report includes seven core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures
IV. Quality Study
V. 2015 Opportunities for Improvement - MCO Response
VI. 2016 Strengths and Opportunities for Improvement
VII. Summary of Activities

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

Information for Sections II and III of this report is derived from Island Peer Review Organization's (IPRO's) validation of each BH-MCO's performance improvement projects (PIPs) and performance measure submissions. The Performance Measure validation as conducted by IPRO included a repeated measurement of 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, 2015 Opportunities for Improvement – MCO Response, includes the BH-MCO's responses to opportunities for improvement noted in the 2015 EQR Technical Report, and presents the degree to which the BH-MCO addressed each opportunity for improvement. Section VI has a summary of the BH-MCO's strengths and opportunities for improvement for this review period (2016) as determined by IPRO, and a "report card" of the BH-MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HealthChoices Behavioral Health Managed Care Organization. Lastly, Section VII provides a summary of EQR activities for the BH-MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA Regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

I: Structure and Operations Standards

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the structure and operations standards. In review year (RY) 2015, 64 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 of the 67 counties have signed agreements using the right of first opportunity and have sub-contracted with a private sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four counties have elected not to enter into a capitated agreement and as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties. 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 Cambria, Crawford, Mercer and Venango Counties) hold contracts with VBH. The Department contracts directly with VBH to manage the HC BH program for Greene County. **Table 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: HealthChoices Oversight Entities, HC BH Contractors and Counties

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

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of VBH by OMHSAS monitoring staff within the past three review years (RYs 2015, 2014, 2013). 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 2015. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year timeframe under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review Substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's Program Standards and Requirements (PS&R) are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2016 and entered into the PEPS Application as of October 2016 for RY 2015. 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. As was done for the prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The RY 2015 crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in **Appendix A** and **B**, respectively. The review findings for selected OMHSAS-specific Substandards are reported in **Appendix C**.

Because OMHSAS'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 2015, RY 2014, and RY 2013 provided the information necessary for the 2016 assessment. Those standards not reviewed through the PEPS system in RY 2015 were evaluated on their performance based on RY 2014 or RY 2013 decisions, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed.

For VBH, this year a total of 163 Items were identified as being required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations. In addition, 16 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Substandards were relevant to more than one BBA regulation or provision, and that one or more provisions apply to each of the

categories listed within the subpart headings. Because of this, the same PEPS Item may contribute more than once to the total number of Items required and/or reviewed. **Table 2** provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of VBH against the Structure and Operations Standards for this report. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH-MCO and associated HealthChoices Oversight Entities against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for VBH

Table 2: Substandards Pertinent to BBA Regulations Reviewed for VBH

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2015	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	Not Reviewed[1]
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	9	3	0	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	24	18	2	4	0
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	2	2	0	0
Provider Selection	3	3	0	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	8	0
Practice Guidelines	6	0	2	4	0
Quality Assessment and Performance Improvement Program	23	16	0	7	0
Health Information Systems	1	0	0	1	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	2	9	0	0
General Requirements	14	3	12	0	0
Notice of Action	13	13	0	0	0
Handling of Grievances and Appeals	11	2	9	0	0
Resolution and Notification: Grievances and Appeals	11	2	9	0	0
Expedited Appeals Process	6	2	4	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	2	4	0	0
Effectuation of Reversed Resolutions	6	2	4	0	0

[1] Items "Not Reviewed" were not scheduled or not applicable for evaluation. "Not Reviewed" items, including those that were "Not Applicable," did not substantially affect the findings for any category, if other items within the category were reviewed.

For RY 2015, 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 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 2016 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.

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

For VBH and the six HealthChoices Oversight Entities associated with VBH, 163 PEPS Items were identified as required to fulfill BBA regulations. The six HealthChoices Oversight Entities were evaluated on 163 PEPS Items during the review cycle.

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 C.F.R. § 438.100 [a], [b]). **Table 3** presents the findings by categories consistent with the regulations.

Table 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	12 substandards were crosswalked to this category. All HC BH Contractors were evaluated on 12 substandards. All HC BH Contractors were compliant with 11 substandards and partially compliant with 1 substandard.
Provider-Enrollee Communications 438.102	Compliant	All VBH HC BH Contractors		Compliant as per PS&R sections E.4 (p.52) and A.4.a (p.20).
Marketing Activities 438.104	N/A	N/A	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH-MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	All VBH HC BH Contractors		Compliant as per PS&R sections A.9 (p.70) and C.2 (p.32).
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.37).
Solvency Standards 438.116	Compliant	All VBH Counties		Compliant as per PS&R sections A.3 (p.65) and A.9 (p.70), and 2015-2016 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 2015-2016 Solvency Requirement tracking report.

Of the 12 PEPS substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated. Each HC BH Contractor was evaluated on 12 substandards, compliant with 11 substandards, and partially compliant with 1 substandard.

Enrollee Rights

All HC BH Contractors were partially compliant with Enrollee Rights due to parital complaince with one substandard within PEPS Standard 60 (RY 2014).

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 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.

All HC BH Contractors partially compliant one substandard of Standard 60: Substandard 1 (RY 2015).

> **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 C.F.R. § 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 4** presents the findings by categories consistent with the regulations.

Table 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.57).
Availability of Services (Access to Care) 438.206	Partial		All VBH HC BH Contractors	24 substandards were crosswalked to this category. ach HC BH Contractor was evaluated on 24 substandards, compliant with 22 substandards, partially compliant with 1 substandard and non-compliant with 1 standard.
Coordination and Continuity of Care 438.208	Partial		All VBH HC BH Contractors	2 substandards were crosswalked to this category Each HC BH Contractor was evaluated on 2 substandards, partially compliant with 1 substandard and non-compliant with 1 substandard.
Coverage and Authorization of Services 438.210	Partial		All VBH HC BH Contractors	4 substandards were crosswalked to this category Each HC BH Contractor was evaluated on 4 substandards, compliant with 1 substandard, partially compliant with 2 substandards, and non-compliant with 1 substandard.
Provider Selection 438.214	Compliant	All VBH HC BH		3 substandards were crosswalked to this category.

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
		Contractors		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.49), G.4 (p.59) and C.6.c (p.47).
Subcontractual Relationships and Delegation 438.230	Compliant	All VBH HC BH Contractors		8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards and compliant with 8 substandards.
Practice Guidelines 438.236	Partial		All VBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 4 substandards, partially compliant with 1 substandard and non-compliant with 1 substandard.
Quality Assessment and Performance Improvement Program 438.240	Partial		All VBH HC BH Contractors	23 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards, compliant with 19 substandards and partially compliant with 4 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 five categories and partially compliant with five categories. Two of the five categories that VBH was compliant with—Elements of State Quality Strategies and Confidentiality—were not directly addressed by any PEPS substandards, but were determined to be compliant as per the HealthChoices PS&R.

For this review, 71 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations for all HC BH Contractors associated with VBH, and each HC BH Contractor was evaluated on 71 substandards. Each HC BH Contractor was compliant with 58 substandards, partially compliant with 9 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 for 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 due to partial or 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 2014).

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

All of the HC BH Contractors were partially compliant with one substandard of Standard 28: Substandard 2 (RY 2014).

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

Coordination and Continuity of Care

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

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 13 of this report.

Coverage and Authorization of Services

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

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 13 of this report.

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

All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2015).

Substandard 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).

Practice Guidelines

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

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 13 of this report.

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 four substandards within PEPS Standard 91.

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

All HC BH Contractors were partially compliant with four substandards of Standard 91: Substandards: 2, 5, 11 and 12 (RY 2015).

Substandard 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.
Substandard 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).
Substandard 11: 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); 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.
Substandard 12: The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.

Subpart F: Federal and State Grievance System Standards

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

The PEPS documents include an assessment of the HC BH Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 5** presents the findings by categories consistent with the regulations.

Table 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 5 substandards, partially compliant with 1 substandard and non-compliant with 5 substandards.
General Requirements 438.402	Partial		All VBH HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards, compliant with 7 substandards, partially compliant with 1 substandard, and non-compliant with 6 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	Partial		All VBH HC BH Contractors	11 substandards were crosswalked to this category.

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
438.406				Each HC BH Contractor was evaluated on 11 substandards, compliant with 5 substandards, partially compliant with 1 substandard, and non-compliant with 5 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All VBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 5 substandards, partially compliant with 1 substandard, and non-compliant with 5 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 4 substandard, partially compliant with 1 substandard, and non-compliant with 1 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 on 1 substandard and non-compliant on 1 substandard.
Recordkeeping and Recording Requirements 438.416	Compliant	All VBH HC BH Contractors		Compliant as per the 2015 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 4 substandards, partially compliant with 1 substandard and non-compliant with 1 substandard.
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 4 substandards, partially compliant with 1 substandard and non-compliant with 1 substandard.

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

For this review, 80 substandards were crosswalked to Federal and State Grievance System Standards for all HC BH Contractors associated with VBH. Each HC BH Contractor was evaluated on 80 substandards, compliant with 47 substandards, partially compliant with 8 substandards and non-compliant with 25 substandards. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

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

PEPS Standard 60: See Standard description and determination of compliance under Enrollee Rights on page 12 of this report.

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 non-compliant with four substandards of Standards 68: Substandards 1, 3, 4 and 5 (RY 2014).

Substandard 1: Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how the compliant rights and procedures are made known to members, BH-MCO staff and the provider network. BBA Fair Hearing, 1st level, 2nd level, External.
Substandard 3: Complaint decision letters must be written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
Substandard 4: The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
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 one substandard of Standard 71: Substandard 4 (RY 2014).

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

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services on page 14 of this report.

General Requirements

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

PEPS Standard 60: See Standard description and determination of compliance under Enrollee Rights on page 12 of this report.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services on page 14 of this report.

Notice of Action

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

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services on page 14 of this report.

Handling of Grievances and Appeals

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

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 14 of this report.

Resolution and Notification: Grievances and Appeals

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

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 14 of this report.

Expedited Appeals Process

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

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description determination of compliance under Coverage and Authorization of Services on page 14 of this report.

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 68.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

Continuation of Benefits

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

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and determination of comliance under Coverage and Authorization of Services on page 14 of this report.

Effectuation of Reversed Resolutions

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

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and nondetermination of compliance under Coverage and Authorization of Services on page 14 of this report.

II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH-MCO. Under the existing HealthChoices Behavioral Health agreement with OMHSAS, HC BH Contractors along with the responsible subcontracted entities (i.e., BH-MCOs), are required to conduct a minimum of two focused studies per year. The HC BH Contractors and BH-MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or re-measurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, BH-MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2016 for 2015 activities.

A new EQR PIP cycle began for BH-MCOs and HC BH Contractors in 2014. For this PIP cycle, OMHSAS selected the topic "Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis" as the topic for this PIP. The topic was selected because the Aggregate HealthChoices 30-day Readmission Rate has consistently not met the OMHSAS goal of a rate of 10% or less. In addition, all HealthChoices BH-MCOs continue to remain below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS®[1]) Follow-up After Hospitalization (FUH) metrics.

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

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

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

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

This PIP project will extend from January 2014 through December 2017, with initial PIP proposals submitted in 2014 and a final report due in June 2018. 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. BH-MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. BH-MCOs will be required to submit interim reports in June 2016 and June 2017, as well as a final report in June 2019. BH-MCOs are required to develop performance indicators and implement interventions based on

[1] The Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of the National Committee of Quality Assurance (NCQA).

evaluations of HC BH Contractor-level and BH-MCO-level data, including clinical history and pharmacy data. This PIP is designed to be a collaboration between the HC BH Contractors and BH-MCOs. The BH-MCOs and each of their HC BH Contractors are required to collaboratively develop a root-cause/barrier analysis that identifies potential barriers at the BH-MCO level of analysis. Each of the barriers identified should include the contributing HC BH Contract level data and illustrate how HC BH Contractor knowledge of their high risk populations contributes to the barriers within their specific service areas. Each BH-MCO will submit the single root-cause/barrier analysis according to the PIP schedule.

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

The 2016 EQR is the 13th review to include validation of PIPs. With this PIP cycle, all BH-MCOs/HC BH Contractors share the same baseline period and timeline. To initiate the PIP cycle in 2014, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given to the BH-MCOs/HC BH Contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness. The BH-MCOs 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 BH-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 for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

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

In 2016, OMHSAS elected to begin conducting quarterly PIP review calls with each BH-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, BH-MCOs were asked to submit only one PIP interim report in 2016, rather than two semi-annual submissions.

Validation Methodology

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (*Validating Performance Improvement Projects, Final Protocol, Version 1.0, May 1, 2002*) and meets the requirements of the final rule on the EQR of Medicaid MCOs issued on January 24, 2003. IPRO's review evaluates each project for compliance with the ten 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 nine elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for

each element is based on full, partial, and non-compliance. As calendar year 2016 was an intervention year for all BH-MCOs, IPRO reviewed elements 1 through 9 for each BH-MCO.

Review Element Designation/Weighting

Calendar year 2016 was an intervention year; therefore, scoring cannot be completed for all elements. This section describes the scoring elements and methodology that will occur during the sustainability period.

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 6** presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 6: 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 BH-MCO's overall performance score for a PIP. The seven review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all seven demonstrable improvement elements is 80 points (80% x 100 points for Full Compliance; **Table 7**).

PIPs are also reviewed for the achievement of sustained improvement. This has a weight of 20%, for a possible maximum total of 20 points (**Table 7**). The BH-MCO must sustain improvement relative to the baseline after achieving demonstrable improvement. The evaluation of the sustained improvement area has two review elements.

Scoring Matrix

When the PIPs are reviewed, all projects 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. It 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%.

Table 7: Review Element Scoring Weights

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

Findings

VBH submitted their Year 1 PIP Update document for review in June 2016. As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. IPRO provided feedback and comments to VBH on this submission. **Table 8** presents the PIP scoring matrix for the June 2016 Submission.

VBH clearly identified each of the core objectives in the aim statement of the PIP, along with a description of the denominator/numerator for each. VBH provided short-term and long-term goals for the following indicators: behavioral health readmission, substance abuse readmission, antipsychotic medication adherence for individuals with schizophrenia, and discharge management planning. VBH attained the long-term goal for SAA for MY 2015.

VBH demonstrated clear strengths in their methodology. For claim based performance indicators, they provided a description of the claims warehouse and payment accuracy statistics. For non-claim based performance indicators, they provided a clear description of the care management system and how the data is stored for key interventions. VBH's plan for data collection and analysis was provided. VBH has developed a number of process measures for each intervention, and they have implemented a process for tracking these measures on a quarterly basis.

VBH's barrier analysis was supported by results of surveys and workgroups, and commonly identified barriers were presented. The process by which the barriers were identified and prioritized was very well documented. VBH did an extensive barrier analysis to their current interventions, using real data and input from their counties. VBH clearly described the interventions and the barriers addressed by each intervention. Interventions were categorized as patient-focused [Value Recovery Coordination Program (VRC) and AfterCare Coordination Program (ACP)] as well as provider-focused [DMP- Provider Education on Discharge Planning and Medication Adherence and Increased use of Long Acting Injectables (LAIAs)]. Although VBH provided thorough methodology for the patient-focused interventions, provider-focused interventions were missing details related to timing, content and target population.

VBH presented readmission rates with drill-down analysis by county, contractor, age, race and gender. VBH provided a clear and detailed interpretation of the interventions' progresses, and addressed next steps for analysis in the discussion section. However, analysis of the interventions was not linked to outcome measures. It is recommended that VBH expand their analysis to evaluate the impact of interventions on core outcome measures.

Table 8: 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	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
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%**	**62.5**
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

III: Performance Measures

In 2016, 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 2016. OMHSAS also elected to implement a statewide measure that focuses on substance abuse services, the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) HEDIS measure.

Follow-up After Hospitalization for Mental Illness

This performance measure assessed the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider on the date of discharge up to seven and 30 days after hospital discharge. The measure 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 that they were in service for 2006.

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

For MY 2008 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 their performance measures. Based on these reviews, minor inconsistencies were found in how each BH-MCO produces their 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 six years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider on the date of discharge up to seven and 30 days after hospital discharge.

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

Eligible Population

The entire eligible population was used for all 34 HC BH Contractors participating in the MY 2015 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, 2015;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Six years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2015, 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, 2015. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2016 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 Seven Days after Discharge (Calculation based on Industry Standard codes used in HEDIS)

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

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

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

PA-Specific Follow-up Indicators

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

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

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

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

Quality Indicator Significance

According to the *Global Burden of Disease: 2004 Update* released by the World Health Organization (WHO) in 2008, mental illnesses and mental disorders represent six of the 20 leading causes of disability worldwide. Among developed nations, depression is the leading cause of disability for people ages 0-59 years, followed by drug and alcohol use disorders and psychoses (e.g., bipolar disorder and schizophrenia; 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 percent of overall disease burden in the U.S. (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 (NCQA, 2007). An outpatient visit within at least 30 days (ideally seven days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance and 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 longstanding concern of behavioral health care systems, with some researchers having estimated that 40 to 60 percent of patients fail to connect with an outpatient clinician (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 is 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 2016. For MY 2014 through MY 2016, BH-MCOs will be 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:

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

Interim goals were provided to the BH-MCOs after the MY 2014 rates were received. The interim goals will be updated from MY 2013 to MY 2015. The interim goals are used the BH-MCOs progress in achieving the OMHSAS goal of the 75th percentile.

HEDIS percentiles for the 7-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 2015, 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 and a denominator. The denominator equaled the number of discharges eligible for the quality indicator, while the numerator was the total number of members for which the particular event occurred. The HealthChoices Aggregate for each indicator was the total numerator divided by the total denominator, which represented the rate derived from the total population of discharges that qualified for the indicator. The aggregate rate represented the rate derived from the total population of members that qualified for the indicator (i.e., the aggregate value). Year-to-year comparisons to MY 2014 data were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the Z-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

HC BH Contractors with Small Denominators

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for all HC BH Contractors. Caution should be exercised when interpreting results for small denominators, as they produce rates that are less stable. Rates produced from small denominators may be subject to greater variability or greater margin of error. A denominator of 100 or greater is preferred for drawing conclusions from performance measure results.

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 6-20 year old age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old 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-MCO Average and HC BH Contractors Average rates were also calculated for the indicators.

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

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

The HEDIS follow-up results for the 6 to 64 year old age group and the 6+ year old age groups are compared to the MY 2015 HEDIS national percentiles. NCQA produces annual HEDIS Follow-up After Mental Health benchmarks for the 6+ year age band only; therefore results for the 6 to 64 year old age group are compared to percentiles for the 6+ year age bands. The percentile comparison for the 6 to 64 year old age group is presented to show BH-MCO and HC BH Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile by MY 2016. HEDIS percentile comparisons for the 6+ year old age group are presented for illustrative purposes only. The HEDIS follow-up results for the 6 to 20 year old age group are not compared to HEDIS benchmarks for the 6+ 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 is for all HC BH Contractor and BH-MCO rates to meet or exceed the HEDIS 75th percentile by MY 2015. For MYs 2013 through 2015, BH-MCOs will be 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 9** shows the MY 2015 results compared to their MY 2015 goals and HEDIS percentiles.

Table 9: MY 2015 HEDIS Follow-up Indicator Rates: 6–64 Years Old

	MY 2015							MY 2014	Rate Comparison			
Measure	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2015 Goal	2015 Goal Met?	%	PPD: MY 14 to MY 15	% Change: MY 14 to MY 15[1]	SSD: MY 14 to MY 15	HEDIS MY 2016 Medicaid Percentiles
QI 1 – HEDIS 7-Day Follow-up for Ages 6–64 Years Old												
HealthChoices Aggregate	16,896	36,949	**45.7%**	45.2%	46.2%	48.5%	NO	47.6%	-1.8	-3.84%	YES	Above 50th Percentile, Below 75th Percentile
VBH	2,713	5,829	**46.5%**	45.3%	47.8%	48.6%	NO	47.6%	-1.1	-2.30%	NO	Above 50th Percentile, Below 75th Percentile
Armstrong-Indiana	266	532	**50.0%**	45.7%	54.3%	50.4%	NO	49.4%	0.6	1.29%	NO	Above 50th Percentile, Below 75th Percentile
Beaver	252	605	**41.7%**	37.6%	45.7%	48.1%	NO	47.2%	-5.5	-11.72%	NO	Below 50th Percentile, Above 25th Percentile
Butler	241	450	**53.6%**	48.8%	58.3%	56.3%	NO	55.2%	-1.6	-2.94%	NO	Above 50th Percentile, Below 75th Percentile
Cambria	268	617	**43.4%**	39.4%	47.4%	42.8%	YES	40.8%	2.7	6.59%	NO	Below 50th Percentile, Above 25th Percentile
Fayette	262	569	**46.0%**	41.9%	50.2%	51.5%	NO	50.5%	-4.4	-8.77%	NO	Above 50th Percentile, Below 75th Percentile
Greene	55	119	**46.2%**	36.8%	55.6%	50.6%	NO	49.6%	-3.4	-6.86%	NO	Above 50th Percentile, Below 75th Percentile
Lawrence	135	305	**44.3%**	38.5%	50.0%	46.9%	NO	46.0%	-1.7	-3.80%	NO	Above 50th Percentile, Below 75th Percentile
NWBHP	357	826	**43.2%**	39.8%	46.7%	45.6%	NO	43.4%	-0.2	-0.48%	NO	Below 50th Percentile, Above 25th Percentile
Washington	340	672	**50.6%**	46.7%	54.4%	54.5%	NO	53.4%	-2.8	-5.29%	NO	Above 50th Percentile, Below 75th Percentile
Westmoreland	537	1,134	**47.4%**	44.4%	50.3%	47.7%	NO	46.7%	0.6	1.30%	NO	Above 50th Percentile, Below 75th Percentile
QI 2 – HEDIS 30-Day Follow-up for Ages 6-64 Years Old												
HealthChoices Aggregate	24,408	36,949	**66.1%**	65.6%	66.5%	69.2%	NO	67.9%	-1.8	-2.65%	YES	Above 50th Percentile, Below 75th Percentile
VBH	4,092	5,829	**70.2%**	69.0%	71.4%	73.2%	NO	71.7%	-1.5	-2.14%	NO	Above 50th Percentile, Below 75th Percentile
Armstrong-Indiana	391	532	**73.5%**	69.7%	77.3%	75.3%	NO	77.4%	-3.9	-5.06%	NO	At or Above 75th Percentile
Beaver	422	605	**69.8%**	66.0%	73.5%	70.6%	NO	69.2%	0.6	0.81%	NO	Above 50th Percentile, Below 75th Percentile
Butler	324	450	**72.0%**	67.7%	76.3%	75.0%	NO	73.6%	-1.6	-2.14%	NO	Above 50th Percentile, Below 75th Percentile
Cambria	433	617	**70.2%**	66.5%	73.9%	72.3%	NO	70.8%	-0.7	-0.94%	NO	Above 50th Percentile, Below 75th Percentile
Fayette	391	569	**68.7%**	64.8%	72.6%	72.8%	NO	71.3%	-2.6	-3.69%	NO	Above 50th Percentile,

Measure	MY 2015							MY 2014	Rate Comparison			
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2015 Goal	2015 Goal Met?	%	PPD: MY 14 to MY 15	% Change: MY 14 to MY 15[1]	SSD: MY 14 to MY 15	HEDIS MY 2016 Medicaid Percentiles
												Below 75th Percentile
Greene	84	119	**70.6%**	62.0%	79.2%	73.6%	NO	72.2%	-1.6	-2.21%	NO	Above 50th Percentile, Below 75th Percentile
Lawrence	216	305	**70.8%**	65.6%	76.1%	74.8%	NO	73.3%	-2.5	-3.40%	NO	Above 50th Percentile, Below 75th Percentile
NWBHP	544	826	**65.9%**	62.6%	69.2%	73.5%	NO	72.1%	-6.2	-8.61%	YES	Above 50th Percentile, Below 75th Percentile
Washington	484	672	**72.0%**	68.6%	75.5%	74.4%	NO	73.0%	-0.9	-1.28%	NO	Above 50th Percentile, Below 75th Percentile
Westmoreland	803	1,134	**70.8%**	68.1%	73.5%	70.0%	YES	68.7%	2.2	3.14%	NO	Above 50th Percentile, Below 75th Percentile

[1] Percentage change is the percentage increase or decrease of the MY 2015 rate when compared to the MY 2014 rate. The formula is: (MY 2015 rate – MY 2014 rate)/MY 2014 rate.
N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; NWBHP: Northwest Behavioral Health Partnership, Inc.

The MY 2015 HealthChoices Aggregate HEDIS follow-up rates in the 6 to 64 year age group were 45.7% for QI 1 and 66.1% for QI 2 (**Table 9**). These rates were statistically significantly lower than the HealthChoices Aggregate rates for this age group in MY 2014, which were 47.6% and 67.9% respectively. The HealthChoices Aggregate rates were below the MY 2015 interim goals of 48.5% for QI 1 and 69.2% for QI 2; therefore, both interim goals were not met in MY 2015. 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 2015 for either rate.

The MY 2015 VBH HEDIS follow-up rate for members ages 6 to 64 were 46.5% for QI 1 and 70.2% for QI 2 (**Table 9**); both rates were lower than VBH's corresponding MY 2014 rates of 47.6% for QI 1 and 71.7% for QI 2; however, the year-to-year differences were not statistically significant for either rate. The VBH QI 1 rate for the 6 to 64 year old population was statistically significantly higher than the QI 1 HealthChoices BH-MCO Average of 45.1%, and the QI 2 rate was statistically significantly higher than the QI 2 HealthChoices BH-MCO Average of 65.8% by 4.4 percentage points. Both interim follow-up goals for VBH were not met in MY 2015, as VBH's rates were below its target goals of 48.6% for QI 1 and 73.2% for QI 2. Both HEDIS rates for this age group were between the HEDIS 2016 50th and 75th percentiles; therefore, the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by VBH in MY 2015 for either rate.

As presented in **Table 9**, none of the individual HC BH contractors experienced a statistically significant QI 1 rate change from MY 2014 to MY 2015. The QI 2 rate for this age group statistically significantly decreased 6.2 percentage points in the Northwest Behavioral Health Partnership (NWBHP). Of the ten HC BH Contractors associated with VBH, Cambria met their MY 2015 interim goal for QI 1, and Westmoreland met their MY 2015 interim goal for QI 2. One HC BH Contractor, Armstrong-Indiana, achieved the final OMHSAS goal of meeting or exceeding the NCQA 75th percentile for QI 2.

Figure 1 is a graphical representation of MY 2015 HEDIS follow-up rates in the 6 to 64 year old population for VBH and its associated HC BH Contractors. **Figure 2** shows the HC BH Contractor Averages for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rates for Armstrong-Indiana, Washington and Butler were statistically significantly above the MY 2015 QI 1 HC BH Contractor Average of 45.4%, with differences ranging from 4.6 percentage points higher for Armstrong-Indiana to 8.1 percentage points higher for Butler. The QI 2 rates for Westmoreland, Butler, Washington and Armstrong-Indiana were statistically

significantly higher than the QI 2 HC BH Contractor Average of 67.4%, with differences ranging from 3.4 percentage points for Westmoreland to 6.1 percentage points for Armstrong-Indiana.

Figure 1: MY 2015 HEDIS Follow-up Indicator Rates: 6-64 Years Old

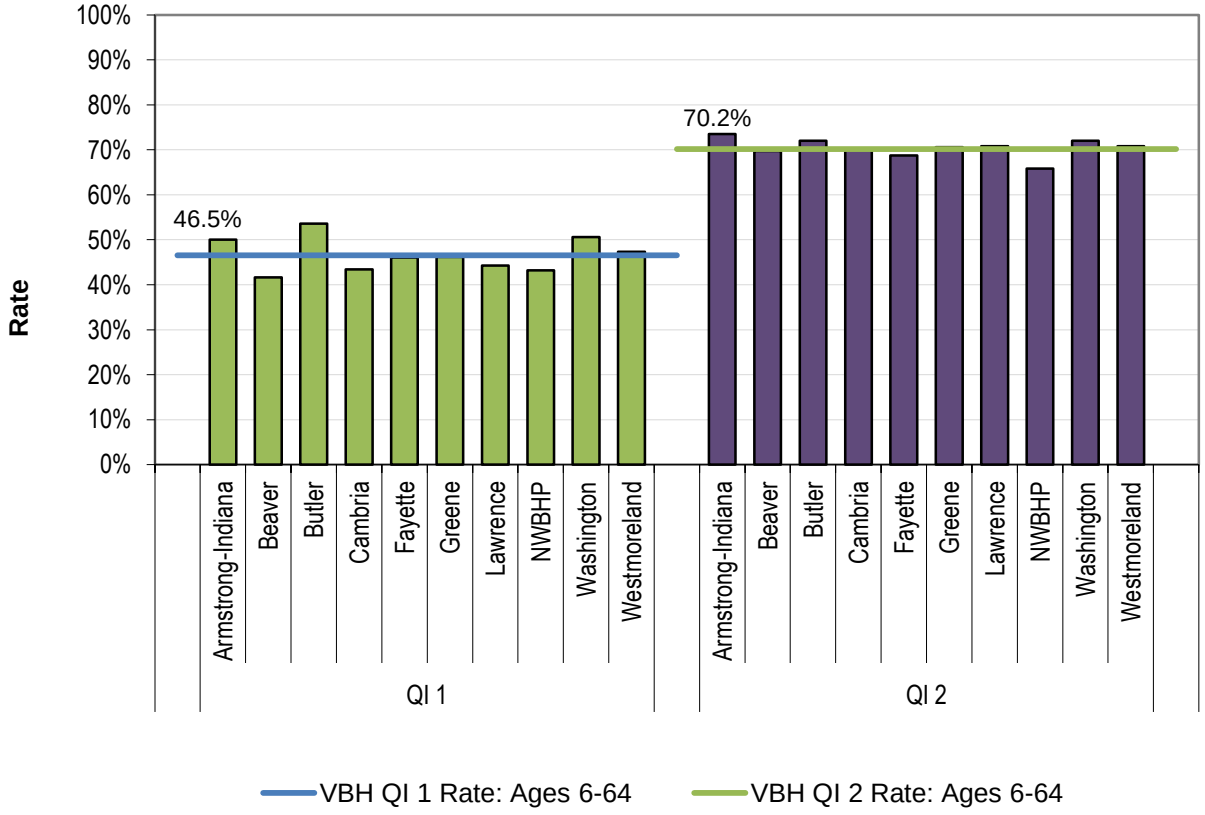
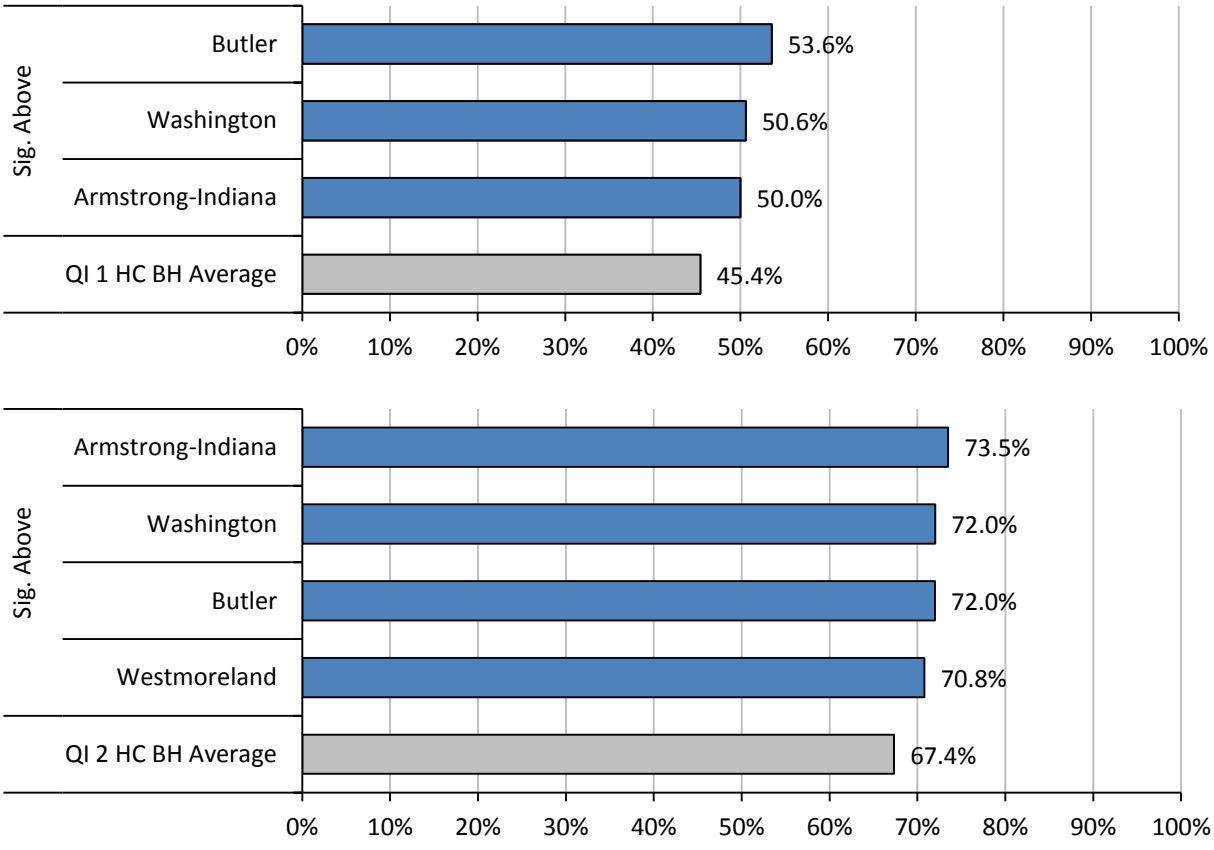


Figure 2: HEDIS Follow-up Rates Compared to MY 2015 HealthChoices HC BH Contractor Average: 6-64 Years Old



(b) Overall Population: 6+ Years Old

Table 10: MY 2015 HEDIS Follow-up Indicator Rates – Overall Population

Measure	MY 2015							MY 2014	Rate Comparison of MY 2015 against:		
									MY 2014		
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	%	PPD	SSD	HEDIS MY 2016 Percentile
QI 1 – HEDIS 7-Day Follow-up for Ages 6+ Years Old (Overall Population)											
HealthChoices Aggregate	17,076	37,505	**45.5%**	45.0%	46.0%	44.9%	45.2%	47.2%	-1.7	YES	Above 50th Percentile, Below 75th Percentile
VBH	2,731	5,907	**46.2%**	45.0%	47.5%			47.3%	-1.0	NO	Above 50th Percentile, Below 75th Percentile
Armstrong-Indiana	269	543	**49.5%**	45.2%	53.8%			48.8%	0.7	NO	Above 50th Percentile, Below 75th Percentile
Beaver	254	615	**41.3%**	37.3%	45.3%			47.0%	-5.7	NO	Below 50th Percentile, Above 25th Percentile
Butler	241	458	**52.6%**	47.9%	57.3%			54.9%	-2.3	NO	Above 50th Percentile, Below 75th Percentile
Cambria	269	627	**42.9%**	38.9%	46.9%			40.5%	2.4	NO	Below 50th Percentile, Above 25th Percentile
Fayette	262	573	**45.7%**	41.6%	49.9%			49.9%	-4.2	NO	Above 50th Percentile, Below 75th Percentile
Greene	56	123	**45.5%**	36.3%	54.7%			48.9%	-3.4	NO	Above 50th Percentile, Below 75th Percentile
Lawrence	138	312	**44.2%**	38.6%	49.9%			45.9%	-1.7	NO	Above 50th Percentile, Below 75th Percentile
NWBHP	358	831	**43.1%**	39.7%	46.5%			42.7%	0.3	NO	Below 50th Percentile, Above 25th Percentile
Washington	342	680	**50.3%**	46.5%	54.1%			53.0%	-2.7	NO	Above 50th Percentile, Below 75th Percentile
Westmoreland	542	1,145	**47.3%**	44.4%	50.3%			46.6%	0.8	NO	Above 50th Percentile, Below 75th Percentile
QI 2– HEDIS 30-Day Follow-up for Ages 6+ Years Old (Overall Population)											
HealthChoices Aggregate	24,662	37,505	**65.8%**	65.3%	66.2%	65.4%	67.0%	67.4%	-1.7	YES	Above 50th Percentile, Below 75th Percentile
VBH	4,124	5,907	**69.8%**	68.6%	71.0%			71.2%	-1.4	NO	Above 50th Percentile, Below 75th Percentile
Armstrong-Indiana	395	543	**72.7%**	68.9%	76.6%			76.8%	-4.1	NO	At or Above 75th Percentile
Beaver	425	615	**69.1%**	65.4%	72.8%			68.9%	0.2	NO	Above 50th Percentile, Below 75th Percentile
Butler	328	458	**71.6%**	67.4%	75.9%			72.9%	-1.2	NO	Above 50th Percentile, Below 75th Percentile
Cambria	437	627	**69.7%**	66.0%	73.4%			70.5%	-0.8	NO	Above 50th Percentile, Below 75th Percentile
Fayette	394	573	**68.8%**	64.9%	72.6%			71.0%	-2.3	NO	Above 50th Percentile, Below 75th Percentile
Greene	86	123	**69.9%**	61.4%	78.4%			71.1%	-1.2	NO	Above 50th Percentile, Below 75th Percentile
Lawrence	219	312	**70.2%**	65.0%	75.4%			72.8%	-2.6	NO	Above 50th Percentile, Below 75th Percentile
NWBHP	545	831	**65.6%**	62.3%	68.9%			71.0%	-5.4	YES	Above 50th Percentile, Below 75th Percentile

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	MY 2015 Lower 95% CI	MY 2015 Upper 95% CI	MY 2015 BH-MCO Average	MY 2015 HC BH Contractor Average	MY 2014 %	Rate Comparison of MY 2015 against: MY 2014 PPD	MY 2014 SSD	HEDIS MY 2016 Percentile
Washington	486	680	**71.5%**	68.0%	74.9%			72.4%	-1.0	NO	Above 50th Percentile, Below 75th Percentile
Westmoreland	809	1,145	**70.7%**	68.0%	73.3%			68.3%	2.3	NO	Above 50th Percentile, Below 75th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; NWBHP: Northwest Behavioral Health Partnership, Inc.

The MY 2015 HealthChoices Aggregate HEDIS follow-up rates were 45.5% for QI 1 and 65.8% for QI 2 (**Table 10**). These rates were statistically significantly lower than the HealthChoices Aggregate rates in MY 2014, which were 47.2% and 67.4% respectively. For VBH, the MY 2015 HEDIS follow-up rates were 46.2% for QI 1 and 69.8% for QI 2; both rates were lower than VBH's corresponding MY 2014 rates of 47.3% for QI 1 and 71.2% for QI 2; however, the year-to-year differences were not statistically significant. The VBH QI 1 rate was statistically significantly higher than the QI 1 HealthChoices BH-MCO Average of 44.9% by 1.3 percentage points, and the QI 2 rate was statistically significantly higher than the QI 2 HealthChoices BH-MCO Average of 65.4% by 4.4 percentage points. VBH had the highest QI 2 rate of the five BH-MCOs evaluated in MY 2015.

As presented in **Table 10**, the QI 2 rate in NWBHP statistically significantly decreased 5.4 percentage points from 71.0% in MY 2014 to 65.6% in MY 2015. There were no other statistically significant year-to-year changes for any of the other individual HC BH Contractors.

Figure 3 is a graphical representation of the MY 2015 HEDIS follow-up rates for VBH and its associated HC BH Contractors. **Figure 4** shows the HC BH Contractor Averages and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rates for Armstrong-Indiana, Washington and Butler were statistically significantly above the MY 2015 QI 1 HC BH Contractor Average of 45.2%, with differences ranging from 4.4 percentage points higher for Armstrong-Indiana to 7.5 percentage points higher for Butler. The QI 2 rates for Westmoreland, Washington, Butler and Armstrong-Indiana were statistically significantly higher than the QI 2 HC BH Contractor Average of 67.0%, with differences ranging from 3.7 percentage points for Westmoreland to 5.8 percentage points for Armstrong-Indiana.

Figure 3: MY 2015 HEDIS Follow-up Indicator Rates – Overall Population

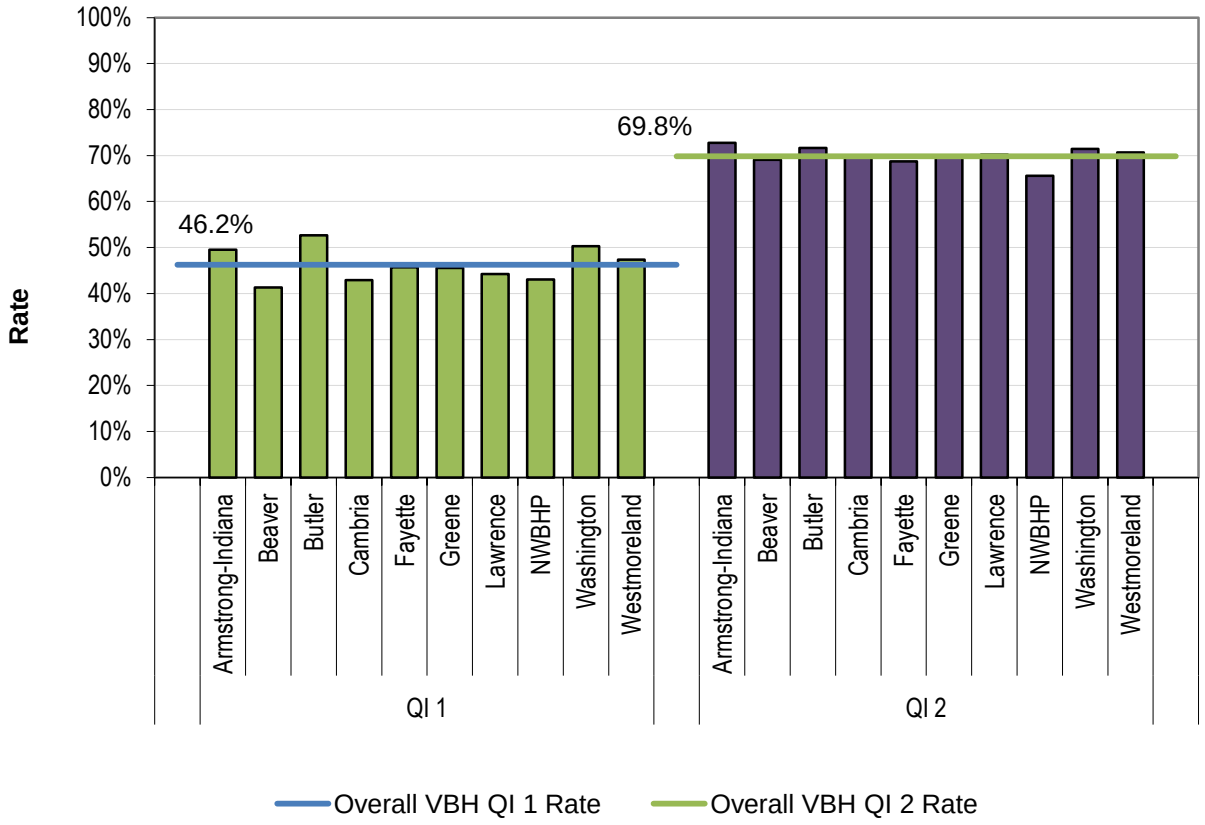
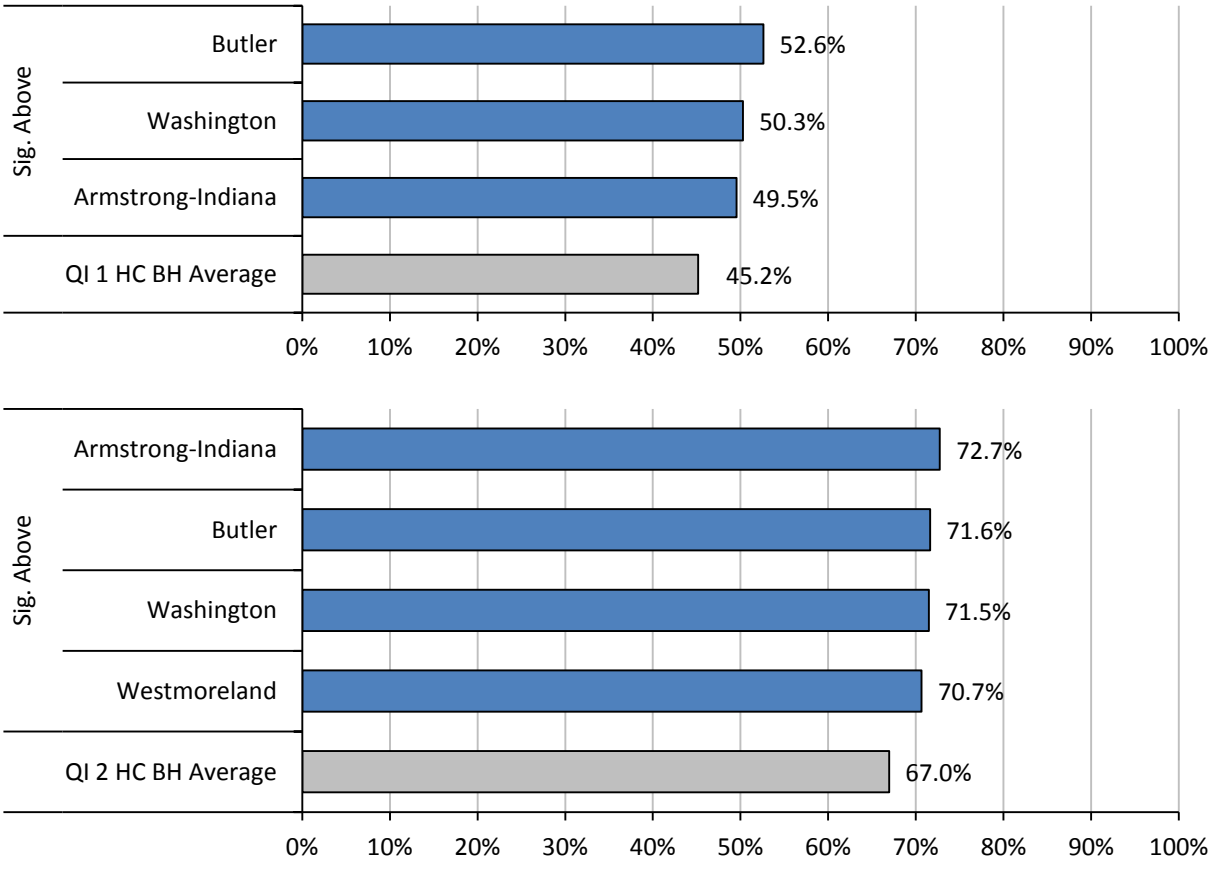


Figure 4: HEDIS Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average – Overall Population



(c) Age Group: 6–20 Years Old

Table 11: MY 2015 HEDIS Follow-up Indicator Rates: 6-20 Years Old

Measure	MY 2015 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2014 %	Rate Comparison: MY 15 vs. MY 14 PPD	SSD
QI 1 – HEDIS 7-Day Follow-up for Ages 6–20 Years Old										
HealthChoices Aggregate	5,736	10,108	**56.7%**	55.8%	57.7%	56.1%	55.7%	56.5%	0.2	NO
VBH	952	1,671	**57.0%**	54.6%	59.4%			60.1%	-3.2	NO
Armstrong-Indiana	74	136	**54.4%**	45.7%	63.2%	e		65.8%	-11.4	NO
Beaver	83	148	**56.1%**	47.7%	64.4%			63.2%	-7.1	NO
Butler	80	116	**69.0%**	60.1%	77.8%			64.9%	4.1	NO
Cambria	92	174	**52.9%**	45.2%	60.6%			52.5%	0.4	NO
Fayette	96	178	**53.9%**	46.3%	61.5%			66.0%	-12.1	YES
Greene	18	37	**48.6%**	31.2%	66.1%			56.8%	-8.1	NO
Lawrence	52	89	**58.4%**	47.6%	69.2%			58.3%	0.1	NO
NWBHP	146	271	**53.9%**	47.8%	60.0%			55.3%	-1.5	NO
Washington	119	182	**65.4%**	58.2%	72.6%			64.4%	0.9	NO
Westmoreland	192	340	**56.5%**	51.1%	61.9%			57.9%	-1.4	NO
QI 2 – HEDIS 30-Day Follow-up for Ages 6-20 Years Old										
HealthChoices Aggregate	7,780	10,108	**77.0%**	76.1%	77.8%	76.4%	76.8%	77.0%	0.0	NO
VBH	1,325	1,671	**79.3%**	77.3%	81.3%			82.8%	-3.5	YES
Armstrong-Indiana	109	136	**80.1%**	73.1%	87.2%			88.8%	-8.7	NO
Beaver	129	148	**87.2%**	81.4%	92.9%			84.9%	2.3	NO
Butler	93	116	**80.2%**	72.5%	87.9%			82.4%	-2.3	NO
Cambria	135	174	**77.6%**	71.1%	84.1%			82.7%	-5.1	NO
Fayette	131	178	**73.6%**	66.8%	80.4%			80.8%	-7.2	NO
Greene	26	37	**70.3%**	54.2%	86.3%			75.7%	-5.4	NO
Lawrence	71	89	**79.8%**	70.9%	88.7%			85.4%	-5.6	NO
NWBHP	205	271	**75.6%**	70.4%	80.9%			80.2%	-4.5	NO
Washington	154	182	**84.6%**	79.1%	90.1%			85.0%	-0.4	NO
Westmoreland	272	340	**80.0%**	75.6%	84.4%			81.0%	-1.0	NO

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; NWBHP: Northwest Behavioral Health Partnership, Inc.

The MY 2015 HealthChoices Aggregate rates in the 6 to 20 year age group were 56.7% for QI 1 and 77.0% for QI 2 (**Table 11**). These rates were comparable to the MY 2014 HealthChoices Aggregate rates for the 6 to 20 year age cohort, which were 56.5% and 77.0% respectively. The VBH MY 2015 HEDIS follow-up rates for members ages 6 to 20 were 57.0% for QI 1 and 79.3% for QI 2; both rates were lower than VBH's corresponding MY 2014 rates of 60.1% for QI 1 and 82.8% for QI 2, with a statistically significant year-to-year decrease for QI 2. The VBH MY 2015 QI 1 rate for this population was not statistically significantly different form QI 1 HealthChoices BH-MCO Average of 56.1%, while the QI 2 rate was statistically significantly higher than the QI 2 HealthChoices BH-MCO Average of 76.4% by 2.9 percentage points.

As presented in **Table 11**, the QI 1 rate for Fayette statistically significantly increased by 12.1 percentage points. There were no statistically significant year-to-year QI 2 changes for any HC BH Contractors associated with VBH.

Figure 5 is a graphical representation of the MY 2015 HEDIS follow-up rates in the 6 to 20 year old population for VBH and its associated HC BH Contractors. **Figure 6** shows the HC BH Contractor Averages for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rates for

Washington and Butler were statistically significantly higher than the QI 1 HC BH Contractor Average of 55.7% by 9.7 and 13.3 percentage points, respectively. For QI 2, rates for Washington and Beaver were statistically significantly higher than the QI 2 HC BH Contractor Average of 76.8% by 7.8 and 10.4 percentage points, respectively.

Figure 5: MY 2015 HEDIS Follow-up Indicator Rates: 6-20 Years Old

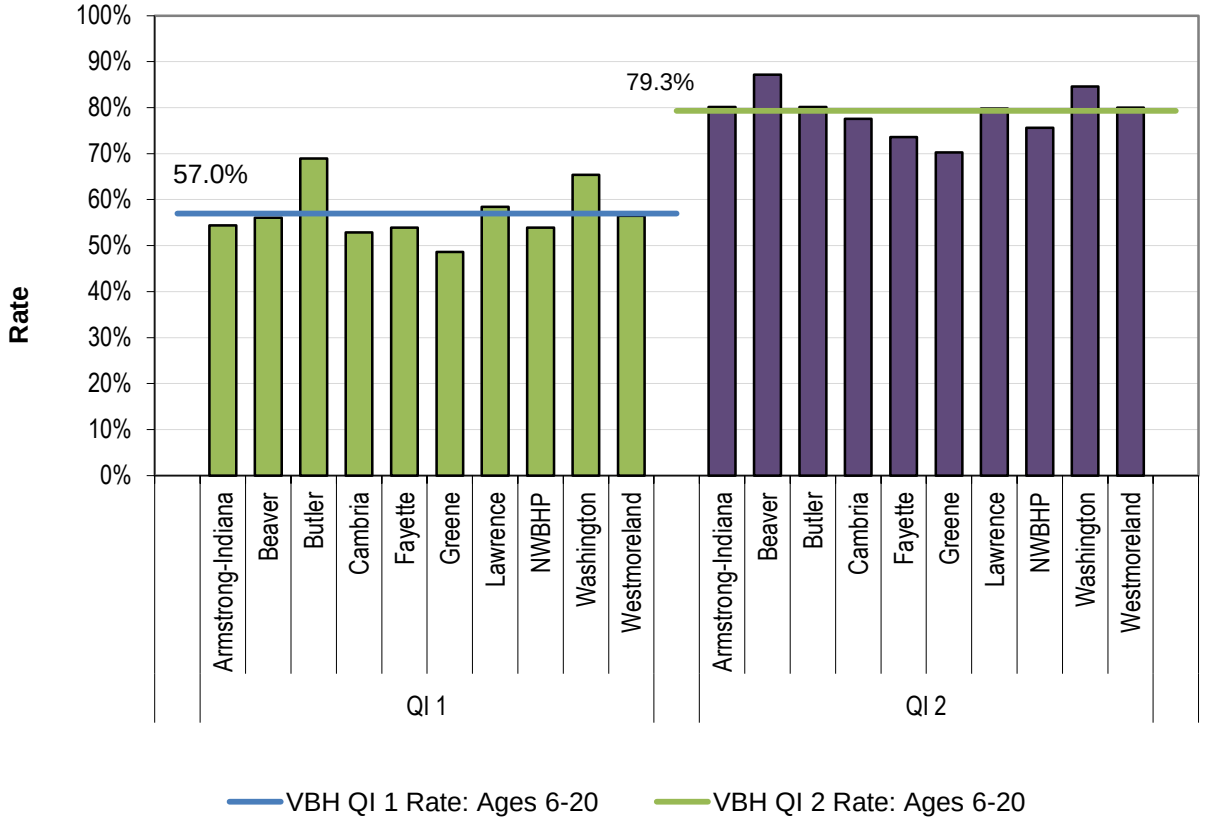
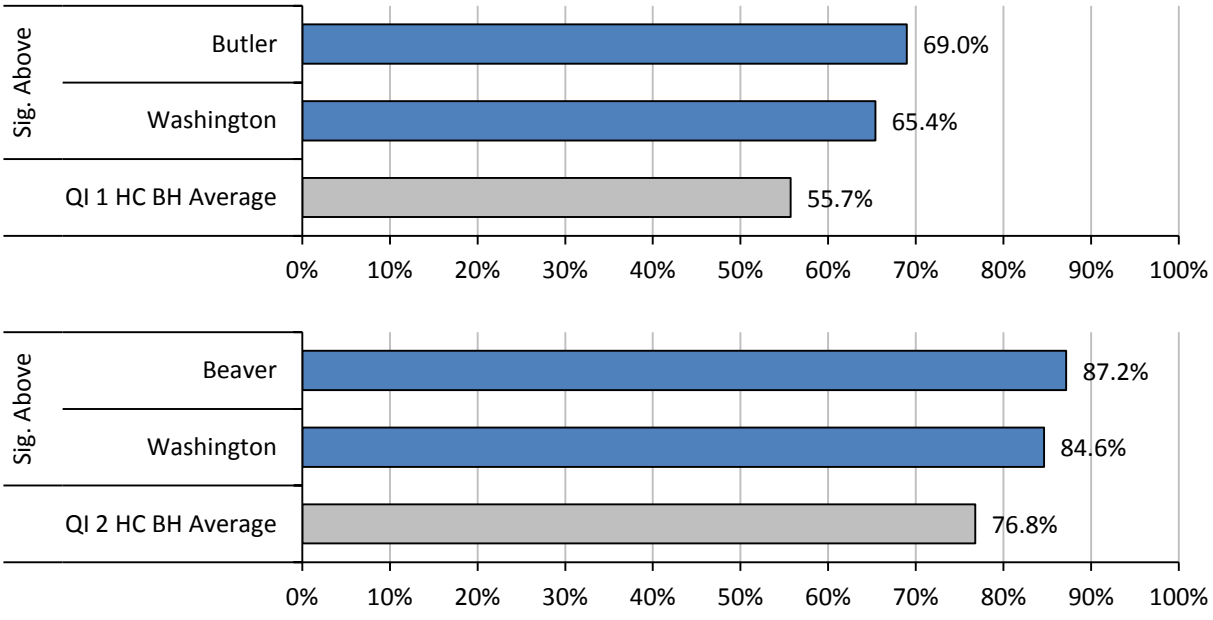


Figure 6: HEDIS Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average: 6-20 Years Old



II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

Table 12: MY 2015 PA-Specific Follow-up Indicator Rates with Year-to-Year Comparisons – Overall Population

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	MY 2015 Lower 95% CI	MY 2015 Upper 95% CI	MY 2015 BH-MCO Average	MY 2015 HC BH Contractor Average	MY 2014 MY 2014 %	MY 2014 Rate Comparison of MY 15 vs. MY 14 PPD	MY 2014 Rate Comparison of MY 15 vs. MY 14 SSD
QI A – PA-Specific 7-Day Follow-up for Ages 6+ (Overall Population)										
HealthChoices Aggregate	21,216	37,505	**56.6%**	56.1%	57.1%	55.8%	55.7%	58.5%	-1.9	YES
VBH	3,290	5,907	**55.7%**	54.4%	57.0%			57.6%	-1.9	YES
Armstrong-Indiana	321	543	**59.1%**	54.9%	63.3%			60.1%	-1.0	NO
Beaver	317	615	**51.5%**	47.5%	55.6%			59.8%	-8.3	YES
Butler	284	458	**62.0%**	57.5%	66.6%			61.8%	0.2	NO
Cambria	342	627	**54.5%**	50.6%	58.5%			52.0%	2.5	NO
Fayette	289	573	**50.4%**	46.3%	54.6%			53.5%	-3.1	NO
Greene	66	123	**53.7%**	44.4%	62.9%			58.5%	-4.8	NO
Lawrence	160	312	**51.3%**	45.6%	57.0%			59.2%	-7.9	NO
NWBHP	435	831	**52.3%**	48.9%	55.8%			53.7%	-1.4	NO
Washington	388	680	**57.1%**	53.3%	60.9%			61.2%	-4.1	NO
Westmoreland	688	1,145	**60.1%**	57.2%	63.0%			59.4%	0.7	NO
QI B – PA-Specific 30-Day Follow-up for Ages 6+ (Overall Population)										
HealthChoices Aggregate	27,371	37,505	**73.0%**	72.5%	73.4%	72.7%	73.5%	74.8%	-1.8	YES
VBH	4,441	5,907	**75.2%**	74.1%	76.3%			76.6%	-1.4	NO
Armstrong-Indiana	422	543	**77.7%**	74.1%	81.3%			83.4%	-5.7	YES
Beaver	450	615	**73.2%**	69.6%	76.8%			76.2%	-3.0	NO
Butler	353	458	**77.1%**	73.1%	81.0%			75.5%	1.6	NO
Cambria	472	627	**75.3%**	71.8%	78.7%			74.9%	0.4	NO
Fayette	406	573	**70.9%**	67.0%	74.7%			72.3%	-1.4	NO
Greene	91	123	**74.0%**	65.8%	82.1%			75.6%	-1.6	NO
Lawrence	227	312	**72.8%**	67.7%	77.9%			76.4%	-3.6	NO
NWBHP	597	831	**71.8%**	68.7%	75.0%			77.1%	-5.3	YES
Washington	513	680	**75.4%**	72.1%	78.7%			77.6%	-2.2	NO
Westmoreland	910	1,145	**79.5%**	77.1%	81.9%			76.3%	3.2	NO

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; NWBHP: Northwest Behavioral Health Partnership, Inc.

The MY 2015 HealthChoices Aggregate rates were 56.6% for QI A and 73.0% for QI B (**Table 12**). Both rates demonstrated statistically significant decreases from the MY 2014 PA-specific follow-up rates: the QI A rate decreased from the MY 2014 rate of 58.5% by 1.9 percentage points, while the QI B rate decreased from the MY 2014 rate of 74.8% percentage points by 1.8 percentage points. The MY 2015 VBH QI A rate was 55.7%, which represents a statistically significant decrease of 1.9 percentage points from the MY 2014 rate. The QI B rate also decreased from the prior year, however the year-to-year decrease was not statistically significant for QI B. The QI A rate for VBH was not statistically significantly different from the QI A HealthChoices BH-MCO Average of 55.8%, while the QI B rate for VBH was statistically significantly higher than the QI B HealthChoices BH-MCO Average of 72.7% by 2.5 percentage points. VBH had the highest QI B rate of the five BH-MCOs evaluated in MY 2015.

As presented in **Table 12**, the MY 2015 QI A rate statistically significantly decreased by 8.3 percentage points in Beaver. Statistically significant QI B rate decreases were noted in NWBHP and Armstrong-Indiana, with percentage point decreases of 5.3 and 5.7, respectively.

Figure 7 is a graphical representation of the MY 2015 PA-specific follow-up rates for VBH and its associated HC BH Contractors. **Figure 8** shows the HC BH Contractor Averages and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI A rates for Westmoreland and Butler were statistically significantly above the MY 2015 QI A HC BH Contractor Average of 55.7% by 4.4 and 6.3 percentage points, respectively. QI A rates for Beaver and Fayette were statistically significantly below the QI A HC BH Contractor Average by 4.2 and 5.3 percentage points, respectively. The QI B rates for Armstrong-Indiana and Westmoreland were statistically significantly above the QI B HC BH Contractor Average of 73.5% by 4.2 and 6.0 percentage points, respectively.

Figure 7: MY 2015 PA-Specific Follow-up Indicator Rates – Overall Population

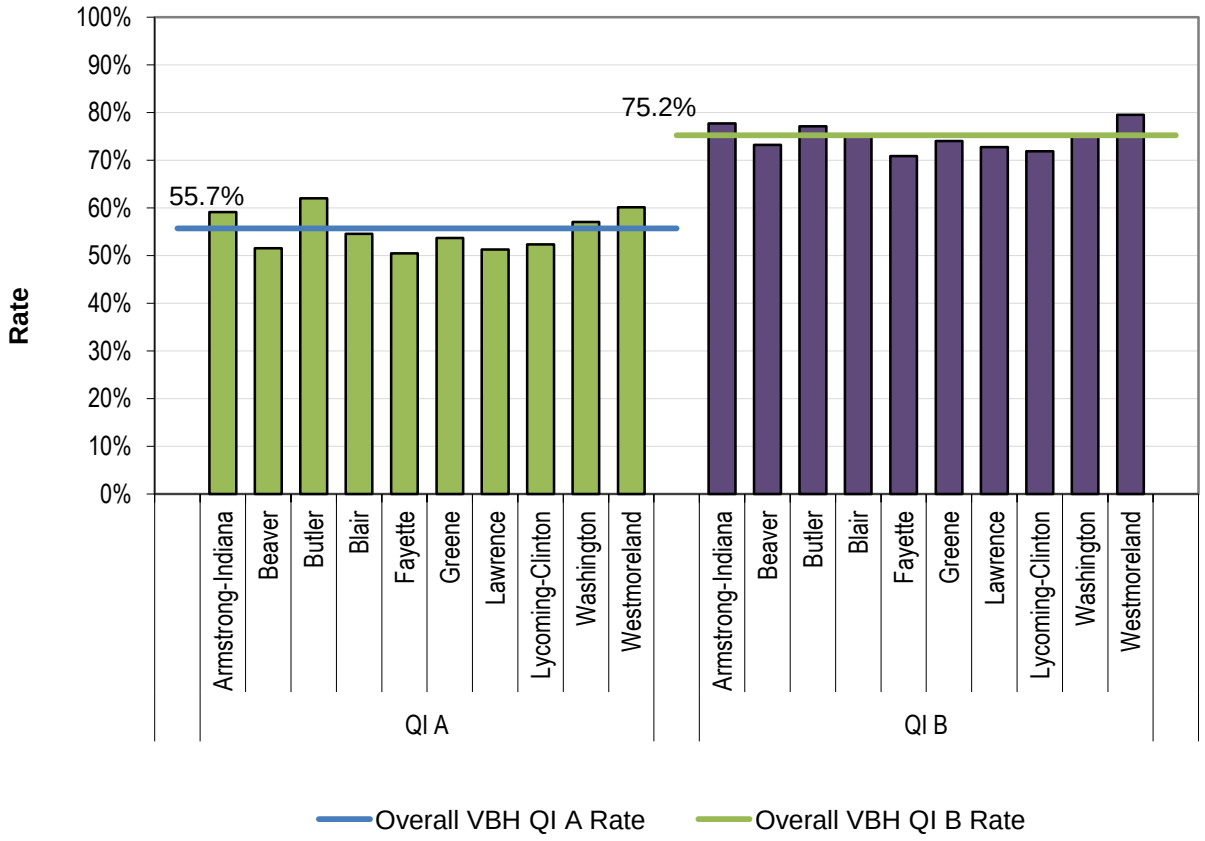
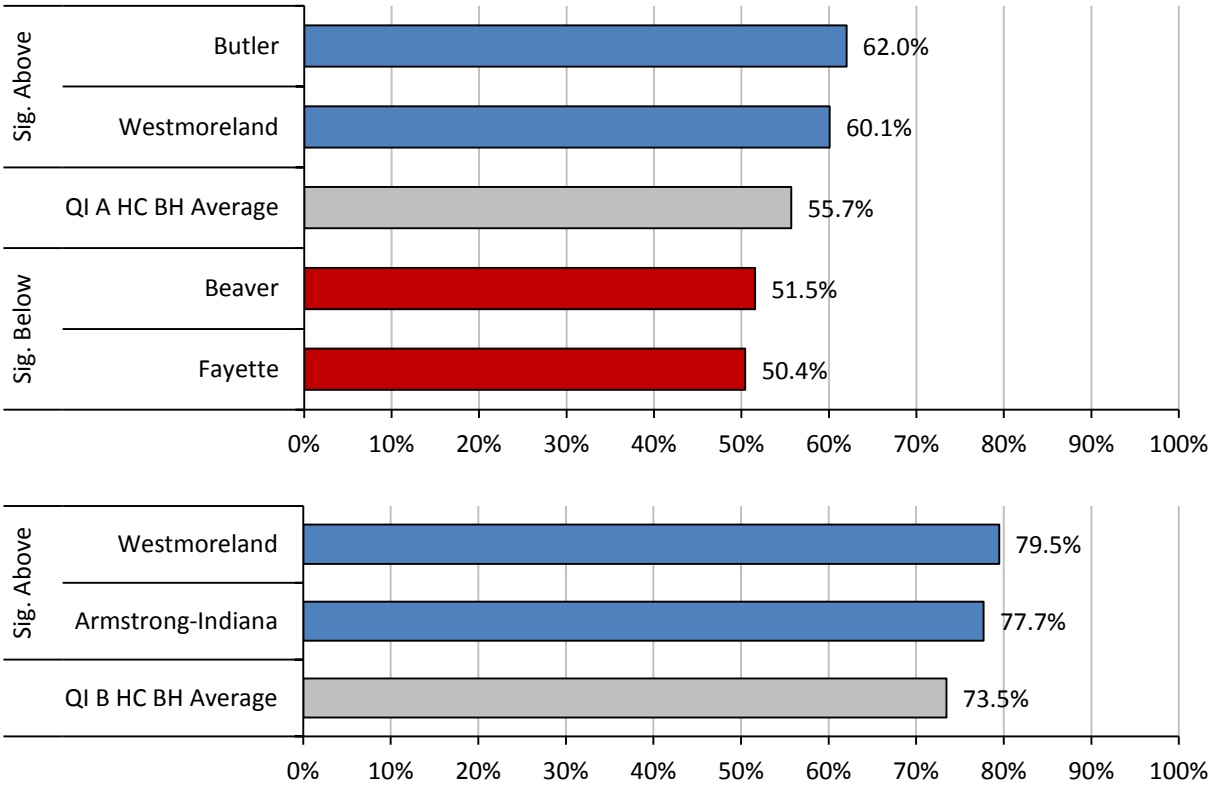


Figure 8: PA-Specific Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average – Overall Population



Conclusion and Recommendations

The study concluded that 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 BH-MCO Average.

In response to the 2015 study, which included results for MY 2014 and MY 2015, the following general recommendations were made 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 during 2012, 2013 and 2014 to promote continuous quality improvement with regard to follow-up care after psychiatric hospitalization. The information contained within this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. Although the current cycle of performance improvement projects were in their baseline period for the PIP implemented at the beginning of MY2015, BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in 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 improving behavioral health 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.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. The findings of this re-measurement indicate that, despite some improvement over the last five measurement years, significant rate disparities persist between racial and ethnic groups. 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 (e.g., Black/African American population). Further, it is important to examine regional trends in disparities. For instance, the results of this study indicate that African Americans in rural areas have disproportionately low follow-up rates, in contrast to the finding that overall follow-up rates are 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 had or did not have evidence of ambulatory follow-up/aftercare visit(s) during the interim period.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-up After Hospitalization for Mental Illness, OMHSAS elected to retain and re-measure the Readmission Within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Re-measurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2015 study conducted in 2016 was the ninth re-measurement of this indicator. Four clarifications were made to the specifications for MY 2014. If a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish a same day readmission from a transfer to another acute facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH Contractor level for MY 2015.

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

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

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

Eligible Population

The entire eligible population was used for all 67 counties and 34 HC BH Contractors participating in the MY 2015 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, 2015;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim must be clearly identified as a discharge.

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

Methodology

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

Performance Goals

OMHSAS designated the performance measure goal as better than (i.e. less than) or equal to 10.0% for the participating BH-MCOs and counties. **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 2015 to MY 2014 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the Z-ratio. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

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

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

Table 13: MY 2015 Readmission Rates with Year-to-Year Comparisons

	MY 2015							MY 2014		
									Rate Comparison of MY 15 vs. MY 14	
Measure	(N)	(D)	%[1]	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	%	PPD	SSD
Inpatient Readmission										
HealthChoices Aggregate	6,737	48,239	**14.0%**	13.7%	14.3%	14.0%	13.4%	14.3%	-0.3	NO
VBH	833	7,120	**11.7%**	10.9%	12.5%			12.1%	-0.4	NO
Armstrong-Indiana	69	620	**11.1%**	8.6%	13.7%			9.5%	1.6	NO
Beaver	115	793	**14.5%**	12.0%	17.0%			13.3%	1.2	NO
Butler	69	595	**11.6%**	8.9%	14.3%			15.1%	-3.5	NO
Cambria	72	711	**10.1%**	7.8%	12.4%			15.4%	-5.3	YES
Fayette	79	688	**11.5%**	9.0%	13.9%			11.4%	0.1	NO
Greene	11	144	**7.6%**	3.0%	12.3%			10.5%	-2.8	NO
Lawrence	49	378	**13.0%**	9.4%	16.5%			10.8%	2.2	NO
NWBHP	106	961	**11.0%**	9.0%	13.1%			8.0%	3.0	YES
Washington	117	850	**13.8%**	11.4%	16.1%			14.5%	-0.8	NO
Westmoreland	146	1,380	**10.6%**	8.9%	12.2%			11.9%	-1.3	NO

[1]The OMHSAS-designated performance measure goal is a readmission rate at or below 10%.
N: numerator; D: denominator; CI: confidence interval; NWBHP: Northwest Behavioral Health Partnership, Inc.

The MY 2015 HealthChoices Aggregate readmission rate was 14.0%, and represents a decrease from the MY 2014 HealthChoices Aggregate rate of 14.3% by 0.3 percentage points (**Table 13**); this difference was not statistically significant. The VBH MY 2015 readmission rate was 11.7%, which was not statistically significantly different from the MY 2014 rate of 12.1%. Compared to the HealthChoices BH-MCO Average of 14.0%, the VBH readmission rate was statistically significantly lower by 2.3 percentage points. Note that for this measure, lower rates indicate better performance. VBH had the lowest readmission rate of the five BH-MCOs evaluated in MY 2015. VBH did not meet the performance goal of a readmission rate below 10.0% in MY 2015.

As presented in **Table 13**, there was a statistically significant decrease (improvement) from MY 2014 in Cambria by 5.3 percentage points, and there was a statistically significant increase in NWBHP by 3.0 percentage points. Greene met the performance goal of a readmission rate below 10.0% in MY 2015.

Figure 9 is a graphical representation of the MY 2015 readmission rates for VBH HC BH Contractors compared to the performance measure goal of 10.0%. **Figure 10** shows the Health Choices HC BH Contractor Average readmission rates and the individual VBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Averages. NWBHP, Westmoreland, Fayette, Cambria and Greene had readmission rates that were statistically significantly lower (better) than the HealthChoices HC BH Contractor Average of 13.4%, with differences that ranged from 2.4 percentage points for NWBHP to 5.8 percentage points for Greene.

Figure 9: MY 2015 Readmission Rates

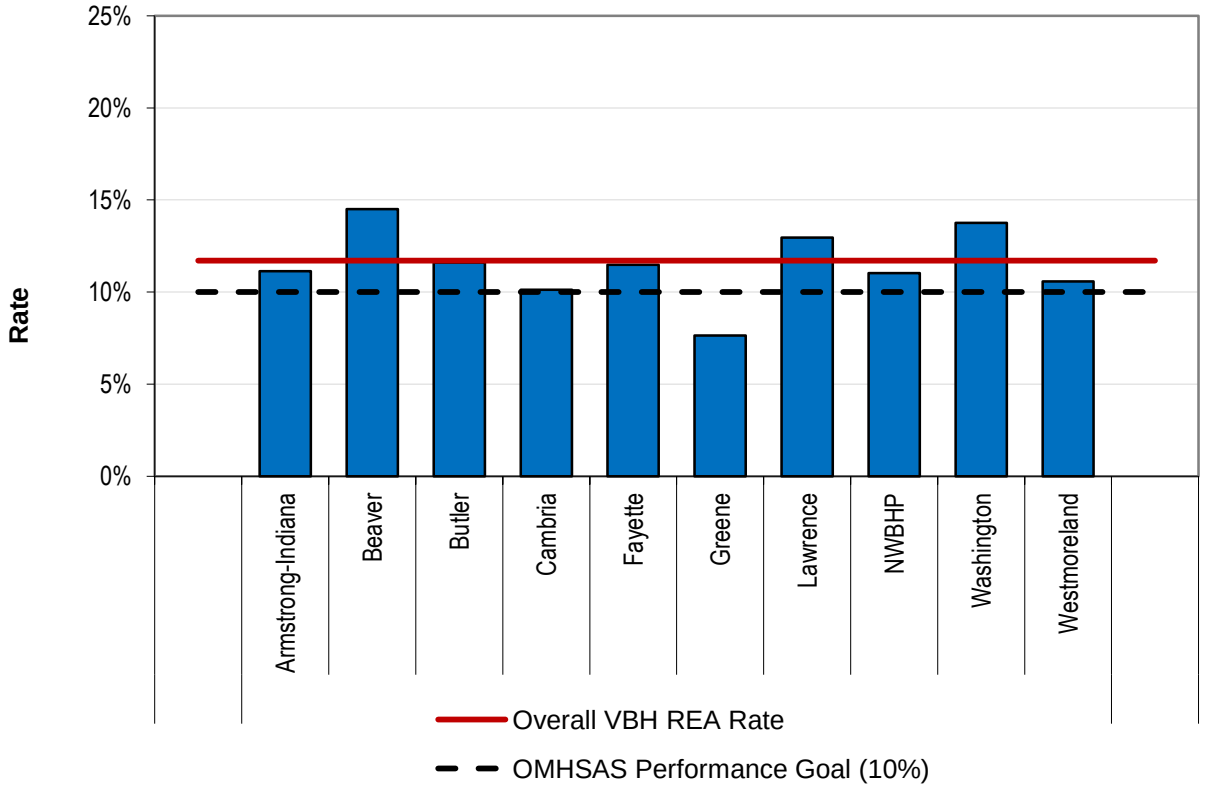
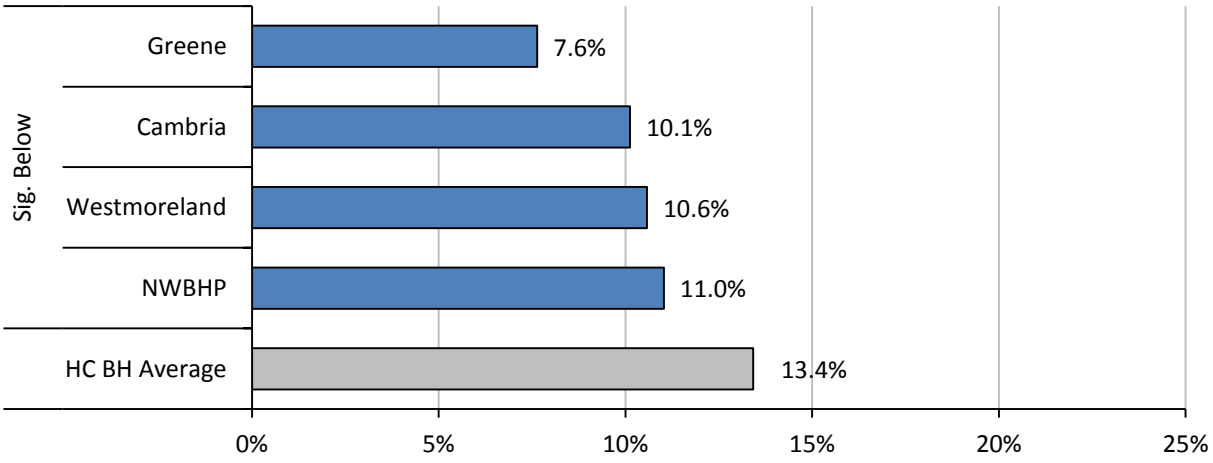


Figure 10: MY 2015 Readmission Rates Compared to HealthChoices HC BH Contractor Average



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-MCO Average.

BH-MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the 2015 (MY 2014) Readmission Within 30 Days of Inpatient Psychiatric Discharge data tables.

Despite a number of years of data collection and interventions, readmission rates have continued to increase. 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 2016 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 during 2012, 2013 and 2014 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. Although the current cycle of performance improvement projects were in their baseline period during the MY 2014 review year, 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. The findings of this re-measurement indicate that there are significant rate disparities between rural and urban settings. It is important for BH-MCOs and HC BH Contractors to target the demographic populations that do not perform as well as their counterparties. 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 either had or did not have evidence of ambulatory follow-up/aftercare visit(s) during the interim period.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

As part of the Center for Medicaid and Medicare Services' (CMS) Adult Quality Measure Grant Program, the Department of Health Services (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' 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' 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 2015 and 2016. The measure was produced according to HEDIS 2016 specifications. The data source was encounter data submitted to DHS by the BH-MCOs and the Physical Health MCOs. As directed by OMHSAS, IPRO produced rates for this measure for the HealthChoices population, by BH-MCO, and by BH HC 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 2016 specifications. 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 30 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 percent of adults had alcohol use disorder problem, 2 percent met the criteria for a drug use disorder, and 1.1 percent 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 vise 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).

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, will be decreased. In 2009 alone, there were nearly 4.6 million drug-related ED visits nationwide (National Institute on Drug Abuse, 2011). Improvement in the socioeconomic situation of patients and lower crime rates will follow if suitable treatments are implemented.

Eligible Population

The entire eligible population was used for all 34 BH HC Contractors participating in the MY 2015 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, 2015;
- Continuously enrolled in both HealthChoices Behavioral Health and Physical Health from 60 days prior to the AOD diagnosis to 44 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 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 an 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 diagnosis of AOD within 30 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 both Physical Health and Behavioral Health encounters, only members who were enrolled in both Behavioral Health and Physical Health HealthChoices where 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 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 of all encounters used in this measure. This 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 Contractors. For each of these rates, the 95% Confidence Interval (CI) was reported. Both the HealthChoices BH-MCO Average and HealthChoices HC BH Contractors Average rates were also calculated for the indicators.

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

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

The performance measure results for the three age cohorts (13 to 17 years old, ages 18+, and ages 13+) 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

Table 14: MY 2015 IET rates with Year-to-Year Comparisons

Measure	MY 2015							MY 2014			Rate Comparison MY 2015 to HEDIS Benchmarks
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	%	PPD	SSD	
Age Cohort: 13–17 Years – Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	924	2,513	**36.8%**	34.9%	38.7%	33.6%	29.3%	37.0%	-0.3	NO	Below 50th Percentile, Above 25th Percentile
VBH	76	290	**26.2%**	21.0%	31.4%			26.2%	0.0	NO	Below 25th Percentile
Armstrong-Indiana	9	27	**33.3%**	13.7%	53.0%			50.0%	-16.7	NO	Below 25th Percentile
Beaver	2	16	**12.5%**	0.0%	31.8%			3.8%	8.7	NO	Below 25th Percentile
Butler	5	24	**20.8%**	2.5%	39.2%			18.8%	2.1	NO	Below 25th Percentile
Cambria	4	21	**19.0%**	0.0%	38.2%			20.0%	-1.0	NO	Below 25th Percentile
Fayette	3	10	**30.0%**	0.0%	63.4%			43.5%	-13.5	NO	Below 25th Percentile
Greene	1	6	**16.7%**	0.0%	54.8%			10.0%	6.7	NO	Below 25th Percentile
Lawrence	0	6	**0.0%**	0.0%	8.3%			41.7%	-41.7	NO	Below 25th Percentile
NWBHP	23	67	**34.3%**	22.2%	46.4%			34.1%	0.2	NO	Below 25th Percentile
Washington	15	60	**25.0%**	13.2%	36.8%			23.8%	1.2	NO	Below 25th Percentile
Westmoreland	14	53	**26.4%**	13.6%	39.2%			15.4%	11.0	NO	Below 25th Percentile
Age Cohort: 13–17 Years – Numerator 2: Engagement of AOD Treatment											

Measure	MY 2015							MY 2014			Rate Comparison MY 2015 to HEDIS Benchmarks
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	%	PPD	SSD	
HealthChoices Aggregate	645	2,513	**25.7%**	23.9%	27.4%	23.1%	18.9%	25.8%	-0.2	NO	At or Above 75th Percentile
VBH	47	290	**16.2%**	11.8%	20.6%			17.8%	-1.6	NO	Above 50th Percentile, Below 75th Percentile
Armstrong-Indiana	6	27	**22.2%**	4.7%	39.8%			50.0%	-27.8	NO	At or Above 75th Percentile
Beaver	0	16	**0.0%**	0.0%	3.1%			3.8%	-3.8	NO	Below 25th Percentile
Butler	4	24	**16.7%**	0.0%	33.7%			12.5%	4.2	NO	Above 50th Percentile, Below 75th Percentile
Cambria	2	21	**9.5%**	0.0%	24.5%			13.3%	-3.8	NO	Below 50th Percentile, Above 25th Percentile
Fayette	0	10	**0.0%**	0.0%	5.0%			17.4%	-17.4	NO	Below 25th Percentile
Greene	1	6	**16.7%**	0.0%	54.8%			10.0%	6.7	NO	Above 50th Percentile, Below 75th Percentile
Lawrence	0	6	**0.0%**	0.0%	8.3%			16.7%	-16.7	NO	Below 25th Percentile
NWBHP	14	67	**20.9%**	10.4%	31.4%			24.7%	-3.8	NO	Above 50th Percentile, Below 75th Percentile
Washington	13	60	**21.7%**	10.4%	32.9%			14.3%	7.4	NO	At or Above 75th Percentile
Westmoreland	7	53	**13.2%**	3.1%	23.3%			9.2%	4.0	NO	Below 50th Percentile, Above 25th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; NWBHP: Northwest Behavioral Health Partnership, Inc.

The MY 2015 HealthChoices Aggregate rates in the 13-17 year age group were 36.8% for Initiation and 25.7% for Engagement (**Table 14**). These rates were comparable to the MY 2014 13-17 year old HealthChoices Aggregate rates of 37.0% and 25.8%, respectively. The HealthChoices Aggregate rate for Initiation was between the HEDIS percentiles for the 25th and 50th percentiles, while the HealthChoices Aggregate rate for Engagement was above the 75th percentile.

The VBH MY 2015 13-17 year old IET rates were 26.2% for the Initiation rate and 16.2% for the Engagement rate; neither rate was statistically significantly different from MY 2014 (**Table 14**). Compared to the HealthChoices BH-MCO Average of 33.6% for Initiation, the VBH Initiation rate was statistically significantly lower by 7.4 percentage points. The Engagement rate for VBH was statistically significantly lower than the HealthChoices BH-MCO Average of 23.1% by 6.9 percentage points. The VBH Initiation rate for 13-17 year olds was below the HEDIS 2016 25th percentile and the VBH Engagement rate for 13-17 year olds was between the 50th and 75th percentile. None of the individual HC BH Contractors demonstrated a statistically significant rate change from the prior year for either rate.

Figure 11 is a graphical representation of the 13-17 year old Initiation rates and Engagement rates for VBH and its associated HC BH Contractors. **Figure 12** shows the HealthChoices HC BH 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 Contractor Average. The Initiation rate for Lawrence was 0.0%, and was statistically significantly below the MY 2015 Initiation HC BH Contractor Average of 29.3%. The Engagement rates for Lawrence, Fayette and Beaver were also 0.0%, and were also statistically significantly below the MY 2015 Engagement HC BH Contractor Average of 18.9%.

Figure 11: MY 2015 IET Rates: 13–17 Years Old

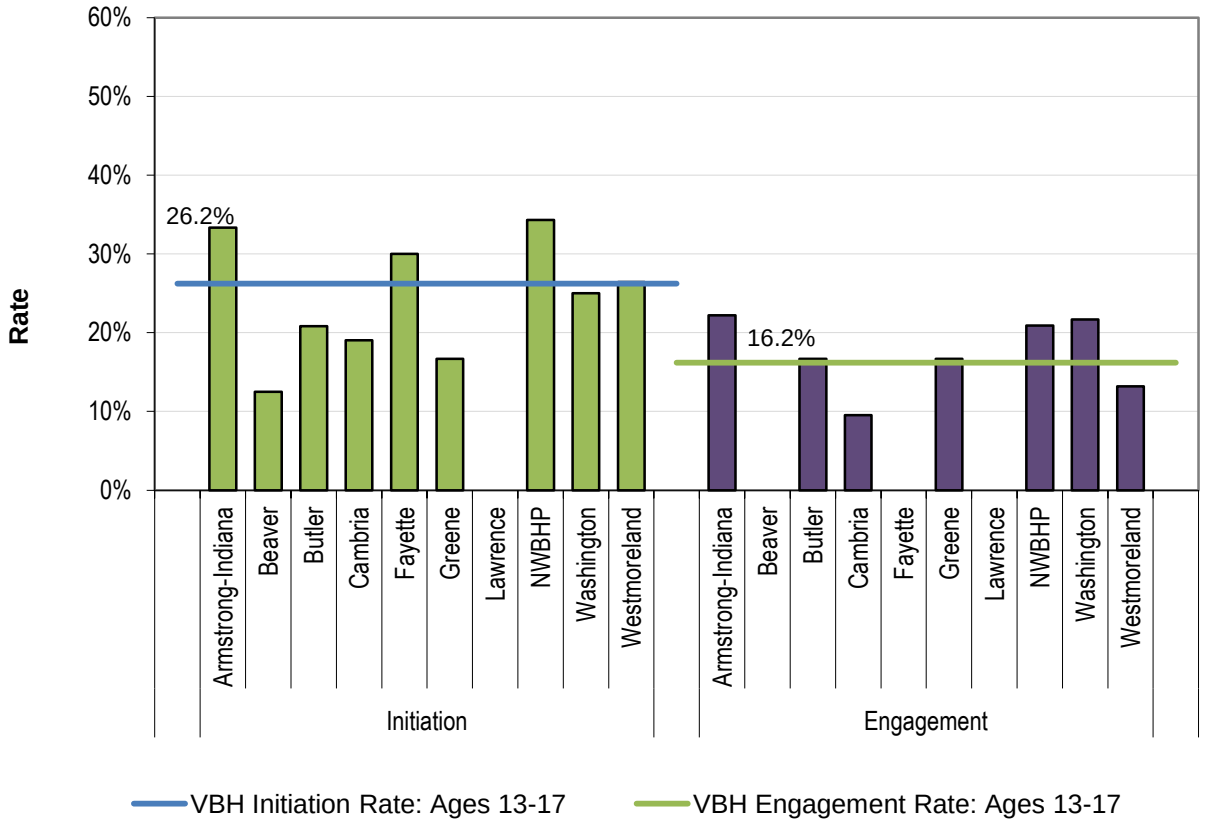
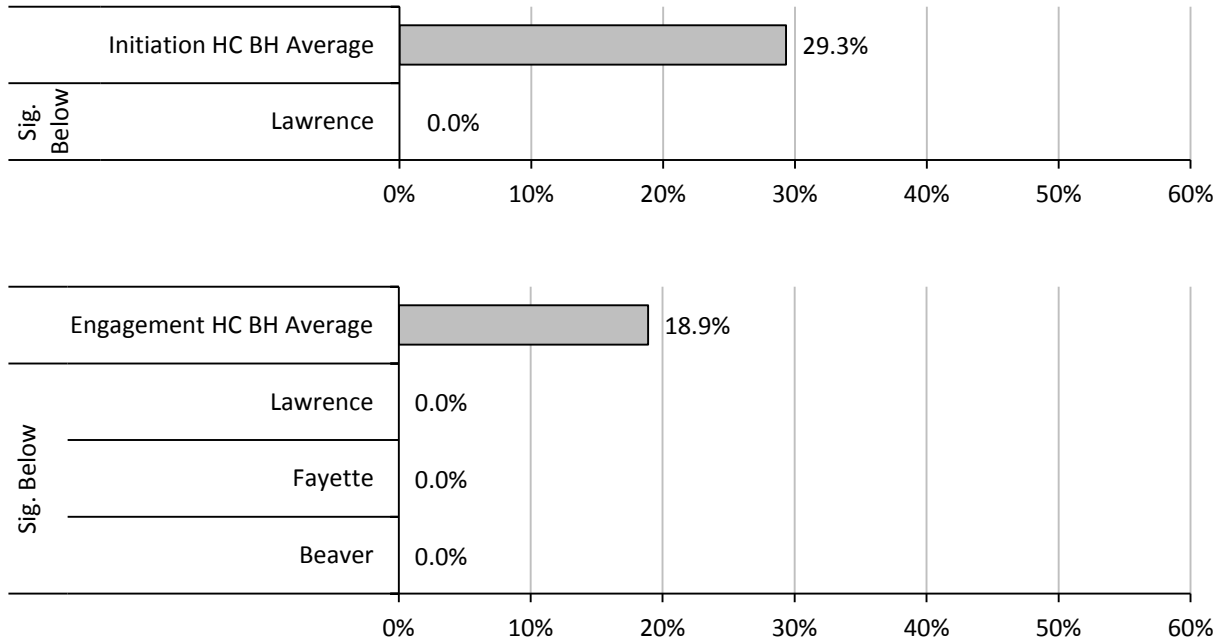


Figure 12: MY 2015 IET Rates Compared to HealthChoices County Average: 13–17 Years Old



(b) Age Group: 18+ Years Old

Table 15: MY 2015 IET Rates: 18+YearsWith Year-to-Year Comparisons

Measure	MY 2015 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	MY 2014 %	PPD	SSD	Rate Comparison MY 2015 to HEDIS Benchmarks
Age Cohort: 18+ Years –Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	8,493	31,768	**26.7%**	26.2%	27.2%	26.7%	27.7%	29.8%	-3.1	YES	Below 25th Percentile
VBH	1,334	4,626	**28.8%**	27.5%	30.2%			27.0%	1.8	YES	Below 25th Percentile
Armstrong-Indiana	75	394	**19.0%**	15.0%	23.0%			32.6%	-13.6	YES	Below 25th Percentile
Beaver	135	444	**30.4%**	26.0%	34.8%			17.7%	12.7	YES	Below 25th Percentile
Butler	86	325	**26.5%**	21.5%	31.4%			29.6%	-3.1	NO	Below 25th Percentile
Cambria	103	425	**24.2%**	20.0%	28.4%			15.9%	8.3	YES	Below 25th Percentile
Fayette	154	508	**30.3%**	26.2%	34.4%			26.9%	3.4	NO	Below 25th Percentile
Greene	30	112	**26.8%**	18.1%	35.4%			23.7%	3.1	NO	Below 25th Percentile
Lawrence	97	296	**32.8%**	27.3%	38.3%			37.7%	-4.9	NO	Below 25th Percentile
NWBHP	193	772	**25.0%**	21.9%	28.1%			23.5%	1.5	NO	Below 25th Percentile
Washington	258	629	**41.0%**	37.1%	44.9%			27.0%	14.0	YES	Below 50th Percentile, Above 25th Percentile
Westmoreland	203	721	**28.2%**	24.8%	31.5%			31.7%	-3.5	NO	Below 25th Percentile
Age Cohort: 18+ Years – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	5,899	31,768	**18.6%**	18.1%	19.0%	18.3%	19.4%	20.1%	-1.5	YES	Above 50th Percentile, Below 75th Percentile
VBH	1,023	4,626	**22.1%**	20.9%	23.3%			17.3%	4.8	YES	At or Above 75th Percentile
Armstrong-Indiana	51	394	**12.9%**	9.5%	16.4%			21.7%	-8.8	YES	Below 50th Percentile, Above 25th Percentile
Beaver	105	444	**23.6%**	19.6%	27.7%			10.7%	12.9	YES	At or Above 75th Percentile
Butler	59	325	**18.2%**	13.8%	22.5%			21.1%	-2.9	NO	Above 50th Percentile, Below 75th Percentile
Cambria	79	425	**18.6%**	14.8%	22.4%			7.5%	11.1	YES	Above 50th Percentile, Below 75th Percentile
Fayette	92	508	**18.1%**	14.7%	21.6%			15.5%	2.6	NO	Above 50th Percentile, Below 75th Percentile
Greene	21	112	**18.8%**	11.1%	26.4%			14.0%	4.8	NO	Above 50th Percentile, Below 75th Percentile
Lawrence	84	296	**28.4%**	23.1%	33.7%			22.7%	5.7	NO	At or Above 75th Percentile
NWBHP	146	772	**18.9%**	16.1%	21.7%			13.8%	5.1	YES	Above 50th Percentile, Below 75th Percentile
Washington	221	629	**35.1%**	31.3%	38.9%			19.9%	15.2	YES	At or Above 75th Percentile
Westmoreland	165	721	**22.9%**	19.7%	26.0%			21.7%	1.2	NO	At or Above 75th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; NWBHP: Northwest Behavioral Health Partnership, Inc.

The MY 2015 HealthChoices Aggregate rates in the 18 and older age group were 26.7% for Initiation and 18.6% for Engagement (**Table 15**). Both rates were statistically significantly lower than the corresponding MY 2014 rates: the HealthChoices Aggregate Initiation rate decreased by 3.1 percentage points and the Engagement rate decreased by 1.5

percentage points from the prior year. The MY 2015 HealthChoices Aggregate Initiation rate in this age cohort was below the HEDIS 2016 25th percentile, while the Engagement rate was between the 50th and 75th percentiles.

The VBH MY 2015 Initiation and Engagement rates for the 18+ population was 28.8% (**Table 15**). This rate was below the 25th percentile, and was statistically significantly higher than the MY 2014 rate by 1.8 percentage points. Compared to the HealthChoices BH-MCO Average of 26.7% for Initiation, the VBH Initiation rate was statistically significantly higher by 2.1 percentage points. The VBH MY 2015 Engagement rate for this age cohort was 22.1%, and was above the HEDIS 75th percentile. The VBH Engagement rate for this age group was statistically significantly higher than the MY 2014 rate of 17.3%, and was statistically significantly higher than the BH-MCO Average of 18.3% by 3.8 percentage points.

As presented in **Table 15**, there was statistically significant improvement in the Initiation rate for Cambria, Beaver and Washington, with year-to-year increases ranging from 8.3 percentage points for Cambria to 14.0 percentage points for Washington. There was a statistically significant decrease in the Initiation rate for Armstrong-Indiana, which had a rate decrease of 13.6 percentage points from 32.6% in MY 2014 to 19.0% in MY 2015. Initiation rates in the 18+ age group were below the 25th percentile for nine of the ten VBH HC BH Contractors; one HC BH Contractor, Washington, had an Initiation rate between the HEDIS 25th and 50th percentiles. For the Engagement rate, statistically significant improvement was noted in NWBHP, Cambria, Beaver and Washington, with year-to-year increases ranging from 5.1 percentage points for NWBHP to 15.2 percentage points for Washington. There was a statistically significant decrease in the Engagement rate for Armstrong-Indiana, which had a rate decrease of 8.8 percentage points from 21.7% in MY 2014 to 12.9% in MY 2015. The Engagement rate for Armstrong-Indiana was between the HEDIS 25th and 50th percentiles. Five VBH HC BH Contractors had Engagement rates between the HEDIS 50th and 75th percentiles, and four HC BH Contractors had engagement rates above the75th percentile.

Figure 13 is a graphical representation MY 2015 IET rates for VBH and its associated HC BH Contractors for the 18+ age group. **Figure 14** 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. The Initiation rate for Washington was statistically significantly above the HealthChoices HC BH Contractor Average Initiation rate of 27.7% by 13.3 percentage points, while the Initiation rate for Armstrong-Indiana was statistically significantly below the Average by 8.7 percentage points. The Engagement rates for Westmoreland, Beaver, Lawrence and Washington were statistically significantly above the HC BH Contractor Average Engagement rate of 19.4%, with differences ranging from 3.5 percentage points for Westmoreland to 15.7 percentage points for Washington. The Engagement rate for Armstrong-Indiana was statistically significantly below the Average by 6.4 percentage points.

Figure 13: MY 2015 IET Rates – 18+Years

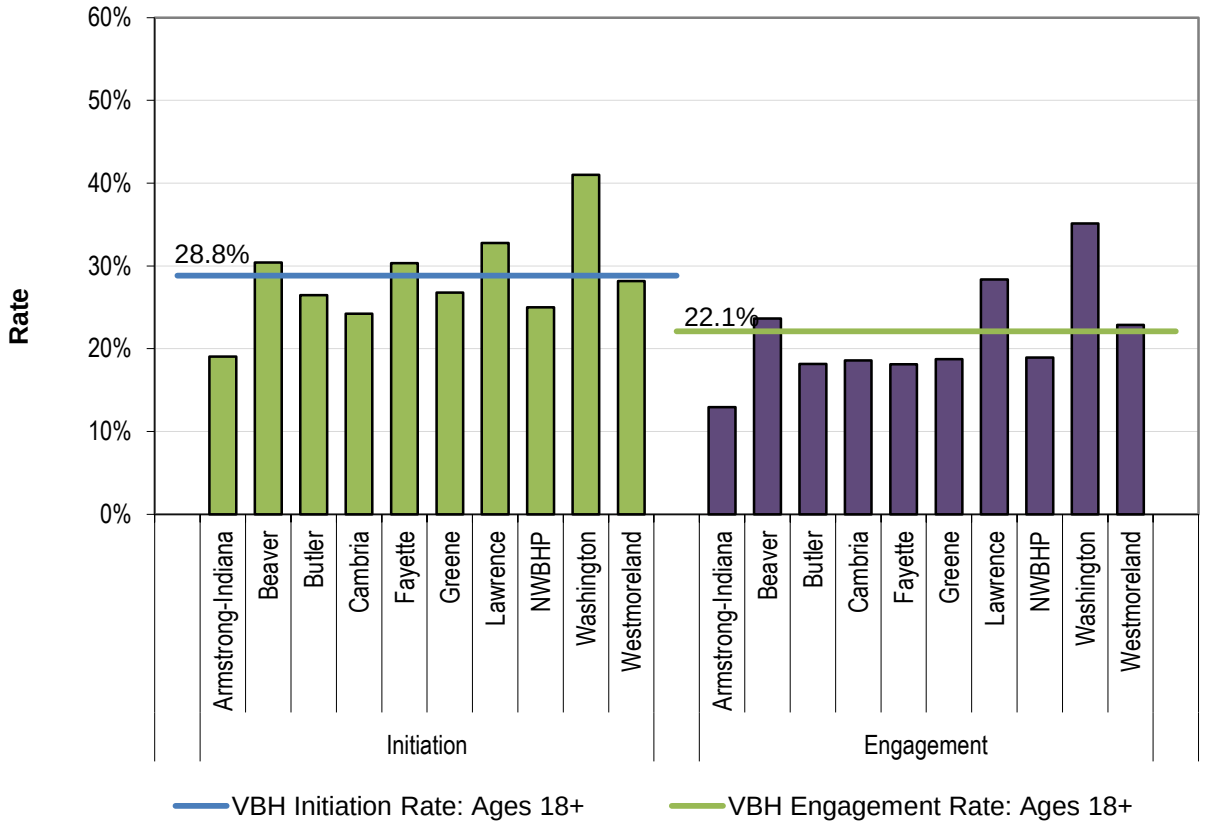
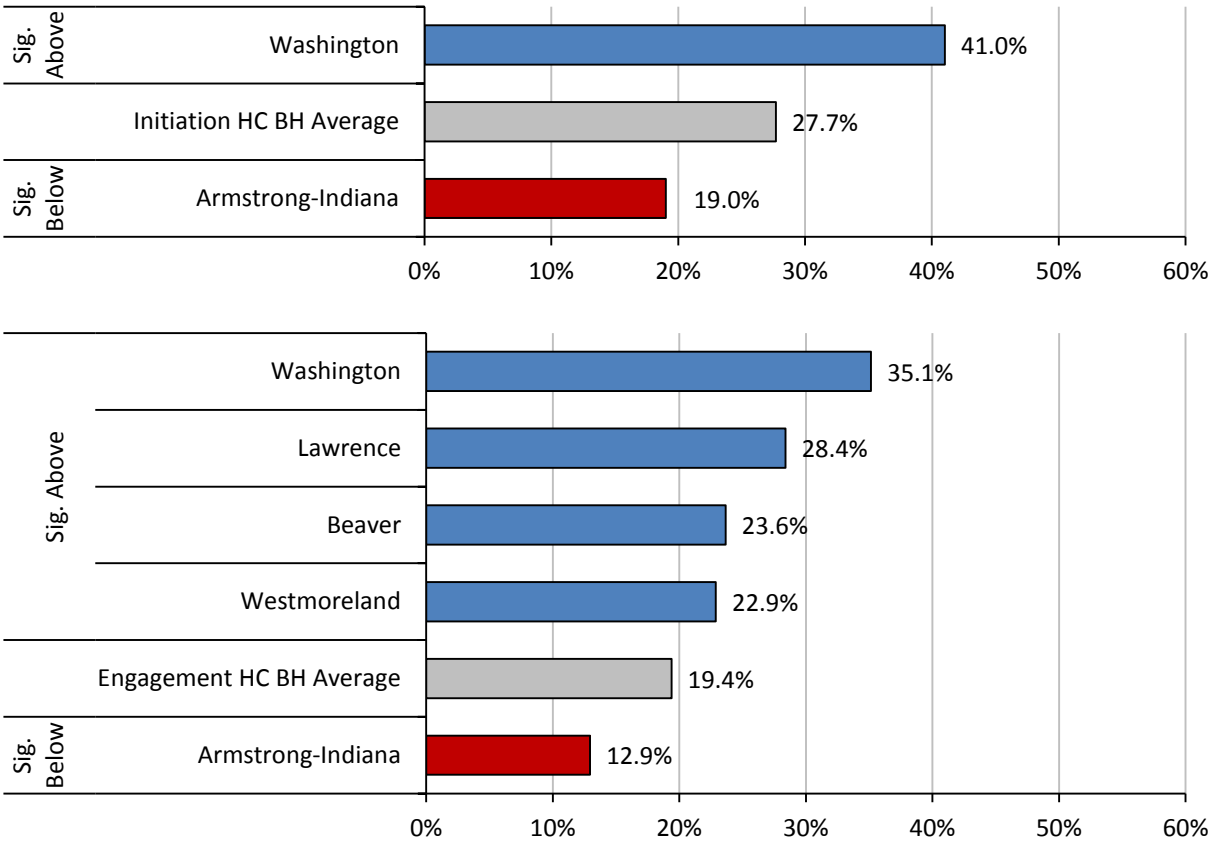


Figure 14: MY 2015 IET Rates Compared to HealthChoices HC BH Contractor Average – 18+ Years



(c) Age Group: 13+ Years Old

Table 16: MY 2015 IET Rates – 13+Years with Year-to-Year Comparisons

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	MY 2015 Lower 95% CI	MY 2015 Upper 95% CI	MY 2015 BH-MCO Average	MY 2015 BH HC Contractor Average	MY 2014 %	MY 2014 PPD	MY 2014 SSD	Rate Comparison MY 2015 to HEDIS Benchmarks
Age Cohort: Total – Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	9,417	34,281	**27.5%**	27.0%	27.9%	27.2%	28.0%	30.3%	-2.8	YES	Below 25th Percentile
VBH	1,410	4,916	**28.7%**	27.4%	30.0%			26.9%	1.8	YES	Below 25th Percentile
Armstrong-Indiana	84	421	**20.0%**	16.0%	23.9%			33.5%	-13.5	YES	Below 25th Percentile
Beaver	137	460	**29.8%**	25.5%	34.1%			17.1%	12.7	YES	Below 25th Percentile
Butler	91	349	**26.1%**	21.3%	30.8%			28.8%	-2.7	NO	Below 25th Percentile
Cambria	107	446	**24.0%**	19.9%	28.1%			16.1%	7.9	YES	Below 25th Percentile
Fayette	157	518	**30.3%**	26.3%	34.4%			27.5%	2.8	NO	Below 25th Percentile
Greene	31	118	**26.3%**	17.9%	34.6%			22.6%	3.7	NO	Below 25th Percentile
Lawrence	97	302	**32.1%**	26.7%	37.6%			37.8%	-5.7	NO	Below 25th Percentile
NWBHP	216	839	**25.7%**	22.7%	28.8%			24.3%	1.4	NO	Below 25th Percentile
Washington	273	689	**39.6%**	35.9%	43.3%			26.7%	12.9	YES	Above 50th Percentile, Below 75th Percentile
Westmoreland	217	774	**28.0%**	24.8%	31.3%			30.8%	-2.8	NO	Below 25th Percentile
Age Cohort: Total – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	6,544	34,281	**19.1%**	18.7%	19.5%	18.7%	19.5%	20.5%	-1.4	YES	At or Above 75th Percentile
VBH	1,070	4,916	**21.8%**	20.6%	22.9%			17.3%	4.5	YES	At or Above 75th Percentile
Armstrong-Indiana	57	421	**13.5%**	10.2%	16.9%			23.2%	-9.7	YES	At or Above 75th Percentile
Beaver	105	460	**22.8%**	18.9%	26.8%			10.3%	12.5	YES	At or Above 75th Percentile
Butler	63	349	**18.1%**	13.9%	22.2%			20.5%	-2.4	NO	At or Above 75th Percentile
Cambria	81	446	**18.2%**	14.5%	21.9%			7.7%	10.5	YES	At or Above 75th Percentile
Fayette	92	518	**17.8%**	14.4%	21.1%			15.5%	2.3	NO	At or Above 75th Percentile
Greene	22	118	**18.6%**	11.2%	26.1%			13.7%	4.9	NO	At or Above 75th Percentile
Lawrence	84	302	**27.8%**	22.6%	33.0%			22.5%	5.3	NO	At or Above 75th Percentile
NWBHP	160	839	**19.1%**	16.4%	21.8%			14.7%	4.4	YES	At or Above 75th Percentile
Washington	234	689	**34.0%**	30.4%	37.6%			19.4%	14.6	YES	At or Above 75th Percentile
Westmoreland	172	774	**22.2%**	19.2%	25.2%			21.0%	1.2	NO	At or Above 75th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; NWBHP: Northwest Behavioral Health Partnership, Inc.

The MY 2015 HealthChoices Aggregate rates in the 13 and older age group were 27.5% for Initiation and 19.1% for Engagement (**Table 16**). The Initiation rate was statistically significantly lower than the MY 2014 Initiation rate by 2.8 percentage points, and the Engagement rate was statistically significantly lower than the MY 2014 Engagement rate by 1.4 percentage points. The MY 2015 HealthChoices Aggregate Initiation rate was below the HEDIS 2016 25th percentile, while the Engagement rate was above and 75th percentile.

The VBH MY 2015 Initiation and Engagement rates for the 18+ population was 28.7% (**Table 16**). This rate was below the 25th percentile, and was statistically significantly higher than the MY 2014 rate by 1.8 percentage points. Compared to the HealthChoices BH-MCO Average of 27.2% for Initiation, the VBH Initiation rate was statistically significantly higher by

1.5 percentage points. The VBH MY 2015 Engagement rate for this age cohort was 21.8%, and was above the HEDIS 75th percentile. The VBH Engagement rate for this age group was statistically significantly higher than the MY 2014 rate of 17.3%, and was statistically significantly higher than the BH-MCO Average of 18.7% by 3.1 percentage points. VBH had the highest Engagement rate of the five BH-MCOs evaluated in MY 2015.

As presented in **Table 16**, there was statistically significant improvement in the Initiation rate for Cambria, Beaver and Washington, with year-to-year increases ranging from 7.9 percentage points for Cambria to 12.9 percentage points for Washington. There was a statistically significant decrease in the Initiation rate for Armstrong-Indiana, which had a rate decrease of 13.5 percentage points from the prior year. Initiation rates in the 13+ age group were below the 25th percentile for nine of the ten VBH HC BH Contractors; and one HC BH Contractor, Washington, had an Initiation rate between the HEDIS 25th and 50th percentiles. For the Engagement rate, statistically significant improvement was noted in NWBHP, Cambria, Beaver and Washington, with year-to-year increases ranging from 4.4 percentage points for NWBHP to 14.6 percentage points for Washington. There was a statistically significant decrease in the Engagement rate for Armstrong-Indiana, which had a rate decrease of 9.7 percentage points from the prior year. Engagement rates for all VBH HC BH Contractors were above the HEDIS 75th percentile.

Figure 15 is a graphical representation MY 2015 IET rates for VBH and its associated HC BH Contractors for the 18+ age group. **Figure 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. The Initiation rate for Washington was statistically significantly above the HealthChoices HC BH Contractor Average Initiation rate of 28.0% by 11.7 percentage points, while the Initiation rate for Armstrong-Indiana was statistically significantly below the Average by 8.0 percentage points. The Engagement rates for Lawrence and Washington were statistically significantly above the HC BH Contractor Average Engagement rate of 19.5% by 8.4 and 14.5 percentage points, respectively. The Engagement rate for Armstrong-Indiana was statistically significantly below the Average by 5.9 percentage points.

Figure 15: MY 2015 IET Rates: 13+Years

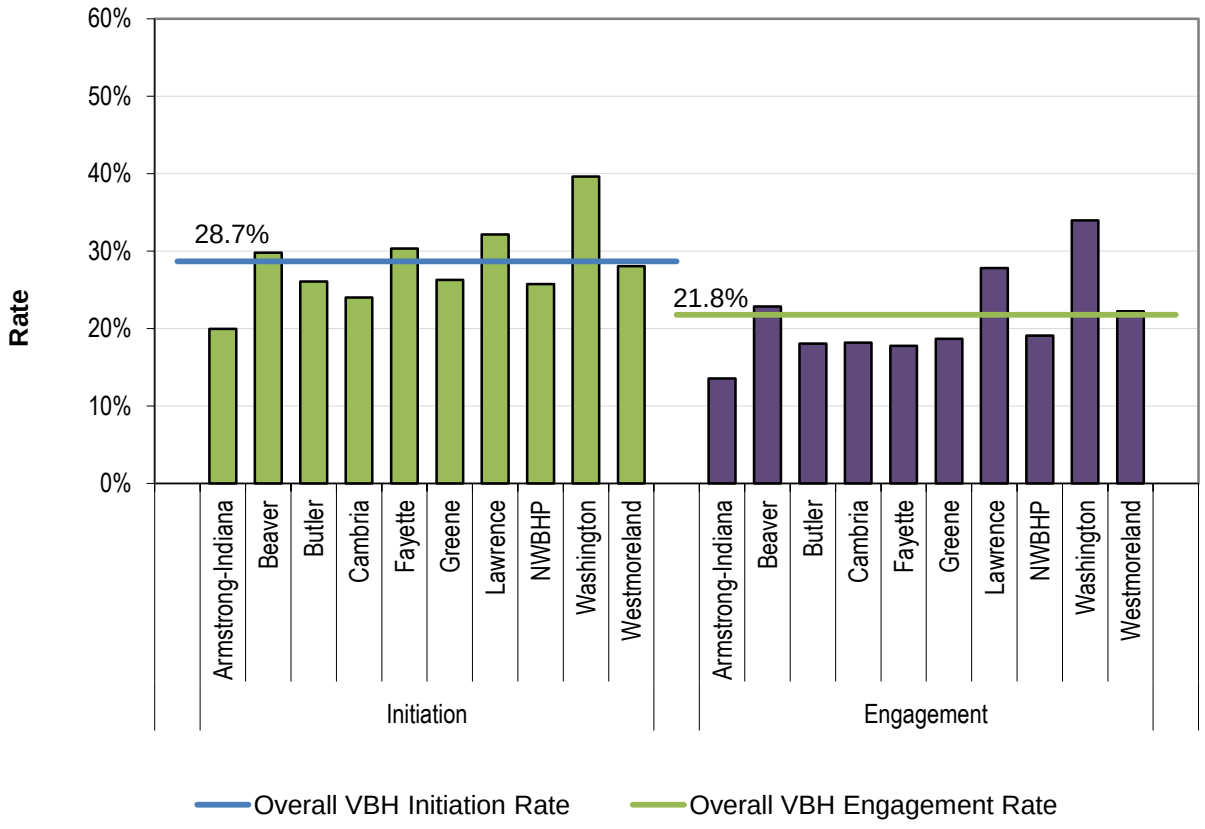
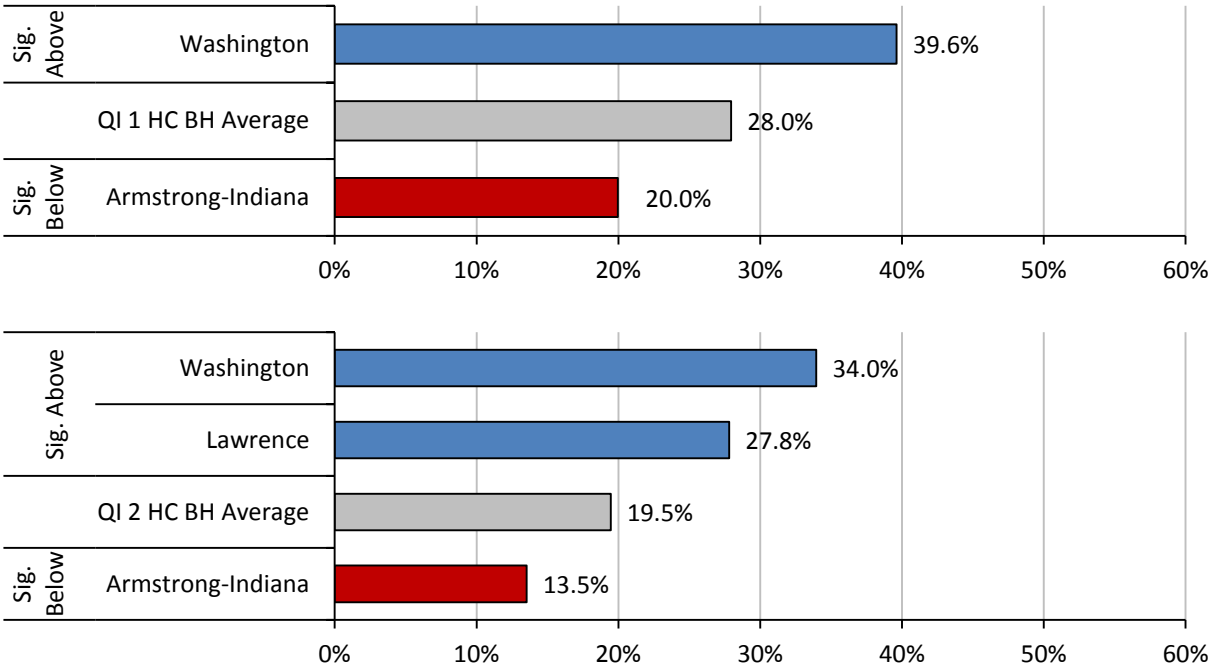


Figure 16: MY 2015 IET Rates Compared to HealthChoices HC BH Contractor Average: 13+ Years



Conclusion and Recommendations

For MY 2015, the aggregate HealthChoices rate in the 13+ population (overall population) was 27.5% for the Initiation rate and 19.1% for the Engagement rate. The Initiation rate was below the HEDIS 25th percentile while the Engagement rate was above the 75th percentile. The Initiation and the Engagement rates both statistically significantly decreased from MY 2014 rates. As seen with other performance measures, there is significant variation between the HC BH Contractors. The following general recommendations are applicable to all five participating BH-MCOs:

- BH-MCOs should begin to implement 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.
- When developing reporting and analysis programs, BH-MCOs should focus on the Initiation rate, as all five BH-MCOs had a rate below the HEDIS 25th percentile for this numerator.

IV: Quality Study

The purpose of this section is to describe a quality study performed between 2015 and 2016 for the HealthChoices population. The study is included in this report as an optional EQR activity which occurred during the Review Year (42 CFR §438.358 (c)(5)).

Overview/Study Objective

DHS commissioned IPRO to conduct a study to identify factors associated with initiation and engagement rates among members enrolled in the Pennsylvania Medicaid Behavioral Health HealthChoices program who had a diagnosis of opioid abuse. A claims-based study was developed to determine what demographic and clinical factors are associated with lower initiation and engagement rates, with an objective of combining physical health and behavioral health encounter data to identify factors across both domains of care. The goal of this study was to provide data to guide targeted quality improvement interventions by identifying subpopulations with low initiation and engagement rates. Emphasis was placed on identifying factors across domains of care, i.e. physical and behavioral co-morbidities that are associated with lower initiation and engagement rates, and vice versa.

Data Collection and Analysis

This study analyzed behavioral and physical health encounter data for inpatient, outpatient, partial hospitalization, and intensive outpatient services for members with a primary or secondary diagnosis of opioid abuse between 1/1/14 and 11/15/14 in order to measure the percentage of members who receive these services after the opioid abuse diagnosis (defined as the index event). The primary source of data was claims that were submitted to and accepted by the DHS PROMISe encounter system through 10/28/15 and received by IPRO. Any claims not submitted to or not accepted by PROMISe were not included in this study. Additional analyses compared initiation and engagement rates for various subpopulations. Subpopulations were distinguished by member demographics, opioid diagnosis details, co-occurring substance abuse, and type of encounters/level of care, stratified by the behavioral and physical health domains. Analyses were done to identify what factors or combinations of factors correlate with the index event type, medication-assisted treatment for opioid dependence, and time to service initiation.

Results/Conclusions

There were a total of 10,829 members that met the denominator criteria that were included in this study, of which all had physical health and behavioral health encounters. The overall initiation rate for MY 2014 was 40.68%, and the overall engagement rate was 28.29%.

There were a number of demographic factors that were statistically significantly correlated with lower initiation and engagement rates. For both initiation and engagement, members from urban settings had lower rates than members from rural settings, African American members had lower rates than white members, and males had lower rates than females. It is noted that rates declined for both genders, though this was only statistically significant for initiation. The highest rates were for members aged 25-40.

Although opioid usage details were unspecified for about 85% of the sample, those with a continuous opioid diagnosis had lower initiation and engagement rates than members with any unspecified diagnosis, and lower initiation rates than members with any episodic opioid diagnosis. Members with a diagnosis of opioid dependence have higher initiation and engagement rates than those diagnosed with non-dependent abuse. Opioid diagnosis was the primary diagnosis for 74.6% members; these members had significantly higher rates than those with a non-opioid primary diagnosis (31.9% higher for initiation, and 26.0% higher for engagement). A co-occurring substance abuse diagnosis was associated with lower rates than opioid abuse alone (4.9% lower for initiation and 0.2% lower for engagement). Alcohol, cannabis, and cocaine were the most frequently co-diagnosed drugs; of these, alcohol had the lowest rates (34.3% for initiation and 24.1% for engagement).

Of the five types of index events (inpatient, emergency department, detoxification, outpatient/alternative levels of care, and outpatient/alternative levels of care stratified into behavioral and physical health encounters), intensive outpatient and methadone services had the highest initiation rates (86.7% and 85.4%, respectively) and engagement rates (80.1% and 68.8%, respectively). Members with a primary diagnosis of opioid abuse for the index event have higher initiation and engagement rates (31.9% and 26.0%, respectively) than members with a secondary diagnosis of opioid abuse.

Members with no active prescriptions for medication-assisted treatment for opioid dependence have an initiation rate 24.1% lower than those with an active prescription, and an engagement rate 21.7% lower. Members that initiated treatment within one week of the index event had a higher percentage of engagement than members who initiated treatment during the second week for all services except methadone.

V: 2015 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 2015 EQR Technical Reports, which were distributed in April 2016. The 2016 EQR Technical Report is the ninth report to include descriptions of current and proposed interventions from each BH-MCO that address the 2015 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 May 30, 2016 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 2016, as well as any additional relevant documentation provided by the BH-MCO.

Table 17 presents VBH's responses to opportunities of improvement cited by IPRO in the 2015 EQR Technical Report, detailing current and proposed interventions.

Table 17: Current and Proposed Interventions

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) 2012, RY 2013, and RY 2014 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 5/30/16/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
VBH 2015.01	Within Subpart C: Enrollee Rights and Protections Regulations, VBH was partially compliant on one out of seven categories – Enrollee Rights.	Date(s) of follow-up action(s) taken through 5/30/16: Completed June 2013	Standard 108: Substandard 1, 2,10 (NWBHP-RY 2012)  NW3 PEPS 2012 CAP DPW Letter_01-16-14.
		Date(s) of follow-up action(s) taken through 5/30/16: None required	Standard 108: Substandard 5 (Cambria County- no CAP required)  Cambria RY 2012.pdf
		Date(s) of follow-up action(s) taken through 5/30/16: Dates completed in attached document	Standard 60: Substandard 1 (RY 2014)  Standard 60: Substandard 1.docx  QMOrganizationChart2016.pdf  PeerReview_Grievance Organizational Char
		Date(s) of future action(s) planned / None	Describe one follow-up action. Leave blank, if none.
VBH 2015.02	VBH was partially compliant on five out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care) 2) Coordination and Continuity of Care 3) Coverage and Authorization of Services 4) Practice Guidelines 5) Quality Assessment and Performance Improvement Program	Date(s) of follow-up action(s) taken through 5/30/16: Completed	Standard 1: substandard 2 (RY 2012)  SW6_Exception Response Letter .pdf
		Date(s) of follow-up action(s) taken through 5/30/16: Completed October 2015	Standard 28: substandard 1 and 2 (RY 2014)  Std 28 Substandard 1 and 2.docx
		Date(s) of follow-up action(s) taken through 5/30/16: Quarterly review with internal auditing	Standard 72: substandard 1 and 2  STD 72 CAP .docx  Denial Monitoring Tool (Oct 2014).docx

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		Date(s) of follow-up action(s) taken through 5/30/16: Annual submission	Standard 91: substandard 1-5, 7, 12 DHS_Year End Documents Receipt C
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
VBH 2015.03	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	Date(s) of follow-up action(s) taken through 5/30/16: Quarterly updates	Standard 68: substandard 1,3,4,5 Std 68 (RY2014) CAP.docx Standard 71: Grievance Std 71 (RY 2014) CAP.docx
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
VBH 2015.04	VBH did not meet the OMHSAS designated performance goal of 10.0% for the Readmission Within 30 Days of Inpatient Psychiatric Indicator	Date(s) of follow-up action(s) taken through 5/30/16: Quarterly Updates to IPRO	PIP Year 2 Update VBH-PA PIP Successful Transitions
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
VBH 2015.05	VBH's rates for the MY 2014 Follow-up After Hospitalization for Mental Illness HEDIS Follow-up indicators (QI 1 and QI 2) for ages 6-64 did not meet the OMHSAS interim goals for MY 2014, nor did they achieve the goal of meeting or exceeding the 75th percentile.	See attached for various actions and associated dates	Frm_2015 BH PM RCA Response_VBH
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.

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 2014, VBH began to address opportunities for improvement related to Standards 1, 28, 60, 68, 71, 72, 91 and 108. Proposed actions and evidence of actions taken by VBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring VBH into compliance with the relevant Standards.

Root Cause Analysis and Action Plan

The 2016 EQR is the eighth for which BH-MCOs are required to prepare a Root Cause Analysis and Action Plan for performance measures performing statistically significantly poorer than the BH-MCO Average and/or as compared to the prior measurement year. For performance measures that were noted as opportunities for improvement in the 2015 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.

For the 2016 EQR, VBH was required to prepare a Root Cause Analysis and Action Plan for the following performance measures and quality indicators:

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6–64 Years (**Table 18**)
- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years (**Table 19**)

Table 18: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6–64 Years

RCA: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)		
Instructions: **For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.**		
Managed Care Organization (MCO): *Value Behavioral Health (VBH)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)*	***Response Date:*** 7/29/16
Goal Statement: (Please specify individual goals for each measure): Short term Goal:2014 7day FUH Rate is 47.6, Improve the 7 day FUH rate by 2 percentage points to 49.6 % Long term Goal: Improve the 7 day FUH rates above the 75th percentile		
***Analysis*:** **What factors contributed to poor performance?** **Please enter "N/A" if a category of factors does not apply.**	***Findings***	
Policies (1) (e.g., data systems, delivery systems, provider facilities) • Inpatient providers do not consistently schedule an outpatient aftercare appointment within 7 days for each patient that is discharged. SIPOC Tool for FUH.docx Barriers for follow up_ within 7 and 30	***Initial Response*** • Based on the April 2015 chart abstraction process for the four pilot hospitals selected to participate in the Performance Improvement Plan, only 52 percent of the 120 medical records reviewed had an appointment scheduled for the patient 34% of the records had documentation of an appointment within 7 days of discharge. Monitor rates for improvement in next chart abstraction or self audit. ***Follow-up Status Response*** • The follow up Discharge Management Plan (DMP) audit conducted at the 4 pilot hospitals in 2016 show that the rate for properly documenting aftercare appointments in the patient's medical record has decreased from the previous year. Based on the 2016 chart abstraction process for the four pilot hospitals selected to participate in the Performance Improvement Plan, only 44% of the 120 medical records reviewed had properly documented an appointment scheduled for the patient within 14 days and 35% of the records had proper documentation of an appointment within 7 days of discharge.	
Policies (2) (e.g., data systems, delivery systems, provider facilities) • It was noted that at 3 of the pilot hospitals that are participating in the state-wide Performance Improvement Project (PIP), the patients living in a certain communities and served by particular providers are told to call the provider themselves and arrange an appointment or to go to the provider as a walk-in during certain times of the day. • Patient not consistently included in the formulation of the discharge plan such as availability of the aftercare appointment	***Initial Response*** • Documentation found in the medical records in the 2015 DMP audit substantiates that the patient was to call the provider to schedule (or walk in) for the initial intake and not an appointment with a therapist or psychiatrist. ***Follow-up Status Response*** • VBH-PA staff met with each of the 4 pilot hospitals to discuss results of the DMP audits from 2015. Part of the discussions addressed the importance of the patient having an appointment within 7 days when the patient is discharged as well as awareness of the patient's availability to attend the follow appointment. • A few outpatient providers will not schedule appointments with the hospital for new patients being discharged due to the high 'no-show rate' that providers have experienced.	

RCA: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)	
Policies (3) (e.g., data systems, delivery systems, provider facilities) • Transportation Availability and convenience • MATP Transportation resources are limited and services restricted	***Initial Response*** • Members report difficulty keeping an appointment in rural areas where Medical Assistance Transportation (MATP) requires several hours to get to the appointment and then return home. A trip that should take a reasonable amount of travel time forces consumers to waste a large portion of the day waiting to get a ride back home. Rural consumers report waiting many hours for a return trip home. This barrier can impact timely follow up as some members are unable or unwilling to deal with the wait or inconvenience. In 2014, consumer satisfaction with MATP transportation was below 85% in the SW6, Fayette and Venango Counties. ***Follow-up Status Response*** • Members continue to report through CFST surveys that MATP services can be problematic at times in Fayette and Venango Counties which are both rural counties. In 2015, Consumer satisfaction rates for these two counties remained below 85% from the previous year.
Procedures (1) (e.g., payment/reimbursement, credentialing/collaboration) • Hospital does not notify VBH of the patient's discharge in a timely manner • VBH-PA Aftercare Coordinator is unable to contact some members by phone or by mail after discharge to assist them with appointment reminders or rescheduling their aftercare appointment.	***Initial Response*** • At the time of discharge, patient aftercare contact information provided by the hospital or the routine contact information provided through DPW eligibility tables can be incorrect and outdated. ***Follow-up Status Response*** • Hospitals are not notifying VBH within 24 hours of discharge causing a delay in VBH outreach • Discharge information given to VBH care manager by the hospital can be inaccurate or incomplete during the discharge review. • When the VBH aftercare coordinator attempts to call the discharged patient, at times the phone may be disconnected or the contact letters sent as part of outreach for aftercare are returned to VBH-PA as undeliverable.
Procedures (2) (e.g., payment/reimbursement, credentialing/collaboration) • Electronic discharge submissions are now available for some Inpatient providers. The inpatient providers do not always submit accurate demographic information on the discharge notification form.	***Initial Response*** • Determine the feasibility of requiring mandatory discharge fields when the provider is submitting electronic discharge notifications. ***Follow-up Status Response***
People (1) (e.g., personnel, provider network, patients) • Routine access to Psychiatrists is frequently limited as members may have to wait beyond 7 days for an initial appointment	***Initial Response*** • Members, providers and counties report the need for better access to psychiatrists for medication management after discharge from an inpatient setting within 7 and 30 day timeframes. (There is a known shortage of psychiatrists for non-urban areas). Some providers limit medication services to members concurrently receiving outpatient services at their facility. As a result, Health Choices members may rely on Primary Care Physicians or other non-

RCA: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)	
	psychiatric specialty doctors to get medication management that they need after discharge (follow up claim cannot be reported). ***Follow-up Status Response*** • Psychiatrist shortage remains a factor identified across the state of PA as seen in this Pittsburgh Post-Gazette newspaper article. An estimated 2,600 more are needed to eliminate 3,900 federally designated "mental health professional shortage areas," including parts of Allegheny, Washington and Westmoreland counties.  Psychiatrists in Short Supply.docx
People (2) (e.g., personnel, provider network, patients) • Inpatient providers are not routinely having discussions with the patient regarding barriers that will prevent them from keeping a follow up appointment, such as childcare, transportation, or starting back to work after discharge.	***Initial Response*** • Only eight percent (8%) of the records reviewed during the chart abstraction process in April 2015 at the 4 pilot hospitals (9/117) had documentation of discussions regarding barriers to follow up treatment with the patient by hospital staff. ***Follow-up Status Response*** • From the 4 hospitals audited in 2016, there was an increase to 30% (36/120) in a discussion of barriers with the patient before discharge.
Provisions (1) (e.g., screening tools, medical record forms, provider and enrollee educational materials) • Patient may be unaware why keeping the aftercare appointment is important	***Initial Response*** • VBH-PA routinely contacts the discharged member to provide assistance and to see if the member is aware of a scheduled follow up appointment or other support services are need. Members discharged with complete medication and aftercare appointment information increase the likelihood of the member keeping an appointment and improving the chance for improved mental health and symptom reduction. ***Follow-up Status Response***
Complete next page of corresponding action plan.	

Action Plan: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2015. 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) • Letter mailed to all MH Inpatient providers (CEO and the BH Program Director) with attached 'Components of Discharge Management Plan' (DMP) handout that emphasizes that aftercare appointments should be scheduled within 7 days and the appointment information must be included in the patient's discharge instructions.  Components of Discharge Manageme	December 2014 January 2015 January 2016	***Initial Response*** • Educational outreach to the Inpatient providers is intended to increase the awareness of the provider network of the requirement to schedule the aftercare appointments within 7 days and included in the patient information at discharge. ***Follow-up Status Response*** • This educational effort will impact provider and member awareness and can indirectly influence an increase in follow up rates, but this intervention is not directly measureable and may be confounded by other factors. • Continued measurement and monitoring through annual audits will help increase the provider documentation process for scheduling aftercare within 7 days • Additionally the Value Added Provider Newsletter with DMP information was distributed in early 2016
Action (2) • A pilot has started in Beaver and Greene Counties with members discharged from acute inpatient care and can not be reached by phone.	October 2015 Ongoing action - daily Quarterly reporting	***Initial Response*** • Each member discharged will receive a letter and brochure as part of a toolkit regarding the importance of following up with an aftercare appointment and the importance of staying on discharge medications. Also included is VBH-PA contact and website information. This additional intervention was added to the current protocol of contacting all members by phone after discharge from acute care by the Aftercare Coordinator  Aftercare Letter.docx  After Discharge Brochure.pub ***Follow-up Status Response*** • Aftercare Coordinator continue to mail a letter and brochures after phone

Action Plan: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)		
		call attempt.15 of the 140 letters sent were returned as undeliverable (10.7%). For Greene County 31 members were called for aftercare and 120 members in Beaver County were called. Each was followed up with a letter and brochure (attached above) reminding the member about the importance of follow up after discharge with suggestions to maintain a recovery plan for wellness. Effectiveness of interventions will be seen in reduced readmissions to the hospital and individual member adherence to aftercare recommendations.  Aftercare data.docx
Action (3) • Increase the number of psychiatrists within the network to increase member access for timely medication management.	April 2016 ongoing	***Initial Response*** • Efforts have begun within VBH-PA to develop strategies to increase the number of psychiatrists within the network. This is being led by senior VBH-PA management. Associated measurements have not been determined.. ***Follow-up Status Response*** • Providers are seeking to fill the gap with using locum tenems while actively recruiting to hire full time psychiatrists. (Cambria County) • VBH-PA CEO is coordinating outreach to recruit psychiatrists in 2016 through provider collaboration.
Action (4) • All discharges members are routinely contacted by phone after VBH is notified that a member has been discharged from the hospital. (non-pilot counties)	Each business day	***Initial Response*** • The aftercare appointment is confirmed with the member or an offer is made by the aftercare coordinator to assist in scheduling follow up for a missed appointment. (3 phone attempts) ***Follow-up Status Response***
Action (5) • 'LIVEWIRE' will use SMS technology to send appointment reminders to VBH-PA members who have been recently discharged from MH/SA acute care. It will include the provider contact information and ask if they kept the appointment. The aftercare coordinator will be notified if they did not keep appointment for additional follow up.	Projected for 4th quarter 2016	***Initial Response*** Required items to bring program to scale: • 50% of SMS messages sent to the member receive a response • Aftercare adherence rates will increase from baseline rates (2015 HEDIS) (prior to SMS technology intervention date) ***Follow-up Status Response*** • This intervention has not been implemented due to the initial investment; however, discussions are being held for cost sharing at this time. Once this

Action Plan: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)		
Project Charter-LifeWIRE.pdf		barrier is resolved, the project will proceed in 2016.
Action (6) • All Inpatient providers were encouraged to complete a self-audit based on the discharge management plan requirements of the statewide PIP. • Results to be distributed to each participating provider in 2016 • Engage those providers with poor scores to discuss their outcomes and develop strategies for improvement.	Self-audit completed in 2015 Providers notified May 2016	***Initial Response*** • In 2015, all providers have received a copy of the DMP tool and have been asked to complete a self-audit and submit results to VBH-PA. ***Follow-up Status Response*** • Twenty providers voluntarily participated • As providers incorporate new documentation requirements, the member will have accurate follow up information upon discharge. Self audit results.docx result letter to self audit providers v2.do
Action (7) • VBH-PA QM Manager met with the four pilot hospitals during the 4th quarter 2015 and reinforced the expectation that follow up appointments must be made for the patient by hospital staff prior to the member's discharge. • The need for barriers identification for the member's attendance at a follow up appointment was reinforced with the hospital BH Directors in February 2016. • Barriers should be discussed with the patient and documented in the patient chart by the social worker or staff in charge of the member's discharge plan. • Continuing education of the member and provider will improve barrier identification and discussion of solutions	November 2015 February 2016	***Initial Response*** • A low percentage of the 120 records reviewed (8%) as part of the statewide Performance Improvement Project had documentation for FUH barrier identification. ***Follow-up Status Response*** • Barrier identification results from 2016 DMP Pilot hospital audits: Increased to 36%, up from previous 8% for the four pilot hospitals
Action (8) • Promoting the use of Telepsychiatry has continued from previous years by six counties and VBH-PA. This will increase the number of members receiving psychiatric services despite the documented shortage of psychiatrists in Western PA.	New Program approved in May 2016	***Initial Response*** • Comparison of FY 2013-14 with FY 2014-15 showed an 18 percent increase in the number of distinct members receiving telepsychiatry services and a 9 percent increase in costs. The average units per member remained relatively the same. There are 5 providers serving 4 county contracts. A provider in Greene and Indiana Counties have increased the number of members served and one new provider was added in Fayette County in FY 14-15.

Action Plan: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)		
		Follow-up Status Response
		• Telepsychiatry claims data has shown a member increase from CY 2014 to CY 2015 specifically in Fayette and Lawrence counties that are receiving services. This has resulted in an 8.1 percent increase from 1505 members in 2014 to 1628 members in 2015. • VBH has received a program request for telepsychiatry in Greene County, Westmoreland County and another program request was approved for Fayette County in 2016. • Increasing the number of telepsychiatry satellites will reduce the wait for psychiatric appointments and supplement the outpatient clinics ability to meet the 7 day access standard for HealthChoices members
• VBH-PA to consider making electronic discharge fields mandatory and will discuss with Data Analytics and Development for feasibility of these data entry changes	September 2016	***Initial Response***
		• Department leadership will collaborate Informatics and Data analytics feasibility of system enhancements during the third quarter 2016
		Follow-up Status Response

Table 19: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years

RCA: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)		
Instructions: **For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.**		
Managed Care Organization (MCO): *Value Behavioral Health (VBH)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)*	***Response Date:*** 7/29/16
Goal Statement: (Please specify individual goals for each measure): Short term Goal: Improve the 30 day FUH rate by 2 percent to 73.7 %. Long term Goal: Improve the 30 day FUH rates above the 75th percentile.		
***Analysis*:** **What factors contributed to poor performance?** **Please enter "N/A" if a category of factors does not apply.**	***Findings***	
Policies (1) (e.g., data systems, delivery systems, provider facilities) • Beacon Health Options corporate accuracy of the information for provider affiliations • Providers do not report changes in their provider status in a timely fashion, such as 'Is the provider taking Medicaid patients?', 'Is the therapist still practicing at a certain location?'	***Initial Response*** • Private therapist vs. facility is not always correct in the referral portion of CareConnect and causes inconvenience for the member when they call for a referral and the care manager giving out incorrect information • VBH will form an internal workgroup to discuss actions to improve to correctness of referral information. ***Follow-up Status Response***	
People (1) (e.g., personnel, provider network, patients) • Patient not consistently included in the formulation of the discharge plan such as availability of the aftercare appointment Patients are not familiar with support services that are available in the community that would contribute to successful recovery.	***Initial Response*** • A low percentage of the 120 records reviewed (8%) as part of the statewide Performance Improvement Project had documentation for FUH barrier identification. ***Follow-up Status Response*** • Barrier identification results from 2016 DMP Pilot hospital audits: Increased to 36%, up from previous 8% for the four pilot hospitals	
People (2) (e.g., personnel, provider network, patients) • Patient's current providers are not consistently notified of their patient's admission or discharge in a timely manner and are unable to participate in the formulation of the discharge plan	***Initial Response*** • CFST focus groups have reported that their established treatment providers are not consulted during their inpatient care by the hospital. • Chart documentation reviewed during DMP audits in 2015 and 2016 support patient's comments that their provider is not routinely notified of admission. • VBH-PA routinely notifies the county contact of the member's admission to inpatient ***Follow-up Status Response***	
People (3) (e.g., personnel, provider network, patients)	***Initial Response*** • Discharge Notification by the provider to VBH in bundle format causes delays in the notification	

RCA: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)	
• Hospital can notify VBH of recent discharges in a bundle which can delay data entry by VBH Continued Stay Reviewers and can delay aftercare contacts.	of the member for aftercare follow up. Aftercare is not notified until the discharge information is manually entered into the CareConnect system. An automatic inquiry is generated in the aftercare queue notifying aftercare coordinator to contact a discharge member. ***Follow-up Status Response***
Complete next page of corresponding action plan.	

Action Plan: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2015. 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) • Case Management providers in Cambria, Fayette, Beaver, Butler, Armstrong, Greene and Lawrence counties are notified by VBH-PA of their daily inpatient census of Health Choices members as well as those that have Case Managers. These providers in turn, depending on their internal process, notify the community liaison, Assertive Community Treatment (ACT) or other providers of recent admissions of their current clients. • VBH-PA expects case management providers notified of an inpatient admission, to collaborate with the identified member's support system and to contact the inpatient unit within 1 day following receipt of notifications to provide collaborative information to expedite the discharge planning process with the member's support system and outpatient treatment teams	September 2015 Ongoing Semi- annual	***Initial Response*** • Measuring the Blended Case Managers encounters with members within 7 & and 30 days of discharge can indicate opportunities to provide the assistance needed for treatment adherence for the member. • Annual measurement of: - number of discharges with BCM services - number of members with BCM claims within 30 days of those discharges. ***Follow-up Status Response*** • Initial baseline data for 2015 - 89- number of discharges with case management services - 81- number of members with case management claims within 30 days of discharge • This will be measured semi-annually to measure improvements.
Action (2) • VBH-PA implemented a tiered care management system in Beaver, Cambria, Washington and Greene Counties since March 2014 targeting members with higher than average utilization patterns for	Started March 2014. Program is ongoing	***Initial Response*** • A formalized way to track member's level of participation in the VRC program and outcomes based on utilization of services has been developed. Data analysis will be completed in the 4th Quarter 2015.

Action Plan: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)		
BH services. One of interventions includes the **Value Recovery Coordinator** (VRC) establishing a collaborative relationship with members identified needing additional support. • This enhanced level of intervention will assist in increasing member's engagement in aftercare, through motivational interviewing techniques, education about the importance of keeping medication and therapy appointments, screenings (SF12, PHQ9) and incorporating recovery principles in the conversations. The frequency of VRC contact is based on need and the member's level of readiness for change. This Care Plan is used at each VRC intervention. • If the member misses the 30 day appointment after discharge or other treatment appointments, and if the VRC at VBH-PA cannot reach the member, the VRC at will reach out to other resources (such as BCM or current therapist). The BCM or other treatment providers can assist VRC with addressing the barrier for treatment adherence.	Semi-annual data reviewed in 2016	***Follow-up Status Response*** • Reductions in readmissions and improvements in member's FUH rates will help to determine the effectiveness of VRC. - Members referred to VRC due to high utilization of services - Members engaged by phone or face to face - Inpatient admissions and FUH rates of participants Value Rec Coord..docx
Action (3) • Continue to instruct **the Consumer/ Family Satisfaction teams** to provide member information pamphlets during satisfaction surveys as appropriate to address the need for family and community support services information. • **Educate members** about who is VBH-PA and what we can do for them as their insurance company.	2014 and 2015 data reviewed Data prepared annually May 2016	***Initial Response*** Effectiveness of interventions can be measured in improvement of CFST satisfaction data**.** • 2014 Consumer Family Satisfaction Team (CFST) data for inpatient level of care is below 85% in six Counties for the question "Has your provider made you aware of the support services available in your community?" Continue to monitor these counties for improvements through the Quality Management Committee (QMC) and request committee member feedback • 2014 Consumer Family Satisfaction Team (CFST) data for inpatient level of care is below 85% for the question, "Does your family get the education or support they need to be helpful to you?" For the eight counties that have been surveyed for this level of care in 2014, five counties are below the 85% standard. These counties will be monitored for improvement at the QMC. • Bring attention to these two questions at the CFST trainings scheduled in October 2015 for monitoring. Ask CFST surveyors to attempt to increase consumer surveys for inpatient satisfaction. 318 surveys were completed for inpatient level of care, goal is to increase by 10% or 31 additional surveys. Four of thirteen counties had less than 10 satisfaction surveys completed for inpatient satisfaction. The goal is for each CFS team to get at least 10 surveys. ***Follow-up Status Response*** • 2015 Consumer Family Satisfaction Team (CFST) data for inpatient level of care is below 85% in four of nine Counties (a small improvement) for the

Action Plan: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)		
		question "Has your provider made you aware of the support services available in your community?" • 2015 Consumer Family Satisfaction Team (CFST) data for inpatient level of care is below 85% for the question, "Does your family get the education or support they need to be helpful to you?" For the eight counties that have been surveyed for this level of care in 2015, six counties are below the 85% standard • The goal for the increase of CFST surveys was not met. There was a decrease in the number of surveys in 2015 to 244 from 318 the previous year. Barriers for collecting surveys involve accessibility of members during and after discharge for the CFST surveyors. • The CFST teams give the member contact information for the member to call VBH-PA to inquire about support services or education about recovery. CFST also instruct member about the VBH—PA website where aftercare information can be downloaded. (See below) • These data were reviewed with CFST surveyors at the semi-annual training May 2016 • Many additional member resources are made available on the member section of the VBH-PA website http://www.vbh-pa.com/  About_VBH-PA.pdf  A_Visit_with_a_Psychiatrist.pdf
eAction (4) • Other opportunities for **member education** come through the various Member and Family Forums held each year where members can talk with providers and learn about community services and the annual Member Newsletter. • VBH-PA continues to be active in various venues through the **Provider Relations department** staff who provides Health Choices information to assist members learn about provider or community based support services. • Members can access the Member's Directory and Resource Guide specific to their county.	Four forums held annually for member education Annual mailings Second Quarter 2016	***Initial Response*** • Opportunities for Member Education to learn about various community services in 2015 • 281,000 Member newsletters were mailed (Words of Wellness) • Four Annual Consumer/Family Recovery Forums are attended by Health Choices members, County representatives, and providers • Newsletter contains consumer information for Recovery and Consumer Satisfaction Survey information  2016-Member-Newsletter.pdf  County_Provider_Directory.pdf

Action Plan: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)		
		Follow-up Status Response
Action (5) • Update care connect referral data. Department leadership will collaborate Informatics and Data analytics feasibility of system enhancements during the third quarter 2016 for process changes • Implement policy regarding receipt of bundled discharged information from the provider. • Encourage providers to use electronic discharge information screens in Provider Connect. • These policy and procedure changes can improve internal VBH information flow.	Third Q 2016 Ongoing process	***Initial Response*** • CareConnect referral information used by the VBH–PA care manager that designates Private therapist vs. facility is not always correct and causes inconvenience for the member when they call for a referral and the care manager giving out incorrect information • Discharge Notification faxed by the provider to VBH in bundle format causes delays in the notification of the member for aftercare follow up. Aftercare is not notified until the discharge information is manually entered into the CareConnect system. Then, an automatic inquiry is generated in the aftercare queue for the coordinator to place the phone call to the member. • Effectiveness can be observed in the reduction of delayed notifications of Aftercare coordinators. • Eliminate incomplete electronic discharge information from the provider ***Follow-up Status Response***

VI: 2016 Strengths and Opportunities for Improvement

The review of VBH's 2016 (MY 2015) performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH-MCO.

Strengths

- VBH's rate for the MY 2015 7-Day Follow-up After Hospitalization for Mental Illness – HEDIS Indicator for the total population (QI 1) was statistically significantly higher than the MY 2015 HealthChoices BH-MCO Average of 44.9% by 1.3 percentage points.
- VBH's rate for the MY 2015 30-Day Follow-up After Hospitalization for Mental Illness – HEDIS Indicator for the total population (QI 2) was statistically significantly higher than the MY 2015 HealthChoices BH-MCO Average of 65.4% by 4.4 percentage points.
- VBH's rate for the MY 2015 30-Day Follow-up After Hospitalization for Mental Illness – PA-specific Indicator (QI B) was statistically significantly higher than the MY 2015 HealthChoices BH-MCO Average of 72.7% by 2.5 percentage points.
- VBH's rate for the MY 2015 Readmission Within 30 Days of Inpatient Psychiatric Indicator was statistically significantly lower than the MY 2015 HealthChoices BH-MCO Average of 14.0% by 2.3 percentage points.
- VBH's rate for the MY 2015 Initiation of AOD Treatment performance measure was statistically significantly higher than the MY 2015 HealthChoices BH-MCO Average of 27.2% by 1.5 percentage points.
- VBH's rate for the MY 2015 Engagement of AOD Treatment performance measure was statistically significantly higher than the MY 2015 HealthChoices BH-MCO Average of 18.7% by 3.1 percentage points.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2013, RY 2014, and RY 2015 found VBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
    - VBH was partially compliant with one out of seven categories within Subpart C: Enrollee Rights and Protections. The partially compliant category is Enrollee Rights.
    - 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 Continuity of Care 3) Coverage and Authorization of Services 4) Practice Guidelines 5) Quality Assessment and Performance Improvement Program.
    - VBH was partially compliant on nine out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.
- VBH did not meet the OMHSAS designated performance goal of 10.0% for the Readmission Within 30 Days of Inpatient Psychiatric Indicator.
- VBH's rates for the MY 2015 Follow-up After Hospitalization for Mental Illness HEDIS Follow-up indicators (QI 1 and QI 2) for ages 6-64 did not meet the OMHSAS interim goals for MY 2015, nor did they achieve the goal of meeting or exceeding the 75th percentile.

Performance Measure Matrices

The Performance Measure (PM) Matrices provide a comparative look at quality indicators (QIs) included in the External Quality Review (EQR) evaluation for Quality Performance of the HealthChoices BH-MCO. The 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 as described in **Table 20**.

Table 20: BH-MCO Performance and HEDIS Percentiles

Color Code	Definition
	PA-specific Follow-up After Hospitalization Measures: Indicates that the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Indicates that the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014. **HEDIS Follow-up After Hospitalization Measures– Ages 6–64:** At or above 90th percentile. BH-MCOs may have internal goals to improve.
	PA-specific Follow-up After Hospitalization Measures: Either the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014 or that the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average but there is no change from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014 or that the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average but there is no change from MY 2014. **HEDIS Follow-up After Hospitalization Measures– Ages 6–64:** At or above 75th and below 90th percentile. BH-MCOs may identify continued opportunities for improvement.
	PA-specific Follow-up After Hospitalization Measures: The BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014 or the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average but trends down from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** The BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014 or the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average but trends up from MY 2014. **HEDIS Follow-up After Hospitalization Measures– Ages 6–64**: N/A No action is required although MCOs should identify continued opportunities for improvement.
	PA-specific Follow-up After Hospitalization Measures: Either the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or that the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or that the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014. **HEDIS Follow-up After Hospitalization Measures– Ages 6–64:** At or above 50th and below 75th percentile. A root cause analysis and plan of action is required.
	PA-specific Follow-up After Hospitalization Measures: the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014. **HEDIS Follow-up After Hospitalization Measures – Ages 6–64**: At or below the 50th percentile. A root cause analysis and plan of action is required.

Table 21 is a three-by-three matrix depicting the horizontal comparison between the BH-MCO's performance and the applicable HealthChoices BH-MCO Average. When comparing a BH-MCO's rate to the HealthChoices BH-MCO Average for each indicator, the BH-MCO rate can be above average, equal to the average or below average. Whether or not a BH-MCO performed statistically significantly above or below average is determined by whether or not that BH-MCO's 95% confidence interval for the rate included the HealthChoices BH-MCO Average for the specific indicator.

Table 21: Performance Measure Matrix

Year to Year Statistical Significance Comparison	Trend	HealthChoices BH-MCO Average Statistical Significance Comparison		
		Below / Poorer than Average	Average	Above / Better than Average
	⬆	C	B	A
	No Change	D	C	B FUH QI B REA[1]
	⬇	F	D FUH QI A	C

[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: A: Performance is notable. No action required. BH-MCOs may have internal goals to improve. B: No action required. BH-MCOs may identify continued opportunities for improvement. C: No action required although BH-MCOs should identify continued opportunities for improvement. D: Root cause analysis and plan of action required. F: Root cause analysis and plan of action required.
Color Key: See **Table 20.**
FUH QI A: Follow-up After Hospitalization for Mental Illness (PA-Specific 7-Day); FUH QI B: Follow-up After Hospitalization for Mental Illness (PA-Specific 30-Day); REA: Readmission Within 30 Days of Inpatient Psychiatric Discharge

Table 22 represents the BH-MCO's performance for each measure in relation to prior year's rates for the same indicator for MY 2011 to MY 2015. The BH-MCO's rate can be statistically significantly higher than the prior year's rate (▲), have no change from the prior year, or be statistically significantly lower than the prior year's rate (▼). For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the Z-ratio. A Z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

Table 22: Performance Measure Rates

Quality Performance Measure	MY 2012 Rate	MY 2013 Rate	MY 2014 Rate	MY 2015 Rate	MY 2015 HC BH-MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)	55.5% =	56.4% =	57.6% =	55.7% ▼	55.8%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)	75.3% =	75.9% =	76.6% =	75.2% =	72.7%
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	9.9% =	11.4% =	12.1% =	11.7% =	14.0%

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

Table 23: HEDIS Follow-up After Hospitalization 7-Day/30-Day Performance Measure Matrix: Ages 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. These rates may differ slightly from the overall rate.
FUH QI 1: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day); FUH QI 2: Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)

Table 24 illustrates the rates achieved compared to the HEDIS 75th percentile goal. Results are not compared to the prior year's rates.

Table 24: HEDIS Follow-up After Hospitalization 7-Day/30-Day Performance Measure Rates Ages 6–64 Years

Quality Performance Measure	MY 2015		HEDIS MY 2015 Percentile
	Rate[1]	Compliance	
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day)	46.5%	Not Met	Below 75th and at or above 50th percentile
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	70.2%	Not Met	Below 75th and at or above 50th percentile

[1] Rates shown are for ages 6–64 years. These rates are slightly higher than the overall rate.

Table 25 summarizes the key points based on the findings of the performance measure matrix comparisons.

Table 25: Key Points of Performance Measure Comparisons

A – Performance is notable. No action required. BH-MCOs may have internal goals to improve.
• No VBH performance measure rate fell into this comparison category.
B – No action required. BH-MCO may identify continued opportunities for improvement.
• Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day) • Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]
C – No action required although BH-MCO should identify continued opportunities for improvement.
• No VBH performance measure rate fell into this comparison category.
D – Root cause analysis and plan of action required.
• Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day) • Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day – 6 to 64 years) • Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day – 6 to 64 years)
F – Root cause analysis and plan of action required.
• No VBH performance measure rate fell into this comparison category.

[1] 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.

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 2015, RY 2014, and RY 2013 were used to make the determinations.

Performance Improvement Projects

- VBH submitted a Year 1PIP Update in 2016. VBH participated in quarterly meetings with OMHSAS and IPRO throughout 2016 to discuss ongoing PIP activities.

Performance Measures

- VBH reported all performance measures and applicable quality indicators in 2016.

2015 Opportunities for Improvement MCO Response

- VBH provided a response to the opportunities for improvement issued in 2015.

2016 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for VBH in 2016. The BH-MCO will be required to prepare a response for the noted opportunities for improvement in 2017.

Appendices

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

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by 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 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

BBA Category	PEPS Reference	PEPS Language
		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).
	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 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.

BBA Category	PEPS Reference	PEPS Language
§438.210 Coverage and authorization of services	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 72.1	Denial notices are issued to members 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).
§438.2104 Provider Selection	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as, other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for: 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	Standard 91.1	QM program description outlines ongoing quality assessment, performance improvement activities, a continuous quality improvement process, and places

BBA Category	PEPS Reference	PEPS Language
assessment and performance improvement program		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 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 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,

BBA Category	PEPS Reference	PEPS Language
		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.
§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
	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 b 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

BBA Category	PEPS Reference	PEPS Language
		• 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.
	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 • 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

BBA Category	PEPS Reference	PEPS Language
		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 action	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 72.1	Denial notices are issued to members according to required timeframes and use the

BBA Category	PEPS Reference	PEPS Language
		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
	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

BBA Category	PEPS Reference	PEPS Language
		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
	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;

BBA Category	PEPS Reference	PEPS Language
		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
	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	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

BBA Category	PEPS Reference	PEPS Language
MCO or PIHP appeal and the State fair hearing are pending		• 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).
§438.424 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).

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Standard 108.2	C/FST budget is sufficient to: hire staff proportionate to HC covered lives, has adequate office space, purchase equipment, travel and attend on-going training.
	Standard 108.5	The C/FST has access to providers and HC members to conduct surveys and employs of a variety of survey mechanisms to determine member satisfaction e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Standard 108.6	The problem resolution process specifies the role of the County, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
	Standard 108.7	The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
	Standard 108.8	The Annual Mailed/Telephonic survey results are representative of HC membership, identify systemic trends and actions have been taken to address areas found deficient, as applicable.
	Standard 108.10	The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.
§438.206 Availability of Service	Standard 1.1	• 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.

BBA Category	PEPS Reference	PEPS Language
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).
	Standard 1.5	BH-MCO has notified DPW of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 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 was 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 was provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational/vocational status and Changes in living status.
§438.208 Coordination and Continuity of Care	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.210 Coverage and	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.

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

BBA Category	PEPS Reference	PEPS Language
improvement program		source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines, the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services, provider network adequacy, penetration rates, appropriateness of service authorizations, inter-rater reliability, complaint, grievance and appeal process, denial rates, grievance upheld and overturn rates and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other HV/HR services).
	Standard 91.8	The QM work plan includes monitoring activities conducted to evaluate the quality and performance of the provider network (quality of individualized service plans and treatment planning, adverse incidents, collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance).
	Standard 91.9	The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	The QM work plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator for : ---Mental Health ---Substance Abuse External Quality Review: ---Follow up After Mental Health Hospitalization QM Annual Summary Report
	Standard 91.11	The identified Performance Improvement Projects must include the following: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality. 3. Evaluation of the effectiveness of the interventions. 4. Planning and initiation of activities for increasing or sustaining improvement. 5. Timeline for reporting status and results of each project to DPW. 6. Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year.
	Standard 91.12	The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.
	Standard 91.13	The BH-MCO has a process for its own evaluation of the impact and effectiveness of its quality management program annually. A report of this evaluation will be submitted to DPW by April 15th.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates,

BBA Category	PEPS Reference	PEPS Language
		Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational/vocational status and Changes in living status.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH-MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for Coordination with Other Service Agencies and School.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
§438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External

BBA Category	PEPS Reference	PEPS Language
		• Expedited
	Standard 71.2	100% of grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing

BBA Category	PEPS Reference	PEPS Language
		• 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing

BBA Category	PEPS Reference	PEPS Language
		• 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 decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.408 Resolution and notification: Grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

BBA Category	PEPS Reference	PEPS Language
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.410 Expedited resolution of appeals	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • 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

BBA Category	PEPS Reference	PEPS Language
		where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.414 Information about the grievance system to providers and subcontractors	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External
	Standard 71.1	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 and the State fair hearing are pending	Standard 71.1	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 in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.424 Effectuation of reversed appeal resolutions	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External • Expedited

BBA Category	PEPS Reference	PEPS Language
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

Appendix B: OMHSAS-Specific PEPS 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 **Appendix AA** 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		
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

Category	PEPS Reference	PEPS Language
		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 2015, 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 Items, along with the relevant categories.

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

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2015	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	Not Reviewed
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)	4	0	4	0	0
Grievances and State Fair Hearings (Standard 71)	4	0	4	0	0
Denials					
Denials (Standard 72)	1	1	0	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	3	0	0	0

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 on selected ongoing OMHSAS-specific monitoring standards.

Findings

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 2014. VBH partially met the criteria for compliance on 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	Status by HC BH Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Standard 27.7	RY 2014		All HC BH Contractors	
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	RY 2014		All HC BH Contractors	

PEPS Standard 27: Care management staffing is sufficient to meet member needs. Appropriate supervisory staff, including access to senior clinicians (peer reviewers, physicians, etc.) is evident.

VBH partially met the criteria for compliance on Substandard 27.7 (RY 2014).

Substandard 27.7: Other: Significant onsite review findings related to Standard 27.

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

VBH partially met the criteria for compliance on Substandard 28.3 (RY 2014).

Substandard 28.3: Other: Significant onsite review findings related to Standard 28.

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO and HC BH Contractor-specific review standards. Eight substandards were evaluated for all HC BH Contractors during RY 2014. Fayette was reviewed for eight substandards, met three substandards, partially met one substandard, and did not meet four substandards. Greene was reviewed for six substandards, met three substandards, partially met one substandard, and did not meet two substandards. The remaining HC BH Contractors were reviewed for seven substandards, met three substandards, partially met one substandard, and did not meet three 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	Status by HC BH Contractor			
			Met	Partially Met	Not Met	Not Reviewed
Second Level Complaints and Grievances						
Complaints	Standard 68.1	RY 2014			Fayette	Beaver, Cambria, NWBHP, Greene, Armstrong-Indiana, Butler, Lawrence, Washington, Westmoreland
	Standard 68.6	RY 2014	All HC BH Contractors			
	Standard 68.7	RY 2014	All HC BH Contractors			
	Standard 68.8	RY 2014			All HC BH Contractors	
Grievances and State Fair Hearings	Standard 71.1	RY 2014			Beaver, Cambria, NWBHP, Fayette, Armstrong-Indiana, Butler, Lawrence, Washington, Westmoreland	Greene
	Standard 71.5	RY 2014			All HC BH Contractors	
	Standard 71.6	RY 2014	All HC BH Contractors			
	Standard 71.7	RY 2014		All HC BH Contractors		

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.

Nine HC BH Contractors were not reviewed for county-specific Substandard 68.1 in RY 2014. Fayette was reviewed for and did not meet the criteria of county-specific Substandard 68.1:

> **Substandard 68.1:** Where applicable there is evidence of county oversight and involvement in the second level complaint process.

None of the VBH HC BH Contractors met the criteria for compliance for Substandard 68.8:

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

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

Greene was not reviewed for Substandard 71.1 in RY 2014. The remaining HC BH Contractors (Beaver, Cambria, NWBHP, Fayette, Armstrong-Indiana, Butler, Lawrence, Washington, and Westmoreland) did not meet the criteria for compliance for county-specific Substandard 71.1:

> **Substandard 71.1:** Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.

None of the VBH HC BH Contractors met the criteria for compliance for Substandard 71.5:

> **Substandard 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.

All of the VBH HC BH Contractors partially met the criteria for compliance for Substandard 71.7:

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

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2015. 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	Status
Denials			
Denials	Standard 72.3	RY 2015	Met

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 2014. County-specific Substandard 78.5 was not reviewed for NWBHP, Armstrong-Indiana, Butler, Lawrence, Washington or Westmoreland during RY 2014. The remaining four contractors were reviewed for and found compliant with

Substandard 78.5. VBH was reviewed for and met the criteria of Substandard 86.3. The status for these substandards is presented in **Table C.5**.

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

Category	PEPS Item	Review Year	Status By HC BH Contractor	
			Met	Not Reviewed
Care Management				
County Executive Management	Standard 78.5	RY 2014	Beaver, Cambria, Fayette, Green	NWBHP, Armstrong-Indiana, Butler, Lawrence, Washington, Westmoreland
BH-MCO Executive Management	Standard 86.3	RY 2014	All HC BH Contractors	

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, 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	Status by HC BH Contractor	
			Met	Partially Met
Second Level Complaints and Grievances				
Consumer/Family Satisfaction	Standard 108.3	RY 2015	All VBH HC BH Contractors	
	Standard 108.4	RY 2015	All VBH HC BH Contractors	
	Standard 108.9	RY 2015	All VBH HC BH Contractors	

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