



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

**2012 External Quality Review Report  
Value Behavioral Health  
FINAL REPORT**

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## GLOSSARY OF TERMS

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<b>Average</b> (i.e., arithmetic mean or mean)	The sum of all items divided by the number of items in the list. All items have an equal contribution to the calculation; therefore, this is un-weighted.
<b>Confidence Interval</b>	Confidence 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.
<b>HealthChoices Aggregate Rate</b>	The sum of all behavioral health (BH) managed care organization (MCO) numerators divided by the sum of all BH MCO denominators.
<b>HealthChoices BH MCO Average</b>	The sum of the individual BH MCO rates divided by the total number of BH MCOs (five BH MCOs). Each BH MCO has an equal contribution to the HealthChoices BH MCO Average value.
<b>HealthChoices County Average</b>	The sum of the individual County rates divided by the total number of Counties (67 Counties). Each County has an equal contribution to the HealthChoices County Average value.
<b>Rate</b>	A proportion indicated as a percentage of members who received services out of the total population of identified eligible members.
<b>Percentage Point Difference</b>	The arithmetic difference between two rates.
<b>Weighted Average</b>	Similar to an arithmetic mean (the most common type of average), where instead of each of the data points contributing equally to the final average, some data points contribute more than others.
<b>Statistical Significance</b>	A result that is unlikely to have occurred by chance. The use of the word significance in statistics is different from the standard one, which suggests that something is important or meaningful.
<b>Z-ratio</b>	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

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### Purpose and Background

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

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

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

The 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 Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2012 EQRs for the HealthChoices Behavioral Health (BH) MCOs and to prepare the technical reports. This technical report includes six core sections:

- I: Structure and Operations Standards
- II: Performance Improvement Projects
- III: Performance Measures
- IV: 2011 Opportunities for Improvement - MCO Response
- V: 2012 Strengths and Opportunities for Improvement
- VI: 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 conducted by OMHSAS of the BH MCOs against the Commonwealth's Program Evaluation Performance Summary (PEPS) review tools and/or Readiness Assessment Instrument (RAI), as applicable.

Information for Sections II and III of this report is derived from IPRO's validation of each BH MCO's performance improvement projects (PIPs) and performance measure submissions. Performance measure validation as conducted by IPRO includes two performance measures – Follow-up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge.

Section IV, 2011 Opportunities for Improvement – MCO Response, includes the BH MCO's responses to opportunities for improvement noted in the 2011 EQR Technical Report, and presents the degree to which the BH MCO addressed each opportunity for improvement.

Section V has a summary of the BH MCO's strengths and opportunities for improvement for this review period (2011) as determined by IPRO, and a "report card" of the BH MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HealthChoices Behavioral Health Managed Care Organization.

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



## I: STRUCTURE AND OPERATIONS STANDARDS

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This section of the EQR report presents a review by IPRO of the BH MCO Value Behavioral Health's (VBH's) compliance with the structure and operations standards. In Review Year (RY) 2011, 66 PA Counties participated in this compliance evaluation.

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

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

Beaver, Fayette, Greene, and an alliance of Armstrong, Butler, Indiana, Lawrence, Washington and Westmoreland Counties called the Southwest Behavioral Health Management, Inc. hold contracts with VBH. Four North/Central County Option (NC/CO) Counties – Cambria, Crawford, Mercer and Venango – also hold contracts with VBH. Erie County held a contract with VBH through June 30, 2011 and contracted with another BH MCO as of July 1, 2011. While Medicaid managed care members may choose a Physical Health (PH) MCO for physical health care services, each HealthChoices enrollee is assigned a BH MCO based on his or her County of residence. IPRO's EQR is based on OMHSAS' reviews of VBH and the 13 Counties associated with the BH MCO.

### **Methodology**

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of VBH by OMHSAS monitoring staff within the past three years. These evaluations are performed at the BH MCO and County levels, and the findings are reported in OMHSAS' PEPS review tools for Review Year (RY) 2011. 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 Counties 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 2012 and entered into the PEPS tools as of October 2012 for RY 2011. Information captured within the PEPS tools informs this report. The PEPS tools are a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each County/BH MCO. Within each standard, the tool specifies the sub-standards or Items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional reviewer comments. Based on the tools, a County/BH MCO is evaluated against substandards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS' more rigorous monitoring criteria.



At the implementation of the PEPS tools in 2004, IPRO evaluated the standards in the tools and created a crosswalk to pertinent BBA regulations. For standards with substandards, all of the substandards within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the substandards required for fulfilling BBA requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS' ongoing monitoring. In the amended crosswalk, the supplemental substandards no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Substandards concerning first level complaints and grievances inform the compliance determination of the BBA categories relating to Federal & State Grievance Systems Standards. All of the PEPS Substandards concerning second level complaints and grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category. As was done for the prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The RY 2011 crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in Appendix A and B, respectively. The review findings for selected OMHSAS-specific Substandards are reported in Appendix C.

Because OMHSAS review of the Counties and their subcontracted BH MCOs expands 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 2011, RY 2010, and RY 2009 provided the information necessary for the 2012 assessment. Those standards not reviewed through the PEPS system in RY 2011 were evaluated on their performance based on RY 2010 and/or RY 2009 decisions, or other supporting documentation, if necessary. For those Counties that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed. Since Erie County contracted with two BH MCOs in 2011 and because all applicable standards were reviewed for both BH MCOs within the three-year time frame, Erie County's review findings for RY 2011, RY 2010 and RY 2009 were not included in the assessment of compliance for either BH MCO.

For VBH, this year a total of 159 Items were identified as being required for the evaluation of County/BH MCO compliance with the BBA regulations. In addition, 11 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS 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. Tables 1.1a and 1.1b provide a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of the VBH Counties against the Structure and Operations Standards for this report. In Appendix C, Tables C.1a and C.1b provide a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH MCO and associated Counties against other state-specific Structure and Operations Standards.



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

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

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	Not Reviewed*
Enrollee Rights	12	5	0	0	7
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	2	4	16	0
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	3	0	0	1
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	2	4	0	0
Quality Assessment and Performance Improvement Program	23	16	7	0	0
Health Information Systems	1	1	1	0	0
Statutory Basis and Definitions	11	10	0	0	1
General Requirements	14	13	0	0	1
Notice of Action	11	1	0	9	1
Handling of Grievances and Appeals	11	10	0	0	1
Resolution and Notification: Grievances and Appeals	11	10	0	0	1
Expedited Appeals Process	6	5	0	0	1
Information to Providers and Subcontractors	2	2	0	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	5	0	0	1
Effectuation of Reversed Resolutions	6	5	0	0	1

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



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

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	Not Reviewed*
<b>Subpart C: Enrollee Rights and Protections</b>					
Enrollee Rights	12	5	0	7	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
<b>Subpart D: Quality Assessment and Performance Improvement</b>					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	2	4	16	0
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	3	0	0	1
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	2	4	0	0
Quality Assessment and Performance Improvement Program	23	16	7	0	0
Health Information Systems	1	0	1	0	0
<b>Subpart F: Federal &amp; State Grievance Systems Standards</b>					
Statutory Basis and Definitions	11	10	0	0	1
General Requirements	14	13	0	0	1
Notice of Action	11	1	0	9	1
Handling of Grievances and Appeals	11	10	0	0	1
Resolution and Notification: Grievances and Appeals	11	10	0	0	1
Expedited Appeals Process	6	5	0	0	1
Information to Providers and Subcontractors	2	2	0	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	5	0	0	1
Effectuation of Reversed Resolutions	6	5	0	0	1

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

For RY 2011, nine categories, 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements were not directly addressed by the PEPS Substandards reviewed. As per OMHSAS' judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health Program's PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH MCOs. The category of Marketing Activities is Not Applicable because, as a result of the Centers for Medicare and Medicaid Services (CMS) HealthChoices waiver, DPW has been granted an allowance to offer only one BH MCO per County.



In evaluations prior to the 2008 report, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all Counties and BH MCOs based only on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. Beginning with the 2008 report, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories by OMHSAS. Hence, Solvency Requirement tracking reports, Encounter Monthly Aggregate Complaint/Grievance records (EMG) and Encounter Monthly Complaint/Grievance Synopsis records (MCG) were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

### **Determination of Compliance**

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

### **Format**

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

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

### **Findings**

For VBH and the 13 Counties associated with the BH MCO included in the structure and operations standards for RY 2011, 159 PEPS Items were identified as required to fulfill BBA regulations. The 13 Counties were evaluated on 150 PEPS Items during the review cycle. There were nine Items that were not scheduled or not applicable for evaluation for RY 2011.



## Subpart C: Enrollee Rights and Protections

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

**Table 1.2 Compliance with Enrollee Rights and Protections Regulations**

Enrollee Rights and Protections				
Subpart C: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Partial	Beaver, Fayette, Greene, Venango, Southwest Six	Cambria, Crawford, Mercer	12 substandards were crosswalked to this category.  Beaver, Greene, Fayette and Southwest Six Counties were evaluated on 5 substandards and compliant on 5 substandards.  Venango County was evaluated on 12 substandards, and compliant on 12 substandards.  Cambria, Crawford, Mercer Counties were evaluated on 12 substandards, compliant on 9 substandards and partially compliant on 3 substandards.
Provider-Enrollee Communications 438.102	Compliant	All VBH Counties		Compliant as per PS&R sections E.4 (p.49) and A.3.a (p.20).
Marketing Activities 438.104	N/A	N/A	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	All VBH Counties		Compliant as per PS&R sections A.9 (p.64) and C.2 (p.30).
Cost Sharing 438.108	Compliant	All VBH Counties		Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	All VBH Counties		Compliant as per PS&R section 3 (p.34).
Solvency Standards 438.116	Compliant	All VBH Counties		Compliant as per PS&R sections A.3 (p.59) and A.9 (p.66), and 2011-2012 Solvency Requirements tracking report.

There are seven categories within Enrollee Rights and Protections Standards. VBH was compliant on five categories, partially compliant on one category, and received a waiver for one category. Of the five



compliant categories, four were compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50-447.60. The category Solvency Standards was compliant based on the 2011-2012 Solvency Requirement tracking report, and the category Marketing Activities was waived and deemed Not Applicable.

Beaver, Fayette, Greene, Venango and the Southwest Six Counties were compliant on six categories of the Enrollee Rights and Protections Standards. The remaining 4 Counties (Cambria, Crawford and Mercer) were compliant on five categories.

Of the 12 PEPS substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated for Cambria, Crawford, and Mercer Counties and they were compliant on 9 substandards and partially compliant on 3 substandards. Venango County was evaluated on all 12 substandards, and compliant on 12 substandards. Beaver, Fayette, Greene, and the Southwest Six Counties were evaluated on 5 substandards and compliant on 5 Items. Some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

### **Enrollee Rights**

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

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

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

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

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

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

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

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

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

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



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

**Substandard 6:** The problem resolution process specifies the role of the County, BH MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.

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

## 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 County include an assessment of the County/BH MCO’s compliance with regulations found in Subpart D. Table 1.3 presents the findings by categories consistent with the regulations.

**Table 1.3 Compliance with Quality Assessment and Performance Improvement Regulations**

Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	MCO Compliance Status	By County		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Elements of State Quality Strategies 438.204	Compliant	All VBH Counties		Compliant as per PS&R section G.3 (p.53).
Availability of Services (Access to Care) 438.206	Partial		All VBH Counties	22 substandards were crosswalked to this category Each County was evaluated on 22 substandards, compliant on 19 substandards, partially compliant on 2 substandards and non-compliant on 1 substandard.
Coordination and Continuity of Care 438.208	Partial		All VBH Counties	2 substandards were crosswalked to this category Each County was evaluated on 2 substandards, partially compliant on 1 substandard and non-compliant on 1 substandard.
Coverage and Authorization of Services 438.210	Partial		All VBH Counties	4 substandards were crosswalked to this category Each County was evaluated on 3 substandards, partially compliant on 2 substandards and non-compliant on 1 substandard.



Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	MCO Compliance Status	By County		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Provider Selection 438.214	Compliant	All VBH Counties		3 substandards were crosswalked to this category.  Each County was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	All VBH Counties		Compliant as per PS&R sections D.2 (p.46), G.4 (p.55) and C.6.c (p.44).
Subcontractual Relationships and Delegation 438.230	Compliant	All VBH Counties		8 substandards were crosswalked to this category.  Each County was evaluated on 8 substandards and compliant on 8 substandards.
Practice Guidelines 438.236	Partial		All VBH Counties	6 substandards were crosswalked to this category.  Each County was evaluated on 6 substandards, compliant on 3 substandards, partially compliant on 2 substandards and non-compliant on 1 substandard.
Quality Assessment and Performance Improvement Program 438.240	Partial		All VBH Counties	23 substandards were crosswalked to this category.  The Southwest Six Counties (Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland) and Fayette County were evaluated on 23 substandards, compliant on 20 substandards and partially compliant on 3 substandards.  Beaver, Greene, NC/CO Counties (Cambria, Crawford, Mercer, and Venango) were evaluated on 23 substandards, compliant on 19 substandards and partially compliant on 4 substandards.
Health Information Systems 438.242	Compliant	All VBH Counties		1 substandard was crosswalked to this category.  Each County was evaluated on 1 substandard and compliant on this substandard.

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

For this review, 69 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations for all 13 Counties associated with VBH, and each County was evaluated on 68 items. There was one item that was not scheduled or not applicable for evaluation for RY 2011. The



Southwest Six Counties (Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland) were evaluated on 68 Items, compliant on 54 Items and partially compliant on 10 Items and non-compliant on 4 Items. Fayette, Beaver, Greene, NC/CO Counties (Cambria, Crawford, Mercer, and Venango) were evaluated on 68 Items, compliant on 53 Items and partially compliant on 11 substandards and non-compliant on 4 Items. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

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

All 13 Counties associated with VBH were partially compliant with Availability of Services due to partial or non-compliance with substandards of PEPS Standards 28 and 93.

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

**All of the VBH Counties** were non-compliant on one substandard of Standard 28: Substandard 1 RY 2011).

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

**All of the VBH Counties** were partially compliant on one substandard of Standard 28: Substandard 2 (RY 2011).

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

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

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

**Substandard 4:** The BH MCO reports monitoring results for Treatment Outcomes: readmission rates, follow up after hospitalization rates, consumer satisfaction, changes in employment/educational/vocational status and changes in living status.

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

All 13 Counties 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. See Standard description, and partially and non-compliant substandard determinations under Availability of Services (Access to Care) on pages 13-14 of this report.

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

All 13 Counties associated with VBH were partially compliant with Coverage and Authorization of Services due to partial or non-compliance with substandards of PEPS Standards 28 and 72.

**PEPS Standard 28:** See Standard description, and partially and non-compliant substandard determinations under Availability of Services (Access to Care) on pages 13-14 of this report.



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

**All of the VBH Counties** were partially compliant on one substandard of Standard 72: Substandard 1 (RY 2011).

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

### **Practice Guidelines**

All 13 Counties associated with VBH were partially compliant with Practice Guidelines due to partial or non-compliance with two substandards of PEPS Standard 28. For Standard 28, see description and partially and non-compliant substandard determinations under Availability of Services (Access to Care) on pages 13-14 of this report.

### **Quality Assessment and Performance Improvement Program**

All 13 Counties associated with VBH were partially compliant with Quality Assessment and Performance Improvement Program due to partial compliance with one substandard within PEPS Standard 93. See Standard 93's description and partially compliant substandard determination under Availability of Service (Access to Care) on page 14 of this report.

**Southwest Six Counties** were partially compliant on two substandards of Standard 91: Substandards 5 and 8 (RY 2011).

**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 process, denial rates, grievance upheld and overturn rates and treatment outcomes).

**Substandard 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).

**Fayette County was** partially compliant on two substandards of Standard 91: Substandards 5 and 8 (RY 2011).

**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 process, denial rates, grievance upheld and overturn rates and treatment outcomes).



**Substandard 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).

**Beaver, Greene, and NC/CO Counties** were partially compliant on three substandards of Standard 91: Substandards 5, 8 and 12 (RY 2011).

**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 process, denial rates, grievance upheld and overturn rates and treatment outcomes).

**Substandard 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).

**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 County/BH MCO's compliance with regulations found in Subpart F. Table 1.4 presents the findings by categories consistent with the regulations.

**Table 1.4 Compliance with Federal and State Grievance System Standards**

Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By County		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All VBH Counties	11 substandards were crosswalked to this category.  Each County was evaluated on 10 substandards, compliant on 2 substandards, partially compliant on 4 substandards and non-compliant on 4 substandards.
General Requirements 438.402	Partial		All VBH Counties	14 substandards were crosswalked to this category.  Each County was evaluated on 13 substandards, compliant on 5 substandards, partially compliant on 4 substandards and non-compliant on 4 substandards.



Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By County		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Notice of Action 438.404	Partial		All VBH Counties	11 substandards were crosswalked to this category.  Each County was evaluated on 10 substandards, compliant on 9 substandards, and partially compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All VBH Counties	11 substandards were crosswalked to this category.  Each County was evaluated on 10 substandards, compliant on 2 substandards, partially compliant on 4 substandards and non-compliant on 4 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All VBH Counties	11 substandards were crosswalked to this category.  Each County was evaluated on 10 substandards, compliant on 2 substandards, partially compliant on 4 substandards and non-compliant on 4 substandards.
Expedited Appeals Process 438.410	Partial		All VBH Counties	6 substandards were crosswalked to this category.  Each County was evaluated on 5 substandards, compliant on 1 substandard, partially compliant on 2 substandards and non-compliant on 2 substandards.
Information to Providers & Subcontractors 438.414	Partial		All VBH Counties	2 substandards were crosswalked to this category.  Each County was evaluated on 2 substandards, partially compliant on 1 substandard and non-compliant on 1 substandard.
Recordkeeping and Recording Requirements 438.416	Compliant	All VBH Counties		Compliant as per 2011 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.
Continuation of Benefits 438.420	Partial		All VBH Counties	6 substandards were crosswalked to this category.  Each County was evaluated on 5 substandards, compliant on 1 substandard, partially compliant on 2 substandards and non-compliant on 2 substandards.



Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By County		MCO Compliance Status
		Fully Compliant	Partially Compliant	
Effectuation of Reversed Resolutions 438.424	Partial		All VBH Counties	6 substandards were crosswalked to this category.  Each County was evaluated on 5 substandards, compliant on 1 substandard, partially compliant on 2 substandards and non-compliant on 2 substandards.

There are 10 categories in the Federal and State Grievance System Standards. VBH was compliant on one category and partially compliant on nine categories. The category Recordkeeping and Recording Requirements was compliant as per the 2011 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.

For this review, 78 substandards were crosswalked to Federal and State Grievance System Standards for all 13 Counties associated with VBH. Each County was evaluated on 70 substandards, compliant on 23 substandards, partially compliant on 24 substandards and non-compliant on 23 substandards. Eight substandards were not scheduled or not applicable for evaluation for RY 2011. 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 13 Counties associated with VBH were partially compliant with nine of the 10 categories (all but Recordkeeping and Recording Requirements) pertaining to Federal State and Grievance System Standards due to partial or non-compliance with substandards within PEPS Standards 68, 71 and 72.

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

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

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

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

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

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



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

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

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

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

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

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

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

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



## II: PERFORMANCE IMPROVEMENT PROJECTS

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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, primary contractors (i.e., the Counties), along with the responsible subcontracted entities (i.e., BH MCOs), are required to conduct a minimum of two focused studies per year. The Counties and BH MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, BH MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2012 for 2011 activities.

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

The 2012 EQR is the ninth review to include validation of PIPs. With this PIP cycle, all BH MCOs/Counties share the same baseline period and timeline. To initiate the PIP cycle in 2008, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, remeasurement, and sustained improvement. Direction was given to the BH MCOs/Counties with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness.

The BH MCOs are required by OMHSAS to submit their projects using the National Committee for Quality Assurance (NCQA™) Quality Improvement Activity (QIA) form, which is consistent with the CMS protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

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

### Validation Methodology

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

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

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



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

## Review Element Designation/Weighting

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

**Table 2.1 Review Element Scoring Designations and Definitions**

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

## Overall Project Performance Score

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

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

## Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred through 2011. At the time of the review, a project is reviewed for only the elements that are due, according to the PIP submission schedule. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule.

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

**Table 2.2 Review Element Scoring Weights**

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



Review Element	Standard	Scoring Weight
1S	Subsequent or modified Interventions Aimed at Achieving Sustained Improvement	5%
2S	Sustained Improvement	15%
<b>Total Sustained Improvement Score</b>		<b>20%</b>
<b>Overall Project Performance Score</b>		<b>100%</b>

## Findings

As per the timeline distributed by OMHSAS for this review period, BH MCOs were required to submit information for the review elements of Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement. VBH submitted the required elements of the FUH PIP for review.

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

### Follow-up After Hospitalization for Mental Illness

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

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

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



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

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

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

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

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



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

Remeasurement results calculated in 2011 for January 1, 2010 through December 31, 2010 were presented, with comparisons of MY 2010 rates against the baseline rates. Rates increased for all four indicators, and Demonstrable Improvement was achieved. QI 1 increased to 44.37%, QI 2 increased to 68.36%, QI A increased to 56.86%, and QI B increased to 76.26%. Although all rates remained below the OMHSAS benchmark of 90%, all exceeded the MCO's goals for remeasurement. VBH also analyzed results at the County level, indicating counties that did not show an increase on all indicators. VBH noted that its Quality Management Department has made continuing, sustained efforts to ensure that the issue of improving FUH rates remains an ongoing discussion with stakeholders and especially with county Quality Management Committee (QMC) membership. Data on FUH rates and services accessed within seven and 30 days of discharge were presented and discussed at the QMC meetings on a quarterly basis for three years running. As a result, several counties began or continued targeted efforts at improving their follow-up rates. Information on county-specific follow-up rates and services is presented at the county QMC meetings for discussion, feedback, and identification of action plans, as warranted.

VBH stated that the BH MCO's analysis of data on services accessed in 2010 appeared to provide evidence that several interventions/action plans relating to specific services were successful. VBH noted that these interventions continued as subsequent interventions, and updated intervention activities. VBH indicated that telepsychiatry, peer support, and blended case management services were expanded to more counties, and cited increases in the number of members accessing services. Additionally, the scope of the peer support program expanded to include more peer activity and specialization, additional education, and availability in housing units. Blended case management services were expanded to include more timely notification and coordination with members within the inpatient units. New interventions included an acute stabilization program to be used as a step-down program after inpatient hospitalization, and a mobile psychiatric nursing/medication management program to keep patients consistent with medication adherence through self-administration and eventual self-sufficiency.

VBH received full credit for the elements of the study evaluated that reflect activities in 2011 (Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement). As indicated by the DPW timeline, Sustained Improvement will be evaluated in 2013, based on activities conducted in 2012 to assess performance in 2011.

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

Review Element	Compliance Level	Scoring Weight	Final Points Score
1. Project Title, Type, Focus Area	Full	5%	5
2. Topic Relevance	Full	5%	5
3. Quality Indicators	Full	0%	0
4. Baseline Study and Analysis (Calendar Year (CY) 2008, reported in CY 2009)	Full	20%	20
5. Baseline Study Population and Baseline Measurement Performance (CY 2008)	Full	10%	10



Review Element	Compliance Level	Scoring Weight	Final Points Score
6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010)	Full	20%	20
7. Demonstrable Improvement (CY 2010, reported in 2011)	Full	20%	20
<b>Total Demonstrable Improvement Score</b>			<b>80</b>
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Full	5%	5
2S. Sustained Improvement (CY 2011, reported in 2012)	Not Determined	15%	TBD
<b>Total Sustained Improvement Score</b>			<b>TBD</b>
<b>Overall Project Performance Score</b>			<b>TBD</b>

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

Project	2008	2009/2010	2010	2010/2011	Comparison Benchmark for Review Year
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge (QI 1)	40.6%	NA	44.37% <sup>1</sup>	TBD	90%
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	65.8%	NA	68.36% <sup>1</sup>	TBD	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge. (Standard HEDIS Codes and PA codes) (QI A)	53.2%	NA	56.86% <sup>1</sup>	TBD	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge. (Standard HEDIS Codes and PA codes) (QI B)	73.6%	NA	76.26% <sup>1</sup>	TBD	90%
Project Status	Baseline Study	Interventions	Remeasurement #1	Remeasurement #2	

<sup>1</sup> Indicates Demonstrable Improvement, eligible for subsequent evaluation of Sustained Improvement.



### III: PERFORMANCE MEASURES

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In 2012, OMHSAS and IPRO conducted two EQR studies. Both the Follow-up After Hospitalization for Mental Illness and Readmission within 30 Days of Inpatient Psychiatric Discharge studies were re-measured.

#### **Follow-up After Hospitalization for Mental Illness**

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

In MY 2002, the initial measurement year, IPRO and OMHSAS worked together to adapt the measures from the HEDIS methodology, allowing for a significant reduction in the time period needed for indicator development. Senior medical staff at IPRO reviewed the adapted methodology in detail to ensure consistency was maintained with regard to the specifications. Project management staff at both IPRO and OMHSAS also collaborated extensively during the indicator development phase, especially with regard to which local PA codes were considered for inclusion in the list of qualifying procedure codes, while still maintaining consistency with the HEDIS measure specifications. In addition to the adapted indicators, OMHSAS expanded the measures to include services with high utilization in the HealthChoices Behavioral Health Program. For MY 2002, since two codes of interest could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits, QI 3 and QI 4 were developed to capture these codes, while still generating rates for measures (i.e., QIs 1 and 2) that could be compared to national benchmarks. For the second re-measure in MY 2004, the indicator specifications were updated to reflect changes in the HEDIS 2005 Volume 2, Technical Specifications and four more local codes were added – to bring the total to six – to QIs 3 and 4. OMHSAS staff provided IPRO with a PA local code to national code mapping document to assist in this regard. The MY 2005 re-measure saw very few changes to the measure specifications, of which the main change to the methodology involved the exclusion of an expired PA local code. The MY 2006 re-measure, however, saw significant changes to QI 3 and QI 4 from prior years. Codes added to the measures as per suggestions from OMHSAS, the Counties, and BH MCOs changed the measures substantially, and rates for these indicators were no longer comparable to those from preceding measurement years. Consequently, these indicators were updated to QI A and QI B, respectively. As these indicators represented a significant deviation from HEDIS measure specifications, comparisons to HEDIS rates were not made. In addition, for MY 2006 the follow-up measure was collected for the newly implemented HealthChoices Northeast Counties – Lackawanna, Luzerne, Susquehanna, and Wyoming. These Counties were asked to collect data for the six-month time frame that they were in service for 2006 (July to December). In effect, MY 2006 was a baseline measurement year for collection of QIs A and B, and for the Northeast region across all indicators.

For MY 2007, the indicator specifications were updated to reflect changes in the HEDIS 2008 Volume 2, Technical Specifications. The primary change was the addition of a Place of Service (POS) code requirement to select Current Procedural Terminology (CPT) codes in the HEDIS and PA-specific measure specifications. In addition, all PA local codes previously mapped to standard CPT and Healthcare Common Procedure Coding System (HCPCS) codes as per HIPAA requirements were retired and removed. For the study, the follow-up measure was implemented for the 23 North/Central State Option Counties implemented in January 2007, and the 15 North/Central County Option Counties implemented in July 2007. As with the Northeast Counties for MY 2006, the North/Central County Option



Counties were asked to collect data for the six-month time frame that they were in service for 2007 (July to December).

For MY 2008, indicator specifications were again aligned to the HEDIS 2009 Volume 2, Technical Specifications. Two Diagnosis Related Group (DRG) codes were removed, and one Universal/Uniform Billing (UB) type of bill code was added to the criteria to identify non-acute care exclusions. Additionally, five POS codes were added to select CPT codes. Two procedure codes (one CPT and one HCPCS code) to identify eligible follow-up visits were added to the PA-specific measures per suggestions from OMHSAS, the Counties, and the BH MCOs. These codes were added to the existing 17 PA-specific codes, totaling 19 additional service codes that distinguish the PA-specific measure from the HEDIS measure in the MY 2008 study. Furthermore, as requested by OMHSAS, the MY 2008 findings by age are presented as three cohorts: Ages 6-20 years, Ages 21-64 years, and Ages 65 years and over. The Ages 21-64 years cohort was reported as two age ranges (Ages 21-59 years and Ages 60-64 years) in prior studies including MY 2007. As a result, the population previously reported as two cohorts are combined for comparative purposes.

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

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

For MY 2011, indicators had very few changes based on the HEDIS 2012 Volume 2: Technical Specifications. One POS code was added to select CPT codes in the criteria to identify outpatient visits. In all, MY 2011 is the fifth re-measurement for QIs A and B, and is the fourth re-measurement for the Counties in the North/Central County and State Options regions across all indicators.

### **Measure Selection and Description**

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

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

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

### **Eligible Population**

The entire eligible population was used for all 67 Counties participating in the MY 2011 study.



Eligible cases were defined as those members in the HealthChoices Behavioral Health 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, 2011;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Six years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

## **I: HEDIS Indicators**

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

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

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

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

## **II: PA-Specific Indicators**

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

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

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

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

## **Quality Indicator Significance**

According to the *Global Burden of Disease: 2004 Update* released by the World Health Organization (WHO) in 2008, mental illnesses and mental disorders represent six of the 20 leading causes of disability worldwide. Among developed nations, depression is the leading cause of disability for people ages 0-59 years, followed by drug and alcohol use disorders and psychoses (e.g., bipolar disorder and



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

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

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

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

## **Methodology**

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

## **Performance Goals**

Performance goals were set for this review year at the OMHSAS designated gold standard of 90% for all measures. In addition, the HEDIS measures were compared to industry benchmarks, in that the aggregate and BH MCO indicator rates were compared to the *HEDIS 2012 Audit Means, Percentiles and*



*Ratios.* These benchmarks contained means, 10<sup>th</sup>, 25<sup>th</sup>, 50<sup>th</sup> (median), 75<sup>th</sup> and 90<sup>th</sup> percentiles, and the enrollment ratios for nearly all HEDIS measures. There were tables published by product line (i.e., Commercial, Medicaid, and Medicare). The appropriate Medicaid benchmarks available for the measurement year were used for comparison. As indicated previously, the PA-specific measures were not comparable to these industry benchmarks.

## **Data Analysis**

The quality indicators were defined as rates, based on a numerator and a denominator. The denominator equaled the number of discharges eligible for the quality indicator, while the numerator was the total number of members for which the particular event occurred. The overall, or aggregate, performance rate for each indicator was the total numerator divided by the total denominator. The aggregate rate represented the rate derived from the total population of members that qualified for the indicator (i.e., the aggregate value). Year-to-year comparisons to MY 2010 data were provided where applicable. Of note is that the MY 2011 rates for Erie County are based on a six-month time period (January 1, 2011 – June 30, 2011), as Erie's contract with VBH ended on June 30, 2011. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

## **Findings**

### **BH MCO and County Results**

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

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

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



**Table 3.1 MY 2011 HEDIS Indicator Rates with Year-to-Year Comparisons**

	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
<b>QI 1</b>										
<b>HealthChoices</b>	16,621	36,038	<b>46.1%</b>	45.6%	46.6%	45.8%	47.3%	46.1%	0.0	NO
<b>VBH</b>	2,784	6,099	<b>45.7%</b>	44.4%	46.9%			44.4%	1.3	NO
Armstrong	168	288	<b>58.3%</b>	52.5%	64.2%			48.9%	9.5	NO
Beaver	266	540	<b>49.3%</b>	45.0%	53.6%			51.0%	-1.8	NO
Butler	231	445	<b>51.9%</b>	47.2%	56.7%			49.3%	2.6	NO
Cambria	166	493	<b>33.7%</b>	29.4%	37.9%			28.5%	5.2	NO
Crawford	165	336	<b>49.1%</b>	43.6%	54.6%			47.2%	1.9	NO
Erie*	196	512	<b>38.3%</b>	34.0%	42.6%			41.2%	-2.9	NO
Fayette	269	539	<b>49.9%</b>	45.6%	54.2%			43.9%	6.0	NO
Greene	71	186	<b>38.2%</b>	30.9%	45.4%			40.0%	-1.8	NO
Indiana	89	200	<b>44.5%</b>	37.4%	51.6%			55.7%	-11.2	NO
Lawrence	146	324	<b>45.1%</b>	39.5%	50.6%			49.7%	-4.6	NO
Mercer	165	431	<b>38.3%</b>	33.6%	43.0%			41.4%	-3.1	NO
Venango	105	202	<b>52.0%</b>	44.8%	59.1%			42.3%	9.7	NO
Washington	250	572	<b>43.7%</b>	39.6%	47.9%			42.6%	1.1	NO
Westmoreland	497	1,031	<b>48.2%</b>	45.1%	51.3%			48.7%	-0.5	NO
<b>QI 2</b>										
<b>HealthChoices</b>	24,159	36,038	<b>67.0%</b>	66.6%	67.5%	66.8%	70.7%	66.9%	0.1	NO
<b>VBH</b>	4,210	6,099	<b>69.0%</b>	67.9%	70.2%			68.4%	0.7	NO
Armstrong	238	288	<b>82.6%</b>	78.1%	87.2%			78.5%	4.2	NO
Beaver	387	540	<b>71.7%</b>	67.8%	75.6%			72.0%	-0.3	NO
Butler	327	445	<b>73.5%</b>	69.3%	77.7%			69.5%	4.0	NO
Cambria	295	493	<b>59.8%</b>	55.4%	64.3%			51.5%	8.4	YES
Crawford	229	336	<b>68.2%</b>	63.0%	73.3%			71.4%	-3.2	NO
Erie*	350	512	<b>68.4%</b>	64.2%	72.5%			66.0%	2.4	NO
Fayette	368	539	<b>68.3%</b>	64.2%	72.3%			65.7%	2.6	NO
Greene	118	186	<b>63.4%</b>	56.2%	70.6%			64.8%	-1.3	NO
Indiana	140	200	<b>70.0%</b>	63.4%	76.6%			76.4%	-6.4	NO
Lawrence	240	324	<b>74.1%</b>	69.1%	79.0%			77.9%	-3.9	NO
Mercer	279	431	<b>64.7%</b>	60.1%	69.4%			69.9%	-5.2	NO
Venango	147	202	<b>72.8%</b>	66.4%	79.2%			70.9%	1.9	NO
Washington	375	572	<b>65.6%</b>	61.6%	69.5%			68.5%	-3.0	NO
Westmoreland	717	1,031	<b>69.5%</b>	66.7%	72.4%			70.4%	-0.8	NO

\* The MY 2011 rates for Erie County are based on a six-month time period (January 1, 2011 – June 30, 2011),



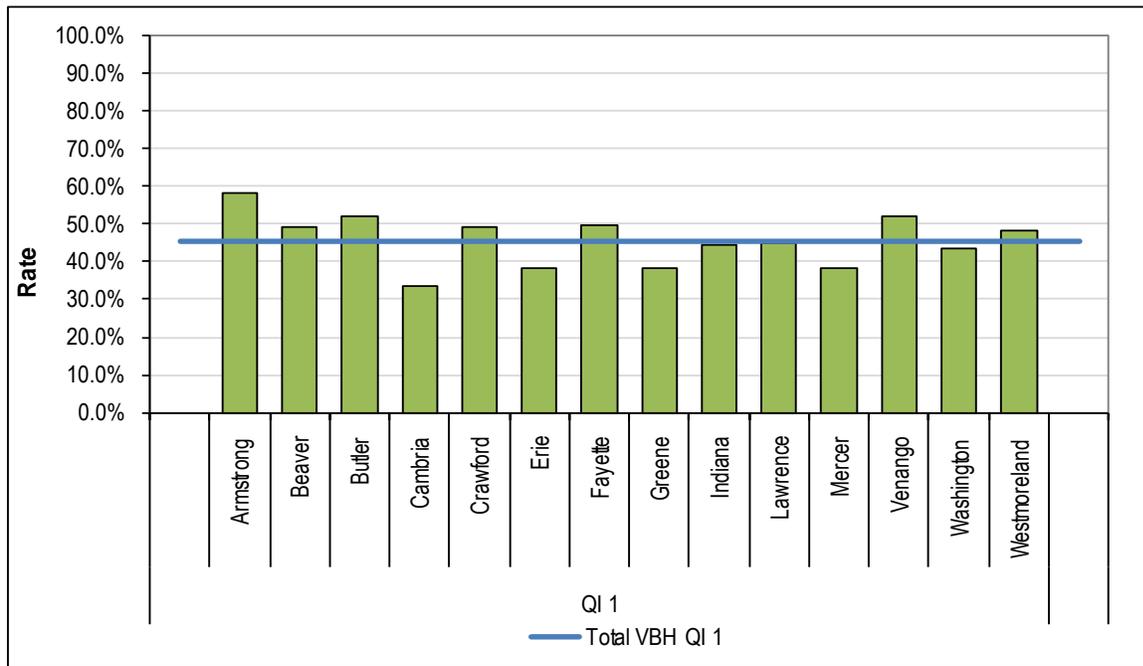
The MY 2011 HealthChoices aggregate rates were 46.1% for Q1 1 and 67.0% for Q1 2 with no statistically significant differences from the prior year. VBH's MY 2011 Q1 1 rate was 45.7% and Q1 2 rate was 69.0%. Neither rate statistically significantly differed from the prior year.

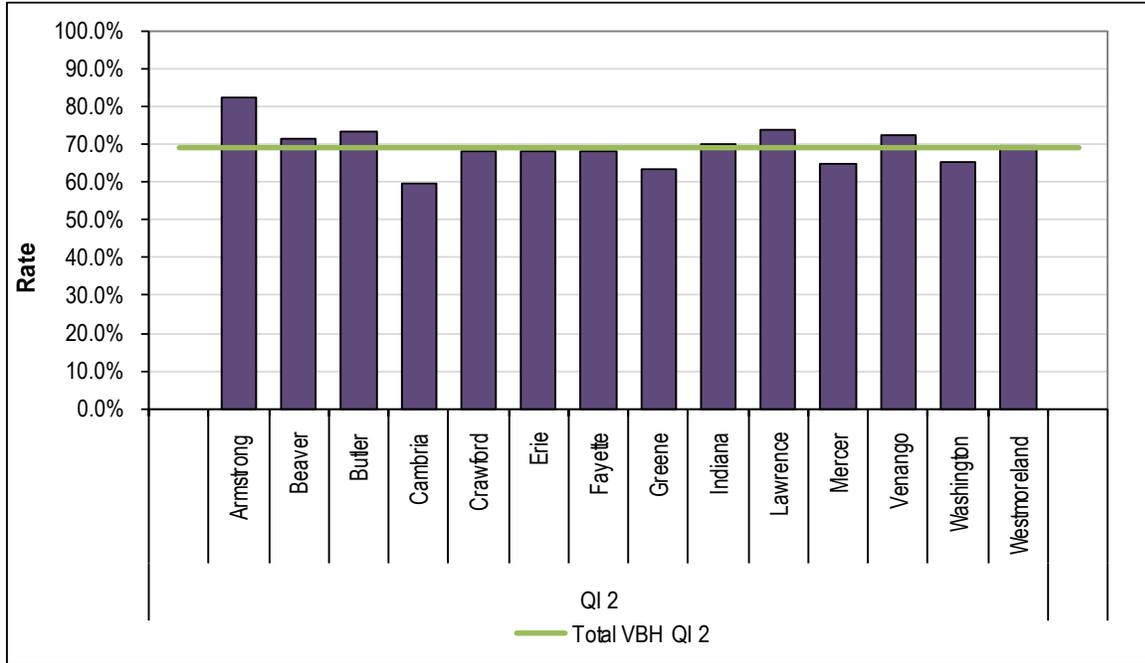
For MY 2011, VBH's Q1 1 rate of 45.7% was comparable to (i.e., not statistically significantly different from) the MY 2011 Q1 1 HealthChoices BH MCO Average of 45.8%. The MY 2011 Q1 2 rate of 69.0% was also comparable to (i.e., not statistically significantly different from) the MY 2011 Q1 2 HealthChoices BH MCO Average of 66.8%.

As presented in Table 3.1, the Q1 2 rate for Cambria County statistically significantly increased between MY 2010 and MY 2011. All other County rate changes for Q1 1 and Q1 2 were not statistically significant.

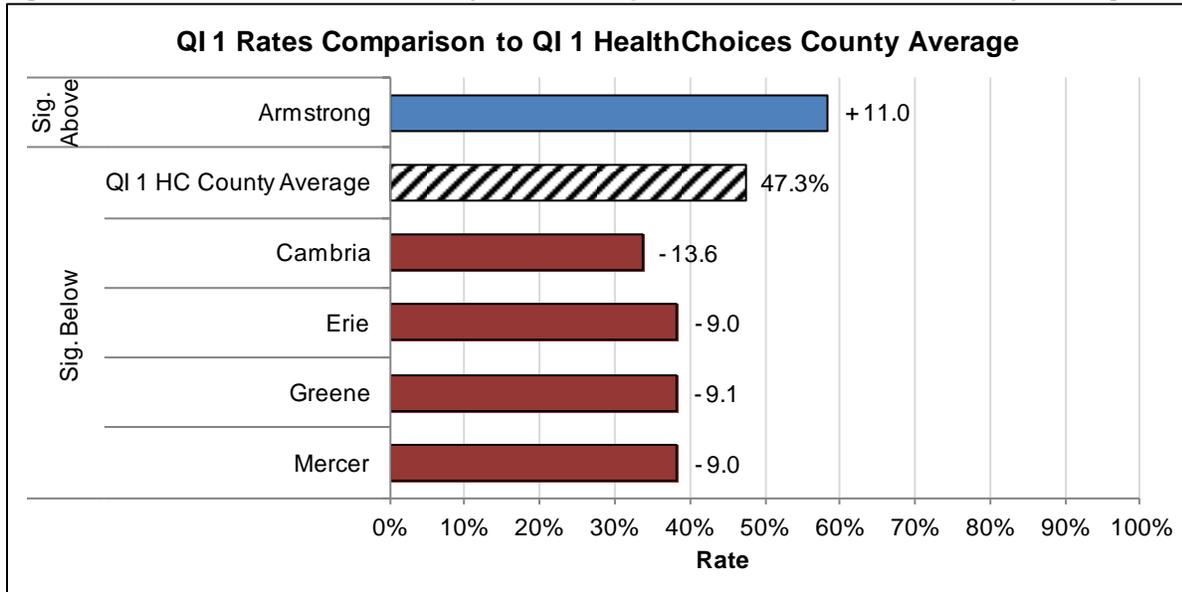
Figure 3.1 displays a graphical representation of the MY 2011 HEDIS follow-up rates for VBH and its respective Counties. Figure 3.2 presents the individual VBH Counties that performed statistically significantly above or below the MY 2011 Q1 1 and Q1 2 HealthChoices County Averages.

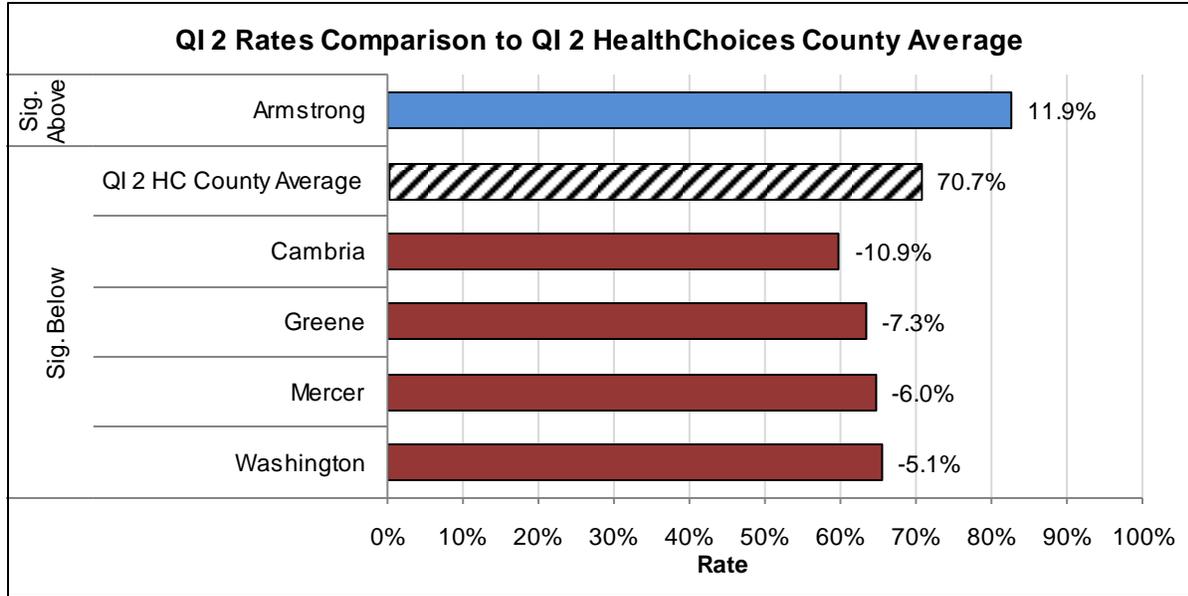
**Figure 3.1 MY 2011 HEDIS Indicator Rates**





**Figure 3.2 MY 2011 HEDIS County Rates Compared to HealthChoices County Average**





In MY 2011, one VBH County (Armstrong County) performed statistically significantly above and four VBH Counties (Cambria, Erie, Greene and Mercer) performed statistically significantly below the MY 2011 QI 1 HealthChoices County Average of 47.3%. For QI 2, one County (Armstrong) performed statistically significantly above, while four Counties (Cambria, Greene, Mercer, and Washington) had rates statistically significantly lower than the MY 2011 QI 2 HealthChoices County Average of 70.7%.

**Table 3.2 MY 2011 PA-Specific Indicator Rates with Year-to-Year Comparisons**

	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
<b>QI A</b>										
<b>HealthChoices</b>	20,830	36,038	<b>57.8%</b>	57.3%	58.3%	57.6%	58.6%	58.1%	-0.3	NO
<b>VBH</b>	3,474	6,099	<b>57.0%</b>	55.7%	58.2%			56.9%	0.1	NO
Armstrong	194	288	<b>67.4%</b>	61.8%	72.9%			60.1%	7.3	NO
Beaver	307	540	<b>56.9%</b>	52.6%	61.1%			57.1%	-0.3	NO
Butler	277	445	<b>62.3%</b>	57.6%	66.9%			65.0%	-2.8	NO
Cambria	228	493	<b>46.3%</b>	41.7%	50.8%			39.6%	6.7	NO
Crawford	195	336	<b>58.0%</b>	52.6%	63.5%			53.3%	4.8	NO
Erie*	287	512	<b>56.1%</b>	51.7%	60.4%			60.0%	-3.9	NO
Fayette	293	539	<b>54.4%</b>	50.1%	58.7%			51.9%	2.5	NO
Greene	105	186	<b>56.5%</b>	49.1%	63.8%			63.8%	-7.4	NO
Indiana	120	200	<b>60.0%</b>	53.0%	67.0%			62.7%	-2.7	NO
Lawrence	192	324	<b>59.3%</b>	53.8%	64.8%			63.0%	-3.7	NO



	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
Mercer	231	431	<b>53.6%</b>	48.8%	58.4%			52.1%	1.5	NO
Venango	120	202	<b>59.4%</b>	52.4%	66.4%			46.5%	12.9	YES
Washington	323	572	<b>56.5%</b>	52.3%	60.6%			56.9%	-0.4	NO
Westmoreland	602	1,031	<b>58.4%</b>	55.3%	61.4%			61.8%	-3.4	NO
<b>QI B</b>										
<b>HealthChoices</b>	26,939	36,038	<b>74.8%</b>	74.3%	75.2%	74.7%	77.1%	74.6%	0.1	NO
<b>VBH</b>	4,652	6,099	<b>76.3%</b>	75.2%	77.3%			76.3%	0.0	NO
Armstrong	245	288	<b>85.1%</b>	80.8%	89.4%			82.5%	2.6	NO
Beaver	410	540	<b>75.9%</b>	72.2%	79.6%			76.8%	-0.9	NO
Butler	351	445	<b>78.9%</b>	75.0%	82.8%			79.1%	-0.2	NO
Cambria	353	493	<b>71.6%</b>	67.5%	75.7%			63.5%	8.1	YES
Crawford	251	336	<b>74.7%</b>	69.9%	79.5%			75.1%	-0.4	NO
Erie*	401	512	<b>78.3%</b>	74.7%	82.0%			78.2%	0.2	NO
Fayette	396	539	<b>73.5%</b>	69.7%	77.3%			72.6%	0.8	NO
Greene	139	186	<b>74.7%</b>	68.2%	81.2%			80.0%	-5.3	NO
Indiana	157	200	<b>78.5%</b>	72.6%	84.4%			79.2%	-0.7	NO
Lawrence	258	324	<b>79.6%</b>	75.1%	84.2%			82.1%	-2.5	NO
Mercer	322	431	<b>74.7%</b>	70.5%	78.9%			75.6%	-0.9	NO
Venango	154	202	<b>76.2%</b>	70.1%	82.4%			72.3%	3.9	NO
Washington	428	572	<b>74.8%</b>	71.2%	78.5%			75.8%	-0.9	NO
Westmoreland	787	1,031	<b>76.3%</b>	73.7%	79.0%			78.3%	-2.0	NO

\* The MY 2011 rates for Erie County are based on a six-month time period (January 1, 2011 – June 30, 2011),

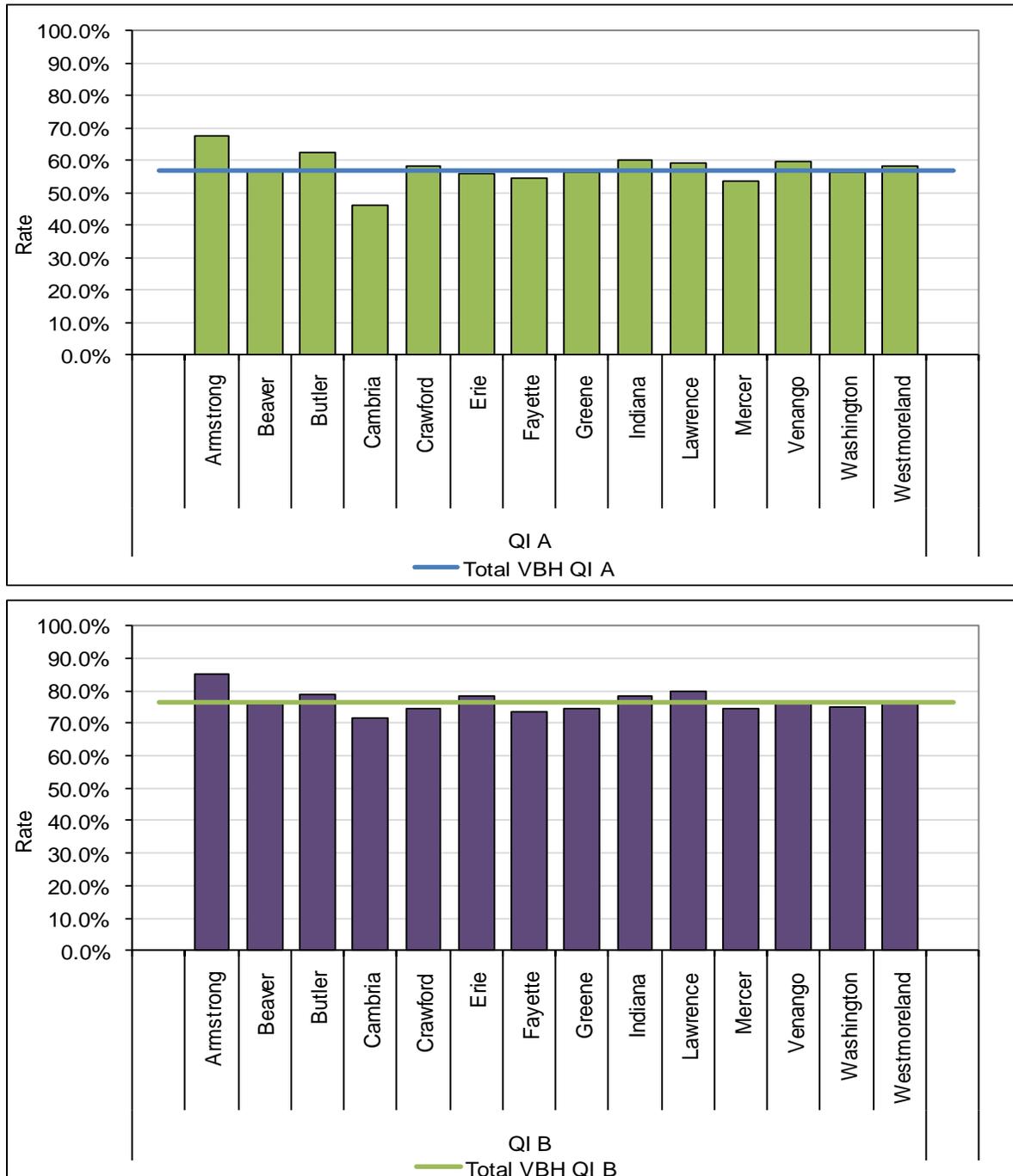
The MY 2011 HealthChoices aggregate rates were 57.8% for QI A and 74.8% for QI B. Both rates were comparable to (i.e., not statistically significantly different from) MY 2010 rates. VBH's MY 2011 QI A rate of 57.0% and QI B rate of 76.3% were comparable to (i.e., not statistically significantly different from) MY 2010 rates.

For MY 2011, VBH's QI A rate of 57.0% was not statistically significantly different from the QI A HealthChoices BH MCO Average of 57.6%. VBH's QI B rate of 76.3% was statistically significantly higher than the QI B HealthChoices BH MCO Average of 74.7% by 1.6 percentage points. The QI A rate for Venango County was statistically significantly higher than the rate from the prior year by 12.2 percentage points. For QI B, the rate for Cambria County was statistically significantly higher than the rate from the prior year by 8.1 percentage points. As presented in Table 3.2, none of the remaining year-to-year County rate changes were statistically significant.

Figure 3.3 displays a graphical representation of the MY 2011 PA-specific follow-up rates for VBH and its associated Counties. Figure 3.4 presents the individual VBH Counties that performed statistically significantly above or below the MY 2011 QI A and QI B HealthChoices County Averages. In MY 2011, the QI A rate for one Armstrong County was statistically significantly above and the rates for Cambria and

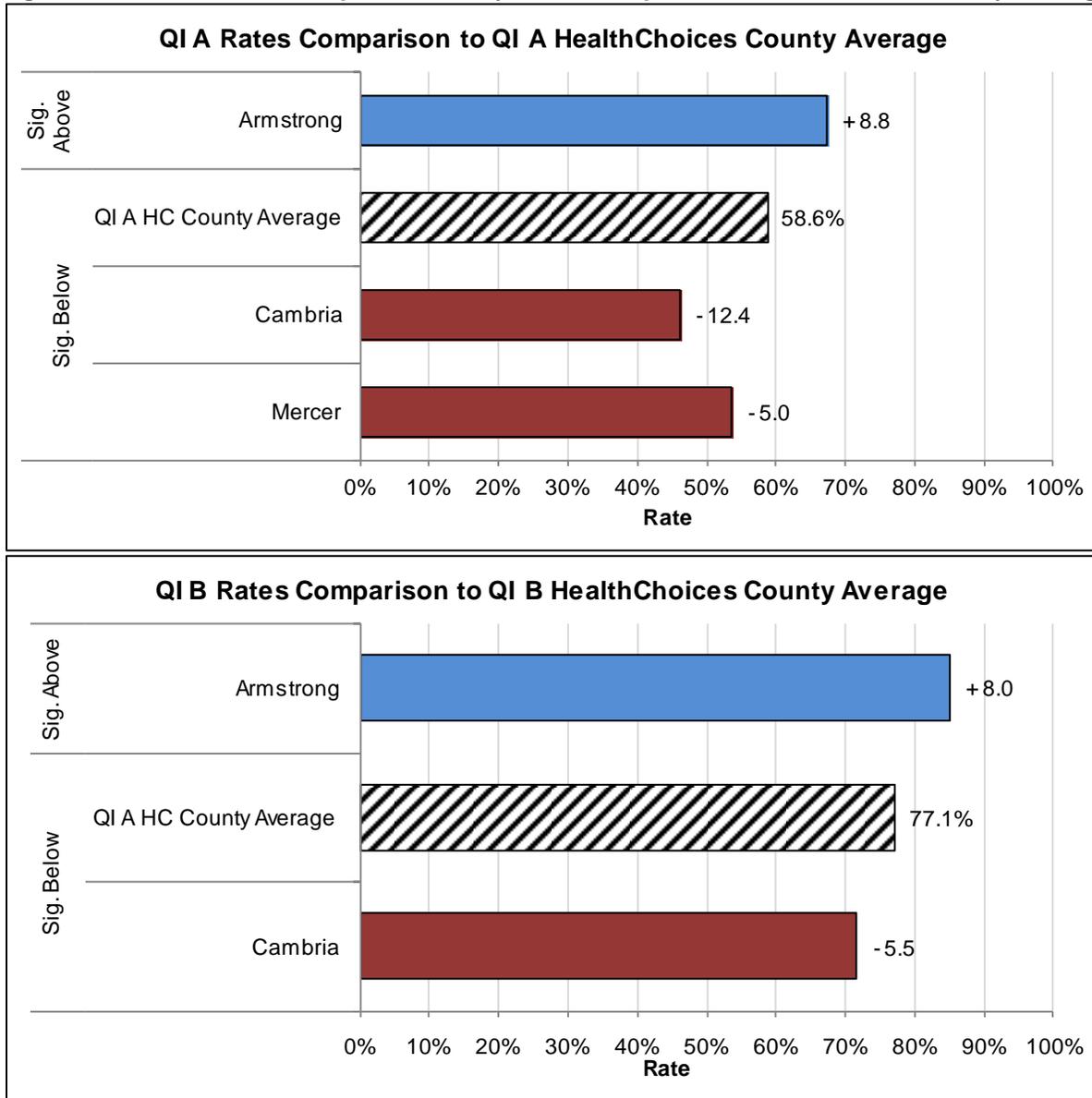
Mercer Counties were statistically significantly below the MY 2011 QI A HealthChoices County Average of 58.6%. For QI B, the MY 2011 rate for Armstrong County was statistically significantly above, and the rate for Cambria County was statistically significantly below, the MY 2011 QI B HealthChoices County Average of 77.1%. Rates for the remaining Counties did not differ statistically significantly from the respective HealthChoices County averages.

**Figure 3.3 MY 2011 PA-Specific Indicator Rates**





**Figure 3.4 MY 2011 PA-Specific County Rates Compared to HealthChoices County Average**



**Comparison to HEDIS® Medicaid Benchmarks**

The HealthChoices HEDIS indicator rates and BH MCO rates were compared to the *HEDIS 2012 Audit Means, Percentiles and Ratios* published by NCQA. The reference rates for national normative data contain means, 10<sup>th</sup>, 25<sup>th</sup>, 50<sup>th</sup>, 75<sup>th</sup> and 90<sup>th</sup> percentiles, and the enrollment ratios for nearly all HEDIS measures. There are tables by product lines (i.e., Commercial, Medicaid, and Medicare), so that the appropriate Medicaid benchmarks were used for comparison. NCQA's means and percentiles for each product line are generated annually using HMO, POS, and HMO/POS combined products from BH MCOs that underwent a HEDIS Compliance Audit™. Data were included from BH MCOs, regardless of whether the BH MCO did or did not report individual HEDIS rates publicly. The means and percentiles displayed in the *HEDIS 2012 Audit Means, Percentiles and Ratios* tables are based on data from the 2011 measurement year. The benchmark values for Medicaid are presented in Table 3.3.



**Table 3.3 HEDIS 2012 Medicaid Benchmarks**

MEDICAID	SUMMARY STATISTICS FOR RATES ACROSS MCOS					
	MEAN	10TH %ILE	25TH %ILE	MEDIAN	75TH %ILE	90TH %ILE
Follow-up After Hospitalization for Mental Illness – 7 Days	46.5	24.0	32.2	46.1	57.7	69.6
Follow-up After Hospitalization for Mental Illness – 30 Days	65.0	36.0	57.3	67.7	77.5	84.3

For MY 2011, the HealthChoices rates were 46.1% for QI 1 and 67.0% for QI 2. As compared to the HEDIS 2012 (MY 2011) Medicaid benchmarks, the QI 1 rate fell between the 50<sup>th</sup> and 75<sup>th</sup> percentiles, while the QI 2 rate fell between the 25<sup>th</sup> and 50<sup>th</sup> percentiles. In previous benchmark comparisons for MY 2010, the rates for both QI 1 and QI 2 fell between the 50<sup>th</sup> and 75<sup>th</sup> percentiles.

When comparing the MY 2011 VBH rates to the HEDIS 2012 benchmarks, the QI 1 rate of 45.7% fell between the 25<sup>th</sup> and 50<sup>th</sup> percentiles and the QI 2 rate of 69.0% fell between the 50<sup>th</sup> and 75<sup>th</sup> percentiles. In MY 2010, VBH's QI 1 rate of 44.4% and QI 2 rate of 68.4% fell between the 50<sup>th</sup> and 75<sup>th</sup> percentile ranges of the HEDIS 2010 benchmarks.

**Conclusion and Recommendations**

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

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the 2012 (MY 2011) Follow-up After Hospitalization for Mental Illness data tables.

In response to the 2012 study, the following general recommendations are applicable to all five participating BH MCOs:

**Recommendation 1:** The purpose of this re-measurement study is to inform OMHSAS, the Counties and the BH MCOs of the effectiveness of the interventions implemented between MY 2010 and MY 2011 to promote continuous quality improvement with regard to follow-up care after psychiatric hospitalization. The information contained within this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. The Counties and BH MCOs participating in this study should continue to evaluate the current interventions in place with respect to their follow-up rates to assess how these interventions affected change in follow-up rates from the prior measurement years MY 2010 and MY 2009. The Counties and BH MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care, and then implement action and monitoring plans to further increase their rates.

**Recommendation 2:** The findings of this re-measurement indicate that disparities in rates between demographic populations continue to persist as seen in prior studies. Within each of the demographic populations examined (race, age, gender, ethnicity), results were similar to MY 2010. Statistically significantly lower rates were observed on three or four indicators for: 1) African Americans, 2) members over 21 years old, 3) males, and 4) non-Hispanic members. While OMHSAS contracted Counties and their subcontracted BH MCOs are working to improve their overall follow-up rates, it is also important for these entities to continue to target the demographic populations that do not perform as well as their counterparts. Furthermore, it is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. It is recommended that BH MCOs and Counties continue to focus interventions on populations that continue to exhibit lower follow-up rates (e.g.,



Black/African American population). Possible reasons for these rate disparities include access, cultural differences and financial factors, which should all be considered and evaluated to determine their potential impact on performance. Additionally, the BH MCOs should be encouraged to initiate targeted interventions to address disparate rates between study populations.

**Recommendation 3:** BH MCO and Counties are encouraged to review the findings of the follow-up study in conjunction with inpatient psychiatric readmission rates, as professional literature consistently indicate a high correlation between these measures. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either had or did not have evidence of ambulatory follow-up/aftercare visit(s) during the interim period.

**Recommendation 4:** Additional analyses of each BH MCO's data should be conducted in order to determine if any other trends are noted. For example, lower follow-up rates may be associated with individuals with particular diagnoses, with co-occurring conditions such as substance abuse and/or addiction, or with particular services. Each BH MCO should evaluate its data for trends, including those indicated within this report. After evaluating the BH MCO data for trends, subject-specific findings should be transmitted to BH MCO and/or County care managers for implementation of appropriate action.

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

In addition to Follow up After Hospitalization for Mental Illness, OMHSAS elected to re-measure the Readmission within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Re-measurements were conducted in 2010 and 2011 on MY 2009 and MY 2010 data, respectively. The MY 2011 study conducted in 2012 was the fifth re-measurement of this indicator, and the indicator specification had no significant changes as compared to MY 2010. This measure continued to be of interest to OMHSAS for the purposes of comparing County and BH MCO rates to the OMHSAS performance goal and to prior rates.

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

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

### **Eligible Population**

The entire eligible population was used for all 67 Counties participating in the MY 2011 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, 2011;
- 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. During the validation process, it was discovered that there were differing interpretations of the specifications with regard to the denominator discharge date. Interpretations differed regarding whether to use December 1 or December 31 when calculating the denominator. IPRO observed a discrepancy in the specifications regarding how to calculate the denominator. IPRO and OMHSAS agreed to examine the specifications for the next review year. For the MY 2011 study, the existing methodology as previously interpreted and utilized by the majority of BH MCOs was maintained, and IPRO worked with the BH MCOs to ensure that the methodology was consistent across all BH MCOs.

## Performance Goals

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

## Findings

### BH MCO and County Results

The results are presented at the BH MCO and then County level when multiple Counties contract with a single BH MCO. Year-to-year comparisons of MY 2011 to MY 2010 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. As with the Follow-up After Hospitalization for Mental Illness measure, the MY 2011 rate for Erie County is based on a six-month time period (January 1, 2011 – June 30, 2011), through the end of Erie's contract with VBH. 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. The average takes the sum of the individual rates and divides the sum by the total number of sub-groups within the category; therefore, all averages presented in this study are *not* weighted. Whether or not an individual rate performed statistically significantly above or below average was determined by whether or not that rate's 95% CI included the average for the indicator.

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



**Table 3.4 MY 2011 Readmission Rates with Year-to-Year Comparisons**

	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
<b>HealthChoices</b>	5,798	48,312	<b>12.0%</b>	11.7%	12.3%	12.3%	9.9%	12.2%	-0.2	NO
<b>VBH</b>	750	7,987	<b>9.4%</b>	8.7%	10.0%			10.5%	-1.1	NO
Armstrong	39	359	<b>10.9%</b>	7.5%	14.2%			12.5%	-1.6	NO
Beaver	53	690	<b>7.7%</b>	5.6%	9.7%			7.7%	0.0	NO
Butler	75	599	<b>12.5%</b>	9.8%	15.3%			11.1%	1.4	NO
Cambria	56	646	<b>8.7%</b>	6.4%	10.9%			11.6%	-2.9	NO
Crawford	25	407	<b>6.1%</b>	3.7%	8.6%			8.2%	-2.0	NO
Erie*	97	741	<b>13.1%</b>	10.6%	15.6%			13.6%	-0.5	NO
Fayette	52	688	<b>7.6%</b>	5.5%	9.6%			8.0%	-0.5	NO
Greene	20	236	<b>8.5%</b>	4.7%	12.2%			9.3%	-0.8	NO
Indiana	28	264	<b>10.6%</b>	6.7%	14.5%			10.3%	0.3	NO
Lawrence	36	426	<b>8.5%</b>	5.7%	11.2%			12.3%	-3.9	NO
Mercer	33	529	<b>6.2%</b>	4.1%	8.4%			6.5%	-0.2	NO
Venango	18	257	<b>7.0%</b>	3.7%	10.3%			13.5%	-6.5	NO
Washington	79	820	<b>9.6%</b>	7.5%	11.7%			10.7%	-1.0	NO
Westmoreland	139	1,325	<b>10.5%</b>	8.8%	12.2%			9.9%	0.5	NO

\* The MY 2011 rate for Erie County is based on a six-month time period (January 1, 2011 – June 30, 2011)

The aggregate MY 2011 HealthChoices readmission rate was 12.0%. VBH's MY 2011 rate of 9.4% did not differ statistically significantly from the MY 2010 rate, but was statistically significantly below (better than) the MY 2011 HealthChoices BH MCO Average of 12.3% by 2.9 percentage points. The VBH rate was 0.6 percentage points below the designated performance goal of 10%. Note that this measure is an inverted rate, in that lower rates are preferable.

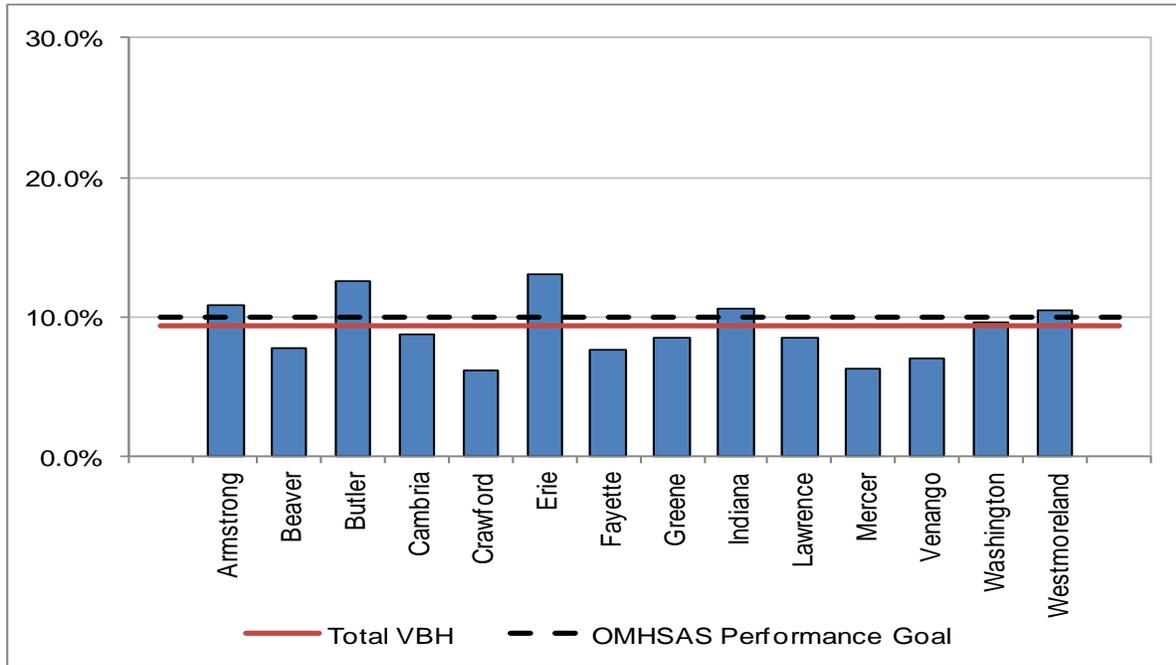
As presented in Table 3.4, year-to-year County rate changes were not statistically significant. For MY 2011, rates for nine VBH Counties (Beaver, Cambria, Crawford, Fayette, Greene, Lawrence, Mercer, Venango, and Westmoreland) met the performance goal of 10.0%.

In MY 2011, the rates for Beaver, Crawford, Fayette, and Mercer Counties were statistically significantly lower (better), while the rate for Erie County was statistically significantly higher (poorer) than the MY 2011 HealthChoices County Average of 9.9%. Note that this measure is an inverted rate, in that lower rates are preferable. The readmission rates for the remaining VBH Counties did not statistically significantly differ from the MY 2011 HealthChoices County Average.

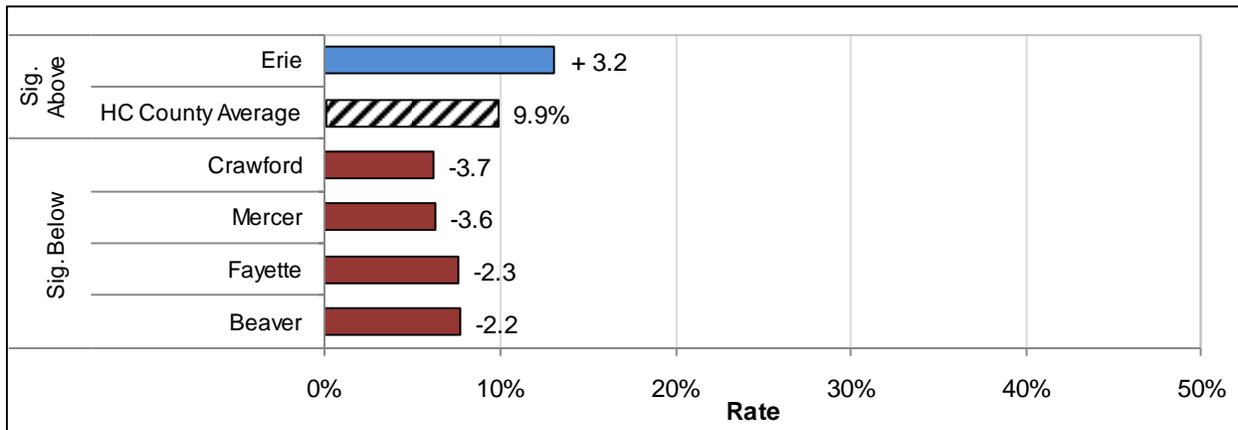
Figure 3.5 provides a graphical presentation of the MY 2011 readmission rates for VBH and its associated counties. Figure 3.6 displays percentage point differences for the individual VBH Counties that performed statistically significantly higher or lower than the MY 2011 HealthChoices County Average.



**Figure 3.5 MY 2011 Readmission Rates**



**Figure 3.6 MY 2011 Readmission Rates Compared to HealthChoices County 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 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 2012 (MY 2011) Readmission within 30 Days of Inpatient Psychiatric Discharge data tables.

In response to the 2012 study, the following general recommendations are applicable to all five participating BH MCOs:



- As with MY 2010, no significant improvement was noted for any of the BH MCOs for MY 2011. IPRO recommends that the Counties and BH MCOs participating in this study conduct root cause analyses to help determine what factors are negatively impacting readmission rates, and develop interventions that target specific barriers to improving the readmission rates.
- Each BH MCO should conduct additional analyses of the data in order to determine if any other trends are noted. For example, higher readmission rates may be associated with those individuals with particular diagnoses or co-occurring conditions such as substance abuse and/or addiction. Targeted analyses such as these should be evaluated as part of any root cause analysis. In addition, BH MCOs and Counties are encouraged to review the findings of the readmission study in conjunction with follow-up after hospitalization rates.
- Unlike MY 2010, the MY 2011 readmission rates observed for Black/African American and the White populations were not statistically significantly different. Similar to MY 2011, however, fifty-six percent of all African American discharges in MY 2011 again occurred in Philadelphia County. The statistically significantly lower rates for African Americans in MY 2010 appeared to be driven by the Philadelphia County population, and IPRO recommended that a performance improvement project to focus on Disparities in Healthcare, with a focus on Philadelphia County, be undertaken. Although no formal project began, CBH, which is comprised solely of Philadelphia County, observed the largest improvement among the BH MCOs. This finding may suggest further study across BH MCOs to explore the potential for further improvements that can be sustained.
- IPRO recommends continued annual evaluation of Inpatient Readmission after Psychiatric Discharge rates for OMHSAS contracted Counties and their subcontracted BH MCOs.
- Case management consideration should be given to those individuals who appear to be the highest utilizers of inpatient acute psychiatric care and have shown to be at risk for frequent readmission.
- As with MY 2010, considerable variation by county was again observed for all of the BH MCOs for MY 2011. BH MCOs should further evaluate individual County rates, explore the underlying causes of variance by County, and identify those County practices or systems that may contribute to lower readmission rates.

## IV: 2011 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 2011 EQR Technical Reports, which were distributed in April 2012. The 2012 EQR Technical Report is the fifth report to include descriptions of current and proposed interventions from each BH MCO that address the 2011 recommendations.

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

- Follow-up actions that the BH MCO has taken through September 30, 2012 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 2012, as well as any additional relevant documentation provided by VBH.

**Table 4.1 Current and Proposed Interventions: Opportunities for Improvement**

Reference Number	Opportunity for Improvement	MCO Response	
<b>Structure and Operations Standards</b>			
VBH 1	Within Subpart C: Enrollee Rights and Protections Regulations, VBH was partially compliant on one out of seven categories – Enrollee Rights.	<p>Follow Up Actions Taken Through 09/30/12</p> <p><b>PEPS 108: All follow up CAPS and revisions based on recommendations will be monitored by OMHSAS in the 2012 Annual HealthChoices Review scheduled in 2013.</b></p> <p><b>Substandard 1</b></p>	<p><b>Files and attachments submitted by VBH</b></p>  <p><b>VBH Attachments</b></p> <p>County updates:</p> <p><b>Armstrong/Indiana (2008)</b>- As a response to recommendations in the 2008 PEPS review and follow-up submission, all revised resolution procedures, documentation of accountability, and reporting procedures continue to be followed. No CAP was required.</p> <p><b>Lawrence County (2008)</b> – Beginning in 2011, administrative review meetings convened quarterly by MH/MR Administrator, with monthly monitoring of documentation to continue per the CAP submitted in response to PEPS Review RY 2008. Revisions of monthly CFST reports include break out of face-to-face vs. telephonic interviews for all levels of care. Emphasis is placed on CFST getting on site with providers and including Drug and Alcohol Providers in surveys. CFST contract revisions adhere to CAP submitted by</p>

Reference Number	Opportunity for Improvement	MCO Response	
		<p><b>Substandard 2</b></p>	<p>SW6 County 09/09/09.</p> <p><b>Fayette (2008)</b> - The 2008 PEPS review states the standard was fully met without recommendations. <a href="#">Attachment 1</a></p> <p><b>Armstrong/Indiana (2008)</b> No CAP was required.</p> <p><b>Mercer</b> No CAP Required Mercer County adjusted the CFST budget to allow for procurement of professional services to provide technical assistance with management functions, has worked to make the CFST more autonomous, and continues to follow action plans approved 5/10/20.</p> <p><b>Crawford (2009)</b> No CAP required</p> <p><b>Lawrence (2008)</b> Continues to follow the Corrective Action Plan approved and completed 10/15/10.</p>
		<p><b>Substandard 5</b></p>	<p><b>Cambria County (RY2009):</b> In fiscal year 2012-13, Cambria entered into the first full year of contracting with the Peer Empowerment Network (PEN) for Consumer/Family Satisfaction Surveying. One key adjustment of the contract was a more realistic expectation on the minimum number of surveys conducted with members receiving D&amp;A services and treatment. In general, there was a record number of interviews across D&amp;A and Mental Health services. With the C/FST's base of operations being in the local Drop In Center, in fiscal year 2011-12 there was also a 57% increase in the number of face-to-face surveys being completed. With the CFST having two members, participating in the Quality Management Committee the input and observations of the team is incorporated and integrated into planning, studies and general discussion around systemic issues.</p> <p><b>Armstrong/Indiana (2008)</b> Continues to follow CAP. County MH/MR staff assisted the C/FST director in gaining access to providers not previously accessed. Currently, the C/FST does surveys for all providers in both counties. The C/FST Director also monitors the number of surveys from each provider, and contacts the MH/MR representative if numbers start decreasing. The MH/MR representative contacts the provider asking for assistance in increasing C/FST access to consumers who receive services from that particular agency within the various programs offered. The MH/MR</p>

Reference Number	Opportunity for Improvement	MCO Response	
		Substandard 6	<p>representative sends out annual letters to all providers informing them of the total number of surveys completed for the year in general, how many were completed for their agency (broken down by level of care when appropriate), and ask for assistance to improve deficiencies/low numbers.</p> <p><b>Lawrence (2008)</b> Continues to follow the plan implemented with regular CFST/county meetings to review specific strategies and survey mechanisms.</p> <p><b>Butler (2008)</b> The 2008 PEPS review states the standard was fully met without recommendations. <a href="#">Attachment 2</a></p> <p><b>Cambria (2009)</b> One key adjustment of the PEN contract was a more realistic expectation on the minimum number of surveys conducted with members receiving D&amp;A services and treatment. In general, there were an overall record number of interviews across D&amp;A and Mental Health services.</p> <p><b>Armstrong/Indiana (2008)</b> The revised problem resolution procedures that were put in place following PEPS review continue and will be reaudited in the 2012 Annual HealthChoices Review. Separate roles are spelled out for every party involved, as are specific time frames for follow-ups and responses. Concerns that appear urgent or emergency in nature are brought directly to the attention of the MH/MR representative and/or the VBH Ombudsman for further problem resolution. Written feedback is then given back to the C/FST as to the outcome of the issues. Meetings are also held with providers to go over reports, discuss specific issues identified by consumers, and any survey question where the rate falls below the 85% standard.</p> <p><b>Mercer (2009)</b> No CAP Required Continues to follow recommendation response approved 5/10/10</p> <p><b>Lawrence (2008)</b> Continues to follow the Corrective Action Plan approved and completed 10/15/10</p> <p>Listed as partially compliant for Armstrong/Indiana, Butler, Lawrence, Washington and Westmoreland Counties. The quarterly reports to OMHSAS include numeric results by level of care, and narrative information about trends and actions taken on behalf of individual consumers. Beginning in 4th quarter 2011, the reports also include numeric surveys by provider.</p>
		Substandard 7	



Reference Number	Opportunity for Improvement	MCO Response	
		<p><b>Substandard 10</b></p>	<p><b>Attachment 3</b></p> <p><b>Armstrong/Indiana (2008)</b> No CAP required; see previous updates.</p> <p><b>Mercer (2009)</b> Continues to follow the CAP approved 5/10/10.</p> <p><b>Crawford (2009)</b> No CAP required</p> <p><b>Cambria (2009)</b> No CAP Required</p> <p>The C/FST's base of operations being in the local Drop-In Center, in fiscal year 2011-12 there was also a 57% increase in the number of face-to-face surveys being completed. With the CFST having two members, participating in the Quality Management Committee, the input and observations of the team are incorporated and integrated into planning, studies and general discussion around systemic issues.</p> <hr/> <p><b>Future Actions Planned</b> Review to be conducted by OMHSAS 2013</p>
<p><b>VBH 2</b></p>	<p>VBH was partially compliant on five out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were:</p> <ol style="list-style-type: none"> <li>1) Availability of Services (Access to Care)</li> <li>2) Coordination and Continuity of Care</li> <li>3) Coverage and Authorization of Services</li> <li>4) Practice Guidelines</li> <li>5) Quality Assessment and Performance Improvement Program.</li> </ol>	<p>Follow Up Actions Taken Through 09/30/12</p> <p><b>Availability of Services</b> <b>PEPS 28</b> <b>Substandard 1</b> <b>Substandard 2</b></p> <p><b>PEPS 93</b> <b>Substandard 4</b></p>	<p>As response to the HealthChoices Triennial Review conducted in April 2012, VBH-PA submitted CAPS, which were approved September 26, 2012 by OMHSAS.</p> <p><b>*Attachment 4 Approval Letter</b></p> <p><b>*Attachment 5 VBH-PA response see pages 6-14 for Standard 28</b></p> <p>Quality Management Department reports Treatment Outcomes and Readmissions at least bimonthly at QMCs and annually, FUH quarterly at QMCs and annually, and Consumer Satisfaction at least bi-monthly at QMCs and annually.</p> <p><b>*Attachment 6 -2012 Work Plan</b></p> <p><b>*Attachment 7 -2012 QMC Schedules</b></p> <p>POMS data addresses changes in employment education vocational and living status and is submitted quarterly</p> <p><b>*Attachment 8 POMS</b> *No CAP is required</p> <p>*VBH-PA Annual Evaluation for 2012 will be submitted to OMHSAS by March 1, 2013. It will include a monitoring of changes in employment/educational/ vocational status or changes in living status per POMS data.</p>



Reference Number	Opportunity for Improvement	MCO Response	
		<p><b>Coordination and Continuity of Care</b></p> <p><b>PEPS 28 Substandards 1 &amp; 2</b></p> <p><b>Coverage and Continuity of Care</b></p> <p><b>PEPS 28 Substandards 1 &amp; 2</b></p> <p><b>Coverage and Authorization of Services</b></p> <p><b>PEPS 72 Substandard 1</b></p> <p><b>Quality Assessment and Performance Improvement Program</b></p>	<p>(see above)</p> <p>(see above)</p> <p>The Triennial HealthChoices Annual Review conducted in 2012 indicated a recommendation. No CAP required. Supervisory review of denials letters by VBH-PA continues. (See page 8 Review of Calendar Year 2011 Corrective Action Plan.</p> <p>(see above)</p>
		<p><b>PEPS 93 Substandard 4</b></p>	<p>Future Actions Planned</p> <p>Standard 28 Please see attached document pages 6-14</p> <p>Standard 72 response to recommendation is continuous and ongoing</p> <p>Standard 93 Annual Evaluation will be submitted to OMHSAS Mar 1, 2013</p>
<p><b>VBH 3</b></p>	<p>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:</p> <ol style="list-style-type: none"> <li>1) Statutory Basis and Definitions</li> <li>2) General Requirements</li> <li>3) Notice of Action</li> <li>4) Handling of Grievances and Appeals</li> <li>5) Resolution and Notification: Grievances and Appeals</li> <li>6) Expedited Appeals Process</li> <li>7) Information to Providers and Subcontractors</li> </ol>	<p>Follow Up Actions Taken Through 09/30/12</p> <p><b>PEPS Standard 68 Substandard 2</b></p> <p><b>Substandard 3</b></p> <p><b>PEPS Standard 71 Substandard 1</b></p>	<p>The onsite Triennial review for RY 2011 indicated that all expectations for Substandard 2 are fully met. VBH-PA will continue to utilize the approved templates and processes put in place following the 2008 review.</p> <p>In response to Substandard 3 review, VBH-PA submitted a corrective action plan for RY 2011, which includes establishing an interdepartmental complaint review committee to review the investigation results and recommend follow up action.</p> <p><a href="#">Attachment 5</a></p> <p>In response to RY 2011 onsite review, revisions were made to Authorization for Continuation for BHRS forms to document the member, provider, VBH staff and peer</p>



Reference Number	Opportunity for Improvement	MCO Response	
	8) Continuation of Benefits 9) Effectuation of Reversed Resolutions	PEPS Standard 72 Substandard 1	<p>reviewers are all informed of continuation rights. The forms are placed in the member's case files. The form includes the amount and service the members are currently receiving during the appeal process.</p> <p>No CAP required. VBH-PA supervisory staff will continue to review denial letters for compliance and appropriate content.</p>
			<p><b>Future Actions Planned</b> Complaint review committee to be established in first quarter 2013</p>
<b>Performance Measures</b>			
VBH 4	VBHs rate for the MY 2010 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.	Follow Up Actions Taken Through 09/30/12	<p><b>Follow Up Actions Taken Through 09/30/11</b> <b>Readmission Reporting:</b> VBH-PA reports on readmission rates monthly or bimonthly to all counties at the regularly scheduled QMCs. Annual rates are reviewed by calendar years. Overall readmission rates are also reported by age and gender</p> <p>Based on recommendations from the IPRO Readmissions Report MY 2010, VBH-PA began additional analyses to determine trends based on demographic and diagnostic variables. The initial data is attached; the study is in progress. <b>Attachment 9 Readmissions and Follow-Up Demographics</b></p> <p><b>Complex Care Management:</b> Individuals from all counties who meet hospitalization criteria for Complex Care management are referred on an ongoing basis.</p> <p>Complex Care Management (CCM) services are provided for individuals in high-risk groups and with a history of frequent hospitalizations within a 12-month period. Interventions coordinated by VBH CCM have been shown to decrease hospitalizations. Program outcomes are tracked annually. <b>Attachment 10 Complex Care Management</b></p> <p><b>Specific County Drill Downs</b> VBH-PA does specific drill downs and interventions based on high or increasing readmission rates. In 2012, there was focus on Lawrence, with regular strategic planning meetings with the county, SBHM and Jameson Hospital through the Lawrence County Readmission Oversight Committee (ROC); and with Cambria County through strategic clinical planning meetings and monitoring of individuals through clinical rounds and in aggregate through the RAFT report.</p> <p><b>Cambria County Readmission Follow Up Tracking (RAFT):</b> Individuals identified through the RAFT database are referred to the VBH-PA clinical department for assessment for Complex Care Management, and the</p>



Reference Number	Opportunity for Improvement	MCO Response	
			<p>County contacts outpatient providers involved with the cases to coordinate care. The RAFT report is presented at QMCs.  <a href="#">Attachment 11 Example Cambria Raft Report</a></p> <p><b>Mobile Medication Services :</b>            VBH encourages the use of mobile medication programs in their network. There are currently 5 providers serving seven counties. A copy of annual outcome study for mobile medication services in Mercer County is attached  <a href="#">Attachment 12 Mobile Psychiatric Nursing</a></p>
			<p>Future Actions Planned</p> <p>All actions described are ongoing.            Additionally, regular meetings to monitor readmission activity in Greene County will begin early in 2013 including RAFT reporting.</p>

### Corrective Action Plan

When deficiencies were noted during the PEPS reviews, a Corrective Action Plan response was required from the BH MCO addressing those issues requiring follow-up action.

The following Corrective Action Plan was implemented during the calendar year 2011 to address those deficiencies noted by OMHSAS:

**Table 4.2 Corrective Action Plan for VBH**

Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
Denial Case File Review – PEPS standard 72.1 SW6/NW3: All letters included an explanation of the reason the service was not approved as requested; however, in 51 out of 191 (27%) of the letters the explanation was felt to be inadequate. This is a significant improvement compared to the prior review.					
1. VBH-PA recognizes that improvements have been made, but that the need for continued efforts is essential in the following areas: <ul style="list-style-type: none"> <li>• Correlation between member symptoms, improvements, and reduction in services</li> <li>• Statements irrelevant to the denial</li> <li>• Rationale for denial of BCM needs to be individualized.</li> </ul> These will be reinforced in	Angie Sarneso, Clinical Director  Jenny Randolph, Child, Adolescent, and Family Services Clinical Manager  Gary Kordes, Adult Services Clinical Manager	6/13/2011	12/31/2011	VBH-PA Clinical staff meeting minutes  VBH-PA denial letter review checklist used by supervisors (revised)  Training curriculum and training rosters (presentation attached).  Sign-in Sheets from	VBH-PA, in conjunction with County Oversight, completed a Root Cause Analysis resulting in production of a Quality Improvement Plan to address issues related to denials. Part of the QIP relates to clear understanding/explanation of Medical Necessity, more clear



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
<p>VBH-PA Clinical staff meetings in June, 2011 and ongoing. All letters are reviewed by a clinical supervisor prior to being mailed. A checklist for use in reviewing letters remains in use which includes specific reference to symptoms and behaviors. A targeted audit will be done monthly and submitted to OMHSAS the last week of the following month utilizing the updated audit tool with special focus on the explanation of denied services. The monthly audit will address 10 denial letters from Inpatient level of care, and 25 from BHR.</p> <p>2. A random sample of denials letters across all levels of care will be sent from VBH-PA to OMHSAS and SBHM for review/audit. Ten (10) letters from the first and third week of each month will be sent the second and fourth weeks, respectively. VBH-PA will continue to submit 10 letters to SBHM and DPW bi-monthly and will include VBH-PA findings at the time of submission.</p> <p>3. The OMHSAS and SBHM will respond in writing with feedback within one week of receiving the letters. A monthly conference call to be coordinated by OMHSAS and SBHM to provide any comments regarding the sample of letters reviewed and progress related to the CAP.</p>	<p>Kim Krill, Barb Deller, OMHSAS (#3)</p> <p>Kim Campbell, Dave McAdoo, Sandy Melvin, SBHM (#3)</p> <p>VBH-PA same as above (#3)</p>			<p>staff training (see minutes).</p> <p>RCA findings and QIP produced as a result</p> <p>2. VBH-PA began sending letters in June 2011</p> <p>2. VBH-PA Findings checklist (with next batch of letters and ongoing).</p> <p>#3: Sample of denial letters</p> <p>Written feedback from OMHSAS, SBHM</p> <p>Update (July 2011): Feedback from SBHM attached</p> <p>Documentation of monthly calls with VBH-PA, as coordinated by OMHSAS / SBHM</p>	<p>explanation of reason for denial, and focus on individual/family strengths in denial letters.</p> <p>Significant improvement has been shown since June, 2011. The Office of Mental Health and Substance Abuse Services, Pittsburgh Field Office, in conjunction with OMHSAS QM staff continue to monitor through December 31, 2011.</p>



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
Denial Case File Review – PEPS standard 72.1 SW6/NW3: Number of denial notices received versus the number of denials reported in the denial log					
VBH-PA submitted all denial letters for which the decision was rendered in the month of November 2010. The logic used for the monthly reporting for denials is based on the denial letter sent date. Therefore, the discrepancy is due to this logic difference. For example, a decision could have been rendered on November 30th and the letter date would be in December. VBH-PA has assured that there are no missing letters; all denials rendered have an accompanying letter. In the future, VBH-PA will confirm with OMHSAS in writing the logic for pulling the denial letters prior to the submission.	Angie Sarneso, VBH-PA Clinical Director	05/30/2011	12/31/2011	Written confirmation to and from OHMSAS initiated by VBH-PA to verify logic prior to submission for all future years submissions.	The Office of Mental Health and Substance Abuse Services, Pittsburgh Field Office, in conjunction with OMHSAS QM staff continue to monitor through December 31, 2011.

### Root Cause Analysis and Action Plan

The 2012 EQR is the fourth for which BH MCOs were required to prepare a Root Cause Analysis and Action Plan for performance measures performing statistically significantly poorer than the BH MCO average and/or as compared to the prior measurement year. The performance measures that were noted as opportunities for improvement in the 2011 EQR Technical Report required that the MCO submit:

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

IPRO reviewed each submission, and offered technical assistance to BH MCO staff. The BH MCOs were given the opportunity to revise and re-submit response forms as needed and as time permitted. VBH was not required to submit a root cause analysis and action plan in 2012 based on 2011 Performance.



## **V: 2012 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT**

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The review of VBH's 2012 (MY 2011) performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of, and access to services for Medicaid members served by this BH MCO.

### **Strengths**

- VBH submitted one PIP for validation in 2012, and received full credit for the elements of the study evaluated that reflect activities in 2011 (Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement).
- VBH's rate for the MY 2011 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI B was statistically significantly higher than the QI B HealthChoices BH MCO Average by 1.6 percentage points.
- VBH's rate for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge measure rate was statistically significantly below (better than) the MY 2011 HealthChoices BH MCO Average by 2.9 percentage points. The VBH rate was 0.6 percentage points below the designated performance goal of 10%.

### **Opportunities for Improvement**

- Review of compliance with standards conducted by the Commonwealth in RY 2009, RY 2010, and RY 2011 found VBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.
  - Within Subpart C: Enrollee Rights and Protections Regulations, VBH was partially compliant on one out of seven categories – Enrollee Rights.
  - VBH was partially compliant on five out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Practice Guidelines, and 5) Quality Assessment and Performance Improvement Program.
  - VBH was partially compliant on nine out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers and Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.

Additional strengths and targeted opportunities for improvement can be found in the BH MCO-specific 2012 (MY 2011) Performance Measure Matrix that follows.



## PERFORMANCE MEASURE MATRIX

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

- Compares the BH MCO's own measure performance over the two most recent reporting years [Measurement Year (MY) 2011 and MY 2010]; and
- Compares the BH MCO's MY 2011 performance measure rates to the MY 2011 HealthChoices BH MCO Average.

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

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

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

-  The green box (A) indicates that performance is notable. The BH MCO's MY 2011 rate is statistically significantly above the MY 2011 HealthChoices BH MCO Average and trends up from MY 2010.
-  The light green boxes (B) indicate either that the BH MCO's MY 2011 rate is equal to the MY 2011 HealthChoices BH MCO Average and trends up from MY 2010 or that the BH MCO's MY 2011 rate is statistically significantly above the MY 2011 HealthChoices BH MCO Average but there is no change from MY 2010.
-  The yellow boxes (C) indicate that the BH MCO's MY 2011 rate is statistically significantly below the MY 2011 HealthChoices BH MCO Average and trends up from MY 2010 or that the BH MCO's MY 2011 rate is equal to the MY 2011 HealthChoices BH MCO Average and there is no change from MY 2010 or that the BH MCO's MY 2011 rate is statistically significantly above the MY 2011 HealthChoices BH MCO Average but trends down from MY 2010. *No action is required although MCOs should identify continued opportunities for improvement.*
-  The orange boxes (D) indicate either that the BH MCO's MY 2011 rate is statistically significantly below the MY 2011 HealthChoices BH MCO Average and there is no change from MY 2010 or that the BH MCO's MY 2011 rate is equal to the MY 2011 HealthChoices BH MCO Average and trends down from MY 2010. *A root cause analysis and plan of action is required.*
-  The red box (F) indicates that the BH MCO's MY 2011 rate is statistically significantly below the MY 2011 HealthChoices BH MCO Average and trends down from MY 2010. *A root cause analysis and plan of action is required.*



## Value Behavioral Health (VBH)

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### KEY POINTS

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

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

Measures that had no statistically significant change from MY 2010 to MY 2011 but were statistically significantly above/better than the MY 2011 HealthChoices BH MCO Averages are:

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

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

Measures that had no statistically significant changes from MY 2010 to MY 2011 and were not statistically significantly different from the MY 2011 HealthChoices BH MCO Averages are:

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

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

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

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

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

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

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



VBH performance measure rates for MY 2009, MY 2010, and MY 2011 are displayed in Figure 2. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

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

**Figure 2: Performance Measure Rates – VBH**

Quality Performance Measure	MY 2009 Rate	MY 2010 Rate	MY 2011 Rate	MY 2011 HC BH MCO Average
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	44.4%	44.4% =	45.7% =	45.78%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	68.5%	68.4% =	69.0% =	66.81%
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	57.5%	56.9% =	57.0% =	57.63%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	76.3%	76.3% =	76.3% =	74.67%
Readmission within 30 Days of Inpatient Psychiatric Discharge <sup>1</sup>	11.2%	10.5% =	9.4% =	12.34%

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



## **VI: SUMMARY OF ACTIVITIES**

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### **Structure and Operations Standards**

- VBH was partially compliant on Subparts C, D, and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2011, RY 2010, and RY 2009 were used to make the determinations.

### **Performance Improvement Projects**

- VBH submitted one PIP for validation in 2012 and received full credit for the elements of the study evaluated that reflect activities in 2011 (Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement).

### **Performance Measures**

- VBH reported all performance measures and applicable quality indicators in 2012.

### **2011 Opportunities for Improvement MCO Response**

- VBH provided a response to the opportunities for improvement issued in 2011.

### **2012 Strengths and Opportunities for Improvement**

- Both strengths and opportunities for improvement were noted for VBH in 2012. The BH MCO will be required to prepare a response for the noted opportunities for improvement in 2013.



## APPENDIX

### Appendix A: Crosswalk of Required PEPS Items to Pertinent BBA Regulations

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



BBA Category	PEPS Reference	PEPS Language
	Standard 1.3	Provider Exception report submitted & approved when choice of two providers is not given.
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).
	Standard 1.5	BH-MCO has notified DPW of any drop in provider network. <ul style="list-style-type: none"> <li>• Monitor provider turnover.</li> <li>• Network remains open where needed.</li> </ul>
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.208 Coordination and Continuity of Care	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.210 Coverage and authorization of services	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.2104	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law,



BBA Category	PEPS Reference	PEPS Language
Provider Selection		verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as, other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.240 Quality assessment and performance improvement program	Standard 91.1	QM program description outlines the ongoing quality assessment and performance improvement activities, Continuous Quality Improvement process and places emphasis on, but not limited to High volume/high-risk services and treatment and Behavioral Health Rehabilitation services.
	Standard 91.2	QM work plan includes goal, aspect of care/ service, scope of activity, frequency, data source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines, the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services, provider network adequacy, penetration rates, appropriateness of service authorizations, inter-rater reliability, complaint, grievance and appeal process, denial rates, grievance upheld and overturn rates and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other HV/HR services).

BBA Category	PEPS Reference	PEPS Language
	Standard 91.8	The QM work plan includes monitoring activities conducted to evaluate the quality and performance of the provider network (quality of individualized service plans and treatment planning, adverse incidents, collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance).
	Standard 91.9	The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	The QM work plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator for : ---Mental Health ---Substance Abuse External Quality Review: ---Follow up After Mental Health Hospitalization QM Annual Summary Report
	Standard 91.11	The identified Performance Improvement Projects must include the following: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality. 3. Evaluation of the effectiveness of the interventions. 4. Planning and initiation of activities for increasing or sustaining improvement. 5. Timeline for reporting status and results of each project to DPW. 6. Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year.
	Standard 91.12	The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.
	Standard 91.13	The BH-MCO has a process for its own evaluation of the impact and effectiveness of its quality management program annually. A report of this evaluation will be submitted to DPW by April 15 <sup>th</sup> .
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for Coordination with Other Service Agencies and School.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the



BBA Category	PEPS Reference	PEPS Language
		measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
§438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> </ul>
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality	



BBA Category	PEPS Reference	PEPS Language
		Management Denial Summary Report for the respective review year.
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> </ul>
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.	
Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.	



BBA Category	PEPS Reference	PEPS Language
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.	
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> </ul>
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the

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



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



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

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

Category	PEPS Reference	PEPS Language
<b>Second Level Complaints and Grievances</b>		
Complaints	Standard 68.6	The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 68.9	Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.
Grievances and State Fair	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and



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

**Appendix C: Program Evaluation Performance Summary OMHSAS-Specific Items for VBH Counties**

In RY 2011, 11 substandards were considered OMHSAS-specific monitoring standards, and were reviewed although not required to fulfill BBA requirements. Three standards for Beaver, Fayette, Greene and the Southwest Six Counties were not reviewed during the 2011 review year. Tables C.1a and C.1b provide a count of these substandards, along with the relevant categories. All 11 OMHSAS-specific PEPS Substandards were evaluated for the NC/CO Counties.

**Table C.1a OMHSAS-Specific Substandards Reviewed for Beaver, Fayette, Greene, and the Southwest Six Counties**

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	Not Reviewed
Complaints (Standard 68)	4	4	0	0	0
Grievances and State Fair Hearings (Standard 71)	4	4	0	0	0
Consumer/Family Satisfaction (Standard 108)	3	0	0	0	3

**Table C.1b OMHSAS-Specific Substandards Reviewed for the NC/CO Counties**

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	Not Reviewed
Complaints (Standard 68)	4	4	0	0	0
Grievances and State Fair Hearings (Standard 71)	4	4	0	0	0
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0



**Format**

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

**Findings**

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards, and all eight substandards were evaluated for VBH. VBH met one substandard, partially met four substandards, and did not meet three substandards as seen in Table C.2.

**Table C.2 OMHSAS-Specific Requirements Relating to Second Level Complaints and Grievances for all VBH Counties**

Category	PEPS Item	Review Year	Status
<b>Second Level Complaints and Grievances</b>			
Complaints	Substandard 68.6	RY 2011	Not Met
	Substandard 68.7	RY 2011	Partially Met
	Substandard 68.8	RY 2011	Partially Met
	Substandard 68.9	RY 2011	Partially Met
Grievances and State Fair Hearings	Substandard 71.5	RY 2011	Not Met
	Substandard 71.6	RY 2011	Met
	Substandard 71.7	RY 2011	Not Met
	Substandard 71.8	RY 2011	Partially Met

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

**VBH** was “not met” on Substandard 68.6 (RY 2011):

**Substandard 68.6:** The second level complaint case file includes documentation that the member was contacted about the second level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.

**VBH** was “partially met” on Substandard 68.7 (RY 2011):

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

**VBH** was “partially met” on Substandard 68.8 (RY 2011):

**Substandard 68.8:** 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.

**VBH** was “partially met” on Substandard 68.9 (RY 2011):

**Substandard 68.9:** Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.



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

**VBH** was “not met” on Substandard 71.5 (RY 2011):

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

**VBH** was “not met” on Substandard 71.7 (RY 2011):

**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.

**VBH** was “partially met” on Substandard 71.8 (RY 2011):

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

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are County-specific review standards. All three substandards crosswalked to this category were evaluated for the NC/CO Counties, and their statuses are presented in Table C.3. Beaver, Fayette, Greene, and the Southwest Six Counties were not reviewed during RY 2011. The NC/CO Counties had varying compliance.

**Table C.3 OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for the NC/CO Counties**

Category	PEPS Item	Review Year	Status by County		
			Met	Partially Met	Not Met
<b>Enrollee Satisfaction</b>					
Consumer/Family Satisfaction	Standard 108.3	RY 2009	Crawford, Venango	Cambria, Mercer	
	Standard 108.4	RY 2009		Cambria, Crawford, Venango	Mercer
	Standard 108.9	RY 2009	Cambria	Crawford, Mercer, Venango	

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

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

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

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



**Substandard 108.4:** The C/FST Director is responsible for setting program direction consistent with County direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority and directing staff to perform high quality surveys.

***Mercer County*** was “not met” on Substandard 108.4:

**Substandard 108.4:** The C/FST Director is responsible for setting program direction consistent with County direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority and directing staff to perform high quality surveys.

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

**Substandard 108.9:** Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.

## REFERENCES

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- ii Dombrovski A, Rosenstock J (2004) Bridging General Medicine and Psychiatry: Providing General Medical and Preventive Care for the Severely Mentally Ill. *Current Opinion in Psychiatry*, 17(6):523-529
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