

PROVIDER PROFILING

BEHAVIORAL HEALTH REHABILITATION SERVICES

April 1, 2010-March 31, 2011

OVERVIEW

BHRS is designed to provide in-home and/or community based treatment to children and adolescents with, or at risk for, developing serious behavioral or emotional difficulties. Value Behavioral Health of Pennsylvania (VBH-PA) utilizes a provider profiling system to focus on an assessment of health care delivery and to examine patterns and trends in care. A comprehensive provider profiling system serves as a quality management tool to support administrative and clinical processes, particularly when opportunities for improvement are identified. Provider profiling can be described as the process of identifying those providers who consistently meet established VBH-PA clinical and administrative standards based upon performance indicators and routine data analysis.

VBH-PA utilizes profiling in an analytical process to compare practice patterns of similar providers based on a standard set of measures.

METHODOLOGY

Network data used in this profile are based on claims data by service date for specified BHRS services from **April 1, 2010 to March 31, 2011** for VBH-PA Health Choices members. The methodologies for these sections are explained in detail in the report. The claims data set included only claims that were finalized and not denied. Claims data were chosen because it best reflects what was actually utilized. A lag of three months is used to insure that all claims have been finalized and paid. Diagnostic comparisons are based on the most recent claim submitted within the profile timeframe. **Providers who served less than 40 distinct members were excluded from the high volume provider analyses.** Strength Based Treatment data is not included in this analysis.

PA Autism Insurance -ACT 62 (Effective July 1, 2009) This law requires many private health insurance companies to cover the cost of diagnostic assessment and treatment of autism spectrum disorders for children under the age of 21, up to \$36,000 per year. Once the cap is reached, VBH-PA will assume payment for eligible members. Data in this report could be impacted over time as the member's eligibility changes when the \$36,000 limit is reached and at the beginning of an enrollment period. **As a result, ACT 62 members are not included in this profile.**

An **outlier analysis is completed by cost for the top five diagnoses** using the mean (average) and standard deviation for each indicator. A provider was considered an outlier for an indicator if that indicator was +1 or -1 standard deviation from the mean.

This report is divided into the following sections:

A. TOP SIX DIAGNOSTIC CATEGORIES:

- Average cost per member (ACPM) for the top six diagnostic categories and the VBH-PA Network totals
- Average cost per member yearly comparison

- Average cost and average units per member (AUPM) for the Autism Spectrum Disorder (ASD) and Non ASD disorder categories
- Average cost and average units per member by type of service (Behavioral Specialist Consultant, Mobile Therapist and Therapeutic Support Staff)

B. DEMOGRAPHIC INFORMATION:

- Average cost and percentage paid per member by age and gender

This profile divides the BHRS providers into several comparison groups and includes the following data elements:

C. PROVIDERS of TSS, MT, AND BSC serving at least 40 distinct members from 4/1/2010 – 3/31/2011.

- Average cost and units per member with cost outlier analysis by provider for all diagnoses combined, ASD and ADHD
- Average units per member comparison by year

D. CONCURRENT FAMILY BASED OR INPATIENT MENTAL HEALTH SERVICES DURING THE BHRS AUTHORIZATION PERIOD

E. FOLLOW UP SERVICES AFTER DISCHARGE (Aggregate)

F. SUMMER THERAPEUTIC ACTIVITIES PROGRAM (STAP)

- Listed by provider, specialty, total distinct member count, total paid amount and the average cost per member

G. COMPLAINTS

- Number of member level I complaints listed by provider, percent of complaints based on the number of distinct members
- Number of complaints by category

H. CONSUMER / FAMILY SATISFACTION DATA

- State mandated questions- aggregate
- Provider specific information as available

I. EVALUATORS

- Total distinct count of members, total paid amount, average units per member

J. PROVIDER REPORT CARDS:

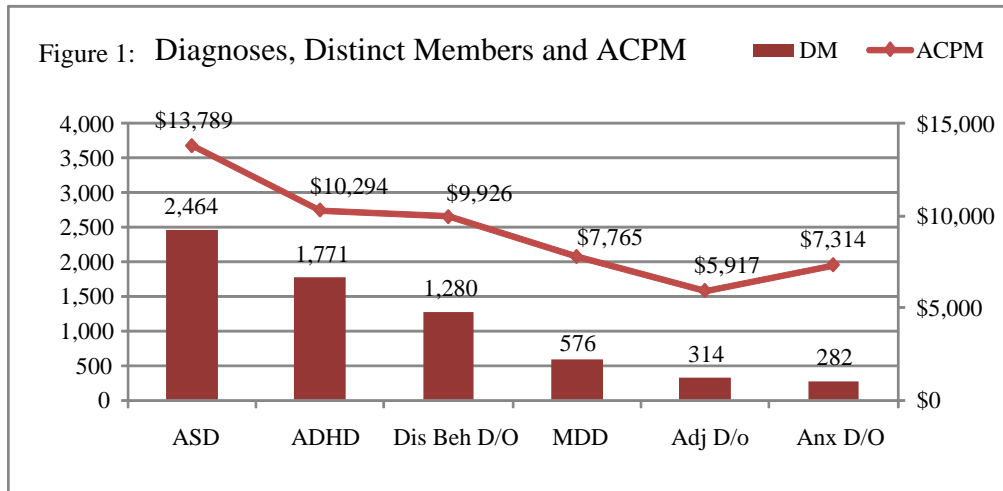
- Average cost per member for the top diagnostic groups compared to VBH-PA
- Outlier Analyses by diagnostic category
- Number of complaints
- Distinct members receiving Family Based and Inpatient Mental Health concurrently with BHRS

PROVIDER NETWORK - TOP SIX DIAGNOSTIC CATEGORIES

The BHRS paid claims data for VBH-PA were sorted by diagnostic category, paid amount and units. This section includes BSC, MT and TSS services only. All Network BHRS providers are included in this diagnostic comparison. **For the purpose of the VBH-PA aggregate these data also include providers with less than 40 distinct members.** The top six diagnostic categories for the service center are listed below, as well as the VBH-PA totals for all diagnoses: *As previously stated, ACT 62 members and any associated costs are not included in this report.*

Table 1: Top Six Diagnostic Categories	DM	Paid Amount	ACPM	2010-11 % of Paid Amount	2009-10 % of Paid Amount
Autism Spectrum Disorders	2,464	\$33,974,921	\$13,789	44%	48%
ADHD	1,771	\$18,229,881	\$10,294	23%	20%
Disruptive Behavior Disorder NOS	1,280	\$12,705,823	\$9,926	16%	15%
Major Depression	576	\$4,472,722	\$7,765	6%	6%
Adjustment Disorders	314	\$1,857,988	\$5,917	2%	3%
Anxiety Disorders	282	\$2,062,681	\$7,314	3%	3%
Total for All Diagnoses 2010/11	6,976	\$77,885,563	\$11,165		
Total for All Diagnoses 2009/10	6,887	\$83,097,372	\$12,066		

(The Autism Spectrum Disorder category includes Autistic Disorder, Rett’s Disorder, Asperger’s Disorder, Pervasive Developmental Disorder NOS, and Childhood Disintegrative Disorder.)



Including all BHRS providers, **the top six diagnostic categories account for 94% of the total paid amount** for BSC, MT and TSS provided for members living in the fourteen counties. The VBH-PA BHRS **distinct members count increased 1.2%**. The overall **paid amount decreased by 6.3% in the past year** and over 13% since 2008/09.

Table 2 shows the average cost per member (ACPM) by diagnoses for the last three years and the percentage change from the previous 12 months. When compared with the 2009/10 results, the **average cost decreased by 7.5% from \$12,066 to \$11,165.**

Table 2: Average Cost per Member by Diagnosis				
Diagnosis	2008-09	2009-10	2010-11	% Change (12 mos.)
Autism Spectrum Disorder (ASD)	\$17,234	\$15,640	\$13,789	-11.8%
Bipolar	\$11,111	\$12,821	\$11,575	-9.7%
ADHD	\$10,748	\$10,230	\$10,294	0.6%
Disruptive Behavior D/O	\$11,222	\$10,318	\$9,926	-3.8%
Major Depression	\$9,300	\$8,571	\$7,765	-9.4%
Adjustment Disorders	\$6,754	\$5,561	\$5,917	6.4%
All Diagnoses	\$13,052	\$12,066	\$11,165	-7.5%

In Table 3, based on paid claims, the average units (AUPM) for members with a Non ASD diagnosis is 1091. This is a decrease of 3.9% from last year. **Members with a primary diagnosis within the Autism Spectrum Disorders had a 12.3% decrease in AUPM** from the previous twelve months. Contributing factors for these decreases may be that prescribers are “right-sizing” the prescription for BHRS as their understanding has improved for medical necessity criteria. Additionally, VBH-PA continues the management of these services by the clinical department and encourages prescribers to utilize more stringent diagnostic protocols that are endorsed by the PA Bureau of Autism Services (BAS).

Table 3: Non-ASD vs. ASD						
	DM	% of Total DM	ACPM	AUPM 2010-11	AUPM 2009-10	AUPM 2008-09
Non ASD	4,547	65%	\$9,657	1091	1135	1247
ASD	2,464	35%	\$13,789	1612	1839	2052

PROVIDER NETWORK - TYPE OF SERVICE

Analyzing the data by type of service illustrates that Therapeutic Support Staff (TSS) has the highest percentage of the paid amount at 62%. Behavioral Specialist Consultant (BSC) is second at 29%, followed by Mobile Therapy (MT) at 8%. **The AUPM for TSS decreased 6.7%** from the previous 12 month period. AUPM for BSC decrease 4.5% and AUPM for MT remained nearly the same.

Table 4: Type of Service							
Service	DM	Paid Amount	ACPM	% Paid Amount	AUPM	AUPM	AUPM
					2010-11	2009-10	2008-09
BSC	6,053	\$22,720,486	\$3,754	29%	291	305	310
MT	3,007	\$6,511,733	\$2,166	8%	206	205	200
TSS	5,006	\$48,653,344	\$9,719	62%	1307	1401	1540
Total	6,976	\$77,885,563	\$11,165		1280	1403	1551

PROVIDER NETWORK - AGE and GENDER

Methodology:

Claims data were utilized to obtain all distinct members receiving BHR services from April 1, 2010 to March 31, 2011. **The data set includes 6976 members who received BSC, MT and TSS services.** The age and gender data includes all VBH providers.

Table 5a: Age for All Distinct Members				
	DM	Paid Amount	ACPM	Percent Paid of Grand Total
0-5	1,281	\$11,345,677	\$8,857	15%
6-12	4,115	\$50,591,496	\$12,294	65%
13-17	1,376	\$14,039,396	\$10,203	18%
18-21	203	\$1,908,957	\$9,404	2%
Grand Totals	6,976	\$77,885,563	\$11,165	
Table 5b: Males				
	DM	Paid Amount	ACPM	Percent Paid of Grand Total
0-5	984	\$8,822,935	\$8,966	15%
6-12	3,001	\$38,970,240	\$12,986	65%
13-17	954	\$10,685,452	\$11,201	18%
18-21	134	\$1,424,850	\$10,633	2%
Total Males	5,074	\$59,903,514	\$11,806	
Table 5c: Females				
	DM	Paid Amount	ACPM	Percent Paid of Grand Total
0-5	297	\$2,522,742	\$8,494	14%
6-12	1,114	\$11,621,256	\$10,432	65%
13-17	422	\$3,353,945	\$7,948	19%
18-21	69	\$484,107	\$7,016	3%
Total Females	1,902	\$17,982,049	\$9,454	

The three highest utilizing age groups by the total paid amount are males 6-12, females 6-12 and males 13-17, this remains unchanged from the previous year. **The highest average cost per member by gender and age is male 6-12 at \$12,986. The highest utilization age group overall (male and female combined) is 6-12** which represents 59% of the distinct member count and 65% of total paid amount.

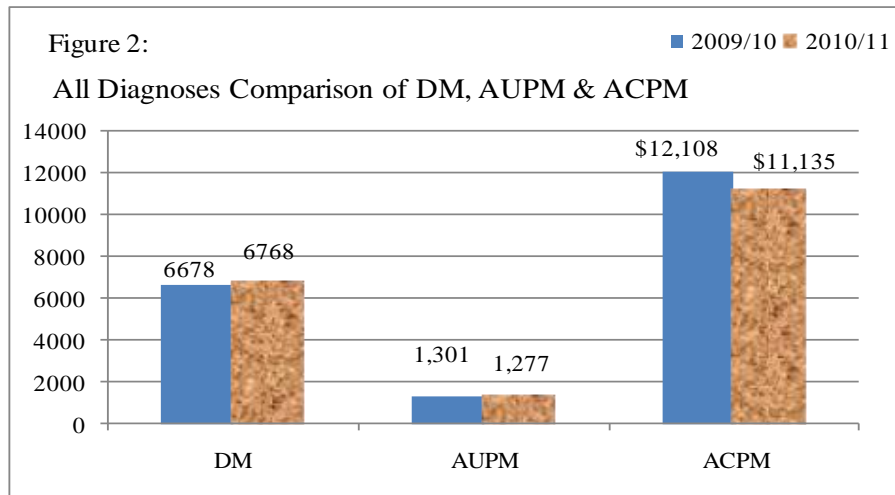
The total number of males receiving BHRS is 5,074, and the total number of females is 1,902. **The ratio of males to females is 2.7 to 1.** Males utilized 77% of the paid dollars, while females utilized 23%. The ratio of male to females and the percentages of paid dollars remain unchanged from the previous year.

ALL DIAGNOSES

Figure 2 shows the overall comparisons for distinct members, average units per member and the average costs per member for all of the diagnostic categories for the profiled providers.

Improvements:

- The overall AUPM decreased 1.8% from last year.
- The average cost per member decreased 8 percent



The 42 BHRS high volume providers in Table 6 are listed according to the average cost per member for combined BSC, MT and TSS services. The following analysis compares BHRS providers who serve members with all diagnoses. The AUPM in ***bold italics*** represents increases in paid units from the previous year for six providers.

In the past, some psychologists/ psychiatrists submitted claims under one provider name. This has changed and these providers now submit claims separately. Some of the data from the prior year is not available due to these billing changes. Where data is available, **25 of the 31 previously profiled providers (81%) had decreases in the average units per member.**

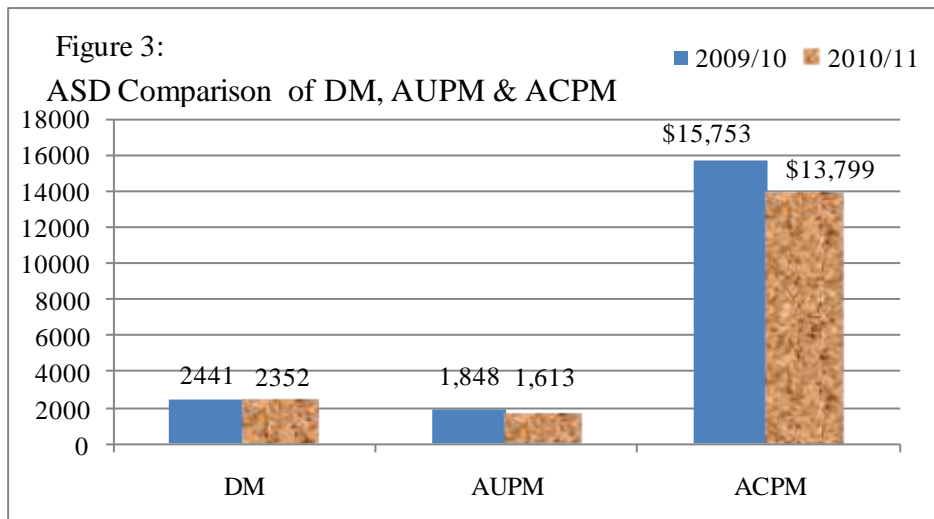
Table 6 All Diagnostic Categories Provider #	DM	Paid Amount	ACPM	Cost Outlier	AUPM 2010/11	AUPM 2009/10
12	81	\$1,484,175	\$18,323	2.21	2094	2369
4	424	\$6,956,237	\$16,406	1.62	1889	1778
30	349	\$5,267,503	\$15,093	1.21	1805	1892
39	267	\$3,968,942	\$14,865	1.14	1733	1546
20	83	\$1,097,618	\$13,224	0.64	1646	*
6	61	\$796,454	\$13,057	0.59	1390	1640
35	162	\$2,099,547	\$12,960	0.56	1508	1976
11	122	\$1,516,578	\$12,431	0.40	1366	1440
10	219	\$2,722,179	\$12,430	0.40	1402	1491
8	593	\$7,018,130	\$11,835	0.21	1409	1732
34	48	\$561,158	\$11,691	0.17	1390	*
26	220	\$2,549,078	\$11,587	0.14	1309	1414
27	266	\$2,987,536	\$11,231	0.03	1135	*
42	175	\$1,963,102	\$11,218	0.03	1348	1661
3	232	\$2,512,347	\$10,829	-0.09	1301	1404
16	918	\$9,541,420	\$10,394	-0.23	1160	1308
28	222	\$2,224,539	\$10,020	-0.34	1133	1295
36	52	\$515,332	\$9,910	-0.38	1108	927
22	49	\$467,139	\$9,533	-0.49	1075	1214
15	223	\$2,020,990	\$9,063	-0.64	1135	1554
18	180	\$1,617,299	\$8,985	-0.66	997	1070
21	50	\$448,441	\$8,969	-0.66	1049	1317
9	53	\$472,944	\$8,923	-0.68	972	*
2	112	\$998,846	\$8,918	-0.68	1035	1131
40	74	\$644,129	\$8,704	-0.75	963	778
41	138	\$1,199,609	\$8,693	-0.75	950	1117
24	57	\$474,391	\$8,323	-0.86	894	*
5	119	\$964,849	\$8,108	-0.93	937	929
29	61	\$485,620	\$7,961	-0.97	901	*
25	64	\$504,571	\$7,884	-1.00	857	*
19	145	\$1,119,213	\$7,719	-1.05	796	858
14	69	\$526,965	\$7,637	-1.07	899	*
23	154	\$1,152,554	\$7,484	-1.12	835	924
17	46	\$298,565	\$6,491	-1.42	704	*
1	454	\$2,935,758	\$6,466	-1.43	765	798
32	123	\$794,509	\$6,459	-1.43	758	712
33	94	\$583,490	\$6,207	-1.51	751	814
7	85	\$519,372	\$6,110	-1.54	616	690
38	128	\$672,882	\$5,257	-1.80	564	673
31	52	\$251,333	\$4,833	-1.93	570	998
37	56	\$227,475	\$4,062	-2.17	471	*
13	50	\$198,862	\$3,977	-2.20	466	*
Providers 2010/11	6,768	\$75,361,683	\$11,135		1277	1301
Providers 2009/10	6678	\$80,858,631	\$12,108.21		* No data available	

AUTISM SPECTRUM DISORDER

The following analysis compares BHRS providers who serve members diagnosed with Autism Spectrum Disorders (ASD) as the primary diagnoses reported on the most recent paid claim. Treating members with primary diagnoses of **ASD comprised 43% of the BHRS cost and 35% of the total distinct member count.**

Improvements:

- There was a decrease in the average units per member for 22 providers and this led to a **12.7% overall decrease in the AUPM.**
- There was a **16% decrease in the total paid amount** for this diagnosis with a 3.6% decrease in distinct members.



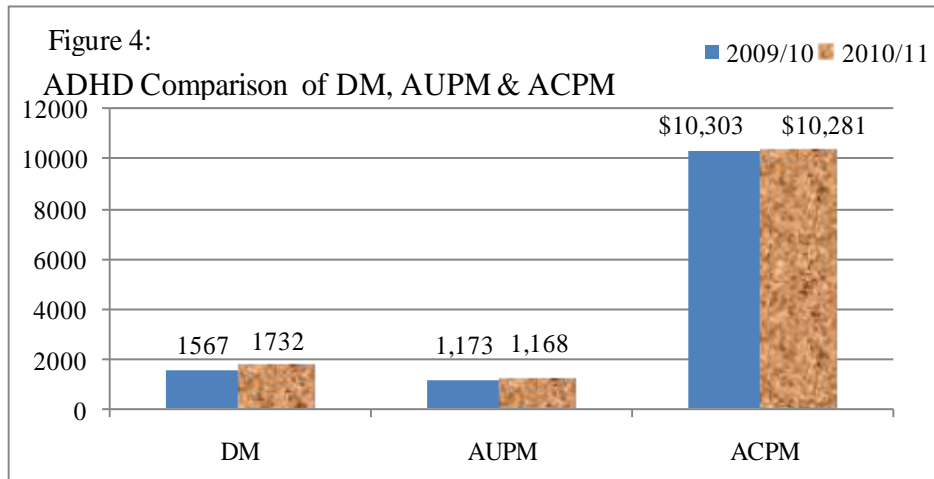
In Table 7, each provider is listed with the ASD distinct member count, the total amount paid, the average cost per member (ACPM) and the outlier analysis based on the average cost. Where the previous year data is available, 22 of the 31 providers (71%) had decreases in the average units per member. The AUPM in ***bold italics*** represents increases in paid units from the previous year for 29% of the providers. In the last two columns, the average units per member (AUPM) for 2010-11 are compared with data from 2009/10.

Table 7						
ASD						
Provider. #	DM	Paid Amount	ACPM	Cost Outlier	AUPM 2010/11	AUPM 2009/10
12	19	\$532,149	\$28,008	2.81	3341	3588
4	72	\$1,704,519	\$23,674	1.95	2821	3265
30	99	\$2,328,013	\$23,515	1.92	2885	2764
11	22	\$481,768	\$21,899	1.60	2538	1747
8	116	\$2,167,570	\$18,686	0.97	2276	3087
3	43	\$799,739	\$18,599	0.95	2292	3018
39	76	\$1,358,306	\$17,872	0.81	2151	1879
20	39	\$692,259	\$17,750	0.78	2245	*
42	61	\$1,045,736	\$17,143	0.66	2101	2325
21	6	\$98,826	\$16,471	0.53	1971	1737
35	77	\$1,220,254	\$15,847	0.40	1875	2468
34	18	\$282,410	\$15,689	0.37	1876	*
10	55	\$837,934	\$15,235	0.28	1766	2024
14	13	\$182,550	\$14,042	0.05	1707	*
6	12	\$152,765	\$12,730	-0.21	1346	971
27	118	\$1,462,447	\$12,394	-0.28	1259	*
16	517	\$6,280,920	\$12,149	-0.33	1383	1544
26	154	\$1,860,168	\$12,079	-0.34	1364	1419
33	6	\$68,599	\$11,433	-0.47	1380	799
36	13	\$147,775	\$11,367	-0.48	1258	891
2	68	\$761,229	\$11,195	-0.51	1335	1451
28	33	\$348,004	\$10,546	-0.64	1225	1657
25	18	\$189,149	\$10,508	-0.65	1188	*
18	43	\$449,364	\$10,450	-0.66	1165	1312
29	14	\$145,390	\$10,385	-0.67	1217	*
24	16	\$164,430	\$10,277	-0.70	1160	*
41	83	\$852,809	\$10,275	-0.70	1152	1355
15	166	\$1,658,085	\$9,988	-0.75	1258	1835
23	77	\$758,192	\$9,847	-0.78	1110	1065
32	12	\$115,716	\$9,643	-0.82	1175	1096
5	14	\$134,248	\$9,589	-0.83	1100	1128
40	64	\$584,722	\$9,136	-0.92	1008	812
1	138	\$1,248,383	\$9,046	-0.94	1100	1195
22	16	\$144,531	\$9,033	-0.94	999	1192
17	8	\$66,876	\$8,359	-1.07	975	*
7	15	\$112,599	\$7,507	-1.24	778	705
19	55	\$400,814	\$7,288	-1.29	760	1000
31	14	\$94,858	\$6,776	-1.39	837	1309
38	55	\$347,020	\$6,309	-1.48	679	893
9	11	\$66,120	\$6,011	-1.54	685	*
13	16	\$65,481	\$4,093	-1.92	493	*
37	12	\$41,448	\$3,454	-2.04	418	*
Providers 2010/11	2,352	\$32,454,170	\$13,799		1613	1848
Providers 2009/10	2,441	\$38,454,084	\$15,753		* No data available	

ATTENTION DEFICIT /HYPERACTIVITY DISORDER

This analysis compares BHRS providers with distinct members diagnosed with ADHD as the primary diagnosis reported on the most recent paid claim. There was an 10.5% increase in the number of distinct members for the 12-month period. **Treating members with a primary diagnosis of ADHD represents 24% of BHRS costs and 26% of the distinct members.** Indicators remained nearly the same as last year.

- There was < 1 % decrease in AUPM (1173 to 1168); remaining nearly the same as last year.
- There was a <1% decrease in the average cost per member.



Each provider in Table 8 is listed with the ADHD distinct member count, the total amount paid, the average cost, the outlier analysis, and the average units per member for 2010/11 and 2009/10. The data in *bold italics* in the AUPM 2010-11 column represents increases in the average units per member from the previous year.

Table 7:						
ADHD Provider #	DM	Paid Amount	ACPM	Cost Outlier	AUPM 2010/11	AUPM 2009/10
12	28	\$507,295	\$18,118	2.14	2059	2135
4	139	\$2,276,153	\$16,375	1.66	1861	1571
34	7	\$101,170	\$14,453	1.14	1741	*
6	23	\$329,707	\$14,335	1.11	1585	1800
35	23	\$328,239	\$14,271	1.09	1684	1875
30	120	\$1,657,371	\$13,811	0.96	1631	1430
39	85	\$1,088,883	\$12,810	0.69	1468	1440
28	57	\$659,337	\$11,567	0.35	1315	1361
27	68	\$748,883	\$11,013	0.20	1128	1130
9	18	\$193,702	\$10,761	0.13	1192	*
8	187	\$1,997,576	\$10,682	0.11	1252	1501
10	68	\$709,855	\$10,439	0.04	1165	1032
3	125	\$1,298,881	\$10,391	0.03	1239	1043
11	33	\$335,605	\$10,170	-0.03	1093	1719
5	31	\$275,197	\$8,877	-0.38	999	881
19	46	\$403,333	\$8,768	-0.41	906	973
29	17	\$146,760	\$8,633	-0.45	981	*
22	9	\$76,995	\$8,555	-0.47	962	1674
16	126	\$1,050,430	\$8,337	-0.53	887	880
26	8	\$63,816	\$7,977	-0.63	832	1430
18	75	\$594,463	\$7,926	-0.64	863	858
32	50	\$386,893	\$7,738	-0.69	916	805
42	42	\$316,449	\$7,534	-0.75	878	1309
21	14	\$104,050	\$7,432	-0.78	881	976
20	13	\$94,080	\$7,237	-0.83	892	*
14	20	\$134,366	\$6,718	-0.97	775	731
25	13	\$82,343	\$6,334	-1.08	693	*
41	14	\$88,118	\$6,294	-1.09	637	881
33	15	\$94,037	\$6,269	-1.09	714	785
17	22	\$134,385	\$6,108	-1.14	643	*
1	166	\$954,326	\$5,749	-1.24	671	671
7	10	\$53,911	\$5,391	-1.33	553	315
36	6	\$30,885	\$5,147	-1.40	557	845
24	10	\$50,667	\$5,067	-1.42	495	*
15	14	\$70,695	\$5,050	-1.43	602	851
31	13	\$65,412	\$5,032	-1.43	593	866
23	12	\$60,067	\$5,006	-1.44	583	*
37	13	\$64,882	\$4,991	-1.44	591	*
38	24	\$109,690	\$4,570	-1.56	500	649
40	3	\$10,838	\$3,613	-1.82	341	402
13	11	\$38,589	\$3,508	-1.85	410	*
2	6	\$18,584	\$3,097	-1.96	306	888
Profiled Providers 10/11	1,732	\$17,806,912	\$10,281		1168	1173
Profiled Providers 09/10	1,567	\$16,144,877	\$10,303		* No data available	

CONCURRENT SERVICES WITH BHRS

Figure 5 illustrates the percentage of distinct members whose claims were paid for Family Based Services (line graph) and /or MH Inpatient (column graph) concurrently with BHRS claims. Seven of the 42 providers had no concurrent Inpatient claims while providing BHRS. Eight providers had no Family Based claims while providing BHRS.

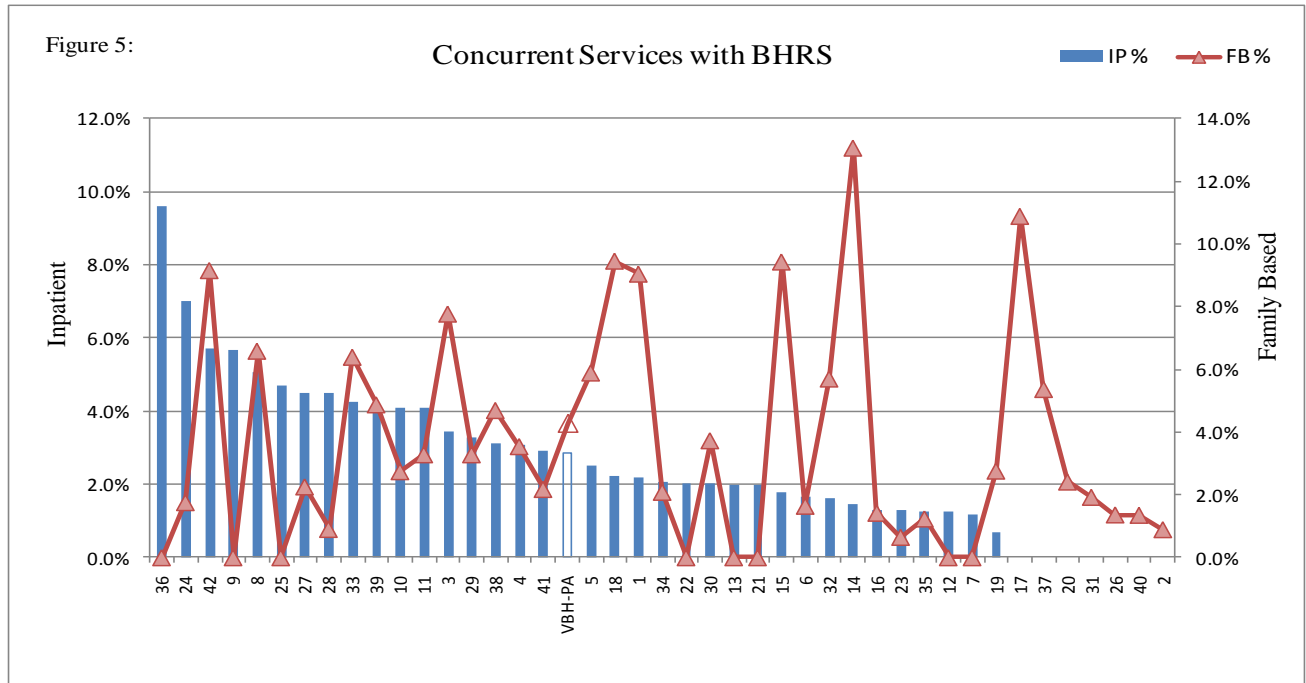


Table 6 on the following page is sorted based on the highest to lowest percentage of concurrent claims for Inpatient Mental Health and BHRS. **The average percentage of distinct members receiving BHRS and Inpatient Services is 2.8% and the average for Family Based Services is 6.3%**

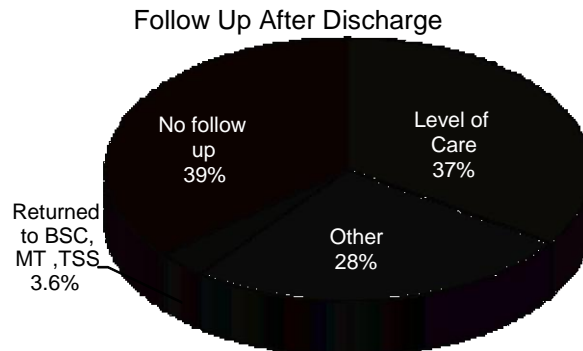
Table 6:					
Concurrent Services	BHRS			Family Based	
Prov. #	DM	Inpatient DM	IP %	DM	FB %
36	52	5	9.6%	0	0.0%
24	57	4	7.0%	1	1.8%
42	175	10	5.7%	16	9.1%
9	53	3	5.7%	0	0.0%
8	593	30	5.1%	39	6.6%
25	64	3	4.7%	0	0.0%
27	266	12	4.5%	6	2.3%
28	222	10	4.5%	2	0.9%
33	94	4	4.3%	6	6.4%
39	267	11	4.1%	13	4.9%
10	219	9	4.1%	6	2.7%
11	122	5	4.1%	4	3.3%
3	232	8	3.4%	18	7.8%
29	61	2	3.3%	2	3.3%
38	128	4	3.1%	6	4.7%
4	424	13	3.1%	15	3.5%
41	138	4	2.9%	3	2.2%
VBH-PA	6,768	192	2.8%	290	4.3%
5	119	3	2.5%	7	5.9%
18	180	4	2.2%	17	9.4%
1	454	10	2.2%	41	9.0%
34	48	1	2.1%	1	2.1%
22	49	1	2.0%	0	0.0%
30	349	7	2.0%	13	3.7%
13	50	1	2.0%	0	0.0%
21	50	1	2.0%	0	0.0%
15	223	4	1.8%	21	9.4%
6	61	1	1.6%	1	1.6%
32	123	2	1.6%	7	5.7%
14	69	1	1.4%	9	13.0%
16	918	12	1.3%	13	1.4%
23	154	2	1.3%	1	0.6%
35	162	2	1.2%	2	1.2%
12	81	1	1.2%	0	0.0%
7	85	1	1.2%	0	0.0%
19	145	1	0.7%	4	2.8%
17	46	0	0%	5	10.9%
37	56	0	0%	3	5.4%
20	83	0	0%	2	2.4%
31	52	0	0%	1	1.9%
26	220	0	0%	3	1.4%
40	74	0	0%	1	1.4%
2	112	0	0%	1	0.9%
Profiled Providers 2010/11	6,768	192	2.8%		
Profiled Providers 2009/10	6678	210	3.1%	276	4.1%

FOLLOW-UP LEVELS OF CARE WITHIN 60 DAYS OF DISCHARGE

For the purpose of this claims review, **discharge is defined as no BSC, MT or TSS claims for the member for 30 consecutive days.** In the initial claims report 2991 DM (43% out of 6,976 members included in the aggregate data had no BSC, MT or TSS service for 30 consecutive days during the profile period. This is the same percentage as last year. Once this population was determined, a report was completed to determine what levels of care or other types of service the members received within 60 days after discharge. **About 61% of those discharged received a subsequent service within 60 days.** This is a decrease from 75.8% last year who received a subsequent service. Members in this category may have lost eligibility due to age, moved, or made a choice not to receive further MH or D&A services.

Table 10: Follow up Services within 60 days of Discharge

Level of Care		Other (Non BSC, MT or TSS services)		Combined Categories: Level Of Care, Other or returned to BHRS		
	DM		DM		DM	Percent
Inpatient MH	40	Evaluations	271	Level of Care	1105	37%
Partial Hospital	99	Independent Evaluations	82	Other	607	28%
Outpatient MH	666	Adolescent Diversion Stabilization Unit	2	Returned to BSC,MT, or TSS w/60 days	107	3.6%
Evaluations	11	Group Home	22	Total rec'd service w/60 days after discharge		
RTF	45	Family Focused Solutions	101		1819	61%
Outpatient D&A	3	STAP (camp)	124	No Service –w/60 days after discharge		
Labs	1	Assist TSS	9		1172	39%
Clozapine	1	AFT(After School Program)	12	Total		
Crisis	9	Strength Base Treatment	26		2991	
FBMH	171	School Based	5			
Psych Rehab	1	MST	10			
Non Hosp Rehab	8	Total		607		
Case Management	1					
RC	32					
Blended CM	409					
Peer Support	3					
Total		1105				



Summer Therapeutic Activities Program (Summer Camp)

Below is the list of providers who conducted summer camps in **2010**. No exclusion criteria were used for this analysis, and only aggregate totals are used. Twenty-eight providers held Summer Therapeutic Activity Programs. In addition to the regular programs which include Social Educational Development (SED), many of the providers offered specialty programs for Autism. There **was an increase of 11.2% in the number of distinct members and a 12.8% increase in the paid amount from 2009 to 2010**. (Due to claims lag of 90 days, 2011 data for STAP is not available at the time of the publication.)

Table 10:

Prov. #	Specialty	DM	Paid Amount	ACPM	Units	AUPM
1	ADHD	162	\$521,678	\$3,220	35,770	221
18	SED	270	\$441,914	\$1,637	28,812	107
46	Autism Spectrum Disorder	77	\$398,384	\$5,174	14,904	194
12	ADHD	144	\$319,453	\$2,218	26,324	183
3	ADHD, OCD, ODD	178	\$293,635	\$1,650	20,625	116
16	Autism Spectrum Disorder	141	\$212,337	\$1,506	13,294	94
44	SED/ ADD	77	\$202,128	\$2,625	15,025	195
15	Autism Spectrum Disorder	82	\$164,914	\$2,011	12,234	149
22	Autism Spectrum Disorder	68	\$154,132	\$2,267	7,006	103
45	SED	60	\$118,920	\$1,982	5,946	99
10	SED	139	\$116,193	\$836	7,092	51
7	SED	91	\$108,910	\$1,197	7,915	87
28	ADHD, ODD, Mood D/O	68	\$99,300	\$1,460	8,275	122
5	SMI, ADHD, Mood D/O	91	\$97,290	\$1,069	10,241	113
43	MH/MR	73	\$90,981	\$1,246	6,612	91
36	SED	86	\$81,817	\$951	5,946	69
17	Autism Spectrum Disorder	49	\$70,188	\$1,432	5,615	115
50	ADHD	44	\$60,741	\$1,380	4,373	99
33	ALL Non-MR	56	\$54,986	\$982	5,794	103
8	SED	51	\$53,789	\$1,055	5,662	111
48	Autism Spectrum Disorder	18	\$46,203	\$2,567	1,996	111
30	Autism Spectrum Disorder	54	\$33,321	\$617	2,777	51
11	ADHD, Mood, Anxiety D/O	29	\$20,640	\$712	1,376	47
26	Autism Spectrum Disorder	11	\$17,453	\$1,587	783	71
35	Autism Spectrum Disorder	18	\$15,375	\$854	615	34
49	Autism Spectrum Disorder, MR	13	\$14,400	\$1,108	800	62
51	ADHD	37	\$13,375	\$361	972	26
47	Autism Spectrum Disorder	3	\$3,634	\$1,211	285	95
	Network Totals	2,182	\$3,826,089	\$1,753	257,069	118

HIGH VOLUME PROVIDERS - MEMBER COMPLAINTS

Methodology: The number of complaints per provider was determined by querying the VBH-PA member complaint database for Level I complaints. **Fourteen of the 42 providers (33%)** included in this profile had member complaints regarding BHRS services from April 1, 2010 to March 31, 2011. Table 11 shows the percentage of complaints based on the number of members that received services. The overall complaint rate is < 0.5%, a slight improvement from the previous year.

Table 11: Prov. #	DM	Complaints	Percent
21	50	2	4.0%
26	220	7	3.2%
17	46	1	2.2%
23	154	3	1.9%
25	64	1	1.6%
40	74	1	1.4%
4	424	2	0.5%
10	219	1	0.5%
1	454	2	0.4%
3	232	1	0.4%
39	267	1	0.4%
8	593	2	0.3%
30	349	1	0.3%
16	918	1	0.1%
Profiled Providers 2010/11	6768	26	0.4%
Profiled Providers 2009/10	6678	48	0.7%

The complaints for all BHRS providers are categorized below.

Table 12: Complaint Categories	Total	Percent
Provider Office Unsatisfactory	12	35%
Dissatisfied With Tx Received	11	32%
Treatment Delayed	5	15%
Unethical/Inappropriate Behavior	3	9%
Denied Services The Member Requested	1	3%
No Call Back	1	3%
Refused To Treat Member	1	3%
Total Complaints/ All Providers	34	

NETWORK PROVIDERS - CONSUMER/FAMILY SATISFACTION RESULTS

Overview: The focus of the Consumer/Family Satisfaction Team (C/FST) program is to solicit input from consumers (both children and adults) and families of consumers utilizing mental health and substance abuse services. This is accomplished through face to face and telephonic interviews by the C/FST. The purpose of the C/FST program is to determine whether consumers and families are satisfied with services in terms of access, delivery, outcomes, appropriateness of service, and being treated with dignity and respect. C/FST interviews also assist in early identification and resolution of potential problem areas.

Methodology: Each Consumer Satisfaction Team uses a survey tool that is compliant with the DPW Appendix L. Most VBH-PA Counties use the same survey tool. All CFST gather and report data in a formalized fashion to their County office, VBH-PA and OMHSAS. All Counties/CFS Teams have processes

in place for providing feedback to the providers and requesting action plans from providers when sufficient number of surveys are completed and the scores fall below the acceptable level.

The following results from the DPW questions are representative of BHRS providers in most counties.

Table 13:		STATE CFST			
Questions					
Question	Yes	Sometimes	No		
In the past 12 months, did your child have problems getting the help he or she needed?	6.4%	7.7%	85.9%		
Question	Yes	Sometimes	Never		
Were you (or your child) given the chance to make treatment decisions?	94.2%	4.1%	1.8%		
Question	Much Better	Little Better	Same	Little Worse	Much Worse
What effect has the treatment you received had on the quality of your life (or your child's life)?	43.1%	44.5%	11%	1%	0.4%

Of the state questions, “In the past 12 months, did your child have problems getting the help he or she needed?” 6.4% said ‘Yes’. This is an improvement from 14% last year. This question is not specific enough to determine at what point the family or member had problems or the type of help that was needed. The question, “Were you (or your child) given the chance to make treatment decisions?” improved slightly from 93% to 94.2% and the final state question, “What effect has the treatment you received had on the quality of your life (or your child’s life)?” The much better category improved from 41% last year to 43% this year.

PROVIDER SPECIFIC SURVEYS

The question, “Has your provider made you aware of the support services available in your community?” scored below 85% for 3 of the 12 providers. The question, “If you desired, did your provider to involve your family in treatment planning/goals?” scored 95% or above for all providers.

CFST Survey results for providers with 10 or more surveys are on the following page. Scores below the 85% standard are italicized.

Table 14		CFST Survey Questions 2010-2011											
Provider Number	1	4	11	14	15	16	26	28	30	33	39	10	
Number of Surveys	42	24	10	22	62	14	18	30	10	20	48	28	
1. Do you know you can choose where you get your treatment?	100%	100%	100%	95%	98%	100%	100%	96%	100%	100%	100%	100%	
2. Is the provider staff respectful and friendly?	100%	100%	100%	100%	100%	93%	100%	97%	100%	95%	100%	100%	
3. When you first called for an appointment, were services provided in a timely manner?	98%	100%	100%	100%	94%	86%	89%	80%	100%	90%	100%	96%	
4. Were the services provided sensitive and understanding to your race, religion, and ethnic background?	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	
5. Do you feel your confidentiality is respected by your provider?	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	
6. Has this provider talked to you about how to get help if you have a mental health/substance abuse emergency?	95%	100%	100%	95%	89%	100%	94%	100%	100%	90%	100%	93%	
7. Do you have the feeling that expressing your opinion to your provider is OK?	98%	100%	100%	100%	98%	86%	100%	100%	100%	95%	90%	100%	
8. If you had a problem with your provider, would you file a complaint?	100%	100%	80%	100%	97%	93%	100%	97%	100%	95%	85%	100%	
9. Are you asked to participate in treatment planning/goals?	100%	100%	100%	100%	100%	100%	94%	100%	90%	100%	100%	100%	
10. If you desired, did your provider involve your family in treatment planning/goals?	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	
11. Has your provider made you aware of the support services available in your community?	98%	100%	100%	100%	95%	75%	83%	87%	100%	95%	81%	96%	
12. Do you feel the services you are receiving are helping you reach your goals?	98%	96%	100%	100%	100%	79%	100%	80%	100%	100%	100%	89%	
13. Does your provider offer you hope of improvement/recovery?	95%	100%	100%	100%	100%	93%	100%	79%	100%	100%	100%	93%	
14. Overall, are you satisfied with the services you are receiving?	95%	96%	100%	100%	98%	77%	94%	83%	100%	100%	90%	93%	

NETWORK PROVIDERS - EVALUATIONS

Sixty-nine (69) providers performed evaluations for 20 or more distinct members. The table below is sorted in descending order based on the average units/member. The average units/evaluation has a range of 2 to 15 units. The VBH-PA average is 12 units per member.

Table 15:				
Evaluators	DM	Amount Paid	Units	AUPM
68	75	\$38,071	1,127	15
74	50	\$25,725	700	14
62	185	\$89,025	2,562	14
48	379	\$180,125	5,035	13
55	41	\$20,288	541	13
51	426	\$175,234	5,581	13
20	76	\$25,231	991	13
47	48	\$23,363	623	13
71	223	\$107,363	2,863	13
53	90	\$33,163	1,134	13
61	115	\$47,190	1,430	12
75	28	\$13,013	347	12
49	20	\$8,940	246	12
67	375	\$164,933	4,587	12
59	27	\$7,937	330	12
3	331	\$103,312	4,038	12
16	704	\$196,704	8,516	12
72	248	\$118,204	2,984	12
84	249	\$111,285	2,974	12
69	214	\$80,322	2,544	12
46	90	\$28,295	1,034	11
56	255	\$107,764	2,919	11
85	112	\$47,775	1,282	11
43	56	\$22,918	640	11
44	200	\$85,200	2,272	11
79	336	\$132,749	3,803	11
1	401	\$127,087	4,499	11
65	20	\$5,940	222	11
41	137	\$34,163	1,500	11
63	396	\$110,811	4,331	11
32	113	\$36,146	1,222	11
25	92	\$25,688	992	11
33	73	\$22,868	772	11
58	107	\$28,425	1,124	11
38	169	\$42,555	1,760	10
29	83	\$31,880	856	10
26	122	\$32,134	1,258	10
2	91	\$20,984	936	10
5	73	\$22,022	746	10
82	23	\$6,289	235	10
22	59	\$15,067	590	10

Evaluators Continued	DM	Amount Paid	Units	AUPM
31	47	\$10,938	464	10
18	86	\$21,998	841	10
7	72	\$18,443	704	10
23	34	\$9,638	331	10
24	69	\$17,168	662	10
17	78	\$17,273	736	9
70	89	\$24,750	838	9
78	91	\$25,380	854	9
83	176	\$61,226	1,642	9
50	132	\$36,600	1,220	9
81	313	\$72,255	2,867	9
80	22	\$4,416	192	9
15	139	\$33,411	1,209	9
64	179	\$69,345	1,505	8
52	32	\$5,850	266	8
73	26	\$5,475	215	8
39	97	\$18,778	790	8
54	75	\$18,066	608	8
13	34	\$6,068	268	8
60	37	\$6,533	268	7
30	68	\$10,938	444	7
45	102	\$23,757	620	6
57	44	\$5,729	227	5
35	22	\$2,231	96	4
77	211	\$89,176	380	2
66	50	\$20,208	82	2
76	307	\$127,661	497	2
43	57	\$19,125	86	2
TOTAL VBH-PA	8,676	\$3,389,796.38	102,649	12

Results of the Provider Profile Advisory Committee Action Plans From 2010

ACTION ITEMS:

- In the past, providers were billing with Adjustment Disorder as the primary diagnosis on the most recent paid claim. Only a modest use of this diagnosis is appropriate. Claim submissions should accurately reflect the clinician’s diagnosis. If there are multiple diagnoses in Axis I, the first line should reflect the most clinically significant diagnosis. In 2009 and 2010, letters were sent to each provider that had claims with adjustment disorder as the primary diagnosis. Due to an increase from last year, this action item will be monitored again this year and letter will be sent to the providers who show frequent use of this diagnosis.
- There was a significant increase in the number of distinct members and costs for STAP (Summer Therapeutic Activities Program) in 2009. In 2010, a best Practice for STAP was presented to the Clinical Advisory Committee and was approved. The Provider Relations staff members visited all STAP providers in 2011 to review adherence to STAP standards. A chart audit tool was developed this year and will be used to monitor documentation standards for the STAP program during the 4th quarter of 2011 by the Quality Department.
- Beaver County initiated a pilot project in 2009 to require interventions in each BHRS treatment plan to include 25% natural supports. A recent audit showed all Plan of Care’s examined had at least 25% of the interventions reflecting natural supports. POC forms were amended to include a section titled “Natural Supports include:” encouraging providers to complete this section.

Beaver County case managers and VBH-PA CAFS Coordinators included the discussion of natural supports in every ISPT meeting. The focus of the VBH-PA BHRS Summits in 2011 has been to increase provider awareness to include natural supports in the plan of care.

- Last year, 24% of discharges from BHRS did not receive a follow up service within 60 days. The clinical department started a workgroup in December 2010 to address this issue. The BHRS Therapeutic Disengagement and Discharge Best Practices were developed. This document was distributed to BHRS providers in early 2011 at the BHRS Summit. Follow up after discharge from BHRS will continue to be monitored.
- In last year's profile, one of the BHRS providers was identified as a cost outlier for 4 of the top five diagnostic categories. At a recent BHRS summit, the clinical leadership addressed cost outlier utilization for all providers with discussions of service delivery models, improved communication between the prescribers and utilization patterns.

SUMMARY

The demographics of children receiving BHRS remain relatively stable for age, gender and diagnoses. There have been decreases in the average cost per member for some diagnostic categories. There was a 16% decrease in the average cost per ASD member and a 9.4% decrease for Major Depressive Disorder. ADHD costs per member remained nearly the same as last year. The average cost per member for adjustment disorder increased by 6.4%.

When analyzing the concurrent services, 4.3% of the DM receiving BHRS were also receiving Family Based Services and 2.8% were admitted to a mental health inpatient unit during a portion of the BHRS authorization. A specific data analysis would be required to determine the length of time the Family Based Services were concurrent. The Family Based Services could have been provided during a transition period from one level of care to the next.

More members are utilizing Summer Therapeutic Activities Program than the previous profile period.

A discharge in BHRS is defined as no BSC, MT or TSS for a consecutive 30 day period. There were 2991 members with a 30 day lapse in BHRS services. Of those, 61% received follow up mental health service within 60 days. The three highest levels of care received for follow up are outpatient service 60%, blended case management 37%, and Family Based 15%. About 3.6% returned to BHRS and 39% received no follow up treatment within 60 days after discharge.

About one third of providers had at least one complaint from members during the year, but the overall percentage of complaints is relatively low. Overall, CFST data indicates families are satisfied with the quality of services received.