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PerformCare

External Quality Review

Annual Technical Report

April 2024

Review Period: January 1, 2023–December 1, 2023

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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Introduction

The Final Rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an external quality review organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs).[1] This EQR must include an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that an MCO furnishes to Medicaid recipients.

The Commonwealth of Pennsylvania (PA) Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2023 EQRs for HealthChoices (HC) behavioral health MCOs (BH-MCOs) and to prepare the annual technical reports. The subject of this report is one HC BH-MCO: PerformCare. Subsequent references to MCO in this report refer specifically to this HC BH-MCO.

Overview

The HC BH Program is the mandatory managed care program that provides Medical Assistance recipients with BH services in PA. The PA DHS OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with PA for the administration of the HC BH Program. In such cases, DHS holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH contractors, referred to in this report as "Primary Contractors." Primary Contractors, in turn, subcontract with a private-sector BH-MCO to manage the HC BH Program. Effective January 1, 2022, all 67 counties exercised their right of first opportunity to contract, either alone or in combination with other counties, with a BH-MCO.

In the interest of operational efficiency, numerous counties have come together to create HC oversight entities (HC-OEs) that coordinate the Primary Contractors while providing an oversight function of the BH-MCOs. In some cases, the HC-OE is the HC BH contractor, and in other cases, multiple Primary Contractors contract with an HC-OE to manage their HC BH Program. In the PerformCare network, Cumberland, Dauphin, Lancaster, Lebanon, and Perry counties compose an HC-OE called Capital Area Behavioral Health Collaborative (CABHC). The Tuscarora Managed Care Alliance (TMCA) oversees the HC BH Program for Franklin and Fulton counties.

Objectives

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

- validation of performance improvement projects (PIPs),
- validation of MCO performance measures (PMs),
- review to determine plan compliance with structure and operations standards established by the state (*Title 42 Code of Federal Regulations [CFR] Section [§] 438.358*), and
- validation of MCO network adequacy.

Scope of EQR Activities

In accordance with the updates to the Centers for Medicare & Medicaid Services (CMS) EQRO Protocols released in February 2023,[2] this technical report includes eight core sections:

I. Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Compliance with Medicaid Managed Care Regulations
IV. Validation of Network Adequacy
V. Quality Studies
VI. MCO Responses to 2022 EQR Recommendations
VII. 2023 Strengths, Opportunities for Improvement, and Recommendations
VIII. Summary of Activities

For the MCO, information for **Sections I** and **II** is derived from IPRO's validation of the MCO's PIPs and PM submissions. The PM validation, as conducted by IPRO, included a repeated measurement of three PMs: Healthcare Effectiveness Data and Information Set (HEDIS®) Follow-Up After Hospitalization for Mental Illness, PA-specific Follow-Up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. Until 2023, information for compliance with Medicaid Managed Care (MMC) regulations in **Section III** was derived from monitoring and reviews conducted by OMHSAS, as well as the oversight functions of the county or contracted entity, when applicable, against PA's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI). Beginning in 2023, the PEPS standards and compliance data were migrated to the Systematic Monitoring, Access, and Retrieval Technology (SMART) database. **Section IV** discusses the validation of MCO network adequacy in relation to existing federal and state standards. **Section V** discusses the quality study for the Integrated Community Wellness Centers (ICWC) program. **Section VI** includes the MCO's responses to opportunities for improvement noted in the 2022 (measurement year [MY] 2021) EQR annual technical report and presents the degree to which the MCO addressed each opportunity for improvement. **Section VII** includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2022), as determined by IPRO, as well as a "report card" of the MCO's performance as related to the quality indicators included in the EQR evaluation for HC BH quality performance of the MCO. Lastly, **Section VIII** provides a summary of EQR activities for the MCO for this review period. Also included are the following: **References** with a list of publications cited and **Appendices** that include crosswalks of SMART standards to pertinent BBA regulations and to OMHSAS-specific SMART substandards, as well as results of the SMART review for OMHSAS-specific standards.

I: Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

In accordance with current BBA regulations, IPRO validates at least one PIP for the MCO. The Primary Contractors and 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.

The name of the current PIP project is "Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders (SUD)." The Aim Statement for this PIP reads: "Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach."

The PIP has three common clinical objectives (for all MCOs) and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an opioid use disorder (OUD) and/or other SUD.
2. Improve retention in treatment for members with an OUD and/or other SUD diagnosis.
3. Increase concurrent use of drug and alcohol counseling in conjunction with pharmacotherapy (medication-assisted treatment [MAT]).
4. Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH contracting networks. The two "activities" may fall under a single intervention or may compose two distinct interventions. Note that while the emphasis here is on population-based strategies, this non-clinical objective should be interpreted within the PIP to potentially include interventions that target or collaborate with providers and health care systems in support of a specific population (SUD) health objective.

Additionally, OMHSAS identified the following core performance indicators for the PEDTAR PIP:

1. **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)** – This is a HEDIS measure that measures "the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder."[3] It contains two submeasures: continuity of care within 7 days and continuity of care within 30 days of the index discharge or visit.
2. **Substance Use Disorder-Related Avoidable Readmissions (SAR)** – This is a PA-specific measure that measures avoidable readmissions for HC members 13 years of age and older discharged from detox, inpatient rehab, or residential services with an alcohol and other drug (AOD) dependence primary diagnosis. The measure requires 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. This measures discharges, not individuals (starting from Day 1 of the MY; if there are multiple qualifying discharges within any 30-day period, only the earliest discharge is counted in the denominator). The SUD avoidable readmissions submeasure is intended to complement FUI and recognizes that appropriate levels of care for individuals with SUD will depend on the particular circumstances and conditions of the individual. Therefore, for this submeasure, "avoidable readmission" will include detox episodes only.
3. **Mental Health-Related Avoidable Readmissions (MHR)** – This PA-specific measure will use the same denominator as SAR. The measure recognizes the high comorbidity rates of mental health conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for mental health conditions before they reach a critical stage. For this measure, "readmission" will be defined as any acute inpatient admission with a primary mental health diagnosis occurring within 30 days of a qualifying discharge from AOD detox, inpatient rehab, or residential services.
4. **Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD)** – This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of OUD in the measurement period who received both BH counseling services and pharmacotherapy for their OUD during the measurement period. This PA-

specific measure is based on a CMS measure of "the percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year."[4] This measure will be adapted to include members ages 16 years and older. BH counseling is not necessarily limited to addiction counseling.

5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD)** – This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe alcohol use disorder (AUD) in the measurement period who received BH counseling services, as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD, except for members ages 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

MCOs are expected to submit results to IPRO on an annual basis. In addition to running as annual measures, quarterly rates will be used to enable measurement on a frequency that will support continuous monitoring and adjustment by the MCOs and their Primary Contractors.

This PIP project will extend from January 2021 through December 2024, including a one-year extension, with initial PIP proposals submitted in 2020 and a final report due in September 2025. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline.

Technical Methods of Data Collection and Analysis

The MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with CMS protocols. These protocols follow a longitudinal format and capture information related to:

- Project Topic
- Methodology
- Barrier Analysis, Interventions, and Monitoring
- Results
- Discussion

For the PEDTAR PIP, OMHSAS has designated the Primary Contractors to conduct quarterly PIP review meetings with each MCO. The purpose of these meetings will be to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance, as necessary. Plans will be asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, rather than two semiannual submissions, MCOs will submit only one PIP interim report each September starting in 2021.

IPRO's validation of PIP activities is consistent with the protocol issued by CMS[Error! Bookmark not defined.] and meets the requirements of the Final Rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project, as they are reported using an annual form, for compliance with the following eight review elements:

1. Topic Rationale
2. Aim
3. Methodology
4. Identified Study Population Barrier Analysis
5. Robust Interventions
6. Results
7. Discussion and Validity of Reported Improvement
8. Sustainability

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. The evaluation consists of the review findings being considered to determine whether the PIP results should be accepted as valid and reliable. In accordance with the EQR PIP validation protocol issued by CMS in February 2023, BH replaced the former scoring with two qualitative assessments of the PIP, expressed in terms of levels of confidence (High, Moderate, and Low or None): 1) EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases; and 2) EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement.

The results for demonstrable and sustainable improvement will be reported by the MCO and evaluated by the EQRO at the end of the current PIP cycle and reported in a subsequent EQR annual technical report.

Findings

PerformCare successfully submitted a PEDTAR PIP proposal in the fall of 2020 based on an initial baseline period of July 1, 2019, through June 30, 2020. Implementation began in early 2021. The MCO subsequently resubmitted a revised proposal based on the full calendar year (CY) 2020 data with goals, objectives, and interventions recalibrated as needed. IPRO reviewed all baseline PIP submissions for adherence to PIP design principles and standards, including alignment with the statewide PIP aims and objectives, as well as internal consistency and completeness. Clinical intervention highlights include educational provider meetings to help support transitions back to the community, promotion of z-code utilization on claims, development of a screening and assessment toolbox for co-occurring diagnoses, development of a Provider Advisory Board to implement opportunities for improvement around racial/ethnic disparities, development of a provider cultural humility and awareness training, and evaluation of halfway houses and readiness to transition to MAT that aligns with the American Society of Addiction Medicine (ASAM) criteria. For its population-based prevention strategy component, PerformCare is developing educational materials and SUD checklist for parents/guardians to increase awareness of SUD risk factors and prevention programs, as well as a social media awareness campaign with educational materials for children with a depressive disorder diagnosis.

For its Year 2 report, PerformCare is moderately successful in bringing in relevant findings to assess whether interventions are making a difference on performance indicator rates, as, for example, with the link between MAT and readmission rates among members, or in a contrary case, the implementation of Act 32/Act 33, which might have contributed to improvements in (comorbid) MHR readmission rates. Such thoughtful discussion helps the reader navigate the findings and assess their significance. However, there are limitations in the discussion about possible causes of observed results. Many of these stem from incomplete (or incompletely reported) and faulty intervention tracking measures (ITMs), which prevent PerformCare from better understanding where in the chain of causes within the PIP itself (as would be mapped in a logic model of change) interventions are working and where they are not. A notable case involves the extraordinary jump in 7-day and 30-day FUI rates observed in 2022. The jump is explained by references to changes in the FUI specifications, but this explanation does not hold up; in reality, the changes were not significant, and this is borne by the fact that there was almost no change in national HEDIS Quality Compass® benchmark results for FUI between MYs 2021 and 2022. All of this raises questions about the measurement validity of one or more of PerformCare's FUI results going back to baseline. In addition, the extremely low response rate of the Prevention Survey threatens the efficacy of this important intervention and the validity of its corresponding performance indicator (percentage of parents/guardians responding that the mailer had a positive impact on SUD and Prevention Program awareness). Finally, several interventions are either very passive or so brief as to not have any likely impact (e.g., 1b) or are not interventions at all but rather measurements more akin to an ITM (e.g., 3b2, 6a), making it difficult to attribute any observed changes in indicators to the interventions.

Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases

Based on review of PerformCare's Year 2 report, there is moderate confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, data analysis, and interpretation of PIP results. The validation findings generally indicate that the credibility of the PIP results is not at risk. Although PerformCare makes a commendable attempt to begin to bring in data collected from the PIP, along with external considerations like Act 32/Act 33 and rollout of ASAM, to assess the efficacy of its interventions, insights for MY 2022 are somewhat limited by the restricted scope and duration of intervention activities during MY 2022, questionable relevance or significance of many ITMs, inconsistent reporting, and, as relates to the prevention strategy intervention, low response rate. As relates to Rating 1, IPRO recommends the following:

- PerformCare should revisit its logic model of change to ensure the important points and links in its causal chains are being validly measured. In its logic model of change, PerformCare should take into account duration and scope of interventions when considering likely impacts (and when those impacts should occur).
- The logic model of change should inform a review of FUI results and possible revisit or at least clarification of certain ITMs and Indicator 6. Analysis should be carried out according to its data analysis plan, and discussion should be clearly written to describe and then interpret the findings according to its logic model of change while also

describing any threats to internal and external validity, which would aid the reader in assessing the confidence levels of those findings.

- Furthermore, if findings suggest it, the logic model of change itself should be revisited and updated if needed. A report that clearly lays out these considerations will then serve as a document of learning, which is a centerpiece of a PIP.

Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement

There is moderate confidence that the PIP produced evidence of significant improvement. Several indicators like SAR and MHR showed improvement over Year 1, although the jump in FUI rates is not adequately explained. MAT-OUD and MAT-AUD showed worsening trends. Similar to FUI, the results for Indicator 6 (Prevention Survey) are inconclusive due to extremely low response rates. As relates to Rating 2, IPRO recommends the following:

- While some interventions have been discontinued, new interventions in 2023, along with continued analysis of barriers to provision of psychosocial counseling (the counseling component of MAT), promise to help sustain observed improvements while addressing difficult barriers hindering improvement in initiation and engagement in specialty SUD treatment, especially MAT. Spread and sustainability of improvements, however, will depend on the extent to which the challenges noted above related to planning, execution, measurement (particularly for FUI, the Prevention Survey, and certain ITMs), analysis, and learning are addressed.

II: Validation of Performance Measures

Objectives

In MY 2022, OMHSAS's HC Quality Program required MCOs to run three PMs as part of their Quality Assessment and Performance Improvement (QAPI) Program: HEDIS Follow-Up After Hospitalization for Mental Illness (FUH), PA-specific FUH, and Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA). Studies were remeasured in 2022. IPRO validated all three PMs reported by each MCO for MY 2022 to ensure that the PMs were implemented to specifications and state reporting requirements (*Title 42 CFR § 438.330[b][2]*).

Follow-Up After Hospitalization for Mental Illness

This PM assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge. The measure continues to be of interest to OMHSAS for the purpose of comparing county, Primary Contractor, and BH-MCO rates to available national benchmarks and to prior years' rates.

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).

There were four separate measurements related to the FUH measure. All utilized the same denominator but had different numerators.

Eligible Population for HEDIS Follow-Up

The entire eligible population was used for all 24 Primary Contractors participating for MY 2022. Eligible cases were defined as those members in the HC BH 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, 2022;
- a principal International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code indicating one of the specified mental health disorders;
- 6 years of age and older as of the date of discharge; and
- continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2022, greater than 30 days apart with a principal diagnosis indicating one of the mental health disorders specified are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 1, 2022. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS MY 2022 methodology for the FUH measure.

HEDIS Follow-Up Indicators

Quality Indicator 1 (QI 1): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge (Calculation based on industry standard codes used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner up to 7 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator 2 (QI 2): Follow-Up After Hospitalization for Mental Illness Within 30 Days After Discharge (Calculation based on industry standard codes used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner 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.

Eligible Population for PA-Specific Follow-Up

The entire eligible population was used for all 24 Primary Contractors participating for MY 2022. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- members who had one (or more) hospital discharges from any acute care facility with a principal diagnosis of mental illness or intentional self-harm occurring between January 1 and December 2, 2022;
- 6 years of age and older as of the date of discharge; and
- continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 2, 2022, greater than 30 days apart with a principal diagnosis indicating one of the mental health disorders specified are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 2, 2022. The PA-specific measure has been adjusted to allow discharges up through December 2, 2022, which allows for the full 30-day follow-up period where same-day follow-up visits may be counted in the numerator.

PA-Specific Follow-Up Indicators

Quality Indicator A (QI A): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge
Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 7 days after hospital discharge with one of the qualifying industry standards 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
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 standards 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

There are various measures of treatment efficacy, such as service satisfaction, functional status, and health outcomes. Among them, rehospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment.[5] Avoidable inpatient readmission is 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. Additionally, mental illness continues to impact the PA population, including those with substance abuse concerns or SUD.[6] Measuring appropriate care transitions for members with mental illness, therefore, carries wider implications for the OMHSAS quality area related to SUD prevalence and outcomes.

As noted, timely follow-up after hospitalization for mental illness has been and remains a focus for OMHSAS, and results are reviewed for potential trends each year. MY 2022 results will be examined in the context of the 2019 novel coronavirus (COVID-19) pandemic, which has been implicated in the rising prevalence of mental illness.[7] While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research, as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to the FUH measure, OMHSAS elected to retain and remeasure the REA indicator for this year's EQR. This study examined BH services provided to members participating in the HC BH Program. For the indicator, the criteria specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. In order to identify the administrative numerator-positives, the date-of-service, and diagnosis/procedure code criteria were outlined, as were other specifications as needed. This measure's calculation was based on administrative data only.

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

Eligible Population

The entire eligible population was used for all 67 counties and 24 Primary Contractors participating for MY 2022. Eligible cases were defined as those members in the HC BH 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 2, 2022;
- a principal ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event; and
- the claim was clearly identified as a discharge.

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

Technical Methods of Data Collection and Analysis

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. 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 to resubmit, as necessary.

Performance Goals

HEDIS percentiles for the 7-day and 30-day FUH All Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each underperforming indicator. Rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request to the BH-MCO for an RCA and QIP. Similarly, REA rates that are greater than the state's goal of 11.75% result in an RCA and QIP assignment. For this measure, lower rates indicate better performance. This process is further discussed in **Section VI**.

Data Analysis

The quality indicators were defined as rates, based on a numerator of qualifying events or members and a denominator of qualifying events or members, defined according to the specifications of the measure. The HC aggregate (statewide) for each indicator was the total numerator divided by the total denominator, which represented the rate derived for the statewide population of denominator-qualifying events or members. Year-to-year comparisons to MY 2021 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *Z*-test statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

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

Where:

*N*1 = current year numerator,
*N*2 = prior year numerator,
*D*1 = current year denominator, and
*D*2 = prior year denominator.

The single proportion estimate was then used for estimating the standard error (SE). The *Z*-test statistic was obtained by dividing the difference between the proportions by the standard error of the difference. Analysis that uses the *Z*-test assumes that the data and their test statistics approximate a normal distribution. To correct for approximation error, the Yates correction for continuity was applied:

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

Where:

*p*1 = current year quality indicator rate, and
*p*2 = prior year quality indicator rate.

Two-tailed statistical significance tests were conducted at $p = 0.05$ to test the null hypothesis of:

$$H_0: p1 = p2$$

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

Limitations

The tables and figures in this section present rates, CIs, and tests of statistical significance for Primary Contractors. Due to differences in 7-day versus 30-day quality indicators, scales in figures may vary. Caution should be exercised when interpreting results for small denominators. A denominator of 100 or greater is preferred for drawing conclusions from *Z*-tests of the PM results. In addition, this analysis assumes that the proportions being compared come from independent samples. To the extent that this is not the case, the findings should be interpreted with caution.

Conclusions and Comparative Findings

The HEDIS follow-up indicators are presented for three age groups: ages 18–64 years, ages 6+ years, and ages 6–17 years. The 6+ years ("All Ages") age group results are presented to show the follow-up rates for the overall HEDIS population, and the 6–17 years age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years only.

The results are presented at the BH-MCO and Primary Contractor levels. The BH-MCO-specific rates were calculated using the numerator and denominator for that particular BH-MCO (and Primary Contractor with the same contracted BH-MCO). The Primary Contractor-specific rates were calculated using the numerators and denominators for that particular Primary Contractor. For each of these rates, the 95% CI is reported. The HC BH aggregate (statewide) rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HC BH statewide rates to determine if they were statistically significantly above or below that value. Statistically significant BH-MCO differences are noted. Primary Contractor-specific rates were also compared to the HC BH statewide rates to determine if they were statistically significantly above or below that value. Statistically significant Primary Contractor-specific differences are noted.

The HEDIS follow-up results for the All Ages and the 18–64 years age groups are compared to the HEDIS 2023 (MY 2022) national percentiles to show BH-MCO and Primary Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile. The HEDIS follow-up results for the 6–17 years age group are not compared to HEDIS benchmarks.

I: HEDIS Follow-Up Indicators

a) Age Group: Ages 18–64 Years

Table 2.1 shows the MY 2022 results for both the HEDIS 7-day and 30-day follow-up measures for members ages 18–64 years compared to MY 2021.

Table 2.1: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Indicators (Ages 18–64 Years)

Measure[1]	MY 2022 (N)	MY 2022 (D)	MY 2022 %	MY 2022 95% CI Lower	MY 2022 95% CI Upper	MY 2021 %	MY 2022 Rate Comparison to MY 2021 PPD	MY 2022 Rate Comparison to MY 2021 SSD	MY 2022 Rate Comparison to MY 2022 HEDIS Medicaid Percentiles
QI 1 − HEDIS 7-Day Follow-Up (Ages 18−64 Years)									
Statewide	8965	27548	**32.5%**	32.0%	33.1%	34.3%	-1.7	Yes	Below 75th percentile, above 50th percentile
PerformCare	739	2953	**25.0%**	23.4%	26.6%	31.9%	-6.9	Yes	Below 25th percentile
CABHC	653	2669	**24.5%**	22.8%	26.1%	31.6%	-7.1	Yes	Below 25th percentile
Franklin-Fulton	86	284	**30.3%**	24.8%	35.8%	35.3%	-5.0	No	Below 50th percentile, above 25th percentile
QI 2 − HEDIS 30-Day Follow-Up (Ages 18−64 Years)									
Statewide	14322	27548	**52.0%**	51.4%	52.6%	53.7%	-1.7	Yes	Below 50th percentile, above 25th percentile
PerformCare	1261	2953	**42.7%**	40.9%	44.5%	52.5%	-9.8	Yes	Below 25th percentile
CABHC	1093	2669	**41.0%**	39.1%	42.8%	51.2%	-10.3	Yes	Below 25th percentile
Franklin-Fulton	168	284	**59.2%**	53.3%	65.0%	65.1%	-5.9	No	Below 75th percentile, above 50th percentile

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2022 and MY 2021 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization for Mental Illness; CI: confidence interval; N: numerator; D: denominator; PPD: percentage-point difference; SSD: statistically significant difference; QI: quality indicator; CABHC: Capital Area Behavioral Health Collaborative.

Figure 2.1 is a graphical representation of MY 2022 HEDIS FUH 7-day and 30-day follow-up rates in the ages 18–64 years population for PerformCare and its associated Primary Contractors. The orange line represents the MCO average.

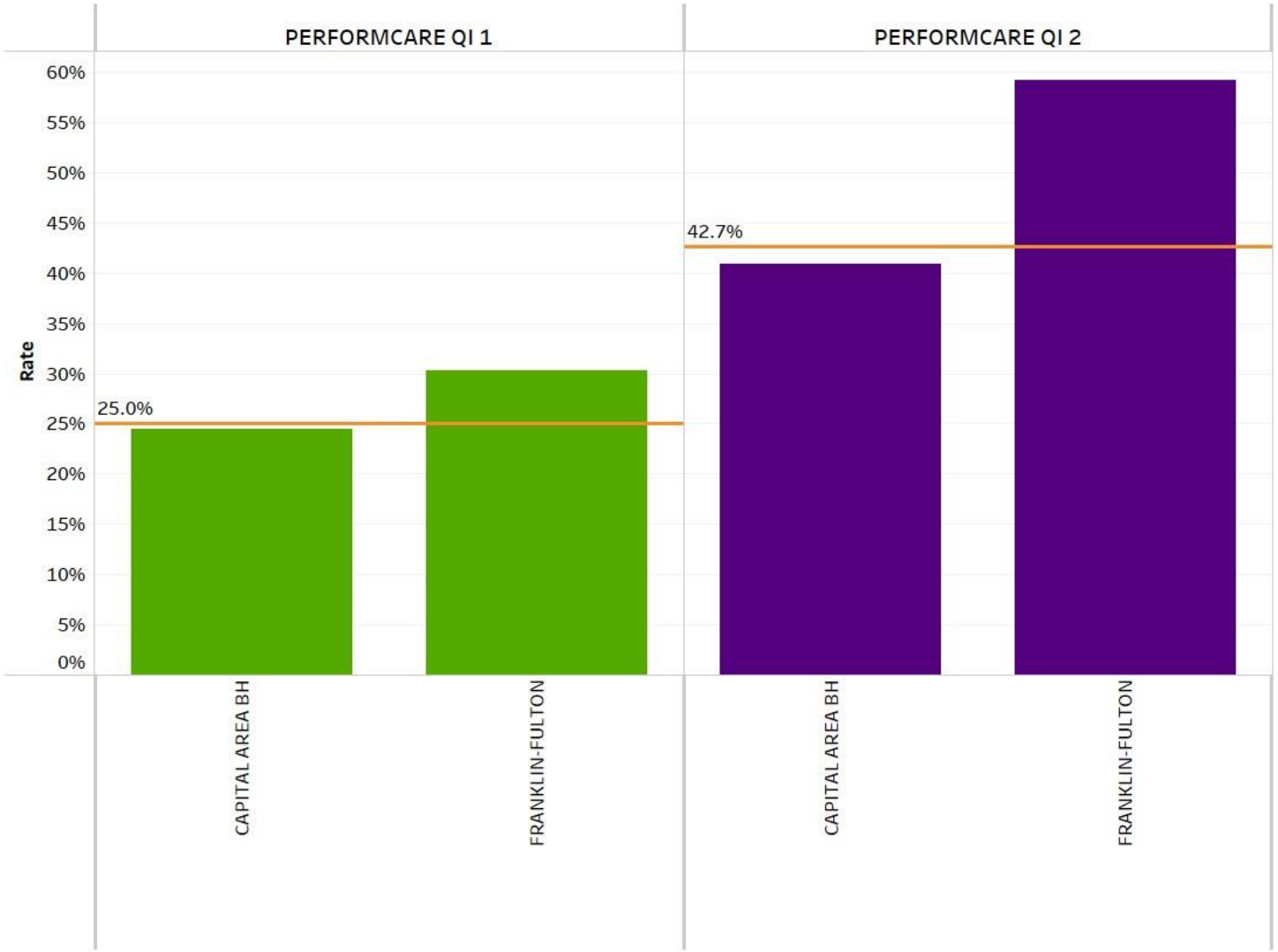

Figure 2.1: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Rates (Ages 18–64 Years)

Figure 2.2 shows the HC BH (statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide rate.

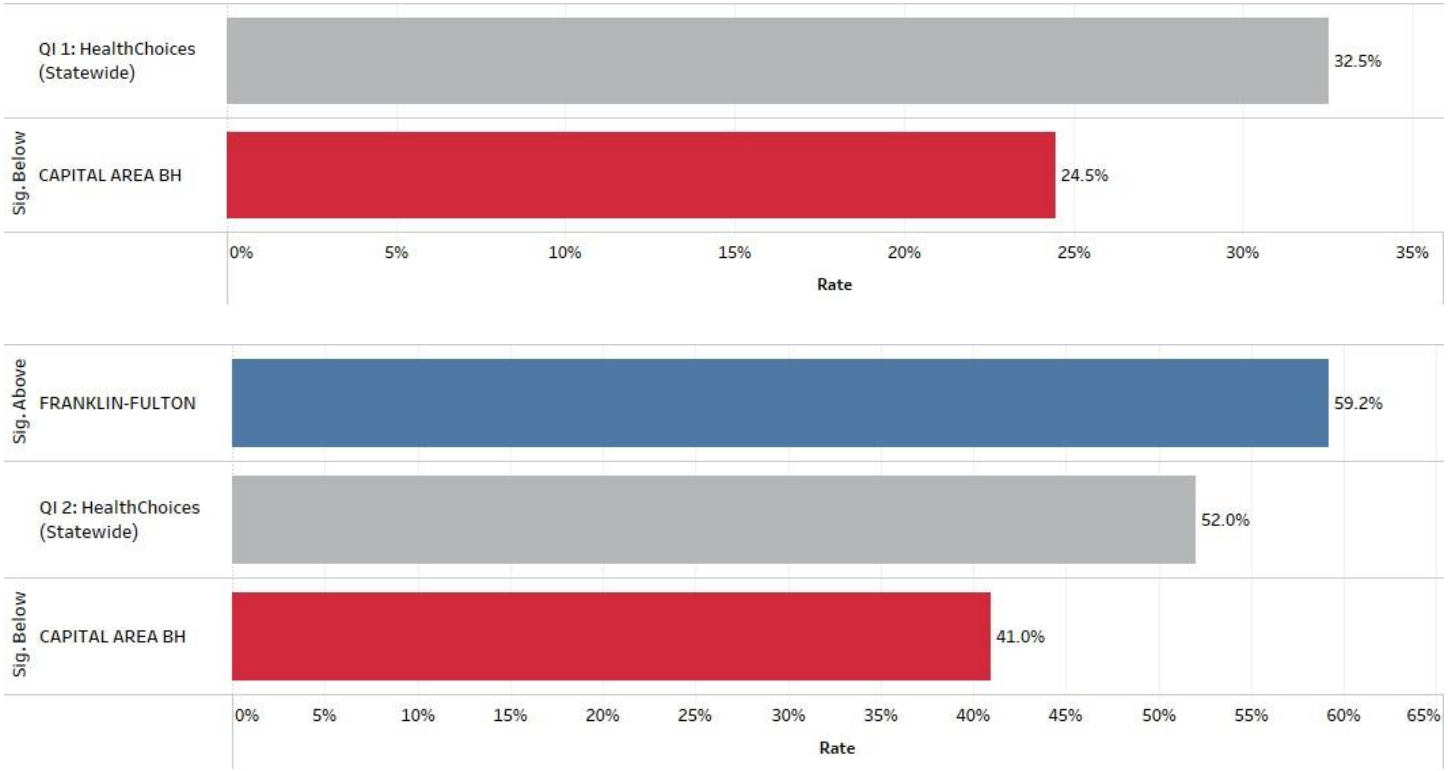

Figure 2.2: SSDs in PerformCare Contractor MY 2022 HEDIS FUH Rates (Ages 18–64 Years) PerformCare Primary Contractor MY 2022 HEDIS FUH rates for 18–64 years of age that are statistically significantly different than statewide rates.

b) Overall Population: Ages 6+ Years

Table 2.2 shows the MY 2022 aggregate results for both the HEDIS 7-day and 30-day follow-up measures compared to MY 2021.

Table 2.2: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Indicators (All Ages)

Measure[1]	MY 2022 (N)	MY 2022 (D)	MY 2022 %	MY 2022 95% CI Lower	MY 2022 95% CI Upper	MY 2021 %	MY 2022 Rate Comparison to MY 2021 PPD	MY 2022 Rate Comparison to MY 2021 SSD	MY 2022 Rate Comparison to MY 2022 HEDIS Medicaid Percentiles
QI 1 − HEDIS 7-Day Follow-Up (All Ages)									
Statewide	13025	35443	**36.7%**	36.2%	37.3%	37.7%	-1.0	Yes	Below 75th percentile, above 50th percentile
PerformCare	1148	3851	**29.8%**	28.4%	31.3%	36.1%	-6.3	Yes	Below 25th percentile
CABHC	1028	3495	**29.4%**	27.9%	30.9%	35.7%	-6.3	Yes	Below 25th percentile
Franklin-Fulton	120	356	**33.7%**	28.7%	38.8%	40.0%	-6.3	No	Below 50th percentile, above 25th percentile
QI 2 − HEDIS 30-Day Follow-Up (All Ages)									
Statewide	20002	35443	**56.4%**	55.9%	57.0%	57.9%	-1.4	Yes	Below 50th percentile, above 25th percentile
PerformCare	1875	3851	**48.7%**	47.1%	50.3%	57.5%	-8.9	Yes	Below 25th percentile
CABHC	1651	3495	**47.2%**	45.6%	48.9%	56.4%	-9.2	Yes	Below 25th percentile
Franklin-Fulton	224	356	**62.9%**	57.8%	68.1%	67.9%	-5.0	No	Below 75th percentile, above 50th percentile

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2022 and MY 2021 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization for Mental Illness; CI: confidence interval; N: numerator; D: denominator; PPD: percentage-point difference; SSD: statistically significant difference; QI: quality indicator; CABHC: Capital Area Behavioral Health Collaborative.

Figure 2.3 is a graphical representation of the MY 2022 HEDIS FUH follow-up rates for PerformCare and its associated Primary Contractors. The orange line represents the MCO average.

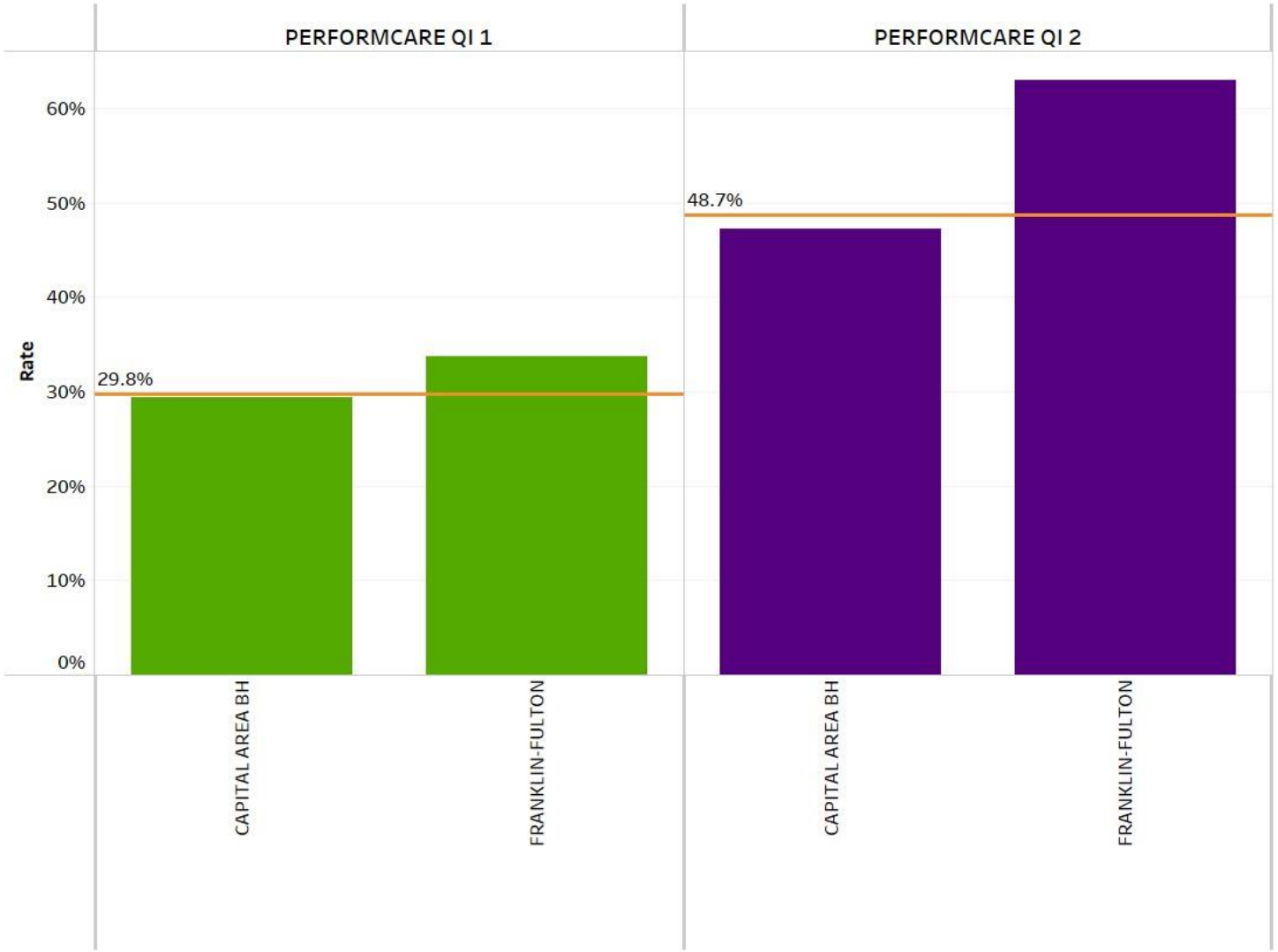

Figure 2.3: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Rates (All Ages)

Figure 2.4 shows the HC BH (statewide) rates and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide rate.

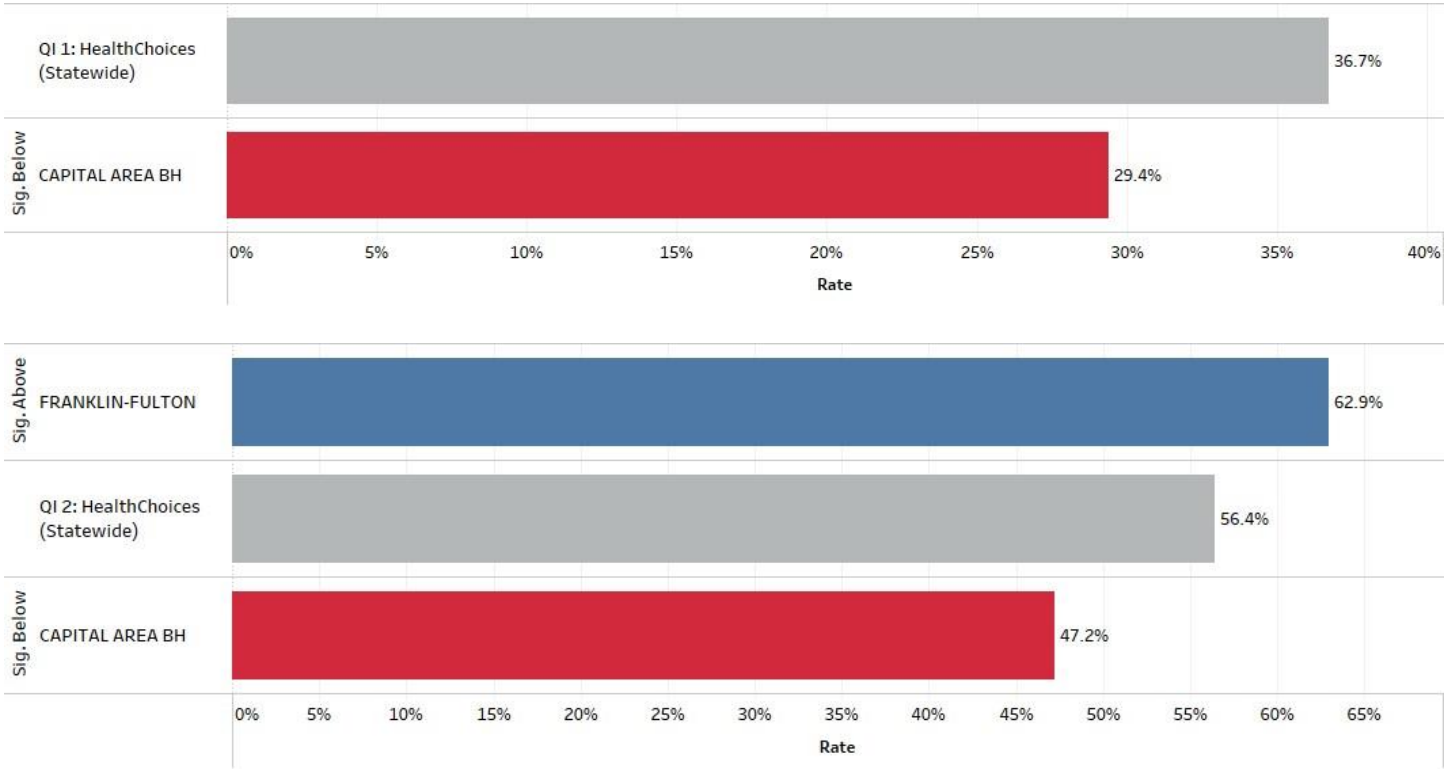

Figure 2.4: SSDs in PerformCare Contractor MY 2022 HEDIS FUH Rates (All Ages) PerformCare Primary Contractor MY 2022 HEDIS FUH rates for all ages that are statistically significantly different than statewide rates.

c) Age Group: Ages 6–17 Years

Table 2.3 shows the MY 2022 results for both the HEDIS FUH 7-day and 30-day follow-up measures for members ages 6–17 years compared to MY 2021.

Table 2.3: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Indicators (Ages 6–17 Years)

Measure[1]	MY 2022 (N)	MY 2022 (D)	MY 2022 %	MY 2022 95% CI Lower	MY 2022 95% CI Upper	MY 2021 %	MY 2022 Rate Comparison to MY 2021 PPD	MY 2022 Rate Comparison to MY 2021 SSD
QI 1 − HEDIS 7-Day Follow-Up (Ages 6−17 Years)								
Statewide	3881	7144	**54.3%**	53.2%	55.5%	52.3%	2.0	Yes
PerformCare	393	838	**46.9%**	43.5%	50.3%	51.9%	-5.0	Yes
CABHC	363	774	**46.9%**	43.3%	50.5%	51.4%	-4.5	No
Franklin-Fulton	30	64	**46.9%**	N/A	N/A	54.9%	-8.0	N/A
QI 2 − HEDIS 30-Day Follow-Up (Ages 6−17 Years)								
Statewide	5406	7144	**75.7%**	74.7%	76.7%	75.9%	-0.2	No
PerformCare	592	838	**70.6%**	67.5%	73.8%	76.4%	-5.8	Yes
CABHC	541	774	**69.9%**	66.6%	73.2%	76.1%	-6.2	Yes
Franklin-Fulton	51	64	**79.7%**	N/A	N/A	78.4%	1.3	N/A

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2022 and MY 2021 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization for Mental Illness; CI: confidence interval; N: numerator; D: denominator; PPD: percentage-point difference; SSD: statistically significant difference; QI: quality indicator; N/A: not applicable, confidence intervals were not calculated if denominators of rates contained fewer than 100 members; CABHC: Capital Area Behavioral Health Collaborative.

Figure 2.5 is a graphical representation of the MY 2022 HEDIS FUH 7-day and 30-Day follow-up rates in the ages 6–17 years population for PerformCare and its associated Primary Contractors. The orange line represents the MCO average.

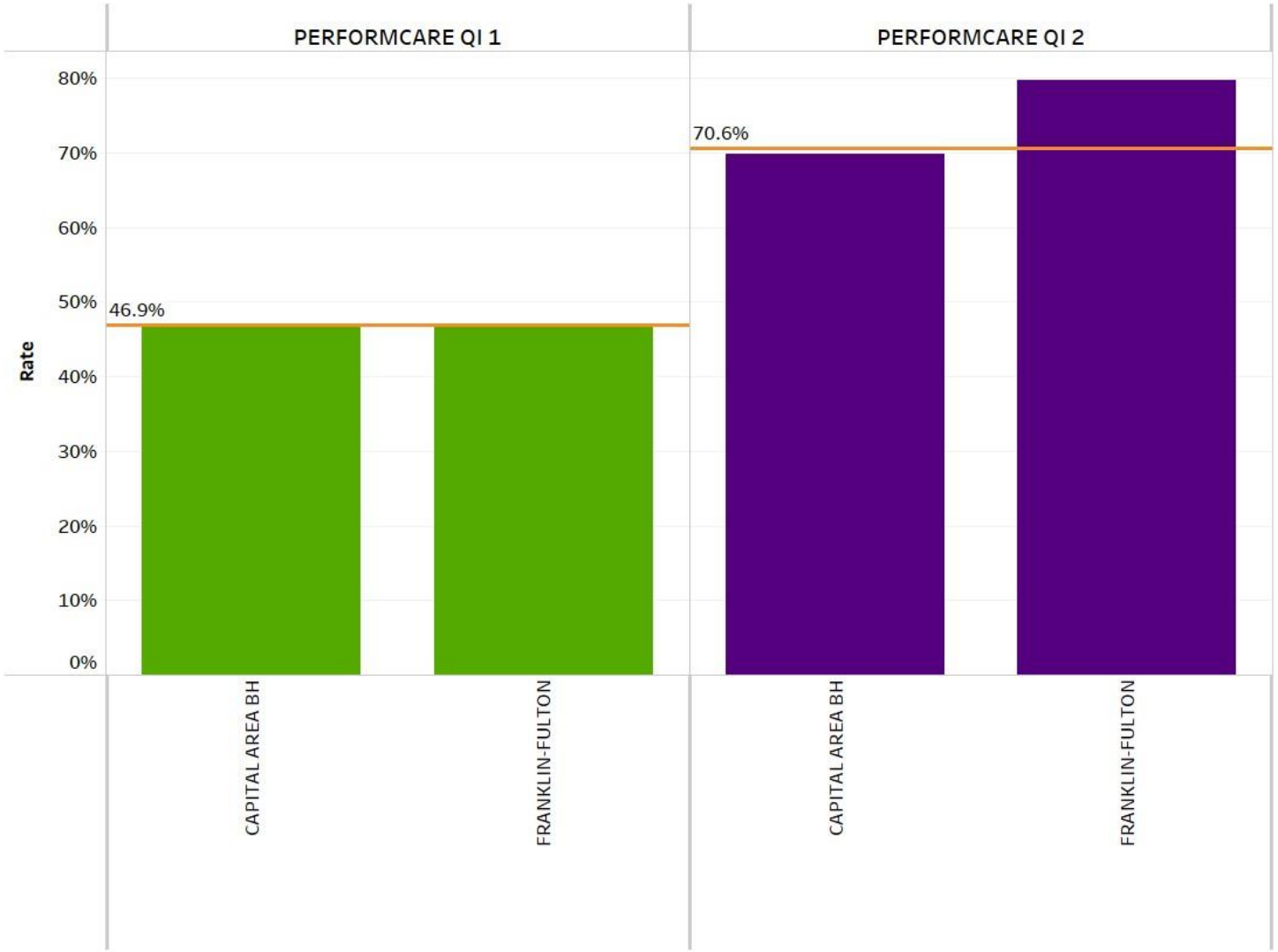

Figure 2.5: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Rates (Ages 6–17 Years)

Figure 2.6 shows the HC BH (statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide rate.

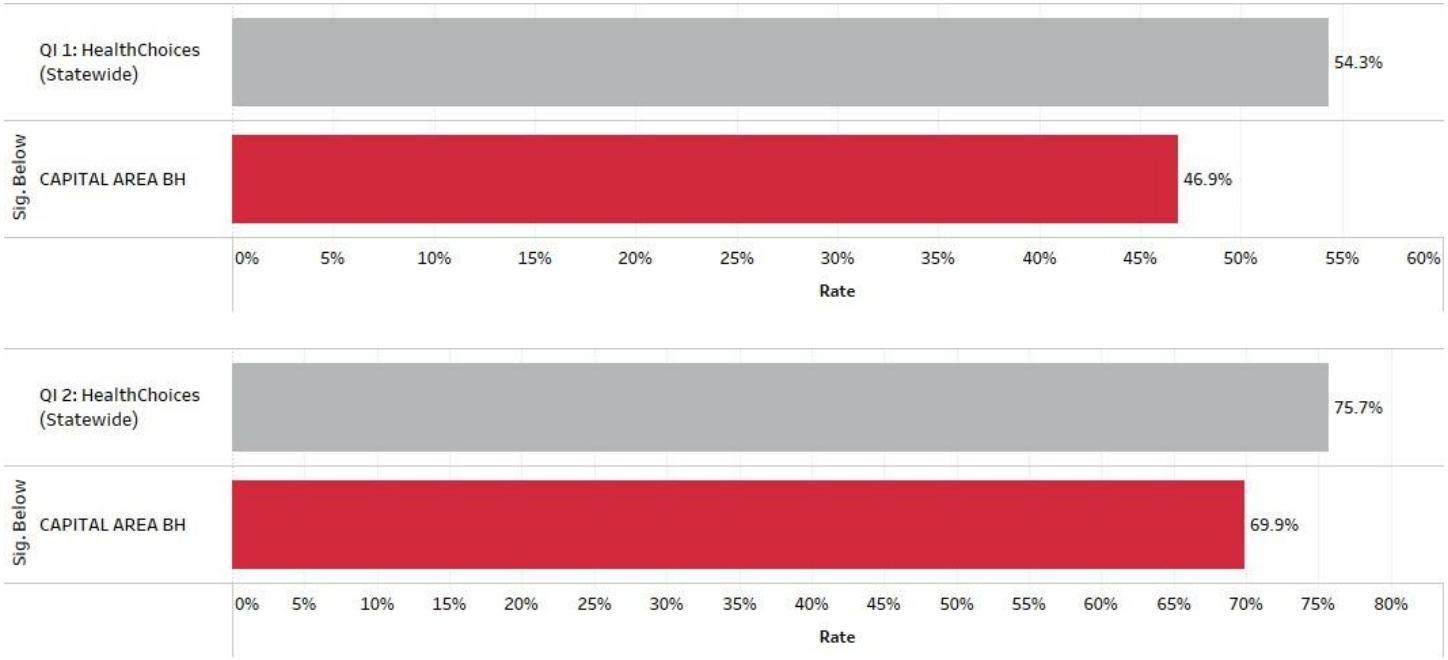

Figure 2.6: SSDs in PerformCare Contractor MY 2022 HEDIS FUH Rates (Ages 6–17 Years) PerformCare Primary Contractor MY 2022 HEDIS FUH rates for 6–17 years of age that are statistically significantly different than statewide rates.

II: PA-Specific Follow-Up Indicators

a) Overall Population: Ages 6+ Years

Table 2.4 shows the MY 2022 PA-specific FUH 7-day and 30-day follow-up indicators for all ages compared to MY 2021.

Table 2.4: MY 2022 PA-Specific FUH 7-Day and 30-Day Follow-Up Indicators (All Ages)

Measure[1]	MY 2022 (N)	MY 2022 (D)	MY 2022 %	MY 2022 95% CI Lower	MY 2022 95% CI Upper	MY 2021 %	MY 2022 Rate Comparison to MY 2021 PPD	MY 2022 Rate Comparison to MY 2021 SSD
QI A – PA-Specific 7-Day Follow-Up (All Ages)								
Statewide	15210	34916	**43.6%**	43.0%	44.1%	48.8%	-5.3	Yes
PerformCare	1113	3739	**29.8%**	28.3%	31.2%	46.7%	-16.9	Yes
CABHC	1020	3388	**30.1%**	28.5%	31.7%	45.6%	-15.5	Yes
Franklin-Fulton	93	351	**26.5%**	21.7%	31.3%	56.3%	-29.8	Yes
QI B – PA-Specific 30-Day Follow-Up (All Ages)								
Statewide	21363	34916	**61.2%**	60.7%	61.7%	65.9%	-4.7	Yes
PerformCare	1753	3739	**46.9%**	45.3%	48.5%	65.6%	-18.7	Yes
CABHC	1596	3388	**47.1%**	45.4%	48.8%	64.5%	-17.4	Yes
Franklin-Fulton	157	351	**44.7%**	39.4%	50.1%	75.7%	-30.9	Yes

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2022 and MY 2021 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization for Mental Illness; CI: confidence interval; N: numerator; D: denominator; PPD: percentage-point difference; SSD: statistically significant difference; QI: quality indicator; CABHC: Capital Area Behavioral Health Collaborative.

Figure 2.7 is a graphical representation of the MY 2022 PA-specific follow-up rates for PerformCare and its associated Primary Contractors. The orange line represents the MCO average.

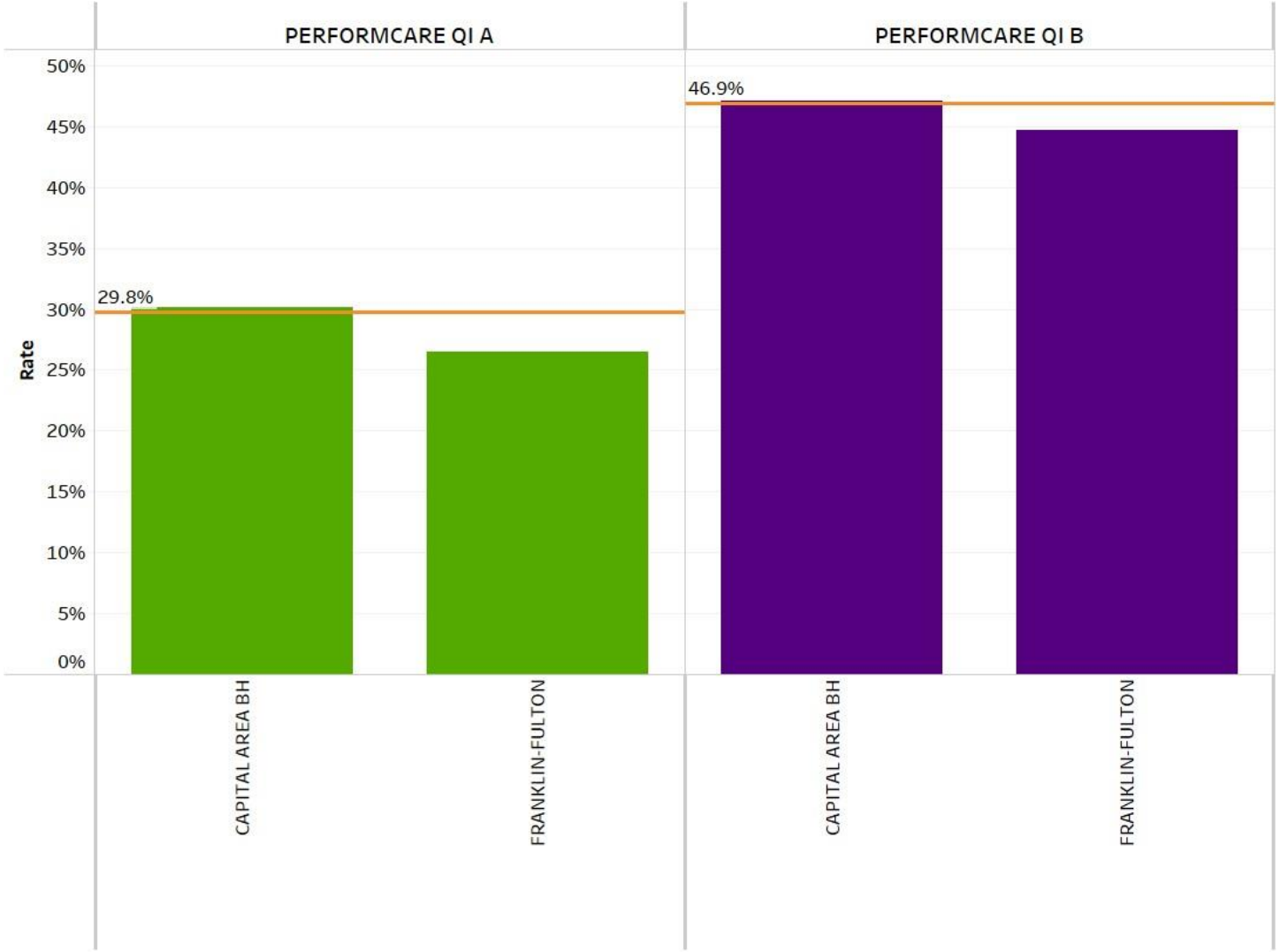

Figure 2.7: MY 2022 PA-Specific FUH 7-Day and 30-Day Follow-Up Rates (All Ages)

Figure 2.8 shows the HC BH (statewide) rates and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide rate.

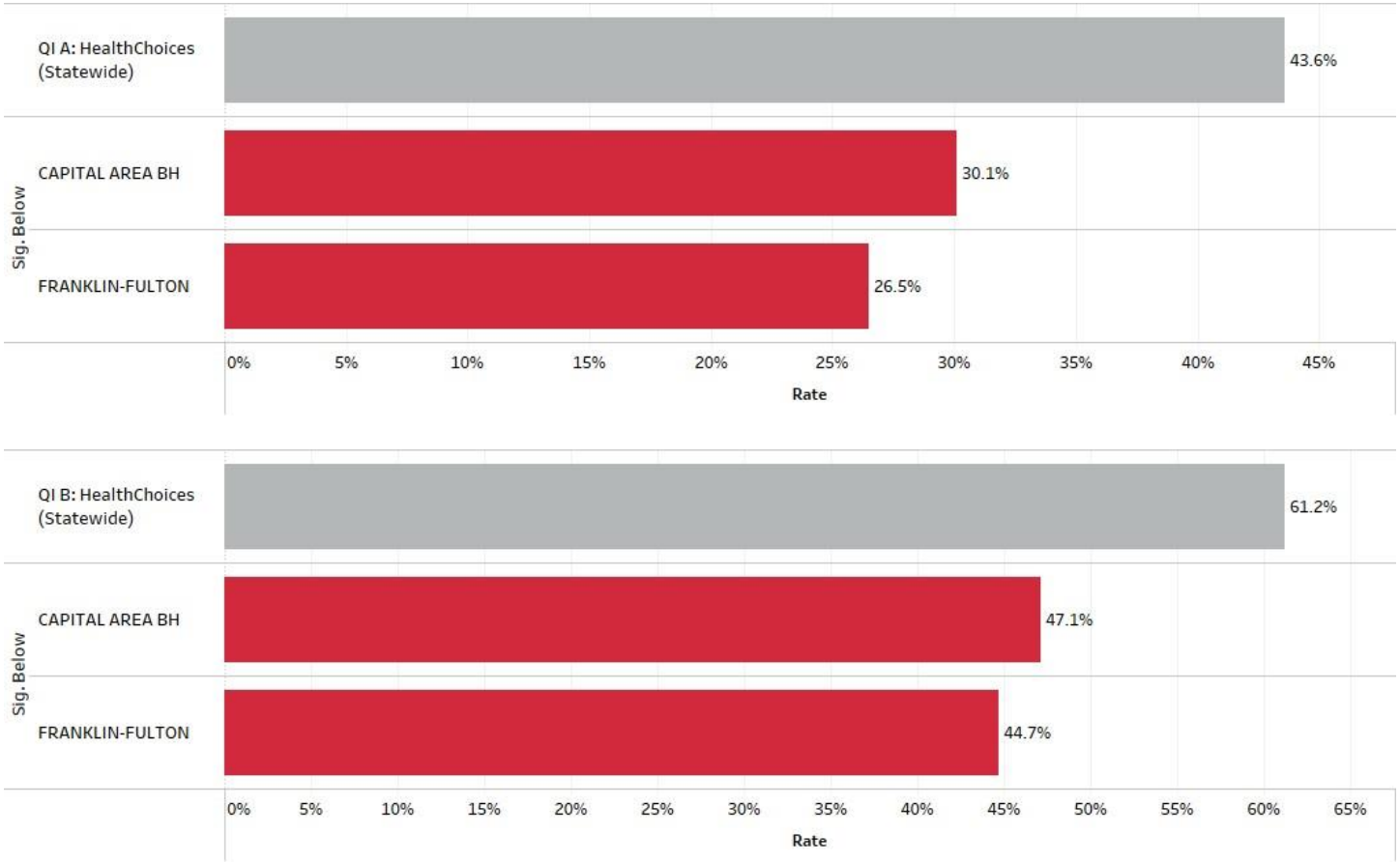

Figure 2.8: SSDs in PerformCare Contractor MY 2022 PA-Specific FUH Rates (All Ages) PerformCare Primary Contractor MY 2022 PA-specific FUH rates for all ages that are statistically significantly different than statewide rates.

III: Readmission Indicators

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2022 to MY 2021 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories. The significance of the difference between two independent proportions was determined by calculating the *Z* score. Statistically significant difference (SSD) at the 0.05 level between groups is noted, as well as the PPD between the rates.

Individual rates were also compared to the categorical average. Rates statistically significantly above or below the average are indicated.

Lastly, aggregate rates were compared to the OMHSAS-designated PM goal of 11.75%. Individual BH-MCO and Primary Contractor rates are *not* required to be statistically significantly below 11.75% in order to meet the PM goal (**Table 2.5**).

Table 2.5: MY 2022 REA Readmission Indicators (All Ages)

Measure[1,2]	MY 2022 (N)	MY 2022 (D)	MY 2022 %	MY 2022 95% CI Lower	MY 2022 95% CI Upper	MY 2021 %	MY 2022 Rate Comparison to MY 2021 PPD	MY 2022 Rate Comparison to MY 2021 SSD
Inpatient Readmission								
Statewide	5821	44420	**13.1%**	12.8%	13.4%	13.2%	-0.1	No
PerformCare	553	4393	**12.6%**	11.6%	13.6%	12.9%	-0.3	No
CABHC	515	3992	**12.9%**	11.8%	14.0%	13.1%	-0.2	No
Franklin-Fulton	38	401	**9.5%**	6.5%	12.5%	11.2%	-1.8	No

[1] The OMHSAS-designated PM goal is a readmission rate at or below 11.75%.

[2] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2022 and MY 2021 rates.

MY: measurement year; REA: Readmission Within 30 Days of Inpatient Psychiatric Discharge; CI: confidence interval; N: numerator; D: denominator; PPD: percentage-point difference; SSD: statistically significant difference; CABHC: Capital Area Behavioral Health Collaborative.

Figure 2.9 is a graphical representation of the MY 2022 readmission rates for PerformCare and its associated Primary Contractors. The orange line represents the MCO average.

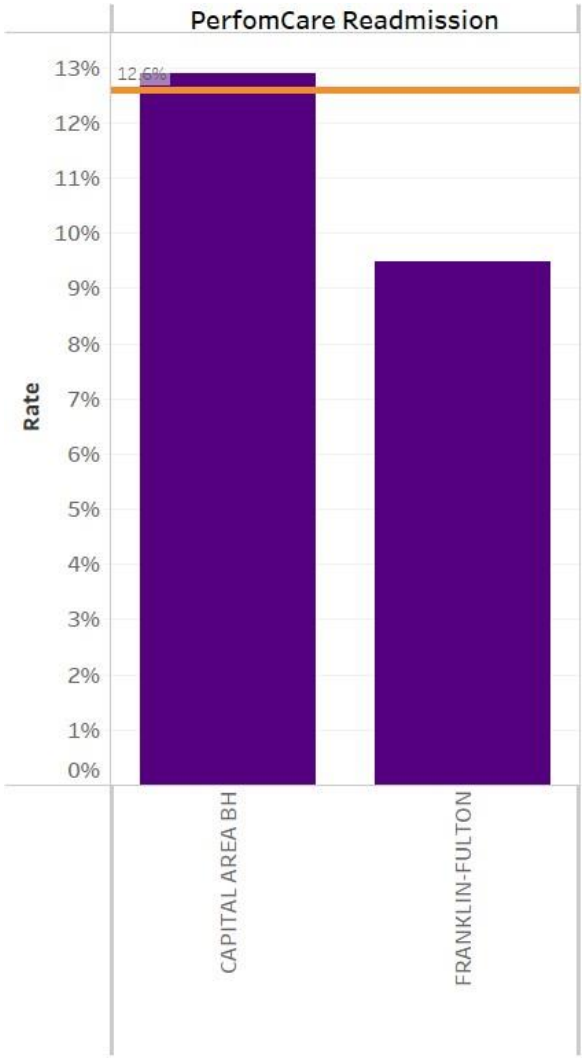

Figure 2.9: MY 2022 REA Rates for PerformCare Primary Contractors (All Ages)

Figure 2.10 shows the HC BH (statewide) readmission rate and the individual PerformCare Primary Contractors that performed statistically significantly higher (red) or lower (blue) than the statewide rate.

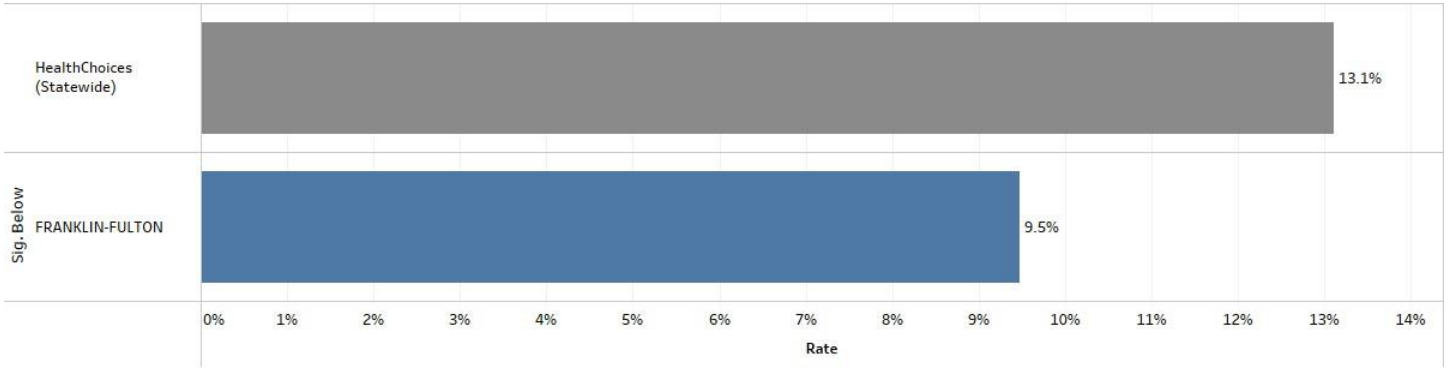

Figure 2.10: SSDs in PerformCare Primary Contractor MY 2022 REA Rates (All Ages) PerformCare Primary Contractor MY 2022 REA rates for all ages that are statistically significantly different than statewide rates.

Recommendations

MY 2022 FUH rates continued their long decline for PerformCare and its Primary Contractors for all of the age cohorts measured, except for Franklin-Fulton's 30-day FUH for the ages 6−17 years set. Most of the drops were statistically significant. The year-over-year drops in the PA-specific FUH were particularly dramatic. PerformCare's HEDIS FUH All Ages rates were below the HEDIS Quality Compass 25th percentiles. In contrast, PerformCare's REA rate improved (declined), although the change was not statistically significant. PerformCare's REA was also above (worse than) the statewide goal of 11.75%. The fact that follow-up rates worsened suggest that the improvement in readmission rates was driven by factors other than those related to follow-up services.

Efforts should continue to be made to improve FUH performance, particularly for those BH-MCOs that performed below the HC BH statewide rate. The following are recommendations that are informed by the MY 2022 review:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2013 and 2022, which included actions taken as part of the previous PIP cycle, to promote continuous quality improvement with regard to timely follow-up care after psychiatric hospitalization. The information contained in this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. BH-MCOs are expected to demonstrate meaningful improvement in BH follow-up rates in the next few years as a result of their interventions. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving BH follow-up. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to receiving follow-up care and then implement action and monitoring plans to further increase their rates. Unfortunately, PerformCare's RCA and QIP in response to the MY 2022 FUH underperformance was inadequate. While the RCA listed factors, there was little evidence of data drilldowns and analysis to inform a logic model of change or even a general understanding of how the factors operate and interact in the context of PerformCare's network. As a result, the QIP correspondingly lists mostly vague actions with no clear delineation of how those actions will address specific barriers (many of the lists repeat from barrier to barrier) to improving FUH, who will perform what roles, how progress and ultimately success will be measured, and when downstream impacts are expected to occur (and why the timeframes are hypothesized).
- As mentioned, the year-over-year drops in the PA-specific FUH were particularly dramatic, with drops ranging from 15.5 to 30.9 percentage points, raising the question of whether some of the decrease may have been from measurement error. These PMs are validated each year, but validation relies on member-level denominator-flagged data submitted by the plans. An Information Systems Capabilities Assessment (ISCA) performed in 2022 showed that PerformCare's report generation process utilizes Microsoft® Structured Query Language (SQL)/SQL Server Integration Services for the application of the measurement algorithm and information reporting into a relational database for PM reporting. PerformCare should scrutinize their identification denominator episodes in MY 2021 and MY 2022 to see if any issues with their algorithm or underlying enrollment or encounters data might have introduced errors in the calculation of PA-specific FUH rates for MY 2021 and/or MY 2022.
- It is essential to ensure that improvements are consistent, sustained across MYs, and applicable to all groups. As previously noted, although not enumerated in this report, further stratified comparisons such as Medicaid Expansion versus non-Medicaid Expansion were carried out in a separate 2023 (MY 2022) FUH Rates Report produced by the EQRO and made available to BH-MCOs in an interactive Tableau® workbook. BH-MCOs and Primary Contractors should review their data mechanisms to accurately identify this population. PerformCare's RCA and QIP for the HEDIS FUH all ages MY 2022 results reports finding no racial or ethnic disparities in rates, but this assessment seems based on superficial comparison of rates between groups as opposed to statistical analysis. In fact, the 2023 (MY 2022) Tableau FUH Rates Report shows that there were in fact racial disparities at the MCO level. For example, Asian members had significantly higher rates than White members for the 7-day rates, while White members had significantly higher rates than Black/African Americans members for the 30-day rates. The 2023 (MY 2022) FUH Rates Report is a resource that PerformCare should utilize.
- BH-MCOs and Primary Contractors are encouraged to review the 2023 (MY 2022) FUH Rates Report in conjunction with the corresponding 2023 (MY 2022) REA Rates Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission in less than 30 days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

Continued efforts should be made to improve performance with regard to REA, particularly for those BH-MCOs and Primary Contractors that did not meet the performance goal and/or performed below the HC BH statewide rate. As stated, PerformCare's REA rate improved (declined), although the change was not statistically significant. PerformCare's REA was also above (worse than) the statewide goal of 11.75%. In response to the 2022 study, the following are recommendations for improving (reducing) readmission rates after psychiatric discharge:

- The information contained within this study should be used to further develop strategies for decreasing the likelihood that at-risk members will be readmitted. In 2020, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. A PIP starting in 2021 builds on the previous PIP by, among other things, including a performance indicator that measures mental health-related readmissions within 30 days of a discharge for SUD. BH-MCOs are expected to bring about meaningful improvement in BH readmission rates for this subpopulation with comorbid BH conditions and for their HC BH members more generally. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission. Unfortunately, PerformCare's RCA and QIP in response to the MY 2022 REA underperformance was also inadequate. The RCA listed "findings" with little specifics provided on quantitative results or statistical significance tests. As with HEDIS FUH, the RCA listed factors with little evidence of data drilldowns and analysis to inform a logic model of change or even a general understanding of how the factors operate and interact in the context of PerformCare's network. The REA QIP was even thinner than the QIP response to the HEDIS FUH; the same list of vague actions is, for the most part, repeated for all the barriers, with minimal nuances of wording. Once again, no understanding is conveyed for how proposed actions will improve REA rates (and for which target populations), who will perform what roles, how progress and ultimately success will be measured, and when downstream impacts are expected to occur (and why the timeframes are hypothesized).

III: Compliance with Medicaid Managed Care Regulations

Objectives

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the MMC structure and operations standards. In review year (RY) 2022, 67 PA counties participated in this compliance evaluation.

Operational reviews are completed for each HC-OE. The Primary Contractor, whether contracting with an OE arrangement or not, is responsible for their regulatory compliance with federal and state regulations and the HC BH PS&R Agreement. The HC BH PS&R Agreement includes the Primary Contractor's responsibility for the oversight of the BH-MCO's compliance.

Cumberland, Dauphin, Lancaster, Lebanon, and Perry counties formed an HC-OE called CABHC. The Tuscarora Managed Care Alliance oversees the HC BH program for Franklin and Fulton counties. **Table 3.1** shows the name of the HC-OE, the associated HC Primary Contractor(s), and the county/counties encompassed by each Primary Contractor.

Table 3.1: PerformCare HealthChoices Oversight Entities, Primary Contractors, and Counties

HealthChoices Oversight Entity	Primary Contractor	County
Capital Area Behavioral Health Collaborative	Capital Area Behavioral Health Collaborative	Cumberland County
		Dauphin County
		Lancaster County
		Lebanon County
		Perry County
Tuscarora Managed Care Alliance	Tuscarora Managed Care Alliance	Franklin County
		Fulton County

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of PerformCare by OMHSAS monitoring staff within the past three RYs (RYs 2022, 2021, and 2020). These evaluations are performed at the BH-MCO and Primary Contractor levels, and the findings are reported in the SMART application for 2022. 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 HC BH 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 Primary Contractors 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 HC BH PS&R are also used.

Description of Data Obtained

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in late 2022 and entered into the SMART application as of early 2023. Information captured within the SMART application informs this report. The SMART application contains a comprehensive set of monitoring standards that OMHSAS staff review on an ongoing basis for each BH-MCO. Within each standard, the SMART application specifies the substandards or items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect or capture additional reviewer comments. Based on the SMART application, a BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations ("categories"), as well as against related supplemental OMHSAS-specific SMART substandards that are part of OMHSAS's more rigorous monitoring criteria.

The standards that are subject to EQR review are contained in *Title 42 CFR Part 438*, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E. Substandard tallies for each category and section roll-up were correspondingly updated. From time to time, standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions or changes to state

standards. As changes are made to EQR reporting requirements, IPRO works with PA OMHSAS to update its crosswalk to the PS&R Agreement, SMART data, ISCAs, external audit findings, and any other relevant data that pertain to federal provisions or state standards. Standards or substandards that are introduced or retired are done so following the rotating three-year schedule for all five BH-MCOs. This may, in turn, change the category tally of standards from one reporting year to the next. A null value is indicated where no crosswalk was available for a given provision for the RY period or no data for the applicable RY period were available for the reviewed managed care plan (MCP). The CMS EQRO protocols released in 2023[Error! Bookmark not defined.] included modifications to the BBA provisions that are now required for reporting. These updates to reporting include the addition of three new federal standards (Disenrollment, Enrollee Rights, and Emergency and Post-Stabilization Services) with results becoming available for MCPs following the aforementioned three-year schedule.

As was done for prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The review findings for selected OMHSAS-specific substandards are reported in **Appendix C**. The RY 2022 crosswalks of substandards to pertinent BBA regulations and to pertinent OMHSAS-specific substandards can be found in **Appendix A** and **Appendix B**, respectively.

Because OMHSAS's review of the Primary Contractors and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that timeframe. The three-year period is alternatively referred to as the Active Review period. The substandards from RY 2022, RY 2021, and RY 2020 provided the information necessary for the 2022 assessment. Those triennial standards not reviewed through the system in RY 2022 were evaluated on their performance based on RY 2021 and/or RY 2020 determinations, or other supporting documentation, if necessary. For those HC-OEs that completed their Readiness Reviews within the three-year timeframe under consideration, RAI substandards were evaluated when none of the substandards crosswalked to a particular BBA category were reviewed.

For PerformCare, a total of 88 unique substandards were applicable for the evaluation of BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2022, 2021, 2020). In addition, 31 OMHSAS-specific substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. Some substandards crosswalk to more than one BBA category, while each BBA category crosswalks to multiple substandards. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific substandards that are not required as part of BBA regulations but are reviewed within the three-year cycle to evaluate the BH-MCO and the associated Primary Contractors against other state-specific structure and operations standards.

Table 3.2 tallies the substandard reviews used to evaluate the BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2020–2022). Substandard counts under RY 2022 comprised annual and triennial substandards. Substandard counts under RYs 2021 and 2020 comprised only triennial substandards. By definition, only the last review of annual substandards is counted in the three-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 3.2**, 124, differs from the unique count of substandards that came under active review (88).

Table 3.2: Tally of Substandards Pertinent to BBA Regulations Reviewed for PerformCare

	Evaluated SMART Substandards[1]		SMART Substandards Under Active Review[2]		
BBA Regulations	**Total**	**NR**	**2022**	**2021**	**2020**
CMS EQR Protocol 3 "sections" − Standards, including Enrollee Rights and Protections					
Assurances of Adequate Capacity and Services (*Title 42 CFR § 438.207*)	5	-	5	-	-
Availability of Services (*Title 42 CFR § 438.206, Title 42 CFR § 10(h)*)	24	-	16	6	2
Confidentiality (*Title 42 CFR § 438.224*)	4	-	4	-	-
Coordination and Continuity of Care (*Title 42 CFR § 438.208*)	2	-	-	-	2

BBA Regulations	Evaluated SMART Substandards[1]		SMART Substandards Under Active Review[2]		
	Total	NR	2022	2021	2020
Coverage and Authorization of Services (*Title 42 CFR § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114*)	4	-	2	-	2
Disenrollment Requirements and Limitations (*Title 42 CFR § 438.56*)	1	-	1	-	-
Emergency and Post-Stabilization Services (*Title 42 CFR § 438.114*)	5	-	5	-	-
Enrollee Rights Requirements (*Title 42 CFR § 438.100*)	6	-	1	5	-
Health Information Systems (*Title 42 CFR § 438.242*)	6	-	6	-	-
Practice Guidelines (*Title 42 CFR § 438.236*)	6	-	4	-	2
Provider Selection (*Title 42 CFR § 438.214*)	3	-	-	3	-
Subcontractual Relationships and Delegation (*Title 42 CFR § 438.230*)	8	-	8	-	-
CMS EQR Protocol 3 "sections" – Quality Assessment and Performance Improvement Program					
Quality Assessment and Performance Improvement Program (*Title 42 CFR § 438.330*)	33	-	27	6	-
CMS EQR Protocol 3 "sections" – Grievance System					
Grievance and Appeal Systems (*Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424*)	17	-	2	-	15
Total	124	-	81	20	23

[1] The total number of substandards required for the evaluation of Primary Contractor/BH-MCO compliance with the BBA regulations. Any substandards not reviewed indicate substandards that were deemed not applicable to the Primary Contractor/BH-MCO.
[2] The number of substandards that came under active review during the cycle specific to the review year. Because substandards may crosswalk to more than one category, the total tally of substandard reviews, 124, differs from the unique count of substandards that came under active review (88).
BBA: Balanced Budget Act; SMART: Systematic Monitoring, Access, and Retrieval Technology; NR: substandards not reviewed; CMS: Centers for Medicare & Medicaid Services; EQR: external quality review; CFR: Code of Federal Regulations; §: section.

Determination of Compliance

To evaluate Primary Contractor/BH-MCO compliance with individual provisions, IPRO grouped the required and relevant SMART substandards by provision (category) and evaluated the Primary Contractors' and BH-MCO's compliance status with regard to the SMART substandards. Each substandard was assigned a value of "compliant," "partially compliant," or "non-compliant" in the SMART application submitted by PA. If a substandard was not evaluated for a particular Primary Contractor/BH-MCO, it was assigned a value of "not reviewed." Compliance with the BBA provisions was then determined based on the aggregate results across the three-year period of the SMART items linked to each provision. If all items were met, the Primary Contractor/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the Primary Contractor/BH-MCO was evaluated as partially compliant. If all items were not met, the Primary Contractor/BH-MCO was evaluated as non-compliant. A value of not applicable (N/A) was assigned to provisions for which a compliance review was not required. A value of null was assigned to a provision when none of the existing substandards directly covered the items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results within a given category were aggregated to arrive at a summary compliance status for the category. For example, compliance findings relating to provider network mix and capacity are summarized under Assurances of Adequate Capacity and Services, *Title 42 CFR § 438.207*.

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 sections set out in the BBA regulations and described in Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.[Error! Bookmark not defined.] Under each general section heading are the individual regulatory categories appropriate to those headings. IPRO's findings are therefore organized under Standards, including Enrollee Rights and Protections; QAPI Program; and Grievance System.

This format reflects the goal of the review, which is to gather sufficient foundation for IPRO's required assessment of the Primary Contractor/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 documents.

Findings

Eighty-eight unique substandards were used to evaluate PerformCare and its Primary Contractors' compliance with BBA regulations in RY 2022.

Standards, Including Enrollee Rights and Protections

The general purpose of the regulations included in this section is to ensure that each Primary Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable federal and state laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees. **Table 3.3** presents the MCO and Primary Contractor substandard findings by categories.

Table 3.3: Compliance with Standards, Including Enrollee Rights and Protections

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Assurances of Adequate Capacity and Services (*Title 42 CFR § 438.207*)	5	Compliant	All PerformCare Primary Contractors	1.1, 1.2, 1.4, 1.5, 1.6	-	-
Availability of Services (*Title 42 CFR § 438.206*)	24	Partially compliant	All PerformCare Primary Contractors	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 23.1, 23.2, 23.3, 23.4, 23.5, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 28.1, 93.1, 93.2, 93.3, 93.4	-	28.2
Confidentiality (*Title 42 CFR § 438.224*)	4	Compliant	All PerformCare Primary Contractors	120.1, 142.1, 144.1, 145.1	-	-
Coordination and Continuity of Care (*Title 42 CFR § 438.208*)	2	Partially compliant	All PerformCare Primary Contractors	28.1	-	28.2

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Coverage and Authorization of Services (*Title 42 CFR § 438.210(a–e), § 441, Subpart B, and § 438.114*)	4	Partially compliant	All PerformCare Primary Contractors	28.1, 72.1, 72.2	-	28.2
Disenrollment Requirements and Limitations (*Title 42 CFR § 438.56*)	1	Compliant	All PerformCare Primary Contractors	120.1	-	-
Emergency and Post-Stabilization Services (*Title 42 CFR § 438.114*)	5	Compliant	All PerformCare Primary Contractors	72.2, 91.3, 91.5, 91.7, 91.9	-	-
Enrollee Rights Requirements (*Title 42 CFR § 438.100*)	6	Compliant	All PerformCare Primary Contractors	11.2, 24.3, 24.4, 24.5, 24.6, 72.2	-	-
Health Information Systems (*Title 42 CFR § 438.242*)	6	Compliant	All PerformCare Primary Contractors	120.1, 142.1, 143.1, 144.1, 145.1	-	141.1
Practice Guidelines (*Title 42 CFR § 438.236*)	6	Partially compliant	All PerformCare Primary Contractors	28.1, 93.1, 93.2, 93.3, 93.4	-	28.2
Provider Selection (*Title 42 CFR § 438.214*)	3	Compliant	All PerformCare Primary Contractors	10.1, 10.2, 10.3	-	-
Subcontractual Relationships and Delegation (*Title 42 CFR § 438.230*)	8	Compliant	All PerformCare Primary Contractors	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8	-	-

MCO: managed care organization; CFR: Code of Federal Regulations; §: section.

There are 12 categories within Standards, including Enrollee Rights and Protections. PerformCare was compliant with eight categories and non-compliant with four categories.

There were 74 substandard reviews for PerformCare and its Primary Contractors within Compliance with Standards, including Enrollee Rights and Protections. PerformCare and its Primary Contractors were compliant in 69 reviews and non-compliant in five reviews. Some substandards apply to more than one BBA category. As a result, one partially compliant or non-compliant rating for an individual substandard could result in several BBA categories with partially compliant or non-compliant ratings.

Availability of Services
PerformCare and its Primary Contractors were partially compliant with Availability of Services due to non-compliance with Substandard 2 within Standard 28 (RY 2020).

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

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

Coordination and Continuity of Care
PerformCare and its Primary Contractors were partially compliant with Coordination and Continuity of Care due to non-compliance with Substandard 2 within Standard 28 (RY 2020).

Standard 28: See Standard description and determination of compliance under Availability of Services.

Substandard 2: See substandard description and determination of compliance under Availability of Services.

Coverage and Authorization of Services
PerformCare and its Primary Contractors were partially compliant with Coverage and Authorization of Services due to non-compliance with Substandard 2 within Standard 28 (RY 2020).

Standard 28: See Standard description and determination of compliance under Availability of Services.

Substandard 2: See substandard description and determination of compliance under Availability of Services.

Health Information Systems
PerformCare and its Primary Contractors were partially compliant with Health Information Systems due to non-compliance with Substandard 1 within Standard 141 (RY 2022).

Standard 141: There is a process to ensure claims are controlled and entered into the claims processing system in a timely manner.

Substandard 1: BH-MCO has met the Department's standards of clean claims each of the 12 months: 90% @ 30 days, 100% @ 45 days.

Practice Guidelines
PerformCare and its Primary Contractors were partially compliant with Practice Guidelines due to non-compliance with Substandard 2 within Standard 28 (RY 2020).

Standard 28: See Standard description and determination of compliance under Availability of Services.

Substandard 2: See substandard description and determination of compliance under Availability of Services.

Quality Assessment and Performance Improvement Program
The general purpose of the regulations included under this subpart is to ensure that all services available under PA's MMC program, the HC Program, are available and accessible to MCO enrollees. The documents include an assessment of the Primary Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 3.4** presents the findings by categories consistent with the regulations.

Table 3.4: Compliance with Quality Assessment and Performance Improvement Program

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Quality Assessment and Performance Improvement Program (*Title 42 CFR § 438.330*)	33	Compliant	All PerformCare Primary Contractors	91.1, 91.2, 91.3, 91.4, 91.5, 91.6, 91.7, 91.8, 91.9, 91.10, 91.11, 91.12, 91.13, 91.14, 91.15, 93.1, 93.2, 93.3, 93.4, 98.1, 98.2, 98.3, 100.1, 104.1, 104.2, 104.3, 104.4, 108.2, 108.5, 108.6, 108.7, 108.8, 108.10	-	-

MCO: managed care organization; CFR: Code of Federal Regulations; §: section.

For this review, 33 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 33 substandards were reviewed for all Primary Contractors associated with PerformCare. PerformCare and its Primary Contractors were compliant with all 33 substandards.

Grievance System

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances. The documents include an assessment of the Primary Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 3.5** presents the findings by categories consistent with the regulations.

Table 3.5: Compliance with Grievance System

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Grievance and Appeal Systems (*Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424*)	17	Partially compliant	All PerformCare Primary Contractors	60.1, 60.3, 68.2, 68.3, 68.7, 71.1, 71.2, 71.3, 71.4, 71.7, 71.9, 72.1, 72.2	60.2, 68.1, 68.4, 68.9	-

MCO: managed care organization; CFR: Code of Federal Regulations; §: section.

For this review, 17 substandards were crosswalked to Grievance System. All 17 substandards were reviewed for all Primary Contractors associated with PerformCare. PerformCare and its Primary Contractors were compliant with 13 substandards and partially compliant with four substandards.

Grievance and Appeal Systems

PerformCare was partially compliant with Grievance and Appeal Systems due to partial compliance with Substandard 2 within Standard 60 (RY 2020) and Substandard 1, Substandard 4, and Substandard 9 within Standard 68 (RY 2020).

Standard 60: Complaint and Grievance Staffing and Policies and Procedures.

Substandard 2: Training rosters and training curriculums identify that Complaint and Grievance staff has been adequately trained on Member rights related to the processes and how to handle and respond to member Complaints and Grievances.

Standard 68: The Complaint and Fair Hearing processes, procedures and Member rights related to the processes are made known to Members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

Substandard 1: Interview with Complaint Coordinator(s) demonstrate a clear understanding of the Complaint process including how Member rights and Complaint procedures are made known to Members, BH-MCO staff and the provider network.

- 1st level
- 2nd level
- External
- Expedited
- Fair Hearing

Substandard 4: Complaint Acknowledgement and 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 9: Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.

IV: Validation of Network Adequacy

Objectives

As set forth in *Title 42 CFR § 438.358*, validation of network adequacy is a mandatory EQR activity. Title 42 CFR § 438.68(a) requires states that contract with an MCP to deliver services, as well as develop, monitor, and enforce network adequacy standards consistent with the requirements under *Title 42 CFR § 438.68(b)(1)(iii)* and *§ 457.1218*. For BH, those requirements include: applying quantitative network adequacy standards, ensuring timely access to services, ensuring provider accessibility, allowing access to out-of-network providers, documenting an MCO's capacity to serve all enrollees, and adhering to the 2008 Mental Health Parity and Addictions Equity Act (MHPAEA) regulations on treatment limitations.[8] The EQRO is expected to validate network adequacy reporting for each MCP that assesses the confidence level of network adequacy findings for each applicable standard. EQRO validation is limited to assessment of the validity of network adequacy findings and does not include assessment of the network adequacy standards themselves. The purpose of this section is to report the EQRO's validation assessment of network adequacy findings for the BH-MCO and its associated Primary Contractors. In accordance with the updates to the CMS EQRO protocols released in February 2023,[Error! Bookmark not defined.] the EQRO is to conduct six activities, as outlined in **Table 4.1**.

Table 4.1: Network Adequacy Validation Activities

Activity	Category
Define the scope of the validation	Planning
Identify data sources for validation	Planning
Review information systems	Analysis
Validate network adequacy	Analysis
Communicate preliminary findings to MCO	Reporting
Submit findings to the state	Reporting

MCO: managed care organization.

Starting in February 2024, states must have in place a network adequacy monitoring and reporting program that stipulates state standards for the applicable plan type and corresponding quantitative indicators for network adequacy and collects data, analyzes those data, and reports findings on network adequacy on a regular basis. Regardless of whether network adequacy monitoring and reporting is conducted by the MCO or the state, the EQRO is expected to assess the validity of data collected on each applicable indicator, as well as the validity of the analyses and resulting findings. While MY 2022 predates the publication of the February 2023 protocol, IPRO was able to work with PA OMHSAS on the six EQR activities. These activities enumerated the relevant standards and corresponding indicators that were in effect in MY 2022, collected MY 2022 results, and, finally, assessed the validity of those results.

Technical Methods of Data Collection and Analysis

IPRO gathered information from PA OMHSAS to conduct preliminary network adequacy validation activities using worksheets 4.1, 4.2, and 4.3 of the 2023 CMS EQR protocols. PA OMHSAS completed the three worksheets, which listed and described: the network adequacy standards that were in effect for the MY (Worksheet 4.1), the quantitative indicators used to assess compliance with the network adequacy standards (Worksheet 4.2), and the data source(s) used for each indicator (Worksheet 4.3). IPRO supplemented this information using results from an ISCA conducted on the MCO in 2023. Using this information, IPRO then assessed the data sources and data collection procedures for validity, including measurement validity, accuracy, and completeness. For MY 2022, network adequacy monitoring and reporting were carried out by PA using its Medicaid Enterprise Monitoring Module (MEMM) to collect and analyze data, submitted by the MCO, on geographic access by provider type. Results are compared to its network adequacy standards and recorded in its SMART compliance application at the Primary Contractor level. An extract of the SMART data for MY 2022 was then shared with IPRO.

Description of Data Obtained

Table 4.2 summarizes the state network adequacy standards that were applicable to BH-MCOs and their Primary Contractors in MY 2022, the frequencies of data reporting by the MCO, and corresponding network adequacy indicators.

Table 4.2 BH-MCO Network Adequacy Standards and Indicators Applicable in MY 2022

Network Adequacy Standard	Applicable Provider Type	Data and Documentation Submitted by MCO (Frequency)	Network Adequacy Indicator
The Primary Contractor and its BH-MCO must maintain a Provider network for all Members which is geographically accessible to Members. All levels of care must be accessible in a timely manner. Members must have a choice of at least two Providers.	Intensive Behavioral Health Services	Provider network data files (weekly)	Proportion of members living in an urban designated county who have access to each level of care within 30 minutes travel time from their residence; proportion of members living in a rural designated county who have access to each level of care within 60 minutes travel time from their residence.
	Clozaril Support	Provider network data files (weekly)	
	Medically Managed Intensive Inpatient Services (ASAM Level 4)	Provider network data files (weekly)	
	Medically Managed Intensive Inpatient Withdrawal Management (ASAM Level 4 WM)	Provider network data files (weekly)	
	Drug and Alcohol Methadone Maintenance	Provider network data files (weekly)	
	Drug and Alcohol Outpatient	Provider network data files (weekly)	
	Family Based Mental Health Services	Provider network data files (weekly)	
	Inpatient Psychiatric – Adult	Provider network data files (weekly)	
	Inpatient Psychiatric – Child/Adolescent	Provider network data files (weekly)	
	Mental Health Crisis Intervention	Provider network data files (weekly)	
	Mental Health Outpatient (Psychiatric Clinic)	Provider network data files (weekly)	
	Mental Health Partial Hospitalization – Child/Adolescent	Provider network data files (weekly)	
	Peer Support	Provider network data files (weekly)	
	Residential Treatment Facility (RTF)	Provider network data files (weekly)	
	Targeted Case Management (TCM)	Provider network data files (weekly)	
	Center of Excellence (OUD Treatment)	Provider network data files (weekly)	

BH-MCO: behavioral health managed care organization; ASAM: American Society of Addiction Medicine.

Findings

One network adequacy indicator for each applicable provider type was used by PA OMHSAS to measure compliance by the MCO and its Primary Contractors on the network adequacy standard that was in place in MY 2022. IPRO's ISCA of PerformCare in MY 2022 revealed PerformCare utilizes Quest Analytics® Suite software and reporting to monitor provider network adequacy across geographic areas. The ISCA showed that PerformCare adequately met Information Systems utility requirements for reviewing provider network adequacy. The provider network data files are submitted to PA's MEMM and subsequently analyzed each year by OMHSAS to calculate rates for the network adequacy indicator for each provider category. These results are then recorded under Primary Contractor results for Substandard 1.2 in the SMART application:

Standard 1: The Program must include a full array of in-plan services available to adults and children.
Provider contracts are in place.

> **Substandard 2:** 100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.

For MY 2022, PerformCare and all of its Primary Contractors were found to be fully compliant (for all provider categories) with Substandard 1.2 and the corresponding network adequacy standard.

After review of the relevant ISCA findings, network adequacy data and methods, IPRO has high confidence in the validity of these MY 2022 results.

V: Quality Studies

Objectives

The purpose of this section is to describe quality studies performed in 2022 for the HC population. The studies are included in this report as optional EQR activities that occurred during the RY.[Error! Bookmark not defined.]

Integrated Community Wellness Centers

In 2019, PA DHS made the decision to discontinue participation in the Certified Community Behavioral Health Clinic (CCBHC) Demonstration but to continue and build on the CCBHC model in a PA DHS-administered ICWC program under an MMC agreement with CMS. The purpose of the CCBHC Demonstration was to develop and test an all-inclusive (and all-payer) prospective payment system model for community clinics to integrate behavioral and physical health care services in a more seamless manner. The model is centered on the provision of nine core services. Crisis services, BH screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services, along with outpatient clinic primary care screening and monitoring, are provided or managed directly by the ICWC clinics. The remaining sour services, including targeted case management, peer support, psychiatric rehabilitation services, and intensive community-based mental health care to members of the armed forces and veterans, may be provided through a contract with a designated collaborating organization (DCO). To receive CCBHC certification, clinics also had to provide a minimum set of evidence-based practices (EBP), which was selected based on community needs assessments and centered on recovery-oriented care and support for children, youth, and adults. Under ICWC, the same nine core services of the CCBHC model are provided under PA's HC MMC program using a similar bundled payment arrangement with clinics certified to participate as ICWC clinics. For the first year of ICWC, 2020, the following original seven clinics were invited to participate in the new program: Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA).

Description of Data Obtained

Like CCBHC, ICWC features a process measure dashboard, hosted by the EQRO. Clinics enter monthly, quarterly, and year-to-date (YTD) data into a REDCap® project that feeds, on a weekly basis, a server-based Tableau workbook in which clinics are able to monitor progress on the implementation of their ICWC model. Using the dashboard, clinics in 2022 tracked and reported on clinical activities in a range of quality domains reflecting the priorities of the initiative: clinic membership, process, access and availability, engagement, evidence-based practices, and client satisfaction. The Tableau workbook also featured a comparative display that showed clinic and statewide results on each process measure.

Findings

In 2022, the number of individuals receiving at least one core service dropped to 15,345 from 22,690 in 2021. The unweighted average (across all the clinics) of the number of days until initial evaluation increased to 12.4 days from 10.8 days in 2021. In the area of depression screening and follow-up, 89% of positive screenings resulted in the documentation of a follow-up plan the same day. A little over 2,700 individuals within the ICWC program received drug and alcohol outpatient or intensive outpatient treatment during the period, down 50% from 5,400 in 2021.

Process measures reflect important progress in increasing both the access and quality of community-based care for individuals with BH conditions, but the ICWC quality measures are designed to more meaningfully measure the impact of these efforts. Under the CMS-approved ICWC preprint, a subset of the CCBHC measures is reported to CMS on an annual CY basis, along with the HEDIS FUI measure. **Table 5.1** summarizes how well the ICWC clinics performed on quality measures compared to applicable performance targets and national benchmarks.

Table 5.1: ICWC Quality Performance Compared to Targets and National Benchmarks

Measure	ICWC CY 2022 Weighted Average	Comparison	
		ICWC CY 2022 Performance Target	Benchmark Performance
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 7 day	13.0%	32.5%	Between the 5th and 10th percentiles of the HEDIS 2023 Quality Compass
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 30 day	21.0%	53.8%	Below the 5th percentile of the HEDIS 2023 Quality Compass
Follow-Up Care for Children Prescribed ADHD Medication (ADD) − Initiation	66.0%	80.2%	Above the 95th percentile of the HEDIS 2023 Quality Compass
Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Continuation and Maintenance	75.0%	81.5%	Above the 95th percentile of the HEDIS 2023 Quality Compass
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) − 7 day	43.8%	26.7%	Between the 90th and 95th percentiles of the HEDIS 2023 Quality Compass
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) − 30 day	66.7%	39.0%	Above the 95th percentile of the HEDIS 2023 Quality Compass
Follow-Up After Emergency Department Visit for Mental Illness (FUM) − 7 day	100%	100%	Above the 95th percentile of the HEDIS 2023 Quality Compass
Follow-Up After Emergency Department Visit for Mental Illness (FUM) − 30 day	100%	100%	Above the 95th percentile of the HEDIS 2023 Quality Compass
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18–64 years − Initiation	21.9%	N/A	Below the 5th percentile of the HEDIS 2023 Quality Compass
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18–64 years − Engagement	7.2%	N/A	Between the 10th and 25th percentiles of the HEDIS 2023 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 18–64 years (FUH-A) − 7 day	10.6%	30.2%	Below the 5th percentile of the HEDIS 2023 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 18–64 years (FUH-A) − 30 day	19.1%	41.6%	Below the 5th percentile of the HEDIS 2023 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 6–17 years (FUH-C) − 7 day	19.5%	43.8%	Between the 5th and 10th percentiles of the HEDIS 2023 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 6–17 years (FUH-C) − 30 day	28.3%	55.6%	Below the 5th percentile of the HEDIS 2023 Quality Compass
Antidepressant Medication Management (AMM) − Acute	56.1%	62.5%	Between the 25th and 33rd percentiles of the HEDIS 2023 Quality Compass

Measure	ICWC CY 2022 Weighted Average	Comparison	
		ICWC CY 2022 Performance Target	Benchmark Performance
Antidepressant Medication Management (AMM) - Continuation	39.8%	38.5%	Between the 25th and 33rd percentiles of the HEDIS 2023 Quality Compass
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	55.9%	62.1%	Between the 25th and 33rd percentiles of the HEDIS 2023 Quality Compass
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	77.3%	85.0%	Between the 25th and 33rd percentiles of the HEDIS 2023 Quality Compass
Plan All-Cause Readmissions Rate (PCR) – Observed Rate	30.0%	3.8%	N/A (HEDIS 2023 Quality Compass Observed Rate benchmarks not available)
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	59.5%	100%	Between the 70th and 80th percentiles of the MIPS 2023 (eCQM)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	32.2%	100%	Between the 50th and 60th percentiles of the MIPS 2023 (eCQM)
Screening for Depression and Follow-Up Plan (CDF-BH)	36.8%	47.5%	Between the 50th and 60th percentiles of the MIPS 2023 (eCQM)
Depression Remission at Twelve Months (DEP-REM-12)	63.3%	15.0%	Above the 95th percentile of the MIPS 2023 (eCQM)
Body Mass Index (BMI) Screening and Follow-Up Plan	42.7%	62.5%	Between the 10th and 20th percentiles of the MIPS 2023 (eCQM)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)	63.9%	80.0%	Between the 80th and 90th percentiles of the MIPS 2023 (eCQM)
Tobacco Use: Screening and Cessation Intervention (TSC)	87.4%	N/A	Between the 60th and 70th percentiles of the MIPS 2023 (CQM)
Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	65.5%	N/A	Between the 50th and 60th percentiles of the MIPS 2023 (CQM)

ICWC: Integrated Community Wellness Center; HEDIS: Healthcare Effectiveness Data and Information Set; ADHD: attention deficit/hyperactivity disorder; MIPS: Merit-Based Incentive Pay System; eCQM: electronic clinical quality measure; CQM: clinical quality measure; N/A: not applicable, no performance target was set for measurement year 2022.

Quality measures where the ICWC clinics met or surpassed targets include: Follow-Up After Emergency Department Visit for Mental Illness (FUM), Antidepressant Medication Management (AMM) − Continuation, and Depression Remission at Twelve Months (DEP-REM-12).

VI: MCO Responses to 2022 EQR Recommendations

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 2022 (MY 2021) EQR annual technical report and in the 2023 (MY 2022) FUH All Ages Goal Report.

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 PA Medicaid BH-MCOs. These activities follow a longitudinal format and are designed to capture information relating to:

- follow-up actions that the BH-MCO has taken through June 30, 2023, 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 MCO responses submitted to IPRO in September 2023 to address partial and non-compliant standards findings, as well as any additional relevant documentation provided by the BH-MCO.

The request for MCO response to the opportunities for improvement related to MY 2021 underperformance in the HEDIS FUH All Ages measures was distributed, along with the MY 2021 results, in January 2023. The RCA and QIP form similarly provides for a standardized format for BH-MCOs to describe root causes of underperformance and propose a detailed QIP to address those factors, complete with a timeline of implementation, monitoring, and reporting activities. BH-MCOs submitted their responses by March 17, 2023, and the Primary Contractors submitted their responses by March 31, 2023.

Quality Improvement Plan for Partial and Non-compliant SMART Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2021, PerformCare began to address opportunities for improvement related to compliance categories within two of the three CMS sections pertaining to compliance with MMC regulations. Within Compliance with Standards, including Enrollee Rights and Protections, PerformCare was partially compliant with the following BBA categories: Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, and Practice Guidelines. Within Compliance with Grievance System, PerformCare was partially compliant with Grievance and Appeal Systems. Proposed actions and evidence of actions taken by PerformCare were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring PerformCare into compliance with the relevant Standards.

The embedded document presents PerformCare's responses to opportunities for improvement cited by IPRO in the 2022 (MY 2021) EQR annual technical report, detailing current and proposed interventions. Original references to "PEPS" have been replaced with "SMART." The entire MCO response is available upon request.

Frm_2023_BH_Opps_Response_PerformCare

Root Cause Analysis and Quality Improvement Plan

For PMs that are noted as opportunities for improvement in the EQR annual technical report, BH-MCOs are required to submit:

- a goal statement;
- RCA 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.

In 2023, OMHSAS made a few important changes to the PM remediation process. First, it added REA to the process by requiring BH-MCOs and Primary Contractors to submit QIPs for rates above the statewide goal of 11.75%. BH-MCOs assigned a QIP are also required to complete an RCA that informs their QIP. Furthermore, QIPs must address any racial or ethnic disparities in PM rates. Finally, OMHSAS extended the timeframe of RCAs and QIPs to every two years. This is designed to give interventions more time to work while reducing the administrative burden.

In MY 2022, PerformCare scored below the HEDIS Quality Compass 75th percentile on both the HEDIS FUH 7-day and 30-day measures and, as a result, was required to complete an RCA and QIP response for both measures. PerformCare's REA rate was above the 11.75% benchmark and was therefore also required to complete and RCA and QIP to address REA.

The embedded documents present PerformCare's responses to opportunities for improvement cited by IPRO in the 2022 (MY 2021) EQR annual technical report, detailing current and proposed interventions. The entire MCO response is available upon request.


HEDIS 7-day FUH RCA and QIP Respons


HEDIS 30-day FUH RCA and QIP Respons


HEDIS REA RCA and QIP Response_202403

VII: 2023 Strengths, Opportunities for Improvement, and Recommendations

This section provides an overview of PerformCare's MY 2022 performance with identified strengths and opportunities for improvement in the following areas: structure and operations standards, PIPs, and PMs. This section also provides an assessment of the strengths and weaknesses of PerformCare with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity, as described in *Title 42 CFR 438.310(c)(2)*.

Strengths

- Review of compliance with MMC regulations conducted by PA in RY 2020, RY 2021, and RY 2022 found PerformCare to be fully compliant with Quality Assessment and Performance Improvement Program.
- For MY 2022, PerformCare and its Primary Contractors were found to be fully compliant (for all provider categories) with Standard 1.2 and the corresponding network adequacy standard. After review of the relevant ISCA findings, network adequacy data, and methods, IPRO has high confidence in the validity of these MY 2022 results.

Opportunities for Improvement

- Based on review of PerformCare's Year 2 PIP report, there is moderate confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, data analysis, and interpretation of PIP results.
- There is moderate confidence that the PIP produced evidence of significant improvement.
- PerformCare's MY 2022 HEDIS 7-day and 30-day FUH rates (QI 1 and QI 2) for the ages 6+ years and ages 18–64 years cohorts were below the HEDIS Quality Compass 75th percentiles.
- PerformCare's MY 2022 PA-specific 7-day and 30-Day FUH rates (QI A and QI B) for ages 6+ years were significantly below the MY 2021 rate.
- PerformCare's MY 2022 REA rate did not meet the OMHSAS designated performance goal of 11.75%.
- Review of Compliance with Standards conducted by PA in RY 2020, RY 2021, and RY 2022 found PerformCare to be partially compliant with two sections associated with MMC regulations.
    - PerformCare was partially compliant with 5 out of 12 categories within Compliance with Standards, including Enrollee Rights and Protections. The partially compliant categories are: 1) Availability of Services, 2) Coordination and Continuity of Care 3) Coverage and Authorization of Services, 4) Health Information Systems, and 5) Practice Guidelines.
    - PerformCare was partially compliant with the single category of Grievance and Appeal Systems within Grievance System.

Assessment of Quality, Timeliness, and Access

Responsibility for **quality** of, **timeliness** of, and **access** to health care services and supports is distributed among providers, payers, and Primary Contractors. Due to the BH carve-out within PA's HC program, BH-MCOs and physical health managed care organizations (PH-MCOs) operate under separate contracts, with BH-MCOs contracting with non-overlapping Primary Contractors, making this distribution even more complex. However, when it comes to improving healthcare quality, timeliness, and access, the BH-MCO can focus on factors within its control.

Table 7.1 details the full list of recommendations that are made for the MCO for each of the applicable EQR activities. For PIPs, the recommendations are based on the review that was conducted for MY 2022. The PIP recommendations may include issues from prior years if they remain unresolved. For PMs, the strengths and opportunities noted above in this section summarize findings from the current report, while recommendations are based on issues that were not only identified as opportunities from the current report but were also identified as outstanding opportunities from last year's EQR technical report.

Table 7.1: EQR Recommendations

EQR Task/Measure	MY 2021 Recommendation	MY 2022 Finding	MY 2022 Recommendation	Standards
Performance Improvement Projects (PIPs)				
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders (SUD)	Opportunities for improvement center primarily on reporting and discussion of findings. This includes further clarifying ITMs to more meaningfully monitor intervention activities and downstream impacts. For example, IPRO recommended PerformCare implement ITMs for two interventions with the same ITM that will distinguish their upstream activities from one another and thus enable PerformCare to identify where breakdowns or successes are occurring in the implementation of the interventions.	Based on review of PerformCare's Year 2 report, there is moderate confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, data analysis, and interpretation of PIP results (Rating 1). The validation findings generally indicate that the credibility of the PIP results is not at risk. Although PerformCare makes a commendable attempt to begin to bring in data collected from the PIP, along with external considerations like Act 32/Act 33 and rollout of ASAM, to assess the efficacy of its interventions, insights for MY 2022 are somewhat limited by the restricted scope and duration of intervention activities during MY 2022, questionable relevance or significance of many ITMs, inconsistent reporting, and, as relates to the prevention strategy intervention, low response rate. There is moderate confidence that the PIP produced evidence of significant improvement (Rating 2). Several indicators like SAR and MHR showed improvement over Year 1, although the jump in FUI rates is not	As relates to Rating 1, IPRO recommends the following: • PerformCare should revisit its logic model of change to ensure the important points and links in its causal chains are being validly measured. In its logic model of change, PerformCare should take into account duration and scope of interventions when considering likely impacts (and when those impacts should occur). • This should inform a review of FUI results and possibly revisiting or at least clarifying certain ITMs and possibly Indicator 6. Analysis should be carried out according to its data analysis plan, and discussion should be clearly written to describe and then interpret the findings according to its logic model of change while also describing any threats to internal and external validity, which would aid the reader in assessing the confidence levels of those findings. • Furthermore, if findings suggest it, the logic model of change itself should be revisited and updated if needed. A report that clearly lays out these considerations will then serve as a document of learning, which is a centerpiece of a PIP. As relates to Rating 2, IPRO recommends the following: • While some interventions have been discontinued,	Quality, Timeliness, Access

EQR Task/Measure	MY 2021 Recommendation	MY 2022 Finding	MY 2022 Recommendation	Standards
		adequately explained, as noted. MAT-OUD and MAT-AUD showed worsening trends. Similar to FUI, the results for Indicator 6 (Prevention Survey) are inconclusive due to extremely low response rates.	new interventions in 2023, along with continued analysis of barriers to provision of psychosocial counseling (the counseling component of MAT), promise to help sustain observed improvements while addressing difficult barriers hindering improvement in initiation and engagement in specialty SUD treatment, especially MAT. Spread and sustainability of improvements, however, will depend on the extent to which the challenges noted above related to planning, execution, measurement (particularly for FUI, the Prevention Survey, and certain ITMs), analysis, and learning are addressed.	
Performance Measures				
HEDIS Follow-Up After Hospitalizatio n for Mental Illness (FUH)	PerformCare's FUH rates continue to decrease. IPRO concurs with PerformCare's findings of its RCA and proposed remediations in its QIP, which center on addressing: expanding Re-Engineered Discharge (RED) with two additional mental health inpatient providers; "develop a joint operating agreement between facilities and mental health outpatient providers to ensure communications between the MH IP facilities, Members and MH OP providers and compliance with new value based purchasing requirements;" and development and dissemination of resources and information related to telehealth and viable	MY 2022 FUH rates continued their long decline for PerformCare and its Primary Contractors for all of the age cohorts measured except for Franklin-Fulton's 30-day FUH for the ages 6−17 years group. Most of the drops were statistically significant. PerformCare's HEDIS FUH All Ages rates were below the HEDIS Quality Compass 25th percentiles. Unfortunately, PerformCare's RCA and QIP in response to the MY 2022 FUH underperformance was inadequate. While the RCA listed factors, there	PerformCare and its Primary Contractors should revisit its RCA and build out a robust logic model of change that delineates chain(s) of causes and effects based on rigorous data collection and analysis of the barriers to improving FUH rates. The current static list of factors, in other words, needs to be operationalized into a causal model that takes into account flows of data, information, activities (e.g., workflows), resources, people, and other elements that link up in a chain of causes and effects and where those flows are typically characterized by time delays. These links and their quantitative impacts should be grounded in	Timeliness, Access

EQR Task/Measure	MY 2021 Recommendation	MY 2022 Finding	MY 2022 Recommendation	Standards
	alternatives for members. PerformCare also noted a lack of engagement among both providers and members related to getting aftercare. IPRO recommends PerformCare leverage interviews, focus groups, member satisfaction surveys, and similar sources to drill deeper into the causes of this lack of engagement so that it can identify concrete interventions to address it.	was little evidence of data drilldowns and analysis to inform a logic model of change or even a general understanding of how the factors operate and interact in the context of PerformCare's network. As a result, the QIP correspondingly lists mostly vague actions with no clear delineation of how those actions will address specific barriers (many of the lists repeat from barrier to barrier) to improving FUH, who will perform what roles, how progress and ultimately success will be measured, and when downstream impacts are expected to occur (and why the timeframes are hypothesized). PerformCare's RCA and QIP for the HEDIS FUH all ages MY 2022 results reports finding no racial or ethnic disparities in rates, but this assessment seems based on superficial comparison of rates between groups as opposed to statistical analysis. In fact, the 2023 (MY 2022) Tableau FUH Rates Report shows that there were in fact racial disparities at the MCO level. For example, Asian members had significantly higher rates than White members for the 7-day rates, while White members had significantly higher rates than Black/African	data. The resulting model will help identify leverage points for changing the ultimate downstream outcome-of-interest as appropriately stratified to address any observed racial or ethnic disparities. Importantly, the model will inform interventions that address barriers to change and measurement points along the chains to monitor progress, using appropriate timeframes, and adjust course as needed. Finally, among the resources already available, PerformCare should utilize the IPRO Tableau FUH Rates Report.	

EQR Task/Measure	MY 2021 Recommendation	MY 2022 Finding	MY 2022 Recommendation	Standards
		American members for the 30-day rates.		
PA FUH	PerformCare's FUH rates continue to decrease. IPRO concurs with PerformCare's findings of its RCA and proposed remediations in its QIP, which center on addressing: expanding Re-Engineered Discharge (RED) with two additional mental health inpatient providers; "develop a joint operating agreement between facilities and mental health outpatient providers to ensure communications between the MH IP facilities, Members and MH OP providers and compliance with new value based purchasing requirements;" and development and dissemination of resources and information related to telehealth and viable alternatives for members. PerformCare also noted a lack of engagement among both providers and members related to getting aftercare. IPRO recommends PerformCare leverage interviews, focus groups, member satisfaction surveys, and similar sources to drill deeper into the causes of this lack of engagement so that it can identify concrete interventions to address it.	The year-over-year drops in the PA-specific FUH were particularly dramatic, with drops ranging from 15.5 to 30.9 percentage points, raising the question of whether some of the decrease may have been from measurement error. These PMs are validated each year, but validation relies on member-level denominator-flagged data submitted by the plans. An ISCA performed in 2022 showed that PerformCare's report generation process utilizes Microsoft Structured Query Language (SQL)/SQL Server Integration Services for the application of the measurement algorithm and information reporting into a relational application for PM reporting.	See HEDIS FUH. PerformCare should also scrutinize their identification of denominator episodes in MY 2021 and MY 2022 to see if any issues with their algorithm or underlying enrollment or encounters data might have introduced errors in calculation of PA-specific FUH rates for MY 2021 and/or MY 2022.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA)	PerformCare's REA rates fell in MY 2021, led by its Franklin-Fulton contract. For its SUD PEDTAR PIP, PerformCare identified the subpopulation of members with co-occurring SUD and MH conditions as being at elevated risk for	PerformCare's REA rate improved (declined), although the change was not statistically significant. PerformCare's REA was also above (worse than) the statewide goal of 11.75%. The fact that	PerformCare and its Primary Contractors should revisit its RCA and build out a robust logic model of change that delineates chain(s) of causes and effects based on rigorous data collection and analysis of the barriers to reducing	Timeliness, Access

EQR Task/Measure	MY 2021 Recommendation	MY 2022 Finding	MY 2022 Recommendation	Standards
	readmission, in part due to missed opportunities for coordinating care. PerformCare also identified a need to increase timely stepped-down care from detox, MAT penetration, as well as treatment retention rates, particularly among African American members. An underlying barrier to improvement common to many of these areas related to SDoH. PerformCare's interventions will include the development and distribution to network-providers of a "toolbox of resources" centered on facilitating screenings, assessments, and referrals to appropriate levels and modalities of care, including the use of Certified Recovery Specialists (CRS). Guiding this implementation at PerformCare will be a dedicated team of BH specialists and clinicians monitoring provider data and informed by an "SU Evidence-Based Treatment Internal Resource Guide." PerformCare's multi-pronged approach to its PEDTAR PIP, starting with the development of internal data- and EBP-driven teams, places it in a strong position to improving outcomes for its members at risk for or afflicted with SUD. Its PEDTAR PIP may well serve as a model for bringing about similar improvements for its members, more generally. A next logical step is to conduct Difference in Difference (DiD) tests to compare rates of	follow-up rates worsened suggest that the improvement in readmission rates was driven by factors other than those related to follow-up services. Unfortunately, PerformCare's RCA and QIP in response to the MY 2022 REA underperformance was inadequate. The RCA listed "findings" with little specifics provided on quantitative results or statistical significance tests. As with HEDIS FUH, the RCA listed factors with little evidence of data drilldowns and analysis to inform a logic model of change or even a general understanding of how the factors operate and interact in the context of PerformCare's network. The REA QIP was even thinner than the QIP response to the HEDIS FUH; the same list of vague actions is, for the most part, repeated for all the barriers with minimal nuances of wording. Once again, no understanding is conveyed for how proposed actions will improve REA rates (and for which target populations), who will perform what roles, how progress and ultimately success will be measured, and when downstream impacts are expected to occur (and	REA rates. The current static list of factors, in other words, needs to be operationalized into a causal model that takes into account flows of data, information, activities (e.g., workflows), resources, people, and other elements that link up in a chain of causes and effects and where those flows are typically characterized by time delays. These links and their quantitative impacts should be grounded in data. The resulting model will help identify leverage points for changing the ultimate downstream outcome-of-interest as appropriately stratified to address any observed racial or ethnic disparities. Importantly, the model will inform interventions that address barriers to change and measurement points along the chains to monitor progress, using appropriate timeframes, and adjust course as needed. Finally, among the resources already available, PerformCare should utilize the IPRO Tableau REA Rates Report.	

EQR Task/Measure	MY 2021 Recommendation	MY 2022 Finding	MY 2022 Recommendation	Standards
	improvement in REA between members who carry an SUD diagnosis and those who don't to assess whether PIP interventions are being effective. Similar analysis could be conducted for members with SPMI who are participating in the ICP program (and compared to those who are not) to determine whether specific BH-PH integration interventions are also impacting REA.	why the timeframes are hypothesized).		
Compliance with Medicaid Managed Care Regulations				
Availability of Services	PerformCare was noncompliant with one of the substandards concerned with denial letters. IPRO concurs with the corrective action plan finding that "PerformCare must institute a process to ensure that all denial letters include a) an individualized clinical rationale; and b) the [medical necessity criteria] MNC that was used to make the determination is accurately identified in the denial letter."	Prior findings on the noted triennial substandard deficiencies remain until next review.	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	Quality, Timeliness, Access
Coordination and Continuity of Care	PerformCare was noncompliant with one of the substandards concerned with denial letters. IPRO concurs with the corrective action plan finding that "PerformCare must institute a process to ensure that all denial letters include a) an individualized clinical rationale; and b) the [medical necessity criteria] MNC that was used to make the determination is accurately identified in the denial letter."	Prior findings on the noted triennial substandard deficiencies remain until next review.	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	Quality, Timeliness, Access

EQR Task/Measure	MY 2021 Recommendation	MY 2022 Finding	MY 2022 Recommendation	Standards
Coverage and Authorization of Services	For this BBA standard, PerformCare was noncompliant with a substandard requiring 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. In addition to the above recommendation, IPRO concurs with the corrective plan finding that "PerformCare must ensure the Denial rationale is easy to understand and free of medical jargon. They should ensure the reference to [medical necessity criteria] MNC in the rationale is consistent with the direction in OMHSAS' denial templates."	Prior findings on the noted triennial substandard deficiencies remain until next review.	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	Quality, Timeliness, Access
Health Information Systems	Not Applicable	HealthChoices Behavioral Health Program Analysis of Claims Processing reports for 2022 for both CABHC and TMCA contracts were reviewed. For the CABHC contract, the threshold was met for the percentage of clean claims adjudicated within 30 days. For clean claims adjudicated within 45 days, the percentage was below 100% in the months of September 2022 (99.99%) and December 2022 (99.81%). 100% of all claims were adjudicated within 90 days. For the TMCA contract, for clean claims adjudicated within 30 days, the percentage was below 90% in the months of March 2022	A Corrective Action Plan has been assigned by OMHSAS to remediate.	Quality, Timeliness, Access

EQR Task/Measure	MY 2021 Recommendation	MY 2022 Finding	MY 2022 Recommendation	Standards
		(74.04%), May 2022 (80.14%), and September 2022 (86.67%). For clean claims adjudicated within 45 days, the percentage was below 100% in the months of March 2022 (97.55%), June 2022 (99.44%), August 2022 (99.98%), and November 2022 (99.97%).		
Practice Guidelines	For this BBA standard, PerformCare was noncompliant with a substandard requiring 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. In addition to the above recommendation, IPRO concurs with the corrective plan finding that "PerformCare must ensure the Denial rationale is easy to understand and free of medical jargon. They should ensure the reference to [medical necessity criteria] MNC in the rationale is consistent with the direction in OMHSAS' denial templates."	Prior findings on the noted triennial substandard deficiencies remain until next review.	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	Quality, Timeliness, Access
Grievance and Appeal Systems	PerformCare was partially compliant with three substandards related to their complaints process. IPRO concurs with OMHSAS' recommendations and CAPs: PerformCare must follow Appendix H; § B.2.l. requirements; specifically, regarding the 1st Level Complaint process. The Member may elect not to attend the Complaint Review meeting; but the	Prior findings on the noted triennial substandard deficiencies remain until next review.	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	Quality, Timeliness, Access

EQR Task/Measure	MY 2021 Recommendation	MY 2022 Finding	MY 2022 Recommendation	Standards
	meeting must be conducted with the same protocols as if the Member was present. PerformCare should continue to ensure the rationales of Complaint letters are written in clear; easily understandable language in order to maintain at least a 90% compliance with this Standard. PerformCare should continue to ensure the list of member Complaints in the Acknowledgement Letter matches the list of member Complaints in the Decision Letter. PerformCare should continue to improve their internal processes to ensure that they are able to provide clear documentation in each case file as to whether follow-up or corrective action is necessary; and whether it was sufficiently completed.			

EQR: external quality review; MCO: managed care organization; MY: measurement year; FUI: Follow-Up After High-Intensity Care for Substance Use Disorder; MAT-OUD: Medication-Assisted Treatment for Opioid Use Disorder; SDoH: social determinants of health; MHR: Mental Health-Related Avoidable Readmissions; SAR: Substance Use Disorder-Related Avoidable Readmissions; MAT-AUD: Medication-Assisted Treatment for Alcohol Use Disorder; ITM: intervention tracking measure; ASAM: American Society of Addiction Medicine; RCA: root cause analysis; QIP: quality improvement plan; MH: mental health; IP: inpatient; OP: outpatient; PA: Pennsylvania; PM: performance measure; ISCA: Information Systems Capabilities Assessment; SPMI: serious persistent mental illness; BH: behavioral health; PH: physical health; HEDIS: Healthcare Effectiveness Data and Information Set; OMHSAS: Office of Mental Health and Substance Abuse Services; CAP: corrective action plan; CABHC: Capital Area Behavioral Health Collaborative; TAMC: Tuscarora Managed Care Alliance.

VIII: Summary of Activities

Validation of Performance Improvement Projects

- PerformCare successfully implemented their PEDTAR PIP for MY 2022.

Validation of Performance Measures

- PerformCare reported all PMs and applicable quality indicators for MY 2022.

Compliance with Medicaid Managed Care Regulations

- PerformCare was compliant with Quality Assessment and Performance Improvement Program and partially compliant with Standards, including Enrollee Rights and Protections and Grievance System. As applicable, compliance review findings from RY 2022, RY 2021, and RY 2020 were used to make the determinations.

Validation of Network Adequacy

- PerformCare was compliant with all network adequacy standards in MY 2022, and the findings were assigned a validity rating of high confidence.

Quality Studies

- For any of its members receiving ICWC services in MY 2022, PerformCare covered those services under a Prospective Payment System rate.

MCO Responses to 2022 EQR Recommendations

- PerformCare provided a response to the opportunities for improvement issued in 2022.

2023 Strengths, Opportunities for Improvement, and Recommendations

- Both strengths and opportunities for improvement were noted for PerformCare in 2023 (MY 2022). The BH-MCO will be required to prepare a response in 2024 for the noted opportunities for improvement.

References

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Appendix A. Required SMART Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for required SMART substandards pertinent to BBA Regulations.

Table A.1: Required SMART Substandards Pertinent to BBA Regulations

BBA Category	SMART Reference	SMART Language
Assurances of Adequate Capacity and Services (*Title 42 CFR § 438.207*)	1.1	Updated Provider Network Report, to include the following: A completed listing of all contracted and credentialed providers; Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standards is used by DOH) for each level of care; Group all providers by type of service, e.g., all outpatient providers should be listed on the same page or consecutive pages.
	1.2	100% of members are given a choice of 2 providers at each level of care within 30/60 urban/rural met
	1.4	The BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs populations or specific services)
	1.5	The BH-MCO has notified the Department of any drop in provider network. Monitor provider turnover. Network remains open where needed
	1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees
Availability of Services (*Title 42 CFR § 438.206, Title 42 CFR § 10(h)*)	1.1	Updated Provider Network Report, to include the following: A completed listing of all contracted and credentialed providers; Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standards is used by DOH) for each level of care; Group all providers by type of service, e.g., all outpatient providers should be listed on the same page or consecutive pages.
	1.2	100% of members are given a choice of 2 providers at each level of care within 30/60 urban/rural met
	1.3	Provider exception report submitted and approved when choice of two providers is not given
	1.4	The BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs populations or specific services)
	1.5	The BH-MCO has notified the Department of any drop in provider network. Monitor provider turnover. Network remains open where needed
	1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees
	1.7	Confirm FQHC providers
	23.1	BH-MCO has assessed if 5% requirement is applicable (see b in Standard Description)
	23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	23.3	List of oral interpreters is available for non-English speakers.
	23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	24.1	BH-MCO provider application includes information about handicapped accessibility
	24.2	Provider network database contains required information for ADA compliance
	24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services

BBA Category	SMART Reference	SMART Language
	24.4	BH-MCO is able to access interpreter services
	24.5	BH-MCO has the ability to accommodate people who are hard of hearing
	24.6	BH-MCO can make alternate formats available upon request
	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
	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
	93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
Confidentiality (*Title 42 CFR § 438.224*)	120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
	142.1	The PC/BH-MCO uses the required reference files as evidenced through correct, complete, and accurate reference information submitted on encounter data records. Diagnosis Code Files; Procedure Code Files
	144.1	98% of Professional Encounters and 95% of Institutional Encounters submitted each month must be HIPAA Compliant and submitted and approved in PROMISe™ (i.e., pass PROMISe™ edits).
	145.1	All encounters must be HIPAA Compliant and submitted and approved in PROMISe™ (i.e., pass PROMISe™ edits) within 90 days following the date that the BH-MCO paid/adjudicated the provider's claim or encounter.
Coordination and Continuity of Care (*Title 42 CFR § 438.208*)	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
	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
Coverage and Authorization of Services (*Title 42 CFR § 438.210(a–e)*, *Title 42 CFR 440.230*, *Title 42 CFR § 441*, Subpart B)	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
	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
	72.1	Denial notices are issued to members according to required timeframes and use the required template language
	72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DHS Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

BBA Category	SMART Reference	SMART Language
Disenrollment Requirements and Limitations (*Title 42 CFR § 438.56*)	120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Emergency and Post-Stabilization Services (*Title 42 CFR § 438.114*)	72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DHS Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
	91.3	The QM Program Description includes the following basic elements: a. Performance improvement projects b. Collection and submission of performance measurement data c. Mechanisms to detect underutilization and overutilization of services d. Emphasis on, but not limited to, high-volume/high-risk services and treatment, such as IBHS. e. Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs
	91.5	The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).
	91.7	The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members: a. Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates. b. Appropriateness of service authorizations and inter-rater reliability. c. Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates. d. Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction.
	91.9	The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services: a. Telephone access and responsiveness rates b. Overall utilization patterns and trends including IBHS and other high-volume/high-risk services
Enrollee Rights Requirements (*Title 42 CFR § 438.100*)	11.2	100% of new providers have received orientation, including member rights and protection.
	24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services
	24.4	BH-MCO is able to access interpreter services
	24.5	BH-MCO has the ability to accommodate people who are hard of hearing
	24.6	BH-MCO can make alternate formats available upon request
	72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DHS Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

BBA Category	SMART Reference	SMART Language
Health Information Systems (*Title 42 C.F.R. § 438.242*)	120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
	141.1	BH-MCO has met the Department's standards of clean claims each of the 12 months: 90% @ 30 days, 100% @ 45 days
	142.1	The PC/BH-MCO uses the required reference files as evidenced through correct, complete, and accurate reference information submitted on encounter data records. Diagnosis Code Files; Procedure Code Files
	143.1	The PC/BH-MCO uses the required provider files as evidenced through correct, complete, and accurate provider information submitted on encounter data records. PRV 414; PRV 415; PRV 430; PRV 435; PRV 720
	144.1	98% of Professional Encounters and 95% of Institutional Encounters submitted each month must be HIPAA Compliant and submitted and approved in PROMISe™ (i.e., pass PROMISe™ edits).
	145.1	All encounters must be HIPAA Compliant and submitted and approved in PROMISe™ (i.e., pass PROMISe™ edits) within 90 days following the date that the BH-MCO paid/adjudicated the provider's claim or encounter.
Practice Guidelines (Title 42 CFR § 438.236)	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
	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
	93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
	10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or edibility BH-MCO onsite review, as applicable.
	10.2	100% of decisions made within 180 days of receipt of application
	10.3	Recredentialing incorporates results of provider profiling
Provider Selection (*Title 42 CFR § 438.214*)	10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or edibility BH-MCO onsite review, as applicable.
	10.2	100% of decisions made within 180 days of receipt of application
	10.3	Recredentialing incorporates results of provider profiling
Subcontractual Relationships and Delegation (*Title 42 CFR § 438.230*)	99.1	The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning
	99.2	The BH-MCO reports monitoring results for adverse incidents
	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
	99.4	The BH-MCO reports monitoring results for administrative compliance

BBA Category	SMART Reference	SMART Language
	99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals
	99.6	Provider profiles and individual monitoring results are reviewed with providers
	99.7	Providers are evaluated based on established goals and corrective action taken as necessary
	99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy
Quality Assessment and Performance Improvement Program (*Title 42 CFR § 438.330*)	91.1	The QM Program Description clearly outlines the BH-MCO QM structure
	91.2	The QM Program Description clearly outlines the BH-MCO QM content.
	91.3	The QM Program Description includes the following basic elements: a. Performance improvement projects b. Collection and submission of performance measurement data c. Mechanisms to detect underutilization and overutilization of services d. Emphasis on, but not limited to, high-volume/high-risk services and treatment, such as IBHS. e. Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs
	91.4	The QM Work Plan includes: a. Objective b. Aspect of care/service c. Scope of activity d. Frequency e. Data source f. Sample size g. Responsible person h. Specific, measurable, attainable, realistic and timely performance goals, as applicable
	91.5	The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).
	91.6	The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.
	91.7	The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members: a. Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates. b. Appropriateness of service authorizations and inter-rater reliability. c. Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates. d. Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction.
	91.8	The QM Work Plan includes a provider profiling process.
	91.9	The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services: a. Telephone access and responsiveness rates b. Overall utilization patterns and trends including IBHS and other high-volume/high-risk services
	91.10	The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: a. Quality of individualized service plans and treatment planning b. Adverse incidents

BBA Category	SMART Reference	SMART Language
		c. Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance
	91.11	The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO
	91.12	The QM Work Plan addresses PA-specific, HEDIS and other performance measures, as applicable: a. Pay-for-Performance Appendix GG of PS&R – PA-specific and HEDIS FUH 7-day and 30-day and REA within 30 days of discharge b. EQRO Annual Technical Report (ATR) identification of Opportunities For Improvement (OFI) for Follow up After Mental Health Hospitalization (FUH) – BH-MCO should address EQRO's identification of OFI in their Annual Workplan and Annual Evaluation c. QM Annual Evaluation
	91.13	The identified performance improvement projects must include the following: a. Measurement of performance using objective quality indicators b. Implementation of system interventions to achieve improvement in quality c. Evaluation of the effectiveness of the interventions d. Planning and initiation of activities for increasing or sustaining improvement e. Timeline for reporting status and results of each project to the Department of Human Services (DHS) f. 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
	91.14	The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the Annual Evaluation and any Corrective Actions required from previous reviews
	91.15	The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan.
	93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
	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.
	98.2	The BH-MCO reports monitoring results for overall utilization patterns and trends, including IBHS service utilization and other high-volume/high-risk services patterns of over- or under-utilization. BH-MCO takes action to correct utilization problems, including patterns of over- and under-utilization.
	98.3	The BH-MCO reports monitoring results for coordination with other service agencies and schools
	100.1	The BH-MCO assesses provider satisfaction with network management; specifically: claims processing, provider relations, credentialing, prior authorization, service management and quality management

BBA Category	SMART Reference	SMART Language
	104.1	The BH-MCO must measure and report its performance using standard measures required by DHS
	104.2	The BH MCO must submit data to DHS, as specified by DHS, that enables the measurement of the BH-MCO's performance. QM program description must outline timeline for submission of QM program description, work plan, annual QM summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.
	104.3	Performance Improvement Plans status reported within the established time frames
	104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly SMART Reports
	108.2	C/FST budget is sufficient to: hire staff proportionate to HealthChoices covered lives; have adequate office space; purchase equipment; travel and attend on-going training.
	108.5	The C/FST has access to providers and HealthChoices members to conduct surveys, and employs a variety of survey mechanisms to determine member satisfaction; e.g., provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	108.6	The problem resolution process specifies the role of the County, BH-MCO, C/FST and providers, and results in timely follow-up of issues identified in quarterly surveys.
	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.
	108.8	The annual mailed/telephonic survey results are representative of HealthChoices membership, and identify systemic trends. Actions have been taken to address areas found deficient, as applicable.
	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.
Grievance and Appeal Systems (*Title 42 CFR § 438.228*)	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.
	60.2	Training rosters and training curriculums identify that Complaint and Grievance staff has been adequately trained on Member rights related to the processes and how to handle and respond to member Complaints and Grievances.
	60.3	The BH-MCO's Complaint and Grievance policies and procedures comply with the requirements set forth in Appendix H.
	68.1	Interview with Complaint Coordinator(s) demonstrate a clear understanding of the Complaint process including how Member rights and Complaint procedures are made known to Members, BH-MCO staff and the provider network. • 1st level • 2nd level • External • Expedited Fair Hearing
	68.2	• Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

BBA Category	SMART Reference	SMART Language
	68.4	Complaint Acknowledgement and 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).
	68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.
	71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the Grievance process, including how Grievance rights and procedures are made known to Members, BH-MCO staff and the provider network: • Internal • External • Expedited Fair Hearing
	71.2	• Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	71.4	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.
	71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file as to where the documentation can be obtained for review.
	72.1	Denial notices are issued to members according to required timeframes and use the required template language
	72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DHS Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

SMART: Systematic Monitoring, Access, and Retrieval Technology; BBA: Balanced Budget Act; CFR: Code of Federal Regulations; §: section; DOH: Department of Health; BH: behavioral health; MCO: managed care organization; PH: physical health; FQHC: federally qualified health center; PC: Primary Contractor; HIPAA: Health Insurance Portability and Accountability Act; OMHSAS: Office of Mental Health and Substance Abuse Services; DHS: Department of Human Services; QM: quality management; HEDIS: Healthcare Effectiveness Data and Information Set; PS&R: Program Standards and Requirements; EQRO: external quality review organization; ADA: Americans with Disabilities Act; TTY: teletype; IBHS: intensive behavioral health services; MA: Medicaid; C/FST: Consumer/Family Satisfaction Team.

Appendix B. OMHSAS-Specific SMART Substandards

Refer to **Table B.1** for OMHSAS-specific SMART substandards.

Table B.1: OMHSAS-Specific SMART Substandards

Category	SMART Reference	SMART Language
Care Management		
Care Management (CM) Staffing	27.1	BH-MCO has staffing standard for the number of care managers needed.
Care Management (CM) Staffing	27.2	Current staffing pattern is in compliance with the stated standard.
Care Management (CM) Staffing	27.3	BH-MCO care management staff represents specialty area of mental health, drug and alcohol, child and adult, and experience in the field.
Care Management (CM) Staffing	27.4	BH-MCO has a staffing standard for the number of physician and peer reviews needed.
Care Management (CM) Staffing	27.5	Current staffing pattern is in compliance with the stated standard.
Care Management (CM) Staffing	27.6	Physician and peer reviews represent specialty areas of mental health, drug and alcohol, child and adults, and experience in field.
Care Management (CM) Staffing	27.7	Other: Significant onsite review findings related to Standard 27
Longitudinal Care Management (and Care Management Record Review)	28.3	Other: Significant onsite review findings related to Standard 28
Complaints and Grievances		
Complaints	68.5	A verbatim transcript and/or recording of the second level Complaint review meeting is maintained to demonstrate appropriate representation, adherence to the Complaint review meeting process, familiarity with the issues being discussed and that the decision was based on input from all panel members.
Complaints	68.6	Sign-in sheets are included for each Complaint review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature (facilitator documents participant’s virtual attendance if they are not present to sign) and acknowledgement of the confidentiality requirement. Member consent is documented on the sign-in sheet or elsewhere in the complaint case record for participants that require member consent.
Complaints	68.8	Complaint case files include Member and provider contacts related to the Complaint case, investigation notes and evidence, Complaint review summary and identification of all review committee participants, including name, affiliation, job title and role.
Complaints	68.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including, but not limited to: the Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
Complaints	68.1.2	Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints.

Category	SMART Reference	SMART Language
Grievances	71.5	A verbatim transcript and/or recording of the Grievance review meeting is maintained to demonstrate appropriate representation, adherence to the Grievance review meeting process, familiarity with the issues being discussed and that input was provided from all panel members.
Grievances	71.6	Sign-in sheets are included for each Grievance review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature (facilitator documents participant's virtual attendance if they are not present to sign) and acknowledgement of the confidentiality requirement. Member consent is documented on the sign-in sheet or elsewhere in the complaint case record for participants that require member consent.
Grievances	71.8	Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role.
Grievances	71.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
Grievances	71.1.2	Training rosters and training curriculums demonstrate that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.
Denial		
Denials	72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to Appendix AA requirements.
Education and Prevention Programs		
Education and prevention programs	59.1	BM-MCO has implemented public education and prevention programs, including behavioral health educational materials.
Enrollee Satisfaction		
Consumer/Family Satisfaction	108.3	County's/BH-MCO's role of fiduciary (if applicable) is clearly defined, and provides supportive function as defined in the C/FST Contract, as opposed to directing the program.
Consumer/Family Satisfaction	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.
Consumer/Family Satisfaction	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.

Category	SMART Reference	SMART Language
Executive Management		
County Executive Management	78.1	Updated County Table of Organization – evidence of sufficient staff.
County Executive Management	78.2	Review of County/Corporation management minutes demonstrate actions taken. BH-MCO written notification of key staff changes received within seven days-watch for high turnover, vacant positions.
County Executive Management	78.3	County formal review of BH-MCO is completed on an annual basis.
County Executive Management	78.4	There is evidence of County leadership to promote recovery and resiliency.
County Executive Management	78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	86.1	Updated BH-MCO table of organization – evidence of sufficient staff.
BH-MCO Executive Management	86.2	OMHSAS onsite review is conducted every 3 years
BH-MCO Executive Management	86.3	Other: Significant onsite review findings related to Standard 86

SMART: Systematic Monitoring, Access, and Retrieval Technology; OMHSAS: Office of Mental Health and Substance Abuse Services; BH-MCO: behavioral health managed care organization; C/FST: Consumer/Family Satisfaction Team.

Appendix C: OMHSAS-Specific SMART Substandards for PerformCare Primary Contractors

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2022, 31 OMHSAS-specific substandards were evaluated for PerformCare and its Primary Contractors. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in 2022, along with the relevant categories.

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

	Evaluated SMART Substandards[1]		SMART Substandards Under Active Review[2]		
Category (SMART Standard)	Total	NR	RY 2022	RY 2021	RY 2020
Care Management					
Care Management (CM) Staffing	7	-	0	0	7
Longitudinal CM (and CM Record Review)	1	-	0	0	1
Complaints and Grievances					
Complaints	5	-	0	0	5
Grievances	5	-	0	0	5
Denial					
Denials	1	-	1	0	0
Executive Management					
County Executive Management	5	-	0	0	5
BH-MCO Executive Management	3	-	0	0	3
Enrollee Satisfaction					
Consumer/Family Satisfaction	3	-	0	3	0
Education and Prevention Programs					
Education and Prevention Programs	1	-	0	1	0
Total	31	-	1	4	26

[1] The total number of OMHSAS-specific substandards required for the evaluation of Primary Contractor/BH-MCO compliance with OMHSAS standards. Any SMART substandards not reviewed indicate substandards that were deemed not applicable to the Primary Contractor/BH-MCO.

[2] The number of OMHSAS-specific substandards that came under active review during the cycle specific to the review year.

OMHSAS: Office of Mental Health & Substance Abuse Services; SMART: Systematic Monitoring, Access, and Retrieval Technology; RY: review year; NR: substandards not reviewed; BH-MCO: behavioral health managed care organization.

Format

This document groups the monitoring standards under the subject headings Care Management, Complaints and Grievances, Denials, Executive Management, Enrollee Satisfaction, and Education and Prevention Programs. The status of each substandard is presented as it appears in the SMART Review Application (i.e., compliant, partially compliant, non-compliant) and/or applicable RAI tools (i.e., complete, pending) submitted by OMHSAS. This format reflects the goal of this supplemental review, which is to assess the Primary Contractor/BH-MCO's compliance with selected ongoing OMHSAS-specific monitoring standards.

Findings

Care Management

The OMHSAS-specific SMART substandards relating to Care Management are MCO-specific review standards. Eight substandards crosswalk to this category, and PerformCare and its Primary Contractors were compliant with all substandards. The status for these substandards is presented in **Table C.2**.

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

Category	SMART Item	RY	Status by Primary Contractor		
			Compliant	Partially Compliant	Non-compliant
Care Management					
Care Management (CM) Staffing	Substandard 27.1	2020	All PerformCare Primary Contractors	-	-
	Substandard 27.2	2020	All PerformCare Primary Contractors	-	-
	Substandard 27.3	2020	All PerformCare Primary Contractors	-	-
	Substandard 27.4	2020	All PerformCare Primary Contractors	-	-
	Substandard 27.5	2020	All PerformCare Primary Contractors	-	-
	Substandard 27.6	2020	All PerformCare Primary Contractors	-	-
	Substandard 27.7	2020	All PerformCare Primary Contractors	-	-
Longitudinal CM (and CM Record Review)	Substandard 28.3	2020	All PerformCare Primary Contractors	-	-

OMHSAS: Office of Mental Health & Substance Abuse Services; SMART: Systematic Monitoring, Access, and Retrieval Technology; RY: review year.

Complaints and Grievances

The OMHSAS-specific SMART substandards relating to second-level complaints and grievances include MCO-specific and county-specific review standards. PerformCare and its Primary Contractors were evaluated on 10 of the 10 applicable substandards.

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

Category	SMART Item	RY	Status by Primary Contractor		
			Compliant	Partially Compliant	Non-compliant
Complaints and Grievances					
Complaints	Substandard 68.1.1	2020	Capital Area Behavioral Health Collaborative, Inc. (Cap5/CABHC)	The Tuscarora Managed Care Alliance	-
	Substandard 68.1.2	2020	-	The Tuscarora Managed Care Alliance	Capital Area Behavioral Health Collaborative, Inc. (Cap5/CABHC)
	Substandard 68.5	2020	All PerformCare Primary Contractors	-	-
	Substandard 68.6	2020	-	All PerformCare Primary Contractors	-
	Substandard 68.8	2020	All PerformCare Primary Contractors	-	-
Grievances	Substandard 71.1.1	2020	-	All PerformCare Primary Contractors	-
	Substandard 71.1.2	2020	-	The Tuscarora Managed Care Alliance	Capital Area Behavioral Health Collaborative, Inc. (Cap5/CABHC)
	Substandard 71.5	2020	-	-	All PerformCare Primary Contractors
	Substandard 71.6	2020	-	All PerformCare Primary Contractors	-
	Substandard 71.8	2020	-	All PerformCare Primary Contractors	-

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One Primary Contractor associated with PerformCare (The Tuscarora Managed Care Alliance) was partially compliant with Substandard 1 and Substandard 2 of SMART Standard 68.1 (RY 2020). One Primary Contractor associated with PerformCare (Cap5/CABHC) was non-compliant with Substandard 2 of SMART Standard 68.1 (RY 2020).

Standard 68.1: The Primary Contractor is responsible for monitoring the Complaint process for compliance with Appendix H and the Program Evaluation Performance Summary (SMART).

Substandard 1: Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including but not limited to: The Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.

Substandard 2: Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints.

PerformCare and its Primary Contractors were partially compliant with Substandard 6 of Standard 68 (RY 2020).

Standard 68: The Complaint and Fair Hearing processes, procedures and Member rights related to the processes are made known to Members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

Substandard 6: Sign-in sheets are included for each Complaint review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature (facilitator documents participant's virtual attendance if they are not present to sign) and acknowledgement of the confidentiality requirement. Member consent is documented on the sign-in sheet or elsewhere in the complaint case record for participants that require member consent.

PerformCare was partially compliant with Substandard 1 of Standard 71.1 (RY 2020). One Primary Contractor associated with PerformCare (The Tuscarora Managed Care Alliance) was partially compliant with Substandard 2 of SMART Standard 71.1 (RY 2020), and one Primary Contractor associated with PerformCare (Cap5/CABHC) was non-compliant with Substandard 2 of SMART Standard 71.1 (RY 2020).

Standard 71.1: The Primary Contractor is responsible for monitoring the Grievance process for compliance with Appendix H and the Program Evaluation Performance Summary (SMART).

Substandard 1: Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.

Substandard 2: Training rosters and training curriculums demonstrate that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.

PerformCare was non-compliant with Substandard 5 of Standard 71 (RY 2020) and partially compliant with Substandard 6 and Substandard 8 of Standard 71 (RY 2020).

Standard 71: The Grievance and Fair Hearing processes, procedures and Member rights related to the processes are made known to Members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

Substandard 5: A verbatim transcript and/or recording of the Grievance review meeting is maintained to demonstrate appropriate representation, adherence to the Grievance review meeting process, familiarity with the issues being discussed and that input was provided from all panel members.

Substandard 6: Sign-in sheets are included for each Grievance review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature (facilitator documents participant's virtual attendance if they are not present to sign) and acknowledgement of the confidentiality requirement. Member consent is documented on the sign-in sheet or elsewhere in the complaint case record for participants that require member consent.

Substandard 8: Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role.

Denials

The OMHSAS-specific SMART substandard relating to Denials is an MCO-specific review standard. PerformCare and its Primary Contractors were evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

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

Category	SMART Item	RY	Status by Primary Contractor		
			Compliant	Partially Compliant	Non-compliant
Denials					
Denials	Substandard 72.3	2022	All PerformCare Primary Contractors	-	-

OMHSAS: Office of Mental Health & Substance Abuse Services; SMART: Systematic Monitoring, Access, and Retrieval Technology; RY: review year.

Executive Management

There are eight OMHSAS-specific SMART substandards relating to Executive Management. PerformCare and its Primary Contractors were compliant with all substandards in County Executive Management. PerformCare and all its Primary Contractors were non-compliant in one substandard of BH-MCO Executive Management. The status for these substandards is presented in **Table C.5**.

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

Category	SMART Item	RY	Status by Primary Contractor		
			Compliant	Partially Compliant	Non-compliant
Executive Management					
County Executive Management	Substandard 78.1	2020	All PerformCare Primary Contractors	-	-
	Substandard 78.2	2020	All PerformCare Primary Contractors	-	-
	Substandard 78.3	2020	All PerformCare Primary Contractors	-	-
	Substandard 78.4	2020	All PerformCare Primary Contractors	-	-
	Substandard 78.5	2020	All PerformCare Primary Contractors	-	-
BH-MCO Executive Management	Substandard 86.1	2020	All PerformCare Primary Contractors	-	-
	Substandard 86.2	2020	All PerformCare Primary Contractors	-	-
	Substandard 86.3	2020	-	-	All PerformCare Primary Contractors

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PerformCare was non-compliant with Substandard 3 of Standard 86 (RY 2020).

Standard 86: Required duties and functions are in place. The BH-MCO Table of Organization depicts relationships between the following functions/positions:

- Chief Executive Officer
- The appointed Medical Director is a board-certified psychiatrist licensed in Pennsylvania with at least five years of experience in MH and SA
- Chief Financial Officer
- Director of Quality Management
- Director of Utilization Management
- Management Information Systems
- Director of Prior/Service Authorization
- Director of Member Services
- Director of Provider Services

Substandard 3: Other: Significant onsite review findings related to Standard 86.

Enrollee Satisfaction

The OMHSAS-specific SMART substandards relating to Enrollee Satisfaction are county-specific review standards. PerformCare and its Primary Contractors were compliant on all three substandards. The status by Primary Contractor for these is presented in **Table C.6**.

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

Category	SMART Item	RY	Status by Primary Contractor		
			Compliant	Partially Compliant	Non-compliant
Enrollee Satisfaction					
Consumer/ Family Satisfaction	Substandard 108.3	2021	All PerformCare Primary Contractors	-	-
	Substandard 108.4	2021	All PerformCare Primary Contractors	-	-
	Substandard 108.9	2021	All PerformCare Primary Contractors	-	-

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Education and Prevention Programs

The OMHSAS-specific SMART substandard relating to Education and Prevention Programs is MCO-specific. PerformCare and its Primary Contractors were compliant on the substandard. The status by Primary Contractor is presented in **Table C.7**.

Table C.7: OMHSAS-Specific Requirements Relating to Education and Prevention Programs

Category	SMART Item	RY	Status by Primary Contractor		
			Compliant	Partially Compliant	Non-compliant
Education and Prevention Programs					
Education and Prevention Programs	Substandard 59.1	2021	All PerformCare Primary Contractors	-	-

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