



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

2011 External Quality Review Report  
Magellan Behavioral Health  
**FINAL REPORT**

Completed on: April 6, 2012



## REPORT CONTENT

---

<b>Glossary of Terms.....</b>	<b>p. 3</b>
<b>Introduction.....</b>	<b>p. 4</b>
<b>I: Structure and Operations Standards.....</b>	<b>p. 5</b>
Program Evaluation Performance Summary Items Pertinent to BBA Regulations	p. 7
Program Evaluation Performance Summary OMHSAS-Specific Items	p. 14
<b>II: Performance Improvement Projects.....</b>	<b>p. 17</b>
<b>III: Performance Measures.....</b>	<b>p. 22</b>
Follow-up After Hospitalization for Mental Illness	p. 22
Readmission within 30 Days of Inpatient Psychiatric Discharge	p. 32
<b>IV: 2010 Opportunities for Improvement MCO - Response.....</b>	<b>p. 36</b>
Current and Proposed Interventions	p. 36
Corrective Action Plan	p. 50
Root Cause Analysis and Action Plan	p. 54
<b>V: 2011 Strengths and Opportunities for Improvement.....</b>	<b>p. 56</b>
Performance Measure Matrix	p. 57
<b>VI: Summary of Activities.....</b>	<b>p. 61</b>
<b>Appendix.....</b>	<b>p. 62</b>
Appendix A: Crosswalk of Required PEPS Items to Pertinent BBA Regulations	p. 62
Appendix B: OMHSAS-Specific PEPS Items	p. 71
<b>References.....</b>	<b>p. 73</b>



## GLOSSARY OF TERMS

---

<b>Average</b> (i.e., arithmetic mean or mean)	The sum of all items divided by the number of items in the list. All items have an equal contribution to the calculation therefore this is un-weighted.
<b>Confidence Interval</b>	Confidence intervals (CIs) are ranges of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% CI indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would be within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the CI 95 times, or 95% of the time.
<b>HealthChoices Aggregate Rate</b>	The sum of all behavioral health (BH) managed care organization (MCO) numerators divided by the sum of all BH MCO denominators.
<b>HealthChoices BH MCO Average</b>	The sum of the individual BH MCO rates divided by the total number of BH MCOs (five BH MCOs). Each BH MCO has an equal contribution to the HealthChoices BH MCO Average value.
<b>HealthChoices County Average</b>	The sum of the individual County rates divided by the total number of Counties (67 Counties). Each County has an equal contribution to the HealthChoices County Average value.
<b>Rate</b>	A proportion indicated as a percentage.
<b>Percentage Point Difference</b>	The arithmetic difference between two rates.
<b>Weighted Average</b>	Similar to an arithmetic mean (the most common type of average), where instead of each of the data points contributing equally to the final average, some data points contribute more than others.
<b>Statistical Significance</b>	In statistics, a result is described as statistically significant if it is unlikely to have occurred by chance. The use of the word significance in statistics is different from the standard one, which suggests that something is important or meaningful.
<b>Z-ratio</b>	The z-ratio expresses how far and in what direction the calculated rate diverged from the most probable result (i.e., the distribution's mean). Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.



## INTRODUCTION

---

### **Purpose and Background**

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

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

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

The Commonwealth of Pennsylvania (PA) Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2011 EQRs for the HealthChoices Medicaid MCOs and to prepare the technical reports. This technical report includes six core sections:

- I: Structure and Operations Standards
- II: Performance Improvement Projects
- III: Performance Measures
- IV: 2010 Opportunities for Improvement MCO - Response
- V: 2011 Strengths and Opportunities for Improvement
- VI: Summary of Activities

For the Behavioral Health (BH) Medicaid MCOs, the information for the compliance with the Structure and Operations Standards section of the report is derived from monitoring conducted by OMHSAS of the BH MCOs against the Commonwealth's Program Evaluation Performance Summary (PEPS) review tools and/or Readiness Assessment Instrument (RAI), as applicable.

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

Section IV, 2010 Opportunities for Improvement – MCO Response, includes the BH MCO's responses to opportunities for improvement noted in the 2010 EQR Technical Report, and presents the degree to which the BH MCO addressed each opportunity for improvement.

Section V has a summary of the BH MCO's strengths and opportunities for improvement for this review period (2010) as determined by IPRO, and a "report card" of the BH MCO's performance as related to the Pay for Performance (P4P) measures.

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



## I: STRUCTURE AND OPERATIONS STANDARDS

---

This section of the EQR report presents a review by IPRO of Magellan Behavioral Health's (MBH's) compliance with the structure and operations standards. In Review Year (RY) 2010, all 67 PA Counties participated in this compliance evaluation.

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

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

Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. While Medicaid managed care members may choose a Physical Health (PH) MCO for physical health care services, each HealthChoices enrollee is assigned a BH MCO based on his or her County of residence. IPRO's EQR is based on OMHSAS reviews of Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties and MBH.

### **Methodology**

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of MBH by OMHSAS monitoring staff within the past three years. These evaluations are performed at the BH MCO and County levels, and the findings are reported in OMHSAS' PEPS review tools for Review Year (RY 2010). 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 Items are considered Readiness Review Items only. Items reviewed at the time of the Readiness Review upon initiation of the HealthChoices contract are documented in the RAI. If the Readiness Review occurred within the three-year timeframe under consideration, the RAI was provided to IPRO. For those Counties and BH MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review Items were deemed as complete. As necessary, the HealthChoices Behavioral Health Program Standards and Requirements (PS&R) are also used.

### **Data Sources**

The documents informing the current report include the review of structure and operations standards completed by OMHSAS as of October 2011 for RY 2010. Information captured within the PEPS tools informs this report. The PEPS tools are a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each County/BH MCO. Within each standard, the tool specifies the sub-standards or Items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional reviewer comments. Based on the tools, a County/BH MCO is evaluated against Items that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Items that are part of OMHSAS' more rigorous monitoring criteria.

At the implementation of the PEPS tools in 2004, IPRO evaluated the standards in the tools and created a crosswalk to pertinent BBA regulations. For standards with multiple review Items, all of the Items within the standard informed the compliance determination of the corresponding BBA category. In 2009, as



requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the review Items required for fulfilling BBA requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS' ongoing monitoring. In the amended crosswalk, the supplemental Items no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Items concerning first level complaints and grievances inform the compliance determination of the BBA categories relating to Federal & State Grievance Systems Standards. All of the PEPS Items concerning second level complaints and grievances are considered OMHSAS-specific Items, and their compliance statuses are not used to make the compliance determination of the applicable BBA category. As was done for the prior technical reports, review findings pertaining to the required BBA regulations are presented in the first section of this chapter. The review findings for selected OMHSAS-specific Items are reported in the second section of this chapter. The RY 2010 crosswalk of PEPS Items to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Items can be found in this report's Appendices.

Because OMHSAS reviews the Counties and their subcontracted BH MCOs on a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS Items from RY 2010, RY 2009, and RY 2008 provided the information necessary for the 2011 assessment. Those standards not reviewed through the PEPS system in RY 2010 were evaluated on their performance based on RY 2009 and/or RY 2008 decisions, or other supporting documentation, if necessary. For those Counties that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Items were evaluated when none of the PEPS Items crosswalked to a particular BBA category were reviewed.

For MBH, this year a total of 159 Items were identified as being required for the evaluation of County/BH MCO compliance with the BBA regulations. In addition, 11 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Items were relevant to more than one BBA regulation, or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS Item may contribute more than once to the total number of Items required and/or reviewed. Table 1.1 provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of the MBH Counties against the Structure and Operations Standards for this report. Table 1.5 provides a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH MCO and associated Counties against other state-specific Structure and Operations Standards.



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

**Table 1.1 Items Pertinent to BBA Regulations Reviewed for MBH Counties**

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	Not Reviewed*
Enrollee Rights	12	5	0	7	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	0	4	17	1
Coordination and Continuity of Care	2	0	0	2	0
Coverage and Authorization of Services	4	1	0	2	1
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	0	4	2	0
Quality Assessment and Performance Improvement Program	23	16	7	0	0
Health Information Systems	1	0	1	0	0
Statutory Basis and Definitions	11	10	0	0	1
General Requirements	14	13	0	0	1
Notice of Action	11	1	0	9	1
Handling of Grievances and Appeals	11	10	0	0	1
Resolution and Notification: Grievances and Appeals	11	10	0	0	1
Expedited Appeals Process	6	5	0	0	1
Information to Providers and Subcontractors	2	2	0	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	5	0	0	1
Effectuation of Reversed Resolutions	6	5	0	0	1

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

For RY 2010, nine categories, 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements were not directly addressed by the PEPS Items reviewed. As per OMHSAS' judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH MCOs. The category of Marketing Activities is Not Applicable because as a result of the Centers for Medicare and Medicaid



Services (CMS) HealthChoices waiver, DPW has been granted an allowance to offer only one BH MCO per County.

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

### **Determination of Compliance**

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

### **Format**

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

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

### **Findings**

For MBH and the five Counties that subcontract with the BH MCO, 159 PEPS Items were identified as required to fulfill BBA regulations, and the entities were evaluated on 149 Items. There were 10 Items that were not scheduled or not applicable for evaluation for RY 2010



## Subpart C: Enrollee Rights and Protections

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

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

Enrollee Rights and Protections				
Subpart C: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Partial	Bucks, Delaware	Lehigh, Montgomery, Northampton	12 Items were crosswalked to this category.  Each County was evaluated on 12 Items. Bucks and Delaware Counties were compliant on 12 Items. Montgomery County was compliant on 10 Items and partially compliant on 2 Items. Lehigh and Northampton Counties were compliant on 6 Items and partially compliant on 6 Items.
Provider-Enrollee Communications 438.102	Compliant	All MBH Counties		Compliant as per PS&R sections E.4 (p.50) and A.3.a (p.24).
Marketing Activities 438.104	N/A	N/A	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	All MBH Counties		Compliant as per PS&R sections A.9 (p.63) and C.2 (p.34).
Cost Sharing 438.108	Compliant	All MBH Counties		Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	All MBH Counties		Compliant as per PS&R section 3.d (p.31).
Solvency Standards 438.116	Compliant	All MBH Counties		Compliant as per PS&R sections A.3 (p.60) and A.9 (p.63), and 2010-2011 Solvency Requirements tracking report.

Based on the PEPS Items reviewed, the five Counties that subcontract with MBH – Bucks, Delaware, Lehigh, Montgomery and Northampton – were compliant on four categories of Enrollee Rights and Protections Regulations as per the HealthChoices PS&R, and one category as per CMS Regulation 42 CFR 447.50-447.60. The category Solvency Standards was also compliant based on the 2010-2011 Solvency Requirement tracking report. One category, Marketing Activities, was Not Applicable. For the remaining category, Enrollee Rights, Bucks and Delaware Counties were compliant while the other three MBH Counties were partially compliant.



Of the 12 PEPS Items that were crosswalked to the category Enrollee Rights, all 12 were evaluated for each County. Bucks and Delaware Counties were compliant for the category, and were compliant on all 12 Items. Lehigh, Montgomery, and Northampton Counties were partially compliant for the category. Montgomery was compliant on 10 Items and partially compliant on two Items, whereas Lehigh and Northampton Counties were compliant on six Items and partially compliant on six Items.

### **Enrollee Rights**

Lehigh, Montgomery, and Northampton Counties were partially compliant with Enrollee Rights due to partial compliance with substandards within PEPS Standard 108.

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

**Lehigh and Northampton Counties** were partially compliant on six substandards of Standard 108: Substandards 1, 2, 5, 6, 7, and 10 (RY 2008).

**Substandard 1:** County/BH MCO oversight of Consumer/Family Satisfaction Team (C/FST) Program ensures HealthChoices (HC) contractual requirements are met.

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

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

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

**Substandard 7:** The C/FST quarterly reports are 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.

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

**Montgomery County** was partially compliant on two substandards of Standard 108: Substandards 2 and 6 (RY 2008).

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

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



## Subpart D: Quality Assessment and Performance Improvement Regulations

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's Medicaid managed care program are available and accessible to MCO enrollees [42 C.F.R. § 438.206 (a)].

The PEPS documents for each County include an assessment of the County/BH MCO's compliance with regulations found in Subpart D. Table 1.3 presents the findings by categories consistent with the regulations.

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

Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Elements of State Quality Strategies 438.204	Compliant	All MBH Counties		Compliant as per PS&R section G.3 (p.55) for more information.
Availability of Services (Access to Care) 438.206	Partial	Bucks, Delaware, Lehigh, Northampton	Montgomery	22 Items were crosswalked to this category. Each County was evaluated on 21 Items. Bucks, Delaware, Lehigh, and Northampton Counties were compliant on 21 Items. Montgomery County was compliant on 19 Items, partially compliant on 1 Item, and non-compliant on 1 Item.
Coordination and Continuity of Care 438.208	Compliant	All MBH Counties		2 Items were crosswalked to this category. Each County was evaluated on 2 Items and compliant on both.
Coverage and Authorization of Services 438.210	Compliant	All MBH Counties		4 Items were crosswalked to this category. Each County was evaluated on 3 Items and compliant on 3 Items.
Provider Selection 438.214	Compliant	All MBH Counties		3 Items were crosswalked to this category. Each County was evaluated on 3 Items and compliant on 3 Items.
Confidentiality 438.224	Compliant	All MBH Counties		Compliant as per PS&R sections D.2 (p.47), G.4 (p.55-56) and C.7.c (p.46).
Subcontractual Relationships and Delegation 438.230	Compliant	All MBH Counties		8 Items were crosswalked to this category. Each County was evaluated on 8 Items and compliant on 8 Items.
Practice Guidelines 438.236	Compliant	All MBH Counties		6 Items were crosswalked to this category. Each County was evaluated on 6 Items and compliant on 6 Items.
Quality Assessment and Performance Improvement Program 438.240	Compliant	All MBH Counties		23 Items were crosswalked to this category. Each County was evaluated on 23 Items and compliant on 23 Items.



Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Health Information Systems 438.242	Compliant	All MBH Counties		1 Item was crosswalked to this category.  Each County was evaluated on 1 Item and compliant on this Item.

Of the 10 Quality Assessment and Performance Improvement Regulations categories, MBH as a whole was compliant on nine categories. Of these categories, two – Elements of State Quality Strategies and Confidentiality – were not directly addressed by any PEPS Items, but were determined to be compliant as per the HealthChoices PS&R.

For this review, 69 Items were crosswalked to Quality Assessment and Performance Improvement Regulations. Each County was evaluated on 67 Items. There were 2 Items were not scheduled or not applicable for evaluation for RY 2010. Bucks, Delaware, Lehigh, and Northampton Counties were compliant on 67 Items. Montgomery County was compliant on 65 Items, partially compliant on one Item, and non-compliant on one Item. Those Items deemed partially compliant may correlate to a fewer number of PEPS substandards deemed partially compliant. As stated previously, some PEPS standards are crosswalked to more than one category.

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

Montgomery County was partially compliant with Availability of Services (Access to Care) due to partial and non-compliance with substandards within PEPS Standard 1.

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

**Montgomery County** was partially compliant on one substandard of Standard 1: Substandard 2 (RY 2008).

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

**Montgomery County** was non-compliant on one substandard of Standard 1: #3 (RY 2008).

**Substandard 3:** Provider exception report submitted and approved when choice of two providers is not given.

**Subpart F: Federal and State Grievance System Standards**

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

The PEPS documents for each County include an assessment of the County/BH MCO’s compliance with regulations found in Subpart F. Table 1.4 presents the findings by categories consistent with the regulations.



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

Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All MBH Counties	11 Items were crosswalked to this category. Each County was evaluated on 10 Items, compliant on 6 Items, partially compliant on 3 Items, and non-compliant on 1 Item.
General Requirements 438.402	Partial		All MBH Counties	14 Items were crosswalked to this category. Each County was evaluated on 13 Items, compliant on 9 Items, partially compliant on 3 Items, and non-compliant on 1 Item.
Notice of Action 438.404	Compliant	All MBH Counties		11 Items were crosswalked to this category. Each County was evaluated on 10 Items and compliant on 10 Items.
Handling of Grievances and Appeals 438.406	Partial		All MBH Counties	11 Items were crosswalked to this category. Each County was evaluated on 10 Items, compliant on 6 Items, partially compliant on 3 Items, and non-compliant on 1 Item.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All MBH Counties	11 Items were crosswalked to this category. Each County was evaluated on 10 Items, compliant on 6 Items, partially compliant on 3 Items, and non-compliant on 1 Item.
Expedited Appeals Process 38.410	Compliant	All MBH Counties		6 Items were crosswalked to this category. Each County was evaluated on 5 Items and compliant on 5 Items.
Information to Providers & Subcontractors 438.414	Compliant	All MBH Counties		2 Items were crosswalked to this category. Each County was evaluated on 2 Items and compliant on both.
Recordkeeping and Recording Requirements 438.416	Compliant	All MBH Counties		Compliant as per 2010 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.
Continuation of Benefits 438.420	Compliant	All MBH Counties		6 Items were crosswalked to this category. Each County was evaluated on 5 Items and compliant on 5 Items.
Effectuation of Reversed Resolutions 438.424	Compliant	All MBH Counties		6 Items were crosswalked to this category. Each County was evaluated on 5 Items and compliant on 5 Items.

MBH was evaluated for compliance on the 10 categories of Federal and State Grievance System Standards. The BH MCO as a whole was compliant on six categories and partially compliant on four categories. The category Recordkeeping and Recording Requirements was compliant per the 2010



Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports. Each MBH County was also compliant on six categories and partially compliant on four categories.

For this review, 78 Items were crosswalked to this Subpart for all five MBH Counties, and each County was evaluated on 70 Items. Eight Items were not scheduled or not applicable for evaluation for RY 2010. The five Counties were compliant on 54 Items and partially compliant on 12 Items. Those Items deemed partially or non-compliant may correlate to a fewer number of PEPS substandards deemed partially compliant. As stated previously, some PEPS standards are crosswalked to more than one category.

The five MBH Counties were partially compliant with four of the 10 categories pertaining to Federal State and Grievance System Standards due to partial or non-compliance with substandards within PEPS Standard 68.

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

***Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties*** were partially compliant on three substandards of Standard 68: Substandard 2, 3 and 5 (RY 2010).

**Substandard 2:** 100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

**Substandard 3:** The Complaint Case File includes documentation of the steps taken by the BH MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.

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

***Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties*** were non-compliant on one substandard of Standard 68: Substandard 4 (RY 2010).

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

## **Program Evaluation Performance Summary OMHSAS-Specific Items for MBH Counties**

OMHSAS-specific items are not required to fulfill BBA requirements. In RY 2010, 11 Items were considered OMHSAS-specific monitoring standards, and were reviewed. Table 1.5 provides a count of these Items, along with the relevant categories. All 11 OMHSAS-specific PEPS Items were evaluated for the five Counties subcontracting with MBH.



**Table 1.5 OMHSAS-Specific Items Reviewed for MBH**

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	Not Reviewed
<b>Second Level Complaints and Grievances</b>					
Complaints (Standard 68)	4	4	0	0	0
Grievances and State Fair Hearings (Standard 71)	4	4	0	0	0
<b>Enrollee Satisfaction</b>					
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0

**Format**

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

**Findings**

The OMHSAS-specific PEPS Items relating to second level complaints and grievances are MCO-specific review standards. Of the eight Items evaluated, MBH met two Items, partially met four Items, and did not meet two Items, as indicated in Table 1.6.

**Table 1.6 OMHSAS-Specific Requirements Relating to Second Level Complaints and Grievances**

Category	PEPS Item	Review Year	Status
<b>Second Level Complaints and Grievances</b>			
Complaints	Standard 68.6	RY 2010	Partially Met
	Standard 68.7	RY 2010	Met
	Standard 68.8	RY 2010	Met
	Standard 68.9	RY 2010	Partially Met
Grievances and State Fair Hearings	Standard 71.5	RY 2010	Partially Met
	Standard 71.6	RY 2010	Met
	Standard 71.7	RY 2010	Met
	Standard 71.8	RY 2010	Met

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

**MBH** was “partially met” on Substandards 68.6 and 68.9:

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

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



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

**MBH** was “partially met” on Substandard 71.5:

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

The OMHSAS-specific PEPS Items relating to Enrollee Satisfaction are County-specific review standards. All three Items crosswalked to this category were evaluated for the five MBH Counties. Bucks, Delaware, and Montgomery Counties met three Items while Lehigh and Northampton Counties partially met two Items and did not meet one Item. The status by County for these is presented in Table 1.7 below.

**Table 1.7 OMHSAS-Specific Requirements Relating to Enrollee Satisfaction**

Category	PEPS Item	Review Year	Status	Counties
<b>Enrollee Satisfaction</b>				
Consumer/Family Satisfaction	Standard 108.3	RY 2008	Met	Bucks, Delaware, Montgomery
			Partially Met	Lehigh, Northampton
	Standard 108.4	RY 2008	Met	Bucks, Delaware, Montgomery
			Partially Met	Lehigh, Northampton
	Standard 108.9	RY 2008	Met	Bucks, Delaware, Montgomery
			Not Met	Lehigh, Northampton

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

**Lehigh and Northampton Counties** were “partially met” on Substandards 108.3 and 108.4:

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

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

**Lehigh and Northampton Counties** were “not met” on Substandard 108.9:

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



## II: PERFORMANCE IMPROVEMENT PROJECTS

---

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH MCO. Under the existing behavioral health agreement with OMHSAS, primary contractors (i.e., the Counties), along with the responsible subcontracted entities (i.e., BH MCOs) are required to conduct a minimum of two focused studies per year. The Counties and BH MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, BH MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2011 for 2010 activities.

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

The 2011 EQR is the eighth review to include validation of PIPs. With this PIP cycle, all BH MCOs/Counties share the same baseline period and timeline. To initiate the PIP cycle in 2008, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, remeasurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness.

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

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

### Validation Methodology

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

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

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last two relate to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points are awarded for the two phases of the project noted above, and are combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance.



## Review Element Designation/Weighting

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

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

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

## Overall Project Performance Score

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

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

## Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred through 2010. At the time of the review, a project is reviewed for only the elements that are due, according to the PIP submission schedule. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule.

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

**Table 2.2 Review Element Scoring Weights**

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



Review Element	Standard	Scoring Weight
2S	Sustained Improvement	15%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

## Findings

As per the timeline distributed by OMHSAS for this review period, BH MCOs were required to submit information for review element six: Interventions Aimed at Achieving Demonstrable Improvement. MBH submitted the required element of the FUH PIP for review.

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

### Follow-up After Hospitalization for Mental Illness

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

The rationale previously provided for this activity selection included MCO-specific data, information regarding the BH MCO's previous efforts to impact follow-up rates, and information regarding the MBH's identification of areas of concern regarding follow-up care. MBH included baseline rates from previous studies, noting that while their rates for this measure have increased from previous years, the rates still do not meet the standard of 90% established by OMHSAS for all four indicators. MBH pointed out that this issue has been identified as a priority for performance improvement.

MBH also indicated that they recognize, as has been demonstrated in research, the importance of follow-up in reducing the risk of readmission to the hospital and other 24 hour levels of care. MBH noted that, in accordance with PA's Child and Adolescent Service System Program (CASSP) and Community Support Program (CSP) principles, the goal is to work towards treating members at the least restrictive level of cares to the extent possible. According to MBH, doing so supports individuals in their recovery and realizes benefits from both a utilization and cost of care perspective.

MBH emphasized commitment to recovery-focused treatment, detailing a number of clinical management strategies that are in place. MBH indicated that one strategy has been the use of provider/community-based and MBH-staffed peer support services. Although these services have had varying degrees of success, MBH stated that the MCO remains committed to examining and adapting the programs to meet community needs. Other strategies involve the BH MCO's care managers and care workers, who MBH



noted are essential to the follow-up process. MBH indicated that care managers play a critical role in planning for aftercare services by involving the member directly, engaging him/her in treatment that is recovery focused, and ensuring that the aftercare/discharge process is progressing. Care workers are actively involved with the member in attempting to schedule aftercare appointments, which includes discussing barriers with the member and discussing attempts to re-engage the member with providers. For members identified as high risk, MBH noted that their case managers, as part of an intensive case management program supervised by the Clinical Department, work closely with the member and his/her community-based treatment providers to develop inpatient discharge plans that are consistent with the member's identified needs and recovery goals. MBH stated that, as a result of these clinical management activities, the BH MCO's care managers identified discharge planning without a recovery focus and without direct member involvement as a significant quality of care concern. Care managers have also identified miscommunication between discharging facilities and community-based/outpatient providers as a concern. MBH noted that the BH MCO will seek to address these issues to improve follow-up.

Baseline results were calculated in 2009 for the period January 1, 2008 through December 31, 2008 and were presented along with analysis that would lead to interventions initiated in late 2009. The baseline results indicated a rate of 52.0% for QI 1 (HEDIS – seven days), 67.7% for QI 2 (HEDIS – 30 days), 62.6% for QI A (PA-Specific – seven days), and 74.7% for QI B (PA-Specific – 30 days). Following review of baseline data, MBH implemented root cause analysis tools including a brainstorming and fishbone diagram session with the BH MCO's Lehigh and Newtown Offices' Clinical and Quality Management staff to first identify barriers, and then opportunities and interventions to improve performance on the measures. Lehigh staff members included the Medical Director, General Manager, Clinical Director, and Quality Improvement Manager. Newtown staff included the Clinical Officer, Clinical Supervisors, Quality Improvement Director and Quality Improvement Clinical Reviewer. Through brainstorming, MBH identified an extensive list of barriers, which the BH MCO subsequently classified into four broader areas of opportunities via the fishbone diagram process. These four areas, some of which related to concerns identified in the rationale, were: 1) the role of the inpatient/discharging provider, 2) outpatient provider access, 3) members with co-occurring disorder diagnosis; and 4) member engagement in recovery. MBH then developed potential interventions to attempt to address these identified areas.

MBH began implementing Interventions Aimed at Achieving Demonstrable Improvement in early 2009 and continued into 2010. MBH's interventions were developed to address each of the MCO's identified barriers, and were aimed at members, providers, and the BH MCO itself. Some of these interventions included: 1) contracting with peer support specialists, 2) enhancing the provider network for members with co-occurring disorders, 3) acute inpatient provider-specific review of follow-up data for subsequent discussion, corrective action plan, or education, 4) increasing member enrollment in MBH high-risk case management programs, 5) partnering with the Network for Improving Addiction Treatment (NIATx) to work with mental health and substance abuse providers to improve processes that would lead to improved outcomes for members, 6) telephonic auditing of MBH care managers, including staff management of the discharge planning process with providers, 7) arranging and participating in conferences/meetings for members, focusing on what is needed to support individuals to remain in the community.

MBH received full credit for the element of the study evaluated that reflected activities in 2010 (Interventions Aimed at Achieving Demonstrable Improvement). Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement will be evaluated in 2012, based on activities conducted in late 2010 through mid-2011.

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

Review Element	Compliance Level	Scoring Weight	Final Points Score
1. Project Title, Type, Focus Area	Full	5%	5
2. Topic Relevance	Full	5%	5
3. Quality Indicators	Full	0%	0



Review Element	Compliance Level	Scoring Weight	Final Points Score
4. Baseline Study and Analysis (Calendar Year (CY) 2008, reported in CY 2009)	Full	20%	20
5. Baseline Study Population and Baseline Measurement Performance (CY 2008)	Full	10%	10
6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010)	Full	20%	20
7. Demonstrable Improvement (CY 2010, reported in 2011)	Not Determined	20%	TBD
<b>Total Demonstrable Improvement Score</b>			<b>TBD</b>
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Not Determined	5%	TBD
2S. Sustained Improvement (CY 2011, reported in 2012)	Not Determined	15%	TBD
<b>Total Sustained Improvement Score</b>			<b>TBD</b>
<b>Overall Project Performance Score</b>			<b>TBD</b>

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

Project	2008	2009/2010	2010	2010/2011	Comparison Benchmark for Review Year
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge (QI 1)	52.0%	NA	TBD	TBD	90%
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	67.7%	NA	TBD	TBD	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge. (Standard HEDIS Codes and PA codes) (QI A)	62.6%	NA	TBD	TBD	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge. (Standard HEDIS Codes and PA codes) (QI B)	74.7%	NA	TBD	TBD	90%
Project Status	Baseline Study	Interventions	Remeasurement #1	Remeasurement #2	

Note: Table remains unchanged from 2009 Review Year, as no rates were evaluated for the 2010 Review Year.



### III: PERFORMANCE MEASURES

---

In 2011, OMHSAS and IPRO conducted two EQR studies. Both the Follow-up After Hospitalization for Mental Illness and Readmission within 30 Days of Inpatient Psychiatric Discharge studies were re-measured.

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

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

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

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



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

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

For the current study, indicators again had very few changes based on the HEDIS 2011 Volume 2: Technical Specifications. One revenue code was removed from the criteria to identify non-acute care exclusions. In all, MY 2010 is the fourth re-measurement for QIs A and B, and is the third re-measurement for the Counties in the North/Central County and State Options regions across all indicators.

### **Measure Selection and Description**

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

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

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

### **Eligible Population**

The entire eligible population was used for all 67 Counties participating in the MY 2010 study.

Eligible cases were defined as those members in the HealthChoices program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a discharge date occurring between January 1 and December 1, 2010;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;



- Six years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

## I: HEDIS Indicators

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

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

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

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

## II: PA-Specific Indicators

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

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

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

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

## Quality Indicator Significance

According to the *Global Burden of Disease: 2004 Update* released by the World Health Organization (WHO) in 2008, mental illnesses and mental disorders represent six of the 20 leading causes of disability worldwide. Among developed nations, depression is the leading cause of disability for people ages 0-59 years, followed by drug and alcohol use disorders and psychoses (e.g., bipolar disorder and schizophrenia)<sup>i</sup>. Mental disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. Additionally, patients with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities<sup>ii,iii</sup> such as obesity, cardiovascular diseases and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns<sup>iv,v</sup>, reduced use of preventive services<sup>vi</sup> and substandard medical care that they receive<sup>vii,viii,ix</sup>. Moreover, these patients are five times more likely to become homeless than those without these disorders<sup>x</sup>. On the whole, serious mental illnesses account for more than 15 percent of overall disease



burden in the U.S.<sup>xi</sup>, and they incur a growing estimate of \$317 billion in economic burden through direct (e.g. medication, clinic visits, or hospitalization) and indirect (e.g., reduced productivity and income) channels<sup>xii</sup>. For these reasons, timely and appropriate treatment for mental illnesses is essential.

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

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

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

## **Methodology**

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

## **Performance Goals**

Performance goals were set for this review year at the OMHSAS designated gold standard of 90% for all measures. In addition, the HEDIS measures were compared to industry benchmarks, in that the aggregate and BH MCO indicator rates were compared to the *HEDIS 2010 Audit Means, Percentiles and Ratios*. These benchmarks contained means, 10<sup>th</sup>, 25<sup>th</sup>, 50<sup>th</sup> (median), 75<sup>th</sup> and 90<sup>th</sup> percentiles, and the enrollment ratios for nearly all HEDIS measures. There were tables published by product line (i.e., Commercial, Medicaid, and Medicare). The appropriate Medicaid benchmarks available for the measurement year were used for comparison. As indicated previously, the PA-specific measures were not comparable to these industry benchmarks.



## Data Analysis

The quality indicators were defined as rates, based on a numerator and a denominator. The denominator equaled the number of discharges eligible for the quality indicator, while the numerator was the total number of members for which the particular event occurred. The overall, or aggregate, performance rate for each indicator was the total numerator divided by the total denominator. The aggregate rate represented the rate derived from the total population of members that qualified for the indicator (i.e., the aggregate value). Year-to-year comparisons to MY 2009 data were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

## Findings

### BH MCO and County Results

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

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

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

**Table 3.1 MY 2010 HEDIS Indicator Rates with Year-to-Year Comparisons**

	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI 1										
HealthChoices	17,109	37,093	46.1%	45.6%	46.6%	45.4%	48.9%	45.6%	0.5	NO
MBH	2,790	5,493	50.8%	49.5%	52.1%			52.2%	-1.4	NO
Bucks	468	890	52.6%	49.2%	55.9%			52.1%	0.5	NO
Delaware	555	1,197	46.4%	43.5%	49.2%			52.3%	-5.9	YES
Lehigh	628	1,246	50.4%	47.6%	53.2%			53.4%	-3.0	NO
Montgomery	702	1,365	51.4%	48.7%	54.1%			49.9%	1.5	NO
Northampton	437	795	55.0%	51.4%	58.5%			54.5%	0.5	NO



	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI 2										
HealthChoices	24,820	37,093	66.9%	66.4%	67.4%	66.2%	72.5%	65.6%	1.3	YES
MBH	3,760	5,493	68.5%	67.2%	69.7%			69.2%	-0.7	NO
Bucks	614	890	69.0%	65.9%	72.1%			68.4%	0.6	NO
Delaware	787	1,197	65.8%	63.0%	68.5%			68.8%	-3.0	NO
Lehigh	841	1,246	67.5%	64.9%	70.1%			68.5%	-1.0	NO
Montgomery	955	1,365	70.0%	67.5%	72.4%			68.2%	1.8	NO
Northampton	563	795	70.8%	67.6%	74.0%			73.0%	-2.2	NO

The MY 2010 HealthChoices behavioral health rates were 46.1% for QI 1 and 66.9% for QI 2. The QI 2 rate was statistically significantly higher than MY 2009. MBH's MY 2010 QI 1 rate of 50.8% and QI 2 rate of 68.5% were comparable to (i.e., not statistically significantly different from) MY 2009 rates.

For MY 2010, MBH's QI 1 rate of 50.8% was statistically significantly higher than the MY 2010 QI 1 HealthChoices BH MCO Average of 45.4% by 5.4 percentage points. MBH's MY 2010 QI 2 rate of 68.5% was also statistically significantly higher than the MY 2010 QI 2 HealthChoices BH MCO Average of 66.2% by 2.3 percentage points.

As presented in Table 3.1, the QI 1 rate for Delaware County statistically significantly decreased between MY 2009 and MY 2010 by 5.9 percentage points. The MY 2010 QI 1 rates for the remaining four Counties, along with the QI 2 rates for all five Counties, did not statistically significantly change as compared to MY 2009 rates.

**Figure 3.1 MY 2010 HEDIS Indicator Rates**

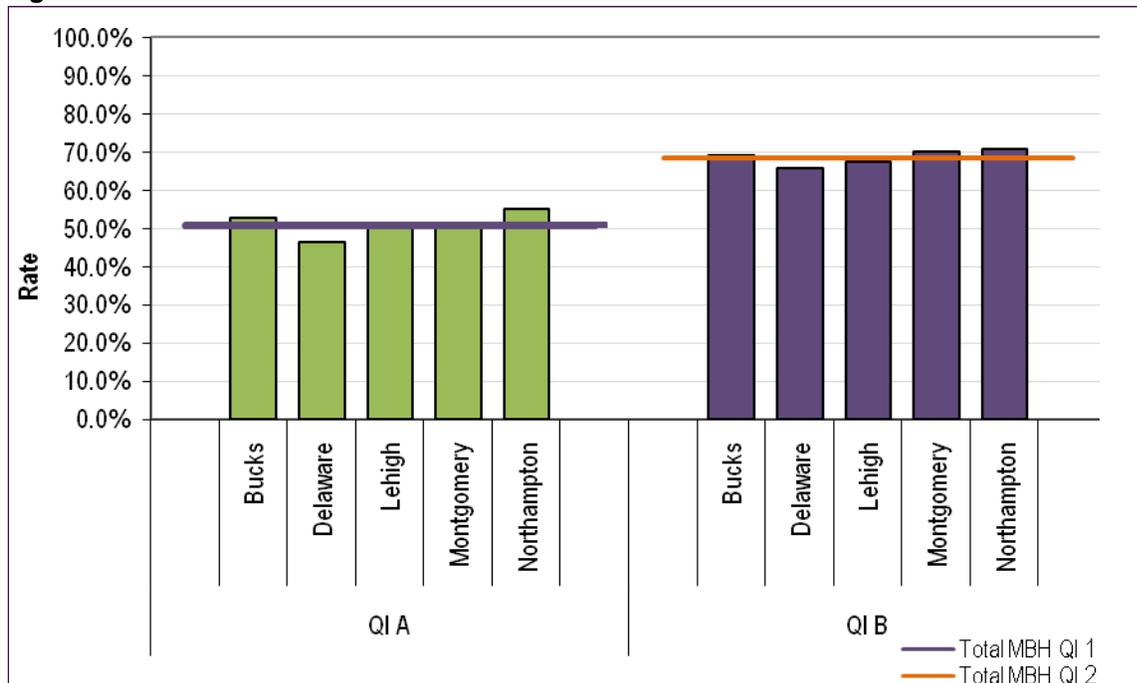
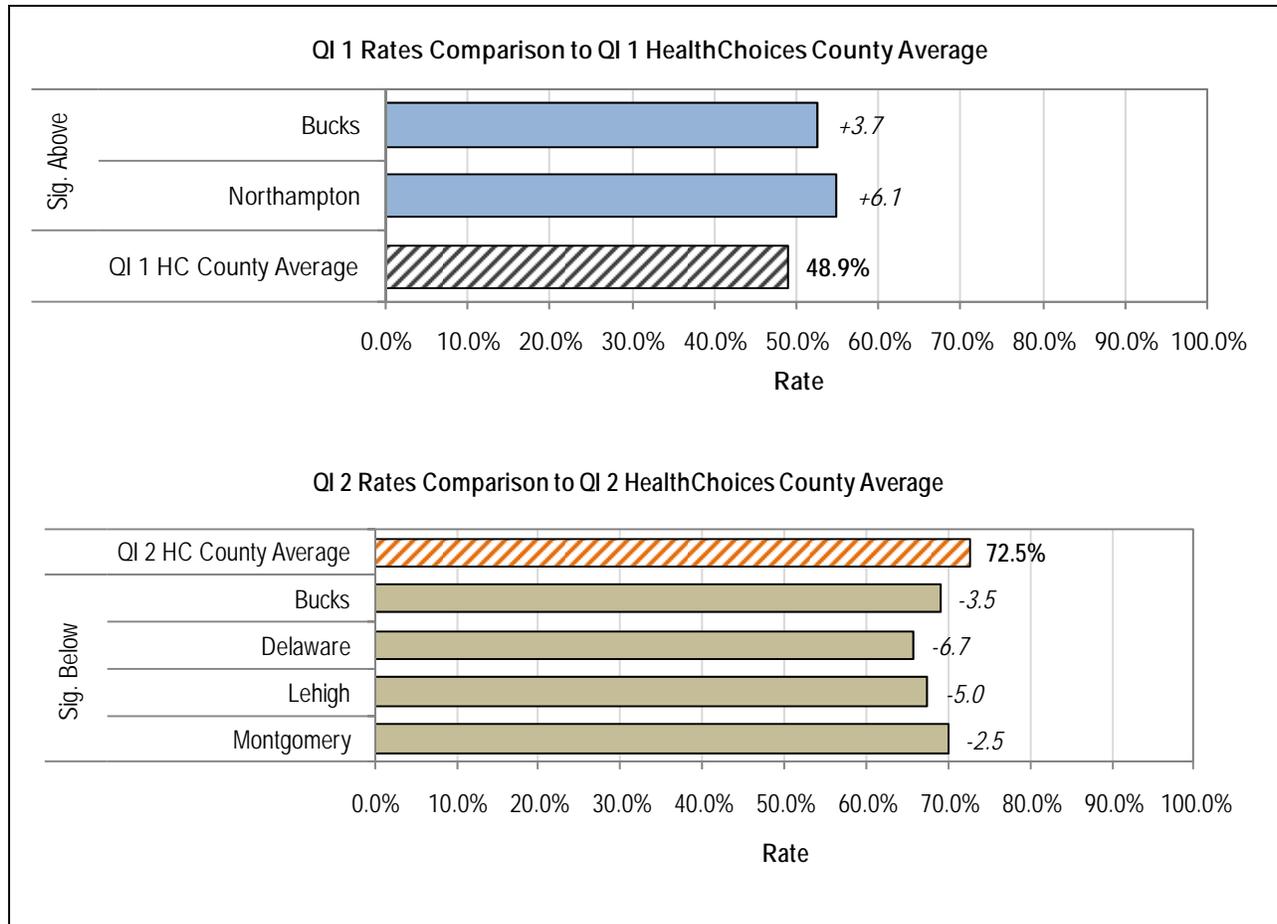




Figure 3.1 displays a graphical representation of the MY 2010 HEDIS follow-up rates for MBH and its associated Counties. Figure 3.2 presents the individual MBH Counties that performed statistically significantly above or below the MY 2010 HealthChoices County Average. In MY 2010, the QI 1 rates for Bucks and Northampton Counties performed statistically significantly higher than the MY 2010 QI 1 HealthChoices County Average of 48.9%. For QI 2, the rates for Bucks, Delaware, Lehigh, and Montgomery Counties were statistically significantly below the MY 2010 QI 2 HealthChoices County Average of 72.5%. Rates for the remaining MBH Counties were not statistically significantly different from the HealthChoices County Average.

**Figure 3.2 MY 2010 HEDIS County Rates Compared to HealthChoices County Average**



**Table 3.2 MY 2010 PA-Specific Indicator Rates with Year-to-Year Comparisons**

	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI A										
HealthChoices	21,551	37,093	58.1%	57.6%	58.6%	57.5%	60.6%	58.9%	-0.8	YES
MBH	3,448	5,493	62.8%	61.5%	64.1%			63.4%	-0.6	NO



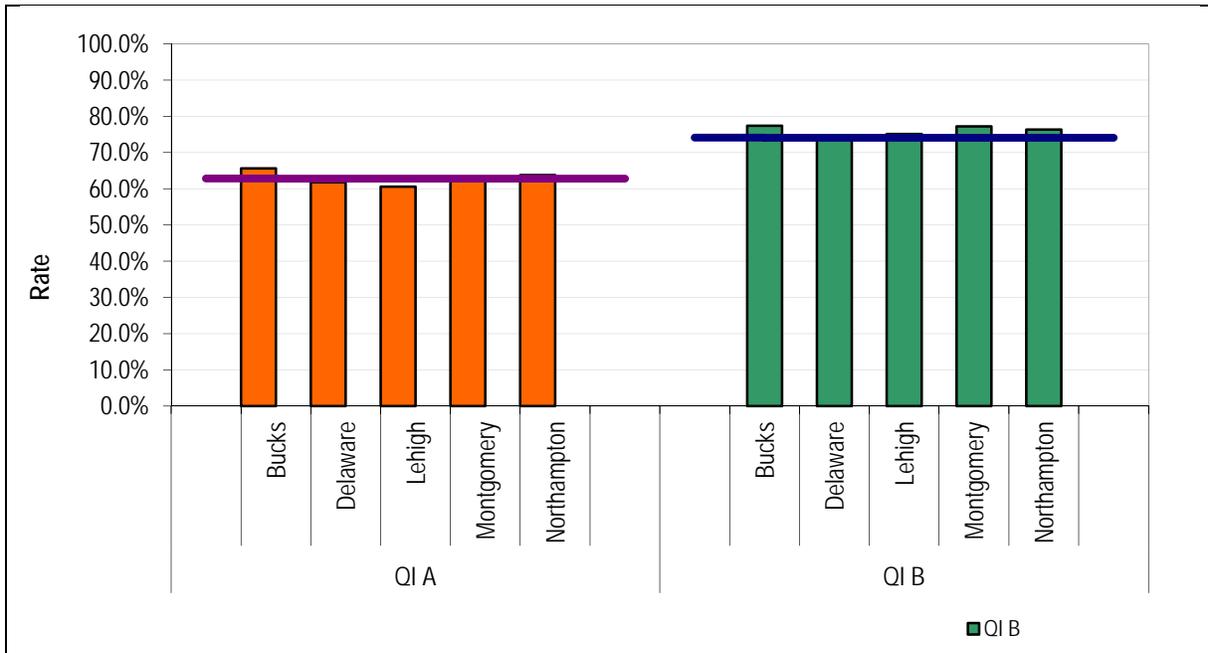
	MY 2010						MY 2009	RATE COMPARISON MY 2010 to MY 2009		
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
Bucks	584	890	65.6%	62.4%	68.8%			64.4%	1.2	NO
Delaware	740	1,197	61.8%	59.0%	64.6%			64.9%	-3.1	NO
Lehigh	755	1,246	60.6%	57.8%	63.3%			64.2%	-3.6	NO
Montgomery	862	1,365	63.2%	60.6%	65.7%			60.8%	2.4	NO
Northampton	507	795	63.8%	60.4%	67.2%			63.5%	0.3	NO
<b>QI B</b>										
<b>HealthChoices</b>	27,679	37,093	74.6%	74.2%	75.1%	74.1%	78.9%	75.0%	-0.4	NO
<b>MBH</b>	4,177	5,493	76.0%	74.9%	77.2%			76.8%	-0.8	NO
Bucks	689	890	77.4%	74.6%	80.2%			77.8%	-0.4	NO
Delaware	891	1,197	74.4%	71.9%	77.0%			77.7%	-3.3	NO
Lehigh	936	1,246	75.1%	72.7%	77.6%			75.9%	-0.8	NO
Montgomery	1,054	1,365	77.2%	75.0%	79.5%			75.3%	1.9	NO
Northampton	607	795	76.4%	73.3%	79.4%			78.2%	-1.8	NO

The MY 2010 HealthChoices behavioral health rates were 58.1% for QI A and 74.6% for QI B. The year-to-year decrease from MY 2009 was statistically significant for QI A. Although MBH's QI A rate of 62.8% and QI B rate of 76.0% decreased from the prior year, the year-to-year changes were not statistically significant.

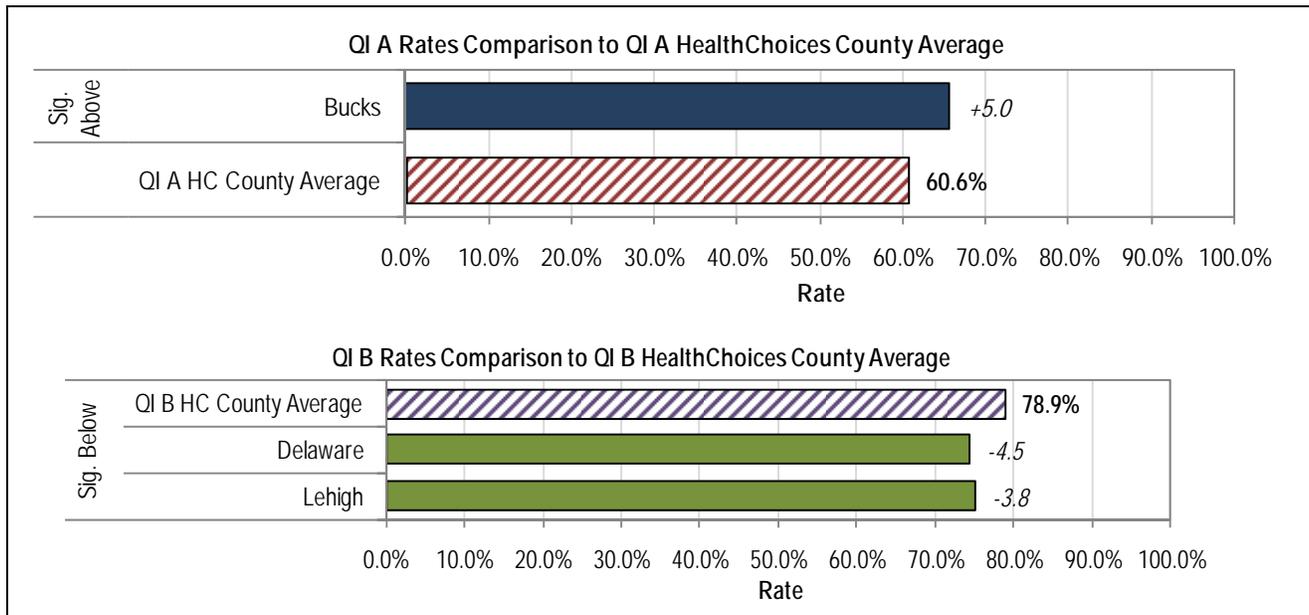
In MY 2010, MBH's QI A rate of 62.8% was statistically significantly higher than the MY 2010 QI A HealthChoices BH MCO Average of 57.5% by 5.3 percentage points. Similarly, MBH's QI B rate of 76.0% was statistically significantly higher than the MY 2010 QI B HealthChoices BH MCO Average of 74.1% by 1.9 percentage points.

As presented in Table 3.2, none of the County rates statistically significantly changed between MY 2009 and MY 2010. Figure 3.3 displays a graphical representation of the MY 2010 PA-specific follow-up rates for MBH and its associated Counties. Figure 3.4 presents the individual MBH Counties that performed statistically significantly higher or lower than the MY 2010 HealthChoices County Average.

**Figure 3.3 MY 2010 PA-Specific Indicator Rates**



**Figure 3.4 MY 2010 PA-Specific County Rates Compared to HealthChoices County Average**



For MY 2010, the QI A rate for Bucks County was statistically significantly higher than the MY 2010 QI A HealthChoices County Average of 60.6%, and the QI B rates for Delaware and Leigh Counties were statistically significantly below the QI B Healthchoices County Average of 78.9%. The rates for the remaining MBH Counties were not statistically significantly different from the respective HealthChoices County Averages.



## Comparison to HEDIS® Medicaid Benchmarks

The HealthChoices HEDIS indicator rates and BH MCO rates were compared to the *HEDIS 2010 Audit Means, Percentiles and Ratios* published by NCQA. The reference rates for national normative data contain means, 10<sup>th</sup>, 25<sup>th</sup>, 50<sup>th</sup>, 75<sup>th</sup> and 90<sup>th</sup> percentiles, and the enrollment ratios for nearly all HEDIS measures. There are tables by product lines (i.e., Commercial, Medicaid, and Medicare), so that the appropriate Medicaid benchmarks were used for comparison. NCQA's means and percentiles for each product line is generated annually using HMO, POS, and HMO/POS combined products from MCOs that underwent a HEDIS Compliance Audit™. Data were included from MCOs, regardless of whether the MCO did or did not report individual HEDIS rates publicly. The means and percentiles displayed in the *HEDIS 2010 Audit Means, Percentiles and Ratios* tables are based on data from the 2009 measurement year. The benchmark values are presented in Table 3.3.

**Table 3.3 HEDIS 2010 Medicaid Benchmarks**

MEDICAID	SUMMARY STATISTICS FOR RATES ACROSS MCOS					
	MEAN	10TH %ILE	25TH %ILE	MEDIAN	75TH %ILE	90TH %ILE
Follow-up After Hospitalization for Mental Illness – 7 Days	42.9	18.2	29.6	43.5	59.1	64.3
Follow-up After Hospitalization for Mental Illness – 30 Days	60.2	31.8	49.0	62.6	74.3	83.6

For MY 2010, the HealthChoices rates were 46.1% for QI 1 and 66.9% for QI 2. As compared to the HEDIS 2010 Medicaid benchmarks, the rates for both QI 1 and QI 2 fell between the 50<sup>th</sup> and 75<sup>th</sup> percentiles. In MY 2009, the QI 1 rate of 45.6% and QI 2 rate of 65.6% also fell between the 50<sup>th</sup> and 75<sup>th</sup> percentiles of the HEDIS 2009 Medicaid benchmarks.

When comparing the MY 2010 MBH rates to HEDIS benchmarks, the QI 1 rate of 50.8% and QI 2 rate of 68.5% both fell between the 50<sup>th</sup> and 75<sup>th</sup> percentile ranges for each respective measure. Similarly, in MY 2009, the MCO's QI 1 rate of 52.2% and QI 2 rate of 68.5% also fell between the 50<sup>th</sup> and 75<sup>th</sup> percentile ranges of the corresponding benchmarks.

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the Follow-up After Hospitalization for Mental Illness EQR final report.

## Conclusion and Recommendations

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

In response to the 2011 study, which represented results for MY 2010, the following general recommendations were made to all five participating BH MCOs:

**Recommendation 1:** The purpose of this re-measurement study is to inform OMHSAS, the Counties and the BH MCOs of the effectiveness of the interventions implemented between MY 2009 and MY 2010 to promote continuous quality improvement with regard to follow-up care after psychiatric hospitalization. The information contained within this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. The Counties and BH MCOs participating in this study should continue to evaluate the current interventions in place with respect to their follow-up rates to assess how these interventions affected change in follow-up rates from the prior measurement years MY 2009 and MY 2008. The Counties and BH MCOs should continue to conduct additional root



cause and barrier analyses to identify further impediments in receiving follow-up care, and then implement action and monitoring plans to further increase their rates.

**Recommendation 2:** The findings of this re-measurement indicate that disparities in rates between demographic populations continue to persist as seen in prior studies. It is clear that the OMHSAS contracted Counties and their subcontracted BH MCOs are working to improve their overall follow-up rates, but it is important for these entities to continue to target the demographic populations that do not perform as well as their counterparts. Furthermore, it is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. It is recommended that BH MCOs and Counties continue to focus interventions on populations that continue to exhibit lower follow-up rates (e.g., Black/African American population). Possible reasons for these rate disparities include access, cultural differences and financial factors, which should all be considered and evaluated to determine their potential impact on performance. Additionally, the BH MCOs should be encouraged to initiate targeted interventions to address disparate rates between study populations.

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

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

Additional recommendations for the 67 Counties and their subcontracted MCOs can be found in the 2011 Follow-up After Hospitalization for Mental Illness EQR final report.

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

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

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

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



## Eligible Population

The entire eligible population was used for all 67 Counties participating in the MY 2010 study.

Eligible cases were defined as those members in the HealthChoices program who met the following criteria:

- Members with one (or more) hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2010;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim must be clearly identified as a discharge.

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

## Methodology

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

## Performance Goals

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

## Findings

### BH MCO and County Results

The results are presented at the BH MCO and then County level when multiple Counties contract with a single BH MCO. Year-to-year comparisons of MY 2010 to MY 2009 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

Individual rates are also compared to the categorical average. Rates statistically significantly above and below the average are indicated. The average takes the sum of the individual rates and divides the sum by the total number of sub-groups within the category. Therefore, all averages presented in this study are *not* weighted. Whether or not an individual rate performed statistically significantly above or below average was determined by whether or not that rate's 95% CI included the average for the indicator.

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



**Table 3.4 MY 2010 Readmission Rates with Year-to-Year Comparisons**

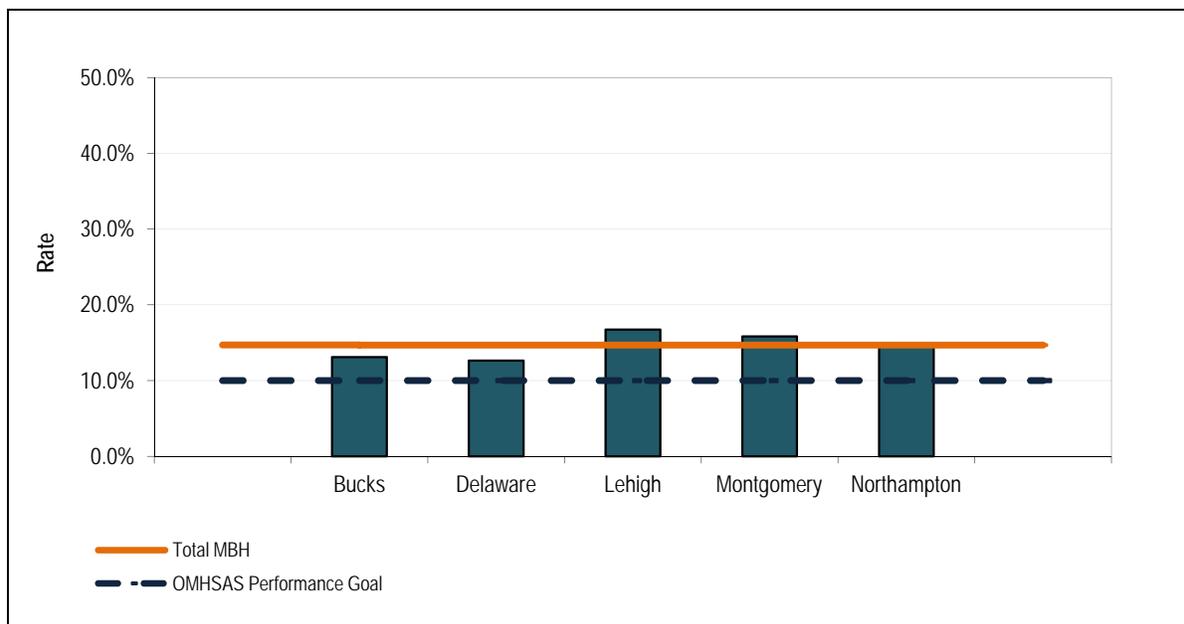
	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
HealthChoices	5,957	48,884	12.2%	11.9%	12.5%	12.4%	10.3%	12.1%	0.1	NO
MBH	1,225	8,338	14.7%	13.9%	15.5%			13.7%	1.0	NO
Bucks	180	1,374	13.1%	11.3%	14.9%			10.7%	2.4	NO
Delaware	231	1,828	12.6%	11.1%	14.2%			12.9%	-0.3	NO
Lehigh	307	1,834	16.7%	15.0%	18.5%			14.1%	2.6	YES
Montgomery	339	2,141	15.8%	14.3%	17.4%			16.4%	-0.6	NO
Northampton	168	1,161	14.5%	12.4%	16.5%			13.2%	1.3	NO

The aggregate MY 2010 HealthChoices readmission rate was 12.2%. MBH's rate of 14.7% was statistically significantly higher than the HealthChoices BH MCO Average of 12.4%, but did not differ statistically significantly from the prior year. Note that this measure is an inverted rate, in that lower rates are preferable. MBH did not meet the performance goal of 10.0% in MY 2010.

As presented in Table 3.4, the rate for Lehigh County statistically significantly increased (became poorer) as compared to MY 2009, and none of the Counties met the performance goal of 10.0% in MY 2010. The rates for all five MBH Counties were statistically significantly higher (poorer) than the HealthChoices County Average of 10.3%. Note that this measure is an inverted rate, in that lower rates are preferable.

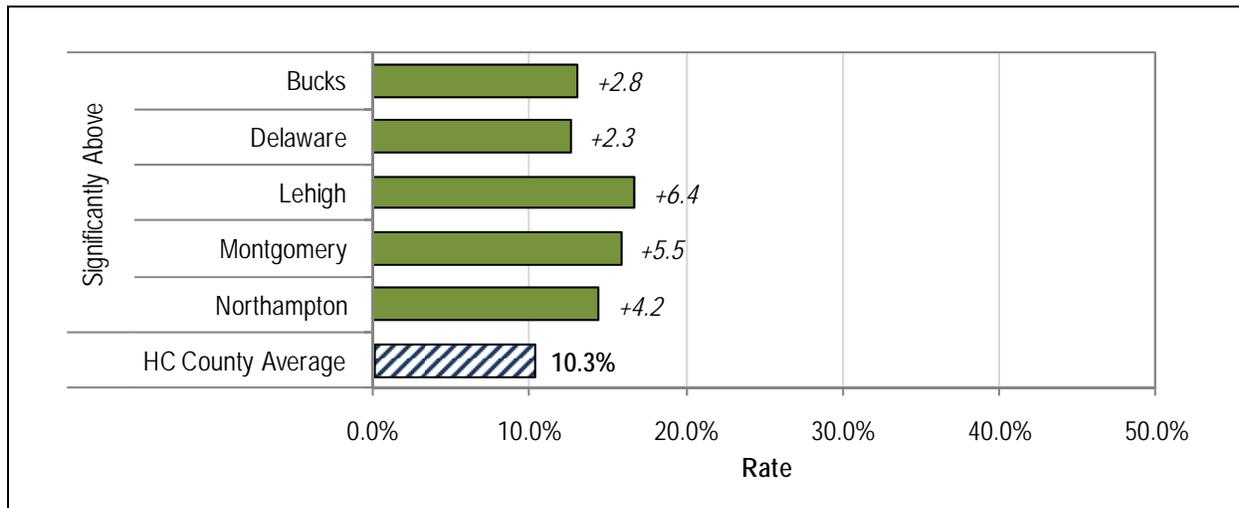
Figure 3.5 provides a graphical presentation of the MY 2010 readmission rates for MBH and its associated counties. Figure 3.6 displays percentage point differences for the individual MBH Counties that performed statistically significantly higher or lower than the MY 2010 HealthChoices County Average.

**Figure 3.5 MY 2010 Readmission Rates**





**Figure 3.6 MY 2010 Readmission Rates Compared to HealthChoices County Average**



### Conclusion and Recommendations

The study concluded that continued efforts should be made to improve performance with regard to Readmission within 30 Days of Inpatient Psychiatric Discharge, particularly for those BH MCOs such as MBH that did not meet the performance goal, and/or performed below the HealthChoices BH MCO Average.

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the Readmission within 30 Days of Inpatient Psychiatric Discharge final report.

In response to the MY 2010 study, the following general recommendations were made to all five participating BH MCOs:

- Given that no significant improvement was noted for any of the BH MCOs, IPRO recommends that the Counties and BH MCOs participating in this study conduct root cause analyses to help determine what factors are negatively impacting readmission rates, and develop interventions that target specific barriers to improving the readmission rates.
- Each BH MCO should conduct additional analyses of the data in order to determine if any other trends are noted. For example, higher readmission rates may be associated with those individuals with particular diagnoses or co-occurring conditions such as substance abuse and/or addiction. Targeted analyses such as these should be evaluated as part of any root cause analysis. In addition, BH MCOs and Counties are encouraged to review the findings of the readmission study in conjunction with follow-up after hospitalization rates.
- Given the statistically different readmission rates observed for Black/African American and the White populations, which is driven by the Philadelphia County population, IPRO recommends that a performance improvement project that focuses on Disparities in Healthcare, with a focus on Philadelphia County, be undertaken. Fifty-six percent of all African American discharges occur in Philadelphia County.
- IPRO recommends continued annual evaluation of Inpatient Readmission after Psychiatric Discharge rates for OMHSAS contracted Counties and their subcontracted BH MCOs.
- Case management consideration should be given to those individuals who appear to be the highest utilizers of inpatient acute psychiatric care and have shown to be at risk for frequent readmission.
- Considerable variation by county was observed for all of the BH MCOs. BH MCOs should evaluate individual County rates, explore the underlying causes of variance by County, and identify those County practices or systems that may contribute to lower readmission rates.



## IV: 2010 OPPORTUNITIES FOR IMPROVEMENT MCO RESPONSE

### Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each BH MCO has effectively addressed the opportunities for improvement cited by IPRO in the 2010 EQR Technical Reports, which were distributed in March 2011. The 2011 EQR Technical Report is the fourth report to include descriptions of current and proposed interventions from each BH MCO that address the 2010 recommendations.

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

- Follow-up actions that the BH MCO has taken through September 30, 2011 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken; and
- The BH MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of October 2011, as well as any additional relevant documentation provided by MBH.

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

Reference Number	Opportunity for Improvement	MCO Response
<b>Structure and Operations Standards</b>		
MBH 1	Within Subpart C: Enrollee Rights and Protections Regulations, Magellan was partially compliant on one out of seven categories – Enrollee Rights.	<p><b><u>Follow Up Actions Taken Through 09/30/11</u></b>  <b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 1 (Lehigh &amp; Northampton)</u></b>            Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Recovery Partnership (Consumer/ Family Satisfaction Team [CFST]) continues to administer at least 552 satisfaction surveys annually. Magellan has also amended their contract in 2011 to provide some Certified Peer Support Services (CPS) for Magellan.</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 2 (Montgomery)</u></b>            CST, MHA and Pro-ACT contracts directly with Montgomery County, as this is a County driven process. The contract is on a fiscal year (7/1 to 6/30). Budget and quarterly reports are forwarded to OMHSAS by Montgomery County 45 days after the quarter ends. Magellan does provide demographic information for surveys, upon request. Magellan also incorporates results into a web based Provider Profile. The three satisfaction groups attend the monthly Montgomery County Quality Management Meeting, as well as monthly meetings to discuss scope of work, closing the loop processes, barriers, etc. In addition, CST moved into a new location which is more conducive to a positive working environment with assistance from Montgomery County and stakeholders from all three satisfaction groups are invited to all Magellan and County sponsored trainings.</p> <p><b><u>Enrollee Rights</u></b></p>

Reference Number	Opportunity for Improvement	MCO Response
		<p><b><u>Standard 108, Substandard 2 (Lehigh &amp; Northampton)</u></b>  Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. CFST was given an increase. Magellan has also amended their contract in 2011 to provide some Certified Peer Support Services (CPS) for Magellan.</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 3 (Lehigh &amp; Northampton)</u></b>  Please refer to Response to 2009 EQR and attachments, particularly the workflow attachment, submitted on 10/5/10. Quarterly meetings were held 11/24/10, 3/2/11, 5/25/11 &amp; 8/31/11 with Recovery Partnership, the Counties and Magellan. Discussion of current processes and workflows is a standing agenda item and will continue to be.</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">   CFST mtg sign in, 11.24.10.pdf </div> <div style="text-align: center;">   CFST agenda, 3.2.11.doc </div> <div style="text-align: center;">   CFST agenda, 5.25.11.doc </div> </div> <div style="text-align: center; margin-top: 20px;">   CFST agenda, 8.31.11.doc </div> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 4 (Lehigh &amp; Northampton)</u></b>  Please refer to Response to 2009 EQR and attachments submitted on 10/5/10, as well as responses to previous sub-standards.</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 5 (Lehigh &amp; Northampton)</u></b>  Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. The number of telephonic surveys has increased but the majority of the surveys are conducted face to face, which is the preferred method. The Director of Recovery Partnership reports they do have the capability to conduct focus groups.</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 6 (Montgomery)</u></b>  A workflow was formulated specifying the role of the County, Magellan and CFST, regarding timely follow-up of issues identified in quarterly surveys for both critical issues and issues regarding questions scoring below the benchmark. Magellan follows up on any area scoring below benchmark. Results are shared at Stakeholder meetings, every other month, and at Montgomery County JQM meetings. Monthly meetings occur between Magellan, CFST and the Counties to review survey results and ongoing processes/workflows. During contract year 2007-2008, CFST, the Counties and Magellan collaborated to revise the questions on the CFST satisfaction survey to be more recovery focused and easier to comprehend for provider profile posting on website. Provider specific results are included in the Provider Profiles on Magellan website. Meetings are held with providers to review and discuss survey feedback; areas of strength and for improvement are identified.</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 6 (Lehigh &amp; Northampton)</u></b>  Please refer to Response to 2009 EQR and attachments submitted on 10/5/10.</p>



Reference Number	Opportunity for Improvement	MCO Response
		<p>Any member concerns reported to Recovery Partnership are discussed with Magellan and the Counties, as well as possible solutions. Follow up occurs with appropriate parties. Magellan implemented a Recovery and Resiliency Workgroup, in May 2011, which has been meeting monthly, and has taken some of the issues brought up by Recovery Partnership to this workgroup for additional consumer/family input and feedback.</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 7 (Lehigh &amp; Northampton)</u></b>  Please refer to Response to 2009 EQR and attachments submitted on 10/5/10, particularly the workflow document and discussion of CFST provider specific survey results which are included in the provider overall audit report to which they are held accountable for any areas for improvement with the submission of a corrective action plan. Feed-back loop is provided to Recovery Partnership. Actions taken on negative responses are reported at Community HealthCare Alliance (CHA) Meetings to providers and members (meetings occur every 2 mos.) and at the HealthChoices Advisory Board (HAB) Meetings. CFST staff has information regarding how members can file a complaint/grievance, so they can inform members who state they do not know. This information is also available on the Magellan of PA HealthChoices website and trainings were provided at CHA and HAB.</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 9 (Lehigh &amp; Northampton)</u></b>  Magellan does not wait for the results of the profile to act on a trend with providers—they are done on a more frequent basis via treatment record review audits, claims audits, compliance audits, ongoing daily and monthly monitoring and reporting of Quality of Care Concerns (QCCs), adverse incident and claims data trends, etc. Providers are held accountable, via a CAP, in addressing any areas needing improvement, as a result of the provider specific CFST member satisfaction survey, immediately after the audit is conducted. The 2011 profiles will include provider specific survey results, if applicable to the providers chosen. From 10/1/10 to present, we had at least 13 providers representing 6 levels of care submit a corrective action plan for an area identified via the survey (majority regarding discharge planning).</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 10 (Lehigh &amp; Northampton)</u></b>  Please refer to Response to 2009 EQR and attachments submitted on 10/5/10 and responses to previous substandards regarding improving relationships, increasing responsibility and incorporation of survey findings regarding provider improvements/accountability.</p> <p><b><u>Future Actions Planned</u></b>  <b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 1 (Lehigh &amp; Northampton)</u></b>  Continue to have at least quarterly meetings with Counties and Recovery Partnership. Improvements/enhancements to workflow will be discussed on an ongoing basis, if issues/ obstacles arise and also at quarterly meetings with Recovery Partnership, the Counties and Magellan. Regular dialogue and seeking out feedback from Recovery Partnership is ongoing. Expected outcomes include improved services for members as additional areas for improvement will be able to be captured at the provider level of care specific area and providers will be held accountable to address these issues. Contractual requirements will continue to be</p>



Reference Number	Opportunity for Improvement	MCO Response
		<p>met. Contracts are reviewed yearly by the General Manager and will continue to be done. Actions are reviewed at the quarterly meetings with Recovery Partnership, the Counties and Magellan.</p> <p><u>Enrollee Rights</u> <u>Standard 108, Substandard 2 (Montgomery)</u> The current interventions will remain in place.</p> <p><u>Enrollee Rights</u> <u>Standard 108, Substandard 2 (Lehigh &amp; Northampton)</u> Contracts are reviewed yearly by the General Manager and will continue to be done, to ensure appropriate payment for services. Actions are reviewed at the quarterly meetings with Recovery Partnership, the Counties and Magellan.</p> <p><u>Enrollee Rights</u> <u>Standard 108, Substandard 3 (Lehigh &amp; Northampton)</u> Actions are reviewed and will continue to be reviewed at the quarterly meetings with Recovery Partnership, the Counties and Magellan. These meetings can be and are increased to monthly when needed. Counties are always involved in actions and meetings with CFST for monitoring and involvement for feedback. Assessment of new contract amendment with CFST for provision of CPS for Magellan is and will continue to be assessed on an ongoing basis.</p> <p><u>Enrollee Rights</u> <u>Standard 108, Substandard 4 (Lehigh &amp; Northampton)</u> Please see response to previous sub-standards as they are all related to the improved workflows and involvement which will continue. Quarterly meetings are scheduled to obtain feedback and monitor progress/discuss any barriers. Meetings are held at least quarterly (Feb./May/Aug./Nov.). New survey questions will continue to be discussed for addition to survey in the future.</p> <p><u>Enrollee Rights</u> <u>Standard 108, Substandard 5 (Lehigh &amp; Northampton)</u> Continue to use and provide the claims information to Recovery Partnership in order for them to have member information from which to contact them to conduct surveys. Recovery Partnership continues to get information regarding upcoming Magellan audits by provider and level of care and reports they have the ability to conduct focus groups, on site interviews at providers, telephonic surveys and surveys via the computer/internet. At least 50% of the surveys will be conducted face to face. It is expected that by increasing the various methods and modes of survey administration that more members will be able to be surveyed. This process will continue to be monitored via ongoing communication with Recovery Partnership staff and at the quarterly meetings with CFST, Counties and Magellan.</p> <p><u>Enrollee Rights</u> <u>Standard 108, Substandard 6 (Montgomery)</u> CST, MHA and Pro-Act will continue to work to identify areas to be surveyed and report the results, so that Montgomery County and Magellan can address issues identified promptly to better meet the needs of our consumers.</p> <p><u>Enrollee Rights</u> <u>Standard 108, Substandard 6 (Lehigh &amp; Northampton)</u> Continue to address any issues that arise as a result of responses from CFST</p>



Reference Number	Opportunity for Improvement	MCO Response
		<p>satisfaction surveys; continue to meet with CFST and Counties quarterly to discuss survey results, etc. Magellan QI Director coordinates the quarterly meetings with CFST and the Counties. Expected outcome is improvement in satisfaction survey scores; improvement in overall member satisfaction. Continuation of quarterly meetings, ongoing communication with CFST and County staff; analysis of quarterly CFST survey results. Continue to utilize workflow previously mentioned and attached and revise if necessary, in collaboration with CFST and the Counties. Continue to utilize the newly formed Recovery and Resiliency Workgroup as an avenue of provision of consumer/family feedback and input as appropriate.</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 7 (Lehigh &amp; Northampton)</u></b>            Continue with the actions mentioned in previous sub-standard. Continue to report to providers their specific level of care results once received from Recovery Partnership and have them address any areas deemed necessary via the report from Recovery Partnership. Recovery Partnership is apprised of actions taken with providers and will continue to be, via ongoing communication and during the quarterly meetings held. Continue interventions re: issues that arise and in areas scoring below benchmark. Expected outcome is improvement in satisfaction survey scores; improvement in overall member satisfaction.</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 9 (Lehigh &amp; Northampton)</u></b>            Provide satisfaction survey backup data as part of the annual provider profiles. Individual provider profile letters will include information regarding results of the provider/level of care specific member satisfaction survey results for those providers who had an audit conducted in the measurement year. Magellan does not wait for the distribution of the provider profiles to have providers act on any areas for improvement. Providers respond via a CAP after the audit occurs, which is much more timely. Expected outcome will be increased provider accountability and improved member satisfaction and services. Monitoring via corrective action plan reviews and follow-up audits.</p> <p><b><u>Enrollee Rights</u></b>  <b><u>Standard 108, Substandard 10 (Lehigh &amp; Northampton)</u></b>            Continue previously mentioned actions, workflows, meetings, oversight and monitoring indicated in the sub-standards addressed under Standard 108. Expected outcome has been, and will continue to be, increased communication between Magellan/Counties and Recovery Partnership, ease in the ability of CFST to have access to members to conduct surveys, increased number of members surveyed, so that more members are heard and more potential issues can be addressed, and improvement in member satisfaction and services, Monitoring via methods previously mentioned.</p>
MBH 2	Magellan was partially compliant on two out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), and	<p><b><u>Follow Up Actions Taken Through 09/30/11</u></b>  <b><u>Availability of Services (Access to Care)</u></b>  <b><u>Standard 1, Substandard 2 (Montgomery)</u></b>            GeoAccess reports are run annually to insure that members have access to network providers within the established standard. A request for Exception of Behavioral HealthChoices Access Standards was submitted for the year 2010 by Montgomery County and approved by OMHSAS on September 9, 2010. The GeoAccess 2010 findings indicate that members did not have a choice of two (2) providers within the access time-frame of thirty (30) min. for the following services: D&amp;A Partial Hospitalization and D&amp;A Halfway House.</p>

Reference Number	Opportunity for Improvement	MCO Response
	2) Subcontractual Relationships and Delegation.	<p>The results of the 2011 GeoAccess report are consistent with the 2010 report with the same two levels of care being out of compliance.</p> <p><b><u>Availability of Services (Access to Care)</u></b>  <b><u>Standard 1, Substandard 3 (Montgomery)</u></b>  An exception request was submitted by Montgomery County and approved by OMHSAS, on September 9, 2010.</p> <p><b><u>Subcontractual Relationships and Delegations</u></b>  <b><u>Standard 99, Substandard 6 (Bucks)</u></b>  Magellan produced MY 2009 Provider Profiles for ten providers, as approved by BCBHS. After completion, profiles were sent to providers for their internal review. Meetings were scheduled and held with each of the providers to review results, discuss areas of strength and areas for improvement, and to gain provider feedback. Meetings were held in July and August 2010.</p> <p><b><u>Subcontractual Relationships and Delegations</u></b>  <b><u>Standard 99, Substandard 6 (Delaware)</u></b>  Magellan produced MY 2009 Provider Profiles for nine providers, as approved by Delaware County OBH. After completion, profiles were sent to providers for their internal review. Meetings were scheduled and held with each of the providers to review results, discuss areas of strength and areas for improvement, and to gain provider feedback. Meetings were held in July and August 2010.</p> <p><b><u>Subcontractual Relationships and Delegations</u></b>  <b><u>Standard 99, Substandard 6 (Montgomery)</u></b>  Magellan produced MY 2009 Provider Profiles for ten providers, as approved by Montgomery County BH. After completion, profiles were sent to providers for their internal review. Meetings were scheduled and held with each of the providers to review results, discuss areas of strength and areas for improvement, and to gain provider feedback. Meetings were held in August 2010.</p> <p><b><u>Subcontractual Relationships and Delegations</u></b>  <b><u>Standard 99, Substandard 6 (Lehigh &amp; Northampton)</u></b>  Magellan produced MY 2010 provider profiles for thirteen providers, as approved by Lehigh &amp; Northampton Counties. After completion, profiles were sent to providers for their internal review. Counties were included in the provider meetings which occurred on 7/26/11 and 7/28/11 to review the profile data. The meetings were attended by representatives from all of the profiled providers. Discussions occurred as well as clarifications made to provider questions regarding data. Letter agreements were distributed for sign off to allow publication of a limited data amount of the profile to the Magellan of PA website. The provider profiling program description was also distributed and reviewed. Letter agreement sign offs were requested to be returned to the QI Department by 8/15/11. Follow up meetings/communications occurred with several providers for further clarifications. Audit results are provided to providers upon completion of the report.</p> <hr/> <p><b><u>Future Actions Planned</u></b>  <b><u>Availability of Services (Access to Care)</u></b>  <b><u>Standard 1, Substandard 2 (Montgomery)</u></b>  No future actions planned.</p> <p><b><u>Availability of Services (Access to Care)</u></b>  <b><u>Standard 1, Substandard 3 (Montgomery)</u></b></p>



Reference Number	Opportunity for Improvement	MCO Response
		<p>No future actions planned.</p> <p><b><u>Subcontractual Relationships and Delegations</u></b>  <b><u>Standard 99, Substandard 6 (Bucks, Delaware &amp; Montgomery)</u></b>            Plans are to continue the current Provider Profile process with providers.</p> <p><b><u>Subcontractual Relationships and Delegations</u></b>  <b><u>Standard 99, Substandard 6 (Lehigh &amp; Northampton)</u></b>            Continue meetings and discussions with providers on ongoing basis for feedback regarding expectations and clarifications. Upon receipt of signed letter agreements, post provider profiles on the Magellan of PA website. Expected outcomes are increased performance outcomes, increased communication with Magellan, better services for members.</p>
MBH 3	<p>Magellan was partially compliant on seven out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were:</p> <ol style="list-style-type: none"> <li>1) Statutory Basis and Definitions,</li> <li>2) General Requirements,</li> <li>3) Handling of Grievances and Appeals, and</li> <li>4) Resolution and Notification: Grievances and Appeals.</li> </ol>	<p><b><u>Follow Up Actions Taken Through 09/30/11</u></b>  <b><u>Standard 68, Substandard 2 (Bucks, Delaware &amp; Montgomery)</u></b>            Please refer to Response to 2009 EQR and attachments submitted on 10/5/10.</p> <p>Updated information: Magellan has clearly documented enrollee requests for extension to the 30-day timeframe in progress notes.</p> <p><b><u>Standard 68, Substandard 2 (Lehigh &amp; Northampton)</u></b>            Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.</p> <p><b><u>Standard 68, Substandard 3 (Bucks, Delaware &amp; Montgomery)</u></b>            Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Updated information: Workgroup initiated as part of prior response was determined to be ineffective due to uniqueness of individual complaint issues. Completeness of complaint reviews and documentation of response efforts continued to be an area of concern, and was noted as such in 2010 PEPS reviewed in 2011.</p> <p><b><u>Standard 68, Substandard 3 (Lehigh &amp; Northampton)</u></b>            Please refer to Response to 2009 EQR and attachments submitted on 10/5/10, as steps outlined by Magellan continue. Lehigh County continues to audit Magellan's 1<sup>st</sup> level complaint and grievance records on a quarterly basis. Feedback on results of the 1<sup>st</sup> level audits occurs within a week to ensure timeliness of feedback and any corrective actions that may be needed by Magellan. Northampton County continues to perform 1<sup>st</sup> level complaint record audits with 2009, 2010 and 1<sup>st</sup> half year of 2011 completed with no major issues cited.</p> <p><b><u>Standard 68, Substandard 4 (Bucks)</u></b>            Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.</p> <p><b><u>Standard 68, Substandard 4 (Delaware)</u></b>            Please refer to Response to 2009 EQR and attachments submitted on 10/5/10.</p> <p>Updated information: 2<sup>nd</sup> level complaint review notice was updated and asks member to contact Magellan if they need assistive devices, teleconferencing, or other arrangements to participate in review.</p>

Reference Number	Opportunity for Improvement	MCO Response
		<div data-bbox="703 262 768 321" data-label="Image"> </div> <p data-bbox="654 325 816 378">DE_2nd Level Complaint Notice</p> <p data-bbox="631 420 1179 449"><b><u>Standard 68, Substandard 4 (Lehigh &amp; Northampton)</u></b></p> <p data-bbox="631 451 1395 508">Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.</p> <p data-bbox="631 541 1073 571"><b><u>Standard 68, Substandard 4 (Montgomery)</u></b></p> <p data-bbox="631 573 1395 602">Please refer to Response to 2009 EQR and attachments submitted on 10/5/10.</p> <p data-bbox="631 632 1401 722">Updated information: 2<sup>nd</sup> level complaint review notice was updated and asks member to contact Magellan if they need assistive devices, teleconferencing, or other arrangements to participate in review.</p> <div data-bbox="703 726 768 785" data-label="Image"> </div> <p data-bbox="654 789 816 842">MO_2nd Level Complaint Notice</p> <p data-bbox="631 884 1008 913"><b><u>Standard 68, Substandard 5 (Bucks)</u></b></p> <p data-bbox="631 915 1395 945">Please refer to Response to 2009 EQR and attachments submitted on 10/5/10.</p> <p data-bbox="631 974 1395 1064">Updated information: Magellan and Bucks, County revised training materials in 2010. Standard met for 2010 PEPS reviewed in 2011. Will continue to use the materials they have developed to train 2<sup>nd</sup> level complaint panel members.</p> <div data-bbox="703 1098 768 1157" data-label="Image"> </div> <p data-bbox="646 1161 824 1213">BU_Cmpl &amp; Griev Panel Mbr Training</p> <div data-bbox="906 1098 971 1157" data-label="Image"> </div> <p data-bbox="865 1161 1011 1213">BU_Panel Mbr Signature Page</p> <p data-bbox="631 1260 1032 1289"><b><u>Standard 68, Substandard 5(Delaware)</u></b></p> <p data-bbox="631 1291 1395 1320">Please refer to Response to 2009 EQR and attachments submitted on 10/5/10.</p> <p data-bbox="631 1350 1419 1440">Updated information: Magellan and Delaware County revised training materials in 2010. Standard met for 2010 PEPS reviewed in 2011. Will continue to use the materials they have developed to train 2<sup>nd</sup> level complaint panel members.</p> <div data-bbox="703 1474 768 1533" data-label="Image"> </div> <p data-bbox="646 1537 824 1589">DE_Cmpl &amp; Griev Panel Mbr Training</p> <div data-bbox="906 1474 971 1533" data-label="Image"> </div> <p data-bbox="865 1537 1011 1589">DE_Panel Mbr Signature Page</p> <p data-bbox="631 1631 1179 1661"><b><u>Standard 68, Substandard 5 (Lehigh &amp; Northampton)</u></b></p> <p data-bbox="631 1663 1440 1900">Northampton County continues to document the review of panel member handbook that includes the addition of the 2/3 panel agreement affording a decision. A training was done to train panel members in the levels of care available to consumers and also in the need to be objective in service on the panel. This training was completed in January 2011. All current panel members were included in the training. Any new panel members will be afforded the same training. Northampton County also has developed a professional handbook for the psychiatrists and psychologists that are part of the panel. The review of this</p>

Reference Number	Opportunity for Improvement	MCO Response
		<p>handbook by the panel member is documented. Lehigh County continues to document each panel member's review of the panel handbook and training booklet and obtains the panel's signature in relation to having participated in the review and receiving the handbook. This is ongoing.</p> <p><b><u>Standard 68, Substandard 5 (Montgomery)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10.</p> <p>Updated information: Magellan Montgomery County revised training materials in 2010. Standard met for 2010 PEPS reviewed in 2011. Will continue to use the materials they have developed to train 2<sup>nd</sup> level complaint panel members.</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">               MO_Compl &amp; Griev Panel Mbr Training         </div> <div style="text-align: center;">               MO_Response to Panel Mbr Training         </div> <div style="text-align: center;">               MO_Panel Mbr Signature Page         </div> </div> <p><b><u>Standard 68, Substandard 6 (Bucks)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.</p> <p><b><u>Standard 68, Substandard 6(Delaware)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.</p> <p><b><u>Standard 68, Substandard 6 (Lehigh &amp; Northampton)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue. In addition, for Lehigh County, at this time, William Sweeney is serving as the primary facilitator and Allison Frantz (HealthChoices Administrator) continues to serve as the back-up facilitator if needed. Because of staffing changes within Lehigh County, an Administrative Assistant will not be trained as facilitator for 2<sup>nd</sup> level complaint and grievance hearings. All other protocols for Lehigh County remain in place.</p> <p><b><u>Standard 68, Substandard 6 (Montgomery)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10.</p> <p>Updated information: Effective 7/1/10, Magellan is responsible for recording 2<sup>nd</sup> level reviews. Magellan uses a digital recording device. No deficiencies have been identified – all recordings have been properly recorded and audible</p> <p><b><u>Standard 71, Substandard 2 (Bucks, Delaware &amp; Montgomery)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Magellan has clearly documented enrollee requests for extension to the 30-day timeframe in progress notes.</p> <p><b><u>Standard 71, Substandard 2 (Lehigh &amp; Northampton)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue. In addition, for Lehigh County at this time, Danielle Sypniewski (Administrative Assistant) was trained on the point person role in October 2010. However, Danielle's role in Lehigh County changed as of</p>

Reference Number	Opportunity for Improvement	MCO Response
		<p>February 1, 2011. Because of such, Matthew Bauder (Quality Assurance Manager) has assumed the role of point person until Lehigh County designates another AA for the HealthChoices program (time frame yet to be determined). Upon first contact with the member or provider for the 2<sup>nd</sup> level complaint or grievance hearing, Matthew communicates his dual role (coordinator and panel member) immediately, to avoid any conflict of interest. Should there be concern about any conflict of interest, Allison Frantz (HealthChoices Administrator) can perform the coordination/point person function on a case by case basis. All necessary time frames continue to be adhered to and it is clearly identified in the client file, if there are justifications for a delay in the time frames or if the consumer does not wish to abide by the time frames for the complaint or grievance hearing to occur. All other protocols for Lehigh County remain in place.</p> <p><b><u>Standard 71, Substandard 3 (Bucks)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.</p> <p><b><u>Standard 71, Substandard 3 (Delaware)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue. Updated information: 2<sup>nd</sup> level grievance review notice was updated and asks member to contact Magellan, if they need assistive devices, teleconferencing, or other arrangements to participate in review.</p> <p> DE_2nd Level Grievance Notice</p> <p><b><u>Standard 71, Substandard 3 (Lehigh &amp; Northampton)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue for Northampton County. Lehigh County continues to maintain a written log in each consumer's 2<sup>nd</sup> level file that documents the communication that has occurred, potential conflicts, and/or need for assistance. This is ongoing.</p> <p><b><u>Standard 71, Substandard 3 (Montgomery)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.  Updated information: 2<sup>nd</sup> level grievance review notice was updated and asks member to contact Magellan, if they need assistive devices, teleconferencing, or other arrangements to participate in review.</p> <p> MO_2nd Level Grievance Notice</p> <p><b><u>Standard 71, Substandard 4 (Bucks)</u></b> Addressed in Response to 2008 External Quality Review Technical Report, submitted 10/16/09.  Updated information: Magellan and Bucks, County revised training materials in 2010. Standard met for 2010 PEPS reviewed in 2011. Will continue to use the materials they have developed to train 2<sup>nd</sup> level complaint panel members.</p>



Reference Number	Opportunity for Improvement	MCO Response
		<p><i>Please see attachments embedded in response to Standard 68, Substandard 5 (Bucks).</i></p> <p><b><u>Standard 71, Substandard 4 (Delaware)</u></b>  Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.</p> <p>Updated information: Magellan and Delaware County revised training materials in 2010. Standard met for 2010 PEPS reviewed in 2011. Will continue to use the materials they have developed to train 2<sup>nd</sup> level complaint panel members.</p> <p><i>Please see attachments embedded in response to Standard 68, Substandard 5 (Delaware).</i></p> <p><b><u>Standard 71, Substandard 4 (Lehigh &amp; Northampton)</u></b>  Northampton County continues to document the review of panel member handbook that includes the addition of the 2/3 panel agreement affording a decision. A training was done to train panel members in the levels of care available to consumers and also in the need to be objective in service on the panel. This training was completed in January 2011. All current panel members were included in the training. Any new panel members will be afforded the same training. Northampton County also has developed a professional handbook for the psychiatrists and psychologists that are part of the panel. The review of this handbook by the panel member is documented.  Lehigh County continues to document each panel member's review of the panel handbook and training booklet and obtains the panel's signature in relation to having participated in the review and received the handbook. This is ongoing. Additionally, all panel members will receive an annual refresher review of the panel handbook and training booklet. This began in January 2011.</p> <p><b><u>Standard 71, Substandard 4 (Montgomery)</u></b>  Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.</p> <p>Updated Information: Magellan and Montgomery County revised training materials in 2010. Standard met for 2010 PEPS reviewed in 2011. Will continue to use the materials they have developed to train 2<sup>nd</sup> level complaint panel members.</p> <p><i>Please see attachments embedded in response to Standard 68, Substandard 5 (Montgomery).</i></p> <p><b><u>Standard 71, Substandard 5 (Bucks)</u></b>  Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.</p> <p><b><u>Standard 71, Substandard 5 (Delaware)</u></b>  Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Same efforts/action steps continue.</p> <p><b><u>Standard 71, Substandard 5 (Lehigh &amp; Northampton)</u></b>  Northampton County continues to follow the action steps from the previous EQR for this subsection. Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. In addition, for Lehigh County at this time, William Sweeney is serving as the primary facilitator and Allison Frantz (HealthChoices</p>

Reference Number	Opportunity for Improvement	MCO Response
		<p>Administrator) continues to serve as the back-up facilitator if needed. Because of staffing changes within Lehigh County, an Administrative Assistant will not be trained as facilitator for 2<sup>nd</sup> level complaint and grievance hearings. All other protocols for Lehigh County remain in place.</p> <p><b><u>Standard 71, Substandard 5 (Montgomery)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10.</p> <p>Updated information: Effective 7/1/10, Magellan is responsible for recording 2<sup>nd</sup> level reviews. Magellan uses a digital recording device. No deficiencies have been identified – all recordings have been properly recorded and audible.</p> <hr/> <p><b><u>Future Actions Planned</u></b></p> <p><b><u>Standard 68, Substandard 2 (Bucks, Delaware &amp; Montgomery)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 68, Substandard 2 (Lehigh &amp; Northampton)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10, as activities outlined are continuing.</p> <p><b><u>Standard 68, Substandard 3 (Bucks, Delaware &amp; Montgomery)</u></b> Updated complaint training curriculum to be developed to improve response to 1<sup>st</sup> level complaints and documentation of actions taken. Staff training took place on 10/5/11.</p> <p>20% of 1<sup>st</sup> level complaints will be audited by respective county to ensure completeness of review and documentation, as well as compliance with applicable regulations.</p> <p><b><u>Standard 68, Substandard 3 (Lehigh &amp; Northampton)</u></b> Magellan efforts continue as outlined in the Response to 2009 EQR and attachments submitted on 10/5/10. Northampton County continues to perform 1<sup>st</sup> level audits every six months, to ensure satisfaction with conduction and completion of the 1<sup>st</sup> level hearing. Lehigh County continues to audit Magellan's 1<sup>st</sup> level complaint and grievance records on a quarterly basis. Feedback on results of the 1<sup>st</sup> level audits occurs within a week to ensure timeliness of feedback and any corrective actions that may be needed by Magellan.</p> <p><b><u>Standard 68, Substandard 4 (Bucks)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 68, Substandard 4 (Delaware)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 68, Substandard 4 (Lehigh &amp; Northampton)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10, as activities outlined are continuing. Ongoing monitoring to ensure compliance with this standard.</p> <p><b><u>Standard 68, Substandard 4 (Montgomery)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 68, Substandard 5 (Bucks)</u></b> Same efforts/action steps will continue.</p>



Reference Number	Opportunity for Improvement	MCO Response
		<p><b><u>Standard 68, Substandard 5(Delaware)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 68, Substandard 5 (Lehigh &amp; Northampton)</u></b> Please refer to Response to 2009 EQR and attachments submitted on 10/5/10, as activities outlined are continuing. Ongoing monitoring to ensure compliance with this standard. Northampton County completed a consumer/family member panel training on January 2011 to increase the knowledge of the panel members.</p> <p><b><u>Standard 68, Substandard 5 (Montgomery)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 68, Substandard 6 (Bucks)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 68, Substandard 6(Delaware)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 68, Substandard 6 (Lehigh &amp; Northampton)</u></b> Continue with protocols mentioned in the Response to 2009 EQR and attachments submitted on 10/5/10 and additional ones mentioned above for ongoing compliance and monitoring.</p> <p><b><u>Standard 68, Substandard 6 (Montgomery)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 71, Substandard 2 (Bucks, Delaware &amp; Montgomery)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 71, Substandard 2 (Lehigh &amp; Northampton)</u></b> Continue timely communication between Counties and Magellan for adherence to timeframes and to ensure ongoing compliance.</p> <p><b><u>Standard 71, Substandard 3 (Bucks)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 71, Substandard 3 (Delaware)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 71, Substandard 3 (Lehigh &amp; Northampton)</u></b> Continue inclusion of all consumer contacts in the tracking system, to ensure that all pertinent information is captured for reporting and compliance purposes. Also continue with new items mentioned above.</p> <p><b><u>Standard 71, Substandard 3 (Montgomery)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 71, Substandard 4 (Bucks)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 71, Substandard 4 (Delaware)</u></b> Same efforts/action steps will continue.</p>

Reference Number	Opportunity for Improvement	MCO Response
		<p><b><u>Standard 71, Substandard 4 (Lehigh &amp; Northampton)</u></b> Continue utilization of improved handbooks and training booklet, with explanation of levels of care and medication necessity criteria, to increase knowledge for panel members. Northampton County completed a consumer/family member panel training on January 2011 to increase the knowledge of the panel members. The County monitors the actions of 2<sup>nd</sup> Level Complaint Meetings and has ongoing and timely communication with Magellan.</p> <p><b><u>Standard 71, Substandard 4 (Montgomery)</u></b> No further actions planned.</p> <p><b><u>Standard 71, Substandard 5 (Bucks)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 71, Substandard 5 (Delaware)</u></b> Same efforts/action steps will continue.</p> <p><b><u>Standard 71, Substandard 5 (Lehigh &amp; Northampton)</u></b> Continue with protocols mentioned in the Response to 2009 EQR and attachments submitted on 10/5/10 and additional ones mentioned above for ongoing compliance and monitoring.</p> <p><b><u>Standard 71, Substandard 5 (Montgomery)</u></b> No further actions planned.</p>
<b>Performance Measures</b>		
<p><b>MBH 4</b></p>	<p>Magellan's rate for the MY 2009 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was significantly higher (poorer) than the MY 2009 HealthChoices BH MCO Average by 1.4 percentage points. The MY 2009 rate did not meet the OMHSAS designated performance goal of 10.0%.</p>	<p><b><u>Follow Up Actions Taken Through 09/30/11</u></b> Root cause analysis (RCA) update regarding Readmission within 30 Days of Inpatient Psychiatric Discharge was completed by Magellan and submitted to IPRO on 10/29/10. An e-mail was received by IPRO on that same day (10/29/10) stating "We will review it shortly and be in touch, if we need any clarifications." A follow up status response is due to IPRO by the end of 2011. Magellan and its five County partners held 2 AIP Provider forums, with the focus on decreasing 30 day readmission rate to AIP (one on 2/3/11 and one on 6/2/11). See Attached meeting agendas: Agenda_AIP forum_2.3.11.doc &amp; Agenda_AIP forum_6.2.11.doc.</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">               Agenda_AIP forum_2.3.11.doc           </div> <div style="text-align: center;">               Agenda_AIP forum_6.2.11.doc           </div> </div> <p>Progress/status updates on interventions implemented by providers was requested and received in September/ October 2011. These will be reviewed and items incorporated into the November forum.</p> <p>Lehigh Valley (LV) CMC is conducting a Lean Six Sigma (LSS) project, with the focus of improving the 30 day readmission rate to AIP. We have also started to use the Follow Up Specialists (FUS) for engagement of members who have readmitted to the AIP within 30 days. FUS meet with members in the AIP unit and focus on the barriers to remaining in the community and the struggles with the previous discharge plan. This information is then provided to the Care Manager covering the facility, which they use to help shape the current discharge plan. The LV CMC has contracted with our local Consumer and Family Satisfaction Team (CFST), Recovery Partnership, which allows us to connect with members whose</p>



Reference Number	Opportunity for Improvement	MCO Response
		engagement with the FUS has been poor, or they are not willing to work with "professionals." Recovery Partnership has one of their Certified Peer Specialists go out to the hospital and meet with the members as peers, which allows the member in the hospital to feel more at ease and open to discussion.
		<p><b>Future Actions Planned</b></p> <p>A follow up status response is due to IPRO, by the end of 2011. Magellan will continue efforts outlined in the Root Cause Analysis and continue activities and efforts of the AIP provider forums. A 3<sup>rd</sup> AIP Provider forum is scheduled for 11/3/11. We will also continue with the additional efforts outlined above, with the hopes of reducing the 30 day readmission rate to AIP.</p>

### Corrective Action Plan

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

The following Corrective Action Plan was implemented during the calendar year 2010 to address those deficiencies noted by OMHSAS:

**Table 4.2 Corrective Action Plan for MBH**

Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
Standard 68.2 <ul style="list-style-type: none"> <li>All issues identified by the member in the 1<sup>st</sup> level complaint must be included in the 1<sup>st</sup> and 2<sup>nd</sup> level complaint acknowledgement letter and decision letter.</li> <li>1<sup>st</sup> and 2<sup>nd</sup> level complaints must be resolved within 30 days unless there is documentation in the case file to support the delay</li> </ul> 1 <sup>st</sup> level complaints must be thoroughly investigated and should not be closed "due to timeframe"					
<ul style="list-style-type: none"> <li>DPW template amended to include section which will report complaint details</li> </ul>	<ul style="list-style-type: none"> <li>John Bottger / Deema Hadid</li> </ul>	10/1/11	10/1/11	Revised templates  BU Attachment 2 A-1st Level Standard	
<ul style="list-style-type: none"> <li>For Newtown CMC-Outlook calendar reminders will be used to remind staff when complaints are due to ensure timely completion</li> </ul>	<ul style="list-style-type: none"> <li>John Bottger</li> </ul>	10/1/11	12/31/11	 MN Attachment 2 A 1st Level Standard Cc	
<ul style="list-style-type: none"> <li>For Lehigh Valley CMC- Sr. Appeals&amp; Comment Coordinator will track complaints to ensure timely completion via excel tracker</li> </ul>	<ul style="list-style-type: none"> <li>Deema Hadid</li> </ul>	10/1/11	Ongoing	 DE 2 A-1st Level Standard Complaint R	
<ul style="list-style-type: none"> <li>Bucks County has in place the</li> </ul>	<ul style="list-style-type: none"> <li>Bern</li> </ul>	1/1/11	Ongoing		

Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
<p>administrative processes and checks to ensure compliance with the resolution timeliness standards. As the ultimate and overriding goal is to meet the needs of the members in a complete and timely manner, the standard timeframe will only be exceeded if the best interest of the member dictates doing so. For example, accommodating the member's scheduling requirements might lead to resolution outside the standard. In such cases, Bucks County will clearly document the reasons for not meeting the standard.</p> <p>For Lehigh Valley CMC; MBH will resolve 1st level complaints within 30 days unless there is documentation in the case file to support the delay.            **Regarding the case that was referenced as closed "due to timeframe" – the wording in the case note states "requested a return call ASAP due to time restraints [sic] to complete the complaint". The complaint was resolved and member's mom did not end up filing a 2nd level complaint. Lehigh County and MBH did not stop resolving a complaint if the 11 business day time frame was reached. The attached e-mail from 2009 illustrates same.</p> <p>Lehigh County and MBH have not, nor will not, stop resolving a complaint because the 30 day time frame has been reached and the file will include accompanying documentation to support the delay.</p>	<p>McBride</p> <p>• Deema Hadid</p> <p>For informational purposes only NA</p>	<p>Immediate</p> <p>NA</p>	<p>Ongoing</p> <p>NA</p>	<p> NHAttachment 2 A-1st Level Standard</p> <p> LE Attachment 2 A-1st Level Standard</p> <p>Outlook calendar reminder procedure</p> <p> Outlook Calendar Complaint Reminder S</p> <p>Excel tracking sheet</p> <p> LVCMC-Complaint Tracker.xls</p> <p>Updated internal staff complaint training and reference guide</p>	

Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
				 LVCMC-Member Complaint Training Gu  Copy of case note  LVCMC case note.pdf  Email documentation  Email Evidence from LE.doc	
<p>Standard 68.4</p> <ul style="list-style-type: none"> <li>All of the member's complaint issues must be thoroughly investigated at the 1<sup>st</sup> level review by the BH-MCO to insure that an informed decision is being made regarding the validity of the complaint.</li> <li>Documentation needs to be obtained from a provider (i.e. medical records, incident reports, policies, etc.) to support their verbal or written response to a complaint.</li> <li>Steps taken by MBH to further investigate a provider's response to a complaint need to be documented in the case file.</li> <li>If a complaint involves a clinical issue then a clinician needs to be part of the 1<sup>st</sup> level committee. The results of the review need to be included in the case file and the decision letter.</li> <li>The complaint case file needs to include documentation of whether or not a member's complaint is substantiated and if any follow up will occur.</li> </ul> <p>The respective County should review 1<sup>st</sup> level complaints from initiation to resolution to determine their satisfaction with the handling of the complaint.</p>					
<ul style="list-style-type: none"> <li>% complaints to 2nd level in 2010                BU= 6% (3 of 47)                DE= 7% (4 of 61)                LE= 6% (2 out of 33)                MN= 6% (5 of 79)                NH= 0% (0 out of 14)</li> <li>Magellan will review responses submitted by a provider with the provider and obtain documentation as appropriate to support a provider's response to a complaint.</li> </ul>	For informational purposes only NA: illustrates that members are satisfied with 1 <sup>st</sup> level resolutions and not taking their issue to the next level.	NA	NA	NA	
	<ul style="list-style-type: none"> <li>John Bottger / Deema Hadid to train Clinical Staff</li> </ul>	10/17/11	10/17/11	Training to occur with Care Managers on September 22, 2011 for Lehigh Valley CMC & October 5, 2011 for Newtown CMC.	

Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
<p>All verbal communication with the provider will be documented in the IP system.</p> <p>Magellan's IP note will indicate if the member's complaint was substantiated or not through the resolution process.</p> <p>Additional steps or actions to be taken after the complaint process will also be recorded in IP.</p> <ul style="list-style-type: none"> <li>For Lehigh Valley CMC- if a complaint involves a clinical issue, it will be forwarded to a clinician for review and resolution.</li> <li>For Lehigh Valley CMC- <ul style="list-style-type: none"> <li>Lehigh County: The above MBH processes have been continuously monitored by Lehigh County QA. Lehigh County HealthChoices reviews all complaint and grievance letters forwarded by Magellan on a weekly basis. In January 2010, Lehigh County began auditing MBH 1<sup>st</sup> level complaint records from initiation to resolution. Lehigh County continues to audit Magellan's 1<sup>st</sup> level complaint and grievance records on a quarterly basis. Feedback on results of the 1<sup>st</sup> level audits occurs within a week (though generally feedback is discussed immediately following the completion of the audit) to ensure timeliness of feedback and any corrective actions that may be needed by Magellan. This process allows Lehigh County HC to insure that members' rights are being upheld as well as the county's satisfaction with how</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Clinical Staff to implement items</li> <li>Deema Hadid</li> <li>Deema Hadid</li> <li>Matthew Bauder – L.C. HC QA Manager</li> </ul>	<p>10/17/11</p> <p>Has been ongoing for 2 years</p>	<p>Ongoing</p> <p>Ongoing</p>	<p>Training to occur with Care Managers on September 22, 2011.</p> <ul style="list-style-type: none"> <li>See audit tools and results for both LE and NH Counties</li> </ul> <p> LVCMC-1st Level Complaint Audit Tool_</p> <p> LVCMC-2nd Q 2011 LE 1st Level Complain</p> <p> LVCMC-1st level Complaint Audit Tool_</p> <p> LVCMC-1st Level Complaint Audit Tool_</p> <p> LVCMC-NH 1st level complaint audit result</p>	



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
<p>complaints are being handled and ultimately resolved.</p> <ul style="list-style-type: none"> <li>■ Northampton County: Northampton County HealthChoices conducts audits of complaint and grievance files twice per year (every 6 months). Feedback is given immediately after the review and a report is provided to MBH by NH County. Audits began in December 2008.</li> <li>■ For Newtown CMC- Starting with Q4 2011 Complaints, Magellan will submit a random sample of 20% of all complaints resolved quarterly to the County for review within 30 days of the end of each quarter.</li> </ul> <p>An audit tool will be provided for the Counties to complete. The results of the audit will be returned to Magellan in order to provide feedback and input.</p> <p>The complaints &amp; audit tool will be provided to the County staff person who oversees all C&amp;G matters.</p>	<ul style="list-style-type: none"> <li>• Tisbine Moussa, N.C. HC QI</li> <li>• John Bottger</li> </ul>	Q4 2011	Ongoing	<ul style="list-style-type: none"> <li>• Audit tool to be developed.</li> </ul>	

### Root Cause Analysis and Action Plan

The 2011 EQR is the third for which BH MCOs were required to prepare a Root Cause Analysis and Action Plan for performance measures performing statistically significantly poorer than the BH MCO average and/or as compared to the prior measurement year. The performance measures that were noted as opportunities for improvement in the 2010 EQR Technical Report required that the MCO submit:

- A goal statement;
- Root cause analysis and analysis findings;
- Action plan to address findings;
- Implementation dates; and



- A monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

IPRO reviewed each submission, and offered technical assistance to BH MCO staff. The BH MCOs were given the opportunity to revise and re-submit response forms as needed and as time permitted. MBH was not required to submit a root cause analysis and action plan in 2011 based on 2010 performance.



## V: 2011 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

---

The review of MBH's 2011 (MY 2010) performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH MCO.

### **Strengths**

- MBH's rates for the MY 2010 Follow-up After Hospitalization for Mental Illness HEDIS indicators, QI 1 and QI 2, were statistically significantly higher than the respective MY 2010 HealthChoices BH MCO Averages by 5.4 and 2.3 percentage points.
- MBH's rates for the MY 2010 Follow-up After Hospitalization for Mental Illness PA-specific indicators, QI A and QI B, were statistically significantly higher than the respective MY 2010 HealthChoices BH MCO Averages by 5.3 and 1.9 percentage points.
- MBH submitted one PIP for validation in 2011 and received full credit for the element of the study evaluated that reflected activities in 2010 (Interventions Aimed at Achieving Demonstrable Improvement).

### **Opportunities for Improvement**

- Review of compliance with standards conducted by the Commonwealth in RY 2008, RY 2009, and RY 2010 found MBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
  - Within Subpart C: Enrollee Rights and Protections Regulations, MBH was partially compliant on one out of seven categories – Enrollee Rights.
  - MBH was partially compliant on one out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant category is Availability of Services (Access to Care).
  - MBH was partially compliant on four out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Handling of Grievances and Appeals, and 4) Resolution and Notification: Grievances and Appeals.
- MBH's rate for the MY 2010 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (poorer) than the MY 2010 HealthChoices BH MCO Average by 2.3 percentage points. MBH's rate did not meet the OMHSAS designated performance goal of 10.0%.

Additional strengths and targeted opportunities for improvement can be found in the BH MCO-specific 2011 (MY 2010) Performance Measure Matrix that follows.



## PERFORMANCE MEASURE MATRIX

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

- Compares the Behavioral Health Managed Care Organization's (BH MCO's) own measure performance over the two most recent reporting years (Measurement Year (MY) 2010 and MY 2009); and
- Compares the BH MCO's MY 2010 performance measure rates to the MY 2010 HealthChoices BH MCO Average.

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

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

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

-  The green box (A) indicates that performance is notable. The BH MCO's MY 2010 rate is statistically significantly above the MY 2010 HealthChoices BH MCO Average and trends up from MY 2009.
-  The light green boxes (B) indicate either that the BH MCO's MY 2010 rate is equal to the MY 2010 HealthChoices BH MCO Average and trends up from MY 2009 or that the BH MCO's MY 2010 rate is statistically significantly above the MY 2010 HealthChoices BH MCO Average but there is no change from MY 2009.
-  The yellow boxes (C) indicate that the BH MCO's MY 2010 rate is statistically significantly below the MY 2010 HealthChoices BH MCO Average and trends up from MY 2009 or that the BH MCO's MY 2010 rate is equal to the MY 2010 HealthChoices BH MCO Average and there is no change from MY 2009 or that the BH MCO's MY 2010 rate is statistically significantly above the MY 2010 HealthChoices BH MCO Average but trends down from MY 2009. *No action is required although MCOs should identify continued opportunities for improvement.*
-  The orange boxes (D) indicate either that the BH MCO's MY 2010 rate is statistically significantly below the MY 2010 HealthChoices BH MCO Average and there is no change from MY 2009 or that the BH MCO's MY 2010 rate is equal to the MY 2010 HealthChoices BH MCO Average and trends down from MY 2009. *A root cause analysis and plan of action is required.*
-  The red box (F) indicates that the BH MCO's MY 2010 rate is statistically significantly below the MY 2010 HealthChoices BH MCO Average and trends down from MY 2009. *A root cause analysis and plan of action is required.*



**KEY POINTS**

■ **A - No MBH performance measure rate fell into this comparison category.**

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

Measures that had no statistically significant change from MY 2009 to MY 2010 but were statistically significantly above the MY 2010 HealthChoices BH MCO Averages are:

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)
- Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)
- Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)

■ **C - No MBH performance measure rate fell into this comparison category.**

■ **D - Root cause analysis and plan of action required.**

Measure that had no statistically significant change from MY 2009 to MY 2010 but was statistically significantly below/poorer than the MY 2010 HealthChoices BH MCO Averages was:

- Readmission within 30 Days of Inpatient Psychiatric Discharge<sup>1</sup>

■ **F - No MBH performance measure rate fell into this comparison category.**

---

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



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

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

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

<sup>2</sup> Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



Performance measure rates for MY 2008, MY 2009, and MY 2010 are displayed in Figure 2. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

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

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

Quality Performance Measure	MY 2008 Rate	MY 2009 Rate	MY 2010 Rate	MY 2010 HC BH MCO Average
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	52.0%	52.2% =	50.8% =	45.4%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	67.7%	69.2% =	68.5% =	66.2%
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	62.6%	63.4% =	62.8% =	57.5%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	74.7%	76.8% ▲	76.0% =	74.1%
Readmission within 30 Days of Inpatient Psychiatric Discharge <sup>3</sup>	15.4%	13.7% ▼	14.7% =	12.4%

<sup>3</sup> Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



## VI: SUMMARY OF ACTIVITIES

---

### **Structure and Operations Standards**

- MBH was partially compliant on Subparts C, D, and F. As applicable, compliance review findings from RY 2010, RY 2009, and RY 2008 were used to make the determinations.

### **Performance Improvement Projects**

- MBH submitted one PIP for validation in 2011 and received full credit for the element of the study evaluated that reflected activities in 2010 (Interventions Aimed at Achieving Demonstrable Improvement).

### **Performance Measures**

- MBH reported all performance measures and applicable quality indicators in 2011.

### **2010 Opportunities for Improvement MCO Response**

- MBH provided a response to the opportunities for improvement issued in 2010. MBH submitted a corrective action plan implemented in calendar year 2010.

### **2011 Strengths and Opportunities for Improvement**

- Both strengths and opportunities for improvement were noted for MBH in 2011. The BH MCO will be required to prepare a response for the noted opportunities for improvement in 2012.



## APPENDIX

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

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



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



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

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



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

BBA Category	PEPS Reference	PEPS Language
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> </ul>
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> <li>• BBA Fair Hearing</li> <li>• 1st Level</li> <li>• 2nd Level</li> <li>• External</li> <li>• Expedited</li> </ul>
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.	
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if



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



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



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



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

### Appendix B: OMHSAS-Specific PEPS Items

Category	PEPS Reference	PEPS Language
<b>Second Level Complaints and Grievances</b>		
Complaints	Standard 68.6	The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 68.9	Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.
Grievances and State Fair Hearings	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a



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

## REFERENCES

---

- i World Health Organization. (2008) WHO Global Burden of Disease: 2004 Update. Available from: [www.who.int/healthinfo/global\\_burden\\_disease/2004\\_report\\_update/en/index.html](http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html)
- ii Dombrovski A, Rosenstock J (2004) Bridging General Medicine and Psychiatry: Providing General Medical and Preventive Care for the Severely Mentally Ill. *Current Opinion in Psychiatry*, 17(6):523-529
- iii Moran M. (2009) Schizophrenia Patients Show High Rates of Comorbid Illness. *Psychiatric News*, 44(18):22.
- iv Gill SS. (2005). Stable Monotherapy with Clozapine or Olanzapine Increases the Incidence of Diabetes Mellitus in People with Schizophrenia. *Evid Based Ment Health*, 8(1):24.
- v Leslie DL, Rosenheck RA. (2004) Incidence of Newly Diagnosed Diabetes Attributable to Atypical Antipsychotic Medications. *Am J Psychiatry*, 161:1709–11.
- vi Druss BG, Rosenheck, RA, Desai MM, & Perlin, J. B. (2002). Quality of Preventive Medical Care for Patients with Mental Disorders. *Medical Care*, 40(2):129–136.
- vii Desai M, Rosenheck RA, Druss BG, Perlin J.B. (2002) Mental Disorders and Quality of Diabetes Care in Veterans Health Administration. *Am J Psychiatry*, 159:1584-1590
- viii Frayne SM., Halanych JH., Miller D.R., et al. (2005) Disparities in Diabetes Care: Impact of Mental Illness. *Arch Intern Med*, 165(22):2631-8.
- ix Druss BG, Bradford DW, Rosenheck RA et al. (2000) Mental Disorders and Use of Cardiovascular Procedures After Myocardial Infarction *JAMA*, 283(4):506-11.
- x Averyt JM, Kuno E, Rothbard AB, Culhane DP. (1997) Impact of Continuity of Care on Recurrence of Homelessness Following an Acute Psychiatric Episode. *Continuum* 4.3
- xi National Institute of Mental Health — Statistics. <http://www.nimh.nih.gov/health/topics/statistics/index.shtml>. updated Mar 31,2009. Accessed May 20, 2009.
- xii Insel TR. (2008) Assessing the Economic Costs of Serious Mental Illness. *Am J Psychiatry*, 165:663-65.
- xiii D’Mello DA, Boltz MK, Msibi B. (1995) Relationship between Concurrent Substance Abuse in Psychiatric Patients and Neuroleptic Dosage. *Am J Drug Alcohol Abuse*, 2:257-65.
- xiv National Committee for Quality Assurance (NCQA, 2007). *The State of Health Care Quality 2007*. Washington, DC: National Committee for Quality Assurance. Available at [http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC\\_2007.pdf](http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_2007.pdf) (Accessed July 12, 2010).
- xv van Walraven C, Mamdani M, Fang J, Austin PC. (2004) Continuity of Care and Patient Outcomes After Discharge. *J Gen Intern Med*, 19:624-31
- xvi Hermann RC. (2000) Quality measures for mental health care: results from a National Inventory. *Medical Care Research and Review*, 57:136-54

---

xvii Ibid.

xviii Cuffel BJ, Held M, Goldman W. (2002) Predictive Models and the Effectiveness of Strategies for Improving Outpatient Follow-up Under Managed Care. *Psychiatric Services* 53:1438-43.

xix Nelson EA, Maruish ME, Axler JL. (2000) Effects of Discharge Planning and Compliance with Outpatient Appointments on Readmission Rates. *Psychiatric Services*, 51:885-889.

xx Ibid.

xxi Adair CE, McDougall GM, Mitton CR. (2005) Continuity of Care and Health Outcomes Among Persons with Severe Mental Illness. *Psychiatric Services*, 56(9):1061-69.

xxii Mitton CR, Adair CE, McDougall GM, Marcoux G. (2005) Continuity of Care and Health Care Costs Among Persons with Severe Mental Illness. *Psychiatric Services*, 56(9):1070-6.

xxiii Chien C, Steinwachs DM, Lehman AF, et al. (2000) Provider Continuity and Outcomes of Care for Persons with Schizophrenia. *Mental Health Services Research*, 2:201-11.

xxiv Ibid.