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

2013 External Quality Review Report
Magellan Behavioral Health
FINAL REPORT

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REPORT CONTENT

GLOSSARY OF TERMS

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

INTRODUCTION

Purpose and Background

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

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

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

The HealthChoices Behavioral Health is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2013 EQRs for the HealthChoices Behavioral Health (BH) MCOs and to prepare the technical reports. This technical report includes six core sections:

I: Structure and Operations Standards
II: Performance Improvement Projects
III: Performance Measures
IV: 2012 Opportunities for Improvement - MCO Response
V: 2013 Strengths and Opportunities for Improvement
VI: Summary of Activities

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

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

Section IV, 2012 Opportunities for Improvement – MCO Response, includes the BH MCO's responses to opportunities for improvement noted in the 2012 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 (2012) as determined by IPRO, and a "report card" of the BH MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HealthChoices Behavioral Health Managed Care Organization.

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

I: STRUCTURE AND OPERATIONS STANDARDS

This section of the EQR report presents a review by IPRO of the BH MCO Magellan Behavioral Health's (MBH's) compliance with the structure and operations standards. In Review Year (RY) 2012, 66 PA Counties participated in this compliance evaluation.

Organization of the HealthChoices Behavioral Health Program

OMHSAS determined that the County governments would be offered the right-of-first opportunity to enter into capitated contracts with the Commonwealth with regard to the administration of Medicaid managed care behavioral health and substance abuse services. Forty-three of the 67 Counties subcontract directly with BH MCOs to administer behavioral health services. These 43 Counties provide monitoring and oversight of the BH MCOs. The remaining 24 Counties contract directly with DPW since the Counties elected not to bid for the HealthChoices contract. Each County subsequently chose a BH MCO subcontractor, which operates under the authority of that County, to administer behavioral health and substance abuse services provided via the HealthChoices BH Program. During RY 2011, one County, Erie, held a contract with one BH MCO through June 30, 2011 and contracted with another BH MCO as of July 1, 2011.

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 Review Years (RYs 2012, 2011, 2010). 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) 2012. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-County reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year timeframe under consideration, the RAI was provided to IPRO. For those Counties and BH MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review Substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's Program Standards and Requirements (PS&R) are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2013 and entered into the PEPS tools as of October 2013 for RY 2012. Information captured within the PEPS tools informs this report. The PEPS tools are a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each County/BH MCO. Within each standard, the tool specifies the sub-standards or Items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional reviewer comments. Based on the tools, a County/BH MCO is evaluated against substandards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS' more rigorous monitoring criteria.

At the implementation of the PEPS tools in 2004, IPRO evaluated the standards in the tools and created a crosswalk to pertinent BBA regulations. For standards with substandards, all of the substandards within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the substandards required for fulfilling BBA requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS' ongoing monitoring. In the amended crosswalk, the supplemental substandards no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Substandards concerning first level complaints and grievances inform the compliance determination of the BBA categories relating to Federal & State Grievance Systems Standards. All of the PEPS Substandards concerning second level complaints and grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category. As was done for the prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The RY 2012 crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in Appendix A and B, respectively. The review findings for selected OMHSAS-specific Substandards are reported in Appendix C.

Because OMHSAS review of the Counties and their subcontracted BH MCOs expands over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS Substandards from RY 2012, RY 2011, and RY 2010 provided the information necessary for the 2013 assessment. Those standards not reviewed through the PEPS system in RY 2012 were evaluated on their performance based on RY 2011 and/or RY 2010 decisions, or other supporting documentation, if necessary. For those Counties that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed. Since Erie County contracted with two BH MCOs in 2011 and because all applicable standards were reviewed for both BH MCOs within the three-year time frame, Erie County's review findings for RY 2012, RY 2011 and RY 2010 were not included in the assessment of compliance for either BH MCO.

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, 10 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Substandards were relevant to more than one BBA regulation or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS Item may contribute more than once to the total number of Items required and/or reviewed. Table 1.1 provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of MBH against the Structure and Operations Standards for this report. In Appendix C, Table C.1 provides a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH MCO and associated Counties against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for MBH

Table 1.1 Substandards Pertinent to BBA Regulations Reviewed for MBH

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	Not Reviewed*
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	2	7	3	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Availability of Services	22	4	17	0	1
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	1	2	0	1
Provider Selection	3	0	3	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	8	0	0	0
Practice Guidelines	6	4	2	0	0
Quality Assessment and Performance Improvement Program	23	23	0	0	0
Health Information Systems	1	1	0	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	1	0	9	1
General Requirements	14	1	0	12	1
Notice of Action	11	1	9	0	1
Handling of Grievances and Appeals	11	1	0	9	1
Resolution and Notification: Grievances and Appeals	11	1	0	9	1
Expedited Appeals Process	6	1	0	4	1
Information to Providers and Subcontractors	2	0	0	2	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	1	0	4	1
Effectuation of Reversed Resolutions	6	1	0	4	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 2012, nine categories, 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements were not directly addressed by the PEPS Substandards reviewed. As per OMHSAS' judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health Program's PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH MCOs. The category of Marketing Activities is Not Applicable because as a result of the Centers for Medicare and

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

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

Determination of Compliance

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

Format

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

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

Findings

Of the 159 PEPS Items identified as required to fulfill BBA regulations, 149 Items were evaluated for MBH, and 10 Items were not scheduled or not applicable for evaluation for RY 2012.

Subpart C: Enrollee Rights and Protections

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

Table 1.2 Compliance with Enrollee Rights and Protections Regulations

Enrollee Rights and Protections				
Subpart C: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Compliant	All MBH Counties		12 substandards were crosswalked to this category. Each County was evaluated on 12 substandards and compliant on 12 substandards.
Provider-Enrollee Communications 438.102	Compliant	All MBH Counties		Compliant as per PS&R sections E.4 (p.49) and A.3.a (p.20).
Marketing Activities 438.104	N/A	N/A	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	All MBH Counties		Compliant as per PS&R sections A.9 (p.64) and C.2 (p.30).
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 (p.34).
Solvency Standards 438.116	Compliant	All MBH Counties		Compliant as per PS&R sections A.3 (p.59) and A.9 (p.64), and 2012-2013 Solvency Requirements tracking report.

Based on the PEPS substandards reviewed, All MBH Counties were compliant on six 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 2011-2012 Solvency Requirement tracking report. One category, Marketing Activities, was Not Applicable.

Of the 12 PEPS substandards that were crosswalked to the category Enrollee Rights, all 12 were evaluated for each County and all MBH Counties were compliant on all 12 Items.

Subpart D: Quality Assessment and Performance Improvement Regulations

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

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

Table 1.3 Compliance with Quality Assessment and Performance Improvement Regulations

Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	**MCO Compliance Status**	**By County**		**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.53).
Availability of Services (Access to Care) 438.206	Compliant	All MBH Counties		22 substandards were crosswalked to this category. Each County was evaluated on 21 substandards and compliant on 21 substandards.
Coordination and Continuity of Care 438.208	Compliant	All MBH Counties		2 substandards were crosswalked to this category. Each County was evaluated on 2 substandards and compliant on both.
Coverage and Authorization of Services 438.210	Partial		All MBH Counties	4 substandards were crosswalked to this category. Each County was evaluated on 3 substandards, compliant on 2 substandards and partially compliant on 1 substandard.
Provider Selection 438.214	Compliant	All MBH Counties		3 substandards were crosswalked to this category. Each County was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	All MBH Counties		Compliant as per PS&R sections D.2 (p.46), G.4 (p.55) and C.6.c (p.44).
Subcontractual Relationships and Delegation 438.230	Compliant	All MBH Counties		8 substandards were crosswalked to this category. Each County was evaluated on 8 substandards and compliant on 8 substandards.
Practice Guidelines 438.236	Compliant	All MBH Counties		6 substandards were crosswalked to this category. Each County was evaluated on 6 substandards and compliant on 6 substandards.
Quality Assessment and Performance Improvement Program 438.240	Compliant	All MBH Counties		23 substandards were crosswalked to this category. Each County was evaluated on 23 substandards and compliant on 23 substandards.

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 substandard was crosswalked to this category. Each County was evaluated on 1 substandard and compliant on this substandard.

Of the 10 Quality Assessment and Performance Improvement Regulations categories, MBH as a whole was compliant on nine categories and partially compliant on one Item. 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 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations. Each County was evaluated on 67 substandards. There were 2 substandards not scheduled or not applicable for evaluation for RY 2012. All MBH Counties were compliant on 66 substandards and partially compliant on one substandard. Some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Coverage and Authorization of Services

All MBH Counties were partially compliant with Coverage and Authorization of Services due to partial and non-compliance with one of three substandards within PEPS Standard 72: Substandard 1 (RY 2012)

PEPS Standard 72: Denials or reduction of services are provided, in writing, to the member, parent/custodian of a child/adolescent, and/or county C and Y agency for children in substitute care. [E.3), p.39 and Appendix AA, Attachments 2a, 2b and 2c]. The denial notice includes: a. Specific reason for denial. b. Service approve at a lesser rate. c. Service approved for a lesser amount than requested. d. Service approved for shorter duration than requested. e. Service approved using a different service or item then requested and description of the alternative service if given. f. Date decision will take effect. g. Name of contact person. h. Notification that member may file a grievance and/or request a DPW Fair Hearing. i. If currently receiving services, the right to continue to receive services during the grievance and/or DPW Fair Hearing process.

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

Subpart F: Federal and State Grievance System Standards

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

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

Table 1.4 Compliance with Federal and State Grievance System Standards

Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All MBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 5 substandards, partially compliant on 4 substandards, and non-compliant on 1 substandard.
General Requirements 438.402	Partial		All MBH Counties	14 substandards were crosswalked to this category. Each County was evaluated on 13 substandards, compliant on 8 substandards, partially compliant on 4 substandards, and non-compliant on 1 substandard.
Notice of Action 438.404	Partial		All MBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards and compliant on 9 substandards and partially compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All MBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 5 substandards, partially compliant on 4 substandards, and non-compliant on 1 substandard.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All MBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 5 substandards, partially compliant on 4 substandards, and non-compliant on 1 substandard.
Expedited Appeals Process 38.410	Partial		All MBH Counties	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards and compliant on 4 substandards and partially compliant on 1 substandard.
Information to Providers & Subcontractors 438.414	Compliant	All MBH Counties		2 substandards were crosswalked to this category. Each County was evaluated on 2 substandards and compliant on both.

Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Recordkeeping and Recording Requirements 438.416	Compliant	All MBH Counties		Compliant as per 2012 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.
Continuation of Benefits 438.420	Partial		All MBH Counties	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards and compliant on 4 substandards and partially compliant on 1 substandard.
Effectuation of Reversed Resolutions 438.424	Partial		All MBH Counties	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards and compliant on 4 substandards and partially compliant on 1 substandard.

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 two categories and partially compliant on eight categories. The category Recordkeeping and Recording Requirements was compliant per the 2012 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports. Each MBH County was also compliant on two categories and partially compliant on eight categories.

For this review, 78 substandards were crosswalked to this Subpart for all five MBH Counties, and each County was evaluated on 70 substandards. Eight substandards were not scheduled or not applicable for evaluation for RY 2012. The five Counties were compliant on 46 substandards, partially compliant on 20 substandards and non-compliant on four. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

The five MBH Counties were partially compliant with eight 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 PEPS 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.

All MBH Counties were partially compliant with Coverage and Authorization of Services due to partial and non-compliance on one substandard PEPS Standard 72: Substandard 1 (RY 2011)

PEPS Standard 72: See Standard description and non-compliance substandard determination under Coverage and Authorization of Services on page 11 of this report.

II: PERFORMANCE IMPROVEMENT PROJECTS

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH MCO. Under the existing HealthChoices Behavioral Health agreement with OMHSAS, 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 2013 for 2012 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 remained below the previous OMHSAS-established benchmark of 90%. FUH for the Medicaid Managed Care (MMC) population continues to be an area of interest for OMHSAS.

The 2013 EQR is the tenth review to include validation of PIPs. With this PIP cycle, all BH MCOs/Counties share the same baseline period and timeline. To initiate the PIP cycle in 2008, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, remeasurement, and sustained improvement. Direction was given to the BH MCOs/Counties with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness.

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

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

Validation Methodology

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

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

1S. Subsequent or Modified Interventions
2S. Sustained Improvement

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

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

Review Element Designation/Weighting

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

Table 2.1 Review Element Scoring Designations and Definitions

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

Overall Project Performance Score

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

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

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred through 2012. 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%
Total Demonstrable Improvement Score		**80%**

Review Element	Standard	Scoring Weight
1S	Subsequent or modified Interventions Aimed at Achieving Sustained Improvement	5%
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 the final review element of Sustained Improvement. MBH submitted the required elements of the FUH PIP for review.

The project had previously received full credit for all elements through Subsequent or modified Interventions Aimed at Achieving Sustained Improvement. Of these, Topic Selection had been pre-determined by OMHSAS and pre-populated by IPRO into QIA forms that were sent to the BH MCOs in August 2009. As outlined in the PIP submission guidelines, 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 performances 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®) 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 previously 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. As a result of these clinical management activities, MBH stated that 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 also identified miscommunication between discharging facilities and community-based/outpatient providers as a concern. MBH noted that the BH MCO would seek to address these issues to improve follow-up.

Baseline results calculated in 2009 for the period January 1, 2008 through December 31, 2008 were previously presented along with analysis that led to interventions initiated in late 2009. 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.

Remeasurement results calculated in 2011 for January 1, 2010 through December 31, 2010 were presented along with additional analysis to compare the MY 2010 rates against the baseline rates, against the statewide HC BH-MCO average, and against the goal. Rates increased for three of the four indicators: QI 2 (HEDIS – 30 days), QI A (PA-Specific – seven days), and QI B (PA-Specific – 30 days). Because of the increases to these indicators, Demonstrable Improvement was achieved. QI 2 increased to 68.45, QIA increased to 62.77%, and QIB increased to 76.04%. Although all rates remained below the OMHSAS benchmark of 90%, QIA and QIB exceeded the MCO's goals for remeasurement (67.74% and 74.65%, respectively). Greater improvements were observed for the 30-day measures. Additionally, MBH noted rates were higher than the statewide HC BH-MCO average for all indicators.

MBH noted that, following review of the 2010 re-measurement results, the barriers identified through the initial brainstorming process were reviewed and were identified as remaining, with no additional barriers

identified. MBH's subsequent interventions included ongoing previous interventions aimed at achieving demonstrable improvement, with MBH providing updates for a number of them. MBH continued to contract with additional Certified Peer Support providers. The MCO also increased the number and focus of its provider-specific acute inpatient reviews, which resulted in repeated and additional provider-specific meetings, corrective action plans, and educational sessions. The telephonic auditing process of care managers continued, with the goal for the Care Management Centers (CMCs) to complete five audits per care manager per month. MBH also continued to enroll additional members in its high risk case management programs, and continued its member conferences and meetings. Additionally, the MCO included a number of new interventions, including 1) Mental Health Inpatient Provider Forums to discuss barriers, data trends, areas for improvement, and best practices as well as requested action plans. MBH plans to continue these forums and incorporate Outpatient providers; 2) MBH's Lehigh Care Management Center contracted with Recovery Partnership to offer Certified Peer Specialist (CPS) services to visit members who readmit into IP MH facilities. MBH's Lehigh Care Management Center contracted with Recovery Partnership to offer Certified Peer Specialist (CPS) services to visit members who readmit into IP MH facilities. The CPS conducts the visits for chronic SMI members who prefer not to be seen by MCO staff; 3) The Lehigh CMC worked with a local Outpatient Mental Health provider to develop a Tele-Health program model focusing on the SMI population and on particular members who have a history of readmission; 4) Addition of medical mobile crisis services in the network for Lehigh CMC.

As indicated by the DPW timeline, Sustained Improvement was evaluated in 2013, based on activities conducted in 2012 to assess performance in 2011. While quality improvement efforts are encouraged for all measures, Sustained Improvement were evaluated in 2013 for Indicators 2, A, and B, as these were the measures for which Demonstrable Improvement was achieved. Remeasurement results calculated in 2012 for January 1, 2011 through December 31, 2011 were presented along with additional analysis to compare the MY 2011 rates against the baseline rates, against the statewide HC BH-MCO average, and against the goal. The rate for QI 2 increased to 67.9%, the rate for QI A decreased to 67.9% and the rate for QI B increased to 75.6% over baseline. The rates for QI 2 and QI B demonstrated sustained improvement over baseline.

MBH received full credit for the elements of the study evaluated that reflect activities in 2012 (Sustained Improvement) and received a total score of 100 for this project.

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

Review Element	Compliance Level	Scoring Weight	Final Points Score
1. Project Title, Type, Focus Area	Full	5%	5
2.Topic Relevance	Full	5%	5
3. Quality Indicators	Full	0%	0
4. Baseline Study and Analysis (Calendar Year (CY) 2008, reported in CY 2009)	Full	20%	20
5. Baseline Study Population and Baseline Measurement Performance (CY 2008)	Full	10%	10
6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010)	Full	20%	20
7. Demonstrable Improvement (CY 2010, reported in 2011)	Full	20%	20
Total Demonstrable Improvement Score			**80**
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Full	5%	5

Review Element	Compliance Level	Scoring Weight	Final Points Score
2S. Sustained Improvement (CY 2011, reported in 2012)	Full	15%	15
Total Sustained Improvement Score			**20**
Overall Project Performance Score			**100**

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	50.8%	49.7%	90%
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	67.7%	NA	68.5%[1]	67.9%[2]	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	62.8%[1]	62.1%	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	76.0%[1]	75.6%[2]	90%
Project Status	Baseline Study	Interventions	Remeasurement #1	Remeasurement #2	

[1] Indicates Demonstrable Improvement, eligible for subsequent evaluation of Sustained Improvement.
[2] Indicates Sustained Improvement

III: PERFORMANCE MEASURES

In 2013, 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, BHHC, and BH MCO rates to available national benchmarks and to prior years' rates.

MY 2002 was the first year follow-up rates were reported. QI 1 and QI 2 utilize the HEDIS methodology for this measure. The PA-specific indicators were added to include services with high utilization in the HealthChoices BH Program that could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits. Each year the QI 1 and QI 2 specifications are aligned with the HEDIS Follow-up after Mental Health Hospitalization measure. The PA-specific codes that are not included in the HEDIS measure are also reviewed for accuracy on an annual basis.

The last major change to the PA-specific measures was in MY 2006. Codes added to the measures as per suggestions from OMHSAS, the Counties, and BH MCOs changed the measures substantially, and rates for these indicators were no longer comparable to those from preceding measurement years. Consequently, these indicators were renamed to QI A and QI B, respectively. As these indicators represented a significant deviation from HEDIS measure specifications, comparisons to HEDIS rates were not made. In addition, for MY 2006 the follow-up measure was collected for the newly implemented HealthChoices Northeast Counties, and these Counties were asked to collect data for the six-month time frame that they were in service for 2006.

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

For MY 2008, two procedure codes to identify eligible follow-up visits were added to the PA-specific measures per suggestions from OMHSAS, the Counties, and the BH MCOs. Additionally, as requested by OMHSAS, the MY 2008 findings by age were 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 measurements.

For MY 2009, indicators in the study had few changes. As requested by OMHSAS, all data analyses by region were removed, since the regional characteristics had become increasingly geographically diverse and the associated Counties are non-contiguous as the HealthChoices BH Program expanded beyond the initial legacy regions over the years of re-measurement.

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

For MY 2011, there was one minor change to the HEDIS specifications. An additional place of service code was added to the numerator specifications. There was no narrative report produced for MY 2011;

however, aggregate and demographic rates were provided, and recommendations were submitted to OMHSAS.

For MY 2012, indicators again had minor changes based on the HEDIS 2013 Volume 2: Technical Specifications. A clarification was added to only use facility claims, not professional claims, to identify discharges. As requested by OMHSAS, analysis by BHHC was added.

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 2012 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, 2012;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Six years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2012, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified, are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 1st, 2012, The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2013 methodology for the Follow-up After Hospitalization for Mental Illness measure.

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)[i]. 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[ii,iii] such as obesity, cardiovascular diseases and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns[iv,v], reduced use of preventive services[vi] and substandard medical care that they receive[vii,viii,ix]. Moreover, these patients are five times more likely to become homeless than those without these disorders[x]. On the whole, serious mental illnesses account for more than 15 percent of overall disease burden in the U.S.[xi], 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[xii]. 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[xiii]. 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[xiv]. 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[xv]. 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[xvi]. 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[xvii].

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a longstanding concern of behavioral health care systems, with some researchers having estimated that 40 to 60 percent of patients fail to connect with an outpatient clinician[xviii]. 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[xix]. 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[xx]. 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[xxi]. Patients with higher functioning in turn had significantly lower community costs, and improved provider continuity was associated with lower hospital[xxii] and Medicaid costs[xxiii].

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[xxiv]. Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care, and is an effective means to control the cost and maximize the quality of mental health services.

As noted, this measure and the issue of follow-up have been and remain of interest to OMHSAS, and results are reviewed for potential trends each year. While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH MCOs for each 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, as had been done since the implementation of this measure, 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 2013 Audit Means, Percentiles and Ratios.* These benchmarks contained means, 10th, 25th, 50th (median), 75th and 90th 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.

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure as well as the comparisons to the HEDIS benchmarks. As a result of this discussion, OMHSAS adopted HEDIS benchmarks as the goals for the HEDIS indicators. The 3-year OMHSAS goal is to achieve the 75th percentile for ages 6-64, based on the annual HEDIS published benchmarks for 7-day and 30-day FUH. Additionally, HEDIS benchmarks for the 7- and 3-day FUH indicators have been adopted as the

benchmarks for determining the requirement for a root cause analysis for these indicators. Beginning with MY 2012 performance, and as noted in Section V of this report, rates for the HEDIS FUH 7- and 30-day indicators that fall below the 75th percentile benchmarks for each of these respective indicators will result in a request for a root cause analysis. Following MY 2012, performance goals will be established for each BH MCO, County or primary BHHC based on the HEDIS published benchmarks for the previous year.

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, which represented the rate derived from the total population of discharges that qualified for the indicator. The aggregate rate represented the rate derived from the total population of members that qualified for the indicator (i.e., the aggregate value). Year-to-year comparisons to MY 2011 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 (N) and denominator (D) for that particular BH MCO (i.e., across Counties with the same contracted BH MCO). The County-specific rates were calculated using the numerator and denominator for that particular County. For each of these rates, the 95% Confidence Interval (CI) was reported. Both the HealthChoices BH MCO Average and HealthChoices County Average rates were also calculated for the indicators.

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

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

Table 3.1 MY 2012 HEDIS Indicator Rates with Year-to-Year Comparisons

	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
QI 1										
HealthChoices	16,978	35,972	**47.2%**	46.7%	47.7%	46.7%	48.2%	46.1%	1.1	YES
MBH	2,620	5,573	**47.0%**	45.7%	48.3%			49.7%	-2.7	YES

	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
Bucks	396	871	**45.5%**	42.1%	48.8%			46.7%	-1.3	NO
Delaware	499	1,151	**43.4%**	40.4%	46.3%			51.8%	-8.4	YES
Lehigh	653	1,380	**47.3%**	44.6%	50.0%			49.1%	-1.8	NO
Montgomery	630	1,360	**46.3%**	43.6%	49.0%			49.8%	-3.5	NO
Northampton	442	811	**54.5%**	51.0%	58.0%			50.7%	3.8	NO
QI 2										
HealthChoices	24,388	35,972	**67.8%**	67.3%	68.3%	67.4%	72.5%	67.0%	0.8	NO
MBH	3,612	5,573	**64.8%**	63.5%	66.1%			67.9%	-3.1	YES
Bucks	556	871	**63.8%**	60.6%	67.1%			65.5%	-1.6	NO
Delaware	709	1,151	**61.6%**	58.7%	64.5%			67.9%	-6.3	YES
Lehigh	898	1,380	**65.1%**	62.5%	67.6%			66.1%	-1.0	NO
Montgomery	870	1,360	**64.0%**	61.4%	66.6%			69.7%	-5.7	YES
Northampton	579	811	**71.4%**	68.2%	74.6%			70.7%	0.7	NO

The MY 2012 HealthChoices aggregate rates were 47.2% for QI 1 and 67.8% for QI 2. The QI 1 rate was 1.1 percentage points above the MY 2011 rate which was a statistically significant difference. There was no statistically significant difference between the MY 2012 and MY 2011 QI 2 rates. MBH's MY 2012 QI 1 rate of 47.0% and QI 2 rate of 64.8% were statistically significantly below MY 2011 rates by 2.7 and 3.1 percentage points respectively. Overall, MBH demonstrated the largest year over year rate decreases for QI 1 and QI 2 among the five BH MCOs evaluated in MY 2012.

For MY 2012, MBH's QI 1 rate of 47.0% was comparable to (i.e., not statistically significantly different from) the MY 2012 QI 1 HealthChoices BH MCO Average of 46.7%. MBH's MY 2012 QI 2 rate of 64.8% was statistically significantly lower than the MY 2012 QI 2 HealthChoices BH MCO Average of 67.4% by 2.6 percentage points.

As presented in Table 3.1, the QI 1 rate for Delaware County statistically significantly decreased between MY 2011 and MY 2012 by 8.4 percentage points. The MY 2012 QI 1 rates for the remaining four Counties did not statistically significantly change as compared to MY 2011 rates. The MY 2012 QI 2 rates for Delaware and Montgomery Counties statistically significantly decreased between MY 2011 and MY 2012 by 6.3 and 5.7 percentage points respectively. The MY 2012 QI 2 rates for the remaining three counties were not statistically significantly different from MY 2011.

Figure 3.1 displays a graphical representation of the MY 2012 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 2012 HealthChoices County Average. In MY 2012, the QI 1 rates for Northampton County performed statistically significantly higher than the MY 2012 QI 1 HealthChoices County Average of 48.2% and the rate for Delaware county was statistically significantly lower than the MY 2012 QI 1 HealthChoices County Average of 48.2%. Rates for the remaining MBH Counties were not statistically significantly different from the HealthChoices County Average. For QI 2, the rates for Bucks, Delaware, Lehigh and Montgomery Counties were statistically significantly below the MY 2012 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 3.1 MY 2012 HEDIS Indicator Rates

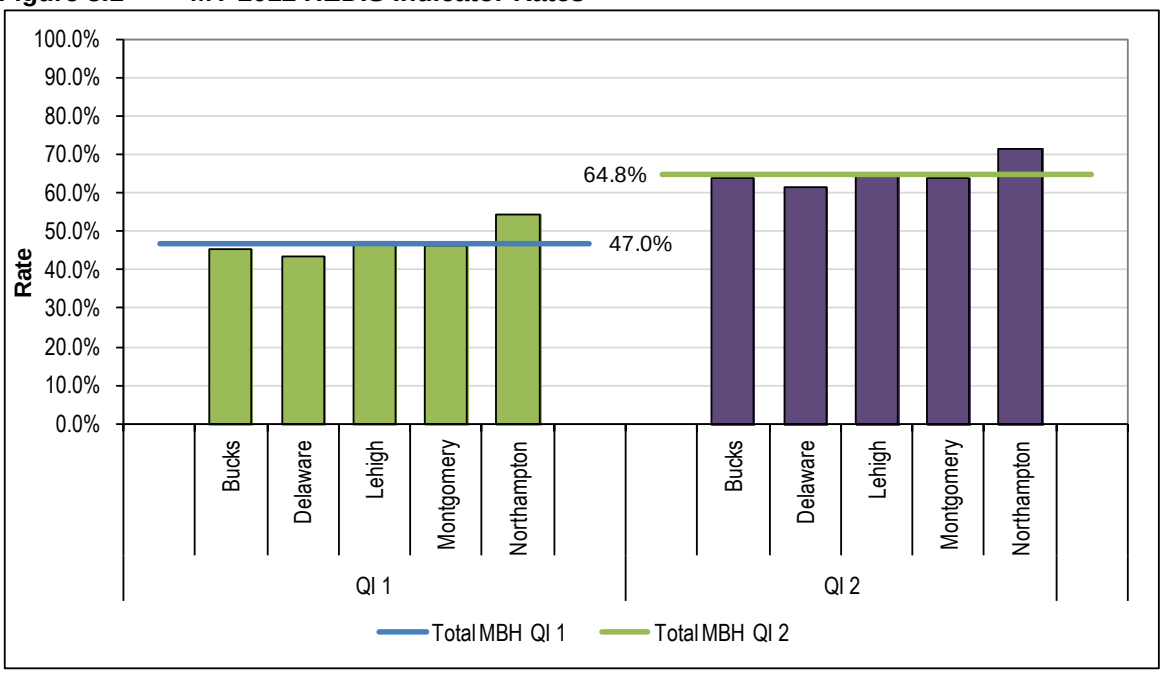
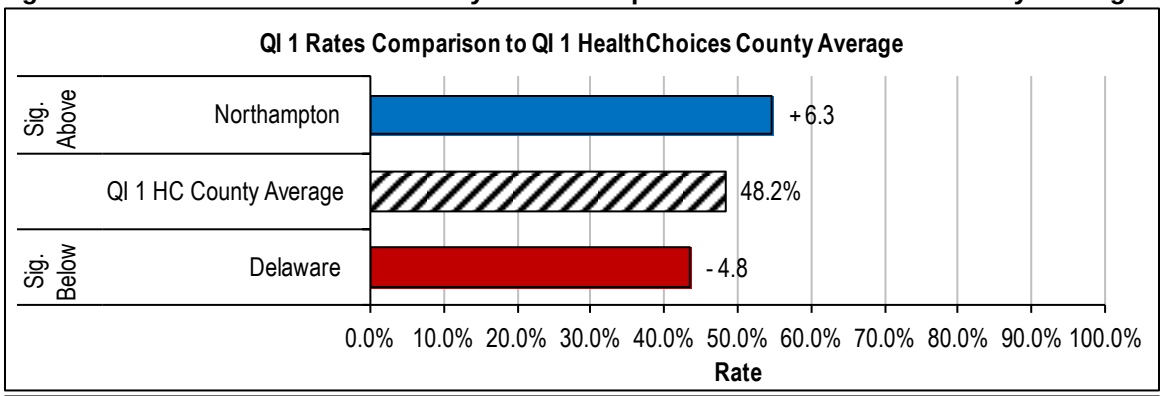


Figure 3.2 MY 2012 HEDIS County Rates Compared to HealthChoices County Average



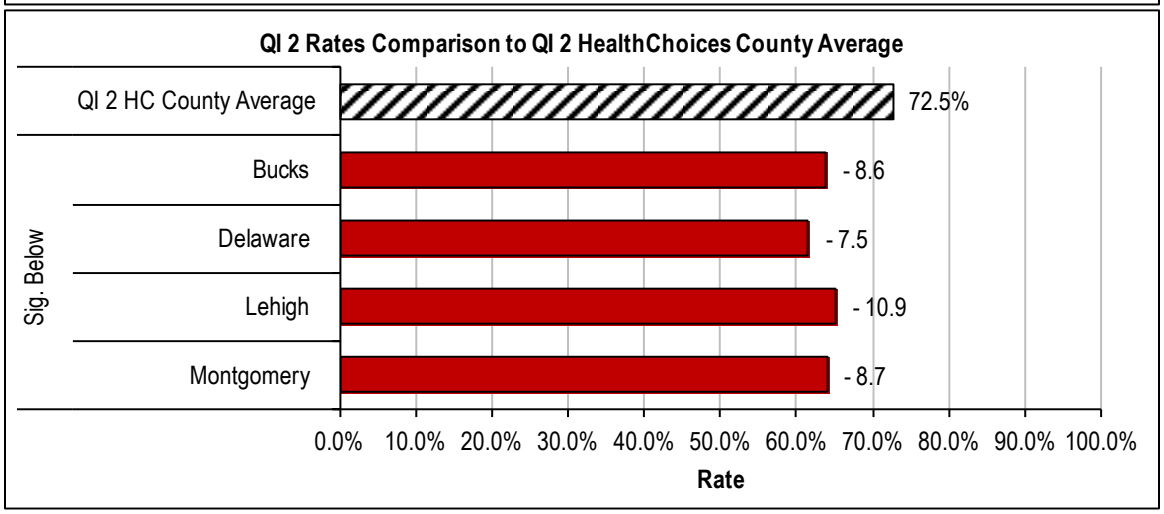


Table 3.2 MY 2012 PA-Specific Indicator Rates with Year-to-Year Comparisons

	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
QI A										
HealthChoices	21,096	35,972	**58.7%**	58.1%	59.2%	58.2%	59.3%	57.8%	0.8	YES
MBH	3,297	5,573	**59.2%**	57.9%	60.5%			62.1%	-2.9	YES
Bucks	483	871	**55.5%**	52.1%	58.8%			59.2%	-3.7	NO
Delaware	698	1,151	**60.6%**	57.8%	63.5%			66.6%	-5.9	YES
Lehigh	790	1,380	**57.3%**	54.6%	59.9%			59.2%	-2.0	NO
Montgomery	829	1,360	**61.0%**	58.3%	63.6%			62.3%	-1.3	NO
Northampton	497	811	**61.3%**	57.9%	64.7%			63.1%	-1.8	NO
QI B										
HealthChoices	26,978	35,972	**75.0%**	74.6%	75.4%	74.8%	78.4%	74.8%	0.2	NO
MBH	4,078	5,573	**73.2%**	72.0%	74.3%			75.6%	-2.5	YES
Bucks	602	871	**69.1%**	66.0%	72.2%			73.3%	-4.2	NO
Delaware	844	1,151	**73.3%**	70.7%	75.9%			76.9%	-3.5	NO
Lehigh	1,000	1,380	**72.5%**	70.1%	74.9%			73.0%	-0.6	NO
Montgomery	1,013	1,360	**74.5%**	72.1%	76.8%			77.4%	-2.9	NO
Northampton	619	811	**76.3%**	73.3%	79.3%			77.8%	-1.5	NO

The MY 2012 HealthChoices aggregate rates were 58.7% for QI A and 75.0% for QI B. The MY 2012 HealthChoices QI A rate statistically significantly higher than the MY 2011 HealthChoices QI B rate by 0.8 percentage points. The MY 2012 QI B rate was comparable to (i.e., not statistically significantly different from) the MY 2011 rate. The MBH rate was 59.2% for QI A and 73.2% for QI B. The MY 2012 QI A rate was statistically significantly lower than the MY 2011 rate by 2.9 percentage points. The MY 2012 QI B rate was statistically significantly below the MY 2011 rate by 2.5 percentage points. Overall, MBH demonstrated the largest year over year rate decreases for QI A and QI B among the five BH MCOs evaluated in MY 2012.

For MY 2012, MBH's QI A rate of 59.2% was comparable to (i.e., not statistically significantly different from) the QI A HealthChoices BH MCO Average of 58.2%. MBH's QI B rate of 73.2% was statistically significantly below the QI B HealthChoices BH MCO Average of 74.8% by 1.6 percentage points.

As presented in Table 3.2, the QI A MY 2012 rate for Delaware County decreased statistically significantly from MY 2011 to MY 2012 by 5.9 percentage points. There were no statistically significant year-to-year differences observed for QI B County rates. Figure 3.3 displays a graphical representation of the MY 2012 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 2012 HealthChoices County Average.

For MY 2012, the QI A rate for Bucks County was statistically significantly lower than the MY 2012 QI A HealthChoices County Average of 59.3%, and the QI B rates for Bucks, Delaware, Leigh and Montgomery Counties were statistically significantly below the QI B HealthChoices County Average of 78.4%. The rates for the remaining MBH Counties were not statistically significantly different from the respective HealthChoices County Averages.

Figure 3.3 MY 2012 PA-Specific Indicator Rates

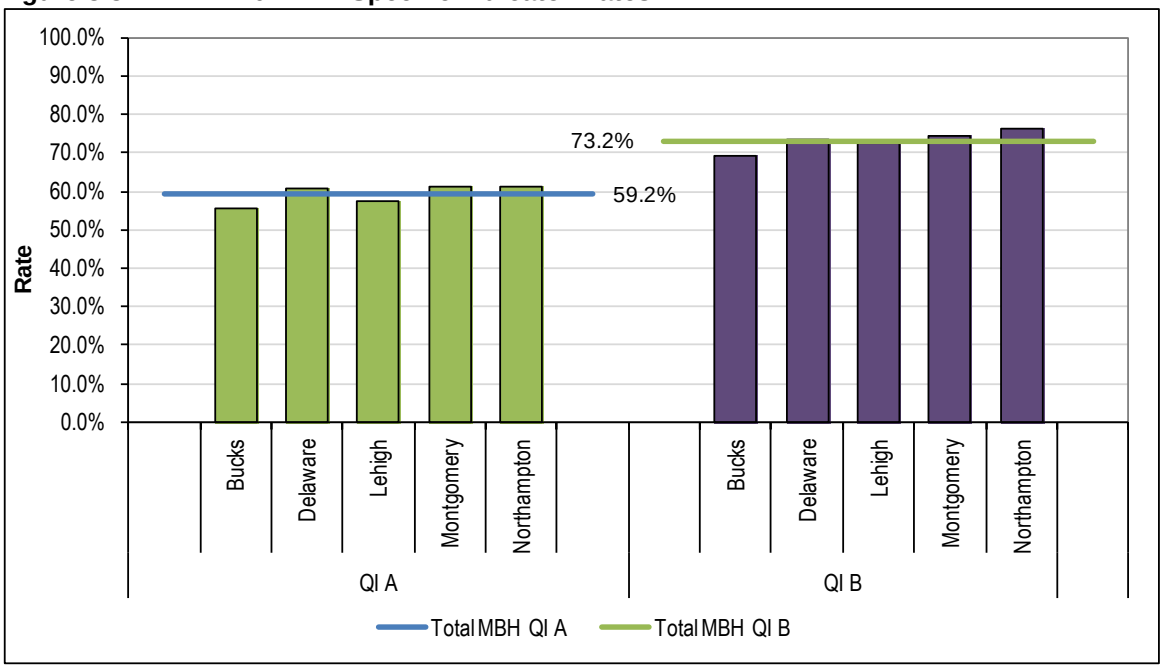
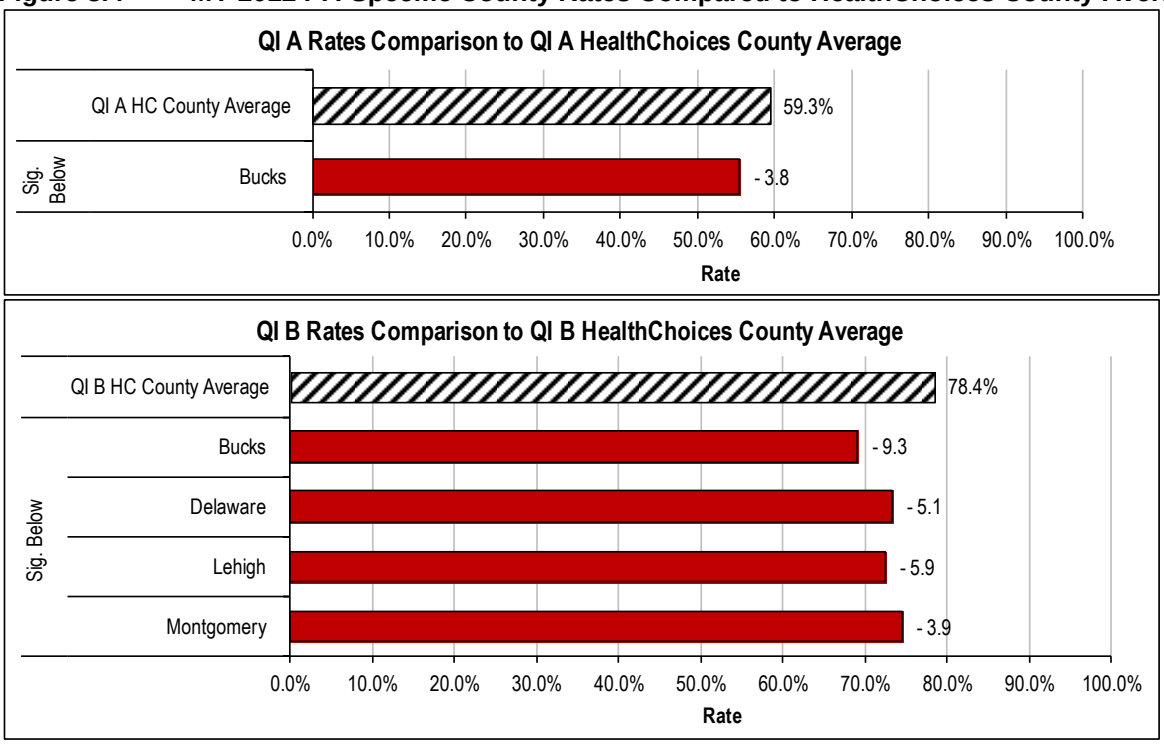


Figure 3.4 MY 2012 PA-Specific County Rates Compared to HealthChoices County Average



Comparison to HEDIS® Medicaid Benchmarks

The HealthChoices HEDIS indicator rates and BH MCO rates were compared to the *HEDIS 2013 Audit Means, Percentiles and Ratios* published by NCQA. The reference rates for national normative data contain means, 10th, 25th, 50th, 75th and 90th percentiles, and the enrollment ratios for nearly all HEDIS measures. There are tables by product lines (i.e., Commercial, Medicaid, and Medicare), so that the

appropriate Medicaid benchmarks were used for comparison. NCQA's means and percentiles for each product line are generated annually using HMO, POS, and HMO/POS combined products from BH MCOs that underwent a HEDIS Compliance Audit™. Data were included from BH MCOs, regardless of whether the BH MCO did or did not report individual HEDIS rates publicly. The means and percentiles displayed in the *HEDIS 2013 Audit Means, Percentiles and Ratios* tables are based on data from the 2012 measurement year. The benchmark values for Medicaid are presented in Table 3.3.

Table 3.3 HEDIS 2013 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	43.8	21.3	31.3	44.7	54.8	68.8
Follow-up After Hospitalization for Mental Illness – 30 Days	63.8	38.1	57.2	65.9	75.7	82.0

For MY 2012, the HealthChoices rates were 47.2 % for QI 1 and 67.8% for QI 2. As compared to the HEDIS 2013 (MY 2012) Medicaid benchmarks, both the QI 1 and QI 2 rates fell between the 50th and 75th percentiles. In previous benchmark comparisons for MY 2011, the HealthChoices rate for QI 1 fell between the 50th and 75th percentiles and the rate for QI 2 fell between the 25th and 50th percentiles.

When comparing the MY 2012 MBH rates to the HEDIS 2013 benchmarks, the QI 1 rate of 47.0% fell between the 50th and 75th percentiles while the QI 2 rate of 64.8% fell between the 25th and 50th percentiles. In MY 2011, when compared to the HEDIS 2012 benchmarks, MBH's QI 1 and QI 2 rates both fell between the 50th and 75th percentile ranges for each respective measure.

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 2013 study, which included results for MY 2011 and MY 2012, 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, the BHHCs, and the BH MCOs of the effectiveness of the interventions implemented between MY 2010 and MY 2012 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, BHHCs, 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 2011 and MY 2010. The Counties, BHHCs and BH MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care, and then implement action and monitoring plans to further increase their rates.

Recommendation 2: The findings of this re-measurement indicate that disparities in rates between demographic populations continue to persist as seen in prior studies. Within each of the demographic populations examined (race, age, gender, ethnicity), results were similar to MY 2011. Statistically significantly lower rates were again observed on three or four indicators for: 1) African Americans, 2) members over 21 years old, and 3) males. Statistically significantly lower rates were observed on QIs 1 and 2 for non-Hispanic members. While OMHSAS contracted Counties, BHHCs, and their subcontracted BH MCOs are working to improve their overall follow-up rates, it is also important for these entities to continue to target the demographic populations that do not perform as well as their counterparts.

Furthermore, it is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. It is recommended that BH MCOs, BHHCs, and Counties continue to focus interventions on populations that continue to exhibit lower follow-up rates (e.g., Black/African American population). Possible reasons for these rate disparities include access, cultural differences and financial factors, which should all be considered and evaluated to determine their potential impact on performance. Additionally, the BH MCOs should be encouraged to initiate targeted interventions to address disparate rates between study populations.

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

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

Readmission within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow up After Hospitalization for Mental Illness, OMHSAS elected to re-measure the Readmission within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Re-measurements were conducted in 2010 and 2011 on MY 2009 and MY 2010 data, respectively. The MY 2012 study conducted in 2013 was the sixth re-measurement of this indicator, and the indicator specification had no significant changes as compared to MY 2011. This measure continued to be of interest to OMHSAS for the purposes of comparing County and BH MCO rates to the OMHSAS performance goal and to prior rates.

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

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

Eligible Population

The entire eligible population was used for all 67 Counties participating in the MY 2012 study.

Eligible cases were defined as those members in the HealthChoices Behavioral Health Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2012;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim must be clearly identified as a discharge.

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

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH MCOs. The source for all administrative data was the BH MCOs' transactional claims systems. The BH MCOs were given the opportunity for resubmission, as necessary. During the validation process for the MY 2011 study, it was discovered that there were differing interpretations of the specifications with regard to the denominator discharge date. Interpretations differed regarding whether to use December 1 or December 31 when calculating the denominator. IPRO observed a discrepancy in the specifications regarding how to calculate the denominator. IPRO and OMHSAS agreed to examine the specifications for the next review year. For the MY 2012 study, the existing methodology was clarified, and IPRO and OMHSAS worked with the BH-MCOs to ensure a consistent denominator timeframe (January 1 2012 – December 1 2012) was used for this measure.

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 2012 to MY 2011 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

Individual rates are also compared to the categorical average. Rates statistically significantly above and/or below the average are indicated. 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 2012 Readmission Rates with Year-to-Year Comparisons

	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
HealthChoices	5,748	45,346	**12.7%**	12.4%	13.0%	12.8%	10.8%	12.0%	0.7	NO
MBH	1,227	7,790	**15.8%**	14.9%	16.6%			14.7%	1.1	NO
Bucks	150	1,228	**12.2%**	10.3%	14.1%			10.9%	1.3	NO
Delaware	232	1,621	**14.3%**	12.6%	16.0%			14.4%	-0.1	NO
Lehigh	342	1,868	**18.3%**	16.5%	20.1%			16.2%	2.1	NO
Montgomery	323	1,970	**16.4%**	14.7%	18.1%			16.8%	-0.4	NO
Northampton	180	1,103	**16.3%**	14.1%	18.5%			13.3%	3.0	NO

The aggregate MY 2012 HealthChoices readmission rate was 12.7%. MBH's rate of 15.8% was statistically significantly higher than the HealthChoices BH MCO Average of 12.8% by 3.0 percentage points, but did not differ statistically significantly from the MY 2011 rate of 14.7%. 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 2012. Overall, MBH demonstrated the largest year over year rate increase for readmission among the five BH MCOs evaluated in MY 2012.

As presented in Table 3.4, none of the Counties contracted with MBH met the performance goal of 10.0% in MY 2012. The rates for Delaware, Lehigh, Montgomery and Northampton Counties were statistically significantly higher (poorer) than the HealthChoices County Average of 10.8%. Note that this measure is an inverted rate, in that lower rates are preferable.

Figure 3.5 provides a graphical presentation of the MY 2012 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 2012 HealthChoices County Average

Figure 3.5 MY 2012 Readmission Rates

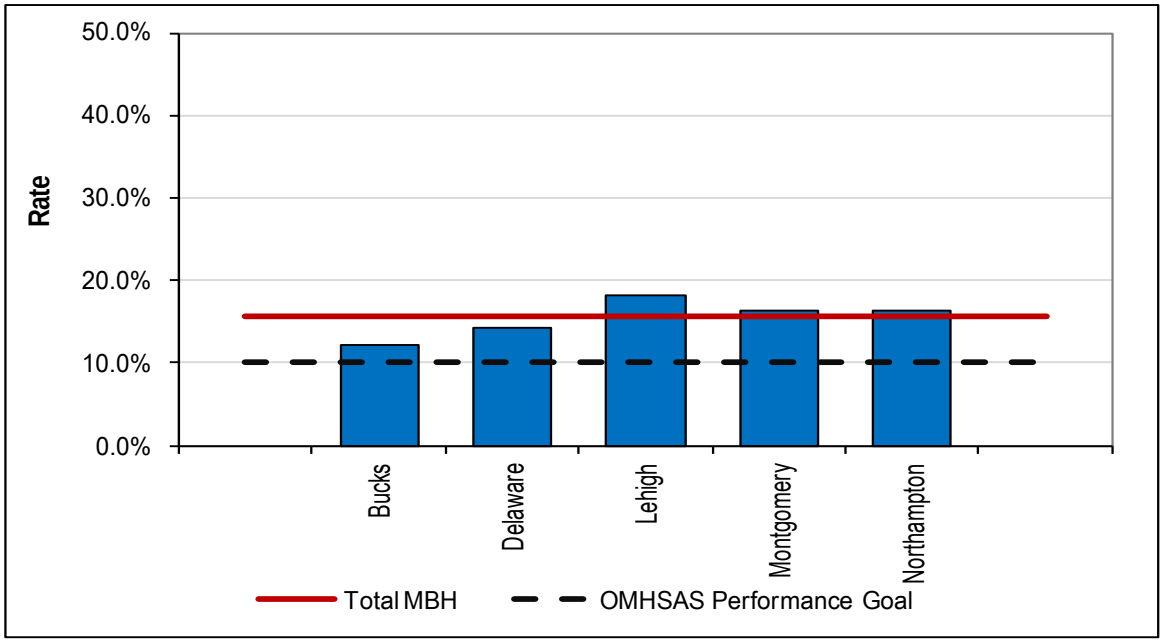
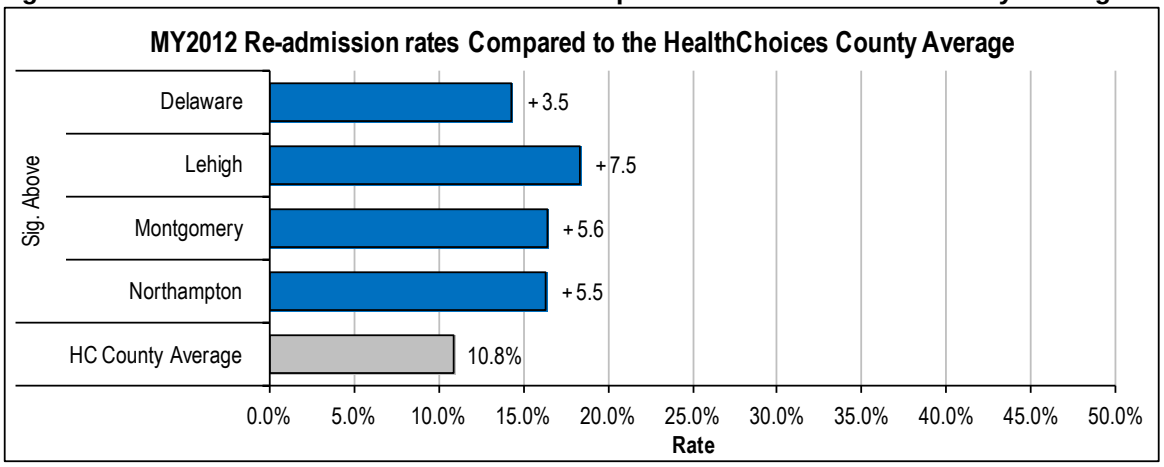


Figure 3.4 MY 2012 Readmission Rates Compared to HealthChoices County Average



Conclusion and Recommendations

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

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the 2013 (MY 2012) Readmission within 30 Days of Inpatient Psychiatric Discharge data tables.

In response to the 2013 study, the following general recommendations are applicable to all five participating BH MCOs:

- As with MY 2011, no significant improvement was noted for any of the BH MCOs for MY 2012. IPRO recommends that the Counties and BH MCOs participating in this study conduct root cause analyses to help determine what factors are negatively impacting readmission rates, and develop interventions that target specific barriers to improving the readmission rates.
- Each BH MCO should conduct additional analyses of the data in order to determine if any other trends are noted. For example, higher readmission rates may be associated with those individuals with particular diagnoses or co-occurring conditions such as substance abuse and/or addiction. Targeted analyses such as these should be evaluated as part of any root cause analysis. In addition, BH MCOs and Counties are encouraged to review the findings of the readmission study in conjunction with follow-up after hospitalization rates.
- Unlike MY 2010, but as observed for MY 2011, the MY 2012 readmission rates observed for Black/African American and the White populations were not statistically significantly different. For MY 2012, 52.4% of all African American discharges occurred in Philadelphia County. The statistically significantly lower rates for African Americans in MY 2010 appeared to be driven by the Philadelphia County population, and IPRO recommended that a performance improvement project to focus on Disparities in Healthcare, with a focus on Philadelphia County, be undertaken. Although no formal project began, CBH, which is comprised solely of Philadelphia County, observed the largest improvement among the BH MCOs for MY 2011. This finding may suggest further study across BH MCOs to explore the potential for further improvements that can be sustained.
- IPRO recommends continued annual evaluation of Inpatient Readmission after Psychiatric Discharge rates for OMHSAS contracted Counties and their subcontracted BH MCOs.
- Case management consideration should be given to those individuals who appear to be the highest utilizers of inpatient acute psychiatric care and have shown to be at risk for frequent readmission.

- As with MY 2011, considerable variation by county was again observed for all of the BH MCOs for MY 2012. BH MCOs should further evaluate individual County rates, explore the underlying causes of variance by County, and identify those County practices or systems that may contribute to lower readmission rates.

IV: 2012 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 2012 EQR Technical Reports, which were distributed in April 2013. The 2013 EQR Technical Report is the sixth report to include descriptions of current and proposed interventions from each BH MCO that address the 2012 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, 2013 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken; and
- The BH MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of the end of 2013, 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
Structure and Operations Standards		
	Review of compliance with standards conducted by the Commonwealth in RY 2009, RY 2010, and RY 2011 found MBH to be partially compliant with two Subparts associated with Structure and Operations Standards.	
MBH 2012.01	MBH was partially compliant on one out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant category is Coverage and Authorization of Services.	**Follow Up Actions Taken Through 09/30/13:** **Coverage and Authorization of Services Standard 72, Substandard 1 (Bucks, Delaware & Montgomery)** Suggested recommendations were immediately implemented. Expectations were re-inforced via trainings and in supervisory review of documentation. The following trainings were conducted: • Complaints and Grievances for Customer Services: 5/9/2012 • Complaint and Grievance Presentations: 8/15/2012 • Denial letter Training: 9/19/2013 • Complaints Grievances and Appeals for Clinicians:10/3/2012 • Complaints and Grievances for Customer Service by John B 6/10/2013 Improvement was noted in the 2012 review year. See attachments [BU County 2012 Denial Notices; DE County 2012 Denial Notices; MN County 2012 Denial Notices].

Reference Number	Opportunity for Improvement	MCO Response
		 BU County 2012 Denial Notices.pdf  DE County 2012 Denial Notices.pdf  MN County 2012 Denial Notices.pdf Denial letters are reviewed by Complaint & Grievance supervisor as well as by a Clinical Supervisor prior to being sent. On 7/24/13 several staff from Magellan went to the denial training held in person in Harrisburg and conducted by OMHSAS staff. **<u>Coverage and Authorization of Services Standard 72, Substandard 1 (Lehigh & Northampton)</u>** Suggested recommendations were immediately implemented. See attached feedback to OMHSAS sent on 12/15/11 as well as clinical training sign in sheet from December 2011. [MBH response to OMHSAS] & [Clinical Training_Dec2011].  MBH response to OMHSAS.pdf  Clinical training_Dec2011.pdf Comment on final 2011 PEPS review findings indicates that this was received and no further corrective action needed-see attachment [2011 PEPS MBH Annual Member Denials 72].  2011 PEPS MBH Annual Member Denia Annual refresher trainings occurred on 3/7/12 & 12/5/12. PEPS review of 2012 yielded the following actions described on these attached documents [CAP Cover letter_Sept2012]; [CAP LE_NH_Sept2012]; [Denial refresher update_Sept 2012]; [Clinical meeting agenda_9.12.12]; [Clinical Team Mtg agenda_9.19.12].  CAP Cover letter_Sept2012.pdf  CAP LE_NH_Sept2012.pdf  Denial refresher update_Sept 2012.p  Clinical meeting agenda_9.12.12.pdf  Clinical Team Mtg agenda_9.19.12.pdf Call w/OMHSAS was held 10/11/12 to discuss and clarify expectations.

Reference Number	Opportunity for Improvement	MCO Response
		A training on Complaints and Grievances for Clinicians was held on 6/6/2013. On 7/24/13 several staff from Magellan went to the denial training held in person in Harrisburg and conducted by OMHSAS staff. Denial letters are reviewed by Complaint & Grievance supervisor as well as by a Clinical Supervisor prior to being sent.
		Future Actions Planned **<u>Coverage and Authorization of Services Standard 72, Substandard 1 (Bucks, Delaware & Montgomery)</u>** Next Denial Letter training is 10/9/13 and next All clinical C&G training is 10/23/13. Continue actions and monitoring that was implemented to ensure compliance with expectations. **<u>Coverage and Authorization of Services Standard 72, Substandard 1 (Lehigh & Northampton)</u>** Continue actions that were put into place as well as monitoring via supervisor. Annual training is scheduled for 10/23/13.
MBH 2012.02	MBH was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.	**Follow Up Actions Taken Through 09/30/13** **<u>Standard 68, Substandard 2 (Bucks, Delaware, Lehigh, Montgomery & Northampton)</u>** Please refer to Response to 2011 EQR and attachments submitted on 1/4/13. Complaint resolution timeframes continue to be followed. Some of the trainings listed under standard 72 above also pertain to complaints. **<u>Standard 68, Substandard 3 (Bucks, Delaware, Lehigh, Montgomery, & Northampton)</u>** Please refer to Response to 2011 EQR and attachments submitted on 1/4/13. Some of the trainings listed under standard 72 above also pertain to complaints. Complaint letters are thoroughly investigated and reflect whether or not the member's complaint was substantiated. Refresher trainings continue. Counties continue to audit 1st level complaint letters on a regular basis and provide feedback of their findings. **<u>Standard 68, Substandard 4 (Bucks, Delaware, Lehigh, Montgomery & Northampton)</u>** Please refer to Response to 2011 EQR and attachments submitted on 1/4/13. Clinicians continue to lead the resolution process for complaints involving a clinical issue. Some of the trainings listed under standard 72 above also pertain to complaints. Counties continue to audit 1st level complaint letters on a regular basis and provide feedback of their findings. **<u>Standard 68, Substandard 5 (Bucks, Delaware, Lehigh, Montgomery & Northampton)</u>** Please refer to Response to 2011 EQR and attachments submitted on 1/4/13.

Reference Number	Opportunity for Improvement	MCO Response
		Some of the trainings listed under standard 72 above also pertain to complaints. Continue with ongoing practices of identifying any provider performance concerns. Other outcomes have been member record audits, review of provider policy and procedures, etc.
		Future Actions Planned **Standard 68, Substandard 2 (Bucks, Delaware, Lehigh, Montgomery & Northampton)** Continue efforts/actions outlined in the CAP submitted in 2011 to ensure timeframes are being met. **Standard 68, Substandard 3 (Bucks, Delaware, Lehigh, Montgomery, & Northampton)** Will continue quarterly audit of at least 20% of 1st level complaints by respective county to ensure completeness of review and documentation, as well as compliance with applicable regulations. This process will continue for oversight and collaboration. **Standard 68, Substandard 4 (Bucks, Delaware, Lehigh, Montgomery & Northampton)** Continue efforts/actions outlined in the CAP and as indicated in 2011 EQR response. Ongoing monitoring to ensure compliance with this standard. **Standard 68, Substandard 5 (Bucks, Delaware, Lehigh, Montgomery & Northampton)** Same efforts/action steps will continue. Ongoing monitoring to ensure compliance with this standard and make sure that documentation includes if a complaint was substantiated.
Performance Measures		
MBH 2012.03	MBH's rate for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (poorer) than the MY 2011 HealthChoices BH MCO Average by 2.4 percentage points. MBH's rate did not meet the OMHSAS designated performance goal of 10.0%.	**Follow Up Actions Taken Through 09/30/13** Magellan is working with the county contractors to complete the Readmission RCA. Magellan has been granted an extension by OMHSAS and IPRO for submission of the Readmission RCA until November 8, 2013. This document will be submitted directly to IPRO, as per the instructions.
		Future Actions Planned See above.

Additional documents submitted by MBH:

Frm_2011 Opps Response_Magellan_(

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. MBH was not required to implement any corrective action plans in calendar year 2012.

Root Cause Analysis and Action Plan

The 2013 EQR is the fifth 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 2012 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. For the 2013 EQR, MBH was required to prepare a Root Cause Analysis and Action Plan for the following performance measures and quality indicator:

- Readmission within 30 Days of Inpatient Psychiatric Discharge

MBH submitted a Root Cause Analysis and Action Plan in November 2013.

Table 4.2 Root Cause Analysis for MBH – Readmission within 30 Days of Inpatient Psychiatric Discharge

<table>
<tr><td colspan="2"><u>Performance Measure</u>: Readmission within 30 Days of Inpatient Psychiatric Discharge*</td></tr>
<tr><td colspan="2"><u>Goal Statement:</u> Decrease rate of 30 day readmissions to inpatient psychiatric level of care by a statistically significant amount. Based on MY 2011, a statistically significant (p = 0.05) decrease would be realized at 13.6%.</td></tr>
<tr><td><u>Analysis</u>:
What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.</td><td><u>Findings</u>
MBH remained the same from MY 2010 to MY 2011 but was statistically significantly below/poorer than the MY 2010 HealthChoices BH MCO average of 12.3%. Although not yet included in the EQR report, MBH and its county partners are including the review of the validated MY 2012 IPRO results in this RCA process. The table below provides a comparison of the MY 2010 to MY 2011 to MY 2012 performance per County, for MBH and the HC BH MCO average.
<table>
<tr><th colspan="4">30-Day Readmission</th></tr>
<tr><th></th><th>MY 2010</th><th>MY 2011</th><th>MY 2012</th></tr>
<tr><td>BU</td><td>13.10%</td><td>10.88%</td><td>12.21%</td></tr>
<tr><td>DE</td><td>12.64%</td><td>14.37%</td><td>14.31%</td></tr>
<tr><td>LE</td><td>16.74%</td><td>16.18%</td><td>18.31%</td></tr>
<tr><td>MO</td><td>15.83%</td><td>16.79%</td><td>16.40%</td></tr>
</table></td></tr>
</table>

NH	14.47%	13.29%	16.32%
Magellan	14.69%	14.68%	15.75%
HC BH MCO Average	12.40%	12.34%	12.70%

As prior interventions are not demonstrating the impact on the 30 day readmission rate as expected, it was decided that we needed to refresh our approach to the data analysis. MBH completed a statistical analysis using the most recent three years of IPRO data (MY 2012, MY 2011 and MY 2012) to determine predictive factors of readmission. A logistic regression was used to test the influence of the independent variables identified listed on readmissions. Factors considered initially included: gender; age; diagnosis; vocational/educational participation; ethnicity; priority population status; race; living situation; readmissions prior to 2012 and overall days in hospital for index admission. For children, the additional following factors were also initially considered: school behavior; school attendance; and school performance.

As part of using logistic regression when there are categorical independent/predictor variables, enough cases must fall into each category created when the dependent/outcome variable is crossed with the independent/predictor variable. When too few cases fall into any category, the variable can't be used. Therefore, the following variables were included in the regression:

- Gender
- Age
- Final diagnosis in 2012 (included only for adults)
- Readmissions prior to 2012
- Overall days in hospital at index admission

The analysis found that the statistically significant predictors for adults' readmitting to an IP facility were the number of days in IP at first admission and having one or more readmissions prior to 2012.

- The odds of a readmission for those adults who spent 9+days in the hospital during the index admission are 2500% higher than those who spent 1-6 days.
- An adult's chance of readmission increases 13% for every prior admission.

For children, the only significant predictor of readmissions was the number of days spent in the hospital during their index admission. A child's chance of readmission increases 5% for day spent in the hospital during the first IP admission.

As approximately 90% of all discharges in MY 2011 were adults, attention for barrier/variable identification and intervention development has focused on adults.

The finding relating the significantly increased likelihood of readmission within 30 days when the length of stay is 9 or more days is a new factor to consider. Initial brainstorming sessions with County representatives and MBH quality, clinical and medical leadership identified the potential factors of MBH's 30-day readmission rate. The Fishbone Cause/Effect Diagram is embedded below for reference.

	Magellan_C&E Fishbone Diagram.pdf To further understand this new variable, MBH will further analyze the retrospective data included in the original analysis to identify any related trends. In addition, a one month 'live' data collection will begin. Qualitative data from the Initial Referral Team (IRT) was gathered to choose specific variables to further analyze through quantitative data collection. Comparison groups within this analysis will include those adults for whom this is a 30-day readmission; that group will be further separated for those whose index admission was nine or more days and those whose index admission was less than nine days. Based on this input, the IRT team will track all MH IP admissions for a one month period to gather data regarding the following areas: 1. Community tenure between discharge and readmission 2. Housing status at most recent discharge 3. COD diagnosis 4. Medication adherence 5. Discharge planning Additional Actions/Interventions may be added or current ones may be further enhanced based on the results of these additional analysis.
Policies (e.g., data systems, delivery systems, provider facilities) N/A	***Initial Response*** ***Follow-up Status Response*** *<insert follow-up response here; leave blank for initial response submission>*
Procedures (e.g., payment/reimbursement, credentialing/collaboration) • ***1st treatment episode - more thorough assessment needed*** • ***Illness vs. Recovery*** • ***Lack of Collaboration w OP providers*** • ***Fragmentation of AIP services*** • ***Malingering Symptoms*** • ***Facility trends re LOS***	***Initial Response*** • *Refers to the delay that can result when an individual has no treatment history and so more time is required to assess the effective of treatment interventions due to limited clinical information.* • *Refers to the delay that can result from staff's attitudes about treatment progress and how this translates into actual treatment interventions (e.g. - individuals 'owning' their own recovery). Infers relationship between recovery orientation and pace of treatment.* • *Refers to the delay that can result when AIP providers do not collaborate with community-based providers to obtain already existing information regarding effective vs ineffective treatment interventions* • *Refers to the delay that can occur when different disciplines on the AIP unit do not share information regarding the individuals care e.g. - effective treatment, d/c planning, etc.* • *Refers to the delay that can occur when an individual misrepresents their symptoms e.g. - reporting S/I when none exists- and the physicians' obligation to respond to the individual's self report.* • *This is a point for further analysis and refers to some providers having historically higher LOS as compared to similar providers.* ***Follow-up Status Response***

People (e.g., personnel, provider network, patients) • **AIP 'Culture'** • **Med Changes** • **Medication Adherence** • **Member financial issues** • **Acuity** • **Complex medical issues** • **Medication effectiveness**	***Initial Response*** • *Refers to the provider's underlying organizational attitudes and beliefs about treatment that influence clinical practices in all disciplines and dictate pace of treatment, interventions used, etc.* • *Refers to the delay which results when additional time is required to assess the effectiveness of medications that are new to the individual.* • *Refers to the delay that results from individuals not taking medications as prescribed.* • *Refers to individuals utilizing AIP units to meet their basic needs (shelter, food) because they are unable to meet their needs financially.* • *Refers to the delay that can result when an individual's symptoms are treatment refractory.* • *Refers to the delay that can occur, due to limited resources, when an individual requires specialized medical care concomitant with their psychiatric care upon discharge.* • *Refers to the delay that can result when medications prescribed are not effective in reducing acuity.* ***Follow-up Status Response***
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) • ***Wait lists for EAC*** • ***Complicated disposition (based on high needs, ie fire setting, medical issue)*** • ***Lack of appropriate community-based services/resources*** • ***Reduction in state hospital beds*** • ***Lack of PCHs*** • ***Homelessness*** • ***Pre-admission services inadequate***	***Initial Response*** ***Follow-up Status Response*** • *Refers to the delay that can result when an individual meets MNC for EAC and there is limited to no availability.* • *Refers to the delay that can result when a d/c housing resource cannot be identified due to the presence of behaviors that are frequently identified as exclusionary criteria for housing programs e.g. - fire setting, pedophilia, etc.* • *Refers to the perception that there is a limited array of services within the community.* • *Refers to the delay that can result when an individual has reached his/her baseline however severe acuity persists, historically these individuals would be admitted to the State Hospital for further treatment which is no longer an option.* • *Refers to the delay that can result when a d/c housing resource cannot be identified due to a lack of available PCH placements.* • *Refers to the delay that can result when a d/c housing resource cannot be identified an the individual is unsafe for d/c to a shelter* • *Refers to the delay that can result when services that an individual received prior to admission were not effective in assisting the individual to remain in the community.*
Other (specify) Treatment process • ***Member comfort level*** • ***Use of EBPs*** • ***Lack of trauma informed care*** • ***D/C planning*** • ***'Why now?' not addressed***	***Initial Response*** N/A ***Follow-up Status Response*** • *Refers to the delay in treatment that can result from an individual's acclimation to/comfort level with the AIP environment such that the individual experiences a lack of motivation toward treatment interventions.* • *Refers to the delay that can result when providers utilize clinical interventions that are not proven effective.* • *Refers to the delay that can result when an individual has significant trauma issues for which interventions employed are not designed to*

• ***COD*** • ***Lack of Family Involvement*** • ***Lack of Strength focused treatment*** • ***Lack of active treatment*** • ***No clear assessment of need*** • ***Lack of involving member in own treatment*** • ***Institutionalization***	*address.* • *Refers to the delay that can result when d/c planning is not actively pursued by the provider.* • *Refers to the delay that can result when the 'root cause' of the admission (vs presenting problem) is not adequately addressed by the provider.* • *Refers to the delay that can result when an individual's symptoms are the result of the simultaneous presence of psychiatric symptoms and substance use and interventions are not designed to effectively address both issues.* • *Refers to the delay that can result when an individual's family is not engaged as a support in the treatment process.* • *Refers to the delay in recovery that can result from staff's attitudes about treatment progress and how this translates into actual treatment interventions (e.g. - individuals 'owning' their own recovery). Infers relationship between the use of strength focused treatment approach and delay in progress.* • *Refers to the delay that can result from a more passive approach to treatment that translates into a slower pace with which interventions in all disciplines are employed e.g.- med changes, d/c planning, etc.* • *Refers to the delay that can result from an unclear understanding of areas which require intervention.* • *Refers to the delay in recovery that can result when individuals are not encouraged to actively participate in the treatment process and recovery. Infers relationship between recovery approach and delay in progress.* • *Refers to the delay in treatment that can result from an individual's development of excessive dependency on the AIP unit and its routines.*

**** Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.***

Complete corresponding action plan.

Measure: *Readmission within 30 Days of Inpatient Psychiatric Discharge**

For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2012. Documentation of actions should be continued on additional pages as needed.

Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
In 2012, eight mental health inpatient facilities accounted for 70% of the adult discharges across Magellan's five county partners: Bucks, Delaware, Lehigh, Montgomery and Northampton. An improvement in outcomes performance by these core providers, would considerably impact Magellan's results in OMHSAS performance measures related to this level of care.	4/2014	*The MH IP PIC is being designed in the format of the extremely successful Children's Quality Collaborative (i.e. CQC) for BHRS. For providers who agree to participate, the draft program outline includes:* • *less intense utilization review process* • *quarterly measurement of performance metrics (30-day readmission rates w/goals of statistically significant decreases; 7-day FUH based on HEDIS methodology and ALOS)* • *quarterly group meetings to address: performance*

 MY 2012 Adult MH IP Discharges_Pareto Ch Given the success demonstrated through the programmatic approach of the Partners in Care program with regard to clinical quality, operational practices, provider accountability and fiscal responsibility, Magellan and its partner counties are moving forward to develop the MH IP Partners in Care program.		*metric data; factors contributing to positive and negative results; provider program management processes; and sharing of ideas, challenges and strategies to continue quality improvement.* *Providers will agree to the following expectations: 1) Ensure HEDIS approved services are scheduled within 7 days of discharge (this may be in addition to supportive/linkage services such as TCM and CPS and 2)work with outpatient providers to allow Bridge appointments within the MH IP facility* *Based on successful demonstration of improvement on performance metrics and collaboration in MH IP PIC program, providers can be moved to an alternative payment arrangement; this would likely be a case rate with rate variation based on an individual's readmission within certain time periods.* *The components of this program are under development. Next steps include review with county representatives, presentation to selected providers and planned initial measurement period to begin 4/1/2014.*
Development of interventions to address 30-day readmissions with Regional Vice President for UHS of Delaware, Inc. There are 4 adult psychiatric inpatient facilities overseen by this VP, which accounted for 30% of inpatient discharges in MY 2012.	11/2013	***Initial Response*** *Brainstorming session scheduled for 11/7/13. Conversations to date have included a general agreement to partner and to find ways to incorporate interventions for reducing readmission rates in the 2014 Performance Indicators at (some) of the inpatient facilities.* *Three of these four facilities are included in the proposed MH IP PIC program. Discussion on 11/7/13 will provide a high-level overview of that plan with the purpose of getting provider input during the planning stage. The scheduled brainstorming session remains relevant even with the addition of the MH IP PIC program, as the facilities involved in that program will need to improve readmission rates. This discussion and incorporation of readmission strategies into the facility's internal PI measures can only help move the performance forward.*
Care Coordination Pilot - Began in April 2013 in Lehigh County and in August 2013 in Northampton County. When an individual is admitted to MH IP loc and meets the criteria below, the provider is contacted directly by Magellan for referral to 'fast-tracked' TCM program. 1. Member has no current Outpatient provider, 2. Member has a history of outpatient treatment non-compliance, 3. Member missed his/her last 7 day follow up appointment.	Lehigh – 4/2013 Northampton – 8/2013	***Initial Response*** *There have been approximately 46 individuals served in this program through September 30, 2013. Initial outcomes appear to demonstrate quick engagement and a decreased readmission rate. At this time, formal outcome measurements are being developed. The goal is to establish a performance based incentive payment model. This will require the provider to meet goals on identified performance measures in order to receive additional payment. Performance will be measured and then rewarded on a quarterly basis.* *Performance measures being considered include:*

The TCM meets with individual on day of referral or next day to initiate TCM support. This TCM intervention is planned for a 30 day period with the goal of moving individuals to needed community based service. TCM may be the ongoing service, but that need is assessed during the 30-day period of the Care Coordination program.		• *Individuals are seen within 1 business day of referral* • *Individuals are seen for an outpatient service which meets HEDIS FUH acceptable criteria within 7 days of mh ip* • *30 day readmission rate to be lower than full population* • *60 and 90 day readmission rates will be monitored, unsure if goals or incentives will be connected to this.*
Development of Extended Acute Care (EAC) inpatient psychiatric program for southeast counties. Magellan and CCBH, along with Bucks, Chester, Delaware and Montgomery Counties, put out a RFP for an EAC program in Southeastern PA.	RFP Issued – Spring 2013 Opening - planned Summer 2014	***Initial Response*** *In May 2013, Brooke Glen Behavioral Hospital (BGBH) was awarded the RFP. As of October 31, 2013, all Reinvestment plans from the 4 counties have been approved and BGBH has begun the implementation process. It is expected to take 8 month for renovations to be completed. Opening expected in June/July 2014.* *As part of the implementation process, performance metrics and clinical outcomes to be measured will be established.*
Return to use of OMHSAS 2006 Co-Occurring Disorder Competence Bulletin guidelines with providers. Although OMHSAS will no longer be issuing COD competency certifications to providers, Bucks and Delaware Counties are working with Magellan to re-establish adherence to these guidelines. It is intended that providers will be able to be designated as COD Competent upon demonstration of adherence to the guidelines in the Bulletin		***Initial Response*** *In Bucks County, providers who were previously certified by OMHSAS were asked to complete the COMPASS-EZ self assessment in the spring 2013 and onsite reviews using the OMHSAS site visit audit tool are in the process of being conducted to confirm demonstrated adherence to the Bulletin. Goals for this initiative include ongoing monitoring of COD Competency adherence and a move toward adherence to the COD Enhanced criteria. Based on fund availability, performance based incentives may be developed for those providers who demonstrate adherence to COD Enhanced criteria.* *In Delaware County, Magellan and the Delaware County Office of Behavioral Health (OBH) are working closely to further substantiate the Co-Occurring Disorder (COD) Competence Project in specialized screening, assessment and intervention-services (to include Peer-support priorities). In this direction the Project is utilizing the DDCAT and DDCMHT (Dual Diagnosis Capability in Addiction Treatment and Dual Diagnosis Capability in Mental Health Treatment –tools developed by Mark McGovern, Ph.D. and Dartmouth Psychiatric Research Institute colleagues). These EBP-measures are similar to Minkoff's Compass-EZ –tool but offer more measurable indices across 7-Key Dimensions. Outpatient MH and D&A agencies, D&A Residential services and Acute Psychiatric services are participating in this Project. It is noted that Dr. Mark McGovern is scheduled to visit Delaware County on 11/20/13 to spend a full day outlining his work and these measures with MH and D/A clinicians.* *Beginning in 2008, the Montgomery County offices of Behavioral Health and Mental Health have partnered with Magellan to implement projects addressing the needs of individuals with co-occurring mental health and substance*

		abuse diagnosis (COD). Following a 12-month interval of Dr. David Mee-Lee (ASAM expert on COD and Panel-Chair of the new ASAM-Guideline) of providing seminars and case consultation to 20 provider agencies, Dr. Mee-Lee continues his involvement in a COD-project with the Behavioral Health Court. *In July 2013, the Montgomery County provider group expanded its scope and invited representatives from agencies across the County to further focus on Integrated Assessment protocols and Integrated Interventions. The COD-Collaborative now comprises multiple MH, D&A and Dually-Licensed providers who are in-the-process of utilizing Minkoff and Cline's 68-Item "COMPASS-EZ" (derived from the earlier "Co-morbidity Program Audit and Self-Survey for Behavioral Health Services ") to further identify programmatic areas for modification.*

****Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.***

V: 2013 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of MBH's 2013 (MY 2012) 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 was fully compliant with all seven categories within the Structure and Operations Standards Subpart C: Enrollee Rights and Protections Regulations.

- MBH submitted one PIP for validation in 2013 and received full credit for the element of the study evaluated that reflect activities in 2012 (Sustained Improvement).

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found MBH to be partially compliant with two Subparts associated with Structure and Operations Standards.
    - MBH was partially compliant on one out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant category is Coverage and Authorization of Services.
    - MBH was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.

- MBH's rate for the MY 2012 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 2 was statistically significantly lower than the MY 2012 QI 2 HealthChoices BH MCO Average of 67.4% by 2.6 percentage points

- MBH's rate for the MY 2012 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI B was statistically significantly below the QI B HealthChoices BH MCO Average of 74.8% by 1.6 percentage points.

- MBH's rates for all four MY 2012 Follow-up After Hospitalization for Mental Illness indicators were statistically significantly below the prior year and represented the largest year to year decreases among the five BH MCOs evaluated in MY 2012.

- MBH's rate for the MY 2012 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (poorer) than the MY 2012 HealthChoices BH MCO Average by 3.0 percentage points. MBH's rate did not meet the OMHSAS designated performance goal of 10.0%. MBH demonstrated the largest year over year rate increase for readmission among the five BH MCOs evaluated in MY 2012

Additional strengths and targeted opportunities for improvement can be found in the BH MCO-specific 2013 (MY 2012) Performance Measure Matrices that follow.

PERFORMANCE MEASURE MATRICES

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

The first matrix and table (Figures 1.1 – 1.2):

- Compares the BH MCO's own measure performance over the two most recent reporting years (Measurement Year (MY) 2012 and MY 2011; and
- Compares the BH MCO's MY 2012 performance measure rates to the MY 2012 HealthChoices BH MCO Average.

Figure 1.1 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.

Figure 1.2 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 second matrix and table (Figures 2.1 – 2.2):

- Compares the BH MCO's MY 2012 performance to the HEDIS 90th, 75th , 50th and 25th percentiles for applicable measures (FUH QIs 1 and 2, the HEDIS 7- and 30-day indicators).

Figure 2.1 is a four-by-one matrix. This represents the BH MCO's performance as compared to the HEDIS 90th, 75th 50th and 25th percentiles for the Follow-Up After Hospitalization 7-day/30-day metrics (FUH7/FUH30). A root cause analysis and plan of action is required for items that fall below the 75th percentile.

Figure 2.2 illustrates the rates achieved compared to the HEDIS 75th percentile goal. Results are not compared to the prior year's rates.

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

The green box (A) indicates either that the BH MCO's MY 2012 rate is statistically significantly above the MY 2012 HealthChoices BH MCO Average and trends up from MY 2011.

The light green boxes (B) indicate either that the BH MCO's MY 2012 rate is equal to the MY 2012 HealthChoices BH MCO Average and trends up from MY 2011 or that the BH MCO's MY 2012 rate is statistically significantly above the MY 2012 HealthChoices BH MCO Average but there is no change from MY 2011.

The yellow boxes (C) indicate that the BH MCO's MY 2012 rate is statistically significantly below the MY 2012 HealthChoices BH MCO Average and trends up from MY 2011 or that the BH MCO's MY 2012 rate is equal to the MY 2012 HealthChoices BH MCO Average and there is no change from MY 2011 or that the BH MCO's MY 2012 rate is statistically significantly above the MY 2012 HealthChoices BH MCO Average but trends down from MY 2011. *No action is required although MCOs should identify continued opportunities for improvement.*

The orange boxes (D) indicate either that the BH MCO's MY 2012 rate is statistically significantly below the MY 2012 HealthChoices BH MCO Average and there is no change from MY 2011 or that the BH MCO's MY 2012 rate is equal to the MY 2012 HealthChoices BH MCO Average and trends down from MY 2011. *A root cause analysis and plan of action is required.*

The red boxes (F) indicate that the BH MCO's MY 2012 rate is statistically significantly below the MY 2012 HealthChoices BH MCO Average and trends down from MY 2011. *A root cause analysis and plan of action is required in both cases.*

Magellan Behavioral Health (MBH)

KEY POINTS

- **A - Performance is notable. No action required. BH MCOs may have internal goals to improve.**
  - No MBH performance measure rate fell into this comparison category.

- **B - No action required. BH MCO may identify continued opportunities for improvement.**
  - No MBH performance measure rate fell into this comparison category.

- **C - No action required although BH MCO should identify continued opportunities for improvement.**
  - No MBH performance measure rate fell into this comparison category.

- **D - Root cause analysis and plan of action required.**
  - Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)
  - Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
  - Readmission within 30 Days of Inpatient Psychiatric Discharge[1]

- **F - Root cause analysis and plan of action required.**
  - Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)
  - Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)

[1] Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.

Figure 1.1: Performance Measure Matrix – MBH

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

Performance measure rates for MY 2010, MY 2011, and MY 2012 are displayed in Figure 1.2. 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 1.2: Performance Measure Rates – MBH

Quality Performance Measure	MY 2010 Rate	MY 2011 Rate	MY 2012 Rate	MY 2012 HC BH MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	62.8% =	62.1% =	59.2% ▼	58.2%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	76.0% =	75.6% =	73.2% ▼	74.8%
Readmission within 30 Days of Inpatient Psychiatric Discharge[1]	14.7% =	14.7% =	15.8% =	12.8%

[1] Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.

Figure 2.1: HEDIS Follow-Up After Hospitalization (FUH) 7-day/30-day Performance Measure Matrix – MBH

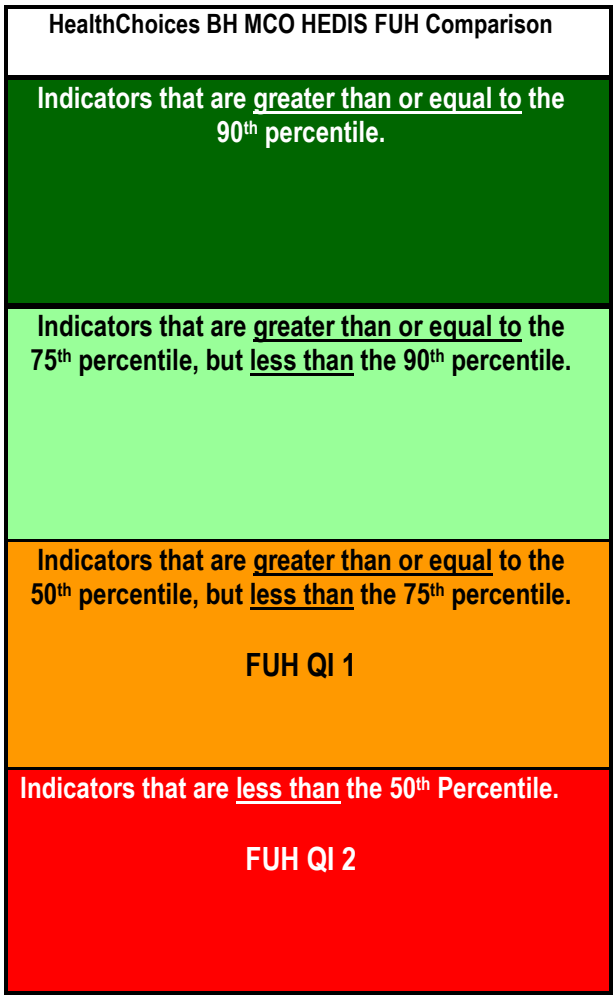


Figure 2.2: HEDIS Follow-Up After Hospitalization (FUH) 7-day/30-day Performance Measure Rates – MBH

Quality Performance Measure	MY 2012 Rate	HEDIS 2013 75%ile
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	47.0% Not Met	54.8%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	64.8% Not Met	75.7%

VI: SUMMARY OF ACTIVITIES

Structure and Operations Standards

- MBH was fully compliant on Subpart C and partially compliant on Subparts D and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2012, RY 2011, and RY 2010 were used to make the determinations.

Performance Improvement Projects

- MBH submitted one PIP for validation in 2013 and received full credit for the element of the study evaluated that reflect activities in 2012 (Sustained Improvement).

Performance Measures

- MBH reported all performance measures and applicable quality indicators in 2013.

2012 Opportunities for Improvement MCO Response

- MBH provided a response to the opportunities for improvement issued in 2012, and submitted a root cause analysis and action plan response in 2013.

2013 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for MBH in 2013. The BH MCO will be required to prepare a response for the noted opportunities for improvement in 2014.

APPENDIX

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

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Standard 108.2	C/FST budget is sufficient to: hire staff proportionate to HC covered lives, has adequate office space, purchase equipment, travel and attend on-going training.
	Standard 108.5	The C/FST has access to providers and HC members to conduct surveys and employs of a variety of survey mechanisms to determine member satisfaction e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Standard 108.6	The problem resolution process specifies the role of the County, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
	Standard 108.7	The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
	Standard 108.8	The Annual Mailed/Telephonic survey results are representative of HC membership, identify systemic trends and actions have been taken to address areas found deficient, as applicable.
	Standard 108.10	The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.
§438.206 Availability of Service	Standard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages. • Excel or Access data base with the following information: Name of Agency (include satellite sites). Address of Agency (and satellite sites) with zip codes. Level of Care (e.g. Partial Hospitalization, D&A Outpatient, etc). Population served (adult, child & adolescent). Priority Population. Special Population.
	Standard 1.2	100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met.

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. • Monitor provider turnover. • Network remains open where needed.
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 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.

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

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

BBA Category	PEPS Reference	PEPS Language
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
§438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

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

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.
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

BBA Category	PEPS Reference	PEPS Language
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.408 Resolution and notification: Grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.

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.
§438.410 Expedited resolution of appeals	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.414 Information about the grievance system to providers and subcontractors	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
§438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

BBA Category	PEPS Reference	PEPS Language
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.424 Effectuation of reversed appeal resolutions	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

Appendix B: OMHSAS-Specific PEPS Substandards

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

Category	PEPS Reference	PEPS Language
	Standard 68.9	Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.
Grievances and State Fair Hearings	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 71.8	Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.
Enrollee Satisfaction		
Consumer / Family Satisfaction	Standard 108.3	County/BH MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.
	Standard 108.4	The C/FST Director is responsible for setting program direction consistent with County direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority and directing staff to perform high quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH MCO provider profiling and have resulted in provider action to address issues identified.

Appendix C: Program Evaluation Performance Summary OMHSAS-Specific Substandards for MBH Counties

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2012, 11 substandards were considered OMHSAS-specific monitoring standards, and were reviewed. Table C.1 provides a count of these Items, along with the relevant categories. All 11 OMHSAS-specific PEPS substandards were evaluated for the five Counties subcontracting with MBH.

Table 1.5 OMHSAS-Specific Substandards Reviewed for MBH

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	Not Reviewed
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	0	0	4	0
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	3	0	0

Format

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

Findings

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards[2]. Of the eight substandards evaluated, MBH met five substandards and partially met three substandards, as indicated in Table C.2.

Table C.2 OMHSAS-Specific Requirements Relating to Second Level Complaints and Grievances

Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
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 Substandards relating to Enrollee Satisfaction are County-specific review standards. All three substandards crosswalked to this category were evaluated for the five MBH Counties and were compliant on all three substandards. The status by County for these is presented in Table C.3 below.

[2] Beginning with RY 2012, MCO-specific substandards 68.9 and 71.8 were changed to County-specific substandards and renumbered to 68.1 and 78.1 respectively under the County-specific standard set. These changes will be reflected in future reports for applicable RY 2012 findings

Table C.3 OMHSAS-Specific Requirements Relating to Enrollee Satisfaction

Category	PEPS Item	Review Year	Status	Counties
Enrollee Satisfaction				
Consumer/Family Satisfaction	Standard 108.3	RY 2011	Met	All MBH Counties
	Standard 108.4	RY 2011	Met	All MBH Counties
	Standard 108.9	RY 2011	Met	All MBH Counties

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