



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

**2013 External Quality Review Report
Community Behavioral HealthCare
Network of Pennsylvania, doing business
as PerformCare
FINAL REPORT**

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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

As of October 2, 2013, Community Behavioral HealthCare Network of Pennsylvania, Inc. (CBHNP) began doing business in Pennsylvania under the trade name PerformCare. The name PerformCare will be used throughout this report¹. This section of the EQR report presents a review by IPRO of the BH MCO PerformCare's compliance with the structure and operations standards. In Review Year (RY) 2011, 66 PA Counties participated in this compliance evaluation.

Organization of the HealthChoices Behavioral Health Program

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

Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties formed an alliance called Capital Area Behavioral Healthcare (CABHC), which holds a contract with PerformCare. North/Central County Option (NC/CO) Counties – Bedford, Blair, Clinton, Franklin, Fulton, Lycoming, and Somerset – also hold contracts with PerformCare. 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 PerformCare and the 12 Counties associated with the BH MCO.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of PerformCare 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

¹ The CBHNP acronym remains in this report for documents that were created prior to the name change.



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 PerformCare, this year a total of 159 Items were identified as being required for the evaluation of County/BH MCO compliance with the BBA regulations. In addition, 11 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Substandards were relevant to more than one BBA regulation or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS Item may contribute more than once to the total number of Items required and/or reviewed. Table 1.1 provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of PerformCare 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 Items Pertinent to BBA Regulations for PerformCare (CBHNP) Counties

Table 1.1a Items Pertinent to BBA Regulations Reviewed for CABHC Counties (Cumberland, Dauphin, Lancaster, Lebanon, and Perry)

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	9	3	0	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	16	2	4	0
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	1	2	0	1
Provider Selection	3	3	0	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	8	0
Practice Guidelines	6	0	2	4	0
Quality Assessment and Performance Improvement Program	23	16	0	7	0
Health Information Systems	1	0	0	1	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	1	9	0	1
General Requirements	14	1	12	0	1
Notice of Action	11	10	0	0	1
Handling of Grievances and Appeals	11	1	9	0	1
Resolution and Notification: Grievances and Appeals	11	1	9	0	1
Expedited Appeals Process	6	1	4	0	1
Information to Providers and Subcontractors	2	0	2	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	1	4	0	1
Effectuation of Reversed Resolutions	6	1	4	0	1

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



Table 1.1b Items Pertinent to BBA Regulations Reviewed for the NC/CO Counties (Bedford, Blair, Clinton, Franklin, Fulton, Lycoming, and Somerset)

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	9	3	0	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					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	16	2	4	0
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	1	2	0	1
Provider Selection	3	3	0	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	8	0
Practice Guidelines	6	0	2	4	0
Quality Assessment and Performance Improvement Program	23	16	0	7	0
Health Information Systems	1	0	0	1	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	1	9	0	1
General Requirements	14	1	12	0	1
Notice of Action	11	10	0	0	1
Handling of Grievances and Appeals	11	1	9	0	1
Resolution and Notification: Grievances and Appeals	11	1	9	0	1
Expedited Appeals Process	6	1	4	0	1
Information to Providers and Subcontractors	2	0	2	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	1	4	0	1
Effectuation of Reversed Resolutions	6	1	4	0	1

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

For PerformCare and the 12 Counties associated with the BH MCO, 159 PEPS Items were identified as required to fulfill BBA regulations. The 12 Counties were evaluated on 150 PEPS Items during the review cycle. There were nine Items that were not scheduled or not applicable for evaluation for RY 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	Compliance	Comments
Enrollee Rights 438.100	Partial	12 substandards were crosswalked to this category. The CABHC Counties were evaluated on 12 substandards and compliant on 12 substandards. The NC/CO Counties were evaluated on 12 substandards. Blair, Bedford, and Clinton, Lycoming and Somerset Counties were compliant on 12 substandards. Franklin and Fulton Counties were compliant on 7 substandards and partially compliant on 5 substandards.
Provider-Enrollee Communications 438.102	Compliant	Compliant as per PS&R sections E.4 (p.49) and A.3.a (p.20).
Marketing Activities 438.104	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	Compliant as per PS&R sections A.9 (p.64) and C.2 (p.30).
Cost Sharing 438.108	Compliant	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	Compliant as per PS&R section 3 (p.34).
Solvency Standards 438.116	Compliant	Compliant as per PS&R sections A.3 (p.59) and A.9 (p.64), and 2012-2013 Solvency Requirements tracking report.

There are seven categories within Enrollee Rights and Protections Standards. PerformCare was compliant on five categories and partially compliant on one category. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50-447.60. The remaining category, Solvency Standards, was compliant based on the 2011-2012 Solvency Requirement tracking report.

Of the 12 PEPS Substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated. The NC/CO Counties were evaluated on 12 substandards. Blair, Bedford, Clinton, Lycoming and Somerset Counties were compliant on all 12 substandards. Franklin and Fulton Counties were compliant on seven substandards and partially compliant on five substandards. The CABHC Counties (Cumberland, Dauphin, Lancaster Lebanon and Perry) were evaluated on twelve substandards and were compliant on twelve substandards. Some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Enrollee Rights

Franklin and Fulton Counties that subcontract with PerformCare were partially compliant with Enrollee Rights due to partial compliance with substandards within PEPS Standard 108.

PEPS Standard 108: The County Contractor/BH-MCO: a) incorporates consumer satisfaction information in provider profiling and quality improvement process; b) collaborates with consumers and family members in



the development of an annual satisfaction survey that meets the requirements of Appendix L; c) provides the department with quarterly and annual summaries of consumer satisfaction activities, consumer issues identified and resolution to problems, and d) provides an effective problem identification and resolution process.

Franklin and Fulton Counties were partially compliant on five substandards of Standard 108: Substandards 1, 5, 6, 7 and 10 (RY 2012).

Substandard 1: County/BH-MCO oversight of C/FST Program ensures HealthChoices contractual requirements are met.

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

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

Substandard 7: The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.

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

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	Compliance	Comments
Elements of State Quality Strategies 438.204	Compliant	Compliant as per PS&R section G.3 (p.53).
Availability of Services (Access to Care) 438.206	Partial	22 substandards were crosswalked to this category. Each County was evaluated on 22 substandards, compliant on 20 substandards, and partially compliant on 2 substandards.
Coordination and Continuity of Care 438.208	Partial	2 substandards were crosswalked to this category. Each County was evaluated on 2 items and was partially compliant on both.
Coverage and Authorization of Services 438.210	Partial	4 substandards were crosswalked to this category. Each County was evaluated on 3 substandards, partially compliant on 2 substandards and non-compliant on 1 item.



Quality Assessment and Performance Improvement Regulations		
Subpart D: Categories	Compliance	Comments
Provider Selection 438.214	Compliant	3 substandards were crosswalked to this category. Each County was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	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	8 substandards were crosswalked to this category. Each County was evaluated on 8 substandards, and compliant on 8 substandards.
Practice Guidelines 438.236	Partial	6 substandards were crosswalked to this category. Each County was evaluated on 6 substandards, compliant on 4 substandards, and partially compliant on 2 substandards.
Quality Assessment and Performance Improvement Program 438.240	Partial	23 substandards were crosswalked to this category. Each County was evaluated on 23 substandards, compliant on 21 substandards and partially compliant on 2 substandards.
Health Information Systems 438.242	Compliant	1 Substandard was crosswalked to this category. Each County was evaluated on 1 Substandard and was compliant on this Item.

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

For this review, 69 Items were crosswalked to Quality Assessment and Performance Improvement Regulations, and all 12 Counties associated with PerformCare were evaluated on 68 Items. There was one Item that was not scheduled or not applicable for evaluation for RY 2012. All of the PerformCare Counties were compliant on 57 Items, partially compliant on 10 Items and non-compliant on one Item. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

All 12 Counties associated with PerformCare were partially compliant with Availability of Services (Access to Care) due to partial compliance with substandards within PEPS Standard 28.

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

All of the PerformCare Counties were partially compliant on two substandards of Standard 28: Substandards 1 and 2 (RY 2011).

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



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

Coordination and Continuity of Care

All 12 Counties associated with PerformCare were partially compliant with Coordination and Continuity of Care due to partial compliance with one substandard of PEPS Standard 28.

Coverage and Authorization of Services

All 12 Counties associated with PerformCare were partially compliant with Coverage and Authorization of Services due to partial compliance with substandards of PEPS Standard 28 and non-compliance with substandard 1 of PEPS Standard 72.

PEPS Standard 28: See Standard description and partially compliant substandard determination under Availability of Services (Access to Care) above.

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

All of the PerformCare Counties were non-compliant on one substandard of Standard 72: Substandard 1 (RY 2012).

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

Practice Guidelines

All 12 Counties associated with PerformCare were partially compliant with Practice Guidelines due to partial compliance with substandards of PEPS Standard 28.

PEPS Standard 28: See Standard description and partially compliant substandard determination under Availability of Services (Access to Care) above.

Quality Assessment and Performance Improvement Program

All 12 Counties associated with PerformCare were partially compliant with Quality Assessment and Performance Improvement Program due to partial compliance with substandards of PEPS Standard 91.

PEPS Standard 91: The BH-MCO has a quality management program that includes a plan for ongoing quality assessment and performance improvement. The BH-MCO conducts performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The QM plans emphasize High volume and High-risk services and treatment and BHRS.

All of the PerformCare Counties were non-compliant on two substandards of Standard 91: Substandards 8 and 12 (RY 2012).



Standard 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 12: The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.

Subpart F: Federal and State Grievance System Standards

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

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

Table 1.4 Compliance with Federal and State Grievance System Standards

Federal and State Grievance System Standards		
Subpart F: Categories	Compliance	Comments
Statutory Basis and Definitions 438.400	Partial	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 8 substandards, partially compliant on 1 substandard and non-compliant on 1 standard.
General Requirements 438.402	Partial	14 substandards were crosswalked to this category. Each County was evaluated on 13 substandards, compliant on 11 substandards, partially compliant on 1 substandard and non-compliant on 1 standard.
Notice of Action 438.404	Partial	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 9 substandards, and non-compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 8 substandards, partially compliant on 1 substandard and non-compliant on 1 standard.
Resolution and Notification: Grievances and Appeals 438.408	Partial	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 8 substandards, partially compliant on 1 substandard and non-compliant on 1 standard.
Expedited Appeals Process 438.410	Partial	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards, compliant on 3 substandards, partially compliant on 1 substandard and non-compliant on 1 standard.



Federal and State Grievance System Standards		
Subpart F: Categories	Compliance	Comments
Information to Providers & Subcontractors 438.414	Compliant	2 substandards were crosswalked to this category. Each County was evaluated on 2 substandards and compliant on both.
Recordkeeping and Recording Requirements 438.416	Compliant	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	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards, compliant on 3 substandards, partially compliant on 1 substandard and non-compliant on 1 standard.
Effectuation of Reversed Resolutions 438.424	Partial	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards, compliant on 3 substandards, partially compliant on 1 substandard and non-compliant on 1 standard.

There are 10 categories in the Federal and State Grievance System Standards. PerformCare was compliant on two of the 10 categories (Information to Providers & Subcontractors and Recordkeeping and Recording Requirements) and partially compliant on eight categories. The category Recordkeeping and Recording Requirements was compliant as per the 2012 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.

For this review, 78 Items were crosswalked to Federal and State Grievance System Standards, and each PerformCare County was evaluated on 70 Items. There were eight Items that were not scheduled or not applicable for evaluation for RY 2012. Each County was compliant on 55 Items, partially compliant on seven Items and non-compliant on eight Items. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

The 12 PerformCare Counties were deemed partially compliant with eight of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with one substandard within PEPS Standard 71 and non-compliance with one substandard within PEPS standard 72.

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

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

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

PEPS Standard 72: See Standard description and non-compliant substandard determination under Coverage and Authorization of Services on page 13.



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%
1S	Subsequent or modified Interventions Aimed at Achieving Sustained Improvement	5%
2S	Sustained Improvement	15%



Review Element	Standard	Scoring Weight
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. PerformCare submitted the required elements of the FUH PIP for review.

The project had previously received full credit for all elements through Interventions Aimed at Achieving Demonstrable Improvement. Of these, Topic Selection had been pre-determined by OMHSAS and pre-populated by IPRO into QIA forms that were sent to the BH MCOs in August 2009. As outlined in the PIP submission guidelines, PerformCare received credit for Topic Selection by attending IPRO's Technical Assistance webinar held on October 5, 2009. PerformCare received no credit for Demonstrable Improvement and partial credit for Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement.

Follow-up After Hospitalization for Mental Illness

OMHSAS selected Follow-up After Hospitalization for Mental Illness as the topic for the PIP for all BH MCOs and Counties. OMHSAS again prioritized this as an area in need of improvement based on cumulative findings from multiple performance measures and data collection activities. In addition to defining the topic, OMHSAS defined the study indicator based on the Healthcare Effectiveness Data Information Set (HEDIS[®]) 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 literature citations and root cause analyses based on BH MCO-and County-specific data. PerformCare cited from literature review that an estimated 40-60% of patients fail to connect with outpatient clinicians, but that those who have kept follow-up appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow-up with outpatient care. The BH MCO also referenced research indicating that factors such as socio-demographic, clinical, and service utilization characteristics can be used to predict those at risk for not receiving adequate follow-up care. PerformCare stated that they continue to use these predictors to develop potential next steps and interventions.

PerformCare discussed the BH MCO's rates on the four indicators, noting that all rates remained well below the 90% OMHSAS-established benchmark. PerformCare indicated that they conducted a separate root cause analysis for each of the five County contracts (four of which are jointers) – The Capital Five Counties, Blair County, Bedford/Somerset, Clinton/Lycoming, and Franklin/Fulton. As a result, the MCO observed multiple overarching problem areas, some of which included: 1) Third Party Liability (TPL) issues, specifically cases for which PerformCare is the secondary payer and follow-up visits were completed by providers under the primary insurance, so the claim would not have been captured by PerformCare, 2) use of Out of Network providers, 3) ineffective or lack of appointment outreach calls, 4) limited provider availability, 5) member preferences for unavailable providers, leading to lack of engagement, 6) lack of data reporting capacity, 7)



hospital discharge planning issues, and 8) lack of access to transportation. PerformCare also referred to the definition used in the HEDIS measure for follow-up visits as a factor impacting the rates. Although the HEDIS definitions are used nationally, PerformCare asserted that rehabilitation services used in PA to maintain contact with a member are not included in the HEDIS measure, and decrease the rates. This issue, however, is not a root cause that can be addressed by the MCO, as the national HEDIS definition has been required for use by OMHSAS for QIs 1 and 2.

As a result of the root cause analysis findings, PerformCare proposed other factors that may prohibit members from attending follow up care, such as substance abuse issues, poor discharge planning, lack of referrals to peer support, and unstable housing. PerformCare noted that these issues appear to persist despite provider education currently in place. Additionally, in response to the issue of ineffective or lack of outreach calls, PerformCare reviewed the BH MCO's own internal process regarding how members are reminded of their appointments. As a result, the BH MCO plans to initiate new procedures to enhance collaboration with Targeted Case Managers (TCM), inpatient units, and parents or guardians.

Baseline results were calculated in 2009 for the period January 1, 2008 through December 31, 2008 and were previously presented along with analysis that would lead to interventions initiated in late 2009. The baseline results indicated a rate of 42.7% for QI 1 (HEDIS – seven days), 66.7% for QI 2 (HEDIS – 30 days), 55.8% for QI A (PA-Specific – seven days), and 73.8% for QI B (PA-Specific – 30 days). For QIs 1 and 2, the comparison goals adopted by PerformCare were the 75th percentile of the HEDIS 2007 Medicaid seven- and 30-day follow-up rates. For QIs A and B, the goals were the 90th percentile of the HEDIS 2007 Medicaid seven- and 30-day follow-up rates. Rates for all indicators were below the goals and the 90% benchmark established by OMHSAS. As part of the MCO's review of baseline data, PerformCare conducted two consecutive barrier analyses jointly for the FUH and Readmission within 30 Days of Inpatient Psychiatric Discharge measures, citing that professional literature consistently indicates a high correlation between these measures. The work group that conducted the analyses consisted of PerformCare Chief Operating Officer, Director of Quality Improvement, a quality improvement specialist, quality improvement clinical managers, and County/provider/member stakeholder representatives. For each of the analyses, the group examined available data additional to baseline data. For the 2009 analysis, the group examined data from 2004 through June 2008. In 2010, the group examined data through June 2009. In both analyses, the MCO discussed year-to-year trends and benchmark comparison results first at the MCO-level, then by County contracts. As part of the analyses, PerformCare repeatedly noted a shortage of provider resources at select Counties/joiners, notably in the low number of available peer specialists, crisis service providers, and TCMs. Results of the workgroup review were presented at Quality Improvement Committee meetings for each of the five County contracts (Capital Five, Lycoming/Clinton, Franklin/Fulton, Bedford/Somerset, and Blair Counties.)

For 2010, PerformCare included updates for previous interventions in its discussion of barrier analysis. The BH MCO noted that a number of the monitoring mechanisms previously put in place yielded information for further intervention in 2010. One example is the quarterly review of "no show"/appointment cancellation rates per hospital for high volume providers. As a result, the MCO implemented an intervention in which Quality Improvement Project Managers provide additional education regarding discharge planning to those providers identified with high "no show"/cancellation rates. Additionally, PerformCare presented several Interventions Aimed at Achieving Demonstrable Improvement that were implemented beginning in April 2009, following the MCO's analysis of baseline. These interventions included 1) a self audit tool distributed to all inpatient facilities including items regarding discharge planning, followed by letters with reminders on the need for good discharge planning, review of possible barriers, and follow-up; 2) the MCO's Enhanced Care Management (ECM) Program, which works to improve outcomes for high-risk members by improving the linkage of high-risk members with Therapeutic Care Management (TCM) and Peer Support Services, improving inpatient discharge plans, and increasing utilization of natural and community supports; and 3) ongoing monthly provider performance reports that are sent to providers and discussed further when there are concerns.

Remeasurement results calculated in 2011 for January 1, 2010 through December 31, 2010 were presented, along with discussion of additional analysis conducted throughout 2010. Remeasurement results show that rates did not increase for any of the indicators. Demonstrable Improvement was not achieved. Additionally, the remeasurement rates did not meet the BH MCO's goals, or the OMHSAS benchmark. The interventions



implemented in 2009 do not appear to have had an impact. The timing of the analysis presented indicates that following the internal workgroup meeting in February 2009, there was a root cause analysis completed in February 2010, during the remeasurement year. Another workgroup meeting was held in April 2010, and a second root cause analysis was conducted in 2011. Although a number of Interventions Aimed at Demonstrable Improvement had previously been implemented, it is not clear if the interventions identified as a result of the analysis occurred in a timely manner to impact change for Remeasurement 1. Additionally, numerous barriers had been identified. However, there does not appear to be a discussion/analysis of the rank order of the barriers, or of the potential to be impacted.

Subsequent interventions were identified on both the QIA Form and in the Barrier Analysis. PerformCare provided updates for the ongoing interventions previously implemented, including 1) The self-audit tool, 2) the ECM program, and 3) ongoing monthly provider performance reports, including contact with providers to review discharge planning requirements and possible barriers to successful discharge planning. However, some of the barriers listed for interventions appear to be variations of the barrier as identified in the discussion of analysis. Additionally, some interventions appear to be implemented differently across counties. It is not clear if they were implemented or continued as the result of analysis or assessment of the effectiveness of prior implementation, or if the interventions were implemented or continued for a wide range of members. For example, a barrier listed in the analysis discussion is the lack of provider awareness of the importance of 7-day follow-up. In the discussion of interventions, this barrier is not listed. However one that is listed is that many providers are not willing or able to commit to scheduling members within the 7 days after discharge, which appears to be a variation and is not listed in the analysis discussion. It is not clear if this difference impacted how the intervention was implemented (e.g., the letter sent to providers encouraged them to make appointments available). Additionally, the QIA description of the interventions indicates distribution of letters, discussions at provider Level of Care meetings, and the exploration of outpatient appointments that can occur as “bridge” appointments post discharge. Within the barrier analysis, it appears that Lycoming/Clinton had a different schedule for discussion, and had not yet begun “bridge” appointments. It is not clear if this intervention addressed the originally identified barrier, or how many members were potentially reached. Because of these issues, PerformCare received partial credit for Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement.

Because Sustained Improvement is evaluated for measures for which Demonstrable Improvement was achieved, this measure was not evaluated for Sustained Improvement in 2013, based on activities conducted in 2012 to assess performance in 2011. Remeasurement results calculated in 2012 for January 1, 2011 through December 31, 2011 were presented, along with discussion of additional analysis conducted throughout 2011. Remeasurement results show that rates for all four measures increased over baseline. While quality improvement efforts continue to be encouraged for all measures, none were eligible for evaluation for Sustained Improvement within this PIP cycle. Additionally, the remeasurement rates did not meet the BH MCO’s goals, or the OMHSAS benchmark.

For the elements of the study evaluated that reflect activities in 2012, PerformCare received no credit for Sustained Improvement. PerformCare received a total score of 62.5 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



Review Element	Compliance Level	Scoring Weight	Final Points Score
6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010)	Full	20%	20
7. Demonstrable Improvement (CY 2010, reported in 2011)	Non-Compliant	20%	0
Total Demonstrable Improvement Score			60
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Partial	5%	2.5
2S. Sustained Improvement (CY 2011, reported in 2012)	Non-Compliant	15%	0
Total Sustained Improvement Score			2.5
Overall Project Performance Score			62.5

**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)	42.7%	NA	41.7%	45.2%	90%
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	66.7%	NA	65.5%	69.9%	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge. (Standard HEDIS Codes and PA codes) (QI A)	55.8%	NA	54.2%	57.4%	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge. (Standard HEDIS Codes and PA codes) (QI B)	73.8%	NA	72.8%	76.7%	90%
Project Status	Baseline Study	Interventions	Remeasurement #1	Remeasurement #2	

* There was no Demonstrable Improvement for any of the indicators.



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 BHC 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
PerformCare (CBHNP)	1,926	4,081	47.2%	45.6%	48.7%			45.2%	2.0	NO
Bedford	35	90	38.9%	28.3%	49.5%			40.7%	-1.8	NO
Blair	246	473	52.0%	47.4%	56.6%			46.9%	5.1	NO
Clinton	57	111	51.4%	41.6%	61.1%			46.9%	4.4	NO
Cumberland	137	297	46.1%	40.3%	52.0%			49.0%	-2.9	NO
Dauphin	372	842	44.2%	40.8%	47.6%			40.4%	3.7	NO
Franklin	149	267	55.8%	49.7%	62.0%			49.2%	6.6	NO
Fulton	11	19	57.9%	33.1%	82.7%			30.8%	27.1	NO
Lancaster	473	1,063	44.5%	41.5%	47.5%			45.6%	-1.1	NO
Lebanon	186	337	55.2%	49.7%	60.6%			60.5%	-5.3	NO



	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
Lycoming	138	332	41.6%	36.1%	47.0%			37.3%	4.2	NO
Perry	33	70	47.1%	34.7%	59.5%			34.5%	12.7	NO
Somerset	89	180	49.4%	41.9%	57.0%			38.2%	11.2	NO
QI 2										
HealthChoices	24,388	35,972	67.8%	67.3%	68.3%	67.4%	72.5%	67.0%	0.8	NO
PerformCare (CBHNP)	2,917	4,081	71.5%	70.1%	72.9%			69.9%	1.6	NO
Bedford	65	90	72.2%	62.4%	82.0%			74.3%	-2.1	NO
Blair	351	473	74.2%	70.2%	78.3%			77.8%	-3.6	NO
Clinton	83	111	74.8%	66.2%	83.3%			81.5%	-6.7	NO
Cumberland	213	297	71.7%	66.4%	77.0%			70.3%	1.4	NO
Dauphin	573	842	68.1%	64.8%	71.3%			64.0%	4.0	NO
Franklin	223	267	83.5%	78.9%	88.2%			82.7%	0.8	NO
Fulton	15	19	79.0%	58.0%	99.9%			53.8%	25.1	NO
Lancaster	739	1,063	69.5%	66.7%	72.3%			67.6%	1.9	NO
Lebanon	267	337	79.2%	74.8%	83.7%			77.8%	1.4	NO
Lycoming	208	332	62.7%	57.3%	68.0%			61.7%	0.9	NO
Perry	50	70	71.4%	60.1%	82.7%			56.9%	14.5	NO
Somerset	130	180	72.2%	65.4%	79.0%			64.6%	7.6	NO

Caution should be exercised when interpreting results for small denominators as they produce rates that are less stable. Rates produced for small denominators are subject to greater variability. For small populations, large differences in rates do not necessarily mean there is a statistically significant difference in rates.

The MY 2012 HealthChoices aggregate rates were 47.2% for QI 1 and 67.8% for QI 2. The QI 1 rate was statistically significantly above the prior year by 1.1 percentage points. The QI 2 rate was 0.8 percentage points above the prior year which was not a statistically significant difference. PerformCare's MY 2012 rate was 47.2% for QI 1 and 71.5% for QI 2. There were no statistically significant differences between the MY 2012 and MY 2011 rates for PerformCare.

For MY 2012, PerformCare's QI 1 rate of 47.2% was above than the QI 1 HealthChoices BH MCO Average of 46.7% by 0.5 percentage points. PerformCare's QI 2 rate of 71.5% was also above the QI 2 HealthChoices BH MCO Average of 67.4% by 4.1 percentage points. There were no statistically significant differences for either rate.

As presented in Table 3.1, 12 Counties were contracted with PerformCare in MY 2012. For QI 1 and QI 2, there were no statistically significant differences observed between MY 2012 and MY 2011 rates for any of the 12 Counties for QI 1 and QI 2.

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

In MY 2012, the QI 1 rates for Franklin and Lebanon counties were statistically significantly above and the rates for Dauphin, Lancaster and Lycoming Counties were statistically significantly below the MY 2012 QI 1

HealthChoices County Average of 48.2%. For Q1 2, the rates Franklin, and Lebanon Counties were statistically significantly higher, while the rates for Dauphin, Lancaster and Lycoming Counties were statistically significantly lower than the MY 2012 Q1 2 HealthChoices County Average of 72.5%. Percentage point differences from the respective averages for Q1 1 and Q1 2 are noted in Figure 3.2.

Figure 3.1 MY 2012 HEDIS Indicator Rates

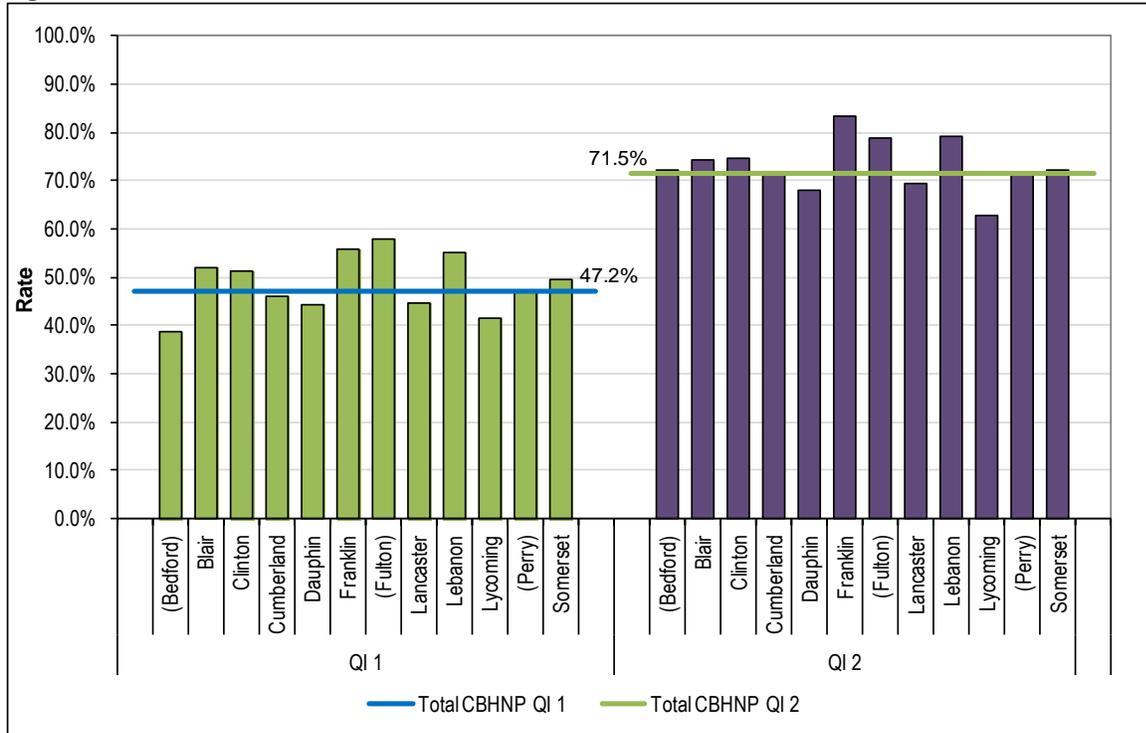
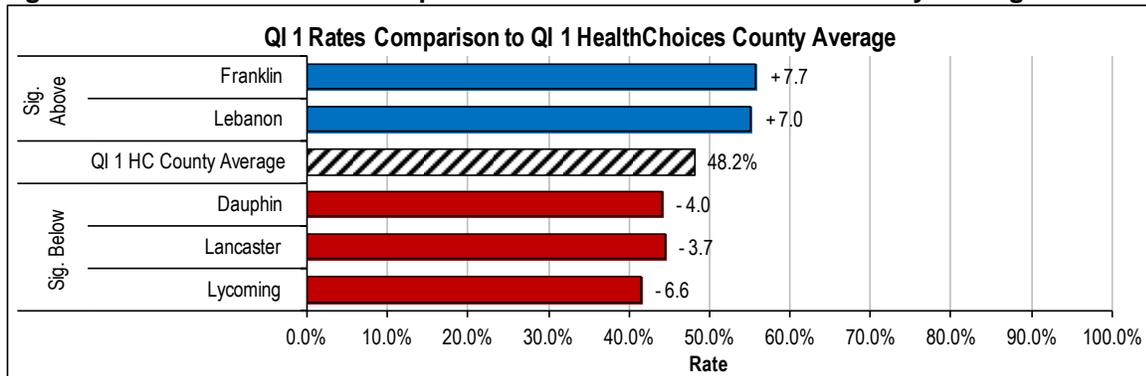


Figure 3.2 HEDIS Rates Compared to MY 2012 HealthChoices County Average



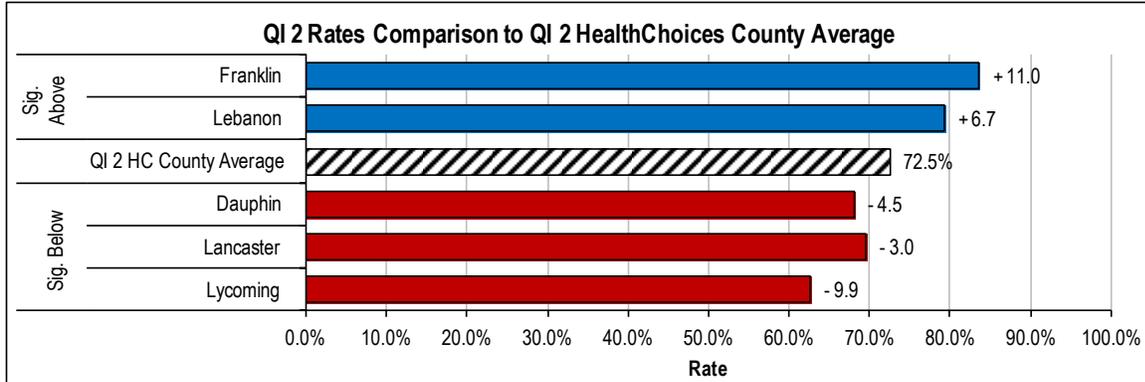


Table 3.2 MY 2012 PA-Specific Indicator Rates with Year-to-Year Comparisons

	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
PerformCare (CBHNP)	2,424	4,081	59.4%	57.9%	60.9%			57.4%	2.0	NO
Bedford	55	90	61.1%	50.5%	71.7%			61.1%	0.0	NO
Blair	307	473	64.9%	60.5%	69.3%			60.3%	4.6	NO
Clinton	65	111	58.6%	48.9%	68.2%			61.7%	-3.2	NO
Cumberland	172	297	57.9%	52.1%	63.7%			57.5%	0.4	NO
Dauphin	540	842	64.1%	60.8%	67.4%			59.9%	4.2	NO
Franklin	177	267	66.3%	60.4%	72.1%			64.6%	1.7	NO
Fulton	12	19	63.2%	38.8%	87.5%			50.0%	13.2	NO
Lancaster	577	1,063	54.3%	51.2%	57.3%			52.1%	2.2	NO
Lebanon	209	337	62.0%	56.7%	67.4%			68.8%	-6.7	NO
Lycoming	164	332	49.4%	43.9%	54.9%			49.1%	0.3	NO
Perry	37	70	52.9%	40.5%	65.3%			41.4%	11.5	NO
Somerset	109	180	60.6%	53.1%	68.0%			51.7%	8.9	NO
QI B										
HealthChoices	26,978	35,972	75.0%	74.6%	75.4%	74.8%	78.4%	74.8%	0.2	NO
PerformCare (CBHNP)	3,182	4,081	78.0%	76.7%	79.3%			76.7%	1.3	NO
Bedford	79	90	87.8%	80.5%	95.1%			85.8%	1.9	NO
Blair	379	473	80.1%	76.4%	83.8%			81.7%	-1.6	NO
Clinton	87	111	78.4%	70.3%	86.5%			85.2%	-6.8	NO
Cumberland	227	297	76.4%	71.4%	81.4%			75.7%	0.8	NO
Dauphin	666	842	79.1%	76.3%	81.9%			76.6%	2.5	NO
Franklin	236	267	88.4%	84.4%	92.4%			87.3%	1.1	NO



	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
Fulton	15	19	79.0%	58.0%	99.9%			65.4%	13.6	NO
Lancaster	794	1,063	74.7%	72.0%	77.4%			71.7%	3.0	NO
Lebanon	282	337	83.7%	79.6%	87.8%			83.5%	0.2	NO
Lycoming	224	332	67.5%	62.3%	72.7%			69.4%	-2.0	NO
Perry	52	70	74.3%	63.3%	85.2%			63.8%	10.5	NO
Somerset	141	180	78.3%	72.0%	84.6%			72.5%	5.9	NO

Caution should be exercised when interpreting results for small denominators as they produce rates that are less stable. Rates produced for small denominators are subject to greater variability. For small populations, large differences in rates do not necessarily mean there is a statistically significant difference in rates.

The MY 2012 HealthChoices aggregate rates were 58.7% for QI A and 75.0% for QI B. The QI A rate was statistically significantly above the prior year by 0.8 percentage points. The QI B rate was 0.2 percentage points above the prior year which was not a statistically significant difference. PerformCare's MY 2012 QI A rate was 59.4% and QI B rate was 78.0%. The QI A rate was a 2.0 percentage point increase from the prior year and the QI B rate was a 1.3 percentage point increase from the prior year. Neither increase was statistically significant.

The MY 2012 HealthChoices BH MCO Averages for QI A and QI B were 58.2% and 74.8%, respectively. For MY 2012, PerformCare's QI A rate was 1.2 percentage points above the HealthChoices BH MCO Average which was not a statistically significant difference. PerformCare's QI B rate was statistically significantly above the QI B HealthChoices BH MCO Average by 3.2 percentage points.

As presented in Table 3.2, for both QI A and QI B, there were no statistically significant differences observed between MY 2012 and MY 2011 rates for the PerformCare Counties. Figure 3.3 displays a graphical representation of the MY 2012 PA-specific follow-up rates for PerformCare and its respective Counties. Figure 3.4 presents the individual PerformCare Counties that performed statistically significantly above or below the MY 2012 QI A and QI B HealthChoices County Averages.

The QI A rates for Blair, Dauphin and Franklin Counties were statistically significantly higher and the rates for Lancaster and Lycoming Counties were statistically significantly lower than the MY 2012 QI A HealthChoices County Average of 59.3%. The QI A rates for the remaining PerformCare Counties did not differ statistically significantly from the MY 2012 QI A HealthChoices County Average.

For QI B, the rates for Bedford, Franklin, and Lebanon Counties were statistically significantly higher and the rates for Lancaster and Lycoming Counties were statistically significantly lower than the MY 2012 QI B HealthChoices County Average of 78.4%. The QI B rates for the remaining PerformCare Counties did not differ statistically significantly from the MY 2012 QI B HealthChoices County Average.



Figure 3.3 MY 2012 PA-Specific Indicator Rates

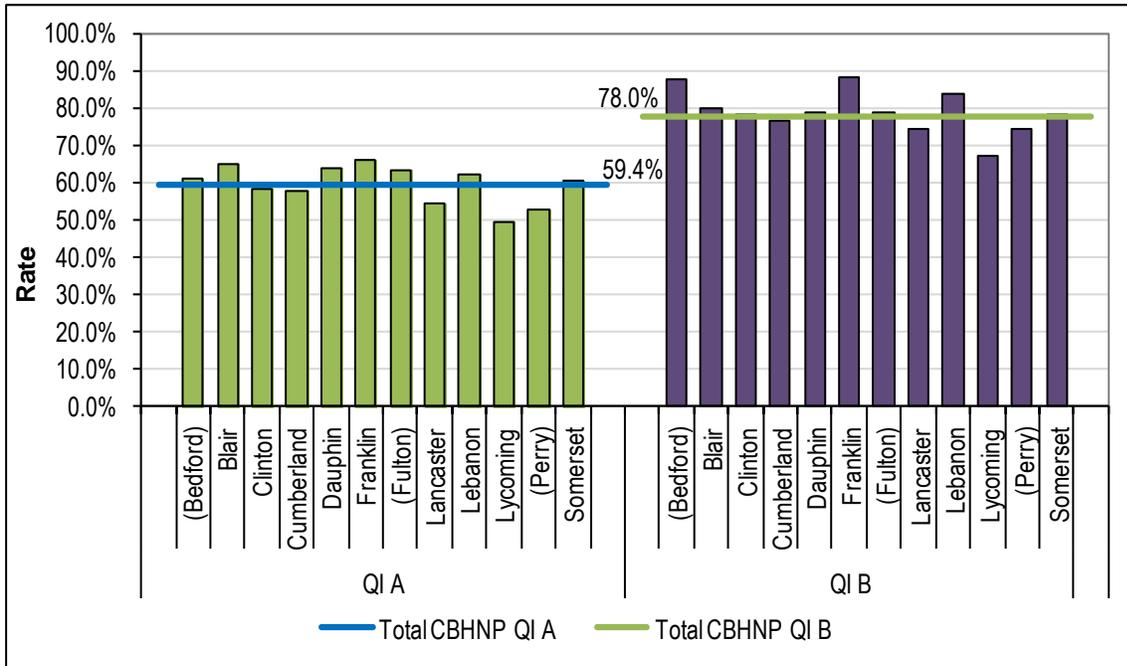
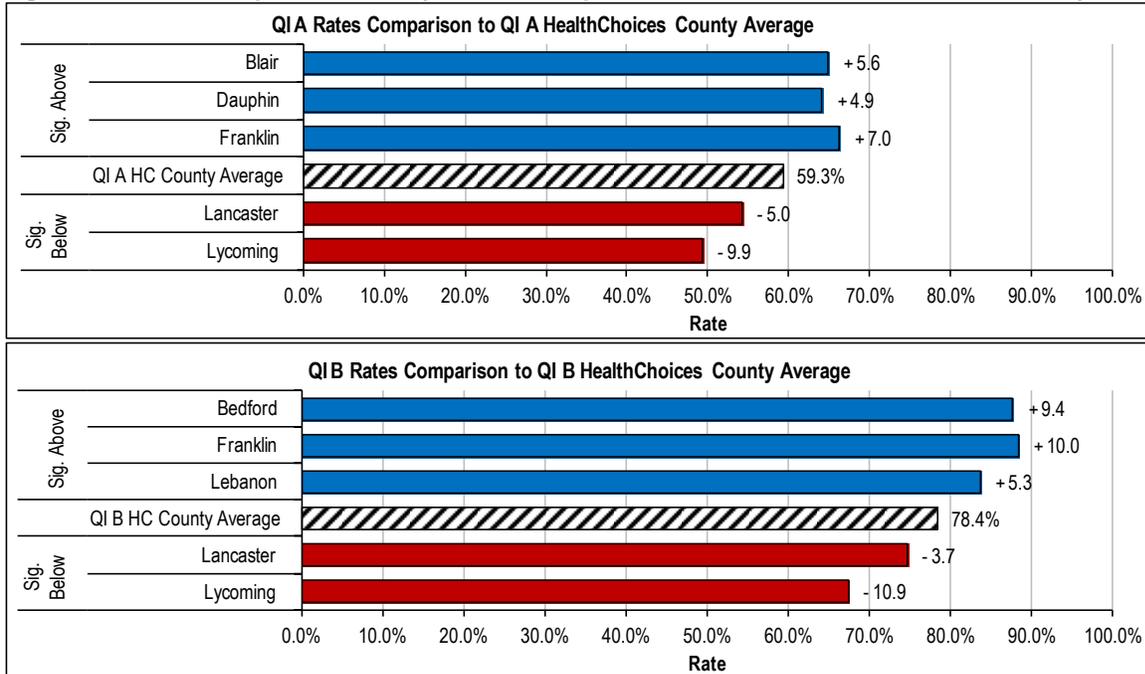


Figure 3.4 PA-Specific County Rates Compared to MY 2012 HealthChoices County Average



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, rates for both QI 1 and QI 2 fell between the 50th and 75th percentiles. In previous benchmark comparisons for MY 2011, the HealthChoices rates for both QI 1 and QI 2 fell between the 50th and 75th and 25th and 50th percentiles respectively.

When comparing the MY 2012 PerformCare rates to the HEDIS 2013 benchmarks, the QI 1 rate of 47.2% fell between the 50th and 75th percentiles while the MY 2012 QI 2 rate of 71.5% fell between the 50th and 75th percentiles. In MY 2011, PerformCare’s QI 1 rate of 45.2% fell between the 25th and 50th percentiles, and the QI 2 rate of 69.9% fell between the 50th and 75th percentiles.

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
PerformCare (CBHNP)	702	4,992	14.1%	13.1%	15.0%			14.8%	-0.8	NO
Bedford	6	101	5.9%	0.8%	11.0%			8.3%	-2.3	NO
Blair	73	590	12.4%	9.6%	15.1%			14.7%	-2.3	NO
Clinton	17	131	13.0%	6.8%	19.1%			11.2%	1.8	NO



	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
Cumberland	46	367	12.5%	9.0%	16.1%			14.1%	-1.6	NO
Dauphin	185	1,090	17.0%	14.7%	19.2%			19.3%	-2.3	NO
Franklin	67	347	19.3%	15.0%	23.6%			13.2%	6.1	NO
Fulton	1	23	4.4%	0.0%	14.9%			11.4%	-7.1	NO
Lancaster	154	1,250	12.3%	10.5%	14.2%			13.6%	-1.3	NO
Lebanon	84	409	20.5%	16.5%	24.6%			15.7%	4.9	NO
Lycoming	38	393	9.7%	6.6%	12.7%			12.4%	-2.7	NO
Perry	18	100	18.0%	10.0%	26.0%			15.0%	3.0	NO
Somerset	13	191	6.8%	3.0%	10.6%			13.1%	-6.3	NO

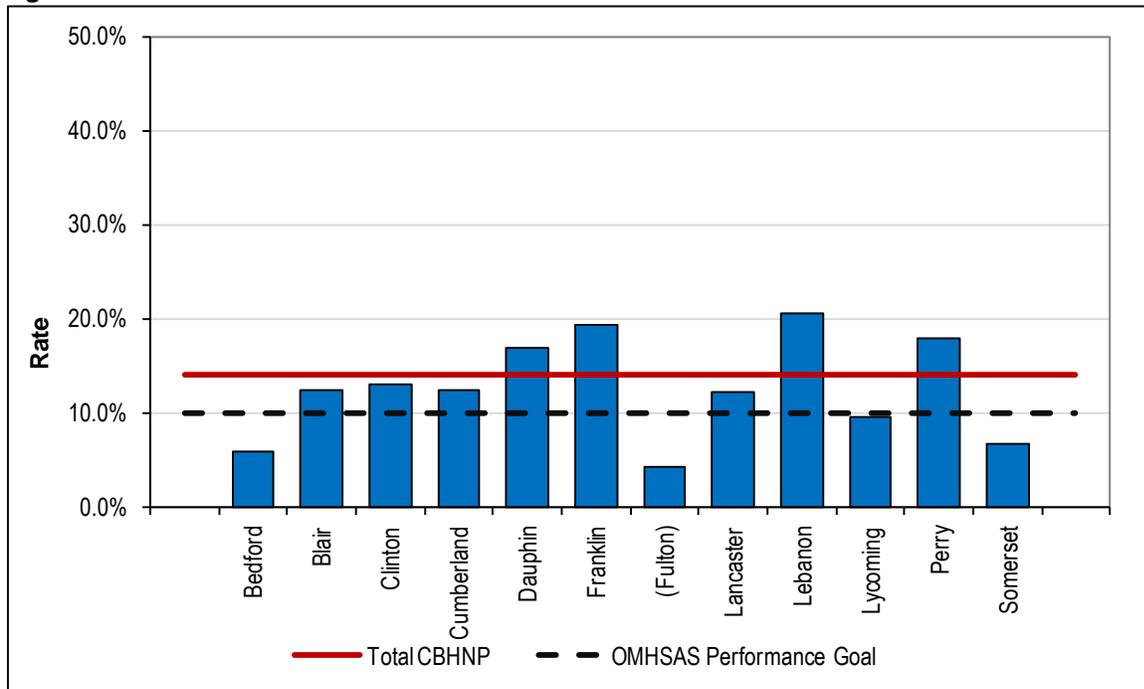
Caution should be exercised when interpreting results for small denominators as they produce rates that are less stable. Rates produced for small denominators are subject to greater variability. For small populations, large differences in rates do not necessarily mean there is a statistically significant difference in rates.

The aggregate MY 2012 HealthChoices readmission rate was 12.7% which was 0.7 percentage points above the MY 2011 rate of 12.0%. This difference was not statistically significant. PerformCare's readmission rate was 14.1% which was statistically significantly higher than the HealthChoices BH MCO Average of 12.8% by 1.3 percentage points, and did not meet the designated performance goal of 10%. PerformCare's MY 2012 rate was below the MY 2011 rate by 0.8 percentage points which was not a statistically significant difference. Note that this measure is an inverted rate, in that lower rates are preferable.

As presented in Table 3.4, 12 Counties were contracted with PerformCare in MY 2012. None of the County rates changed statistically significantly from MY 2011.

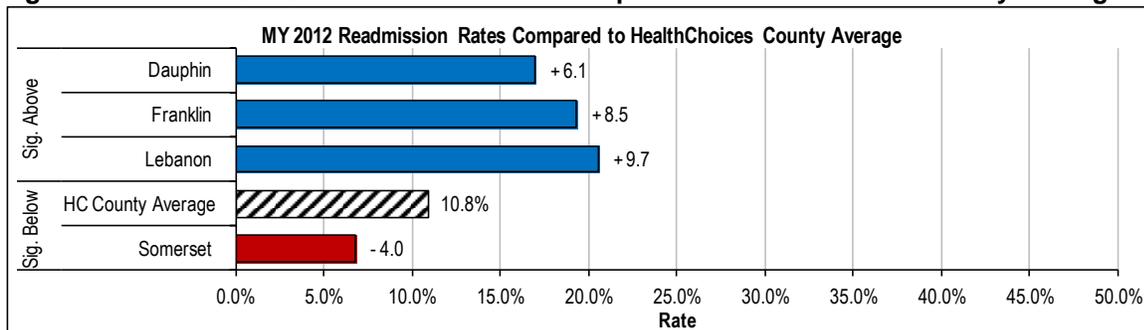
Figure 3.5 displays a graphical representation of the MY 2012 readmission rates for the PerformCare Counties. For MY 2012, the rates for Bedford, Fulton, Lycoming and Somerset Counties met the performance goal of better than or equal to 10.0%. As compared to the MY 2012 HealthChoices County Average of 10.8%, the rates for Dauphin, Franklin and Lebanon Counties were statistically significantly above (poorer than) the average and the rate for Somerset County was statistically significantly below (better than) the HealthChoices County Average. Note that this measure is an inverted rate, in that lower rates are preferable. Percentage point differences compared to the HealthChoices County Average are noted in Figure 3.6.

Figure 3.5 MY 2012 Readmission Rates



Note: Rates represented by less than 100 admissions are indicated in parentheses.

Figure 3.6 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 PerformCare (CBHNP).

Table 4.1 Current and Proposed Interventions: Opportunities for Improvement

Reference Number	Opportunity for Improvement	MCO Response
Structure and Operations Standards		
CBHNP 2012.01	Within Subpart C: Enrollee Rights and Protections Regulations, CBHNP was partially compliant on one out of seven categories – Enrollee Rights.	<p>Follow Up Actions Taken Through 09/30/13 The Complaint and Grievance (C&G) Department had 4 full time and 1 part time staff and 1 supervisor. New employees receive detailed training on Complaint and Grievance processes and in working with Members, families, and providers. Weekly staff meeting and individual weekly supervision are conducted to review pending issues, provide information and answer questions related to policy and procedures. Annual retraining of C&G processes and procedures occurs with C&G staff and other CBHNP Departments. Monthly internal auditing occurs to ensure regulatory requirements are met consistently.</p> <p>Follow up Action taken through 9/30/13: Ongoing review and updates to the C&G Department reference manual occurred as needed to maintain this employee resource appropriately to current expectations, processes, and procedures. 08/13 Annual retraining of all C&G staff occurred relative to processes and expectations, with review of prior and updated information. Ongoing internal auditing to ensure Member rights are clearly explained and documented throughout the Member record.</p> <p>Future Actions Planned Ongoing weekly and annual retraining of staff on C&G processes and expectations to ensure all staff have current information on policies and procedures in managing disputes for Members and to strengthen reminders of expectations of the procedures to process Complaints and Grievances to ensure Member rights. Ongoing internal auditing of documentation to identify any needed areas of improvement and to provide re-education opportunities as needed.</p>
CBHNP 2012.02	CBHNP was partially compliant on five out of 10	<p>Follow Up Actions Taken Through 09/30/13 Refined Psychiatric Access Reporting was launched during Q3 2013 to measure the</p>

Reference Number	Opportunity for Improvement	MCO Response
	categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: <ol style="list-style-type: none"> 1) Availability of Services (Access to Care) 2) Coordination and Continuity of Care 3) Coverage and Authorization of Services 4) Practice Guidelines 5) Quality Assessment and Performance Improvement Program 	<p>availability to psychiatric evaluations. Expanded capacity of field and local care management in some contracts. Continued to define specialized caseloads for priority populations. Improved active care management practices, increasing involvement in ISPT meetings for targeted services/diagnostic groupings. Implemented registration free access to most outpatient levels of care giving Members more immediate access to services. Approved for use practice guidelines for Suboxone, and Bipolar disease in Children. Updated QI/UM work plan to include goals, scope, frequency, data source, etc. when possible. Added detail of joint studies and PH-MCO coordination projects.</p> <p>Future Actions Planned <u>Ongoing:</u> Continued development of service alternatives which are evidence based, person-centered and recovery oriented. Expansion of telepsychiatry/telemedicine. Expansion of peer support services. Review and adoption of additional practice guidelines. <u>Q1 2014:</u> Root cause analysis of substance abuse service delivery. <u>Q3 2013 and ongoing:</u> Increased involvement of physician advisors through CCM case conferencing, high risk Member reviews, and network outreach.</p>
CBHNP 2012.03	CBHNP was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: <ol style="list-style-type: none"> 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 8) Effectuation of Reversed Resolutions 	<p>Follow Up Actions Taken Through 09/30/13 Ongoing internal auditing of a sampling of acknowledgment and decision letters to be sent to Members. Ongoing supervisory review of decision letters prior to being sent to the Member. Continuing supervisory use of Grievance application reports to monitor timeliness of letters sent to Members. Ongoing use of Grievance application that mandates use of a template for Grievance letters to be sent to Members. Ongoing implementation for CBHNP process for transcribing Level Two Grievances. Continuing use of the internal peer post Grievance case reviews with feedback. Continuing use of updated acknowledgment and decision letter templates, as per OMHSAS direction. Ongoing use of quality trigger process to identify areas of concern with service provision to ensure clinical involvement. Continuing process for communication with Clinical Care Managers regarding reversed Grievance decisions. Ongoing implementation of improved Complaint investigations and documentation. Continuing involvement and communication with County Oversights in the Complaint and Grievance processes. Ongoing use of the updated Expedited Appeal process and Continuation of benefits, as per OMHSAS direction. Ongoing use of the developed internal process of clinical coordination when new information is presented during the Grievance process that could potentially impact service provision.</p> <p>Future Actions Planned Ongoing internal auditing of a sampling of acknowledgment and decision letters for accuracy and to ensure proper templates and Member driven rights are documented. Continuing supervisory review of decision letters prior to distribution to the Member/family. Ongoing supervisory review of Grievance application reports to for monitor timeliness of letters sent to Members and families, as well as the use of the Grievance template letters. Continuing assessment of the processes implemented of post internal peer review cases. Through such reviews, areas of necessary re-education are identified. Ongoing assessment of the quality indicator process to ensure the expectations of the process are met, specifically to continue to reduce Grievances, improve prescribing practices and the quality of service provision, and increase clinical involvement in the Grievance process. Ongoing assessment of Grievance volume to occur on a monthly basis to determine if additional initiatives need to be implemented to address presenting concerns.</p>
CBHNP 2012.04	CBHNP submitted one PIP for validation in 2012. CBHNP received no credit for Demonstrable	<p>Follow Up Actions Taken Through 09/30/13 Updated Q1 2012 results showed improvement for Dauphin, Perry, Somerset, Blair, Franklin, Fulton, Lycoming and Clinton Counties. Updated Q2 results showed improvement for Lancaster, Lebanon, Cumberland, Dauphin, Perry, Somerset,</p>

Reference Number	Opportunity for Improvement	MCO Response
	Improvement and partial credit for Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement.	<p>Franklin, Fulton and Lycoming Counties. Updated QA results showed improvement for Cumberland, Dauphin, Lancaster, Perry, Somerset, Blair, Franklin, Fulton and Lycoming Counties. Updated QB results showed improvements for Cumberland, Dauphin, Lebanon, Perry, Bedford, Somerset, Franklin and Fulton Counties.</p> <p><u>1/13-4/13</u> -Quarterly meetings were held with representatives of Divine Providence Hospital, Lycoming-Clinton HealthChoices, and CBHNP to identify obstacles to coordination, share resources and performance data, and improve communication. Part of the focus was on improving discharge-planning, ambulatory follow-up, and reducing readmissions. In 2013, these meetings were conducted in 1/15 and 4/16.</p> <p><u>6/13</u>: The Lycoming-Clinton contract had a Performance Objective to increase the linkage of high-risk adult Members with TCM as a mechanism for reducing hospitalizations and re-admissions and improving participation in follow-up appointments. The region exceeded the target of 68% of high-risk Members linked with TCM during the contract year (with a score of 72.7%).</p> <p><u>8/13</u> - SA Enhanced Care Manager (ECM) is addressing SA recidivism in a pilot phase in which they: Will be adding clinical update calls between reviews to discuss clinical concerns and discharge planning; Will focus on active discharge planning; Will collaborate with counties regarding availability and appropriateness of D&A TCM and MH TCM; Will make outreach calls to Members and involved providers when the Member is in the community to discuss their progress with recovery; and Will make outreach to assure increase in community supports</p> <p><u>9/13</u> - Member Services Staff started a pilot program where they are contacting all MH/SA IP Members who are discharged to ensure discharge instructions are understood, confirm date and time of follow-up appointment and verify attendance plans, verify contact information, provide assistance with rescheduling appointment when needed, assist with any identified barriers by providing warm linkages to community and natural resources, and identify and ensure CCM intervention when needed.</p> <p><u>1/2013 and on</u>: A Crisis Bridge Pilot was implemented in Bedford and Somerset Counties involving Somerset Hospital and Bedford/Somerset MHMR (Cornerstone). The pilot offers appointments when Members are discharged from Somerset Hospital in order to bridge the gap in service between MH IP discharge and traditional OP follow up. The program was implemented in April 2012 and is being utilized currently. Utilization of this service has not been as high as originally projected. A meeting with the provider of this service and Somerset Hospital in scheduled for October 2013 to review Outcomes and utilization. This intervention has the potential to impact all four follow up measures.</p> <p><u>1/13 and ongoing</u>: Franklin/Fulton County regional office, in conjunction with TMCA and various providers, implemented a MH IP Readmission Work Group. After presentation and review of readmission data, a Root Cause Analysis was conducted. Additionally, a Quality Improvement Plan was developed identifying major action steps geared towards decreasing the MH IP readmission rate.</p> <p><u>6/13</u>: Adams Hanover Counseling (True North Counseling Services) added Telepsychiatry to their already existing service array. Efforts will continue to expand the use of Telepsychiatry within the region to improve access.</p> <p><u>1/13 and ongoing</u>: Discussion has continued with MH OP providers regarding feasibility of outpatient appointments being “blocked out” weekly for emergency use and for Members being discharged from MH IP. Several providers are in process of determining possibility of implementation of appoints to be used for emergency access and Members being discharged from MH IP.</p> <p><u>1/13 and ongoing</u>: Continued Member and Provider education of specialized services available: In addition to Peer Support and Psychiatric Rehabilitation (in some contracts) Adams Hanover Counseling began to offer DBT groups in Fulton County in late 2012. Three regional providers were certified in EMDR in 2012 due to scholarship funding from CBHNP and TMCA. Barbara Dickey at Pathways</p>



Reference Number	Opportunity for Improvement	MCO Response
		<p>Counseling now offers DBT as a modality for OP therapy. <u>1/13 and ongoing</u>: Regional CCISC initiative is continuing throughout 2013. Training series focusing on improving Co-Occurring Competency offered to providers in the region. CCISC implementation team meetings occur bi-monthly. Change Agent meetings and training series began continue in 2013. Providers have completed COMPASS-EZ and action plans have been submitted. Provider involvement continues to grow in the initiative. CCISC Implementation team completed the COMPASS-Exec and is in process of developing work plan to address deficiencies identified in the network. <u>1/13 and Ongoing</u>: Franklin/Fulton local TCM provider (service Access Management) is currently providing education to Members while in a local IP unit regarding TCM services. TCM provider is working closely with MH IP units to improve Member access to TCM services by offering to complete intake prior to Member discharging from MH IP. Discussions continue with local TCM provider on possible ways to increase referrals for ICM/RC services. Efforts will continue to raise Member, community, and provider awareness of TCM services.</p> <p>Future Actions Planned 11/13- Crisis Bridge Appointment will be implemented in Lancaster County. Crisis Bridge programs in Dauphin and Cumberland/Perry will be reviewed/updated.</p>
<p>CBHNP 2012.05</p>	<p>CBHNP's rate for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge.</p> <p>1. Performance measure did not meet the OMHSAS designated performance goal of 10.0%.</p> <p>2. Performance measure was statistically significantly higher (poorer) than the HealthChoices BH-MCO Average by 2.5 percentage points</p>	<p>Follow Up Actions Taken Through 09/30/13 2013 CBHNP Completed a Network Wide Root Cause Analysis for 30 Day Readmission. 2013 CBHNP conducted a RCA with Dauphin County for 30 Day Readmission Rate. Key actions included Member profiling which revealed Members diagnosed with personality disorders to have experienced a higher rate of readmission and Grand Rounds case conferencing with PPI – the primary inpatient facility service this county. <u>1/2013 and ongoing</u>: The Crisis Bridge Pilot Program was implemented in Bedford and Somerset Counties. This pilot involves Somerset Hospital and Bedford/Somerset MHMR (Cornerstone). Bedford/Somerset MHMR is now offering appointments when Members are discharged from Somerset Hospital in order to bridge the gap in service between MH IP discharge and traditional OP follow up. The program was implemented in April 2012 and is being utilized currently. Utilization of this service has not been as high as originally projected. A meeting with the provider of this service and Somerset Hospital is scheduled for October 2013 to review Outcomes and utilization. This intervention has the potential to impact all four follow up measures. <u>1/2013 and ongoing</u> – Bedford/Somerset CCISC implementation is continuing throughout 2013. COD Workgroup meetings are occurring monthly. Change Agent meetings are occurring bi-monthly. Providers have completed COMPASS-EZ assessments and action plans have been submitted. The COD Workgroup completed the CO-Fit and has begun to create an action plan based on the identified opportunities. CBHNP completed the COMPASS-Exec and created an action plan based on the results. <u>1/13-4/13</u> -Quarterly meetings were held with representatives of Divine Providence Hospital, Lycoming-Clinton HealthChoices, and CBHNP to identify obstacles to coordination, share resources and performance data, and improve communication. Part of the focus was on improving discharge-planning, ambulatory follow-up, and reducing readmissions. In 2013, these meetings were conducted in 1/15 and 4/16. <u>6/13</u>: The Lycoming-Clinton contract had a Performance Objective to increase the linkage of high-risk adult Members with TCM as a mechanism for reducing hospitalizations and re-admissions and improving participation in follow-up appointments. The region exceeded the target of 68% of high-risk Members linked with TCM during the contract year (with a score of 72.7%). <u>1/13 and ongoing</u>: Franklin/Fulton County regional office, in conjunction with TMCA and various providers, implemented a MH IP Readmission Work Group. Meetings</p>

Reference Number	Opportunity for Improvement	MCO Response
		<p>occur on a regular basis. After presentation and review of readmission data, a Root Cause Analysis and fishbone diagram was developed. Additionally, a Quality Improvement Plan was developed identifying major action steps geared towards decreasing the MH IP readmission rate within the Franklin/Fulton region.</p> <p><u>6/13</u>: Adams Hanover Counseling (True North Counseling Services) added Telepsychiatry to their already existing service array. Efforts will continue to expand the use of Telepsychiatry within the region to improve access.</p> <p><u>1/13 and ongoing</u>: Discussion has continued with MH OP providers within the Franklin/Fulton region regarding feasibility of outpatient appointments being “blocked out” weekly for emergency use and for Members being discharged from MH IP. Several providers are in process of determining possibility of implementation of appoints to be used for emergency access and Members being discharged from MH IP.</p> <p><u>1/13 and ongoing</u>: Continued Member and Provider education of specialized services available within the Franklin/Fulton region: Adams Hanover Counseling began to offer DBT groups in Fulton County in late <u>2012</u>. Three regional providers were certified in EMDR in 2012 due to scholarship funding from CBHNP and TMCA. Barbara Dickey at Pathways Counseling now offers DBT as a modality for OP therapy.</p> <p><u>1/13 and ongoing</u>: Franklin\Fulton regional CCISC initiative is continuing throughout 2013. Training series focusing on improving Co-Occurring Competency offered to providers in the region. CCISC implementation team meetings occur bimonthly. Change Agent meetings and training series began continue in 2013. Providers have completed COMPASS-EZ and action plans have been submitted. Provider involvement continues to grow in the initiative. CCISC Implementation team completed the COMPASS-Exec and is in process of developing work plan to address deficiencies identified in the network.</p> <p><u>1/13 and ongoing</u>: Franklin\Fulton CBHNP regional staff continue to provide Member and Provider education on Peer Support services and Psychiatric Rehabilitation Services offered within the region.</p> <p><u>1/13 and Ongoing</u>: Franklin\Fulton local TCM provider (service Access Management) is currently providing education to Members while in a local IP unit regarding TCM services. TCM provider is working closely with MH IP units to improve Member access to TCM services by offering to complete intake prior to Member discharging from MH IP. Discussions continue with local TCM provider on possible ways to increase referrals for ICM/RC services. Efforts will continue to raise Member, community, and provider awareness of TCM services.</p> <p><u>6/13</u>: Improved psychiatric access reporting was implemented to include reporting from inpatient and TCM providers in attempt to validate access reported by outpatient clinics. First results are due in October, 2013. Reporting will be required quarterly.</p> <p>Future Actions Planned Through CABHC re-investment dollars, four Peer Support Specialists will be hired to work directly in MH IP units. <u>2013 Q4/2014 Q1</u>: Development of specialized services such as DBT, EMDR through use of reinvestment funding. <u>2014</u>: Participate in D PW, DUR Board Meetings to support the standardization of prior authorization criteria for medications (including second generation anti-psychotic medications). <u>2014</u>: Evaluate the availability of providers who offer injection clinics to support the growing demand for injectable medications.</p>



Corrective Action Plan

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

The following Corrective Action Plan was implemented during the calendar year 2012 to address those deficiencies noted by OMHSAS:

Table 4.2 Corrective Action Plan for PerformCare (CBHNP)

Completed: 10/7/13

Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
Standard 27: Recommendation 1. Evaluate Care Management staffing in relation to CBHNP established case loads. Identify where additional staff are needed to ensure sufficient staffing to actively manage care for all consumers. Date Completed: 09/27/2013					
1.a Monthly review of care manager caseload and productivity reports with staffing recommendations presented to CBHNP management. Standard for BHRS CCM caseload is 250. UR CCM standard is 12-14 reviews per day. Management will review monthly reports and review recommendations from the Clinical and QI Directors to determine if additional staff should be added.	Nancy Kocher	Ongoing	Ongoing	Monthly caseload/productivity reports provided to executive management. Staff rosters to demonstration addition to staff.	On a monthly basis, care manager productivity and caseload reports are provided to CBHNP Executive Management and to County Oversight to demonstrate compliance with established standards. Staff rosters are also presented to demonstrate additions to staff to maintain staffing levels. Completed – OMHSAS follow-up on caseload size and productivity reports, and hiring of additional staff will be conducted as part of ongoing Quarterly Monitoring Meetings.
Standard 27: Recommendation 2. Evaluate the process for auditing care management documentation, with consideration of transferring this function from QM to the clinical department as warranted. Date Completed: 09/27/2013					
2.a Transfer responsibility for CCM audits to Clinical Managers and Supervisors to improve supervisory oversight of active care management (QI will retain oversight and reporting	Nancy Kocher	10/01/12	08/01/13	CCM documentation Audit Policy CM-MS-38 and approval by OMHSAS	Clinical Case Manager and Member Service Documentation Auditing Policy CM-MS-038 submitted to OMHSAS and has been reviewed and approved. Completed.



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
responsibility.).					
2.b Train CCMs and QI supervisors on new audit tool after OMHSAS approval of policy.	Jack Pizzoli	04/01/13	08/15/13	Training attendance sheet	Attendance sheets for training of Capital and NC CM and QI Supervisors held on 7/17/13 received by OMHSAS. Completed.
Standard 27: Recommendation 3. Consistent with national standards and the practice of other HC BH-MCOs, ensure that care manager supervisors conduct regular oversight of care managers through live call monitoring. Date Completed: 09/27/2013					
3.a Develop and implement a policy for live call monitoring of care managers including process, auditing, and actions taken to improve performance, if needed. Performance threshold is 80%.	Michelle Kercher Hawley	08/01/12	08/01/13	Call Monitoring Policy CM-039 and approval by OMHSAS.	Call Monitoring Policy CM-MS-039 received by OMHSAS has been reviewed and approved. Completed.
3.b Development of call monitoring tool.	Michelle Kercher Hawley	10/01/12	05/15/13	Call Monitoring tool.	CCM and MSS Call Monitoring tools have been received by OMHSAS. Completed.
3.c Develop a process to provide feedback and recommendations for improvement in accordance with the Auditing Policy.	Michelle Kercher Hawley	08/01/12	08/01/13 10/1/13 10/1/13	Call monitoring and auditing Policy and approval by OMHSAS. Report of score results to be used for feedback as evidence of implementation. Supervisory notes with documentation of corrective actions (if available).	Call Monitoring Policy CM-MS-039 submitted to OMHSAS has been reviewed and approved. Call Monitoring process began 7/1/13. Results for Quarter 3 (JUL-SEP 2013) will be reported at November 2013 QI/UM Committee Meeting. Supervisory intervention will occur with individuals as audits are completed, if needed. Completed – OMHSAS follow-up on call monitoring audit results and supervisory actions will be conducted as part of ongoing Quarterly Monitoring Meetings.



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
Standard 28: Recommendation Consider enhancements to the E-cura client information system to streamline and integrate the referral and documentation of QOC issues to increase efficiency for CM staff and avoid duplicate data entry. Date Completed: 09/27/2013					
4.a Explore the feasibility of enhancements to integrated the referral of QOC issues to either the PA (guiding quality of treatment) of QI (ensuring quality of care) to increase efficiency and avoid duplicate data entry	Mimi Agnew	09/01/12	02/28/13	Documentation of IT review and recommendations of pending request presented to the CQI Committee.	CBHNP Clinical/Quality Improvement Meeting Minutes dated 2/21/13, include a note that Feasibility Study was completed and it was determined since the QOCC process has been under the direction of the QI Manager, the communication and integration issues that existed at the time of the Mercer audit have been resolved and there is not a need for a QOCC event. Under the current process, all QOCC referrals are tracked on a log which is reviewed weekly by the QI Manager and PA responsible for the QOCC process, ensuring timely review and action of all quality of care issues. Completed.
4.b Implementation of recommendations, if feasible	Mimi Agnew	03/01/13	06/30/13	Documentation of enhancements made to eCura.	N/A
Standard 28: Recommendation Consider automating inclusion criteria for the ECM program in E-Cura to improve efficiency and timeliness of the CM review process by having ECM program reference materials readily available to CMs. Date Completed: 09/27/2013					
5.a Explore the feasibility of automating ECM inclusion criteria in E-Cura to facilitate timely and efficient CCM intervention with Members.	Nancy Kocher	08/01/12	07/01/13	Documentation of IT review and recommendations of pending request presented to the CQU Committee.	Strategic Value Assessment review form received by OMHSAS. Document outlines IT review and approval of IT project for including criteria in eCura to facilitate timely and efficiency CCM interventions with Members.
5.b Implementation of recommendations, if	Michelle Kercher	02/01/13	10/01/13	Documentation of enhancements made to	Project is in development. IT moved completion date



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
feasible	Hawley			eCura	to 10/1/13. Incomplete – OMHSAS follow-up on completion of eCura enhancement project will be conducted as part of ongoing Quarterly Monitoring Meetings.
<p>Standard 27: Required Action</p> <p>Revise the audit tool to go beyond assessing if online fields are complete to assessing the degree of active care management, including the promotion of recovery principles, the promotion of EBP and the identification of QOC issues with appropriate referral to a PC for consultation, etc.</p> <p>Date Completed: 09/27/2013</p>					
6.a Revise Care Management audit tool to more effectively assess the CMs' degree of active care management including the promotion of recovery principles, the promotion of EBP and the identification of QOC issues with appropriate referral to a PC for consultation. The tool will be designed to assess CCM analysis of the clinical data, understanding of member needs, addressing provider issues such as lack of information or gaps in care, and exploration of EBP options.	Jack Pizzoli	09/01/12	08/01/13	CCM Documentation Audit Policy CM-038 approved by OMHSAS. Audit tool.	<p>Clinical Documentation Policy CM-MS-038 received by OMHSAS has been reviewed and approved.</p> <p>UR and BHRS audit tools received by OMHSAS. Results for Quarter 4 (OCT-DEC 2013) will be reported at March 2013 CBHNP QI-UM Committee Meeting.</p> <p>Completed – OMHSAS follow-up on Audit results for Quarter 4 and future results will be conducted at ongoing Quarterly Monitoring Meetings.</p>
6.b Account Executives will monitor Provider Performance issues	Sheryl Swanson	03/01/13	05/01/13	Quarterly provider reports	<p>Copy of Provider Performance report, used by Account Executives (AE) for review and discussion at meetings, received by OMHSAS.</p> <p>Completed</p>
6.c Account Executives will assess improvement in provider resolution	Rob Labatch	08/01/13	08/01/13	Example of improvement by provider	Example of improvement by provider, as a result of Account Executive intervention using Provider



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
of concerns addressed by care managers.					Performance Reports, received by OMHSAS. Completed
Standard 28: Required Action Increase the frequency of drug and alcohol (D&A) level of care reviews to ensure that all applicable medical necessity criteria are met. Date Completed: 09/27/2013					
7.a Develop and implement guidelines to assist CCMs with the determination of need for D&A levels of care, as well as the frequency of reviews and discharge planning.	Jennifer Anderson	08/01/12	12/31/12	Documentation of revised CCM guidelines for D&Q reviews.	Document titled Capital Active Care Management (ACM) Proposal for Substance Abuse Rehab (3b/3C): 08/12 submitted to OMHSAS. Document indicates will require P&P revisions. Full implementation in Capital on 7/1/13 and NC on 8/12/13. The full implementation of new protocols for management of members in substance abuse treatment with high levels of recidivism, co-occurring issues, or complex medical needs was implemented in the Capital region in July and in the North Central region in August. It was decided to slightly delay implementation in North Central due to CNHNP's loss of 2 HealthChoices contracts and the need to assess staffing levels and resources. The new protocols have now been fully implemented for all contracts. There are no policy changes. Internal guidelines and workflows were developed to accommodate more active care management. Completed – OMHSASS follow-up on final document and impacted P&P will be conducted as

Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
					part of ongoing Quarterly Monitoring Meeting.
7.b Train CCMs on new guidelines	Jack Pizzoli	02/01/13	08/01/13	Attendance sheets	Attendance sheets received by OMHSAS for 5/8/13 Capital and 8/7/123 North Central CCMs trained on new SA guidelines. Completed.
7.c CCM audit tool will include items to assess CCM compliance with guidelines for D&A reviews and case management.	Jack Pizzoli	09/01/12	08/01/13	CCM Audit Tool	UR and BHRS audit tools received by OMHSAS. Results for Quarter 4 (OCT-DEC 2013) will be reported at March 2013 QI/UM Committee Meeting. Completed – OMHSAS followed-up on Audit Results for Quarter 4 and future results will be conducted as part of ongoing Quarterly Monitoring Meetings.
7.d CCM UR and BHRS audit tools will be implemented	Jack Pizzoli	09/01/12	08/01/13	Audit results	Audit tool training completed and tool has been implemented. Scores for Q4 2013 will be reported at the March 2014 CBHNP QI/UM Committee Meeting. Completed – OMHSAS follow-up on Audit Results for Quarter 4 and future results will be conducted as part of ongoing Quarterly Monitoring Meetings.
7.e Results of CCM audit tool will be used to monitor CCM performance.	Jack Pizzoli	03/01/13	08/15/13	CCM Audit results CCM Documentation Audit Policy CM-MS-038 outlining steps for performance issues identified through the audit. Audit Policy submitted to OMHSAS for approval.	UR and BHRS audit tools received by OMHSAS. Results for Quarter 4 (OCT-DEXC 2013) will be reported at March 2013 CBHNP QI/UM Committee Meeting. CM-MS-038 submitted to OMHSAS reviews and approved.



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
					Completed – OMHSAS follow-up on Audit Results for Quarter 4 and future results will be conducted at ongoing Quarterly Monitoring Meetings.
<p>Standard 28: Required Action</p> <p>Increase training, mentoring and monitoring of CMs with the following objectives.</p> <p>To promote recovery and resilience principles during the care management review process.</p> <p>To promote the identification and application of EPBs as part of the care management process, especially as it relates to considering alternative levels of care and formulating effective discharge plans.</p> <p>To improve documentation in the following areas:</p> <p>Exploration of community based alternatives prior to inpatient and PRTF admissions.</p> <p>Development of meaningful discharge plans that address environmental supports, barriers to engagement with outpatient treatment, sufficient detail about post discharge treatment that goes beyond listing the post discharge service setting to address changes in treatment necessary to increase community tenure and quality of life.</p> <p>Identification of QOC issues with referral to a PC for review, with attendant documentation that the PC review went beyond medical necessity to address the QOC concern.</p> <p>Evidence of active care management, including attempts to impact the quality of care by addressing diagnostic issues, gaps in care, lack of progress or relapse through promoting appropriate use of EBPs, recover/resilience principles and more meaningful treatment plans to improve client engagement. This should be followed by setting expectations for additional information or changes in care by the next review and follow-up on these issues at the enr review, etc.</p> <p>Better documentation of denial determinations, including attempts to gather sufficient clinical information (i.e., symptom history, frequency, intensity and severity), the criteria used to make the denial determination (i.e., PCPC, ASAM, Appendix T, bulletins) and the recommended alternate level of care with confirmation of its availability.</p> <p>Date Completed: 09/27/2013</p>					
8.a Provide CCM training to focus on active care management skills including the promotion of recovery and resiliency principles and the promotion of EBP, especially as it relates to considering alternate levels of care and discharge planning.	Dr. Ed Toyer	08/01/12	12/01/13	Training curriculum Attendance sheets	<p>Clinical Training Plan is final and includes active care management topics. Evidence Based Practice and Recovery and Resiliency training are included in the training Plan See 10 b for curriculum for Recover and Resiliency.</p> <p>8/7/13 EBP Training scheduled 9/10/13; Recovery and Resiliency training scheduled in 14.</p> <p>Completed – OMHSAS follow-up on completion of trainings will be conducted as part of ongoing Quarterly Monitoring Meetings.</p>
8.b Provide CCM and PA training to	Jack Pizzoli	08/01/12	12/01/13	CCM and PA training plan	CCM and PA Care Management Training



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
improve documentation in the exploration of community based alternatives prior to inpatient and PRTF admissions; development of discharge plans; identification of QOC issues and PA referral; demonstration of active care management; and documentation of denial determinations.				Attendance Sheets	Plan submitted to OMHSAS. Does not specify CCM and PA. 8/7/13 EBP Training schedule 9/10/13; Recovery and Resiliency training Completed – OMHSAS follow-up on completion of trainings and conform training plan includes CCMs and Pas, will be conducted as part of ongoing Quarterly Monitoring Meetings.
8.c Revise Care Management audit tool to more effectively assess the CCMs' degree of active care management.	Jack Pizzoli	09/01/12	08/01/13	Revised audit tool to monitor	URE and BHRS audit tools received by OMHSAS. Results for Quarter 4 (OCT-DEC 2013) will be reported at March 2013 CBHNP QI-UM Committee Meeting. Completed
8.d Implementation of the audit tool to assess CCM analysis of the clinical data, understanding of member needs, addressing provider issues such as lack of information or gaps in care, and exploration of EBP options in accordance with the Auditing Policy, Initial benchmark is 80%.	Jack Pizzoli	01/01/13	03/30/14	Report of Audit results Supervisory notes with documentation of corrective actions (if available).	UR and BHRS audit tools received by OMHSAS. Results for Quarter 4 (OCT-DEC 2013) will be reported at March 2013 QI/UM Committee Meeting. Completed – OMHSAS follow-up on Audit Results for Quarter 4 and future results will be conducted at ongoing Quarterly Monitoring Meetings.
Standard 28: Required Action Increase training and monitoring of CMs and PCs to improve the identification and referral of QOC concerns to PCs for consultation. Date Completed: 09/27/2013					
9.a Update CCM Case Consult guidelines for CCM to PA for quality of care	Dr. Jerri Maroney	08/01/12	01/30/13	Documentation of revised CCM Case Consult Guidelines for CCM to PA and PA to PA Case Consults	Updated Case Consult Guidelines for CCM to PA and PA to PA; received by OMHSAS.



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
concerns; Update CCM Case Consult guidelines PA to PA for quality of care concerns.				for QOC Concerns.	Completed
9.b Develop and implement CCM and PA training with expectations for addressing QOCC concerns	Dr. Jerri Maroney	02/01/13	05/01/13	Training curriculum Training attendance sheets	Training Curriculum Training Attendance Sheets received for Capital. Training Attendance Sheets needed for NC training conducted. Clinical Department Training record form received by OMHSAS, which documents that Peer to Peer Guidelines were distributed to Pas on 8/7/13 review. Completed – OMHSAS follow-up on NC Attendance Sheets will be conducted as part of ongoing Quarterly Monitoring Meetings.
9.c Monitor trend in consultation of quality of care concerns to PA's by CCMs.	Nancy Kocher	02/01/13	03/01/13	Report of CCM to PA consults for quality of care reviews	Copy of CCM PA Consult Report received by OMHSAS. CBHNP indicated the Staff to Physician Consult report is reviewed by the CCM supervisors to assure that CCMs consistently refer quality concerns to Pas review. If it is noted that a CCM has few referrals, retraining is provided. Completed
10.d Monitor trend in consultation of quality of care concerns by PA to PA	Nancy Kocher	02/01/13	03/01/13	Report of PA to PA consults for quality of care reviews	PA consult reports are reviewed by clinical management to monitor trends. Copies of sample PA to PA consult reports and review notes received by OMHSAS. CBHNP indicates the QOCC process is utilized



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
					to monitor quality of care concerns that have been referred for PA to PA review. Completed
<p>Standard 28: Required Action</p> <p>Amend documentation audit and other monitoring tools and protocols to assess for:</p> <p>Active care management as noted in corrective action plan (CAP) #2 (effective promotion of recovery and resilience principles, EBPs and active care management as noted under Longitudinal care management findings).</p> <p>Compliance with policy and procedures and related triggers for a consultation for both CMs and PCs.</p> <p>Date Completed: 09/27/2013</p>					
10.a Revise Care Management audit tool to more effectively assess the CMs' degree of active care management including the promotion of recovery and resiliency principles, the promotion of Evidence Based Practices, and the identification of quality of care issues.	Jack Pizzoli	09/01/12	03/30/14	Revised CCM audit tool	UR and BHRS audit tools received by OMHSAS. Results for Quarter 4 (OCT_DEC 2013) will be reported at March 2013 CBHNP QI/UM Committee Meeting. Completed
10.b Provide CCM training to focus on active care management skills including the promotion of recovery principles, the promotion of EBP and the identification of QOC issues.	Dr. Ed Toyer	09/01/12	12/01/13	Training curriculum Supervisory notes with documentation of corrective actions (if available).	Clinical Training Plan is final and includes active care management topics. See 8b for Training Plan. Copy of curriculum is provided in 10b 1) and 10c 1), for EBP and Recovery and Resiliency, respectively. Completed – OMHSAS follow-up on CBHNP Audit Results and supervisory corrective actions in accordance with Auditing policy for Quarter 4 and future results will be conducted at ongoing Quarterly Monitoring Meetings.
<p>Standard 28: Required Action</p> <p>Develop and implement clear protocols to guide ECM activities, including policies regarding frequency and nature of ECM contacts. Develop ECM reports that address the number of members identified, referred and engaged in the ECM program as well as ECM outcomes such as readmission rates and treatment engagement.</p>					



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
Date Completed: 09/27/2013					
11.a Revise ECM Policy to better guide ECM activities and distinguish from High Profile case management, Field Care Management, or Local Care Management. Policy will include the frequency and nature of ECM contacts.	Jack Pizzoli	08/01/12	10/01/13	Revised ECM Policy and Procedures approved by OMHSAS	Guidelines developed to define high profile and EMC criteria. ECM policy still under revision with target completion date revised to 10/01/13. New policy created to include all Active Care Management Programs. CM-050 Care Management Programs was approved at CQI on 8/8/13 and is currently under review by Oversight. Incomplete – OMHSAS follow-up on P&P CM-050 will be coordinated as part of ongoing Quarterly Monitoring Meetings.
11.b Train Care Managers on ECM Policy revisions	Jack Pizzoli	04/01/13	07/01/13	Training attendance sign in sheets	Pending approval of Policy CM-050. Incomplete – OMHSAS follow-up on completion of planned trainings will be conducted as part of ongoing Quarterly Monitoring Meetings.
11.c Develop ECM reports with the Informatics department to identify members meeting contract specific ECM criteria for assignment in ECM program, those engaged in ECM and outcomes.	Nancy Kocher	10/01/12	10/01/13	Automated reports to identify, assign members for ECM program, and monitor participation in ECM. Report to measure ECM outcomes for readmission rate and treatment engagement.	Project is in development. IT moved completion date to 10/01/13. Incomplete – OMHSAS follow-up on completion of IT project development will be conducted as part of ongoing Quarterly Monitoring Meetings.
Standard 86: Required Action CBHNP must improve the oversight of the provider network and develop an effective process of identifying provider performance concerns, tracking and trending provider performance and taking efficacious actions when deficiencies in service quality and performance are substantiated. In addition to informing all providers of profiling results, the identification of poor performing providers would consistently trigger follow up with these individual providers and drive network initiatives (i.e., provider training) to address system wide issues or to reward high performing providers. Date Completed: 09/27/2013					
12.a Development and use of a Provider	Sheryl Swanson	08/01/12	01/31/13	Final Provider Performance Tool and Training Instructions	Copy of Provider Performance tool received



Recommendation					
Major Action Steps	Lead Staff Responsible	Start Date	Planned Completion Date	Documented Evidence of Completion	Field Office Staff Comments
Performance measuring tool that takes into account providers that are deficient and require corrective steps.				for use of tool (one document). Attendance sheets as evidence of completion of AE and CCM training on use of the Provider Performance Tool.	by OMHSAS. Account Executive (1/4/12), and Capital and NC CCM (11/15/12 and 11/21/12), Training Attendance Sheets received by OMHSAS. Completed.
12.b Develop trending reports to identify the need for progressive action when deficiencies are substantiated and remain unaddressed by provider.	Sheryl Swanson	08/01/12	01/31/13	Quarterly provider trend report Protocol for use of reports by Account Executives	Copies of Quarterly Provider Trending reports have been provided for OMHSAS review. Memo dated February 6, 2012 from Sheryl Swanson to CBHNP Network Providers, provided to OMHSAS. Memo outlines areas providers will receive feedback. Memo states information will be reported back to providers through Provider Relations Representative. Memo states PRR will be meeting more frequently with providers to review performance and to provide consultation to promote improvement where needed. Copy of Protocol is needed. Completed – OMHSAS follow-up on Protocol will be conducted as part of ongoing Quarterly Monitoring Meetings.
12.c Define Actions to be taken when deficiencies in provider service and performance are substantiated. Policy update to include protocol for actions to be taken.	Sheryl Swanson	08/01/12	01/31/13	Policy approved by OMHSAS.	PR-024 Progressive Disciplinary Actions for Providers Policy approved by OMHSAS and implemented. Completed



Additional documents for CBHNP:



PEPS Blair 2011 CAP
7-24-13 Docushare.d



TMCA 2011 PEPS
CAP.doc

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, PerformCare (CBHNP) was required to prepare a Root Cause Analysis and Action Plan for the following performance measures and quality indicators:

- Readmission within 30 Days of Inpatient Psychiatric Discharge

PerformCare submitted a Root Cause Analysis and Action Plan in October 2013.

Table 4.3 Root Cause Analysis for PerformCare – Readmission within 30 Days of Inpatient Psychiatric Discharge *

Performance Measure	
Readmission within 30 Days of Inpatient Psychiatric Discharge*	
Goal Statement	
Short Term goal: Decrease 30 day readmission rate by 0.5% per quarter Long Term goal: Decrease 30 day readmission rate by 2% over the next measurement year	
Findings:	
CBHNP's rate for Readmission within 30 days on Inpatient discharge performance measure did not meet the 10% goal for MY 2011. CBHNP's rate had no statistically significant change from MY 2010 to 2011 but was statistically significantly below/poorer than the MY 2011 HealthChoices BH-MCO Average of 12.34% by 2.46%.	
Policies	Initial Response
(e.g., data systems, delivery systems, provider facilities) • Data Systems • Prior Authorization of Medication • Adequate clinic time to	<ul style="list-style-type: none"> • Current reporting is reviewed quarterly, however, it lacks the detail necessary to determine trends, identify barriers or Member specific details. Detail is reviewed manually and is not always feasible for the volume of Members served in all contracts. The data that is collected is based on claims and is therefore not considered to be "real time" reporting. The 2011 Readmission rates for all counties are as follows: Bedford 8.3% Blair 14.7% Clinton 11.2% Cumberland 14.1%



<p>provide injectable medication</p> <ul style="list-style-type: none"> • Policy barrier to accessing injectable medication 	<p>Dauphin 19.3% Franklin 13.2% Fulton* 11.4% Lancaster 13.6% Lebanon 15.7% Lycoming 12.4% Perry* 15.0% Somerset 13.1%</p> <p>* Caution should be exercised when interpreting results for small populations because large differences in rates do not necessarily mean there is a statistically significant difference in rates.</p> <p>To ensure active care management, inpatient discharges are reviewed daily by clinical management to identify Members to be referred to the Enhanced Case Management (ECM) program and other Member Monitoring initiatives.</p> <p>Root Cause: Limited, real time reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system.</p> <ul style="list-style-type: none"> • Providers report that the Prior Authorization of Medication is often very time consuming. <p>Root Cause: Across PH-MCOs the process for prior authorizing medication is not standard and is often dictated by medication and category of medication. This can lead to MH IP facilities not prescribing second generation antipsychotic medications.</p> <ul style="list-style-type: none"> • Providers report that there is not adequate clinic time available to provide injectable medication to Members post discharge which complicates discharge planning. <p>Root Cause: The demand for injectable medications has increased at a greater rate than providers can accommodate.</p> <p>Follow-up Status Response</p>
<p>Procedures (e.g., payment/reimbursement, credentialing/collaboration)</p> <p>Adequate providers who lack training and credentialing specialized services such as DBT</p>	<p>Initial Response</p> <ul style="list-style-type: none"> • MH IP units report that there are not adequate providers to provide specialized services such as DBT for Members. • Data suggest that Members who have more than 3 MH IP readmissions were involved with Substance Use and had a diagnosis of personality disorder. In 2012, of the 478 High Risk Members who had an MH IP admission, 275 of those Members were also receiving services for substance abuse. • Providers in Franklin/Fulton have recently attended EMDR training. <p>Root Cause: There are an inadequate number of Providers who are certified to provide specialized services such as Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR) and providers who are Co-occurring competent in the provider network. Without specialized services available to address specific issues such as trauma and substance abuse Members may not receive adequate treatment needed to stay in the community.</p> <p>Follow-up Status Response</p>
<p>People (e.g., personnel, provider network, patients)</p> <ul style="list-style-type: none"> • Clinical Case Manager • Follow Up Specialist • Member 	<p>Initial Response</p> <ul style="list-style-type: none"> • Member(s) reported that they feel the discharge instructions are too confusing, they are not always included in the planning process with no input into times and dates, provider choice of the follow up appointment and day of discharge planning appears rushed. Lastly, some Members felt the Discharge Planner was “too busy” to talk to them about details or that they needed a family member or natural support person to be present with them when discharge information was reviewed. • Results of the discharge planning audit continue to reveal that family and friends are not documented to be included in the discharge process which can complicate follow up.

- QI Clinical/Manager
- Providers- MH IP, MH OP, TCM
- Peer Support Specialist in MH IP units

- Results of discharge planning audit continue to also reveal that some MH IP providers do not provide education on Recovery tools such as WRAP at discharge.

AREAS OF REVIEW		2010 Overall Avg.	2011 Overall Avg.
1	Was discharge planning initiated within 24 hours of admission?	88%	88%
2	Does the record reflect collaboration with other MH providers at admission?	70%	68%
3	Does the record reflect collaboration with family concerning follow up care?	67%	74%
4	Did follow-up plans identify Natural or Community Supports?	16%	32%
5	Is there documentation in the record that barriers to follow up treatment were discussed with the Member and addressed?	43%	70%
6	Is there documentation that Member was present or in agreement with appoints that were made for follow up?	38%	90%
7	Was the TCM included in the discharge planning process (if applicable)?	61%	88%
8	Is there a relapse prevention plan (post-discharge) that reflects what steps a Member should take if symptoms escalate which includes activities based on strengths? This must consist of phone numbers for 1) natural supports, 2) provider(s), and 3) Crisis Intervention.	64%	77%
9	Was the follow up treatment date within 7 days of discharge?	77%	73%
10	Was the CBHNP Member letter distributed to our Members at time of discharge? (Distributed via Provider Portal 10/7/2010).	n/a *	11%
11	Does the group schedule reflect at least 3 Recovery practices or principles?	56%	94%

- Clearly, there is a slight increase in collaboration with family and friends with an improvement of 67% to 74%, however this remains below Best Practice standards. Additionally community supports identified at time of discharge doubled from 16% to 32%. However this remains well below expectations. Although IP units are addressing barriers to treatment (an increase from 43% to 70%), ironically the follow up rate within 7 days decreased from 77% to 73%. On a positive note the IP units are reporting that Members were present and in agreement with their aftercare appointments 90% of the time in 2011, which is an increase from 38% in 2010. Last, TCM involvement improved from 61% to 88%. Furthermore, Recovery Practices are more utilized on the MH IP units in 2011. The group schedules reflected at least 3 Recovery Practices or Principles 94% of the time in comparison to 56% seen last year.

Root Cause: Best Practice Discharge Processes and Procedures are not completely being followed by many MH IP providers which compounds Member's lack of engagement. Lack of Recovery Practices during MH IP admissions further prohibits engagement in treatment.

- There is a lack of Certified Peer Support (PSS) on staff at MH IP units to assist Members with discharge planning and working with Members while on the MH IP unit. PSS staff are able to provide opportunities for individuals receiving services to direct their own recovery and advocacy process; teach and support acquisition and utilization of the skills needed to facilitate an individual's recovery; promote the knowledge of available service options and choices; promote the utilization of natural resources within the community; and facilitate the development of a sense of wellness and self-worth.
- There is a small number of Members participating in Certified Peer Support Services (PSS). In 2011 only 38 Members participated in PSS 30 days after discharge and 33 Members participated in PSS 60 days after discharge from a MH IP admission.

Root Cause: Utilization of Certified Peer Support (PSS) in the community and MH IP units is poor. PSS are able to assist Members with discharge planning and connecting with natural supports in the community setting that can lead to better involvement with follow-up treatment and decrease readmission to MH IP. Additionally there may be an inadequate pool of certified peer specialists who are



	<p>actively looking for employment. This needs to be reviewed and examined to rule out as a possible cause.</p> <ul style="list-style-type: none"> Involuntary vs. voluntary admissions. Counties reports that it is difficult to divert voluntary admissions and Emergency Room physicians often override or prevent diversion to occur. In 2011 there were a total of 4,943 voluntary admissions compared to 643 involuntary admissions. <p>Root Cause: There is inadequate provider next day appointments available for diversion of MH IP stays which leads emergency room physicians to admit the Member to an inpatient unit.</p> <p>Follow-up Status Response</p>
<p>Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)</p> <ol style="list-style-type: none"> Provider Education Enrollee Education Provider Profiling 	<p>Initial Response</p> <ul style="list-style-type: none"> Results of discharge planning audit continue to also reveal that some MH IP providers do not provide education on Recovery tools such as WRAP at discharge. There appears to be a lack of Member understanding of Recovery principles, treatment options and necessity of follow up to avoid relapse. <p>Root Cause: Providers are not thoroughly informed about Recovery Principles and/or are not encouraging Members to develop a Crisis Plan which leads to poor crisis intervention and ultimately can lead to Member readmission.</p> <p>Follow-up Status Response</p>
<p>Other</p>	<p>Initial Response</p> <p>None</p> <p>Follow-up Status Response</p> <p>None</p>
<ul style="list-style-type: none"> Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance. Complete next page of corresponding action plan. 	

<p>Measure: Readmission within 30 Days of Inpatient Psychiatric Discharge*</p> <p>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.</p>		
Action	Implementation Date	Monitoring Plan
<p>Root Cause: Limited, real time reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system.</p> <p>Action: Modifications to current reporting will be requested through IT. Currently all reporting is claims based and real time data cannot be extrapolated.</p> <ul style="list-style-type: none"> QI staff will advocate the need for real time reporting at meetings with IT Department. QI staff will meet with IT business analysts to review current reports and discuss possible need for additional data. QI staff will monitor reporting quarterly. 		<p>Initial Response</p> <ul style="list-style-type: none"> Quality Management will continue to advocate for the completion of requests for more real time reportable data. Quality Clinical Managers will continue to review readmission rates quarterly, correlate data manually, and initiate new action steps in response to the data results. QI Management will complete Provider Profiling for both Inpatient and Outpatient levels of care. Quality Management will support the assessment of access & availability of psychiatrist, psychologists, <p>Follow-up Status Response</p>
	Ongoing	
	Ongoing	
	Ongoing	



<p>Root Cause: Across PH-MCOs the process for prior authorizing medication is not standard and is often dictated by medication and category of medication. This can lead to MH IP facilities not prescribing second generation antipsychotic medications.</p> <p>Action: CBHNP Medical Director began employment in September 2013 and will participate in the Physical Health Managed Care Medical Director's meeting.</p> <p>Medical Director will attend Medical Director's Meeting that is held between Medical Directors of Physical Health Managed Care Plans, Behavioral Health Managed Care Plans and Office of Medical Assistance.</p>	<p>12/13</p>	<p>Initial Response</p> <ul style="list-style-type: none"> • The Medical Director will attend the Medical Director's Meeting when scheduled. • Medical Director will make recommendations for appropriate prior authorization protocols for medication categories most often used to address behavioral health issues. • Medical Director will discuss prior authorization process with Medical Directors from other PH and BH MCOs to advocate for consistency in processes among PH-MCOs. <p>Follow-up Status Response</p>
<p>Root Cause: The demand for injectable medications has increased at a greater rate than providers can accommodate.</p> <p>Action: Because of Medicare rules a physician needs to be present when a nurse injects medication in order to be able to bill for the service. Because of this obstacle, there is a limited number of clinic hours available to provide injections.</p> <p>CBHNP Account Executives will survey the provider network to determine the status of providers who provide injection clinics.</p> <p>Network Operations will discuss the importance of this service with providers to solicit more hours if needed.</p>		<p>Initial Response</p> <ul style="list-style-type: none"> • Account Executives will assess the availability of access to injectable medication. • QI Manager will explore progressive outpatient clinic models and implementation models for the use of injectable medications to be reviewed through the Communities of Practice group and explored locally with each contract oversight. • Account Executives will monitor the availability of physicians to provide supervision that is required to provide injectable medications at medication clinics. • Account Executives will begin educating providers in selected best practice models. <p>Follow-up Status Response</p>
<p>Root Cause: There are an inadequate number of Providers who are certified to provide specialized services such as Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR) and providers who are Co-occurring competent in the provider network. Without specialized services available to</p>		<p>Initial Response</p> <ul style="list-style-type: none"> • Network Operations will continue to monitor network capacity of providers who are specialized in trauma informed care and specialization such as DBT and EMDR. • Provider Advisory Committee (PAC) will review EMDR as a possible new technology and support the use in treatment. • CBHNP will continue to offer stipends for providers to attend trainings in the several areas including trauma informed care and co-occurring treatment and be reimbursed monetarily by CBHNP. • Quality Improvement Manager will explore incentive options for providers who develop and implement specialized outpatient services which are more effective



<p>address specific issues such as trauma and substance abuse Members may not receive adequate treatment needed to stay in the community.</p> <p>Action: There is not an adequate amount of providers who provide DBT and (EMDR). Franklin/Fulton and B/S continue to expand the Comprehensive Continuous Integrated System of Care (CCISC) program in their counties.</p> <ul style="list-style-type: none"> • Roxbury Psychiatric Hospital is expanding to include treatment for adolescents. Staff is trained in co-occurring treatment. • CCM will continue to encourage MH IP discharge planner to choose a provider that meets the Member's needs. • Continued Stipend program which enables providers to obtain training on trauma and co-occurring treatment and be monetarily reimbursed by CBHNP. • Account Executives will educate providers on importance of trauma informed care. • Continue to monitor outcome of CCISC in Franklin/Fulton and Bedford Somerset to see if readmission rates decrease and more Members are identified as receiving co-occurring treatment. • Monitor the success of EMDR in the Franklin/Fulton by reviewing re-admission rates. • Provider Advisory Committee (PAC) has identified EMDR as possible new technology. At the recommendation of the Communities of Practice Committee, the PAC will review EMDR as a new technology and support. 	<p>12/13</p> <p>Ongoing</p> <p>Ongoing</p> <p>12/13</p> <p>Ongoing</p> <p>10/13</p> <p>9/13</p>	<p>in meeting Member needs.</p> <ul style="list-style-type: none"> • Quality Improvement Staff will monitor the number of providers who utilize training stipends and will promote the use of these funds so that providers are adequately informed to develop specialized services. • CBHNP will continue to support the development of CCISC practices to meet the individual needs of each contract through the local participation in the various CCISC workgroups. <p>Follow-up Status Response</p>
<p>Root Cause: Best Practice Discharge Processes and Procedures are not completely being followed by many MH IP providers which compound Member's lack of engagement. Lack of Recovery Practices during MH IP admissions further prohibits engagement in</p>		<p>Initial Response</p> <ul style="list-style-type: none"> • QMS will monitor MH IP treatment record review results annually and compare results to previous results. When trends are noted and results do not improve, MH IP facilities will be asked to submit a quality improvement plan. • Quality Management staff will continue to monitor Readmission Rates and correlate to each specific hospital. This information will be shared with High Volume providers in a report card format by Account Executives during quarterly meetings.



<p>treatment.</p> <p>Action: The QI Department will continue to educate and monitor MH IP units during treatment record auditing on Best Practice discharge guidelines with a focus on Recovery Principals and collaboration with family, natural supports and aftercare providers.</p> <ul style="list-style-type: none"> • Quality Management Specialist will complete MH IP treatment record review which includes indicators for discharge process. • CBHNP Account Executives will be given clinical information in the form a report card to remind providers during their respective visits of importance of follow-up and Recovery Principals. • CBHNP Member Services Staff (MSS) and Follow-Up Specialist will begin to outreach to Members and Providers to upon discharge from MH IP to confirm accurate discharge information, identify any barriers to follow-up appointments and off any assistance that might be needed. • CBHNP will continue to encourage the development of Crisis Bridge Programs that encourage the coordination of efforts for follow-up care. 	<p>Ongoing</p> <p>12/13</p> <p>9/13</p>	<ul style="list-style-type: none"> • MSS and Follow Up Specialist Staff will monitor the accuracy of discharge planning. They will gather information when speaking with Members during follow-calls that will be initiated when Member is discharged from a MH IP facility. • Account Executives will begin to use report card format to MH IP providers in quarterly meetings that will include information on the importance of follow-up and recovery principles. • CBHNP will continue to encourage the development of Crisis Bridge Programs with MH IP units. <p>Follow-up Status Response</p>
<p>Root Cause: Utilization of Certified Peer Support (PSS) in the community and MH IP units is poor. PSS are able to assist Members with discharge planning and connecting with natural supports in the community setting that can lead to better involvement with follow-up treatment and decrease readmission to MH IP. Additionally there may be an inadequate pool of certified peer specialists who are actively looking for employment. This needs to be reviewed and examined to rule out as a possible cause.</p> <p>Action: Currently there are no MH IP units that have PSS on staff; however the two EAC units have</p>		<p>Initial Response</p> <ul style="list-style-type: none"> • Monitor the readmission rates for the four MH IP units that will have the PSS on staff compare to those MH IP facilities that do not have PSS staff. • QI Staff will continue to participate in the PSS workgroup at CABHC. • QI will continue to monitor the utilization of Peer Support Services in the QI/UM meetings. • Network Operations will monitor the capacity of Peer Support Providers in the network. • Through CABHC re-investment dollars, four Peer Support Specialists will be hired to work directly on MH IP units. <p>Follow-up Status Response</p>



<p>PSS on staff.</p> <ul style="list-style-type: none"> • Encourage MH IP units to utilize PSS in the MH IP unit. • Capital Reinvestment plan will place 4 certified peer specialist In MH IP units. • Monitor the number of PSS in the network who is actively seeking employment to determine if there is adequate peer support certified and available. • CBHNP will explore the feasibility of recommended documentation guidelines for PSS and engage all contracts in the review of proposed guidelines. • Increase capacity of Providers of Peer Support Services. 	<p>10/13</p> <p>12/13</p> <p>10/13</p> <p>10/13</p> <p>Ongoing</p>	
<p>Root Cause: There are inadequate provider next day appointments available for diversion of MH IP stays which leads emergency room physicians to admit the Member to an inpatient unit.</p> <p>Action:</p> <ul style="list-style-type: none"> • NHS is proposing a program utilizing PCP, Nurse Navigators and a Peer Support Specialist as a possible means of diverting from a MH IP stay. Members will be seen the next day by a team member. • Discuss with additional providers to determine if other providers are interested in this type of diversion. • CBHNP will explore Rapid Access diversion to MH inpatient. • Measure programs individual outcomes created to determine the success of the program. 		<p>Initial Response</p> <ul style="list-style-type: none"> • Quality improvement will measure the outcomes set forth by each provider for the program that will include how many Members were seen and how many were diverted. • Programs currently being explored by CBHNP include: <ul style="list-style-type: none"> * Lancaster Transformation Model * Dauphin Co. Same day Diversion proposal * PPI-Evidence Based Proposal of discharge nurse dispensing medication. <p>Follow-up Status Response</p>
<p>Root Cause: Providers are not thoroughly informed about Recovery Principles and/or are not encouraging Members to develop a Crisis Plan which leads to poor crisis intervention and ultimately can lead to Member readmission.</p> <p>Action: Address the lack of Crisis Plans with both Providers and Members and stress the importance of utilization of the plans to avoid readmission when possible.</p>		<p>Initial Response</p> <ul style="list-style-type: none"> • QI Staff will continue to monitor through the quality treatment record reviews if providers are incorporating Crisis Planning in their discharge. • QI Staff will review data through reporting by MSS if Member had a Crisis Plan and if it was used to divert from inpatient admissions. <p>Follow-up Status Response</p>



<ul style="list-style-type: none"> • UR CCM will continue to encourage MH IP and PHP Providers during utilization reviews to utilize the development of a Crisis Plan prior to discharge. 	Ongoing	
<ul style="list-style-type: none"> • Part of treatment plan audit tool. 	Ongoing	
<ul style="list-style-type: none"> • Increase the number of MH IP Treatment Plan audits. 	1/14	
<ul style="list-style-type: none"> • MSS will conduct pilot initiating follow-up call to Members upon discharge from a MH IP discharge identify any barriers to follow up and inquire if Member has a Crisis Plan. 	9/13	
<ul style="list-style-type: none"> • Reinvestment plan to add PSS to MH IP units to encourage Members and educate staff and promote on recover principles. Encourage Mental Health Providers to adopt Recovery Principals. 	12/13	
	Ongoing	

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 PerformCare'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

- PerformCare's rate for the MY 2011 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI B was statistically significantly higher than the QI B HealthChoices BH MCO Average by 3.2 percentage points.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all three Subparts associated with Structure and Operations Standards.
 - Within Subpart C: Enrollee Rights and Protections Regulations, PerformCare was partially compliant on one out of seven categories – Enrollee Rights.
 - PerformCare was partially compliant on five out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Practice Guidelines, and 5) Quality Assessment and Performance Improvement Program.
 - PerformCare 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.
- PerformCare submitted one PIP for validation in 2013. PerformCare received no credit for Sustained Improvement.
- PerformCare's rate for the MY 2012 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.

Additional strengths and targeted opportunities for improvement can be found in the BH MCO-specific 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.*



PerformCare

KEY POINTS

- **A - Performance is notable. No action required. BH MCOs may have internal goals to improve.**

- No PerformCare performance measure rate fell into this comparison category.

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

- Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)

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

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

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

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)
- Readmission within 30 Days of Inpatient Psychiatric Discharge¹

- **F - Root cause analysis and plan of action required.**

- No PerformCare performance measure rate fell into this comparison category.

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



PerformCare (formerly Community Behavioral HealthCare Network of Pennsylvania, CBHNP)

Figure 1.1: Performance Measure Matrix – PerformCare

		HealthChoices BH MCO Average Statistical Significance Comparison			
		Trend	Below / Poorer than Average	Average	Above / Better than Average
Year to Year Statistical Significance Comparison	▲		C	B	A
	No Change		D REA ¹	C FUH QI A	B FUH QI B
	▼		F	D	C

Key to the Performance Measure Matrix Comparison

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

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 – PerformCare

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)	54.2% =	57.4% ▲	59.4% =	58.2%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	72.8% ▼	76.7% ▲	78.0% =	74.8%
Readmission within 30 Days of Inpatient Psychiatric Discharge ²	13.0% =	14.8% =	14.1% =	12.8%

^{1,2} Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



PerformCare (formerly Community Behavioral HealthCare Network of Pennsylvania, CBHNP)

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

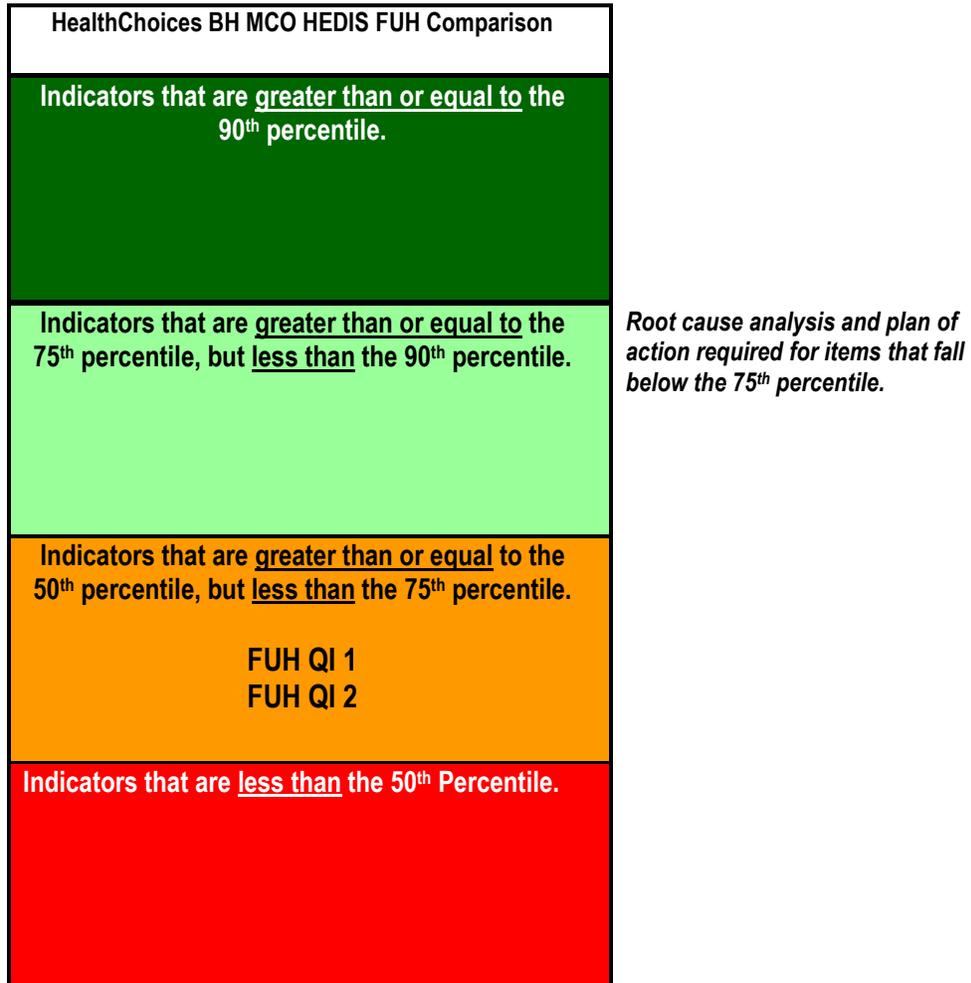


Figure 2.2: HEDIS Follow-Up After Hospitalization (FUH) 7-day/30-day Performance Measure Rates – PerformCare

Quality Performance Measure	MY 2012 Rate	HEDIS 2013 75 th ile
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	47.2% Not Met	54.8%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	71.5% Not Met	75.7%

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



VI: SUMMARY OF ACTIVITIES

Structure and Operations Standards

- PerformCare was partially compliant on Subparts C, 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

- PerformCare submitted one PIP for validation in 2013. PerformCare received no credit for Sustained Improvement.

Performance Measures

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

2011 Opportunities for Improvement MCO Response

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

2012 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for PerformCare 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	<ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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.
§438.2104	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law,



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

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



BBA Category	PEPS Reference	PEPS Language
		measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
§438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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	

BBA Category	PEPS Reference	PEPS Language
		Management Denial Summary Report for the respective review year.
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.	
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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



BBA Category	PEPS Reference	PEPS Language
		C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.408 Resolution and notification: Grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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



BBA Category	PEPS Reference	PEPS Language
		Management Denial Summary Report for the respective review year.
§438.410 Expedited resolution of appeals	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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



BBA Category	PEPS Reference	PEPS Language
		and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.424 Effectuation of reversed appeal resolutions	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • 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.
	Standard 68.9	Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.
Grievances and State Fair	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need



Category	PEPS Reference	PEPS Language
Hearings		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 PerformCare 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. All 11 OMHSAS-specific PEPS Substandards were evaluated for Blair, Franklin, Fulton and CABHC Counties. The remaining NC/CO Counties - Bedford, Clinton, Lycoming and Somerset – were evaluated on 10 of the substandards. For these counties, there was one Substandard that was not scheduled or not applicable for evaluation for RY 2012. Tables C.1a and C.1b provide a count of these Items, along with the relevant categories.

Table C.1a OMHSAS-Specific Substandards Reviewed for Blair, Franklin, Fulton and CABHC Counties

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

Table C.1b OMHSAS-Specific Substandards Reviewed for Bedford, Clinton, Lycoming and Somerset Counties

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	Not Reviewed
Complaints (Standard 68)	4	0	4	0	0
Grievances and State Fair Hearings (Standard 71)	4	0	4	0	0
Consumer/Family Satisfaction (Standard 108)	3	2	0	0	1

*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.



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, or not met) and/or applicable RAI tools (i.e., complete or 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 standards³, and all eight substandards were evaluated for PerformCare. PerformCare met seven substandards and partially met on one item, as seen in Table C.2.

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

Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
Complaints	Standard 68.6	RY 2011	Met
	Standard 68.7	RY 2011	Met
	Standard 68.8	RY 2011	Met
	Standard 68.9	RY 2011	Partially Met
Grievances and State Fair Hearings	Standard 71.5	RY 2011	Met
	Standard 71.6	RY 2011	Met
	Standard 71.7	RY 2011	Met
	Standard 71.8	RY 2011	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.

PerformCare was “partially met” on Substandard 68.9:

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

The OMHSAS-specific Substandards relating to Enrollee Satisfaction are County-specific review standards. Blair and the CABHC Counties were evaluated on three substandards and compliant on all three substandards. Franklin and Fulton County were evaluated on three substandards, met two substandards, and partially met on one item. Bedford, Clinton, Lycoming and Somerset Counties were evaluated on two of the three substandards, and met both substandards. Tables C.3a and C.3b provide a count of these substandards.

³ 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.3a OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for Bedford, Blair, Clinton, Franklin, Fulton, Lycoming, and Somerset Counties (All NC/CO Counties)

Category	PEPS Item	Review Year	Status by County		
			Met	Partially Met	Not Reviewed*
Enrollee Satisfaction					
Consumer/Family Satisfaction	Standard 108.3	RY 2012	Blair, Franklin, Fulton,		Bedford, Clinton, Lycoming, Somerset
	Standard 108.4	RY 2012	All NC/CO Counties		
	Standard 108.9	RY 2012	Bedford, Blair, Clinton Lycoming, Somerset	Franklin, Fulton,	

* 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

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

Franklin and Fulton Counties were "partially met" on Substandard 108.9:

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

Table C.3b OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for CABHC Counties (Cumberland, Dauphin, Lancaster, Lebanon and Perry)

Category	PEPS Item	Review Year	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Standard 108.3	RY 2012	Met
	Standard 108.4	RY 2012	Met
	Standard 108.9	RY 2012	Met



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