Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services

2014 External Quality Review Report
Magellan Behavioral Health
FINAL REPORT

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REPORT CONTENT

GLOSSARY OF TERMS

Average (i.e., arithmetic mean or mean)	The sum of all items divided by the number of items in the list. All items have an equal contribution to the calculation; therefore, this is un-weighted.
Confidence Interval	Confidence interval (CI) is a range of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% CI indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would be within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the CI 95 times, or 95% of the time.
HealthChoices Aggregate Rate	The sum of all behavioral health (BH) managed care organization (MCO) numerators divided by the sum of all BH-MCO denominators.
HealthChoices BH-MCO Average	The sum of the individual BH-MCO rates divided by the total number of BH-MCOs (five BH-MCOs). Each BH-MCO has an equal contribution to the HealthChoices BH-MCO Average value.
HealthChoices HC BH Contractor Average	The sum of the individual HC BH Contractor rates divided by the total number of HC BH Contractors (34). Each HC BH Contractor has an equal contribution to the HC BH Contractor 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.

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 Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2014 EQRs for the HealthChoices Behavioral Health (BH) MCOs and to prepare the technical reports. This technical report includes seven core sections.

I: Structure and Operations Standards
II: Performance Improvement Projects
III: Performance Measures
IV: Quality Study
V: 2013 Opportunities for Improvement - MCO Response
VI: 2014 Strengths and Opportunities for Improvement
VII: 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 and reviews conducted by OMHSAS of the BH-MCOs, as well as the oversight functions of the County or contracted entity when applicable, 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. The Performance Measure validation as conducted by IPRO included a repeated measureument of two Performance Measures – Follow-up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. For the first year, IPRO produced a third Performance Measure, Initiation and Engagement of Alcohol and Other Drug Dependance Treatment. The results of this measure is being studied by PA DHS/OMHSAS, and the data presentation will be included in the 2015 EQR BBA Technical Report.

Section IV contains the results of a Quality Study conducted by OMHSAS and IPRO that examines the HealthChoices Behavioral Health readmission rate, and conducts analysis to determine what factors correlate with an increased 30, 60, or 90 day readmission rate.

Section V, 2013 Opportunities for Improvement – MCO Response, includes the BH-MCO's responses to opportunities for improvement noted in the 2013 EQR Technical Report, and presents the degree to which the BH-MCO addressed each opportunity for improvement.

Section VI has a summary of the BH-MCO's strengths and opportunities for improvement for this review period (2014) 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 VII provides a summary of EQR activities for the BH-MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA Regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

I: STRUCTURE AND OPERATIONS STANDARDS

This section of the EQR report presents a review by IPRO of the BH-MCO Magellan Behavioral Health's (MBH's) compliance with the structure and operations standards. In Review Year (RY) 2013, 63 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 agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program; the mandatory managed care program that provides Medical Assistance recipients with services to treat mental health and/or substance abuse diagnoses/disorders. Forty-three of the 67 counties have signed agreements using the right of first opportunity and have sub-contracted with a private sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four counties have elected not to enter into a capitated agreement and as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties. For economy of scale, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the HC BH Contractors while providing an oversight function of the BH-MCOs.

Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. All counties associated with MBH are individual HC BH Contractors.

In some cases the HealthChoices Oversight Entity is the HealthChoices Behavioral Health (HC BH) Contractor, and in other cases multiple HC BH Contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. Operational reviews are completed for each HealthChoices Oversight Entity. The Department holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH Contractors, who in turn, contracts with a private sector BH-MCO. The HC BH Contractor is responsible for their regulatory compliance to federal and state regulations, and the HC BH PS&R Agreement compliance. The HC BH PS&R Agreement includes the HC BH Contractor's responsibility for the oversight of BH-MCO's compliance. The table below shows the name of the HealthChoices Oversight Entity, the associated HealthChoices HC BH Contractor(s), and the county(ies) encompassed by each HC BH Contractor.

Table 1.0 HealthChoices Oversight Entities, HC BH Contractors, and Counties.

HealthChoices Oversight Entity	HC BH Contractor	County
Bucks County Behavioral Health	Bucks County	Bucks County
Delaware County – "DelCare Program"	Delaware County	Delaware County
Lehigh County HealthChoices	Lehigh County	Lehigh County
Montgomery County Behavioral Health	Montgomery County	Montgomery County
Northampton County	Northampton County	Northampton County

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of MBH by OMHSAS monitoring staff within the past three Review Years (RYs 2013, 2012, 2011). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS' PEPS review tools for Review Year (RY) 2013.

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 HealthChoices Oversight Entities 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 2014 and entered into the PEPS tools as of October 2014 for RY 2013. 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 HealthChoices Oversight Entity/BH-MCO. Within each standard, the tool specifies the sub-standards or Items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional reviewer comments. Based on the tools, a HealthChoices Oversight Entity/BH-MCO is evaluated against sub-standards 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 2013 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 HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS Substandards from RY 2013, RY 2012, and RY 2011 provided the information necessary for the 2014 assessment. Those standards not reviewed through the PEPS system in RY 2013 were evaluated on their performance based on RY 2012 and/or RY 2011 decisions, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities 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.

For MBH, this year a total of 163 Items were identified as being required for the evaluation of HealthChoices Oversight Entity/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 MBH against the Structure and Operations Standards for this report. In Appendix C, Table C.1 provides a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH-MCO and associated HealthChoices Oversight Entities against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for MBH

Table 1.1 Substandards Pertinent to BBA Regulations Reviewed for MBH

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2013	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	Not Reviewed*
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	5	0	7	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	24	7	4	12	1
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	3	0	0	1
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	2	4	0	0
Quality Assessment and Performance Improvement Program	23	16	7	0	0
Health Information Systems	1	0	1	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	10	0	0	1
General Requirements	14	13	0	0	1
Notice of Action	13	6	0	6	1
Handling of Grievances and Appeals	11	10	0	0	1
Resolution and Notification: Grievances and Appeals	11	10	0	0	1
Expedited Appeals Process	6	5	0	0	1
Information to Providers and Subcontractors	2	2	0	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	5	0	0	1
Effectuation of Reversed Resolutions	6	5	0	0	1

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

For RY 2013, 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, DHS has been granted an allowance to offer only one BH-MCO per County. Compliance for the Cost Sharing category is not assessed by PEPS Substandards, as any cost sharing imposed on Medicaid enrollees is in accordance with CMS regulation 42 CFR 447.50-447.60.

Before 2008, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all HC BH Contractors and BH-MCOs based on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. In 2008, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories. In this 2014 report, the Solvency tracking reports and the quarterly reporting of Complaint and Grievances data were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

Determination of Compliance

To evaluate HealthChoices Oversight Entity/BH-MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring substandards by provision, and evaluated the HC BH Contractors' 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 HealthChoices Oversight Entity/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 HealthChoices Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as partially compliant. If all Items were not met, the HealthChoices Oversight Entity/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 HealthChoices Oversight Entity/BH-MCO's compliance with BBA regulations as an element of the analysis of their strengths and weaknesses. In addition, this level of analysis avoids any redundancy with the detailed level of review found in the PEPS documents.

Findings

For MBH and the five HealthChoices Oversight Entities/HC BH Contractors with the BH-MCO who were included in the structure and operations standards for RY 2013, 163 PEPS Items were identified as required to fulfill BBA regulations. Of the 163 PEPS Items, 153 Items were evaluated for MBH, and 10 Items were not scheduled or not applicable for evaluation for RY 2013.

Subpart C: Enrollee Rights and Protections

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

Table 1.2 Compliance with Enrollee Rights and Protections Regulations

Enrollee Rights and Protections				
Subpart C: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Partial	None	All MBH HC BH Contractors	12 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 12 substandards Each HC BH Contractor was compliant on 9 substandards and non-compliant on 3 substandards.
Provider-Enrollee Communications 438.102	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections E.4 (p.52) and A.3.a (p.20).
Marketing Activities 438.104	N/A	N/A	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH-MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections A.9 (p.64) and C.2 (p.32).
Cost Sharing 438.108	Compliant	All MBH HC BH Contractors		Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	All MBH HC BH Contractors		Compliant as per PS&R section 3 (p.37).
Solvency Standards 438.116	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections A.3 (p.59) and A.9 (p.64), and 2013-2014 Solvency Requirements tracking report.

Based on the PEPS substandards reviewed, all MBH HC BH Contractors were compliant on six categories of Enrollee Rights and Protections Regulations as per the HealthChoices PS&R, and one category as per CMS Regulation 42 CFR 447.50-447.60. The category Solvency Standards was also compliant based on the 2013-2014 Solvency Requirement tracking report. One category, Marketing Activities, was Not Applicable.

Of the 12 PEPS substandards that were crosswalked to the category Enrollee Rights, all 12 were evaluated for each HC BH Contractor. All HC BH Contractors associated with MBH were compliant on 9 items and non-complaint on 3 items.

Enrollee Rights

All HC BH Contractors associated with MBH were partially compliant with Enrollee Rights due to non-compliance with three of three substandards within PEPS Standard 60: Substandards 1, 2, and 3 (RY 2013).

PEPS Standard 60: Complaint/Grievance Staffing. The BH-MCO shall identify a lead person responsible for overall coordination of the complaint and grievance process, including the provision of information and instructions to members. (Responsibility includes HIPAA Privacy duties related to complaints and mechanisms for tracking and reporting of HIPAA related complaints.) The BH-MCO shall designate and train sufficient staff responsible for receiving, processing and responding to member complaints and grievances in accordance with the requirements contained in Appendix H. All BH-MCO staff shall be educated concerning member rights and the procedure for filing complaints and grievances.

> **Substandard 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.
>
> **Substandard 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.
>
> **Substandard 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.

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 HC BH Contractor include an assessment of the HC BH Contractors/BH-MCO's compliance with regulations found in Subpart D. Table 1.3 presents the findings by categories consistent with the regulations.

Table 1.3 Compliance with Quality Assessment and Performance Improvement Regulations

Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	**MCO Compliance Status**	**By HC BH Contractor**		**Comments**
		Fully Compliant	**Partially Compliant**	
Elements of State Quality Strategies 438.204	Compliant	All MBH HC BH Contractors		Compliant as per PS&R section G.3 (p.57).
Availability of Services (Access to Care) 438.206	Partial		All MBH HC BH Contractors	24 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards Each HC BH Contractors was compliant on 21 substandards, partially compliant on 1 substandard and non-complaint on 1 substandard.
Coordination and Continuity of Care 438.208	Partial		All MBH HC BH Contractors	2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards Each HC BH Contractors was partially compliant on 1 substandard and non-compliant on 1 substandard
Coverage and Authorization of Services 438.210	Partial		All MBH HC BH Contractors	4 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards Each HC BH Contractor was partially compliant on 2 substandards and non-complaint on 1 substandard.
Provider Selection 438.214	Compliant	All MBH HC BH Contractors		3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections D.2 (p.49), G.4 (p.59) and C.6.c (p.47).
Subcontractual Relationships and Delegation 438.230	Compliant	All MBH HC BH Contractors		8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards and compliant on 8 substandards.
Practice Guidelines	Partial		All MBH HC BH	6 substandards were crosswalked to this category.

Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
438.236			Contractors	Each HC BH Contractor was evaluated on 6 substandards. Each HC BH Contractor was partially compliant on 1 substandard and non-complaint on 1 substandard
Quality Assessment and Performance Improvement Program 438.240	Compliant	All MBH HC BH Contractors		23 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards and compliant on 23 substandards.
Health Information Systems 438.242	Compliant	All MBH HC BH Contractors		1 substandard was crosswalked to this category. Each HC BH Contractor was evaluated on 1 substandard and compliant on this substandard.

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

For this review, 71 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations. Each HC BH Contractor was evaluated on 69 substandards. There were 2 substandards not scheduled or not applicable for evaluation for RY 2013. All MBH HC BH Contractors were compliant on 60 substandards, partially compliant on 5 substandards, and non-compliant on 4 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.

Availability of Services (Access to Care)

All HC BH Contractors associated with MBH were partially compliant with Availability of Services due to partial or non-compliance with substandards of PEPS Standard 28.

PEPS Standard 28: Longitudinal Care Management (and Care Management Record Review). BH-MCO has a comprehensive, defined program of care that incorporates longitudinal disease management.

All MBH HC BH Contractors were non-compliant on one substandard of PEPS Standard 28, Substandard 1 (RY 2013):

> **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.

All MBH HC BH Contractors were partially compliant on one substandard of PEPS Standard 28, Substandard 2 (RY 2013):

> **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 HC BH Contractors associated with MBH were partially compliant with Coordination and Continuity of Care due to partial or non compliance with two substandards of PEPS Standard 28.

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 14 of this report.

Coverage and Authorization of Services

All HC BH Contractors associated with MBH were partially compliant with Coverage and Authorization of Services due to partial or non-compliance with substandards of PEPS Standards 28 and 72.

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 14 of this report.

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

All MBH HC BH Contractors were partially compliant with one substandard within PEPS Standard 72 (RY 2013)

> **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 HC BH Contractors associated with MBH were partially compliant with Practice Guidelines due to partial or non compliance with two substandards of PEPS Standard 28.

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 14 of this report.

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 HC BH Contractor/BH-MCO's compliance with regulations found in Subpart F. Table 1.4 presents the findings by categories consistent with the regulations.

Table 1.4 Compliance with Federal and State Grievance System Standards

Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All MBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 10 substandards, compliant on 5 substandards, partially compliant on 1 substandard,, and non-compliant on 4 substandards.
General Requirements 438.402	Partial		All MBH HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards, compliant on 5 substandards, partially compliant on 1 substandard, and non-compliant on 7 substandards.
Notice of Action 438.404	Partial		All MBH HC BH Contractors	13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 12 substandards and compliant on 11 substandards and partially compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All MBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 10 substandards, compliant on 5 substandards, partially compliant on 1 substandard, and non-compliant on 4 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All MBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 10 substandards, compliant on 5 substandards, partially compliant on 1 substandard, and non-compliant on 4 substandards.

Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Expedited Appeals Process 38.410	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5 substandards, compliant on 4 substandards and partially compliant on 1 substandard.
Information to Providers & Subcontractors 438.414	Partial		All MBH HC BH Contractors	2 substandards were crosswalked to this category. Each HC BH Contractor was compliant on 1 substandard and non-compliant on 1 substandard.
Recordkeeping and Recording Requirements 438.416	Compliant	All MBH HC BH Contractors		Compliant as per the required quarterly reporting of complaint and grievances data
Continuation of Benefits 438.420	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5 substandards and compliant on 4 substandards and partially compliant on 1 substandard.
Effectuation of Reversed Resolutions 438.424	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5 substandards, compliant on 4 substandards and partially compliant on 1 substandard.

MBH was evaluated for compliance on the 10 categories of Federal and State Grievance System Standards. MBH was compliant on one category and partially compliant on nine categories. The category Recordkeeping and Recording Requirements was compliant per the quarterly reporting of complaint and grievances data. Each MBH HC BH Contractor was compliant on one category and partially compliant on nine categories.

For this review, 80 substandards were crosswalked to this Subpart for all five MBH HC BH Contractors, and each HC BH Contractor was evaluated on 72 substandards. Eight substandards were not scheduled or not applicable for evaluation for RY 2013. The five HC BH Contractors were compliant on 44 substandards, partially compliant on 8 substandards and non-compliant on 20 substandards. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

The five MBH HC BH Contractors were partially compliant with 9 of the 10 categories pertaining to Federal State and Grievance System Standards due to partial or non-compliance with substandards within PEPS Standards 60, 68, and 72.

Statutory Basis and Definitions

All HC BH Contractors associated with MBH were partially compliant with Statutory Basis and Definitions due to partial or non-compliance with substandards of PEPS Standard 68 and PEPS Standard 72.

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

All MBH HC BH Contractors were non-compliant with four of the five substandards of Standard 68: Substandards 1, 3, 4 and 5 (RY 2013).

> **Substandard 1:** Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how the compliant rights and procedures are made known to members, BH-MCO staff and the provider network. 1. BBA Fair Hearing 2. 1st level 3. 2nd level 4.External 5.Expedited
>
> **Substandard 3:** Complaint decision letters must be written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
>
> **Substandard 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.
>
> **Substandard 5:** Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.

PEPS Standard 72: See standard description and determination of compliance under Quality Assessment and Performance Improvement Regulations on page 15 of this report.

General Requirements

All HC BH Contractors associated with MBH were partially compliant with General Requirements due to partial or non-compliance with substandards of PEPS Standards 60, 68 and 72.

PEPS Standard 60: See standard description and determination of compliance under Enrollee Rights on page 12 of this report.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions (above).

PEPS Standard 72: See standard description and determination of compliance under Quality Assessment and Performance Improvement Regulations on page 15 of this report.

Notice of Action

All HC BH Contractors associated with MBH were partially compliant with Notice of Action due to partial compliance with one substandard of PEPS Standard 72.

PEPS Standard 72: See standard description and determination of compliance under Quality Assessment and Performance Improvement Regulations on page 15 of this report.

Handling of Grievances and Appeals

All HC BH Contractors associated with MBH were partially compliant with Handling of Grievances and Appeals due to partial or non-compliance with substandards of PEPS Standards 68 and 72.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions on page 18 of this report.

PEPS Standard 72: See standard description and determination of compliance under Coverage and Authorization of Services on page 15 of this report.

Resolution and Notification: Grievances and Appeals

All HC BH Contractors associated with MBH were partially compliant with Resolution and Notification due to partial or non-compliance with substandards of PEPS Standards 68 and 72.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions on page 18 of this report.

PEPS Standard 72: See standard description and determination of compliance under Coverage and Authorization of Services on page 15 of this report.

Expedited Appeals Process

All HC BH Contractors associated with MBH were partially compliant with Expedited Appeals due to partial compliance with one substandard of PEPS Standard 72.

PEPS Standard 72: See standard description and determination of compliance under Coverage and Authorization of Services on page 15 of this report.

Information to Providers & Subcontractors

All HC BH Contractors associated with MBH were partially compliant with Information to Providers and Subcontractors due to partial compliance with Substandard 1 of PEPS Standard 68.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions on page 18 of this report.

Continuation of Benefits

All HC BH Contractors associated with MBH were partially compliant with Continuation of Benefits due to partial compliance with one substandard of PEPS Standard 72.

PEPS Standard 72: See standard description and determination of compliance under Coverage and Authorization of Services on page 15 of this report.

Effectuation of Reversed Resolutions

All HC BH Contractors associated with MBH were partially compliant with Effectuation of Reversed Resolutions due to partial compliance with one substandard of PEPS Standard 72.

PEPS Standard 72: See standard description and determination of compliance under Coverage and Authorization of Services on page 15 of this report.

II: PERFORMANCE IMPROVEMENT PROJECTS

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH-MCO. Under the existing HealthChoices Behavioral Health agreement with OMHSAS, HC BH Contractors along with the responsible subcontracted entities (i.e., BH-MCOs), are required to conduct a minimum of two focused studies per year. The HC BH Contractors 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 2014 for 2013 activities.

A new EQR PIP cycle began for BH-MCOs and HC BH Contractors in 2014. For this PIP cycle, OMHSAS selected the topic, "Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis" as the topic for this PIP. The topic was selected because the Aggregate HealthChoices 30-day Readmission Rate has consistently not met the OMHSAS goal of a rate of 10% or less. In addition, all HealthChoices BH-MCOs continue to remain below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS) Follow-Up After Hospitalization (FUH) metrics.

The Aim Statement for this PIP is "Successful transition from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices members hospitalized with a mental health or a substance abuse diagnosis." OMHSAS selected three common objectives for all BH-MCOs:

1. Reduce behavioral health and substance abuse readmissions post-inpatient discharge.
2. Increase kept ambulatory follow-up appointments post-inpatient discharge.
3. Improve medication adherence post-inpatient discharge.

Additionally, OMHSAS is requiring all BH-MCOs to submit the following core performance measures on an annual basis:

1. **Readmission within 30 Days of Inpatient Psychiatric Discharge (Mental Health Discharges)**
   The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days without a substance abuse diagnosis during the initial stay.
2. **Readmission within 30 Days of Inpatient Psychiatric Discharge (Substance Abuse Discharges)**
   The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days with a substance abuse diagnosis (primary or secondary) during the initial stay.
3. **Adherence to Antipsychotic Medications for Individuals with Schizophrenia**
   The percentage of members diagnosed with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. This measure is based on the HEDIS measure of the same name.
4. **Components of Discharge Management Planning**
   This measure is based on review of facility discharge management plans, and assesses the following:
   a. The percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses and provider phone numbers.
   b. The percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses and provider phone numbers where at least one of the scheduled appointments occurred.

This PIP project will extend from January 2014 through December 2017, with initial PIP proposals submitted in 2014 and a final report due in June 2018. The non-intervention baseline period will be

January 2014 to December 2014. BH-MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. BH-MCOs will be required to submit interim reports in June 2016 and June 2017, as well as a final report in June 2018. BH-MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH Contractor-level and BH-MCO-level data, including clinical history and pharmacy data. This PIP is designed to be a collaboration between the HC BH Contractors and BH-MCOs. The BH-MCOs and each of their HC BH Contractors are required to collaboratively develop a root-cause/barrier analysis that identifies potential barriers at the BH-MCO level of analysis. Each of the barriers identified should include the contributing HC BH Contract level data and illustrate how HC BH Contractor knowledge of their high risk populations contributes to the barriers within their specific service areas. Each BH-MCO will submit the single root-cause/barrier analysis according to the PIP schedule.

This PIP was formally introduced to the BH-MCOs and HC BH Contractors during a Quality Management Directors meeting on June 4th 2014. During the latter half of 2014, OMHSAS and IPRO conducted follow-up calls with the BH-MCOs and HC BH Contractors as needed.

The 2014 EQR is the 11th review to include validation of PIPs. With this PIP cycle, all BH-MCOs/HC BH Contractors share the same baseline period and timeline. To initiate the PIP cycle in 2014, 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/HC BH Contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness.

The BH-MCOs are required by OMHSAS to submit their projects using a standardized PIP template 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 ten review elements:

1. Project Topic And Topic Relevance
2. Study Question (Aim Statement)
3. Study Variables (Performance Indicators)
4. Identified Study Population
5. Sampling Methods
6. Data Collection Procedures
7. Improvement Strategies (Interventions)
8. Interpretation Of Study Results (Demonstrable Improvement)
9. Validity Of Reported Improvement
10. Sustainability Of Documented Improvement

The first nine elements relate to the baseline and demonstrable improvement phases of the project. The last element relates 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

As 2014 is the baseline year, no scoring for the current PIP can occur for this review year. This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods.

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 the 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 will be evaluated for the same elements. The scoring matrix is completed for those elements that have been completed during the review year. 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. At the time each element is reviewed, a finding is given of "Met", "Partially Met", or "Not Met". Elements receiving a "Met" will receive 100% of the points assigned to the element, "Partially Met" elements will receive 50% of the assigned points, and "Not Met" elements will receive 0%.

Table 2.2 Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Topic And Topic Relevance	5%
2	Study Question (Aim Statement)	5%
3	Study Variables (Performance Indicators)	15%
4 / 5	Identified Study Population And Sampling Methods	10%
6	Data Collection Procedures	10%
7	Improvement Strategies (Interventions)	15%
8 / 9	Interpretation Of Study Results (Demonstrable Improvement) and Validity Of Reported Improvement	20%
Total Demonstrable Improvement Score		**80%**
10	Sustainability Of Documented Improvement	20%
Total Sustained Improvement Score		**20%**
Overall Project Performance Score		**100%**

Findings

As per the timeline distributed by OMHSAS for this review period, MBH was required to submit an initial proposal on November 2014. The initial proposal was reviewed by OMHSAS and IPRO and recommendations were provided to MBH. MBH was given the opportunity to schedule a technical assistance meeting to review their changes based on the initial review. MBH's assistance call occurred on February 2015.

MBH submitted their PIP proposal document for review in November 2014. As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care.

MBH's proposal included objectives that align with the proposal objectives, and MBH included a rationale for conducting the PIP based on literature review, focus group results, and survey results. There was no discussion of BH-MCO data regarding readmission rates, follow-up rates, or medication management rates. As the proposal was submitted prior to the end of the baseline year (2014) no baseline data was included in the proposal, nor were final goals set for improvement in subsequent years. These elements will be required for future PIP submissions.

MBH used a variety of methods to complete a barrier analysis including literature review, provider surveys, member surveys, an analysis of readmission rates and follow-up rates for their membership (overall, by admitting diagnosis, demographics, etc.). MBH did not identify barriers related to medication management.

MBH proposed a number of interventions for the first measurement year, including staff and provider trainings, expansions of their Co-Occurring Disorder and telepsychiatry programs, and the creation of a care coordination program "eMbraceCare".

IPRO and OMHSAS met with MBH to review their PIP in November 2014. MBH is required to revise and submit a final proposal in early 2015. There were no elements scored for this review period.

III: PERFORMANCE MEASURES

In 2014, OMHSAS and IPRO conducted three EQR studies. Both the Follow-up After Hospitalization for Mental Illness (FUH) and Readmission within 30 Days of Inpatient Psychiatric Discharge studies were re-measured. OMHSAS also elected to implement a statewide measure that focuses on substance abuse services, the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) HEDIS measure. The results of this measure will be reported in the 2015 BBA Technical Report.

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, HC BH Contractor, 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 follow-up 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 HC BH Contractor was added.

For MY 2013, three clarifications were made to the specifications, and two changes were made to the Performance Measure reporting.

The measure clarifications are: if a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim.

The first reporting change is that the performance measure results are aggregated at the HC BH Contractor level instead of at the County level as in previous years. The second reporting change is the addition of HEDIS 7 and 30 day rates for ages 6 to 64 years old as of the date of discharge. This age cohort is presented to align with OMHSAS performance measure goals for this measure.

Measure Selection and Description

In accordance with DHS 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 34 HC BH Contractors participating in the MY 2013 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, 2013;
- 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, 2013, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified, are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 1, 2013, The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2014 methodology for the Follow-up After Hospitalization for Mental Illness measure.

I: HEDIS Follow-up 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 Follow-up 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 HC BH Contractor 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

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 percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. The 3-year OMHSAS goal is to achieve the 75th percentile for ages 6-64, based on the annual HEDIS published percentiles for 7-day and 30-day FUH by Measurement Year 2016. For Measurement Years 2013 and 2015 BH-MCOs will be given interim goals for the next Measurement Year for both the 7 and 30 day follow-up rates based on their previous years' results.

The interim goals are defined as follows:

1. If a BH-MCO achieves a rate greater than or equal to the NCQA 75th percentile, the goal for the next Measurement Year is to maintain or improve the rate above the 75th percentile.
2. If a BH-MCO's rate is within 2% of the 75th percentile and above the 50th percentile, their goal for the next Measurement Year is to meet or exceed the 75th percentile.
3. If a BH-MCO's rate is more than 2% below the 75th percentile and above the 50th percentile, their goal for the next Measurement Year is to increase their current year's rate by 2%
4. If a BH-MCO's rate is within 2% of the 50th percentile, their goal for the next Measurement Year is to increase their rate by 2%
5. If a BH-MCO's rate is between 2% and 5% below the 50th percentile, their goal for the next Measurement Year is to increase their current year's rate by the difference between their current year's rate and the 50th percentile.
6. If a BH-MCO's rate is greater than 5% below the 50th percentile, their goal for the next Measurement Year is to increase their current year's rate by 5%.

Interim goals were provided to the BH-MCOs after the MY 2012 rates were received. The interim goals will be updated from MY 2013 to MY 2015. The interim goals are used the BH-MCOs progress in achieving the OMHSAS goal of the 75th percentile.

HEDIS percentiles for the 7- and 30-day FUH indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis for these indicators. As noted in Section V of this report, beginning with MY 2012 performance, and continuing for MY 2013, rates for the HEDIS FUH 7- and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request for a root cause analysis.

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 HealthChoices Aggregate 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 2012 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.

HC BH Contractors With Small Denominators

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for all HC BH Contractors. Caution should be exercised when interpreting results for small

denominators, as they produce rates that are less stable. Rates produced from small denominators are subject to greater variability, or greater margin of error.

Findings

BH-MCO and HC BH Contractor Results

The HEDIS follow-up indicators are presented for three age groups: Ages 6-64 years old, 6 years and older and ages 6-20 years old. The results for the 6-64 years old age group are presented to compare the BH-MCOs and HC BH Contractor results to the OMHSAS interim and final goals for this age group. The 6+ years old results are presented to show the follow-up rates for the overall HEDIS population, and the 6-20 year old age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old.

The results are presented at the BH-MCO and HC BH Contractor level when multiple HC BH Contractors 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 HC BH Contractors with the same contracted BH-MCO). The HC BH Contractor's-specific rates were calculated using the numerator and denominator for that particular HC BH Contractors. For each of these rates, the 95% Confidence Interval (CI) was reported. Both the HealthChoices BH-MCO Average and HealthChoices HC BH Contractors 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.

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

The HEDIS follow-up results for the 6-64 year old age group and the 6+ year old age groups are also compared to the MY 2013 HEDIS national percentiles. The HEDIS percentiles are based on results for the 6+ years old population. The percentile comparison for the ages 6-64 year old age group is presented to show BH-MCO and HC BH Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile by MY 2016. HEDIS percentile comparisons for the ages 6+ years old age group are presented for illustrative purposes only.

I: HEDIS Follow-up Indicators

(a) Age Group: 6-64 Years Old

As noted in the Performance Goal section, OMHSAS has elected to set a three year goal for both the HEDIS 7 day and 30 day follow-up measures for members ages 6 to 64 years old. The goal is for all HC BH Contractors and the BH-MCO rate to meet or exceed the HEDIS 75th percentile by Measurement Year 2015. For Measurement Years 2013 to 2015 BH-MCOs will be given interim goals for the next Measurement Year for both the 7 and 30 day follow-up rates based on their previous years' results. Table 3.1 below shows the Measurement Year 2013 results as compared to their Measurement Year 2013 goals and HEDIS percentiles.

Table 3.1 MY 2013 HEDIS Follow-up Indicator Rates: 6-64 years old

	MY 2013							MY 2012	RATE COMPARISON: MY 13 against MY 12			
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2013 Goal	2013 Goal Met?	%	PPD	Percent Change: MY 12 to MY 13*	SSD	HEDIS MY 2013 Medicaid Benchmarks
QI 1 – HEDIS 7 Day Follow-up for Ages 6-64 Years Old												
HealthChoices Aggregate	16,035	34,026	**47.1%**	46.6%	47.6%	48.5%	NO	47.5%	-0.4	-0.9%	NO	Below 75th, at or above 50th percentile
MBH	2,736	5,314	**51.5%**	50.1%	52.9%	48.2%	YES	47.3%	4.2	8.9%	YES	Below 75th, at or above 50th percentile
Bucks	475	917	**51.8%**	48.5%	55.1%	46.8%	YES	45.8%	6.0	13.0%	YES	Below 75th, at or above 50th percentile
Delaware	516	1,106	**46.7%**	43.7%	49.7%	44.7%	YES	43.1%	3.6	8.2%	NO	Below 75th, at or above 50th percentile
Lehigh	651	1,238	**52.6%**	49.8%	55.4%	48.8%	YES	47.9%	4.7	9.9%	YES	Below 75th, at or above 50th percentile
Montgomery	646	1,265	**51.1%**	48.3%	53.9%	47.5%	YES	46.6%	4.5	9.7%	YES	Below 75th, at or above 50th percentile
Northampton	448	788	**56.9%**	53.4%	60.4%	54.8%	YES	55.1%	1.8	3.3%	NO	At or above 75th Percentile
QI 2 – HEDIS 30 Day Follow-up for Ages 6-64 Years Old												
HealthChoices Aggregate	23,081	34,026	**67.8%**	67.3%	68.3%	69.5%	NO	68.1%	-0.3	-0.5%	NO	Below 75th, at or above 50th percentile
MBH	3,647	5,314	**68.6%**	67.3%	69.9%	66.5%	YES	65.2%	3.4	5.2%	YES	Below 75th, at or above 50th percentile
Bucks	616	917	**67.2%**	64.1%	70.3%	65.9%	YES	64.2%	3.0	4.6%	NO	Below 75th, at or above 50th percentile
Delaware	696	1,106	**62.9%**	60.0%	65.8%	64.6%	NO	61.5%	1.4	2.3%	NO	Below 50th, at or above 25th percentile
Lehigh	883	1,238	**71.3%**	68.7%	73.9%	67.0%	YES	65.7%	5.6	8.6%	YES	Below 75th, at or above 50th percentile
Montgomery	861	1,265	**68.1%**	65.5%	70.7%	65.9%	YES	64.4%	3.7	5.7%	NO	Below 75th, at or above 50th percentile
Northampton	591	788	**75.0%**	71.9%	78.1%	73.6%	YES	72.2%	2.8	4.0%	NO	At or above 75th Percentile

* Percentage change is the percentage increase or decrease of the MY 2013 rate when compared to the MY 2012 rate. The formula is: (MY 2013 Rate - MY 2012 Rate) / MY 2012 Rate

The MY 2013 HealthChoices Aggregate rates in the 6-64 year age group were 47.1% for QI 1 and 67.8% for QI 2. These rates were comparable to the MY 2012 HealthChoices Aggregate rates for this age cohort of 47.5% and 68.1%, respectively. The HealthChoices Aggregate HEDIS rates were below the MY 2013 interim goals of 48.5% for QI 1 and 69.5% for QI 2, therefore both interim goals were not met in MY 2013. The MY 2013 QI 1 and QI 2 rates both fell between the HEDIS benchmarks for the 50th and 75th percentile, therefore the OMHSAS goals of meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2013.

The MBH MY 2013 6-64 year old QI 1 rate of 51.5% and QI 2 rate of 68.6% were statistically significantly higher than the MBH MY 2012 rates by 4.2 and 3.4 percentage points, respectively. The MBH QI 1 of rate 51.5% was statistically significantly higher than the QI 1 HealthChoices BH-MCO average of 46.2% by 5.3 percentage points, and the MBH QI 2 rate of 68.6% was statistically significantly higher than the QI 2 BH-MCO average of 66.8% by 1.8 percentage points. MBH achieved its MY 2013 interim goals of 48.5% for QI 1 and 66.5% for QI 2. The MBH QI 1 and QI 2 rates fell between the HEDIS MY 2013 benchmarks for the 50th and 75th percentile, therefore the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by MBH in MY 2013.

As presented in Table 3.1, the 6-64 year old QI 1 rates for Bucks, Lehigh, and Montgomery had statistically significant increases over their MY 2012 rates by 6.0, 4.7 and 4.5 percentage points, respectively. The QI 2 rate for Lehigh statistically significantly increased between MY 2012 and MY 2013 by 5.6 percentage points, rising from 65.7% to 71.3%. All HC BH Contractors associated with MBH met their MY 2013 interim goals for QI 1. For QI 2, only one HC BH Contractor, Delaware, failed to meet its MY 2013 interim goal; the remaining four MBH HC BH Contractors achieved their respective MY 2013 QI 2 interim goals. Northampton achieved the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile for QI 1 and QI 2.

Figure 3.2 is a graphical representation of the MY 2013 6-64 year old HEDIS follow-up rates for MBH and its associated HC BH Contractors. Figure 3.3 shows the HealthChoices HC BH Contractor Average rates and the individual MBH HC BH Contractor rates that were statistically significantly higher or lower than the HC BH Contractor Averages for the 6-64 year age cohort. QI 1 rates for Montgomery, Bucks, Lehigh and Northampton were statistically significantly higher than the QI 1 HC BH Contractor Average of 45.5% by 5.6 to 11.4 percentage points. The QI 1 rate for Delaware was not statistically significantly different from the HC BH Contractor Average; therefore it is not included in Figure 3.3. The QI 2 rates for Lehigh and Northampton were statistically significantly higher than the QI 2 HC BH Contractor Average of 68.0% by 3.3 and 7.0 percentage points respectively, while the QI 2 rate for Delaware County was below the HC BH Contractor average by 5.1 percentage points. QI 2 rates for the remaining MBH HC BH Contractors were not statistically significantly different from the HC BH Contractor Average in this age cohort.

Figure 3.2: MY 2013 HEDIS Follow-up Indicator Rates: 6-64 Years Old

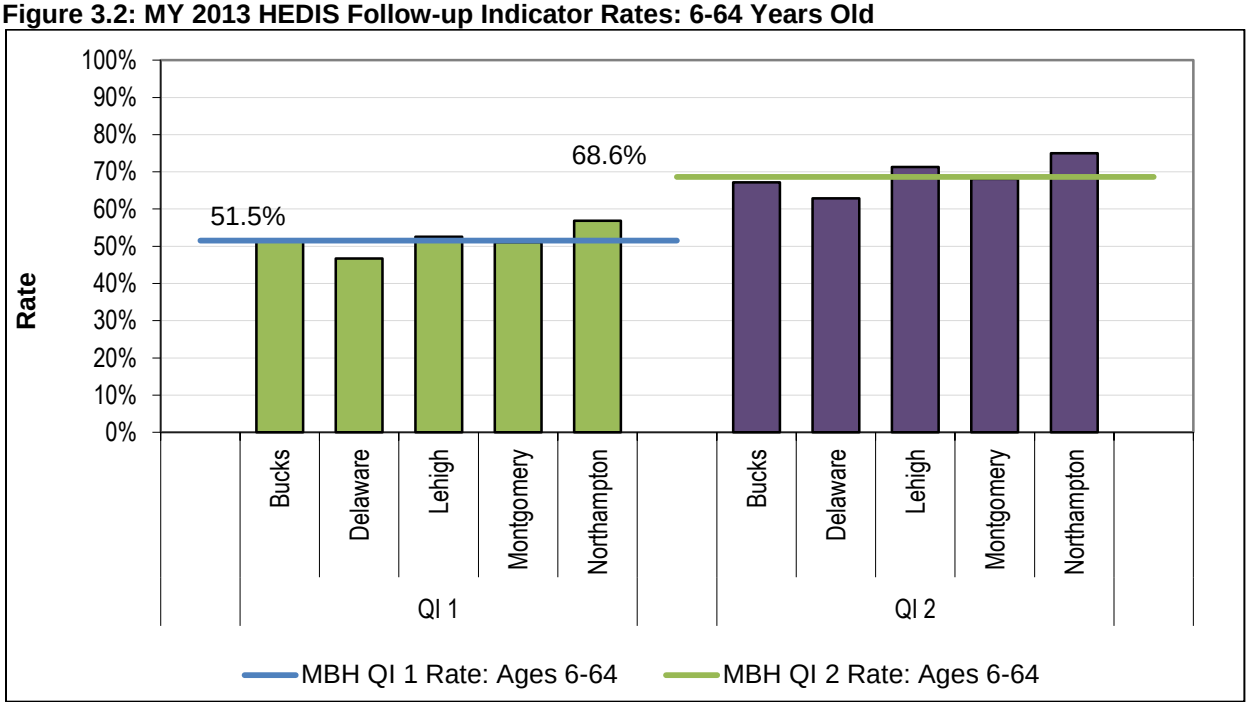
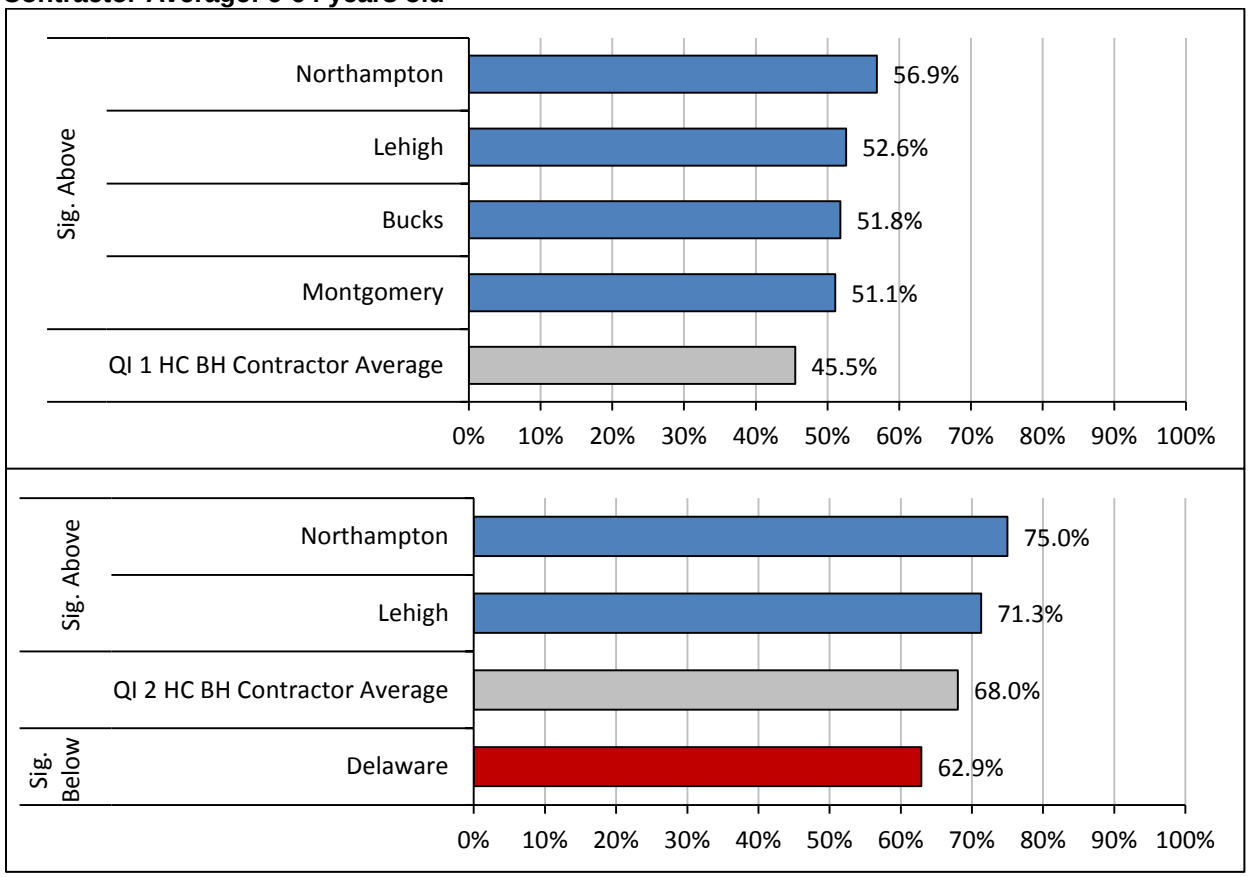


Figure 3.3: HEDIS Follow-up Indicator Rates Compared to MY 2013 HealthChoices HC BH Contractor Average: 6-64 years old



(b) Overall Population: 6+ years old

Table 3.4 MY 2013 HEDIS Follow-up Indicator Rates – Overall Population

	MY 2013							MY 2012	RATE COMPARISON of MY 2013 against MY 2012		
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	%	MY 2012 PPD	MY 2012 SSD	HEDIS MY 2013 Percentile
QI 1 – HEDIS 7 Day Follow-up for Ages 6+ Years Old											
HealthChoices Aggregate	16,196	34,564	**46.9%**	46.4%	47.4%	45.9%	45.2%	47.2%	-0.3	NO	Below 75th, at or above 50th percentile
MBH	2,766	5,389	**51.3%**	50.0%	52.6%			47.0%	4.3	YES	Below 75th, at or above 50th percentile
Bucks	477	922	**51.7%**	48.4%	55.0%			45.5%	6.2	YES	Below 75th, at or above 50th percentile
Delaware	526	1,126	**46.7%**	43.7%	49.7%			43.4%	3.3	NO	Below 75th, at or above 50th percentile
Lehigh	656	1,254	**52.3%**	49.5%	55.1%			47.3%	5.0	YES	Below 75th, at or above 50th percentile
Montgomery	656	1,287	**51.0%**	48.2%	53.8%			46.3%	4.7	YES	Below 75th, at or above 50th percentile
Northampton	451	800	**56.4%**	52.9%	59.9%			54.5%	1.9	NO	At or above 75th Percentile
QI 2– HEDIS 30 Day Follow-up for Ages 6+ Years Old											
HealthChoices Aggregate	23,332	34,564	**67.5%**	67.0%	68.0%	66.5%	67.7%	67.8%	-0.3	NO	Below 75th, at or above 50th percentile
MBH	3,688	5,389	**68.4%**	67.1%	69.7%			64.8%	3.6	YES	Below 75th, at or above 50th percentile
Bucks	618	922	**67.0%**	63.9%	70.1%			63.8%	3.2	NO	Below 75th, at or above 50th percentile
Delaware	709	1,126	**63.0%**	60.1%	65.9%			61.6%	1.4	NO	Below 50th, at or above 25th percentile
Lehigh	892	1,254	**71.1%**	68.6%	73.6%			65.1%	6.0	YES	Below 75th, at or above 50th percentile
Montgomery	874	1,287	**67.9%**	65.3%	70.5%			64.0%	3.9	YES	Below 75th, at or above 50th percentile
Northampton	595	800	**74.4%**	71.3%	77.5%			71.4%	3.0	NO	At or above 75th Percentile

The MY 2013 HealthChoices Aggregate rates were 46.9% for QI 1 and 67.5% for QI 2. These rates were not statistically significantly different from the MY 2012 HealthChoices Aggregate rates of 47.2% and 67.8%, respectively. The MBH MY 2013 QI 1 rate of 51.3% and QI 2 rate of 68.4% were statistically significantly higher than the MBH MY 2012 rates by 4.3 and 3.6 percentage points, respectively. Overall, MBH demonstrated the largest year over year rate increases in HEDIS Follow-up indicators among the five BH-MCOs evaluated in MY 2013. Additionally, MBH demonstrated the highest QI 1 rate of the five BH-MCOs. The MBH QI 1 rate was statistically significantly higher than the MY 2013 HealthChoices BH-

MCO average of 45.9% by 5.4 percentage points, and the MBH QI 2 rate was statistically significantly higher than the MY 2013 HealthChoices BH-MCO Average of 66.5% by 1.9 percentage points.

As presented in Table 3.4, the MY 2013 QI 1 rate for Bucks, Lehigh and Montgomery had statistically significant increases from their MY 2012 rates by 6.2, 5.0 and 4.7 percentage points, respectively. The MY 2013 QI 2 rates for Lehigh and Montgomery statistically significantly increased between MY 2012 and MY 2013 by 6.0 and 3.9 percentage points, respectively. The MY 2013 HEDIS rates for the remaining HC BH Contractors were not statistically significantly different from their MY 2012 rates. None of the MBH HC BH Contractors had statistically significant decreases in their HEDIS Follow-up indicator rates between MY 2012 and MY 2013.

Figure 3.5 is a graphical representation of the MY 2013 HEDIS follow-up rates for MBH and its associated HC BH Contractors. Figure 3.6 shows the HealthChoices HC BH Contractor Average rates and individual MBH HC BH Contractor rates that were statistically significantly higher or lower than the HC BH Contractor Averages. The QI 1 rates for Montgomery, Bucks, Lehigh and Northampton were statistically significantly higher than the QI 1 HC BH Contractor Average of 45.2% by 5.8 to 11.2 percentage points. None of the MBH HC BH Contractor rates for QI 1 were statistically significantly lower than the QI 1 HC BH Contractor Average. The QI 2 rates for Lehigh and Northampton were statistically significantly higher than the QI 2 HealthChoices HC BH Contractor Average of 67.7% by 3.4 and 6.7 percentage points respectively, while the QI 2 rate for Delaware County was below the average by 4.7 percentage points. HEDIS rates for the remaining MBH HC BH Contractors were not statistically significantly different from the HC BH Contractor Average, therefore they are not included in Figure 3.6.

Figure 3.5 MY 2013 HEDIS Follow-up Indicator Rates – Overall Population

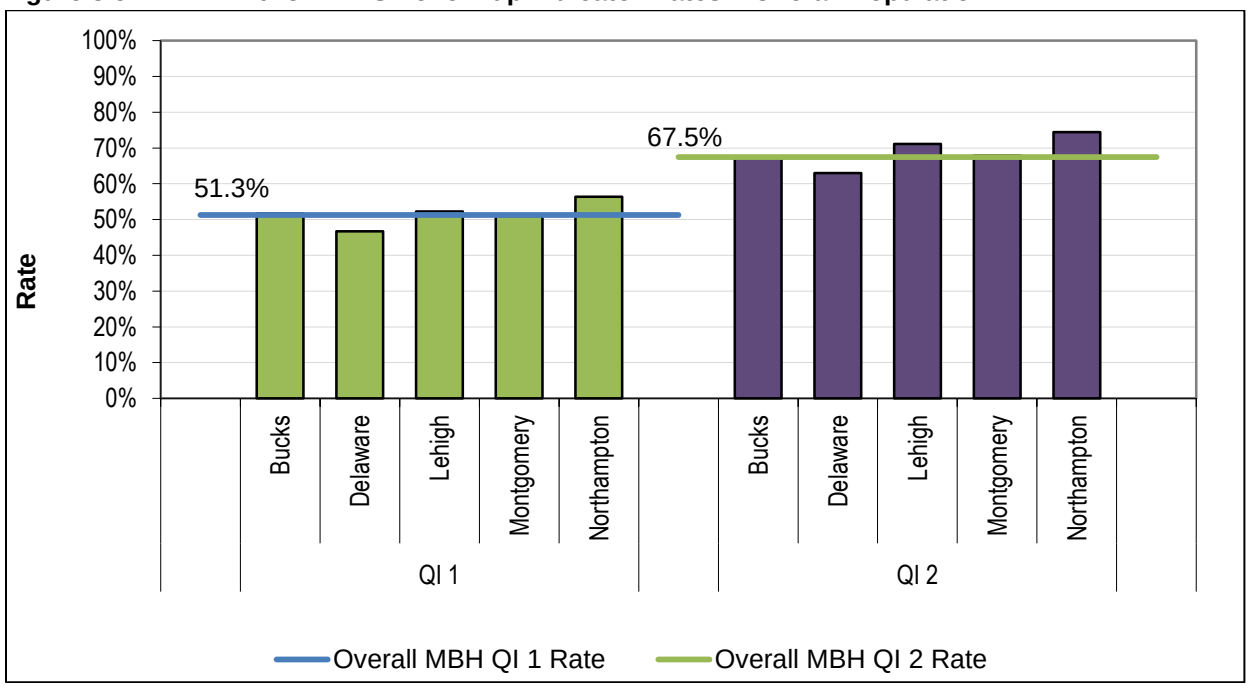
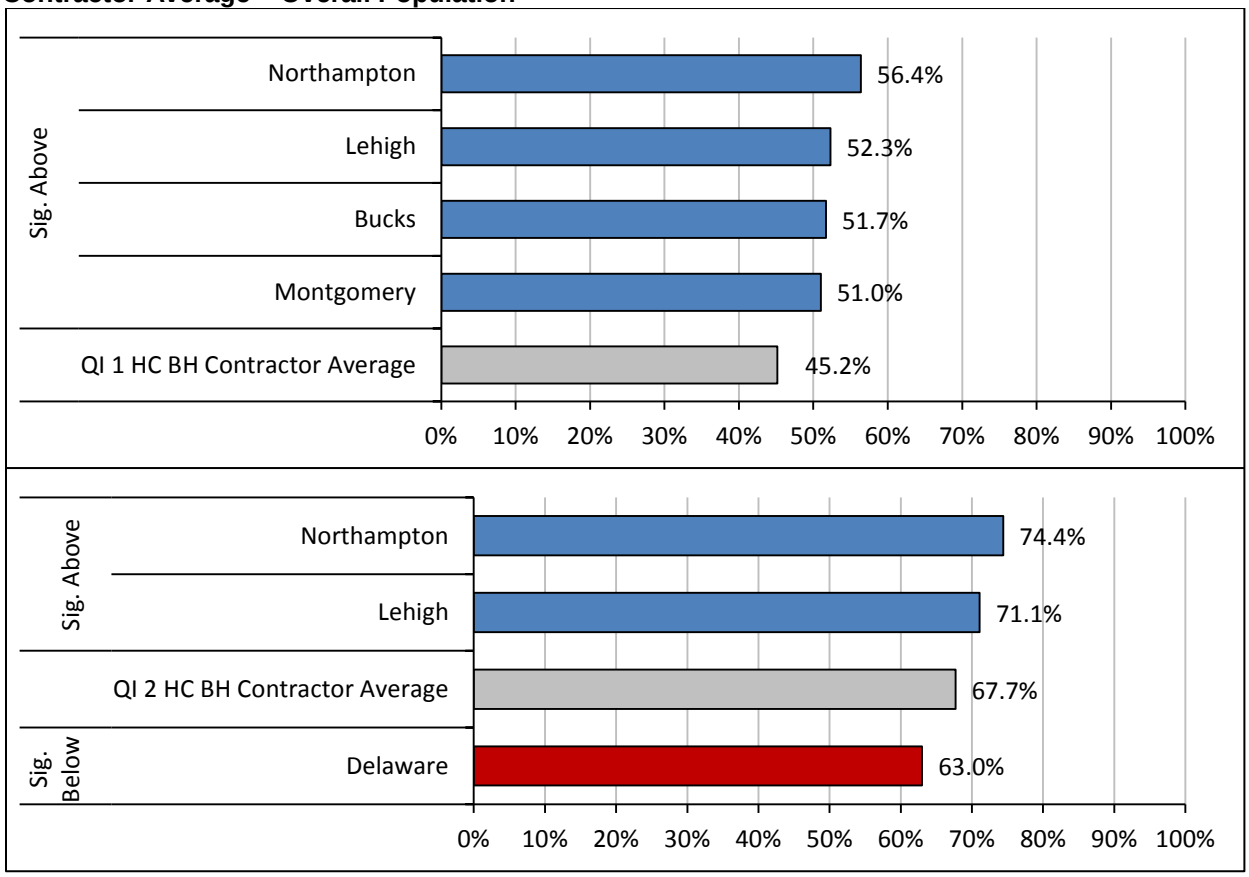


Figure 3.6 HEDIS Follow-up Indicator Rates Compared to MY 2013 HealthChoices HC BH Contractor Average – Overall Population



(c) Age Group: 6-20 Years Old

Table 3.7 MY 2013 HEDIS Follow-up Indicator Rates: 6-20 Years Old

	MY 2013							MY 2012		
	(N)	(D)	MY 2013 %	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2012 %	Rate Comparison of MY 13 against MY 12	
									PPD	SSD
QI 1 – HEDIS 7 Day Follow-up for Ages 6-20 Years Old										
HealthChoices Aggregate	5,382	9,604	**56.0%**	55.0%	57.0%	55.1%	55.2%	55.7%	0.3	NO
MBH	820	1,579	**51.9%**	49.4%	54.4%			48.5%	3.4	NO
Bucks	162	277	**58.5%**	52.5%	64.5%			47.4%	11.1	YES
Delaware	162	357	**45.4%**	40.1%	50.7%			43.2%	2.2	NO
Lehigh	183	348	**52.6%**	47.2%	58.0%			51.9%	0.7	NO
Montgomery	173	350	**49.4%**	44.0%	54.8%			45.4%	4.0	NO
Northampton	140	247	**56.7%**	50.3%	63.1%			56.5%	0.2	NO
QI 2 – HEDIS 30 Day Follow-up for Ages 6-20 Years Old										
HealthChoices Aggregate	7,374	9,604	**76.8%**	76.0%	77.6%	75.9%	77.4%	76.8%	0.0	NO
MBH	1,122	1,579	**71.1%**	68.8%	73.4%			68.0%	3.1	NO
Bucks	205	277	**74.0%**	68.7%	79.3%			67.0%	7.0	NO
Delaware	229	357	**64.1%**	59.0%	69.2%			63.4%	0.7	NO
Lehigh	254	348	**73.0%**	68.2%	77.8%			74.5%	-1.5	NO
Montgomery	236	350	**67.4%**	62.3%	72.5%			63.9%	3.5	NO
Northampton	198	247	**80.2%**	75.0%	85.4%			72.0%	8.2	YES

The MY 2013 HealthChoices Aggregate rates in the 6-20 year age group were 56.0% for QI 1 and 76.8% for QI 2. These rates were comparable to (i.e. not statistically significantly different from) the MY 2012 HealthChoices Aggregate rates for this age group, which were 55.7% and 76.8%, respectively. Similarly, the MBH QI 1 rate of 51.9% and MBH QI 2 rate of 71.1% in the 6-20 age cohort were not statistically significantly different from the prior year.

For MY 2013, the MBH QI 1 rate of 51.9% in the 6-20 year old age group was statistically significantly lower than the MY 2013 QI 1 HealthChoices 6-20 year BH-MCO average of 55.1% by 3.2 percentage points. The MBH QI 2 rate of 71.1% in the 6-20 year old age group was not statistically significantly different from the QI 2 HealthChoices BH-MCO average of 75.9%.

As presented in Table 3.7, the 6-20 year old QI 1 rate for Bucks County increased from 47.4% in MY 2012 to 58.5% in MY 2013, a statistically significant increase of 11.1 percentage points. The 6-20 year old QI 2 rate for Northampton statistically significantly increased between MY 2012 and MY 2013 by 8.2 percentage points, rising from 72.0% to 80.2%. The remaining HC BH Contractors did not have statistically significant HEDIS rate changes from MY 2012 in this age cohort.

Figure 3.8 is a graphical representation of the MY 2013 6-20 year old HEDIS follow-up rates for MBH and its associated HC BH Contractors. Figure 3.9 shows the HealthChoices HC BH Contractor Average rates and the individual MBH HC BH Contractor rates that were statistically significantly higher or lower than the MY 2013 HealthChoices HC BH Contractor Average for the 6-20 year age group. The QI 1 rates for Montgomery and Delaware were statistically significantly lower than the MY 2013 QI 1 HealthChoices HC BH Contractor Average of 55.2% by 5.8 and 9.8 percentage points, respectively. The QI 2 rates for

Montgomery and Delaware were statistically significantly lower than the QI 2 HealthChoices HC BH Contractor Average of 77.4% by 10.0 and 13.3 percentage points, respectively. HEDIS rates for the remaining MBH HC BH Contractors were not statistically significantly different from the HealthChoices HC BH Contractor Average for this age cohort.

Figure 3.8 MY 2013 HEDIS Follow-up Indicator Rates: 6-20 years old

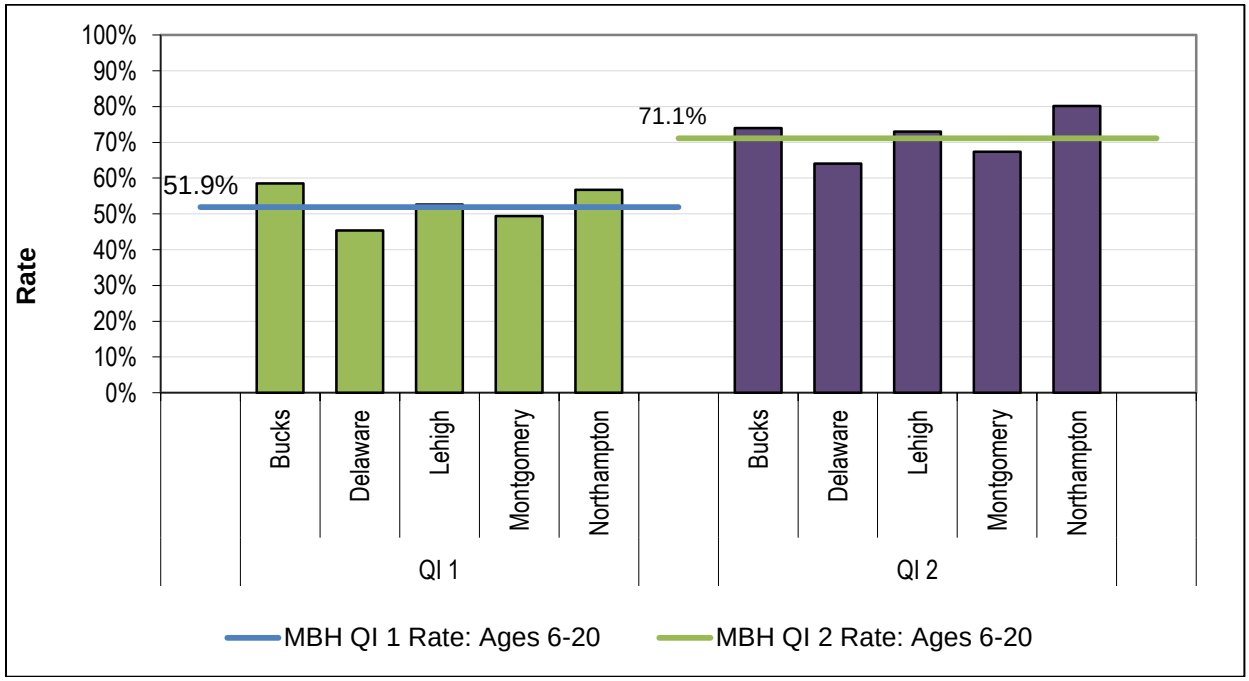
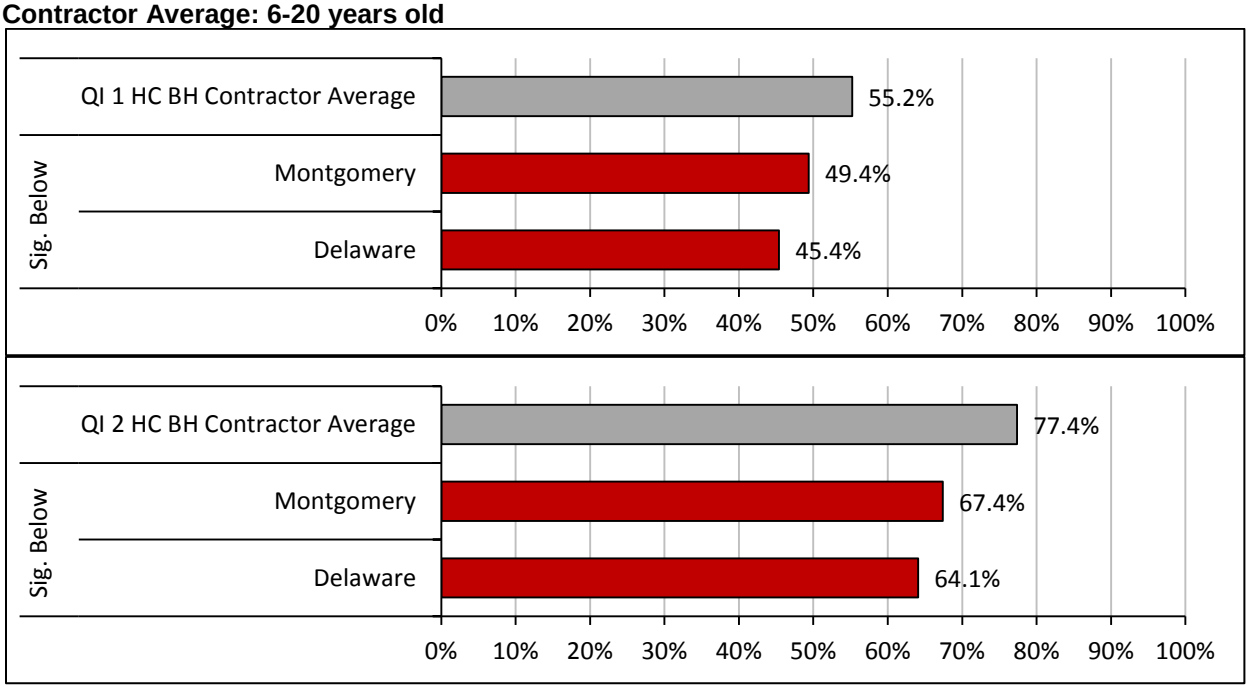


Figure 3.9 HEDIS Follow-up Indicator Rates Compared to MY 2013 HealthChoices HC BH Contractor Average: 6-20 years old



II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ years old

Table 3.10 MY 2013 PA-Specific Follow-up Indicator Rates with Year-to-Year Comparisons – Overall Population

	MY 2013							MY 2012		
	(N)	(D)	MY 2013 %	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2012 %	RATE COMPARISON of MY 13 against MY 12	
									PPD	SSD
QI A										
HealthChoices	19,687	34,564	**57.0%**	56.5%	57.5%	55.7%	55.7%	58.6%	-1.6	YES
MBH	3,366	5,389	**62.5%**	61.2%	63.8%			59.2%	3.3	YES
Bucks	563	922	**61.1%**	57.9%	64.3%			55.5%	5.6	YES
Delaware	704	1,126	**62.5%**	59.6%	65.4%			60.6%	1.9	NO
Lehigh	775	1,254	**61.8%**	59.1%	64.5%			57.2%	4.6	YES
Montgomery	803	1,287	**62.4%**	59.7%	65.1%			61.0%	1.4	NO
Northampton	521	800	**65.1%**	61.7%	68.5%			61.3%	3.8	NO
QI B										
HealthChoices	25,381	34,564	**73.4%**	72.9%	73.9%	72.3%	74.1%	75.0%	-1.6	YES
MBH	4,060	5,389	**75.3%**	74.1%	76.5%			73.2%	2.1	YES
Bucks	671	922	**72.8%**	69.9%	75.7%			69.1%	3.7	NO
Delaware	820	1,126	**72.8%**	70.2%	75.4%			73.3%	-0.5	NO
Lehigh	960	1,254	**76.6%**	74.2%	79.0%			72.5%	4.1	YES
Montgomery	976	1,287	**75.8%**	73.4%	78.2%			74.5%	1.3	NO
Northampton	633	800	**79.1%**	76.2%	82.0%			76.3%	2.8	NO

The MY 2013 HealthChoices Aggregate rates were 57.0% for QI A and 73.4% for QI B. These rates were statistically significantly lower than the MY 2012 HealthChoices Aggregate rates of 58.6% for QI A and 75.0% for QI B by 1.6 percentage points each. The MBH MY 2013 QI A rate of 62.5% and QI B rate of 75.3% were statistically significantly higher than the MBH MY 2012 rates by 3.3 and 2.1 percentage points, respectively. The MY 2013 MBH QI A rate of 62.5% was statistically significantly higher than the QI A HealthChoices BH-MCO average of 55.7% by 6.8 percentage points. Overall, MBH had the highest QI A rate of the five BH-MCOs evaluated in MY 2013. The MBH QI B rate of 75.3% was statistically significantly higher than the QI B HealthChoices BH-MCO average of 72.3% by 3.0 percentage points.

As shown in Table 3.10, the MY 2013 QI A rates for Bucks and Lehigh statistically significantly increased from their MY 2012 rates by 5.6 and 4.6 percentage points, respectively. The QI B rate for Lehigh statistically significantly increased from 72.5% in MY 2012 to 76.6% in MY 2013 by 4.1 percentage points. The MY 2013 PA -Specific Follow-up Indicator rates for the remaining MBH HC BH Contractors were not statistically significantly different from the prior year.

Figure 3.11 is a graphical representation of the MY 2013 PA-Specific follow-up rates for MBH and its associated HC BH Contractors. Figure 3.12 shows the HealthChoices HC BH Contractor Average rates and the individual MBH HC BH Contractor rates that were statistically significantly higher or lower than the HC BH Contractor Averages. The QI A rates for all MBH HC BH Contractors were statistically significantly higher than the QI A HC BH Contractor Average of 55.7% by 5.4 to 9.4 percentage points. The QI B rates for Lehigh and Northampton were statistically significantly above the QI B HC BH Contractor Average of 74.1% by 2.5 and 4.0 percentage points, respectively.

Figure 3.11 MY 2013 PA-Specific Follow-up Indicator Rates – Overall Population

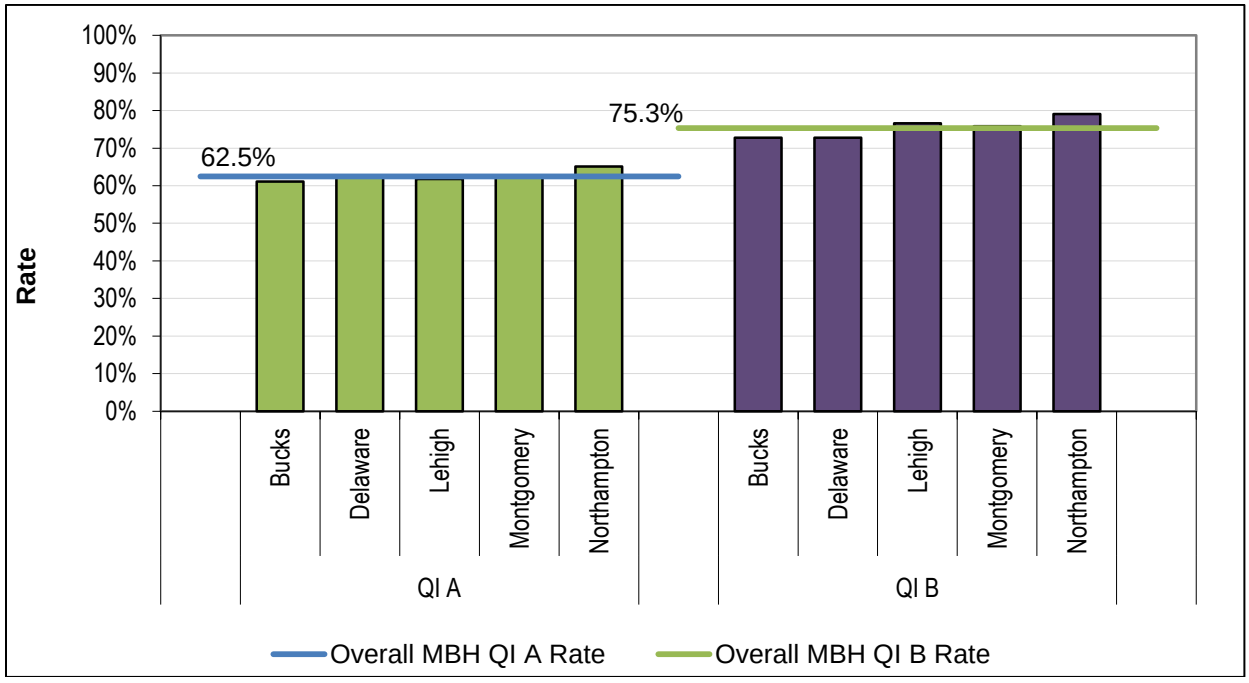
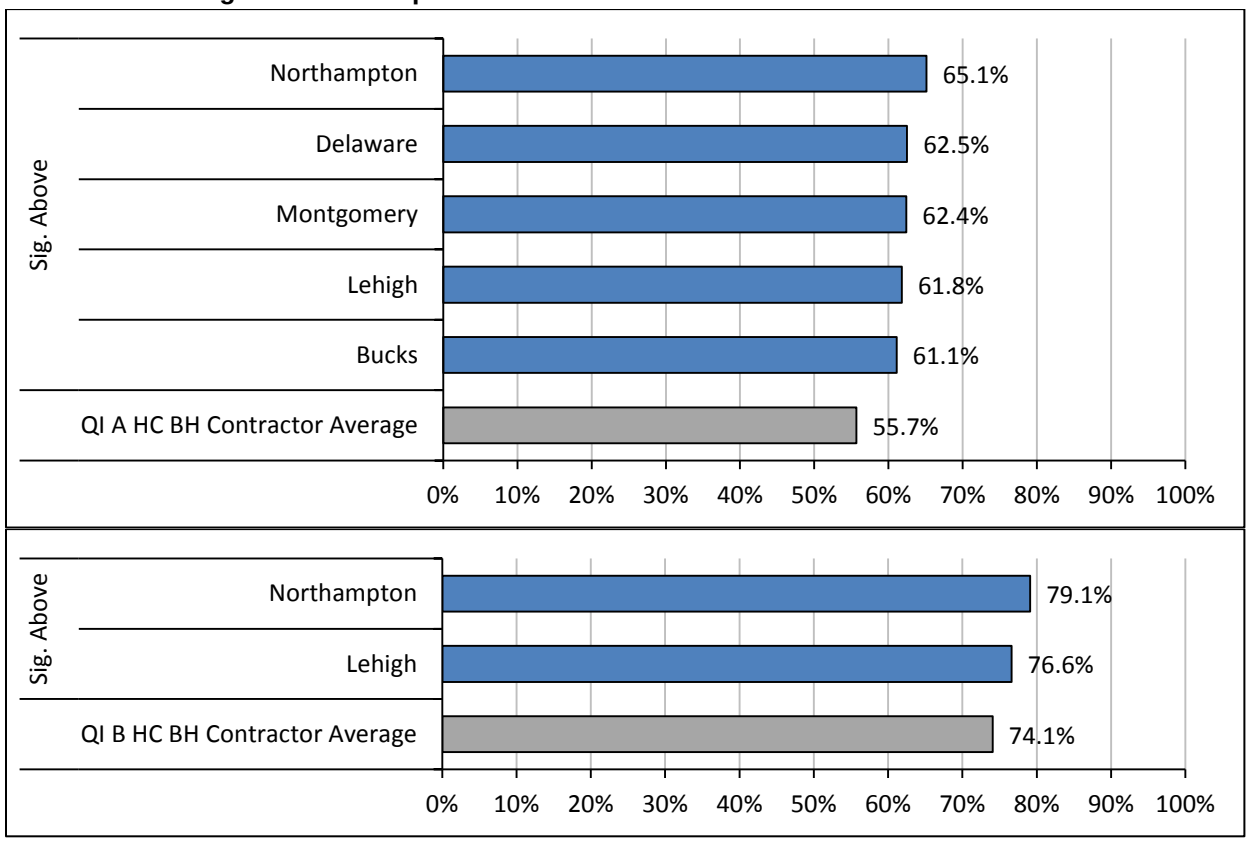


Figure 3.12 PA-Specific Follow-up Indicator Rates Compared to MY 2013 HealthChoices HC BH Contractor Average – Overall Population



III: 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 2014 study, which included results for MY 2012 and MY 2013, the following general recommendations were made to all five participating BH-MCOs:

- Despite a number of years of data collection and interventions, historically FUH rates have not increased meaningfully; in fact FUH rates show a general decline from MY 2012 to MY 2013. FUH for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted, the following recommendations may assist in future discussions.
- The purpose of this re-measurement study is to inform OMHSAS, the HC BH Contractors and the BH-MCOs of the effectiveness of the interventions implemented during 2011, 2012 and 2013 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 HC BH Contractors 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 2012 and MY 2013.The HC BH Contractors 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.
- The findings of this re-measurement indicate that disparities in rates between racial and ethnic groups persist. There were several cases in MY 2013 where improvements or decreases in performance from MY 2012 affected certain racial or ethnic groups disproportionately within BH-MCOs or HC BH Contractors. It is important for these entities to analyze performance rates by racial and ethnic categories and continue to target the demographic populations that do not perform as well as their counterparts. It is recommended that BH-MCOs and HC BH Contractors 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. BH-MCOs should be encouraged to initiate targeted interventions to address disparate rates between study populations.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. For instance, the apparent decrease in gender disparity from MY 2012 to MY 2013 is a consequence of a decline in female performance rates rather than a reflection of sustained and equitable improvements. Historically performance rates in female populations have been prone to some fluctuation relative to male populations. BH-MCOs should investigate root causes for populations where rates demonstrate inconsistent trends.
- BH-MCOs and HC BH Contractors are encouraged to review the findings of the follow-up study in conjunction with inpatient psychiatric readmission rates. 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.

Readmission within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow up After Hospitalization for Mental Illness, OMHSAS elected to retain and 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, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2013 study conducted in 2014 was the seventh re-measurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish a same day readmission from a transfer to another acute facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH Contractor level for MY 2013.

This measure continued to be of interest to OMHSAS for the purposes of comparing HC BH Contractor, 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 and 34 HC BH Contractors participating in the MY 2013 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, 2013;
- 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.

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 HC BH Contractor Results

The results are presented at the BH-MCO and then HC BH Contractor level. Year-to-year comparisons of MY 2013 to MY 2012 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. 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 and HC BH Contractor rates are *not* required to be statistically significantly below 10.0% in order to meet the performance measure goal.

Table 3.13 MY 2013 Readmission Rates with Year-to-Year Comparisons

	MY 2013								MY 2012
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	BH-MCO Average	HC BH Contractor Average	2013 Goal Met?	%
INPATIENT READMISSION									
HealthChoices Aggregate	5,925	43,604	**13.6%**	13.3%	13.9%	13.5%	13.7%	NO	12.7%
MBH	1,084	7,288	**14.9%**	14.1%	15.7%			NO	15.8%
Bucks	201	1,304	**15.4%**	13.4%	17.4%			NO	12.2%
Delaware	205	1,528	**13.4%**	11.7%	15.1%			NO	14.3%
Lehigh	264	1,669	**15.8%**	14.0%	17.6%			NO	18.3%
Montgomery	252	1,745	**14.4%**	12.7%	16.1%			NO	16.4%
Northampton	162	1,042	**15.5%**	13.3%	17.7%			NO	16.3%

The MY 2013 HealthChoices Aggregate readmission rate was 13.6%, statistically significantly higher than the MY 2012 HealthChoices Aggregate rate of 12.7% by 0.9 percentage points. The MBH MY 2013 Readmission rate of 14.9% decreased slightly from the MY 2012 rate of 15.8%, however this change is not statistically significant. The MBH Readmission rate of 14.9% was statistically significantly higher than the HealthChoices BH-MCO Average of 13.5% by 1.4 percentage points. Note that this measure is an inverted rate, in that lower rates indicate better performance. MBH did not meet the OMHSAS performance goal of a readmission rate below 10.0% in MY 2013.

The Readmission rate for Bucks increased from 12.2% in MY 2012 to 15.4% in MY 2013, a statistically significant increase of 3.2 percentage points. None of the other MBH HC BH Contractors has statistically significant changes in their readmission rates from the prior year. As presented in Table 3.13, none of the HC BH Contractors associated with MBH met the performance goal of a readmission rate below 10.0% in MY 2013.

Figure 3.14 is a graphical presentation of the MY 2013 readmission rates for MBH HC BH Contractors compared to the performance measure goal of 10.0%. Figure 3.15 presents individual MBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor average readmission rate of 13.7%. Lehigh's readmission rate of 15.8% was statistically significantly higher (poorer) than the HealthChoices HC BH Contractor average by 2.1 percentage points. Readmission rates for the remaining MBH HC BH Contractors were not statistically significantly different from the HC BH Contractor Average.

Figure 3.14 MY 2013 Readmission Rates

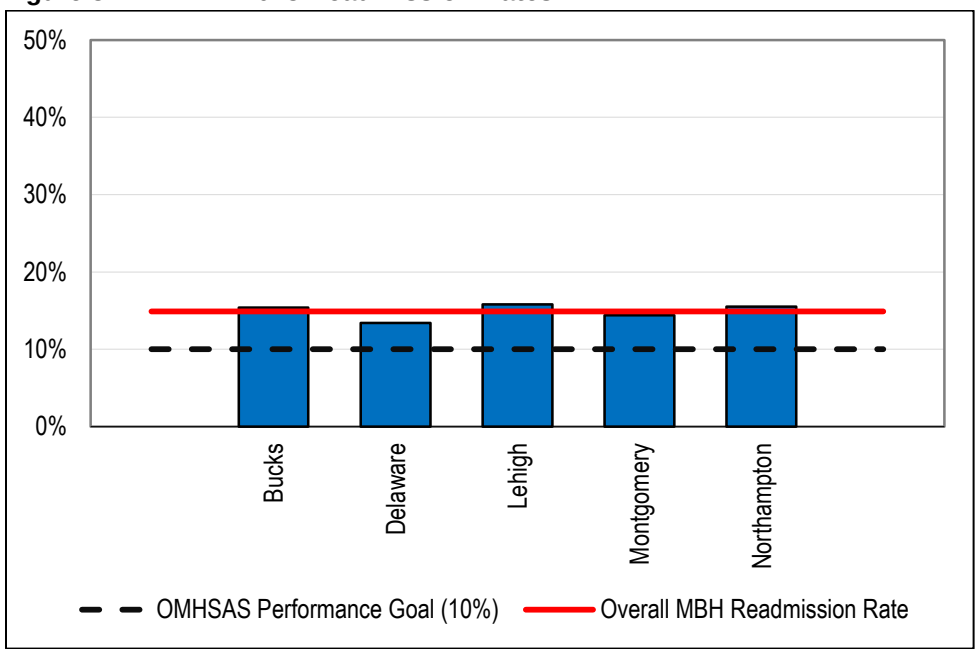
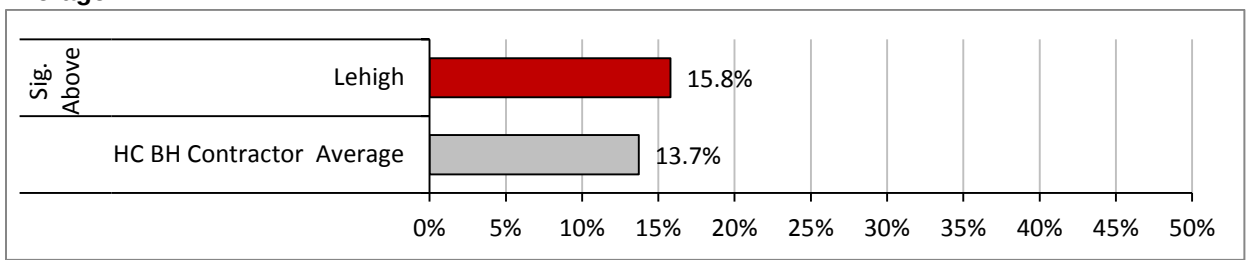


Figure 3.15 MY 2013 Readmission Rates Compared to HealthChoices HC BH Contractor Average*



*This measure is an inverted rate, meaning that rates statistically significantly below the HC BH Contractor Average indicate good performance, and rates statistically significantly above the HC BH Contractor Average indicate poor performance.

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 2014 (MY 2013) Readmission within 30 Days of Inpatient Psychiatric Discharge data tables.

In response to the 2014 study, the following general recommendations are applicable to all five participating BH-MCOs:

- Compared to MY 2012, there was a 0.9 percentage point increase in the HealthChoices Aggregate rate. Additionally, three of the five BH-MCOs had rate increases of 1.4 to 2.2 percentage points. HC BH Contractors 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 HC BH Contractors are encouraged to review the findings of the readmission study in conjunction with follow-up after hospitalization rates.
- As with the MY 2012 study, readmission rates observed for Black/African American and the White populations were not statistically significantly different. The percentage point difference between the White and Black/African American populations was -0.3 (White – 13.7% Black/African American – 13.4%) for MY 2013 compared to 1.0 in MY 2012 (White – 12.5% Black/African American – 13.5%). The decrease in the disparity is due to an increase in the readmission rate for the White population, and the Black/African American rate remaining relatively stable. Within BH-MCOs, there is significant variation between race cohorts. 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 HC BH Contractors 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 2012, considerable variation by county/HC BH Contractor was again observed for all of the BH-MCOs for MY 2013. BH-MCOs should further evaluate individual County/HC BH Contractor rates, explore the underlying causes of variance, and identify those practices or systems that may contribute to lower readmission rates.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

As part of the Center for Medicaid and Medicare Services' (CMS) Adult Quality Measure (AQM) Grant Program, DHS is required to report the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measure. This measure was reported initially by one county for MY 2012 and expanded to the HealthChoices population for MY 2013. Due to several implementation issues identified with BH-MCO access to all applicable data and at DHS' request, this measure was produced by IPRO. IPRO began development of this measure in 2014 for MY 2013. The measure was produced using HEDIS 2014 specifications, and included encounter data that were submitted to DHS by the BH-MCOs and the Physical Health MCOs. As directed by OMHSAS, IPRO produced rates for this measure for the HealthChoices population, by BH-MCO, and by HC BH Contractor. The results were presented to the BH-MCOs and HC BH Contractors in December 2014, and the BH-MCOs and HC BH Contractors were given the opportunity to review and respond to the results. After the results were reviewed and approved, the rates were provided to CMS. As MY 2013 was the first year this measure was produced, no comparison is available for previous years and it is being studied by DHS/OMHSAS. The results for the MY 2014 compared to the MY 2013 will be included in the 2015 BBA Technical Reports.

IV: QUALITY STUDY

The purpose of this section is to describe a quality study performed in 2013 for the HealthChoices population. The study is included in this report as an optional EQR activity which occurred during the Review Year (42 CFR §438.358 (c)(5)).

Overview / Study Objective

OMHSAS commissioned IPRO to conduct a study to identify risk factors for Behavioral Health acute inpatient readmissions among members enrolled in the Pennsylvania Medicaid Behavioral Health HealthChoices program. IPRO and OMHSAS developed a claims based study to determine what demographic and clinical factors are correlated with increased readmission rates. The objective of this study was to provide data to guide targeted BH quality improvement interventions by identifying subpopulations with high readmission rates.

Data Collection and Analysis

This study was a claims based analysis of acute inpatient behavioral health admissions between 12/2/2010 and 12/1/2011. The primary source of data was BH-MCO claims that were submitted to and accepted by the DHS PROMISe encounter system. One BH-MCO had significant data loss during the study period. For this BH-MCO, the Person Level Event (PLE) files that the BH-MCO submitted to OMHSAS for rate setting purposes were used in place of PROMISe data for this BH-MCO. Any claims not submitted to or not accepted by PROMISe are not included in this study. For the BH-MCO with data loss, any encounters not included in their PLE files are not included in this study. The analysis consisted of comparisons of 30, 60, and 90 day readmission rates for various subpopulations. Subpopulations were distinguished by member demographics, diagnosis prior to and during the admission, and the number and type of encounters before and after the inpatient stay. Finally, a regression analysis was done to identify what factors, or combinations of factors correlate with a high readmission rate.

Results / Conclusions

There were a total of 25,792 admissions included in this study. The 30 day readmission rate for the HealthChoices population was 8.5% which is a lower rate than reported for the Readmission within 30 Days of Inpatient Psychiatric Discharge Performance Measure due to the study requirements. The study was completed in April of 2014, and presented to the BH-MCOs and HC BH contractors in June 2014.

There were a number of demographic factors that were statistically significantly correlated with an increased 30 day readmission rate. Males had a higher readmission rate than females, and African American members had a higher readmission rate than White members. Members residing in urban counties had higher readmission rates than members residing in rural counties. Members aged 6-20 years old had the highest readmission rate when the population was stratified into age cohorts. Members who were in an aid category of “Aged/Blind/Disabled” had a higher readmission rate than members in other aid categories. There were also statistically significant differences in readmission rates between the BH-MCOs.

Additionally, there were a number of variables related to the admission that were also correlated to an increased 30 day readmission rate. Admissions with a primary admitting diagnosis of: Schizophrenic Psychoses, Other Nonorganic Psychoses, or Transient Organic Psychotic Conditions had readmission rates more than two percentage points higher than the HealthChoices average. Members who had a history of behavioral health encounters prior to the admission had a higher readmission rate than members with no behavioral health history. The study also showed that members who had a follow-up visit within 30 days of discharge had a lower readmission rate than members who did not have a follow-up visit.

Other factors found that correlated to higher readmission rates were a history of behavioral health inpatient admissions and prescriptions for multiple psychotropic drugs. Members' behavioral health service history also correlated to statistically significant differences in readmission rates. Members with no behavioral health services within 12 months prior to the admission had a 30 day readmission rate of 4.4%, members with only mental health or substance abuse services prior to the admission had readmission rates of 8.7% and 7.3% respectively. Members with both mental health and substance abuse services prior to the admission had the highest readmission rate of 11.1%.

The results of the study were presented to the BH-MCOs and HC BH Contractors in June 2014. The findings of the study assisted in the development of the current Behavioral Health PIP (See Section II). For example, due to the high readmission rate of members with a diagnosis of Schizophrenia, BH-MCOs will be required to report on medication adherence for members with a Schizophrenia diagnosis.

V: 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 2013 EQR Technical Reports, which were distributed in April 2014. The 2014 EQR Technical Report is the seventh report to include descriptions of current and proposed interventions from each BH-MCO that address the 2013 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, 2014 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 2014, as well as any additional relevant documentation provided by MBH.

Table 4.1 Current and Proposed Interventions: Opportunities for Improvement

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found MBH to be partially compliant with all Subparts associated with Structure and Operations Standards.	MCO Response
MBH 2013.01	MBH was partially compliant on one out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant category is Coverage and Authorization of Services.	**Follow-up Actions Taken and Planned Through 9/30/14** **<u>Coverage and Authorization of Services Standard 72, Substandard 1 (Bucks, Delaware, Lehigh, Montgomery & Northampton)</u>** Suggested recommendations were immediately implemented. Expectations were reinforced via trainings and in supervisory review of documentation. The following trainings were conducted: • Complaints Grievances and Appeals for Clinicians:10/23/2013 • Complaints and Grievances for Customer Service : 5/14/2014 • Denial letter Training: 9/24/2014  CG All Staff Training 2014.ppt  Filling Adverse Action Determination Forms Denial letters are reviewed by Complaint & Grievance supervisor as well as by a Clinical Supervisor prior to being sent. **Future Actions Planned** **<u>Coverage and Authorization of Services Standard 72, Substandard 1 (Bucks, Delaware, Lehigh, Montgomery & Northampton)</u>** The next Complaints Grievances and Appeals training for Clinicians is scheduled to be completed by 12/31/2014. Continue actions and monitoring that was implemented to ensure compliance with expectations.

MBH 2013.02	MBH was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, 8) Effectuation of Reversed Resolutions.	**Follow-up Actions Taken and Planned Through 9/30/14** **Standard 68, Substandard 2** Complaint resolution timeframes continue to be followed. The following training was conducted: Complaints and Grievances for Customer Service : 5/14/2014 (see response to Std. 72, substd. 1) **Standard 68, Substandard 3** The following training was conducted: Complaints and Grievances for Customer Service : 5/14/2014 (see response to Std. 72, substd. 1) Complaint letters are thoroughly investigated and reflect whether or not the member's complaint was substantiated. Refresher trainings continue. Counties continue to audit 1st level complaint letters on a regular basis and provide feedback of their findings. **Standard 68, Substandard 4** The following training was conducted: Complaints and Grievances for Customer Service : 5/14/2014 (see response to Std. 72, substd. 1) See CAP submitted 9/16/14 for 2013 Program Evaluation Performance Summary (PEPS) Triennial review. Counties continue to audit 1st level complaint letters on a regular basis and provide feedback of their findings. **Standard 68, Substandard 5** The following training was conducted: Complaints and Grievances for Customer Service : 5/14/2014 (see response to Std. 72, substd. 1) Continue with ongoing practices of identifying any provider performance concerns. Other outcomes have been member record audits, review of provider policy and procedures, etc. **Future Actions Planned** **Standard 68, Substandard 2** The next Complaints Grievances and Appeals training for Clinicians is scheduled to be completed by 12/31/2014. See CAP submitted 9/16/14 for 2013 Program Evaluation Performance Summary (PEPS) Triennial review. Implement & monitor Corrective Action Plan (CAP).  MBH CAP 2013.doc

MBH 2013.03 (cont)	MBH was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, 8) Effectuation of Reversed Resolutions.	**Standard 68, Substandard 3** The next Complaints Grievances and Appeals training for Clinicians is scheduled to be completed by 12/31/2014. See CAP submitted 9/16/14 for 2013 PEPS Triennial review. Implement & monitor CAP. Will continue quarterly audit of at least 20% of 1st level complaints by respective county to ensure completeness of review and documentation, as well as compliance with applicable regulations. This process will continue for oversight and collaboration. **Standard 68, Substandard 4** The next Complaints Grievances and Appeals training for Clinicians is scheduled to be completed by 12/31/2014. See CAP submitted 9/16/14 for 2013 PEPS Triennial review. Implement & monitor CAP. Ongoing monitoring to ensure compliance with this standard. **Standard 68, Substandard 5** The next Complaints Grievances and Appeals training for Clinicians is scheduled to be completed by 12/31/2014. See CAP submitted 9/16/14 for 2013 PEPS Triennial review. Implement & monitor CAP. Ongoing monitoring to ensure that documentation includes if a complaint was substantiated.
MBH 2013.03	MBH's rate for the MY 2012 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 2 was statistically significantly lower than the MY 2012 QI 2 HealthChoices BH-MCO Average of 67.4% by 2.6 percentage points	**Follow-up Actions Taken and Planned Through 9/30/14** Magellan submitted the Follow-up After Hospitalization (FUH) Root Cause Analysis (RCA) to IPRO and OMHSAS by the October 6, 2014 deadline. Frm_2013 BH PM RCA Response_MBH_RCA Barrier Analysis. **Future Actions Planned** See Above
MBH 2013.04	MBH's rate for the MY 2012 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI B was statistically significantly below the QI B HealthChoices BH-MCO Average of 74.8% by 1.6 percentage points.	See response to item MBH 2013.03

MBH 2013.05	MBH's rates for all four MY 2012 Follow-up After Hospitalization for Mental Illness indicators were statistically significantly below the prior year and represented the largest year to year decreases among the five BH-MCOs evaluated in MY 2012.	See response to item MBH 2013.03
MBH 2013.06	MBH's rate for the MY 2012 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (poorer) than the MY 2012 HealthChoices BH-MCO Average by 3.0 percentage points. MBH's rate did not meet the OMHSAS designated performance goal of 10.0%. MBH demonstrated the largest year over year rate increase for readmission among the five BH-MCOs evaluated in MY 2012	See response to item MBH 2013.03

Corrective Action Plan for Partial and Non Compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2012, MBH began to address opportunities for improvement related to Standard 72. Proposed actions and evidence of actions taken by MBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring MBH into compliance with the relevant Standards.

Root Cause Analysis and Action Plan

The 2014 EQR is the sixth 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 2013 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 2014 EQR, MBH 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
- Follow-Up After Mental Health Hospitalization (HEDIS 7 and 30 Day)
- Follow-Up After Mental Health Hospitalization (PA Specific 7 and 30 Day)

MBH submitted a Root Cause Analysis and Action Plan as required in October 2014.

Table 4.2 Root Cause Analysis and Action Plan

Managed Care Organization (MCO): *Magellan Behavioral Health (MBH)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)*	***Response Date:*** ***10/6/2014***
Goal Statement: **(Please specify individual goals for each measure): Increase rate of 7 day HEDIS FUH following discharge from inpatient psychiatric level of care by a statistically significant amount. Based on MY 2012, a statistically significant (p = 0.05) increase would be realized at 48.9%.**		

***Analysis*:**
What factors contributed to poor performance?
Please enter "N/A" if a category of factors does not apply.

Findings

Magellan's (MBH's) MY2012 performance was consistent with the HealthChoices average; however, the decrease in MBH's performance from MY2011 to MY2012 was statistically significant. Although not yet included in the External Quality Review (EQR) report, MBH and its county partners are including the review of the validated MY2013 IPRO results in the RCA process. The table below provides a comparison of MY2010 to MY2011 to MY2012 to MY2013 performance per County, for MBH and the HC average.

QI 1- FUH, HEDIS 7 Day						
	MY2010	MY2011	MY2012	SSD from prior year	MY2013	SSD from MY2012
HC Avg	46.1%	46.1%	47.2%	^	not avail	-
MBH	50.8%	49.7%	47.0%	v	51.3%	^
BU	52.6%	46.7%	45.5%	=	51.7%	^
DE	46.4%	51.8%	43.4%	v	46.7%	=
LE	50.4%	49.1%	47.3%	=	52.3%	^
MO	51.4%	49.8%	46.3%	=	51.0%	^
NH	55.0%	50.7%	54.5%	=	56.4%	=

In the comparison between MY2012 and MY2013 performance, statistically significant improvement was demonstrated for MBH, Bucks, Lehigh and Montgomery counties. In addition to the SSD demonstrated from MY2012 to MY2013, MY2013 comparison to the MY2011 baseline for this RCA also showed improved performance.

	In reviewing Delaware County performance, a statically significant decrease was seen from MY2011 to MY2012; therefore although the change was not significant, improvement from MY2012 to MY2013 is a positive result and demonstrates performance above the HEDIS 2013 median for Medicaid programs. As is addressed through the Cost Driver PIP, Delaware County has a high utilization of case management services. Given the focus on the PA-specific FUH measures in recent years, it is likely that an emphasis has not been placed on ensuring aftercare appointments included a clinical service in addition to the supportive case management services. It is also important to note that although Northampton County's improvement was not statistically significant, the MY2013 rate is greater than the HEDIS 2013 75th percentile of 54.8% for Medicaid programs.
Policies (e.g., data systems, delivery systems, provider facilities) ***N/A***	***Initial Response*** ***Follow-up Status Response***
Procedures (e.g., payment/reimbursement, credentialing/collaboration) • **Poor documentation of discharge plan** • **No process for specialized FUH attention for those likely to readmit or not attend FUH** • **No one calling to remind member of appointment** • **Medication not pre-authorized upon d/c** • **Focus on PA-specific accepted aftercare appointment** • **Providers not submitting claims to document treatment provided**	***Initial Response*** • *The delay that can result when the discharge plan is not communicated clearly to the member including the provider, date and time of the appointment.* • *The delay that can result when there are no specialized interventions employed to increase the likelihood of appointment adherence for individuals at high risk of readmission to the AIP unit or not keeping their FUH.* • *The delay that can result when an individual forgets their FUH appointment information including provider address, date and time of appointment.* • *The delay that can result when an individual is unable to obtain medications following discharge due to a lack of preauthorization.* • *The delay that can result when provider focuses discharge plan on FUH appointments with levels of care that are not included in the HEDIS methodology i.e.- targeted case management.* • *The incomplete data source regarding FUH services provided when claims are not submitted.* ***Follow-up Status Response***
People (e.g., personnel, provider network, patients) • **Mbr choosing not to accept care**	***Initial Response*** • *The delay that can result when an individual chooses to not pursue treatment following discharge from an inpatient setting.*

• **Bad experience w/ provider** • **Medication Changes** • **Substance use relapse** • **Co-morbid medical conditions** • **Medication prescription from d/c not covering time until psychiatrist appt (more likely after 7 days post-dc)**	• *The delay that can result when an individual is dissatisfied with their interactions with a provider such that there is hesitation to return to the provider for treatment.* • *The delay that can result when an individual has difficulty managing the effects of new medications when in the community* • *The delay that can result when an individual resumes use of substances and a substance abusing lifestyle which causes distraction from and/or avoidance of treatment.* • *The delay that can occur, due to limited resources, when an individual requires specialized medical care concomitant with their psychiatric care upon discharge.* • *The delay that can result when an individual's supply of medication is exhausted prior to the FUH appointment.*
	Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) • **Inconvenient FUH appointment(s)** • **Appointment unavailability/immediate access** • **Open Access- no appointment** • **Open Access- no tracking of kept visit or f/u call** • **Transportation** • **OP scheduling flexibility** • **Lack of Psychiatrists** • **Open Access**	***Initial Response*** • *The delay that can result when an individual is unable to keep an FUH appointment due to practical reasons including, but not limited to, geographic location of provider or date/time of appointment.* • *The delay that can result when an individual becomes re-acclimated to their routine post discharge and becomes less likely over time to accommodate treatment into their established schedule.* • *The delay that can result when an individual has a date but no specific time commitment associated with the FUH appointment.* • *The delay that can result when an open access provider does not track individuals referred upon inpatient discharge and the subsequent lack of follow-up with the individual if the 'appointment' is not kept.* • *The delay that can result when an individual is unable to secure means of transportation to and from an appointment.* • *The delay that can result when OP providers are unable to offer a wide array of appointment times throughout the business day i.e.- early morning, evening, that may be more convenient for a number of reasons including, but not limited to, transportation, childcare, etc.* • *The delay that can result when there are a limited number of psychiatric appointments available due to a shortage of psychiatrists.* • *The delay that can result when a provider does not adequately plan for a large influx of*

	individuals utilizing Open Access that particular day and has no plan to accommodate the individuals that present. This can result in individuals who are turned away or cannot stay for the long wait time. ***Follow-up Status Response***
Other (specify): Treatment Process • **Incomplete discharge plan at discharge** • **Lack of appropriate community-based services/resources** • **Lack of active treatment** • **Lack of involving member in own treatment** • **Why now?' not addressed** • **Lack of understanding of d/c plan** • **Lack of family/support person's involvement to assist member w/adherence to d/c plan**	***Initial Response*** • *The delay that can result when the provider does not include critical elements in the discharge plan including appointment location, date of appointment, time of appointment, etc.* • *The delay that can result when an individual has a specialized need that cannot be met by traditional community-based services and results in the member disengaging from treatment.* • *The delay that can result from a more passive approach to treatment that may result in apathy toward treatment.* • *The delay that can result when individuals are not encouraged to participate in the treatment process and recovery. Infers relationship between recovery approach and delay in progress.* • *The delay that can result when the 'root cause' of the admission (vs. presenting problem) is not adequately addressed by the provider.* • *The delay that can result when an individual is unclear on specifics of the discharge plan including location, date, time and their role in it i.e.- securing own transportation, etc.* • *The delay that can result when an individual lacks the support of others in keeping the FUH appointment including, but not limited to, family/support persons providing appointment reminders, transportation, accompanying to appointment, etc.* ***Follow-up Status Response***

Measure: *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)*
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2013. Documentation of actions should be continued on additional pages as needed.

Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	*Monitoring Plan* How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
In 2012, eight mental health inpatient facilities accounted for 70% of the adult discharges across Magellan's five county partners: Bucks, Delaware, Lehigh, Montgomery and Northampton. An improvement in outcomes performance by these core providers, would considerably impact Magellan's results in OMHSAS performance measures related to this level of care.  MY 2012 Adult MH IP Discharges_Pareto Cl Given the success demonstrated through the programmatic approach of the Partners in Care program with regard to clinical quality, operational practices, provider accountability and fiscal responsibility, Magellan and its partner counties developed the MH IP Partners in Care program.	-May 2014 -Ongoing -Monthly involvement (either group or individual meeting) and quarterly performance data reporting to begin with 2015 data	***Initial Response*** • *Quarterly measurement of performance metrics (30-day readmission rates w/goals of statistically significant decreases; 7-day FUH based on HEDIS methodology* and ALOS; chart review scores; and care manager discharge survey results.* *(*success in FUH rates based on HEDIS methodology contribute to improved success in PA-Specific FUH methodology)* • *Every-other month group meetings to address: performance metric data; factors contributing to positive and negative results; provider program management processes; and sharing of ideas, challenges and strategies to continue quality improvement.* • *Based on successful demonstration of improvement on performance metrics and collaboration in MH IP PIC program, providers can be moved to an alternative payment arrangement;* *In May 2014, the MH IP PIC program was introduced by Bucks, Delaware, Lehigh, Montgomery and Northampton Counties and Magellan to the ten providers. In July, the initial group program management meeting was held. At that time, the providers were given their draft performance metric baselines based on 2013 data. As the measurement period will officially begin 1/1/15 for this program, the 'draft' baseline data and goals were provided so the Magellan care managers and provider staff would have an opportunity to understand the data, what is included/excluded and from there, develop ways to positively impact the data.* *Also at the July group meeting, the providers were introduced to the PIP development process (Successful transition from inpatient care to ambulatory care). The providers have each been asked to complete a barrier analysis and develop at least one intervention to address those barriers. The PIC structure offers a forum in which to engage the providers into the interventions to improve the rate at which individuals receive ambulatory services following psychiatric inpatient discharge.* ***Follow-up Status Response***

Managed Care Organization (MCO):	***Measure:***	***Response Date:***
Magellan Behavioral Health (MBH)	*Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)*	***10/6/2014***

Goal Statement: **(Please specify individual goals for each measure): Increase rate of 30 day HEDIS FUH following discharge from inpatient psychiatric level of care by a statistically significant amount. Based on MY 2012, a statistically significant (p = 0.05) increase would be realized at 66.6%.**

***Analysis*:**
What factors contributed to poor performance?
Please enter "N/A" if a category of factors does not apply.

Findings

MBH's MY2012 performance was lower than the HealthChoices average and the decrease in MBH's performance from MY2011 to MY2012 was statistically significant. Although not yet included in the EQR report, MBH and its county partners are including the review of the validated MY2013 IPRO results in the RCA process. The table below provides a comparison of MY2010 to MY2011 to MY2012 to MY2013 performance per County, for MBH and the HC average.

QI 2- FUH, HEDIS 30 Day						
	MY2010	MY2011	MY2012	SSD Change from prior year	MY2013	SSD Change from MY2012
HC Avg	66.9%	67.0%	67.8%	=	not avail	-
MBH	68.5%	67.9%	64.8%	v	68.4%	^
BU	69.0%	65.5%	63.8%	=	67.0%	=
DE	65.7%	67.9%	61.6%	v	63.0%	=
LE	67.5%	66.1%	65.1%	=	71.1%	^
MO	70.0%	69.7%	64.0%	v	67.9%	^
NH	70.8%	70.7%	71.4%	=	74.4%	=

In the comparison between MY2012 and MY2013 performance, statistically significant improvement was demonstrated for MBH, Lehigh and Montgomery counties. Although Bucks, Delaware and Northampton Counties' rates improved from MY2012 to MY2013, this difference was not found to be statistically significant.

For MBH, Bucks, Lehigh and Northampton Counties, MY2013 comparison to the MY2011 baseline for this RCA also showed improved performance.

In reviewing Delaware County performance, a statically significant decrease was seen from

	MY2011 to MY2012; therefore although the change was not significant, improvement from MY2012 to MY2013 is a positive result and demonstrates performance above the HEDIS 2013 median for Medicaid programs. As is addressed through the Cost Driver PIP, Delaware County has a high utilization of case management services. Given the focus on the PA-specific FUH measures in recent years, it is likely that an emphasis has not been placed on ensuring aftercare appointments included a clinical service in addition to the supportive case management services. It is also important to note that although Northampton County's improvement was not statistically significant, the MY2013 rate is approaching the HEDIS 2013 75th percentile of 75.7% for Medicaid programs.
Policies (e.g., data systems, delivery systems, provider facilities) ***N/A***	***Initial Response*** ***Follow-up Status Response***
Procedures (e.g., payment/reimbursement, credentialing/collaboration) • **Poor documentation of discharge plan** • **No process for specialized FUH attention for those likely to readmit or not attend FUH** • **No one calling to remind Mbr of appointment** • **Medication not pre-authorized upon d/c** • **Focus on PA-specific accepted aftercare appointment** • **Medication prescription from d/c not covering time until psychiatrist appt (more likely after 7 days post-dc)** • **Providers not submitting claims to document treatment provided**	***Initial Response*** • *The delay that can result when the discharge plan is not communicated clearly to the member including the provider, date and time of the appointment.* • *The delay that can result when there are no specialized interventions employed to increase the likelihood of appointment adherence for individuals at high risk of readmission to the AIP unit or not keeping their FUH.* • *The delay that can result when an individual forgets their FUH appointment information including provider address, date and time of appointment.* • *The delay that can result when an individual is unable to obtain medications following discharge due to a lack of preauthorization.* • *The delay that can result when provider focuses discharge plan on FUH appointments with levels of care that are not included in the HEDIS methodology ie- targeted case management.* • *The delay that can result when an individual's supply of medication is exhausted prior to the FUH appointment.* • *The incomplete data source regarding FUH services provided when claims are not submitted.* ***Follow-up Status Response***
People *(e.g., personnel, provider network, patients)*	*Initial Response*

• ***Mbr choosing not to accept care***	• *The delay that can result when an individual chooses to not pursue treatment following discharge from an inpatient setting.*
• ***Bad experience w/ provider***	• *The delay that can result when an individual is dissatisfied with their interactions with a provider such that there is hesitation to return to the provider for treatment.*
• ***Medication Changes***	• *The delay that can result when an individual has difficulty managing the effects of new medications when in the community*
• ***Substance use relapse***	• *The delay that can result when an individual resumes use of substances and a substance abusing lifestyle which causes distraction from and/or avoidance of treatment.*
• ***Co-morbid medical conditions***	• *The delay that can occur, due to limited resources, when an individual requires specialized medical care concomitant with their psychiatric care upon discharge.*
• ***Increased or new psycho-social stressors (more likely as time from d/c increases)***	• *The delay that can result when an individual experiences an increase in the number or intensity of new or chronic psychosocial stressors such that the stressor interferes with the ability to participate in treatment i.e.- loss of an automobile, loss of income to afford public transportation, loss of child care provider etc.*
	Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)	***Initial Response***
• **Inconvenient FUH appointment(s)**	• *The delay that can result when an individual is unable to keep an FUH appointment due to practical reasons including, but not limited to, geographic location of provider or date/time of appointment.*
• **Appointment unavailability/immediate access**	• *The delay that can result when an individual becomes re-acclimated to their routine post discharge and becomes less likely over time to accommodate treatment into their established schedule.*
• **Open Access- no appointment**	• *The delay that can result when an individual has a date but no specific time commitment associated with the FUH appointment.*
• **Open Access- no tracking of kept visit or f/u call**	• *The delay that can result when an open access provider does not track individuals referred upon inpatient discharge and the subsequent lack of follow-up with the individual if the 'appointment' is not kept.*
• **Transportation**	• *The delay that can result when an individual is unable to secure means of transportation to and from an appointment.*
• **OP scheduling flexibility**	• *The delay that can result when OP providers are unable to offer a wide array of appointment times throughout the business day i.e.- early morning, evening, that may be more*

	convenient for a number of reasons including, but not limited to, transportation, childcare, etc.
• **Lack of Psychiatrists** • **Open Access**	• *The delay that can result when there are a limited number of psychiatric appointments available due to a shortage of psychiatrists.* • *The delay that can result when a provider does not adequately plan for a large influx of individuals utilizing Open Access that particular day and has no plan to accommodate the individuals that present. This can result in individuals who are turned away or cannot stay for the long wait time.*
	Follow-up Status Response
Other (specify): Treatment Process	***Initial Response***
• **Incomplete discharge plan at discharge**	• *The delay that can result when the provider does not include critical elements in the discharge plan including appointment location, date of appointment, time of appointment, etc.*
• **Lack of appropriate community-based services/resources**	• *The delay that can result when an individual has a specialized need that cannot be met by traditional community-based services and results in the member disengaging from treatment.*
• **Lack of active treatment**	• *The delay that can result from a more passive approach to treatment that may result in apathy toward treatment.*
• **Lack of involving member in own treatment**	• *The delay that can result when individuals are not encouraged to participate in the treatment process and recovery. Infers relationship between recovery approach and delay in progress.*
• **Why now?' not addressed**	• *The delay that can result when the 'root cause' of the admission (vs. presenting problem) is not adequately addressed by the provider.*
• **Lessened impact of treatment benefit from MH IP as time from tx episode increases (more likely as time from d/c increases)**	• *The delay that can result when an individual becomes re-acclimated to their routine post discharge and becomes less likely over time to accommodate treatment into their established schedule.*
• **Lack of understanding of d/c plan**	• *The delay that can result when an individual is unclear on specifics of the discharge plan including location, date, time and and their role in it ie- securing own transportation, etc.*
• **Lack of family/support person's involvement to assist member w/adherence to d/c plan**	• *The delay that can result when an individual lacks the support of others in keeping the FUH appointment including, but not limited to, family/support persons providing appointment reminders, transportation, accompanying to appointment, etc.*

Measure: *Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)*		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2013. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
The Actions listed in the Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day) are all applicable to address the barriers identified for this measure (Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day). Improvement in any 7 day measure will also improve performance in the 30 day measures. The Actions listed above include: • MH IP PIC program • Day of discharge appointments (i.e. Bridge or Mobile Mental Health) • Members with 30 day discharge reviewed in clinical rounds • Weekly clinical rounds for adults and children/adolescents with highest volume MH IP provider • Explore possibility of using Telepsychiatry services in outpatient settings for individuals discharging from inpatient settings.		***Initial Response*** *(See responses above)* ***Follow-up Status Response***

Managed Care Organization (MCO): *Magellan Behavioral Health (MBH)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)*	***Response Date:*** ***10/6/2014***
Goal Statement: **(Please specify individual goals for each measure): Increase rate of 7 day PA-Specific FUH following discharge from inpatient psychiatric level of care by a statistically significant amount. Based on MY 2012, a statistically significant (p = 0.05) increase would be realized at 61.0%.**		
***Analysis*:** **What factors contributed to poor performance?**	***Findings*** MBH's MY2012 performance was consistent with the HealthChoices average; however, the	

Please enter "N/A" if a category of factors does not apply.	decrease in MBH's performance from MY2011 to MY2012 was statistically significant. Although not yet included in the EQR report, MBH and its county partners are including the review of the validated MY2013 IPRO results in the RCA process. The table below provides a comparison of MY2010 to MY2011 to MY2012 to MY2013 performance per County, for MBH and the HC average. QI A- FUH, PA-Specific 7 Day MY2010 / MY2011 / MY2012 / SSD Change from prior year / MY2013 / SSD Change from MY2012 HC Avg: 58.1% / 57.8% / 58.7% / ^ / not avail / - MBH: 62.80% / 62.1% / 59.20% / v / 62.5% / ^ BU: 65.6% / 59.2% / 55.5% / = / 61.1% / ^ DE: 61.8% / 66.6% / 60.6% / v / 62.5% / = LE: 60.6% / 59.2% / 57.2% / = / 61.8% / ^ MO: 63.2% / 62.3% / 61.0% / = / 62.4% / = NH: 63.8% / 63.1% / 61.3% / = / 65.1% / = In the comparison between MY2012 and MY2013 performance, statistically significant improvement was demonstrated for MBH, Bucks and Lehigh counties. Although Delaware, Montgomery and Northampton Counties' rates improved from MY2012 to MY2013, these differences were not found to be statistically significant. For MBH and four of the five counties, MY2013 comparison to the MY2011 baseline for this RCA showed improved performance. In reviewing Delaware County performance, a statically significant decrease was seen from MY2011 to MY2012; therefore although the change was not significant, improvement from MY2012 to MY2013 is a positive result. It is also important to note that although Northampton County's improvement was not statistically significant, the MY2013 rate is the highest of the five counties' and MBH's rate. As the OMHSAS gold standard of 90% is not reached, there continues to be opportunity for improvement.
Policies	***Initial Response***

(e.g., data systems, delivery systems, provider facilities) **N/A**	***Follow-up Status Response***
Procedures (e.g., payment/reimbursement, credentialing/collaboration) • **Poor documentation of discharge plan** • **No process for specialized FUH attention for those likely to readmit or not attend FUH** • **No one calling to remind Mbr of appointment** • **Medication not pre-authorized upon d/c** • **Providers not submitting claims to document treatment provided** • **Medication prescription from d/c not covering time until psychiatrist appt (more likely after 7 days post-dc)** • **Marginal use of CPS services while individual is in inpatient loc** • **Incomplete coordination of care between inpatient and community-based services, such as BCM.**	***Initial Response*** • *The delay that can result when the discharge plan is not communicated clearly to the member including the provider, date and time of the appointment.* • *The delay that can result when there are no specialized interventions employed to increase the likelihood of appointment adherence for individuals at high risk of readmission to the AIP unit or not keeping their FUH.* • *The delay that can result when an individual forgets their FUH appointment information including provider address, date and time of appointment.* • *The delay that can result when an individual is unable to obtain medications following discharge due to a lack of preauthorization.* • *The incomplete data source regarding FUH services provided when claims are not submitted.* • *The delay that can result when an individual's supply of medication is exhausted prior to the FUH appointment.* • *The delay that can result when a CPS is not working with an individual to support engagement in aftercare appointment* • *The delay in connecting with case management services to coordinate community-based care when the inpatient provider does not contact the case mgmt provider.* ***Follow-up Status Response***
People (e.g., personnel, provider network, patients) • **Mbr choosing not to accept care** • **Bad experience w/ provider** • **Medication Changes** • **Substance use relapse** • **Co-morbid medical conditions**	***Initial Response*** • *The delay that can result when an individual chooses to not pursue treatment following discharge from an inpatient setting.* • *The delay that can result when an individual is dissatisfied with their interactions with a provider such that there is hesitation to return to the provider for treatment.* • *The delay that can result when an individual has difficulty managing the effects of new medications when in the community* • *The delay that can result when an individual resumes use of substances and a substance abusing lifestyle which causes distraction from and/or avoidance of treatment.* • *The delay that can occur, due to limited resources, when an individual requires specialized medical care concomitant with their psychiatric care upon discharge.* ***Follow-up Status Response***

Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) • **Inconvenient FUH appointment(s)** • **Appointment unavailability/immediate access** • **Open Access- no appointment** • **Open Access- no tracking of kept visit or f/u call** • **Transportation** • **OP scheduling flexibility** • **Lack of Psychiatrists** • **Open Access**	***Initial Response*** • *The delay that can result when an individual is unable to keep an FUH appointment due to practical reasons including, but not limited to, geographic location of provider or date/time of appointment.* • *The delay that can result when an individual becomes re-acclimated to their routine post discharge and becomes less likely over time to accommodate treatment into their established schedule.* • *The delay that can result when an individual has a date but no specific time commitment associated with the FUH appointment.* • *The delay that can result when an open access provider does not track individuals referred upon inpatient discharge and the subsequent lack of follow-up with the individual if the 'appointment' is not kept.* • *The delay that can result when an individual is unable to secure means of transportation to and from an appointment.* • *The delay that can result when OP providers are unable to offer a wide array of appointment times throughout the business day i.e.- early morning, evening, that may be more convenient for a number of reasons including, but not limited to, transportation, childcare, etc.* • *The delay that can result when there are a limited number of psychiatric appointments available due to a shortage of psychiatrists.* • *The delay that can result when a provider does not adequately plan for a large influx of individuals utilizing Open Access that particular day and has no plan to accommodate the individuals that present. This can result in individuals who are turned away or cannot stay for the long wait time.* ***Follow-up Status Response***
Other (specify): Treatment Process • **Incomplete discharge plan at discharge** • **lack of appropriate community-based services/resources** • **Lack of active treatment**	***Initial Response*** • *The delay that can result when the provider does not include critical elements in the discharge plan including appointment location, date of appointment, time of appointment, etc.* • *The delay that can result when an individual has a specialized need that cannot be met by traditional community-based services and results in the member disengaging from treatment.* • *The delay that can result from a more passive approach to treatment that may result in apathy toward treatment.*

• **Lack of involving member in own treatment** • **Why now?' not addressed** • **Lack of understanding of d/c plan** • **Lack of family/support person's involvement to assist member w/adherence to d/c plan**	• *The delay that can result when individuals are not encouraged to participate in the treatment process and recovery. Infers relationship between recovery approach and delay in progress.* • *The delay that can result when the 'root cause' of the admission (vs. presenting problem) is not adequately addressed by the provider.* • *The delay that can result when an individual is unclear on specifics of the discharge plan including location, date, time and their role in it i.e.- securing own transportation, etc.* • *The delay that can result when an individual lacks the support of others in keeping the FUH appointment including, but not limited to, family/support persons providing appointment reminders, transportation, accompanying to appointment, etc.* ***Follow-up Status Response***

Complete next page of corresponding action plan.

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

For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2013. Documentation of actions should be continued on additional pages as needed.

Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
The Actions listed in the Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day) are all applicable to address the barriers identified for this measure (Follow-up After Hospitalization for Mental Illness QI A (FUH, PA-Specific 7 Day). Improvement in any HEDIS measure will also improve performance in the PA-Specific measures. The Actions listed above include: • MH IP PIC program • Day of discharge appointments (i.e. Bridge or Mobile Mental Health) • Members with 30 day discharge reviewed in clinical rounds • Weekly clinical rounds for adults and children/adolescents with highest volume MH IP provider • Explore possibility of using Telepsychiatry services in outpatient		***Initial Response*** *(See responses above)* ***Follow-up Status Response***

settings for individuals discharging from inpatient settings.		
Lehigh and Northampton Counties Pilot program of ICM services for homeless individuals began in March 2014.	-March 2014 - Ongoing - Quarterly reporting by provider	***Initial Response*** *In response to the identification of homelessness as a factor contributing to individuals' readmission following inpatient discharge, Lehigh and Northampton Counties and Magellan developed a specialized case management program for homeless individuals. Individuals are identified and referred to the program through Magellan's care management processes.* *Since the program began in March 2014, 23 individuals have been enrolled in the program. Of the four people who have successfully discharged, two are currently living in a home/apartment, one is living with family and one is living in a shelter. While a small sample size, these results are encouraging. There are 18 members still receiving this service, so their housing status at discharge will be assessed at the time of their discharge.* ***Follow-up Status Response***

Managed Care Organization (MCO):	***Measure:***	***Response Date:***
Magellan Behavioral Health (MBH)	*Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)*	***10/6/2014***

Goal Statement: **(Please specify individual goals for each measure): Increase rate of 30 day PA-Specific FUH following discharge from inpatient psychiatric level of care by a statistically significant amount. Based on MY 2012, a statistically significant (p = 0.05) increase would be realized at 74.82%.**

***Analysis*:**
What factors contributed to poor performance?
Please enter "N/A" if a category of factors does not appg6ly.

Findings

MBH's MY2012 performance was lower than the HealthChoices average and the decrease in MBH's performance from MY2011 to MY2012 was statistically significant. Although not yet included in the EQR report, MBH and its county partners are including the review of the validated MY2013 IPRO results in the RCA process. The table below provides a comparison of MY2010 to MY2011 to MY2012 to MY2013 performance per County, for MBH and the HC average.

QI B- FUH, PA-Specific 30 Day						
	MY2010	MY2011	MY2012	SSD Change from prior year	MY2013	SSD Change from MY2012
HC Avg	74.6%	74.8%	75.0%	=	not avail	-
MBH	76.0%	75.6%	73.2%	v	75.3%	^
BU	77.4%	73.3%	69.1%	=	72.8%	=
DE	74.4%	76.9%	73.3%	=	72.8%	=
LE	75.1%	73.0%	72.5%	=	76.6%	^
MO	77.2%	77.4%	74.5%	=	75.8%	=
NH	76.4%	77.8%	76.3%	=	79.1%	=

In the comparison between MY2012 and MY2013 performance, statistically significant improvement was demonstrated for MBH, and Lehigh counties. Although Bucks, Montgomery and Northampton Counties' rates improved from MY2012 to MY2013, these differences were not found to be statistically significant.

It is also important to note that although Northampton County's improvement was not statistically

	significant, the MY2013 rate is the highest of the five counties' and MBH's rate. As the OMHSAS gold standard of 90% is not reached, there continues to be opportunity for improvement.
Policies (e.g., data systems, delivery systems, provider facilities) **N/A**	***Initial Response*** ***Follow-up Status Response***
Procedures (e.g., payment/reimbursement, credentialing/collaboration) • **Poor documentation of discharge plan** • **No process for specialized FUH attention for those likely to readmit or not attend FUH** • **No one calling to remind Mbr of appointment** • **Medication not pre-authorized upon d/c** • **Medication prescription from d/c not covering time until psychiatrist appt (more likely after 7 days post-dc)** • **Providers not submitting claims to document treatment provided** • **Marginal use of CPS services while individual is in inpatient loc** • **Incomplete coordination of care between inpatient and community-based services, such as BCM.**	***Initial Response*** • *The delay that can result when the discharge plan is not communicated clearly to the member including the provider, date and time of the appointment.* • *The delay that can result when there are no specialized interventions employed to increase the likelihood of appointment adherence for individuals at high risk of readmission to the AIP unit or not keeping their FUH.* • *The delay that can result when an individual forgets their FUH appointment information including provider address, date and time of appointment.* • *The delay that can result when an individual is unable to obtain medications following discharge due to a lack of preauthorization.* • *The delay that can result when an individual's supply of medication is exhausted prior to the FUH appointment.* • *The incomplete data source regarding FUH services provided when claims are not submitted.* • *The delay that can result when a CPS is not working with an individual to support engagement in aftercare appointment* • *The delay in connecting with case management services to coordinate community-based care when the inpatient provider does not contact the case mgmt provider.* ***Follow-up Status Response***
People (e.g., personnel, provider network, patients) • **Mbr choosing not to accept care** • **Bad experience w/ provider** • **Medication Changes** • **Substance use relapse**	***Initial Response*** • *The delay that can result when an individual chooses to not pursue treatment following discharge from an inpatient setting.* • *The delay that can result when an individual is dissatisfied with their interactions with a provider such that there is hesitation to return to the provider for treatment.* • *The delay that can result when an individual has difficulty managing the effects of new medications when in the community* • *The delay that can result when an individual resumes use of substances and a substance abusing lifestyle which causes distraction from and/or avoidance of treatment.*

• **Co-morbid medical conditions** • **Increased or new psycho-social stressors (more likely as time from d/c increases)**	• *The delay that can occur, due to limited resources, when an individual requires specialized medical care concomitant with their psychiatric care upon discharge.* • *The delay that can result when an individual experiences an increase in the number or intensity of new or chronic psychosocial stressors such that the stressor interferes with the ability to participate in treatment i.e.- loss of an automobile, loss of income to afford public transportation, loss of child care provider etc.* ***Follow-up Status Response***
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) • **Inconvenient FUH appointment(s)** • **Appointment unavailability/immediate access** • **Open Access- no appointment** • **Open Access- no tracking of kept visit or f/u call** • **Transportation** • **OP scheduling flexibility** • **Lack of Psychiatrists** • **Open Access**	***Initial Response*** • *The delay that can result when an individual is unable to keep an FUH appointment due to practical reasons including, but not limited to, geographic location of provider or date/time of appointment.* • *The delay that can result when an individual becomes re-acclimated to their routine post discharge and becomes less likely over time to accommodate treatment into their established schedule.* • *The delay that can result when an individual has a date but no specific time commitment associated with the FUH appointment.* • *The delay that can result when an open access provider does not track individuals referred upon inpatient discharge and the subsequent lack of follow-up with the individual if the 'appointment' is not kept.* • *The delay that can result when an individual is unable to secure means of transportation to and from an appointment.* • *The delay that can result when OP providers are unable to offer a wide array of appointment times throughout the business day i.e.- early morning, evening, that may be more convenient for a number of reasons including, but not limited to, transportation, childcare, etc.* • *The delay that can result when there are a limited number of psychiatric appointments available due to a shortage of psychiatrists.* • *The delay that can result when a provider does not adequately plan for a large influx of individuals utilizing Open Access that particular day and has no plan to accommodate the individuals that present. This can result in individuals who are turned away or cannot stay for the long wait time.* • ***Follow-up Status Response***
Other (specify): Treatment Process	***Initial Response*** • *The delay that can result when the provider does not include critical elements in the discharge*

• **Incomplete discharge plan at discharge** • **Lack of appropriate community-based services/resources** • **Lack of active treatment** • **Lack of involving member in own treatment** • **Why now?' not addressed** • **Lessened impact of treatment benefit from MH IP as time from tx episode increases (more likely as time from d/c increases)** • **Lack of understanding of d/c plan** • **Lack of family/support person's involvement to assist member w/adherence to d/c plan**	*plan including appointment location, date of appointment, time of appointment, etc.* • *The delay that can result when an individual has a specialized need that cannot be met by traditional community-based services and results in the member disengaging from treatment.* • *The delay that can result from a more passive approach to treatment that may result in apathy toward treatment.* • *The delay that can result when individuals are not encouraged to participate in the treatment process and recovery. Infers relationship between recovery approach and delay in progress.* • *The delay that can result when the 'root cause' of the admission (vs. presenting problem) is not adequately addressed by the provider.* • *The delay that can result when an individual becomes re-acclimated to their routine post discharge and becomes less likely over time to accommodate treatment into their established schedule.* • *The delay that can result when an individual is unclear on specifics of the discharge plan including location, date, time and their role in it i.e.- securing own transportation, etc.* • *The delay that can result when an individual lacks the support of others in keeping the FUH appointment including, but not limited to, family/support persons providing appointment reminders, transportation, accompanying to appointment, etc.* ***Follow-up Status Response***

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

For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2013. Documentation of actions should be continued on additional pages as needed.

Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
The Actions listed in the Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day) are all applicable to address the barriers		***Initial Response*** *(See responses above)*

identified for this measure (Follow-up After Hospitalization for Mental Illness QI B (FUH, PA-Specific 30 Day). Improvement in any HEDIS measure and any 7 day measure will also improve performance in this measure. The Actions listed above include: • MH IP PIC program • Day of discharge appointments (i.e. Bridge or Mobile Mental Health) • Members with 30 day discharge reviewed in clinical rounds • Weekly clinical rounds for adults and children/adolescents with highest volume MH IP provider • Explore possibility of using Telepsychiatry services in outpatient settings for individuals discharging from inpatient settings.		***Follow-up Status Response***
Please see the following Action in the Follow-up After Hospitalization for Mental Illness QI A (FUH, PA-Specific 7 Day), which is also applicable for this measure: Pilot program of ICM services for homeless individuals began in March 2014.		***Initial Response*** *(See response above)* ***Follow-up Status Response***

Managed Care Organization (MCO): *Magellan Behavioral Health (MBH)*	***Measure:*** *Readmission within 30 Days of Inpatient Psychiatric Discharge*	***Response Date:*** ***10/6/2014***
Goal Statement: **(Please specify individual goals for each measure): Decrease rate of 30 day readmissions to inpatient psychiatric level of care by a statistically significant amount. Based on MY 2012, a statistically significant (p = 0.05) decrease would be realized at 14.60%.**		
***Analysis*:** **What factors contributed to poor performance?** **Please enter "N/A" if a category of factors does not apply.**	***Findings*** MBH remained statistically the same from MY2011 to MY2012 but was statistically significantly below/poorer than the MY2012 HealthChoices BH-MCO average of 12.8%. Although not yet included in the EQR report, MBH and its county partners are including the review of the validated MY2013 IPRO results in this RCA process. The table below provides a comparison of the MY2010 to MY2011 to MY2012 to MY2013 performance per County, for MBH and the HC BH-MCO average.	

30-Day Readmission				
	MY2010	MY2011	MY2012	MY2013
BU	13.10%	10.88%	12.21%	15.41%
DE	12.64%	14.37%	14.31%	13.42%
LE	16.74%	16.18%	18.31%	15.82%
MO	15.83%	16.79%	16.40%	14.44%
NH	14.47%	13.29%	16.32%	15.55%
Magellan	14.69%	14.68%	15.75%	14.87%
HC BH-MCO Average	12.40%	12.34%	12.80%	

In 2013's RCA in response to MY2011 30-day Readmission Rate performance, MBH's data analysis took a different approach to complete a statistical analysis using the most recent three years of IPRO data (MY2010, MY2011 and MY2012) to determine predictive factors of readmission. Although not formally applicable to the MY2011 RCA, MY2012 data was included as it was IPRO validated and offered more current information in the analysis. [Please see FRM_2012 BH PM RCA Response_MBH_110813 for complete analysis.]

In taking the same approach for this current MY2012 RCA, review of IPRO validated MY2013 30-day Readmission Rate performance is considered.

- Four of the five counties managed by Magellan and Magellan's combined rate improved (i.e. decreased) performance from MY2012 to MY2013.
- Of those five groups, Lehigh County's improvement demonstrates a statistically significant change.
- While not statistically significant, the change from MY2012 to MY2013 in encouraging
- In Bucks County, a 26% increase was seen in this same comparison. This reflected a statistically significant increase in this comparison.

Bucks County analysis

Through routine utilization and financial management activities, Bucks County and Magellan identified a 44% increase in the Per Member Per Month (PMPM) cost from Q1 2012 to Q1 2013. Initial data analysis identified acute inpatient psychiatric (AIP) services as a key cost driver to this PMPM change. This increase was unique to Bucks County, which led to the initiation of a RCA to further understand the underlying causes of this increase. The RCA activity addressed all factors contributing to the use of AIP, including factors of admission and readmission.

	Key findings related to readmission included: • Lack of crisis residential programs within Bucks County • Insufficient clinical engagement with members, such as: ACT/CTT teams not considering crisis residential services and members not contacting ACT/CTT services when challenges arise • Members with D&A treatment needs using AIP
Policies (e.g., data systems, delivery systems, provider facilities) ***N/A***	***Initial Response*** ***Follow-up Status Response***
Procedures (e.g., payment/reimbursement, credentialing/collaboration) • ***1st treatment episode- more thorough assessment needed*** • ***Illness vs. Recovery*** • ***Lack of Collaboration w OP providers*** • ***Fragmentation of AIP services*** • ***Malingering Symptoms***	***Initial Response*** • *When an individual has no treatment history and more time is required to assess the effectiveness of treatment interventions due to limited clinical information.* • *Staff's attitudes about treatment progress and how this translates into actual treatment interventions (e.g. - individuals 'owning' their own recovery). Infers relationship between recovery orientation and pace of treatment.* • *When AIP providers do not collaborate with community-based providers to obtain already existing information regarding effective vs ineffective treatment interventions* • *When different disciplines on the AIP unit do not share information regarding the individuals care e.g. - effective treatment, d/c planning, etc.* • *When an individual misrepresents their symptoms e.g. - reporting S/I when none exists- and the physicians' obligation to respond to the individual's self report* ***Follow-up Status Response***
People (e.g., personnel, provider network, patients) • **AIP 'Culture'** • **Med Changes** • **Medication Adherence** • **Mbr financial issues** • **Acuity**	***Initial Response*** • *The provider's underlying organizational attitudes and beliefs about treatment that influence clinical practices in all disciplines and dictate pace of treatment, interventions used, etc.* • *The effective of medication changes on an individual's symptom experience and how that can impact them once discharged from the hospital.* • *Impact of individuals not taking medications as prescribed.* • *Refers to individuals utilizing AIP units to meet their basic needs (shelter, food) because they are unable to meet their needs financially.* • *Effect on an individual's experience when their symptoms are non-responsive to treatment.* • *When an individual requires specialized medical care concomitant with their psychiatric care upon discharge.*

• **Complex medical issues** • **Medication effectiveness**	• *When medications prescribed are not effective in reducing acuity.* ***Follow-up Status Response***
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) • ***Wait lists for EAC*** • ***Complicated disposition (based on high needs, ie fire setting, medical issue)*** • ***Lack of appropriate community-based services/resources*** • ***Reduction in state hospital beds*** • ***Lack of PCHs*** • ***Homelessness*** • ***Pre-admission services inadequate***	***Initial Response*** • *When an individual meets MNC for EAC and there is limited to no availability.* • *When a d/c housing resource cannot be identified due to the presence of behaviors that are frequently identified as exclusionary criteria for housing programs e.g. - fire setting, pedophilia, etc.* • *Refers to the perception that there is a limited array of services within the community.* • *When an individual has reached his/her baseline however severe acuity persists, historically these individuals would be admitted to the State Hospital for further treatment which is no loner an option.* • *When a d/c housing resource cannot be identified due to a lack of available Personal Care Home (PCH) placements.* • *When a d/c housing resource cannot be identified an the individual is unsafe for d/c to a shelter* • *When services that an individual received prior to admission were not effective in assisting the individual to remain in the community.* ***Follow-up Status Response***
Other (specify) Treatment process • ***Member comfort level*** • ***Use of EBPs*** • ***Lack of trauma informed care*** • ***D/C planning*** • ***'Why now?' not addressed*** • ***COD***	***Initial Response*** • *When an individual's acclimation to/comfort level with the AIP environment is such that the individual experiences a lack of motivation toward treatment interventions.* • *Refers to the limited success that can result when providers utilize clinical interventions that are not proven effective.* • *When an individual has significant trauma issues for which interventions employed are not designed to address.* • *When d/c planning is not actively pursued by the provider.* • *When the 'root cause' of the admission (vs presenting problem) is not adequately addressed by the provider.* • *When individual's symptoms are the result of the simultaneous presence of psychiatric symptoms and substance use and interventions are not designed to effectively address both issues.*

• ***Lack of Family Involvement*** • ***Lack of Strength focused treatment*** • ***Lack of active treatment*** • ***No clear assessment of need*** • ***Lack of involving mbr in own treatment*** • ***Institutionalization***	• *When an individual's family is not engaged as a support in the treatment process.* • *Staff's attitudes about treatment progress and how this translates into actual treatment interventions (e.g. - individuals 'owning' their own recovery). Infers relationship between the use of strength focused treatment approach and delay in progress.* • *When a more passive approach to treatment translates into a slower pace with which interventions in all disciplines are employed e.g.- med changes, d/c planning, etc.* • *When there is an unclear understanding of areas which require intervention.* • *When individuals are not encouraged to actively participate in the treatment process and recovery. Infers relationship between recovery approach and delay in progress.* • *Refers to the delay in effective treatment that can result from an individual's development of excessive dependency on the AIP unit and its routines.* ***Follow-up Status Response***

Complete next page of corresponding action plan.

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

For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2013. Documentation of actions should be continued on additional pages as needed.

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

 MY 2012 Adult MH IP Discharges_Pareto Cl Given the success demonstrated through the programmatic approach of the Partners in Care program with regard to clinical quality, operational practices, provider accountability and fiscal responsibility, Magellan and its partner counties developed the MH IP Partners in Care program.	reporting to begin with 2015 data	• *Every-other month group meetings to address: performance metric data; factors contributing to positive and negative results; provider program management processes; and sharing of ideas, challenges and strategies to continue quality improvement.* • *Providers will agree to the following expectations: 1) Ensure HEDIS approved services are scheduled within 7 days of discharge (this may be in addition to supportive/linkage services such as TCM and CPS and 2)work with outpatient providers to allow Bridge appointments within the MH IP facility* • *Based on successful demonstration of improvement on performance metrics and collaboration in MH IP PIC program, providers may be moved to an alternative payment arrangement;* *In May 2014, the MH IP PIC program was introduced by Bucks, Delaware, Lehigh, Montgomery and Northampton Counties and Magellan to the ten providers. In July, the initial group program management meeting was held. At that time, the providers were given their draft performance metric baselines based on 2013 data. As the measurement period will officially begin 1/1/15 for this program, the 'draft' baseline data and goals were provided so the Magellan care managers and provider staff would have an opportunity to understand the data, what is included/excluded and from there, develop ways to positively impact the data.* *Also at the July group meeting, the providers were introduced to the PIP development process (Successful transition from inpatient care to ambulatory care). The providers have each been asked to complete a barrier analysis and develop at least one interventions address those barriers. The PIC structure offers a forum in which to engage the providers into the interventions to decrease the need for readmission.* ***Follow-up Status Response*** *<insert follow-up response here; leave blank for initial response submission>*
Development of interventions to address 30-day readmissions with Regional Vice President for UHS of Delaware, Inc. There are 4 adult psychiatric inpatient facilities overseen by this VP, which accounted for 30% of inpatient discharges in MY 2012	-11/2013 -Ongoing -Readmission Survey data to be submitted quarterly	***Initial Response*** *In November 2013, Magellan held a meeting and brainstorming session scheduled with five key UHS facilities to find ways to use common goals to work together. The meeting was very successful and resulted in the development of a survey that the adult providers in the group implemented in 2014 for all individuals for whom the current admission is a 30 day readmission.* *As of 9/30/14, data from two quarters has been submitted but does not yet yield reliable results due to the volume (the providers are submitting only Magellan HealthChoices members information). Three of the four providers are administering surveys to all qualifying individuals, regardless of funding so that they can use the information internally. These providers report that from their larger sample, there are trends regarding lack of medication as well as relapse within the first few week following discharge as key reasons for readmission.*

		The four providers administering the survey are included in the MH IP PIC. ***Follow-up Status Response***
Development of Extended Acute Care (EAC) inpatient psychiatric program for southeast counties. Magellan and CCBH, along with Bucks, Chester, Delaware and Montgomery Counties issued a RFP in spring 2013, with a program to open in 2014.	-RFP Issued- Spring 2013 Opening- planned October 2014	***Initial Response*** *In May 2013, Brooke Glen Behavioral Hospital (BGBH) was awarded the RFP. As of October 31, 2013, all Reinvestment plans from the 4 counties have been approved and BGBH has begun the implementation process. Construction is almost complete and the program is expected to accept its first admission in mid-October.* *As part of the implementation process, performance metrics and clinical outcomes to be measured will be established.* ***Follow-up Status Response***
Ensure 100% of members who were readmitted to the hospital within 30 days of discharge are discussed in Clinical Rounds with the Medical Team	-June 2014 -Ongoing -Weekly	***Initial Response*** *Cases identified for Clinical Rounds with the Medical team were previously based on a challenged to progress within the current treatment episode. In June 2014, this approach changed to include anyone readmitted to MH IP loc within 30 days of a prior discharge. This ensures there is a focus in clinical review on the reason for the readmission.* ***Follow-up Status Response***

Weekly Clinical Rounds for adults and children/adolescents with highest volume MH IP provider	-June 2014 -Ongoing -Daily	***Initial Response*** *The five counties and Magellan have worked with the largest MH IP provider through a continuous quality improvement activity with limited success. Challenges were faced in the provider's implementation of the interventions. Although the interventions developed are being implemented, it was determined that a more direct, case by case approach was also needed.* *In May 2014, Magellan met with this provider to review data on key performance metrics and to discuss ways to improve this. At that meeting, it was agreed that weekly clinical rounds between Magellan and the provider (one for children/adolescents and one for adults) would be a way to improve collaboration and understanding outside of the traditional UR process.* ***Follow-up Status Response***

Bucks County Rate increases for Bucks County MH OP providers	-7/2014 -Completed for	***Initial Response*** *The rates for Bucks County MH OP providers who do not participate in the Bucks County Outpatient Enhancement Initiative are significantly lower than the average. A plan to offer*

	listed provider -Ongoing consideration based on rates	*rate increases with associated performance expectations is being considered within the limitations of the rate setting processes.* *In July 2014, rates for New Life, an outpatient provider in Bucks County, were increased with the goal to increase availability.* ***Follow-up Status Response***

Bucks County Partners In Care program management model for ACT	-June 2014 -Ongoing -Quarterly	***Initial Response*** *The key findings of the Bucks County inpatient RCA included insufficient clinical engagement of the ACT/CTT teams with the members in those programs. Magellan's experience with a programmatic approach (Partners in Care, PIC) with providers to clinical management has previously demonstrated success in this area. In order to have increased contact with the ACT/CTT programs, Bucks County and Magellan moved its ACT/CTT programs to this model in June 2014.* ***Follow-up Status Response***

Bucks County Expanding provider network to include Crisis Residential programs in and within close proximity to Bucks County • New Crisis Residential program being developed and expected to open in 2016 • Adding Haven House to provider network as Crisis Residential option within close proximity to Bucks County	-Mid-2016 - Early 2015	***Initial Response*** *The Bucks County specific RCA identified the lack of Crisis Residential programs as a factor to increased readmissions. To address this barrier, work is being done to bring a Crisis Residential program in a neighboring county into the provider network. In addition, in a collaborative process between Bucks County Department of Behavioral Health and Bucks County Office of Mental Health and Developmental Programs and Magellan, a new Crisis Residential program is being developed within Bucks County.* ***Follow-up Status Response***

Lehigh and Northampton Counties Partners In Care program management model for adult community-based services (TCM, ACT, CPS and Psych Rehab)	-October 2014 -Ongoing _Quarterly	***Initial Response*** Given the success demonstrated through the programmatic approach of the Partners in Care (PIC) program with regard to clinical quality, operational practices, provider accountability and fiscal responsibility, the adult community-based services (TCM, ACT, CPS and Psych Rehab) are moving to this model in October 2014. The rationale for this programmatic approach for these levels of care include: • Increase IMPACT (intensive care management program) census and increase focus on complex members. The IMPACT census has averaged 24 members per month for Lehigh County and 20 for Northampton County over the past two years; while the total number of members' eligible for IMPACT: 123 Lehigh and 156 Northampton. By moving to a PIC model we will be able to enroll all members who are eligible into the program. • Increase longitudinal care management, IMPACT Care Manager will follow member and

		review cases in all levels of care. Currently the members are followed by the Care Manager assigned to the facility. • Ability to shape providers at the program level versus case by case • Ensure consistency of care across providers • Share outcomes data with providers on a routine basis • Encourage and promote best practices across providers • Increase ambulatory follow up rates and decrease 30 day re-admission rates • Leverage clinical resources and increase program level knowledge • Low rates of denials for the identified providers going back to 2010. All proposed levels of care in the PIC Program Description have low admission rates to 24 hour levels of care (less than 5%) • Increase BH/PH collaborative efforts for Lehigh and Northampton County members. Care Managers who are currently completing reviews for ACT, CPS, Case Management and Psych Rehab would switch their focus to: coordinating care for members who are engaged with the NHCLV and Haven House integrated PH/BH program and participating in clinical rounds with PH-MCO's. ***Follow-up Status Response***
Northampton County Care Coordination Program	- August 2013 - Expected to continue - Ongoing	***Initial Response*** Following successful decrease in readmission rates for a targeted population of individuals with a history of 30-day readmission to mental health inpatient with this program in another county, Northampton County and Magellan expanded this program for Northampton County members in August 2013. Individuals for whom their current MH IP admission is within 30 days of discharge from the same loc, Magellan's clinical team makes a referral to Care Coordination program. This 'expedited' case management program will meet with the individual within one day of the referral, while the member is on the inpatient unit. The premise is to begin the engagement with the community-based service prior to discharge. The goal of the program is help individuals make a smooth connection to the ongoing community-based services. ***Follow-up Status Response***

VI: 2013 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of MBH's 2014 (MY 2013) 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. As the Initiation and Engagement of Alcohol or Other Drug Dependence Treatment (IET) measure was produced for the first time in MY 2013, BH-MCOs are not expected to respond to opportunities for improvement for this measure for this review year. BH-MCOs will be expected to address opportunities for improvement regarding the IET measure in subsequent review years.

Strengths

- MBH's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness - HEDIS indicators (QI 1 and QI 2) were statistically significantly higher than the BH-MCO averages by 5.4 and 1.9 percentage points respectively.

- MBH's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness - PA Specific indicators (QI A and QI B) were significantly higher than the BH-MCO averages by 6.8 and 3.1 percentage points respectively.

- MBH met the OMHSAS MY 2013 interim goals for Follow-up After Hospitalization for Mental Illness - QI 1 and QI 2 for ages 6-64.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2011, RY 2012, and RY 2013 found MBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
    - MBH was partially compliant on one out of seven categories within Subpart C: Enrollee Rights and Protections. The partially compliant category is Enrollee Rights.
    - MBH was partially compliant on four out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care) 2) Coordination and Continuity of Care 3) Coverage and Authorization of Services 4) Practice Guidelines
    - MBH was partially compliant on nine 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) Information to Providers & Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.

- MBH's rate for the MY 2013 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (poorer) than the MY 2013 HealthChoices BH-MCO Average by 1.4 percentage points. MBH's rate did not meet the OMHSAS designated performance goal of 10.0%.

- MBH's rate for the MY 2013 Follow-up After Hospitalization for Mental Illness HEDIS performance measures did not meet the OMHSAS designated performance goal of the HEDIS 75th percentile for ages 6-64.

Additional strengths and targeted opportunities for improvement can be found in the BH-MCO-specific 2014 (MY 2013) 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) 2013 and MY 2012; and
- Compares the BH-MCO's MY 2013 performance measure rates to the MY 2013 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 2013 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 for ages 6-64).

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:

	PA-specific Follow-Up After Hospitalization Measures: Indicates that the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012. **Readmission within 30 Days of Inpatient Psychiatric Discharge:** Indicates that the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012. **HEDIS Follow-Up After Hospitalization Measures– Ages 6-64**: At or above 90th percentile. *BH-MCOs may have internal goals to improve.*
	PA-specific Follow-Up After Hospitalization Measures: Either the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012 or that the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average but there is no change from MY 2012. **Readmission within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012 or that the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average but there is no change from MY 2012. **HEDIS Follow-Up After Hospitalization Measures– Ages 6-64**: At or above 75th and below 90th percentile. *BH-MCOs may identify continued opportunities for improvement.*
	PA-specific Follow-Up After Hospitalization Measures: The BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012 or the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and there is no change from MY 2012 or the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average but trends down from MY 2012. **Readmission within 30 Days of Inpatient Psychiatric Discharge:** The BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012 or the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and there is no change from MY 2012 or the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average but trends up from MY 2012. **HEDIS Follow-Up After Hospitalization Measures– Ages 6-64:** N/A *No action is required although MCOs should identify continued opportunities for improvement.*
	PA-specific Follow-Up After Hospitalization Measures: Either the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average and there is no change from MY 2012 or that the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012. **Readmission within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average and there is no change from MY 2012 or that the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012. **HEDIS Follow-Up After Hospitalization Measures– Ages 6-64:** At or above 50th and below 75th percentile. *A root cause analysis and plan of action is required.*
	PA-specific Follow-Up After Hospitalization Measures: the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012. **Readmission within 30 Days of Inpatient Psychiatric Discharge:** the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012. **HEDIS Follow-Up After Hospitalization Measures – Ages 6-64:** At or below the 50th percentile. *A root cause analysis and plan of action is required.*

Figure 1.1: Performance Measure Matrix – MBH

Year to Year Statistical Significance Comparison	Trend	HealthChoices BH-MCO Average Statistical Significance Comparison: Below / Poorer than Average	Average	Above / Better than Average
	⬆	C	B	A FUH QI A FUH QI B
	No Change	D REA	C	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 2013 are displayed in Figure 1.2. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

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

Figure 1.2: Performance Measure Rates – MBH

Quality Performance Measure	MY 2010 Rate	MY 2011 Rate	MY 2012 Rate	MY 2013 Rate	MY 2013 HC BH-MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	62.8% =	62.1% =	59.2% ▼	62.5% ▲	55.7%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	76.0% =	75.6% =	73.2% ▼	75.3% ▲	72.3%
Readmission within 30 Days of Inpatient Psychiatric Discharge[1]	14.7% =	14.7% =	15.8% =	14.9% =	13.5%

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

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

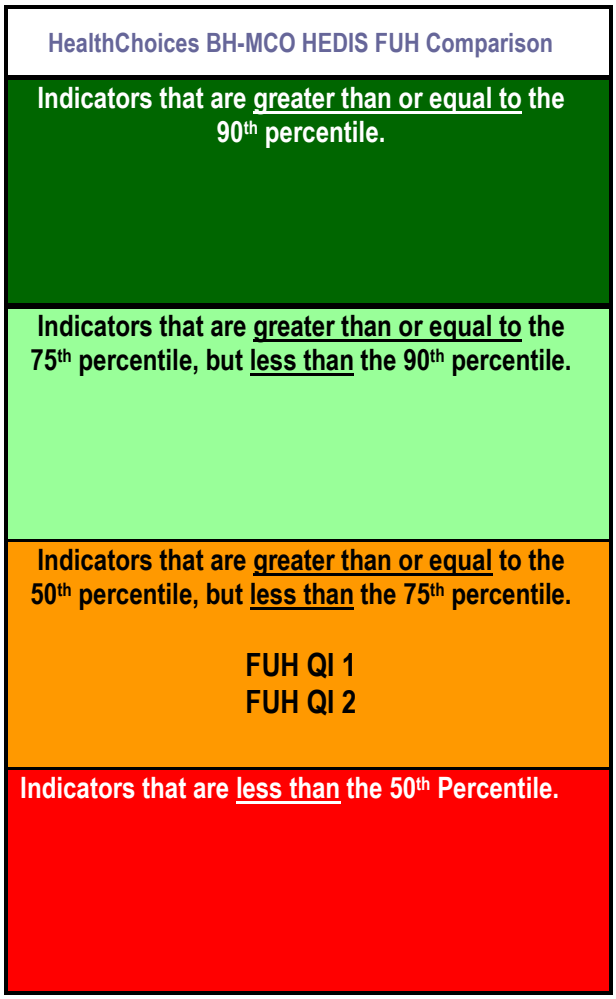


Figure 2.2: HEDIS Follow-Up After Hospitalization (FUH) 7-day/30-day Performance Measure Rates – MBH

Quality Performance Measure	MY 2012 Rate	HEDIS 2013 75%ile
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	51.5% *Not Met*	*Below 75th percentile, at or above 50th percentile*
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	68.6% *Not Met*	*Below 75th percentile, at or above 50th percentile*

Magellan Behavioral Health (MBH)

KEY POINTS

- **A - Performance is notable. No action required. BH-MCOs may have internal goals to improve.**
  - Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)
  - Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)

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

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

- **D - Root cause analysis and plan of action required.**
  - Readmission within 30 Days of Inpatient Psychiatric Discharge[2]
  - Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day) – Ages 6-64
  - Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day) – Ages 6-64

- **F - Root cause analysis and plan of action required.**
  - No MBH performance measure rate fell into this comparison category.

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

VII: SUMMARY OF ACTIVITIES

Structure and Operations Standards

- MBH was partially compliant on Subparts C, D, and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2013, RY 2012, and RY 2011 were used to make the determinations.

Performance Improvement Projects

- MBH submitted one PIP Proposal in 2014

Performance Measures

- MBH reported all performance measures and applicable quality indicators in 2014.

2012 Opportunities for Improvement MCO Response

- MBH provided a response to the opportunities for improvement issued in 2013, and submitted a root cause analysis and action plan response in 2014.

2013 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for MBH in 2014. The BH-MCO will be required to prepare a response for the noted opportunities for improvement in 2015.

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

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Standard 108.2	C/FST budget is sufficient to: hire staff proportionate to HC covered lives, has adequate office space, purchase equipment, travel and attend on-going training.
	Standard 108.5	The C/FST has access to providers and HC members to conduct surveys and employs of a variety of survey mechanisms to determine member satisfaction e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Standard 108.6	The problem resolution process specifies the role of the County, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
	Standard 108.7	The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
	Standard 108.8	The Annual Mailed/Telephonic survey results are representative of HC membership, identify systemic trends and actions have been taken to address areas found deficient, as applicable.
	Standard 108.10	The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.
§438.206 Availability of Service	Standard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages. • Excel or Access data base with the following information: Name of Agency (include satellite sites). Address of Agency (and satellite sites) with zip codes. Level of Care (e.g. Partial Hospitalization, D&A Outpatient, etc). Population served (adult, child & adolescent). Priority Population. Special Population.
	Standard 1.2	100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met.
	Standard 1.3	Provider Exception report submitted & approved when choice of two providers is not given.

BBA Category	PEPS Reference	PEPS Language
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).
	Standard 1.5	BH-MCO has notified DPW of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	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.

BBA Category	PEPS Reference	PEPS Language
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.2104 Provider Selection	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as, other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.240 Quality assessment and performance improvement program	Standard 91.1	QM program description outlines the ongoing quality assessment and performance improvement activities, Continuous Quality Improvement process and places emphasis on, but not limited to High volume/high-risk services and treatment and Behavioral Health Rehabilitation services.
	Standard 91.2	QM work plan includes goal, aspect of care/ service, scope of activity, frequency, data source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines, the joint studies to be conducted.

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

BBA Category	PEPS Reference	PEPS Language
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for Coordination with Other Service Agencies and School.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
§438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action

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

BBA Category	PEPS Reference	PEPS Language
	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.
	Standard72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.404 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 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to

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

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

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

BBA Category	PEPS Reference	PEPS Language
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

Appendix B: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Second Level Complaints and Grievances		
Complaints	Standard 68.1	Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.
	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.
Grievances and State Fair Hearings	Standard 71.1	Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.
	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
Enrollee Satisfaction		
Consumer / Family Satisfaction	Standard 108.3	County/BH MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.
	Standard 108.4	The C/FST Director is responsible for setting program direction consistent with County direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority and directing staff to perform high quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH MCO provider profiling and have resulted in provider action to address issues identified.

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2013, 11 substandards were considered OMHSAS-specific monitoring standards. Of the 11 OMHSAS-specific PEPS Substandards, ten were evaluated for MBH and the five counties subcontracting with MBH. One substandard was not scheduled or not applicable for evaluation in RY 2013. Table C.1 provides a count of these Items, along with the relevant categories.

Table 1.5 OMHSAS-Specific Substandards Reviewed for MBH

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2013	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	Not Reviewed
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	3	0	0	1
Grievances and State Fair Hearings (Standard 71)	4	4	0	0	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0

Format

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

Findings

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards[3]. Of the seven substandards evaluated, MBH met four substandards and did not meet three substandards, as indicated in Table C.2.

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

Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
Complaints	Standard 68.1	RY 2013	Not Met
	Standard 68.6	RY 2013	Not Reviewed
	Standard 68.7	RY 2013	Not Met
	Standard 68.8	RY 2013	Not Met
Grievances and State Fair Hearings	Standard 71.1	RY 2013	Met
	Standard 71.5	RY 2013	Met
	Standard 71.6	RY 2013	Met
	Standard 71.7	RY 2013	Met

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

MBH did not meet the criteria for compliance for Substandards 68.7, 68.8, and 68.1:

> **Substandard 68.1:** Where applicable there is evidence of County oversight and involvement in the second level complaint process.

[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.

Substandard 68.7: Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.

Substandard 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.

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

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

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

i World Health Organization. (2008) WHO Global Burden of Disease: 2004 Update. Available from: www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html

ii Dombrovski A, Rosenstock J (2004) Bridging General Medicine and Psychiatry: Providing General Medical and Preventive Care for the Severely Mentally Ill. Current Opinion in Psychiatry, 17(6):523-529

iii Moran M. (2009) Schizophrenia Patients Show High Rates of Comorbid Illness. Psychiatric News, 44(18):22.

iv Gill SS. (2005). Stable Monotherapy with Clozapine or Olanzapine Increases the Incidence of Diabetes Mellitus in People with Schizophrenia. Evid Based Ment Health, 8(1):24.

v Leslie DL, Rosenheck RA. (2004) Incidence of Newly Diagnosed Diabetes Attributable to Atypical Antipsychotic Medications. Am J Psychiatry, 161:1709–11.

vi Druss BG, Rosenheck, RA, Desai MM, &Perlin, J. B. (2002). Quality of Preventive Medical Care for Patients with Mental Disorders. Medical Care, 40(2):129–136.

vii Desai M, Rosenheck RA, Druss BG, Perlin J.B. (2002) Mental Disorders and Quality of Diabetes Care in Veterans Health Administration. Am J Psychiatry, 159:1584-1590

viii Frayne SM., Halanych JH., Miller D.R., et al. (2005) Disparities in Diabetes Care: Impact of Mental Illness. Arch Intern Med, 165(22):2631-8.

ix Druss BG, Bradford DW, Rosenheck RA et al. (2000) Mental Disorders and Use of Cardiovascular Procedures After Myocardial Infarction JAMA, 283(4):506-11.

x Averyt JM, Kuno E, Rothbard AB, Culhane DP. (1997) Impact of Continuity of Care on Recurrence of Homelessness Following an Acute Psychiatric Episode. Continuum 4.3

xi National Institute of Mental Health — Statistics. http://www.nimh.nih.gov/health/topics/statistics/index.shtml. updated Mar 31,2009. Accessed May 20, 2009.

xii Insel TR. (2008) Assessing the Economic Costs of Serious Mental Illness. Am J Psychiatry, 165:663-65.

xiii D'Mello DA, Boltz MK, Msibi B. (1995) Relationship between Concurrent Substance Abuse in Psychiatric Patients and Neuroleptic Dosage. Am J Drug Alcohol Abuse, 2:257-65.

xiv National Committee for Quality Assurance (NCQA, 2007). The State of Health Care Quality 2007. Washington, DC: National Committee for Quality Assurance. Available at http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_2007.pdf (Accessed July 12, 2010).

xv van Walraven C, Mamdani M, Fang J, Austin PC. (2004) Continuity of Care and Patient Outcomes After Discharge. J Gen Intern Med, 19:624-31

xvi Hermann RC. (2000) Quality measures for mental health care: results from a National Inventory. Medical Care Research and Review, 57:136-54

xvii Ibid.

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

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

xx Ibid.

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

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

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

xxiv Ibid.