



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

**2014 External Quality Review Report
PerformCare
FINAL REPORT**

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IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org



REPORT CONTENT

Glossary of Terms	p. 3
Introduction	p. 4
I: Structure and Operations Standards	p. 6
Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations	p. 9
II: Performance Improvement Projects	p. 22
III: Performance Measures	p. 26
Follow-up After Hospitalization for Mental Illness	p. 26
Readmission within 30 Days of Inpatient Psychiatric Discharge	p. 47
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	p. 52
IV: Quality Study	p. 53
V: 2013 Opportunities for Improvement - MCO Response	p. 55
Current and Proposed Interventions	p. 55
Corrective Action Plan for Partial and Non Compliant PEPS Standards	p. 68
Root Cause Analysis and Action Plan	p. 69
VI: 2014 Strengths and Opportunities for Improvement	p. 78
Performance Measure Matrices	p. 79
VII: Summary of Activities	p. 84
Appendix	p. 85
Appendix A: Crosswalk of Required PEPS Substandards to Pertinent BBA Regulations	p. 85
Appendix B: OMHSAS-Specific PEPS Substandards	p. 95
Appendix C: Program Evaluation Performance Summary OMHSAS-Specific Substandards	p. 96
References	p. 99



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

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 measurement 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 Dependence 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

As of October 2, 2013, Community Behavioral HealthCare Network of Pennsylvania, Inc. (CBHNP) began doing business in Pennsylvania under the trade name PerformCare. The name PerformCare will be used throughout this report¹. This section of the EQR report presents a review by IPRO of PerformCare'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. During RY 2013, three Counties, Blair, Clinton, and Lycoming, held a contract with PerformCare through June 30, 2013 and contracted with another BH-MCO as of July 1, 2013.

Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties formed an HC Oversight Entity called Capital Area Behavioral Health Collaborative (CABHC).. The Tuscarora Managed Care Alliance and Behavioral Health Services of Somerset and Bedford Counties (BHSSBC) oversee the HC BH program for Franklin, Fulton, Bedford and Somerset Counties respectively. The latter two HC Oversight Entities hold contracts with PerformCare.

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 Program Standards & Requirements (PS&R) Agreement compliance. The HC BH PS&R Agreement includes the HC BH Contractor's responsibility for the oversight of the 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.

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



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

HealthChoices Oversight Entity	HC BH Contractor(s)	County(ies)
Capital Area Behavioral Health Collaborative (CABHC)	Cumberland County	Cumberland County
	Dauphin County	Dauphin County
	Lancaster County	Lancaster County
	Lebanon County	Lebanon County
	Perry County	Perry County
Behavioral Health Services of Somerset and Bedford Counties (BHSSBC)	Behavioral Health Services of Somerset and Bedford Counties (BHSSBC)	Bedford County
	Otherwise known as Bedford-Somerset for review	Somerset County
The Tuscarora Managed Care Alliance	The Tuscarora Managed Care Alliance	Franklin County
	Otherwise known as Franklin-Fulton for review	Fulton 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 PerformCare 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. Since Erie, Blair, Clinton, and Lycoming Counties contracted with two BH-MCOs in the review period, and because all applicable standards were reviewed for both BH-MCOs within the three-year time frame, these HealthChoices Oversight Entity review findings were not included in the assessment of compliance for either BH-MCO.

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



Program Evaluation Performance Summary Items Pertinent to BBA Regulations for PerformCare (CBHNP) HC BH Contractors

Table 1.1 Items Pertinent to BBA Regulations Reviewed for PerformCare (CBHNP)

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	2	7	3	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	24	9	17	2	0
Coordination and Continuity of Care	2	0	0	2	0
Coverage and Authorization of Services	4	1	0	2	1
Provider Selection	3	0	3	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	8	0	0	0
Practice Guidelines	6	4	0	2	0
Quality Assessment and Performance Improvement Program	23	23	0	0	0
Health Information Systems	1	1	0	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	1	0	9	1
General Requirements	14	1	0	12	1
Notice of Action	13	6	6	0	1
Handling of Grievances and Appeals	11	1	0	9	1
Resolution and Notification: Grievances and Appeals	11	1	0	9	1
Expedited Appeals Process	6	1	0	4	1
Information to Providers and Subcontractors	2	0	0	2	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	1	0	4	1
Effectuation of Reversed Resolutions	6	1	0	4	1

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



For RY 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 PerformCare and the three HC BH Contractors associated with the BH-MCO, 163 PEPS Items were identified as required to fulfill BBA regulations. The 3 HC BH Contractors were evaluated on 154 PEPS Items during the review cycle. There were nine Items that were not scheduled or not applicable for evaluation for RY 2013. Since two HC BH Contractors, Blair and Lycoming-Clinton, contracted with two BH-MCOs in the review period, and because all applicable standards were reviewed for both BH-MCOs within the three-year time frame, these HealthChoices Oversight Entity review findings are not included in the assessment of compliance for either BH-MCO.



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	Bedford-Somerset, and CABHC	Franklin-Fulton	12 substandards were crosswalked to this category. CABHC and Bedford-Somerset were evaluated on 12 substandards and compliant on 12 substandards. Franklin-Fulton was evaluated on 12 substandards, compliant on 7 substandards and partially compliant on 5 substandards.
Provider-Enrollee Communications 438.102	Compliant	All PerformCare 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 PerformCare HC BH Contractors		Compliant as per PS&R sections A.9 (p.64) and C.2 (p.32).
Cost Sharing 438.108	Compliant	All PerformCare 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 PerformCare HC BH Contractors		Compliant as per PS&R section 3 (p.37).
Solvency Standards 438.116	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R sections A.3 (p.64) and A.9 (p.69), and 2013-2014 Solvency Requirements tracking report.

There are seven categories within Enrollee Rights and Protections Standards. PerformCare was compliant on five categories and partially compliant on one category. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50-447.60. The remaining category, Solvency Standards, was compliant based on the 2013-2014 Solvency Requirement tracking report.



Of the 12 PEPS Substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated. CABHC and Bedford-Somerset Counties were evaluated on 12 substandards, and compliant on all 12 substandards. Franklin-Fulton Counties were compliant on seven substandards and partially compliant on five substandards. Some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Enrollee Rights

Franklin-Fulton was partially compliant with Enrollee Rights due to partial compliance with 5 substandards within PEPS Standard 108.

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

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

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

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

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

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

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



Subpart D: Quality Assessment and Performance Improvement Regulations

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

The PEPS documents for each HC BH Contractor include an assessment of the HC BH Contractor/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	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Elements of State Quality Strategies 438.204	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R section G.3 (p.57).
Availability of Services (Access to Care) 438.206	Partial		All PerformCare HC BH Contractors	24 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 24 substandards, compliant on 22 substandards, and partially compliant on 2 substandards.
Coordination and Continuity of Care 438.208	Partial		All PerformCare HC BH Contractors	2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 items and was partially compliant on both.
Coverage and Authorization of Services 438.210	Partial		All PerformCare HC BH Contractors	4 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards, partially compliant on 3 substandards.
Provider Selection 438.214	Compliant	All PerformCare 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 PerformCare HC BH Contractors		Compliant as per PS&R sections D.2 (p.49), G.4 (p.59) and C.6.c (p.47).



Quality Assessment and Performance Improvement Regulations				
Subpart D: Categories	MCO Compliance	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Subcontractual Relationships and Delegation 438.230	Partial		All PerformCare HC BH Contractors	8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards, compliant on 6 substandards, and partially compliant on 2 substandards.
Practice Guidelines 438.236	Partial		All PerformCare HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant on 4 substandards, and partially compliant on 2 substandards.
Quality Assessment and Performance Improvement Program 438.240	Partial		All PerformCare HC BH Contractors	23 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards, compliant on 22 substandards and partially compliant on 1 substandards.
Health Information Systems 438.242	Compliant	All PerformCare HC BH Contractors		1 Substandard was crosswalked to this category. Each HC BH Contractor was evaluated on 1 Substandard and was compliant on this Item.

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

For this review, 71 Items were crosswalked to Quality Assessment and Performance Improvement Regulations, and all 3 HC BH Contractors associated with PerformCare were evaluated on 70 Items. There was one Item that was not scheduled or not applicable for evaluation for RY 2013. All of the PerformCare HC BH Contractors were compliant on 58 Items, and partially compliant on 12 Items. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

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

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



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

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

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

Coordination and Continuity of Care

All 3 HC BH Contractors associated with PerformCare were partially compliant with Coordination and Continuity of Care due to partial compliance with two substandards of PEPS Standard 28.

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

Coverage and Authorization of Services

All 3 HC BH Contractors associated with PerformCare were partially compliant with Coverage and Authorization of Services due to partial compliance with 2 substandards of PEPS Standard 28 and partial compliance with substandard 1 of PEPS Standard 72.

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

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

All of the PerformCare HC BH Contractors were partially compliant on one substandard of Standard 72: Substandard 1 (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.

Subcontractual Relationships and Delegation

All HC BH Contractors associated with PerformCare were partially compliant with Subcontractual Relationships and Delegation due to partial compliance with 2 substandards of PEPS Standard 99.

PEPS Standard 99: Provider Performance. The BH-MCO Evaluates the Quality and Performance of the Provider Network. Monitor and evaluate the quality and performance of provider network to include, but not limited to Quality of individualized service plans and treatment planning, adverse incidents, Collaboration and cooperation with member complaint, grievance and appeal procedures as well as other medical and human



service programs and Administrative compliance. Procedures and outcome measures are developed to profile provider performance.

All PerformCare HC BH Contractors were partially compliant on two substandards of Standard 99, Substandard 6 and Substandard 8.

Substandard 6: Provider profiles and individual monitoring results are reviewed with providers.

Substandard 8: The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.

Practice Guidelines

All 3 HC BH Contractors associated with PerformCare were partially compliant with Practice Guidelines due to partial compliance with 2 substandards of PEPS Standard 28.

PEPS Standard 28: See Standard description and partially compliant substandard determination under Availability of Services (Access to Care) on page15 of this report.

Quality Assessment and Performance Improvement Program

All 3 HC BH Contractors associated with PerformCare were partially compliant with Quality Assessment and Performance Improvement Program due to partial compliance with 1 substandard of PEPS Standard 91.

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

All of the PerformCare HC BH Contractors were partially compliant on 1 substandard of Standard 91: Substandard 12 (RY 2013).

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



Subpart F: Federal and State Grievance System Standards

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

The PEPS documents include an assessment of the 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	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All PerformCare HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 10 substandards, compliant on 8 substandards, and partially compliant on 2 substandards
General Requirements 438.402	Partial		All PerformCare HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards, compliant on 11 substandards, and partially compliant on 2 substandards.
Notice of Action 438.404	Partial		All PerformCare HC BH Contractors	13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 12 substandards, compliant on 11 substandards, and partially compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All PerformCare HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 10 substandards, compliant on 8 substandards, and partially compliant on 2 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All PerformCare HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 10 substandards, compliant on 8 substandards, and partially compliant on 2 substandards.



Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Expedited Appeals Process 438.410	Partial		All PerformCare HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5 substandards, compliant on 3 substandards, , and partially compliant on 2 substandards.
Information to Providers & Subcontractors 438.414	Compliant	All PerformCare HC BH Contractors		2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards and compliant on both.
Recordkeeping and Recording Requirements 438.416	Compliant	All PerformCare HC BH Contractors		Compliant as per Compliant as per the required quarterly reporting of complaint and grievances data.
Continuation of Benefits 438.420	Partial		All PerformCare HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5 substandards, compliant on 3 substandards, , and partially compliant on 2 substandards.
Effectuation of Reversed Resolutions 438.424	Partial		All PerformCare HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5 substandards, compliant on 3 substandards, , and partially compliant on 2 substandards.

There are 10 categories in the Federal and State Grievance System Standards. PerformCare was compliant on two of the 10 categories (Information to Providers & Subcontractors and Recordkeeping and Recording Requirements) and partially compliant on eight categories. The category Recordkeeping and Recording Requirements was compliant as per the quarterly reporting of Complaint and Grievances data.

For this review, 80 Items were crosswalked to Federal and State Grievance System Standards, and each PerformCare HC BH Contractor was evaluated on 72 Items. There were eight Items that were not scheduled or not applicable for evaluation for RY 2013. Each HC BH Contractor was compliant on 57 Items, and partially compliant on 15 Items. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

The 3 PerformCare HC BH Contractors were deemed partially compliant with 8 of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with one substandard within PEPS Standard 71 and partial compliance with one substandard within PEPS standard 72.



Statutory Basis and Definitions

The three HC BH Contractors associated with PerformCare were partially compliant with Statutory Basis and Definitions due to partial with substandards of PEPS Standards 71 and 72.

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

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

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

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

General Requirements

All HC BH Contractors associated with PerformCare were partially compliant with General Requirements due to partial compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions above.

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

Notice of Action

All HC BH Contractors associated with PerformCare were partially compliant with Notice of Action due to partial compliance with Substandard 1 of Standard 72.

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

Handling of Grievances and Appeals

All HC BH Contractors associated with PerformCare were partially compliant with Handling of Grievances and Appeals due to partial compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions above.

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.



Resolution and Notification: Grievances and Appeals

All HC BH Contractors associated with PerformCare were partially compliant with Resolution and Notification due to partial compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

Expedited Appeals Process

All HC BH Contractors associated with PerformCare were partially compliant with Expedited Appeals Process due to partial compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

Continuation of Benefits

All HC BH Contractors associated with PerformCare were partially compliant with Continuation of Benefits due to partial compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 16 of this report.

Effectuation of Reversed Resolutions

All HC BH Contractors associated with PerformCare were partially compliant with Effectuation of Reversed Resolutions due to partial compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 20 of this report.

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 16 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, BH-MCOs were required to submit an initial proposal on November 2014. The initial proposal was reviewed by OMHSAS and IPRO and recommendations were provided to PerformCare. PerformCare was given the opportunity to schedule a technical assistance meeting to review their changes based on the initial review. PerformCare's assistance call occurred on April 2015.

PerformCare 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.

PerformCare submitted a rationale for the project based on literature review, a discussion of their demographic data, and an admission analysis for members with two or more admissions in a two year period. There was limited discussion of BH-MCO data regarding readmission rates and no analysis of medication management data. 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.

PerformCare's barrier analysis consisted of a discussion of activities done to identify barriers. There was no data presented to support the validity or magnitude of the barriers identified.

PerformCare provided a brief description of interventions planned for the PIP, including development of member and provider education programs, and expansions of their support services. No detail was given regarding the implementation of these interventions, nor were any process measurements proposed to measure their effectiveness.

IPRO and OMHSAS met with PerformCare to review their PIP in December 2014. PerformCare 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.

During MY 2013, two HC BH Contractors (Blair and Lycoming/Clinton) held a contract with PerformCare from January 1 to June 30, and contracted with another BH-MCO as of July 1. As these HC BH Contractors are no longer affiliated with PerformCare, the rates for Blair and Lycoming/Clinton are not shown in Table 3.1 and Figures 3.2 and 3.3. Any discharges or follow-up visits associated with Blair or Lycoming/Clinton prior to July 1 are included in the overall PerformCare rates.



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 PERCENTILE
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
PerformCare	1,425	3,920	36.4%	34.9%	37.9%	48.5%	NO	47.6%	-11.2	-23.59%	YES	Below 50th, at or above 25th percentile
Bedford-Somerset	97	286	33.9%	28.2%	39.6%	47.3%	NO	46.4%	-12.5	-26.93%	YES	Below 50th, at or above 25th percentile
Cumberland	114	343	33.2%	28.1%	38.3%	47.5%	NO	46.6%	-13.4	-28.67%	YES	Below 50th, at or above 25th percentile
Dauphin	297	873	34.0%	30.8%	37.2%	45.4%	NO	44.5%	-10.5	-23.50%	YES	Below 50th, at or above 25th percentile
Franklin-Fulton	117	294	39.8%	34.0%	45.6%	54.8%	NO	56.4%	-16.6	-29.41%	YES	Below 50th, at or above 25th percentile
Lancaster	401	1,202	33.4%	30.7%	36.1%	45.9%	NO	45.0%	-11.6	-25.80%	YES	Below 50th, at or above 25th percentile
Lebanon	162	350	46.3%	40.9%	51.7%	54.8%	NO	55.4%	-9.1	-16.47%	YES	Below 75th, at or above 50th percentile
Perry	35	114	30.7%	21.8%	39.6%	48.1%	NO	47.1%	-16.4	-34.87%	YES	Below 25th 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
PerformCare	2,402	3,920	61.3%	59.8%	62.8%	73.2%	NO	71.8%	-10.5	-14.63%	YES	Below 50th, at or above 25th percentile
Bedford-Somerset	173	286	60.5%	54.7%	66.3%	74.7%	NO	73.2%	-12.7	-17.37%	YES	Below 50th, at or above 25th percentile
Cumberland	206	343	60.1%	54.8%	65.4%	73.9%	NO	72.4%	-12.3	-17.10%	YES	Below 50th, at or above 25th percentile
Dauphin	499	873	57.2%	53.9%	60.5%	69.3%	NO	67.9%	-10.7	-15.84%	YES	Below 50th, at or above 25th percentile
Franklin-Fulton	210	294	71.4%	66.1%	76.7%	75.7%	NO	83.3%	-11.9	-14.28%	YES	Below 75th, at or above 50th percentile
Lancaster	692	1,202	57.6%	54.8%	60.4%	71.4%	NO	70.0%	-12.4	-17.71%	YES	Below 50th, at or above 25th percentile
Lebanon	257	350	73.4%	68.6%	78.2%	75.7%	NO	79.5%	-6.1	-7.66%	NO	Below 75th, at or above 50th percentile
Perry	65	114	57.0%	47.5%	66.5%	72.9%	NO	71.4%	-14.4	-20.17%	NO	Below 50th, at or above 25th 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 not statistically significantly different from the MY 2012 HealthChoices Aggregate rates for this age cohort. 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 goal of meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2013 for either rate.

The PerformCare MY 2013 QI 1 rate of 36.4% in the 6-64 year old cohort statistically significantly decreased from the MY 2012 rate of 47.6% by 11.2 percentage points, and the QI 2 rate of 61.3% statistically significantly decreased from the MY 2012 rate of 71.8% by 10.5 percentage points. The PerformCare MY 2013 QI 1 rate was statistically significantly lower than the HealthChoices BH-MCO QI 1 Average of 46.2% for 6-64 year olds by 9.8 percentage points. The PerformCare QI 2 rate was statistically significantly lower than the HealthChoices BH-MCO QI 2 Average of 66.8% by 5.5 percentage points. The PerformCare HEDIS rates were below their MY 2013 interim goals of 48.5% for QI 1 and 73.2% for QI 2, therefore both interim goals were not met in MY 2013. The QI 1 and QI 2 rates for PerformCare were between the HEDIS MY 2013 benchmarks for the 25th and 50th percentiles, therefore the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by PerformCare in MY 2013 for either rate.

As presented in Table 3.1, all seven of the PerformCare HC BH Contractors had statistically significant QI 1 rate decreases from MY 2012 to MY 2013 in the 6-64 year age group; these rate decreases ranged from 9.1 to 16.6 percentage points. Five of the seven HC BH Contractors had statistically significant QI 2 rate declines from prior year, ranging from 6.1 to 14.4 percentage points. None of the HC BH Contractors associated with PerformCare had rate increases from their MY 2012 performance rates, and none of these HC BH Contractors met their 2013 interim goals for QI 1 or QI 2.

Figure 3.2 is a graphical representation of the 6-64 year old MY 2013 HEDIS follow-up rates for PerformCare and its associated HC BH Contractors. Figure 3.3 shows the HealthChoices HC BH Contractor Average rates and the individual PerformCare HC BH Contractor rates that were statistically significantly higher or lower than the HealthChoices HC BH Contractor Average. None of the HC BH Contractors associated with PerformCare had statistically significantly higher QI 1 rates compared to the HealthChoices HC BH Contractor QI 1 Average of 45.5%. Only Lebanon, with a QI 2 rate of 73.4%, had a QI 2 rate statistically significantly higher than the QI 2 HealthChoices HC BH Contractor Average of 68.0%. QI 1 and QI 2 rates for Lycoming-Clinton, Dauphin, Bedford-Somerset, Lancaster, Cumberland and Perry were statistically significantly lower than the HEDIS HC BH Contractor Averages.

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

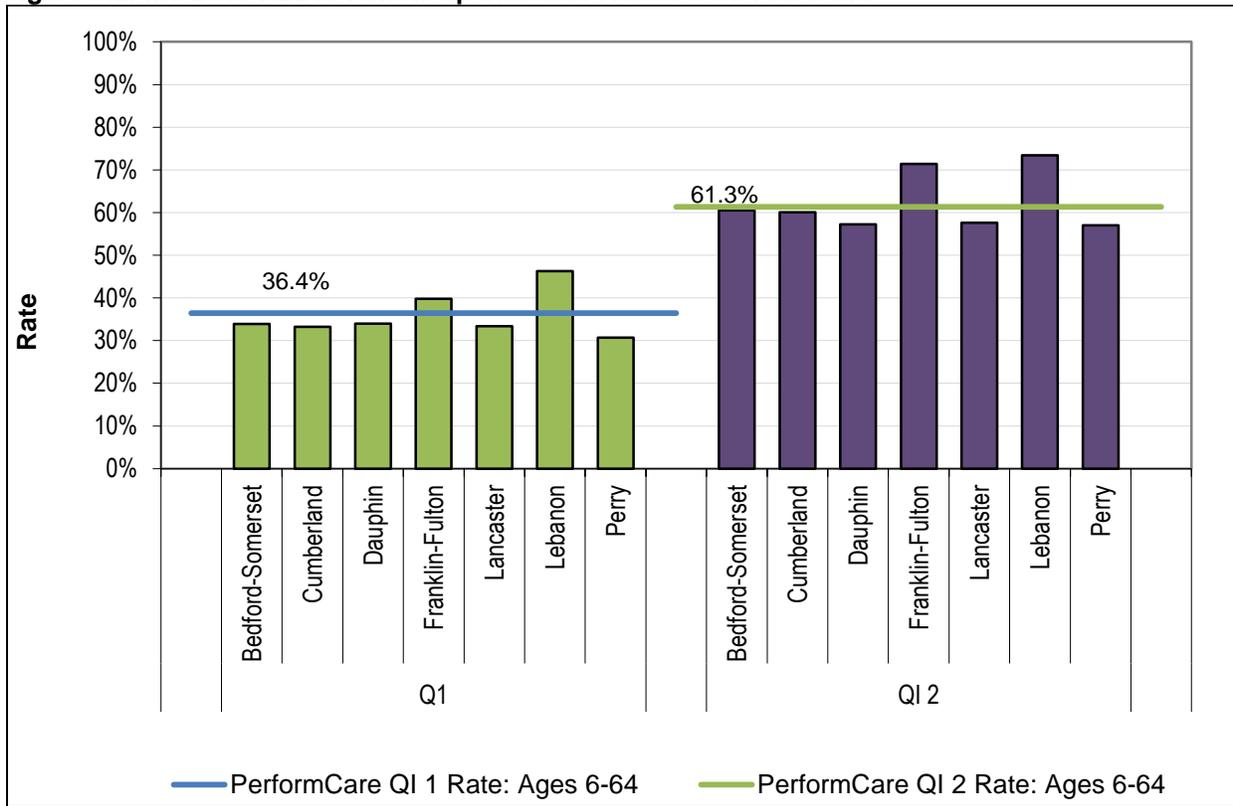
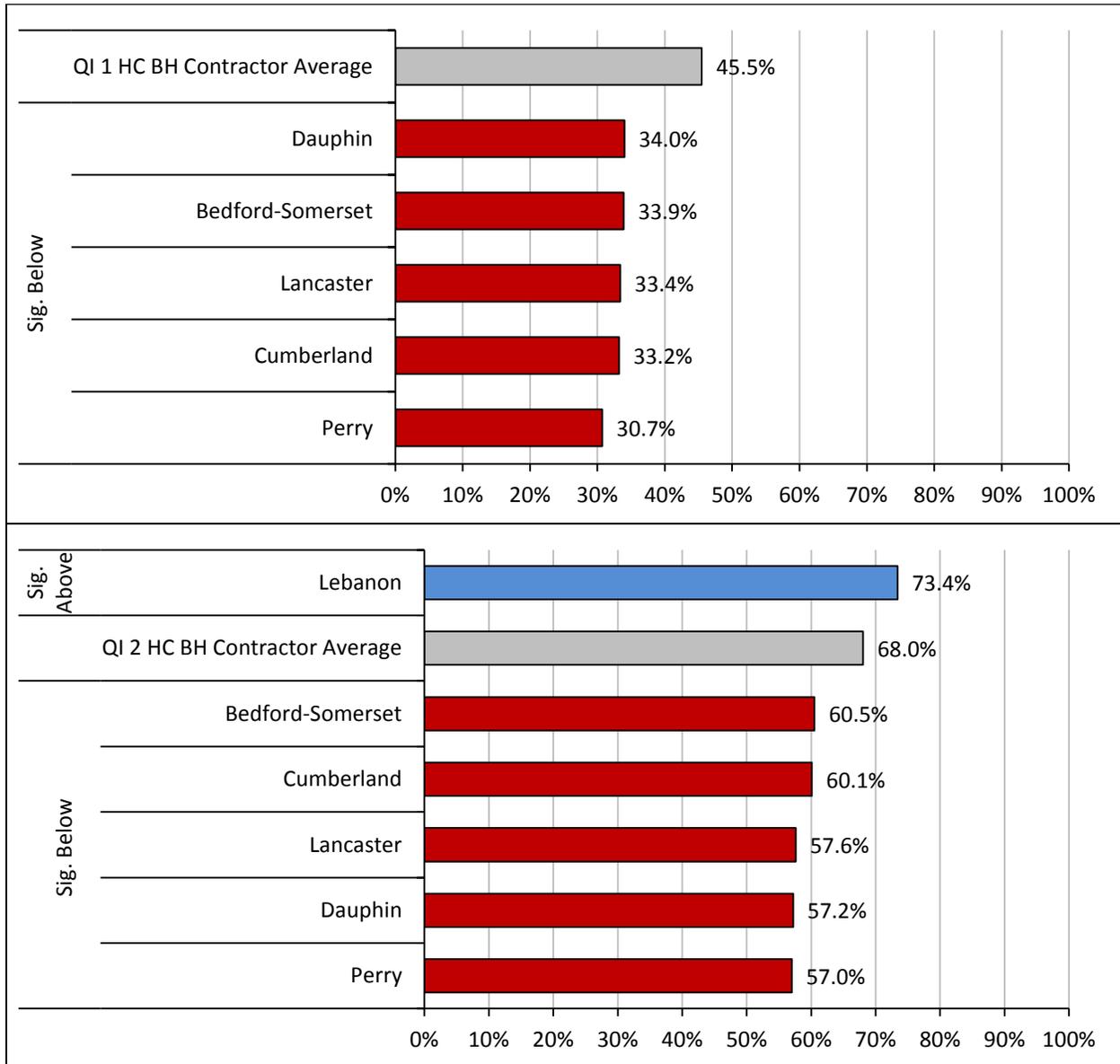




Figure 3.3: HEDIS Rates Compared to MY 2013 HealthChoices HC BH Contractor Average: 6-64 years old





(b) Overall Population: 6+ years old

During MY 2013, two HC BH Contractors (Blair and Lycoming/Clinton) held a contract with PerformCare from January 1 to June 30, and contracted with another BH-MCO as of July 1. The results shown for these HC BH Contractors are for discharges and follow-up visits from January 1 to June 30 2013.

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		HEDIS MY 2013 PERCENTILE
									PPD	SSD	
Q1 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
PerformCare	1,434	3,970	36.1%	34.6%	37.6%			47.2%	-11.1	YES	Below 50th, at or above 25th percentile
Bedford-Somerset	97	289	33.6%	28.0%	39.2%			45.9%	-12.3	YES	Below 50th, at or above 25th percentile
Blair*	129	247	52.2%	45.8%	58.6%			52.0%	0.2	NO	Below 75th, at or above 50th percentile
Cumberland	114	346	32.9%	27.8%	38.0%			46.1%	-13.2	YES	Below 50th, at or above 25th percentile
Dauphin	300	884	33.9%	30.7%	37.1%			44.2%	-10.3	YES	Below 50th, at or above 25th percentile
Franklin-Fulton	117	298	39.3%	33.6%	45.0%			55.9%	-16.6	YES	Below 50th, at or above 25th percentile
Lancaster	404	1,218	33.2%	30.5%	35.9%			44.5%	-11.3	YES	Below 50th, at or above 25th percentile
Lebanon	163	354	46.0%	40.7%	51.3%			55.2%	-9.2	YES	Below 75th, at or above 50th percentile
Lycoming-Clinton*	75	220	34.1%	27.6%	40.6%			44.0%	-9.9	YES	Below 50th, at or above 25th percentile
Perry	35	114	30.7%	21.8%	39.6%			47.1%	-16.4	YES	Below 25th Percentile
Q1 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
PerformCare	2,419	3,970	60.9%	59.4%	62.4%			71.5%	-10.6	YES	Below 50th, at or above 25th percentile
Bedford-Somerset	174	289	60.2%	54.4%	66.0%			72.2%	-12.0	YES	Below 50th, at or above 25th percentile
Blair*	185	247	74.9%	69.3%	80.5%			74.2%	0.7	NO	At or above 75th Percentile
Cumberland	207	346	59.8%	54.5%	65.1%			71.7%	-11.9	YES	Below 50th, at or above 25th



	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		HEDIS MY 2013 PERCENTILE
									PPD	SSD	
											percentile
Dauphin	503	884	56.9%	53.6%	60.2%			68.1%	-11.2	YES	Below 50th, at or above 25th percentile
Franklin-Fulton	210	298	70.5%	65.2%	75.8%			83.2%	-12.7	YES	Below 75th, at or above 50th percentile
Lancaster	696	1,218	57.1%	54.3%	59.9%			69.5%	-12.4	YES	Below 50th, at or above 25th percentile
Lebanon	258	354	72.9%	68.1%	77.7%			79.2%	-6.3	NO	Below 75th, at or above 50th percentile
Lycoming-Clinton*	121	220	55.0%	48.2%	61.8%			65.7%	-10.7	YES	Below 50th, at or above 25th percentile
Perry	65	114	57.0%	47.5%	66.5%			71.4%	-14.4	NO	Below 50th, at or above 25th percentile

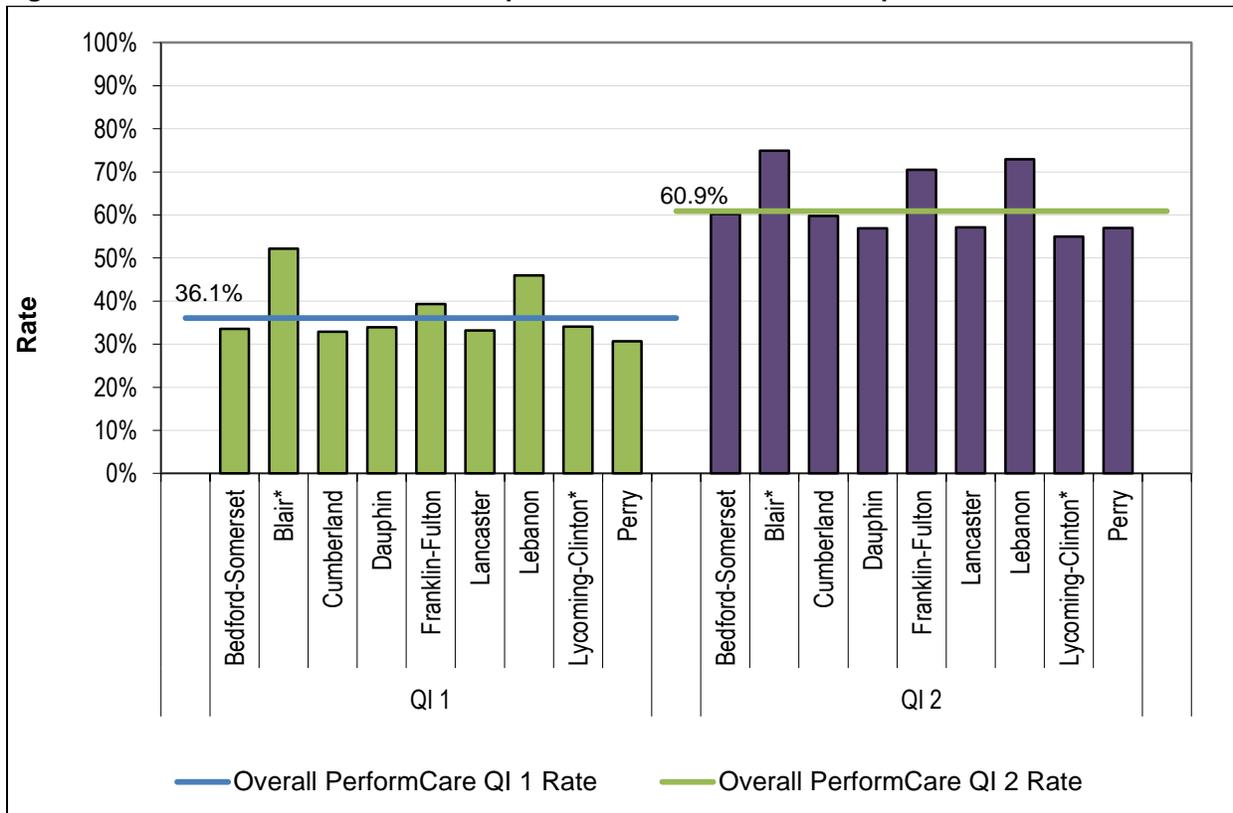
*Results are shown for data between 1/1/13 and 6/30/13.

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 PerformCare QI 1 rate decreased from 47.2% in MY 2012 to 36.1% in MY 2013, a statistically significant decrease of 11.1 percentage points. The PerformCare QI 2 rate also decreased considerably, falling from 71.5% in MY 2012 to 60.9% in MY 2013, a statistically significant decrease of 10.6 percentage points. Overall, PerformCare had the largest year over year rate decreases for QI 1 and QI 2 among the five BH-MCOs. The PerformCare QI 1 rate of 36.1% was statistically significantly lower than the HealthChoices BH-MCO Average of 45.9% by 9.8 percentage points, and the PerformCare QI 2 rate of 60.9% was statistically significantly lower than the HealthChoices BH-MCO Average of 66.5% by 5.6 percentage points. PerformCare had the lowest QI 1 and QI 2 rates of the five BH-MCOs evaluated in MY 2013.

As presented in Table 3.4, the QI 1 rate for eight of the nine HC BH Contractors associated with PerformCare had statistically significant decreases between MY 2012 and MY 2013, with declines that ranged from 9.2 to 16.6 percentage points. Six out of the nine HC BH Contractors had statistically significant QI 2 rate decreases from MY 2012 to MY 2013, with declines that ranged from 10.6 to 12.7 percentage points.

Figure 3.5 is a graphical representation of the MY 2013 HEDIS follow-up rates for PerformCare and its associated HC BH Contractors. Figure 3.6 shows the HealthChoices HC BH Contractor Average rates and individual PerformCare HC BH Contractor rates that were statistically significantly higher or lower than the HealthChoices HC BH Contractor Averages. The QI 1 rate for Blair was statistically significantly higher than the HC BH Contractor Average of 45.2% by 7.0 percentage points. The QI 1 rates for Franklin-Fulton, Lycoming-Clinton, Dauphin, Bedford-Somerset, Lancaster, Cumberland and Perry were statistically significantly lower than the QI 1 HC BH Contractor Average by 5.9 to 14.5 percentage points. For QI 2, rates for Lebanon and Blair were higher than the QI 2 HC BH Contractor Average of 67.7% by 5.2 and 7.2 percentage points, respectively. QI 2 rates for Bedford-Somerset, Cumberland, Lancaster, Perry, Dauphin and Lycoming-Clinton were statistically significantly lower than the HC BH Contractor Average by 7.5 to 12.7 percentage points.

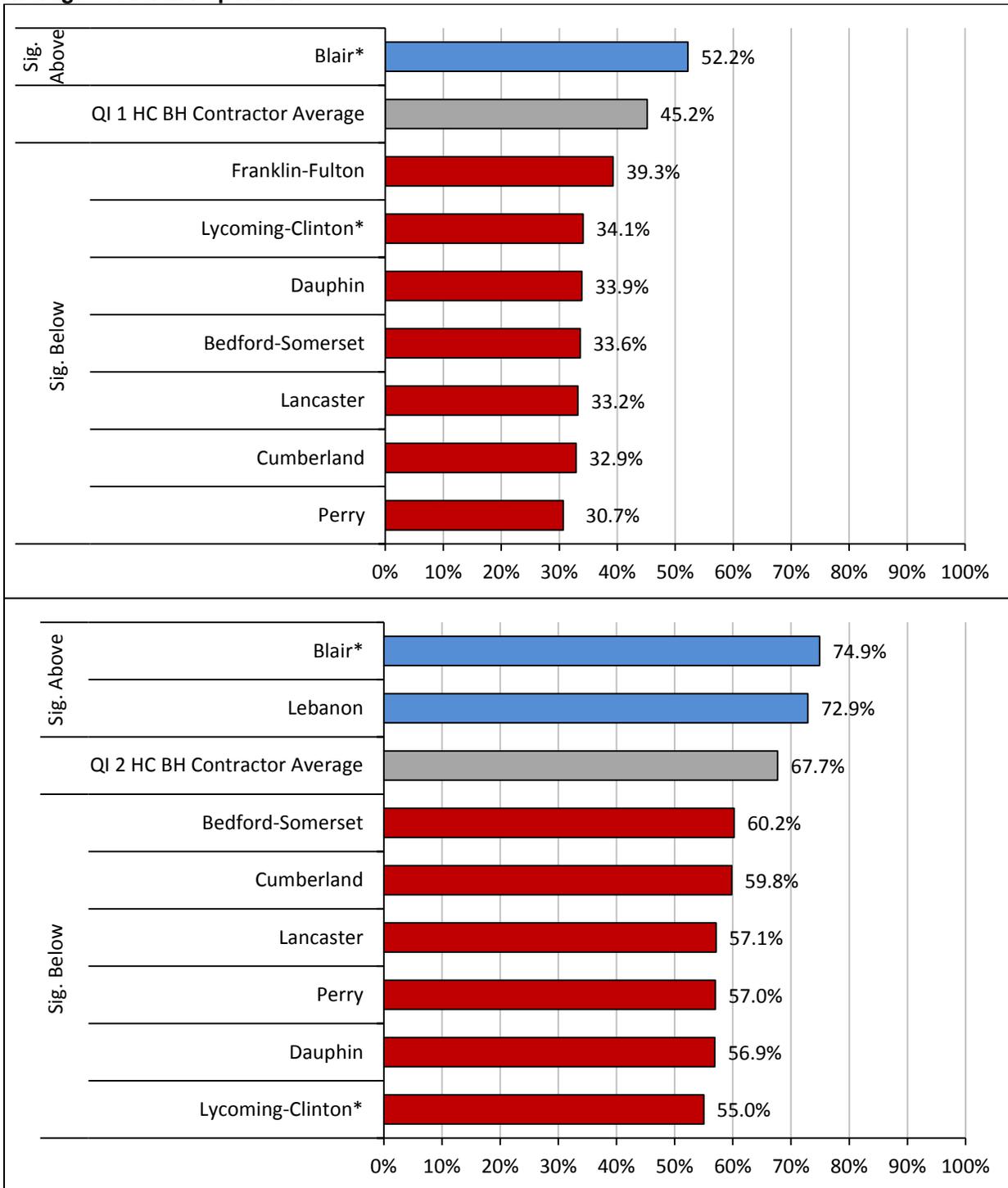
Figure 3.5 MY 2013 HEDIS Follow-up Indicator Rates – Overall Population



*Results are shown for data between 1/1/13 and 6/30/13



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



*Results are shown for data between 1/1/13 and 6/30/13



(c) Age Group: 6-20 Years Old

During MY 2013, two HC BH Contractors (Blair and Lycoming/Clinton) held a contract with PerformCare from January 1 to June 30, and contracted with another BH-MCO as of July 1. The results shown for these HC BH Contractors are for discharges and follow-up visits from January 1 to June 30 2013.

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
Q1 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
PerformCare	639	1,224	52.2%	49.4%	55.0%			62.0%	-9.8	YES
Bedford-Somerset	44	95	46.3%	35.7%	56.9%			58.5%	-12.2	NO
Blair*	50	81	61.7%	50.5%	72.9%			64.2%	-2.5	NO
Cumberland	53	119	44.5%	35.2%	53.8%			57.8%	-13.3	NO
Dauphin	132	239	55.2%	48.7%	61.7%			63.6%	-8.4	NO
Franklin-Fulton	44	87	50.6%	39.5%	61.7%			64.0%	-13.4	NO
Lancaster	179	351	51.0%	45.6%	56.4%			58.2%	-7.2	NO
Lebanon	86	134	64.2%	55.7%	72.7%			71.6%	-7.4	NO
Lycoming-Clinton*	30	70	42.9%	30.6%	55.2%			59.2%	-16.3	YES
Perry	21	48	43.8%	28.7%	58.9%			70.4%	-26.6	YES
Q1 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
PerformCare	911	1,224	74.4%	71.9%	76.9%			82.2%	-7.8	YES
Bedford-Somerset	72	95	75.8%	66.7%	84.9%			84.1%	-8.3	NO
Blair*	68	81	84.0%	75.4%	92.6%			88.3%	-4.3	NO
Cumberland	81	119	68.1%	59.3%	76.9%			75.6%	-7.5	NO
Dauphin	186	239	77.8%	72.3%	83.3%			80.8%	-3.0	NO
Franklin-Fulton	62	87	71.3%	61.2%	81.4%			87.0%	-15.7	YES
Lancaster	249	351	70.9%	66.0%	75.8%			79.7%	-8.8	YES
Lebanon	119	134	88.8%	83.1%	94.5%			88.1%	0.7	NO
Lycoming-Clinton*	41	70	58.6%	46.3%	70.9%			76.2%	-17.6	YES
Perry	33	48	68.8%	54.7%	82.9%			92.6%	-23.8	YES

*Results are shown for data between 1/1/13 and 6/30/13

The MY 2013 HealthChoices Aggregate rates in the 6-20 year old age group were 56.0% for Q1 1 and 76.8% for Q1 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. The PerformCare MY 2013 Q1 1 rate of 52.2% and Q1 2 rate of 74.4% in the 6-20 age cohort were statistically significant rate decreases from the PerformCare MY 2012 rates by 9.8 and 7.8 percentage points, respectively.

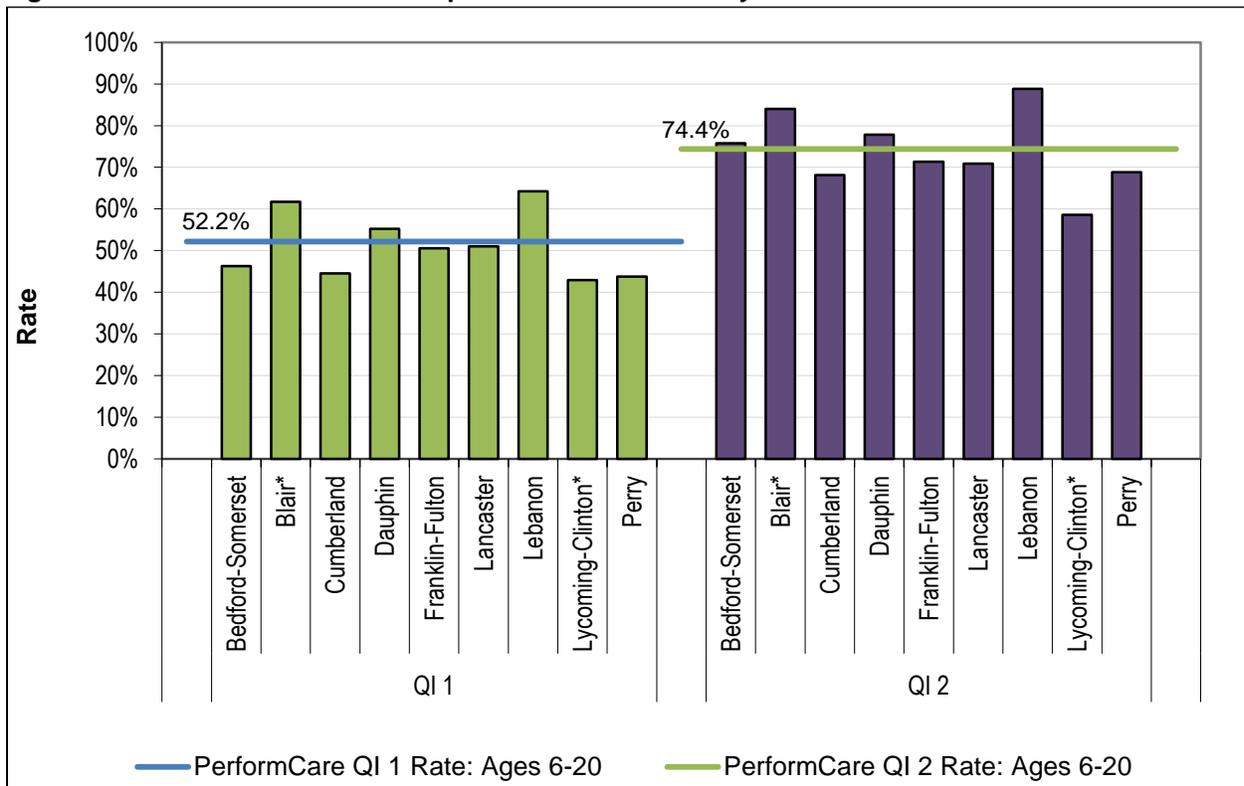


For MY 2013, the PerformCare QI 1 rate of 52.2% for the 6-20 year old age cohort was statistically significantly lower than the QI 1 HealthChoices BH-MCO average of 55.1% by 2.9 percentage points. The PerformCare QI 2 rate of 74.4% was not statistically significantly different from the QI 2 HealthChoices BH-MCO average of 75.9%.

As presented in Table 3.7, the 6-20 year old MY 2013 QI 1 rate for Lycoming-Clinton and Perry had statistically significant decreases from their MY 2012 rates by 16.3 and 26.6 percentage points, respectively. Four HC BH Contractors (Franklin-Fulton, Lancaster, Lycoming-Clinton and Perry) had statistically significant decreases in their QI 2 rates from MY 2012 to MY 2013, with declines that ranged from 8.8 to 23.8 percentage points. The remaining HC BH Contractors did not have statistically significant changes from their MY 2012 HEDIS rates.

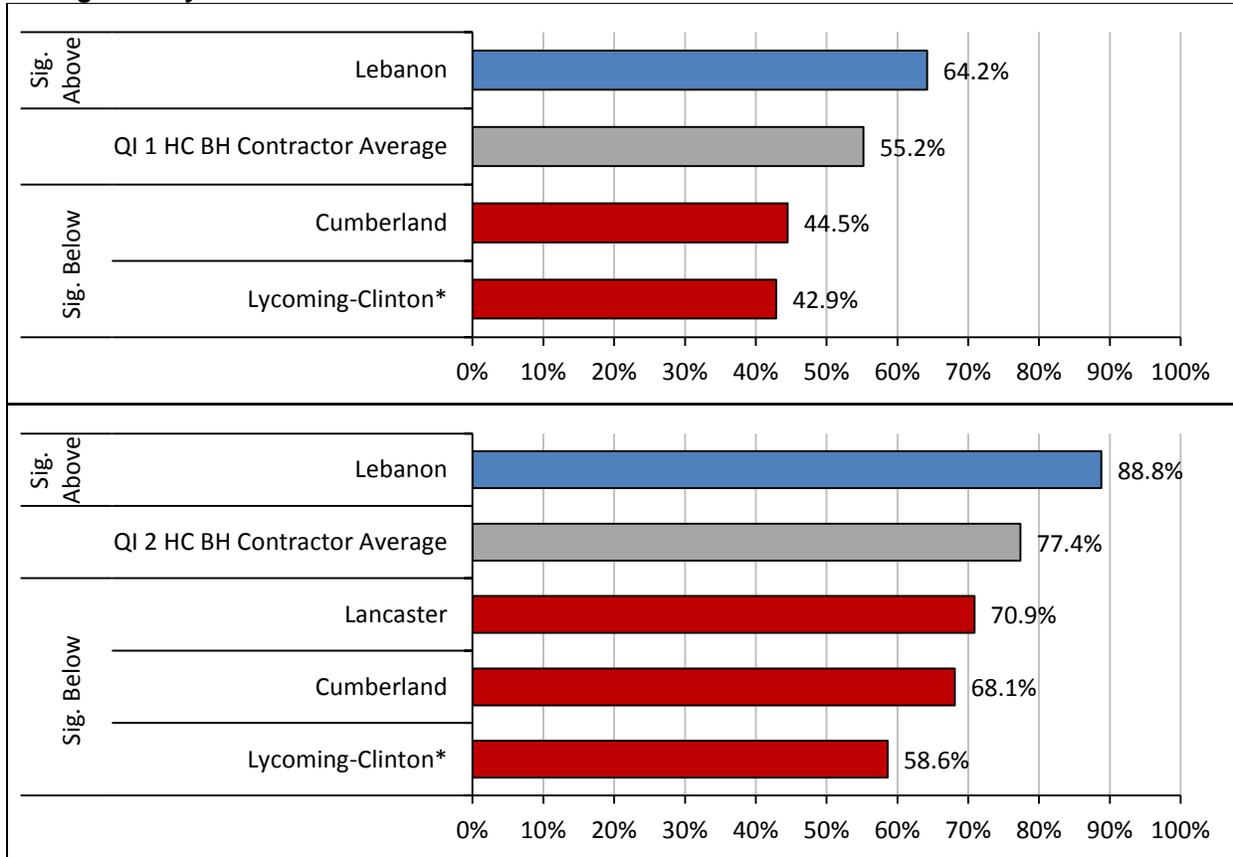
Figure 3.8 is a graphical representation of the MY 2013 HEDIS 6-20 year old follow-up rates for PerformCare and its associated HC BH Contractors. Figure 3.9 shows the HealthChoices HC BH Contractor Average rates and the individual PerformCare HC BH Contractor rates that were statistically significantly higher or lower than the HC BH Contractor Average. Both HEDIS rates for Lebanon were statistically significantly higher than the HealthChoices HC BH Contractor Average of 55.2% for QI 1 (9.0 percentage point difference) and 77.4% for QI 2 (11.4 percentage point difference). The QI 1 rates for Cumberland and Lycoming-Clinton were statistically significantly lower than the QI 1 HC BH Contractor average by 10.7 and 12.3 percentage points. The QI 2 rates for Lancaster, Cumberland and Lycoming-Clinton were statistically significantly lower than the QI 2 HC BH Contractor average by 6.5 to 18.8 percentage points. HEDIS rates for the remaining PerformCare HC BH Contractors were not statistically significantly different from the HC BH Contractor Average for this age group.

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



*Results are shown for data between 1/1/13 and 6/30/13

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



*Results are shown for data between 1/1/13 and 6/30/13



II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ years old

During MY 2013, two HC BH Contractors (Blair and Lycoming/Clinton) held a contract with PerformCare from January 1 to June 30, and contracted with another BH-MCO as of July 1. The results shown for these HC BH Contractors are for discharges and follow-up visits from January 1 to June 30 2013.

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 – PA Specific 7 Day Follow-up for Ages 6+ Years Old										
HealthChoices	19,687	34,564	57.0%	56.5%	57.5%	55.7%	55.7%	58.6%	-1.6	YES
PerformCare	1,936	3,970	48.8%	47.2%	50.4%			59.4%	-10.6	YES
Bedford-Somerset	130	289	45.0%	39.1%	50.9%			60.7%	-15.7	YES
Blair*	158	247	64.0%	57.8%	70.2%			64.9%	-0.9	NO
Cumberland	154	346	44.5%	39.1%	49.9%			57.9%	-13.4	YES
Dauphin	489	884	55.3%	52.0%	58.6%			64.1%	-8.8	YES
Franklin-Fulton	156	298	52.3%	46.5%	58.1%			66.1%	-13.8	YES
Lancaster	526	1,218	43.2%	40.4%	46.0%			54.3%	-11.1	YES
Lebanon	186	354	52.5%	47.2%	57.8%			62.0%	-9.5	YES
Lycoming-Clinton*	94	220	42.7%	35.9%	49.5%			51.7%	-9.0	YES
Perry	43	114	37.7%	28.4%	47.0%			52.9%	-15.2	NO
QI B – PA Specific 30 Day Follow-up for Ages 6+ Years Old										
HealthChoices	25,381	34,564	73.4%	72.9%	73.9%	72.3%	74.1%	75.0%	-1.6	YES
PerformCare	2,742	3,970	69.1%	67.7%	70.5%			78.0%	-8.9	YES
Bedford-Somerset	199	289	68.9%	63.4%	74.4%			81.5%	-12.6	YES
Blair*	200	247	81.0%	75.9%	86.1%			80.1%	0.9	NO
Cumberland	236	346	68.2%	63.1%	73.3%			76.4%	-8.2	YES
Dauphin	630	884	71.3%	68.3%	74.3%			79.1%	-7.8	YES
Franklin-Fulton	227	298	76.2%	71.2%	81.2%			87.8%	-11.6	YES
Lancaster	775	1,218	63.6%	60.9%	66.3%			74.7%	-11.1	YES
Lebanon	266	354	75.1%	70.5%	79.7%			83.7%	-8.6	YES
Lycoming-Clinton*	135	220	61.4%	54.7%	68.1%			70.2%	-8.8	YES
Perry	74	114	64.9%	55.7%	74.1%			74.3%	-9.4	NO

*Results are shown for data between 1/1/13 and 6/30/13

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% (QI A) and 75.0% (QI B) by 1.6 percentage points each. The PerformCare MY 2013 QI A rate of 48.8% and QI B rate of 69.1% were both statistically significantly lower than the PerformCare MY 2012 rates by 10.6 and 8.9 percentage points, respectively. Overall, PerformCare demonstrated the largest year over year rate decreases in PA-Specific follow-up indicators among the five BH-MCOs evaluated in MY 2013. The PerformCare QI A rate of

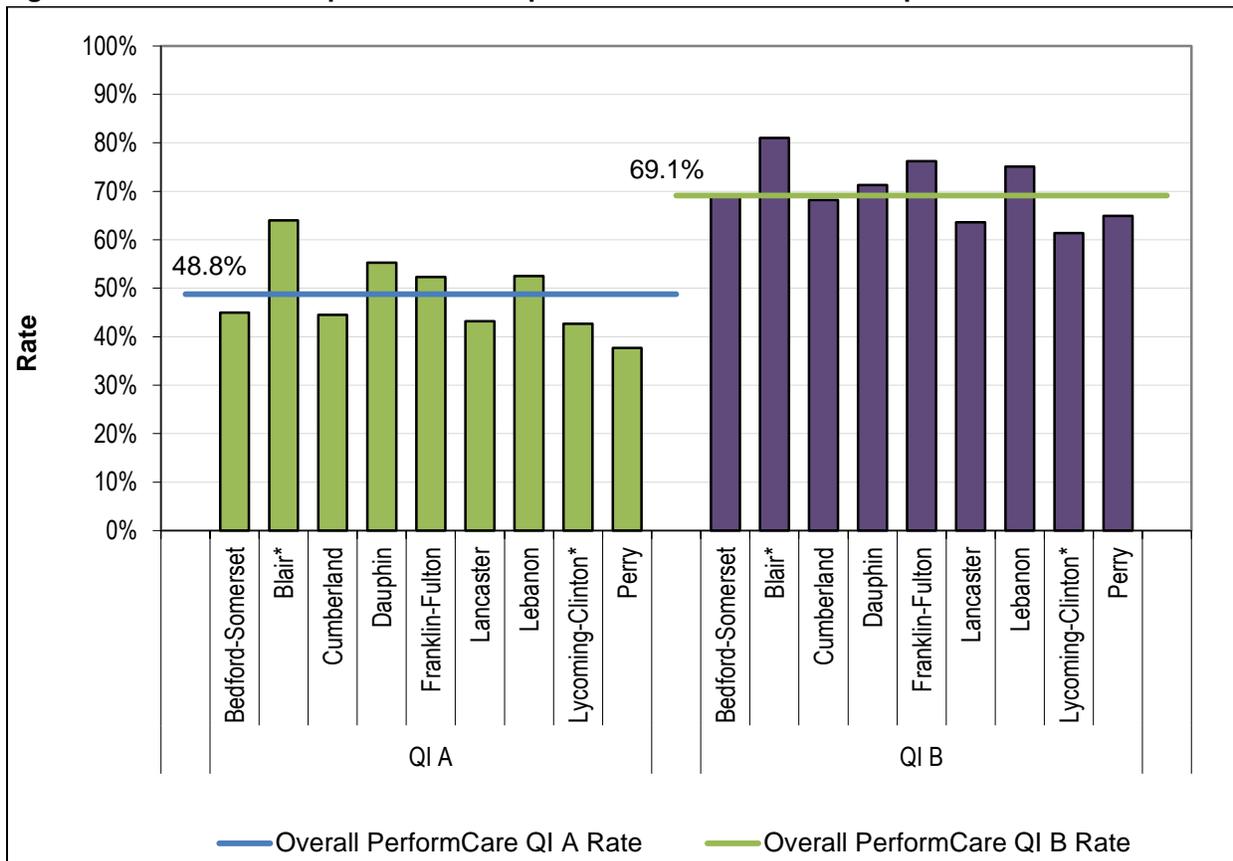


48.8% was statistically significantly lower than the QI A HealthChoices BH-MCO Average of 55.7% by 6.9 percentage points, and the PerformCare QI B rate of 69.1% was statistically significantly lower than the HealthChoices BH-MCO Average of 72.3% by 3.2 percentage points.

As shown in Table 3.10, seven of the nine HC BH Contractors associated with PerformCare had statistically significant declines in their QI A and QI B rates from MY 2012 to MY 2013. These declines ranged from 8.8 to 15.7 percentage points for QI A and 7.8 to 12.6 percentage points for QI B.

Figure 3.11 is a graphical representation of the MY 2013 PA-Specific follow-up rates for PerformCare and its associated HC BH Contractors. Figure 3.12 shows the HealthChoices HC BH Contractor Average rates and the individual PerformCare HC BH Contractor rates that were statistically significantly higher or lower than the HC BH Contractor Averages. Blair's QI A rate of 64.0% was statistically significantly higher than the HealthChoices QI A HC BH Contractor Average of 55.7% by 8.3 percentage points. Five HC BH Contractors (Bedford-Somerset, Cumberland, Lancaster, Lycoming-Clinton and Perry) had QI A rates that were statistically significantly lower than the QI A HC BH Contractor Average by 10.7 to 18.0 percentage points. The QI B rate for Blair, 81.0%, was statistically significantly higher than the HealthChoices HC BH Contractor QI B Average of 74.1% by 6.9 percentage points. QI B rates for Cumberland, Lancaster and Lycoming-Clinton were lower than the HC BH Contractor Average by 5.9, 10.5 and 12.7 percentage points, respectively.

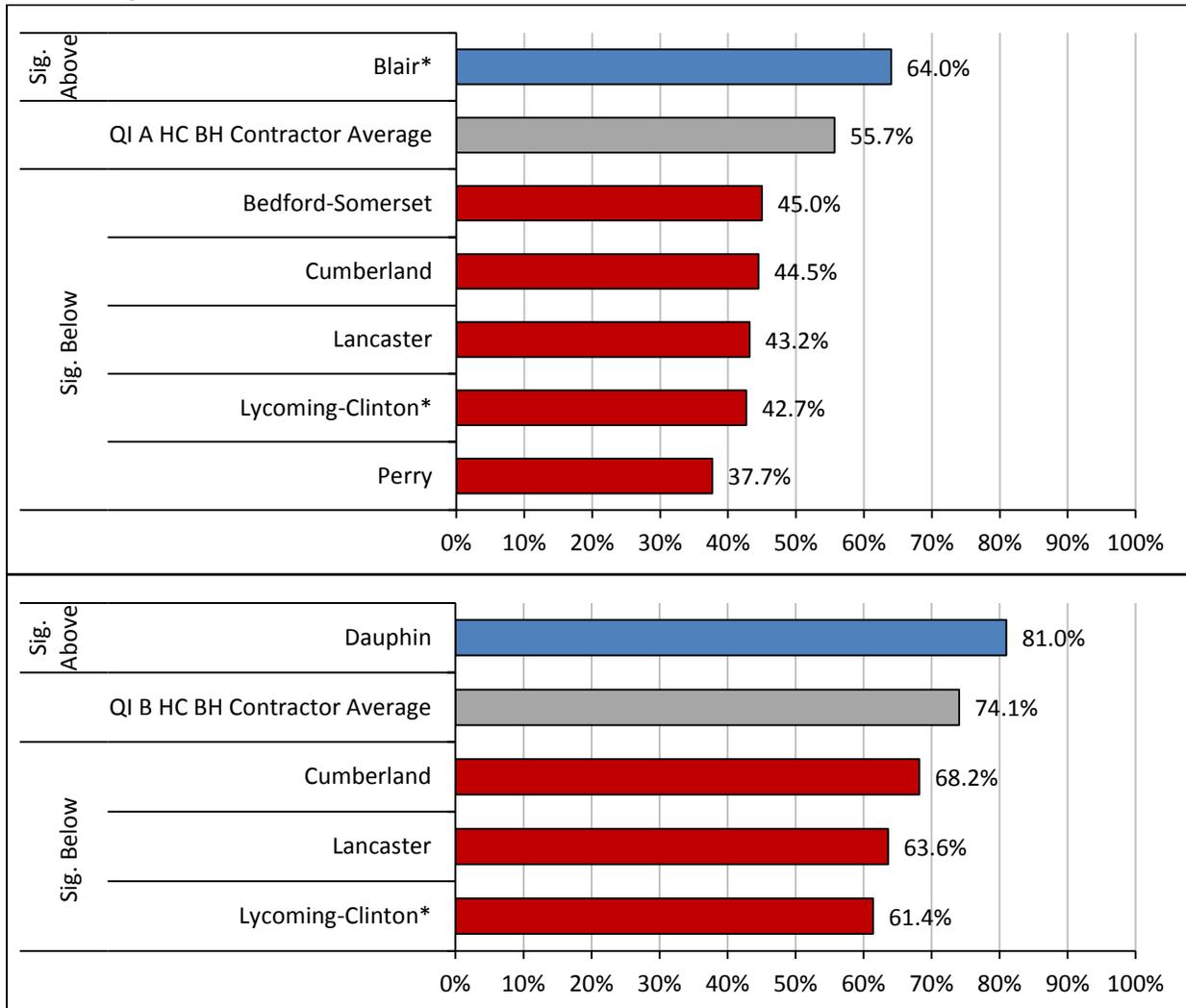
Figure 3.11 MY 2013 PA-Specific Follow-up Indicator Rates – Overall Population



*Results are shown for data between 1/1/13 and 6/30/13



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



*Results are shown for data between 1/1/13 and 6/30/13

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.

During MY 2013, two HC BH Contractors (Blair and Lycoming/Clinton) held a contract with PerformCare from January 1 to June 30, and contracted with another BH-MCO as of July 1. The results shown for these HC BH Contractors are for discharges from January 1 to June 30 2013.



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%
PerformCare	771	4,962	15.5%	14.5%	16.5%			NO	14.1%
Bedford- Somerset	49	347	14.1%	10.3%	17.9%			NO	6.5%
Blair*	54	355	15.2%	11.3%	19.1%			NO	12.4%
Cumberland	55	412	13.3%	9.9%	16.7%			NO	12.5%
Dauphin	198	1,106	17.9%	15.6%	20.2%			NO	17.0%
Franklin-Fulton	60	374	16.0%	12.2%	19.8%			NO	18.4%
Lancaster	204	1,466	13.9%	12.1%	15.7%			NO	12.3%
Lebanon	102	483	21.1%	17.4%	24.8%			NO	20.5%
Lycoming- Clinton*	28	279	10.0%	6.3%	13.7%			YES	10.5%
Perry	21	140	15.0%	8.7%	21.3%			NO	18.0%

*Results are shown for data between 1/1/13 and 6/30/13

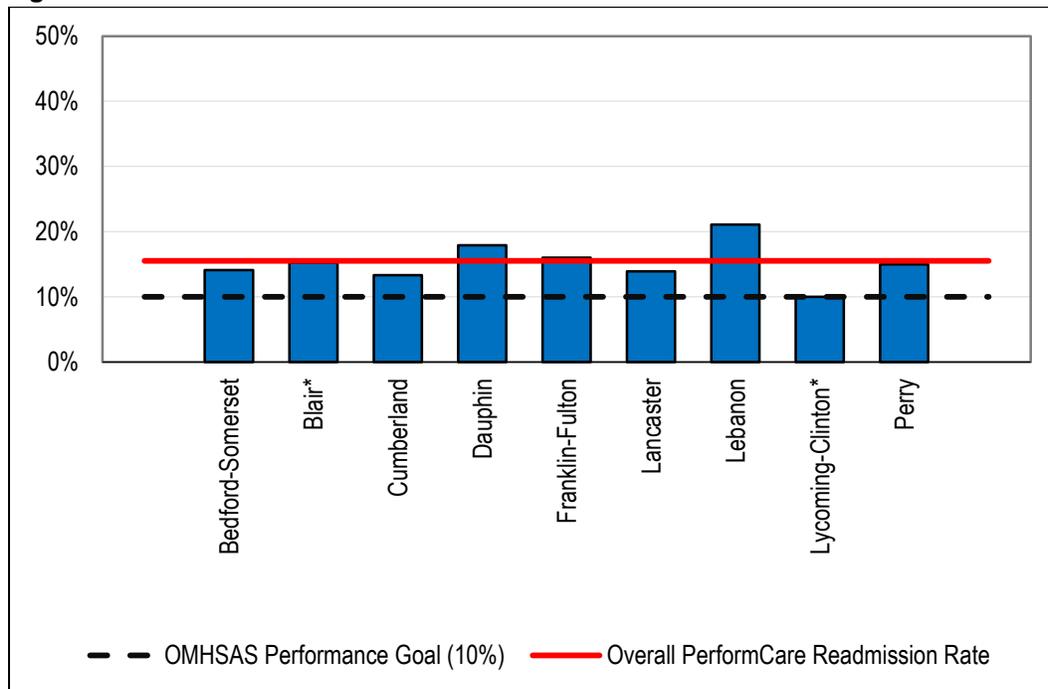


The MY 2013 HealthChoices Aggregate readmission rate was 13.6%, statistically significantly higher than the MY 2012 HealthChoices Aggregate rate of 12.7% by 0.9 percentage points. The PerformCare MY 2013 readmission rate of 15.5% is a statistically significant increase over the PerformCare MY 2012 rate of 14.1% by 1.4 percentage points. Note that this measure is an inverted rate, in that the lower rates indicate better performance. The PerformCare MY 2013 readmission rate of 15.5% is statistically significantly higher than the HealthChoices BH-MCO Average of 13.5% by 2.0 percentage points. Overall, PerformCare had the highest readmission rate of the five BH-MCOs evaluated in MY 2013. PerformCare did not meet the OMHSAS performance goal of a readmission rate at or below 10.0% in MY 2013.

As presented in Table 3.13, the readmission rate for one PerformCare HC BH Contractor, Bedford-Somerset, increased from 6.5% in MY 2012 to 14.1% in MY 2013, a statistically significant increase of 7.6 percentage points. No statistically significant changes from the prior year were noted for the remaining PerformCare HC BH Contractors. Lycoming-Clinton was the only PerformCare HC BH Contractor that met the performance goal of a readmission rate at or below 10.0% in MY 2013.

Figure 3.14 is a graphical representation of the MY 2013 readmission rates for PerformCare HC BH Contractors compared to the performance measure goal of 10.0%. Figure 3.15 shows the Health Choices HC BH Contractor Average readmission rates and the individual PerformCare HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Averages. Lebanon and Dauphin had readmission rates that were statistically significantly higher (poorer) than the HealthChoices HC BH Contractor average of 13.7% by 7.4 and 4.2 percentage points, respectively. Lycoming-Clinton's rate of 10.0% was statistically significantly lower than the HC BH Contractor average by 3.7 percentage points.

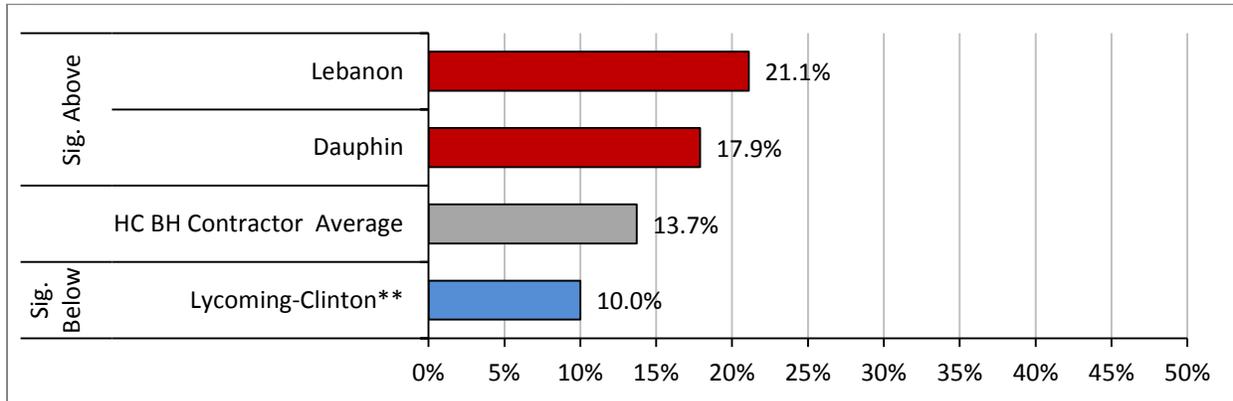
Figure 3.14 MY 2013 Readmission Rates



*Results are shown for data between 1/1/13 and 6/30/13



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.

**Results are shown for data between 1/1/13 and 6/30/13

III: 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 PerformCare (CBHNP).



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 PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
PerformCare 2013.01	Within Subpart C: Enrollee Rights and Protections Regulations, PerformCare was partially compliant on one out of seven categories – Enrollee Rights.	Follow Up Actions Taken Through 09/30/14	<p>The Complaint and Grievance (C&G) Department had 4 full time and 1 part time staff and 1 supervisor. New employees receive detailed training on Complaint and Grievance processes and in working with Members, families, and providers. Weekly staff meeting and individual weekly supervision are conducted to review pending issues, provide information and answer questions related to policy and procedures. Annual retraining of C&G processes and procedures occurs with C&G staff and other PerformCare Departments. Monthly internal auditing occurs to ensure regulatory requirements are met consistently.</p> <p>Follow up Action taken through 9/30/14: The Complaints and Grievance operations were moved to the Contact Center Department. Policies & Procedures were reviewed in detail and revisions initiated.</p> <p>Future Actions Planned: Ongoing weekly and annual retraining of staff on C&G processes and expectations to ensure all staff have current information on policies and procedures in managing disputes for Members and to strengthen reminders of expectations of the procedures to process Complaints and Grievances to ensure Member rights. Ongoing internal auditing of documentation to identify any needed areas of improvement and to provide re-education opportunities as needed.</p>
		Future Actions Planned (Specify Dates)	

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)		
PerformCare 2013.02	PerformCare was partially compliant on five out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Practice Guidelines, 5) Quality Assessment and Performance Improvement Program.	<table border="1"> <tr> <td data-bbox="701 556 862 1255"> Follow Up Actions Taken Through 09/30/14 </td> <td data-bbox="701 1255 862 1436"> Future Actions Planned (Specify Dates) </td> </tr> </table>	Follow Up Actions Taken Through 09/30/14	Future Actions Planned (Specify Dates)	Follow up Action taken through 9/30/14: Ongoing Psychiatric Access Reporting was competed for Q1 and Q2 2014 to measure the availability to psychiatric evaluations. Ongoing field and local care management usage. Continued to define specialized caseloads for priority populations. Improved active care management practices, increasing involvement in Interagency Service Planning Team (ISPT) meetings for targeted services/diagnostic groupings. Implemented registration free access to most outpatient levels of care giving Members more immediate access to services. Continued expansion and revision of tele-psychiatry insuring compliance with Office of Mental Health and Substance Abuse Services (OMHSAS) bulletins Developed Certified Peer Support Programs for Inpatient Psychiatric Facilities Conducted Root Cause Analysis of Substance Abuse Services Increase involvement of physician advisors through Clinical Care Management (CCM) case conferencing Future Actions Planned: Ongoing: Continued development of service alternatives which are evidence based, person-centered and recovery oriented. Expansion of peer support services. Review and adoption of additional practice guidelines.
Follow Up Actions Taken Through 09/30/14	Future Actions Planned (Specify Dates)				

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
PerformCare 2013.03	PerformCare was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: <ol style="list-style-type: none"> 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, 8) Effectuation of Reversed Resolutions. 	Follow Up Actions Taken Through 09/30/14	Follow up Action taken through 9/30/14: Ongoing internal auditing of a sampling of acknowledgment and decision letters to be sent to Members. Ongoing supervisory review of decision letters prior to being sent to the Member. Continuing supervisory use of Grievance application reports to monitor timeliness of letters sent to Members. Ongoing use of Grievance application that mandates use of a template for Grievance letters to be sent to Members. Ongoing implementation for PerformCare process for transcribing Level Two Grievances. Continuing use of the internal peer post Grievance case reviews with feedback. Continuing use of updated acknowledgment and decision letter templates, as per OMHSAS direction. Ongoing use of a quality trigger process to identify areas of concern with service provision to ensure clinical involvement. Continuing process for communication with Clinical Care Managers regarding reversed Grievance decisions. Ongoing implementation of improved Complaint investigations and documentation. Continuing involvement and communication with County Oversights in the Complaint and Grievance processes. Ongoing use of the updated Expedited Appeal process and Continuation of benefits, as per OMHSAS direction. Ongoing use of the developed internal process of clinical coordination when new information is presented during the Grievance process that could potentially impact service provision.

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
		Future Actions Planned (Specify Dates)	Future Actions Planned: Ongoing internal auditing of a sampling of acknowledgment and decision letters for accuracy and to ensure proper templates and Member driven rights are documented. Continuing supervisory review of decision letters prior to distribution to the Member/family. Ongoing supervisory review of Grievance application reports to for monitor timeliness of letters sent to Members and families, as well as the use of the Grievance template letters. Continuing assessment of the processes implemented of post internal peer review cases. Through such reviews, areas of necessary re-education are identified. Ongoing assessment of the quality indicator process to ensure the expectations of the process are met, specifically to continue to reduce Grievances, improve prescribing practices and the quality of service provision, and increase clinical involvement in the Grievance process. Ongoing assessment of Grievance volume to occur on a monthly basis to determine if additional initiatives need to be implemented to address presenting concerns.
PerformCare 2013.04	PerformCare submitted one PIP for validation in 2013. PerformCare received no credit for Sustained Improvement.	Follow Up Actions Taken Through 09/30/14 Future Actions Planned (Specify Dates)	Follow up Action taken through 9/30/14: Implemented Crisis Bridge appointments in Lancaster, Bedford and Somerset (BESO) Counties Crisis Bridge programs in Dauphin and Cumberland/Perry reviewed/updated 6/2014 to 9/2014 Conducted barrier analysis of re-admissions Future Actions Planned: Review and update of Crisis Bridge programs Finalize barriers analysis and determine appropriate interventions

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
PerformCare 2013.05	PerformCare's rate for the MY 2012 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.	Follow Up Actions Taken Through 09/30/14 <i>7/23/14</i> <i>2013</i> <i>Ongoing</i> <i>October 2013</i>	Follow up Action taken through 9/30/14: PerformCare completed a network wide Root Cause Analysis (RCA) for 30 day readmissions. PerformCare conducted a RCA with Dauphin County for 30 day readmission rates. Key actions included Member profiling which revealed Members diagnosed with personality disorders to have experienced a higher rate of readmissions and Grand Rounds case conferencing with Pennsylvania Psychiatric Institute (PPI) – the primary inpatient facility service this county. The Crisis Bridge Pilot Program was implemented in Bedford and Somerset Counties. This pilot involves Somerset Hospital and Bedford/Somerset Mental Health Mental Retardation (MHMR) (Cornerstone). Bedford/Somerset MHMR is offering appointments when Members are discharged from Somerset Hospital in order to bridge the gap in service between Mental Health Inpatient (MH IP) discharge and traditional OP follow up. The program was implemented in April 2012 and is being utilized currently. Utilization of this service has not been as high as originally projected. Meetings with the provider of this service and Somerset Hospital occur every six months to review Outcomes and utilization. The most recent meeting occurred in September 2014. The Crisis Bridge program will be an “opt out” service rather than “opt in” service. Outcomes and utilization review. This intervention has the potential to impact all four follow up measures.

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
		<p>1/2013 and ongoing</p> <p>1/13 to 4/13</p> <p>6/13</p> <p>Ongoing</p>	<p>Bedford/Somerset: Comprehensive, Continuous, Integrated System of Care (CCISC) implementation continued throughout 2013. Co-Occurring Disorder (COD) Workgroup meetings are occurring monthly. Change Agent meetings are occurring bi-monthly. Providers have completed COMPASS-EZ assessments and action plans have been submitted. The COD Workgroup completed the CO-Fit and has begun to create an action plan based on the identified opportunities. Community Behavioral Healthcare Network of Pennsylvania (CBHNP) completed the COMPASS-Exec and created an action plan based on the results.</p> <p>Quarterly meetings were held with representatives of Divine Providence Hospital, Lycoming-Clinton HealthChoices, and CBHNP to identify obstacles to coordination, share resources and performance data, and improve communication. Part of the focus was on improving discharge-planning, ambulatory follow-up, and reducing readmissions. In 2013, these meetings were conducted in 1/15 and 4/16.</p> <p>The Lycoming-Clinton contract had a Performance Objective to increase the linkage of high-risk adult Members with Targeted Case Management (TCM) as a mechanism for reducing hospitalizations and re-admissions and improving participation in follow-up appointments. The region exceeded the target of 68% of high-risk Members linked with TCM during the contract year (with a score of 72.7%).</p> <p>Bedford/Somerset: CCISC implementation is continuing throughout 2014. COD Workgroup meetings are occurring monthly. Change Agent meetings are occurring bi-monthly. Providers have completed COMPASS-EZ assessments and action plans have been submitted. The COD Workgroup completed the CO-Fit and has begun to create an action plan based on the identified opportunities. PerformCare completed the COMPASS-Exec and created an action plan based on the results. The CCISC quick guide was developed. Welcome statements were created and distributed to all providers.</p>

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
		<p>2013-2014; Ongoing</p> <p>2014</p> <p>Ongoing</p> <p>Ongoing</p>	<p>Franklin/Fulton (FF) County regional office, in conjunction with Tuscarora Managed Care Alliance (TMCA) and various providers, implemented a MH IP Readmission Work Group. Meetings occur on a regular basis. After presentation and review of readmission data, a Root Cause Analysis and fishbone diagram was developed. Additionally, a Quality Improvement Plan was developed identifying major action steps geared towards decreasing the MH IP readmission rate within the Franklin/Fulton region.</p> <p>The Franklin/Fulton MH IP Readmission Work Group completed a full analysis of adult Members who had a readmission episode in State Fiscal Year (SFY) 2012 and 2013 in order to determine if any commonalities/trends existed within the population and to identify possible barriers to aftercare treatment. This analysis showed that although the majority of Members with a readmission episode had a subsequent follow-up appointment within 7 days, however, readmission episodes still occurred.</p> <p>Efforts will continue to expand the use of Tele-psychiatry within the region to improve access. Tele-psychiatry services expanded in 2014 in the BESO region. Franklin/Fulton Counties added 3 additional providers of Tele-psychiatry to the network in 2013 and 2014. Discussions with additional providers will occur as interest increases.</p> <p>Discussion has continued with Mental Health Outpatient (MH OP) providers within the Franklin/Fulton region regarding feasibility of outpatient appointments being “blocked out” weekly for emergency use and for Members being discharged from MH IP. Several providers are in process of determining possibility of implementation of appoints to be used for emergency access and Members being discharged from MH IP.</p>



Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
		<p><i>Ongoing</i></p> <p><i>Ongoing</i></p> <p><i>Ongoing</i></p> <p><i>Ongoing</i></p> <p><i>2014</i></p>	<p>Continued Member and Provider education of specialized services available within the Franklin/Fulton region: Adams Hanover Counseling began to offer DBT groups in Fulton County in late 2012. Three regional providers were certified in EMDR in 2012 due to scholarship funding from CBHNP and TMCA. Barbara Dickey at Pathways Counseling now offers DBT as a modality for OP therapy.</p> <p>Franklin\Fulton regional CCISC initiative is continuing throughout 2014. Training series focusing on improving Co-Occurring Competency offered to providers in the region. CCISC implementation team meetings occur bi-monthly. Change Agent meetings and training series began continue in 2014. Providers have completed COMPASS-EZ and action plans have been submitted. Provider involvement continues to grow in the initiative. CCISC Implementation team completed the COMPASS-Exec and is in process of developing work plan to address deficiencies identified in the network.</p> <p>Franklin\Fulton and BESO PerformCare regional staff continue to provide Member and Provider education on Peer Support services and Psychiatric Rehabilitation Services (PRS) offered within the region.</p> <p>A Franklin/Fulton local Targeted Case Management (TCM) provider (service Access Management) is currently providing education to Members while in a local IP unit regarding TCM services. TCM provider is working closely with MH IP units to improve Member access to TCM services by offering to complete intake prior to Member discharging from MH IP. Discussions continue with local TCM provider on possible ways to increase referrals for ICM/RC services. Efforts will continue to raise Member, community, and provider awareness of TCM services.</p> <p>Through Capital Area Behavioral Health Collaborative (CABHC) re-investment dollars, four Peer Support Specialists will be hired to work directly in MH IP units.</p>



Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
		<p>2014</p> <p>2014</p> <p>2014</p> <p>2014</p> <p>Ongoing</p> <p>2014</p> <p>2014</p> <p>Ongoing</p>	<p>2013 Q4/2014 Q1: Development of specialized services such as Dialect Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR) through use of reinvestment funding.</p> <p>Participate in Department of Public Welfare (DPW), Drug Utilization Review (DUR) Board Meetings to support the standardization of prior authorization criteria for medications (including second generation anti-psychotic medications).</p> <p>Evaluate the availability of providers who offer injection clinics to support the growing demand for injectable medications</p> <p>Continue Quality Treatment Record review every three years based on the re-credentialing cycle The benchmark for performance is 75%. Any provider with scores below 75% is asked to complete a Quality Improvement Plan. Once the Quality Improvement Plan has been accepted, the provider will be monitored every three months for improvements.</p> <p>The clinical department continues to utilize Member Monitoring to conduct Member outreach and follow-up to Members who do not meet the criteria for Extended Care Management (ECM). The goal of Member Monitoring is to increase Member stabilization within the community and for early intervention prior to a Member meeting the criteria for ECM.</p> <p>Pyramid Healthcare is expanding existing services within the FF contract to include a dually licensed Mental Health/Substance Abuse (MH/SA) OP Clinic.</p> <p>PerformCare obtained and distributed a recovery board game to Mental Health Inpatient Facilities to use in group education on Recovery.</p> <p>Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex need.</p>



Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
		<p><i>2014</i></p> <p><i>2014</i></p> <p><i>Ongoing</i></p> <p><i>Ongoing</i></p>	<p>Monitor utilization of Brief Treatment Model (BTM), Functional Family Therapy (FFT), Incredible Years (IY), and Parent Child Intensive Therapy (PCIT) (evidence-based programming). Utilization is monitored monthly through Quality Improvement/Utilization Management (QI/UM). BTM utilization has increased, along with FFT. PCIT has had a slow start up in BESO with low utilization. There has been a switch in the IY, for children ages 4 to 8 years. Provider and referrals have been low; it is anticipated that a new advertising campaign will increase the referrals.</p> <p>A regional OP clinic added Mobile-Mental Health to their services in September 2014 in Franklin/Fulton Counties.</p> <p>Capital Counties continue to use Assertive Community Treatment (ACT), Mobile Mental Health Team (MMHT) and Mobile Psychiatric Nurse (MPN) services for in-home services</p> <p>Medical Assistance Transportation Program (MATP) information and contact numbers are available through the PerformCare Contact Center.</p>



Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
		<i>2013 and Ongoing</i>	Provider trainings have been/ will be offered to support the recovery initiative, discharge planning: <ol style="list-style-type: none"> 1. Mental Health First Aid training was held on August 6, 2013 and August 7, 2013 for Bedford/Somerset providers. 2. Mental Health Advance Directive training was held in Somerset on September 24, 2013. 3. Youth Mental Health First Aid training was held on September 30, 2013 and October 1, 2013 for Bedford and Somerset providers. 4. Mental Health Advance Directives training was held on October 15, 2013 in Bedford. 5. Movement toward the Recovery Model training was held with Conemaugh Hospital on December 12, 2013. 6. Motivational Interviewing training series was held in FF region on January 11, March 26, and May 10, 2013 7. Mental Health First Aid Facilitators training was held on January 27, 2014 – January 31, 2014 for Bedford and Somerset providers.

Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
		2013 and Ongoing	<ol style="list-style-type: none"> 8. Treatment Planning for Individuals with Complex Conditions Training was held in FF region on February 20, 2014. 9. Relapse prevent training was held on May 5, 2014 and May 6, 2014 for Bedford and Somerset providers. 10. Recovery- oriented documentation training was held with Conemaugh in May 6, 2014. 11. A physical health/behavioral health training took place on 5/25/14 for Bedford/Somerset providers. 12. Wellness Recovery Action Plan (WRAP) training and WRAP facilitator training series took place in Franklin/Fulton Counties June 5 and 6, 2014 and in September 2014. 13. A mental health recovery and WRAP 1 training was held on July 29, 2014 and August 5, 2014 for Bedford and Somerset providers. 14. A WRAP facilitators training took place August 18, 2014 – August 22, 2014 for Bedford and Somerset providers. 15. Proactive Counseling training was held on September 22, 2014 and September 23, 2014 16. Capital Area training sessions included: <ul style="list-style-type: none"> • Cardio-Vascular Disease in the S.M.I.01/16/13 & 2/27/13 • Mood disorders 02/12 and 02/26/13 • Child & Adolescent Needs and Strengths (CANS) 06/05/13 • Functional Behavioral Assessment (FBA) 6/10, 6/11, & 7/15/13 • Evaluator Training on CANS 9/13/13 • Diagnostic and Statistical Manual – 5 (DSM-5) 9/26 & 9/27/13



Reference Number	Opportunity for Improvement Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found PerformCare to be partially compliant with all Subparts associated with Structure and Operations Standards.	Follow-up Actions Taken and Planned Through 9/30/14 (Specify Dates)	Future Actions Planned (Specify Dates)
		Future Actions Planned (Specify Dates) 2014 2014 2014 2014 2014	Future Actions Planned: Consider implementation of Mobile Services Team (MST) and mobile – psych nursing in counties where the services are not available currently (BESO, Franklin/Fulton) Create and Distribute survey to individuals that have been readmitted within 30 days to gather information related to discharge process and planning and available supports within the community. The survey is an intervention developed for the Readmission Performance Improvement Project and will be monitored through that process quarterly. Exploration and implementation of alternative in-home services has been added to the fiscal year (FY) 2014/2015 service initiatives for BESO. FF region continues to explore alternative options for in-home services for the adult population. Perform Care is making improvements to outcomes reporting specific to level of care and provider. The outcomes reports will give detailed information on Provider Performance

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, PerformCare began to address opportunities for improvement related to Standards 72, 91, and 108. Proposed actions and evidence of actions taken by PerformCare were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring PerformCare into compliance with the relevant Standards.



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

- Readmission within 30 Days of Inpatient Psychiatric Discharge
- Follow-up After Hospitalization for Mental Illness – HEDIS 7 Day
- Follow-up After Hospitalization for Mental Illness– HEDIS 30 Day

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

Table 4.2 Root Cause Analysis for PerformCare

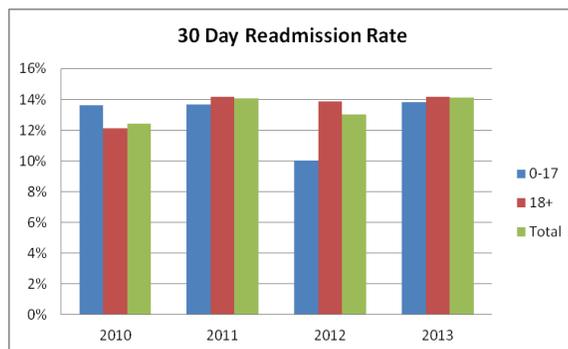
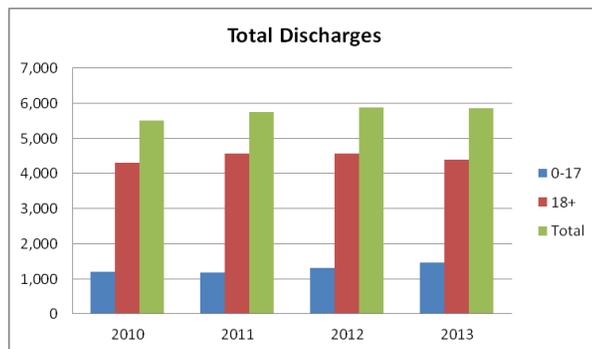
Managed Care Organization (MCO): PerformCare (formerly Community Behavioral HealthCare Network of Pennsylvania, CBHNP)	Measure: Follow-up After Hospitalization (FUH) for Mental Illness Quality Indicator (QI) 1 [Healthcare Effectiveness Data and Information Set (HEDIS) 7 Day]	Response Date: October 6, 2014
Goal Statement: (Please specify individual goals for each measure): Short-Term Goal: Increase QI 1 HEDIS 7 Day Performance to 49% (minimum performance goal plus 1%) by the end of Measurement Year (MY)2015. Long-Term Goal: Increase QI 1 HEDIS 7 Day Performance to 50% (2015 benchmark plus 1%) by the end of MY 2016. Please see Attachment 1: 2014 Ambulatory Follow Up & Re-admission Fishbone.		
Analysis: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.	Findings PerformCare's rate for MY 2013 QI 1 HEDIS 7 Day was 36.4% a decrease from 47.6% in MY 2012 and 45.2% in MY 2011 (inclusive of Blair and Lycoming/Clinton contracts). The short term goal which was established in March, 2012 was achieved; Performance exceeded 44.6% by the end of 2012.	
Policies (e.g., data systems, delivery systems, provider facilities) 1. Provider Network 2. HealthChoices	Initial Response <ul style="list-style-type: none"> • Current Network of psychiatric service providers may impede follow up. There is a shortage of psychiatrists and the rural counties of Franklin/Fulton and Bedford/Somerset have been issued a Professional Shortage Designation with the Department of Health. While telepsychiatry has been developed throughout the network, opportunities to expand this resource should continue through Network Operations. • Current practices at Performcare including credentialing, fee scheduling, enhanced rates, 	

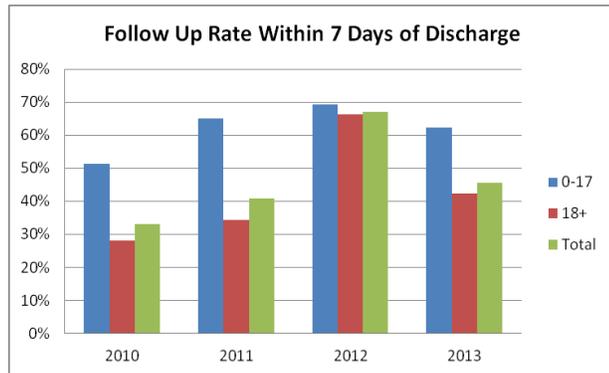
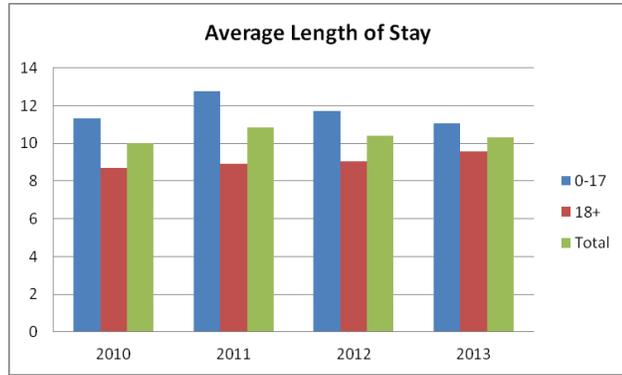
Contract Specifications
 3. Health Insurance Portability and Accountability Act (HIPAA) of 1996

- policies and procedures do not directly impact follow up rates after MH IP discharge.
- If the Member refuses to sign a release to share information with the aftercare Provider, collaboration becomes difficult. Substance Abuse (SA) Providers face unique challenges related to more stringent regulations regarding release of Member information.
- Although reporting capabilities have improved through the development and expansion of an Informatics department, timely and efficient data handling to support the identification of trends and details related to ambulatory follow up is limited. Additional attention should be focused on improving the clinical documentation system (eCura).
- Currently we are unable to rely on formal reporting to include details on race, correlations to readmissions, TCM involvement, and medication compliance.
- Currently, data collection to support Provider Profiling is limited by the data stored within the clinical documentation system (eCura); however we were able to review provider-specific follow-up rates, average length of stay, and readmission rates.

Multi-Year Utilization Comparison

The total number of Mental Health Inpatient (MH IP) discharges has remained fairly steady since 2010. The total number of MH IP discharges has increased slightly every year since 2010 with the exception of 2013, where a decrease of 30 discharges was observed. The 30-day readmission rate has also remained fairly steady, with a decrease from 2011 to 2012, especially in the 0-17 age group, which was at the lowest rate it is had been since before 2009. In 2013, the 30-day readmission rate for Members ages 0-17 increased again and is closer to the readmission rate for Members over the age of 18. The average length of stay (LOS) has remained between 10 and 11 days since 2010, with 2013 showing a slight decrease. . The follow-up rate within 7 days of discharge had been increasing from 2010 through 2012 but then decreased from 67% in 2012 to 46% in 2013. The largest decrease in follow-up rate within 7 days of discharge was observed in the 18+ age group. PerformCare will continue to work collaboratively with physical health services to ensure that Members receive the best care possible. PerformCare will also continue to effectively communicate with Members after discharge to ensure that follow up appointments are kept, thereby possibly avoiding a readmission to MH IP.





Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system. There is a shortage of psychiatrists across the network.

Follow-up Status Response

Procedures
(e.g., payment/reimbursement, credentialing/collaboration)
1. Quality Improvement (QI) Auditing Process

Initial Response

The treatment record review process for Mental Health Inpatient providers include a section related to adequate discharge planning and adherence to recovery principles. Results from 2012 and 2013 reveal providers are still in need of education regarding discharge planning best practice. Indicators remaining below the 75% target appear below:

Discharge Summary:	2012	2013
Were aftercare and follow-up plans identified including Natural Supports?	63%	63%
Is there documentation that the Member was present and in agreement with appointments that were made for follow up?	90%	74%
Was the TCM (Targeted Case Management) included in the discharge planning process (if currently involved)?	100%	59%
Is there a relapse prevention plan (post-discharge) that reflects what steps the Member should take if symptoms escalate which includes activities based on strengths. (must consist of phone numbers for all) A) natural supports, B) provider(s), and C) Crisis Intervention.)	0%	31%
Was the follow up treatment date within 7 days of discharge?	88%	65%
Is there documentation in the record that the PerformCare Member letter was offered to Member at time of discharge?	0%	11%

Are the discharge instructions recovery-oriented (not medical model)? (include Member words, recovery principles, relapse management)	0%	32%
Recovery Orientation (all sections)		
Is there evidence of person-centered language?	0%	26%
Is there evidence of clinician as consultant and Member as expert?	11%	67%
Is progress defined by Member/family?	0%	59%
Have efforts been made to strengthen natural supports?	100%	72%
Is the focus not simply on symptom reduction (i.e. addresses needs of Member; improves quality of life, etc.)?	100%	58%
Are member strengths incorporated into all areas of treatment (intake, treatment plans, recovery/crisis plans, groups)?	0%	8%
Is there documentation that educational/vocational options/strategies were discussed with the Member?	100%	69%

- It should be noted that the MY 2012 audit was completed for one provider at 4 different Inpatient Facilities and the data for MY 2013 represents the audit results for MH Inpatient Providers in Bedford, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry and Somerset counties.

Root Cause: Best Practice Discharge procedures are not completely being followed by many MH IP providers. This could lead to Member's lack of engagement in aftercare. There is a lack of family involvement, collaboration with Mental Health Outpatient (MH OP)/substance abuse providers at times. Providers are not identifying barriers and taking steps to resolve prior to discharge.

Follow-up Status Response

People
(e.g., personnel, provider network, patients)
1. Member
2. Quality Care Manager
3. Providers

Initial Response

- The group discussed the importance of having clear discharge instructions, that the Member be present for arranging aftercare appointments that barriers are addressed, and the times/dates are convenient for the Member.
- Quality Care Manager's report the results of quality treatment record reviews reveal that family and friends are not documented to be included in the discharge process which can complicate follow up.
- The Franklin/Fulton MH IP Readmission Work Group completed a full analysis of adult Members who had a readmission episode in SFY 2012 and 2013 in order to determine if any commonalities/trends existed within the population and to identify possible barriers to aftercare treatment. This analysis showed that although the majority of Members with a readmission episode had a subsequent follow-up appointment within 7 days, however, readmission episodes still occurred.

Root Cause: Due to limited transportation options, scheduling, inadequate discharge instructions and availability of accessible in-home services, follow up has been at a less than desired rate.

Follow-up Status Response

Provisions
(e.g., screening tools, medical record forms, provider and enrollee educational materials)
1. Provider Education

Initial Response

- There appears to be a lack of provider education on how to engage the Member into treatment by motivating the Member while on the MH IP unit. Some providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way.
- There appears to be a lack of Member understanding of Recovery principles, treatment



2. Enrollee Education	options and necessity of follow up to avoid relapse. Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery. Follow-up Status Response
Other (specify)	Initial Response
N/A	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.
Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system. There is a shortage of psychiatrists across the network. Action: <ol style="list-style-type: none"> Existing Crisis Bridge Programs will be monitored and promoted so utilization may increase. Expand tele-psychiatry services across the network. Work with providers to brainstorm ideas related to bringing more psychiatrists to rural areas through the Professional Shortage Designation. [Bedford/Somerset 	Ongoing	Initial Response <ol style="list-style-type: none"> BHSSBC and PerformCare will continue to meet with Cornerstone and Somerset Hospital to evaluate the Crisis Bridge Program. Data is presented by PerformCare and Somerset Hospital at these meetings which occur every 6 months. Data related to this program will also be shared at QI/UM on a bi-annual basis when outcomes reporting is discussed. In the fall of 2014, as result of the presentation of data and the above discussions, the Bedford/Somerset model was adjusted so that participation shifted from an Option-In approach to an Option-Out approach. The total number of tele-psychiatry providers is expected to increase in 2014 and will be monitored through various meetings. Access to psychiatry will be monitored monthly through QI/UM. Franklin/Fulton Counties added 2 additional providers of Telepsychiatry to the network in 2013 and 2014. Discussions with additional providers will occur as interest increases. A partnership between TrueNorth Welless and the Federally Qualified Health Center (FQHC) located in Fulton County is being expanded which will target an increase in Member knowledge regarding MH services available. Meetings are planned to occur with FQHC provider in the fall of 2014 in Bedford/Somerset Counties. This report will be requested through Informatics. Once available, it will be included with regular QI/UM reporting. (Reporting frequency varies by contract). The survey is an intervention developed for the Readmission Performance Improvement Project and will be monitored through that process quarterly.
	Start 2014	
	Ongoing	
	Fall 2014	
	2014	
	2015	
		Follow-up Status Response



<p>(BESO) and Franklin/Fulton (FF) Counties]</p> <p>4. Create detailed ambulatory follow up report that will be linked to average LOS, readmissions, ethnicity, geographical location</p> <p>5. Create and Distribute survey to individuals that have been readmitted within 30 days to gather information related to discharge process and planning and available supports within the community.</p>		
<p>Root Cause: Best Practice Discharge procedures are not completely being followed by many MH IP providers. This could lead to Member's lack of engagement in aftercare. There is a lack of family involvement, collaboration with MH OP/substance abuse providers at times. Providers are not identifying barriers and taking steps to resolve prior to discharge.</p> <p>Action:</p> <p>1. Continue Quality Treatment Record review every three years based on the re-credentialing cycle. Providers with Quality Improvement Plans will be</p>	<p>Ongoing</p> <p>2014</p> <p>2014</p> <p>2011</p>	<p>Initial Response</p> <ol style="list-style-type: none"> Quality Treatment Record reviews are conducted every three years based on the re-credentialing cycle. The benchmark for performance is 75%. Any provider with scores below 75% is asked to complete a Quality Improvement Plan. Once the Quality Improvement Plan has been accepted, the provider will be monitored every three months for improvements. Preliminary outcomes reporting has been developed and implemented and is being operationalized through Quality Improvement/Utilization Management (QI/UM) Committee for monitoring so further interventions can be planned. The report is still being refined for the inpatient level of care. Local Care Managers are continuing to expand their caseloads. Active Care Management strategies continue for PerformCare Clinical Care Managers through Enhanced Care Management (ECM) The clinical department continues to utilize Member Monitoring to conduct Member outreach and follow-up to Members who do not meet the criteria for ECM. The goal of Member Monitoring is to increase Member stabilization within the community and for early intervention prior to a Member meeting the criteria for ECM. CCISC meeting continue in the North Central Contracts. Change Agent Meetings continue in the North Central contracts. There is a Complex condition training planned on 2/20/14 in the Franklin/Fulton region. Pyramid Healthcare is expanding existing services within the FF contract to include a dually licensed Mental Health/Substance Abuse (MH/SA) OP Clinic. PerformCare obtained and distributed a recovery board game to Mental Health Inpatient Facilities to use in group education on Recovery <p>Follow-up Status Response</p>



<p>monitored every three months for improvements.</p> <p>2. Perform Care is making improvements to outcomes reporting specific to level of care and provider. The outcomes reports will give detailed information on Provider Performance.</p> <p>3. Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex needs</p> <p>4. Comprehensive Continuous Integrated System of Care (CCISC) Implementation has occurred in Bedford/Somers et and Franklin/Fulton Counties.</p> <p>5. CCISC meetings and Change Agent Meetings/Trainings have occurred and are ongoing.</p>		
<p>Root Cause: Due to transportation issues and other factors, Members are not following up due to lack of clear discharge instructions and availability of accessible in-home services.</p>	<p>Ongoing monthly</p> <p>2014/2015</p> <p>2014</p>	<p>Initial Response</p> <ol style="list-style-type: none"> 1. Utilization is monitored monthly through QI/UM. BTM utilization has increased, along with Functional Family Therapy (FFT). Parent Child Intensive Therapy (PCIT) has had a slow start up in BESO with low utilization. There has been a switch in the Incredible Years (IY), for children ages 4 to 8 years, Provider and referrals have been low; it is anticipated that a new advertising campaign will increase the referrals. 2. Exploration and implementation of alternative in-home services has been added to the fiscal year (FY) 2014/2015 service initiatives for BESO. 3. FF region continues to explore alternative options for in-home services for the adult population. 4. Capital Counties continue to use Assertive Community Treatment (ACT), Mobile Mental Health Team (MMHT) and Mobile Psychiatric Nurse (MPN) services for



<p>Action:</p> <ol style="list-style-type: none"> 1. Monitor utilization of BTM, FFT, IY, and PCIT (evidence-based programming). 2. Consider implementation of MST and mobile –psych nursing in counties where the services are not available currently (BESO, Franklin/Fulton) 3. A regional OP clinic added Mobile-Mental Health to their services in September 2014 in Franklin/Fulton Counties. 		<p>in-home services</p> <ol style="list-style-type: none"> 5. Medical Assistance Transportation Program (MATP) information and contact numbers are available through the PerformCare Contact Center
<p>Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.</p> <p>Action:</p> <ol style="list-style-type: none"> 17. Provider trainings have been/ will be offered to support the recovery initiative, discharge planning 	<p>Started 2013 Ongoing</p>	<p>Initial Response</p> <ol style="list-style-type: none"> 1. Mental Health First Aid training was held on August 6, 2013 and August 7, 2013 for Bedford/Somerset providers. 2. Mental Health Advance Directive training was held in Somerset on September 24, 2013. 3. Youth Mental Health First Aid training was held on September 30, 2013 and October 1, 2013 for Bedford and Somerset providers. 4. Mental Health Advance Directives training was held on October 15, 2013 in Bedford. 5. Movement toward the Recovery Model training was held with Conemaugh Hospital on December 12, 2013. 6. Motivational Interviewing training series was held in FF region on January 11, March 26, and May 10, 2013 7. Mental Health First Aid Facilitators training was held on January 27, 2014 – January 31, 2014 for Bedford and Somerset providers. 8. ANSA training was held on January 31, 2014 for Franklin/Fulton providers. 9. Child/Adolescent Complex Conditions training was held in FF region on January 9, 2014. 10. Treatment Planning for Individuals with Complex Conditions Training was held in FF region on February 20, 2014. 11. Relapse prevent training was held on May 5, 2014 and May 6, 2014 for Bedford and Somerset providers. 12. Recovery- oriented documentation training was held with Conemaugh in May 6, 2014. 13. A physical health/behavioral health training took place on 5/25/14 for Bedford/Somerset providers. 14. Wellness Recovery Action Plan (WRAP) training and WRAP facilitator training series took place in Franklin/Fulton Counties June 5 and 6, 2014 and in September 2014. 15. A mental health recovery and WRAP 1 training was held on July 29, 2014 and



		<p>August 5, 2014 for Bedford and Somerset providers.</p> <p>16. A WRAP facilitators training took place August 18, 2014 – August 22, 2014 for Bedford and Somerset providers.</p> <p>17. Proactive Counseling training was held on September 22, 2014 and September 23, 2014 for Bedford/Somerset providers.</p> <p>18. Capital Area training sessions included: Cardio-Vascular Disease in the S.M.I. 01/16/13 & 2/27/13 Mood disorders 02/12 and 02/26/13 Child & Adolescent Needs and Strengths (CANS) 06/05/13 Functional Behavioral Assessment (FBA) 6/10, 6/11, & 7/15/13 Evaluator Training on CANS 9/13/13 Diagnostic and Statistical Manual – 5 (DSM-5) 9/26 & 9/27/13</p> <p><i>Follow-up Status Response</i></p>
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VI: 2013 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of PerformCare's 2014 (MY 2013) performance against structure and operations standards, performance improvement projects and performance measures identified opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH-MCO.

Strengths

- No strengths identified

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2011, RY 2012, and RY 2013 found PerformCare to be partially compliant with all three Subparts associated with Structure and Operations Standards.
 - Within Subpart C: Enrollee Rights and Protections Regulations, PerformCare was partially compliant on one out of seven categories – Enrollee Rights.
 - PerformCare was partially compliant on six out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Subcontractual Relationships and Delegation 5) Practice Guidelines, and 6) Quality Assessment and Performance Improvement Program.
 - PerformCare was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.
- PerformCare's rate for the MY 2013 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (worse) than the BH-MCO average by 2.0 percentage points. PerformCare's rate did not meet the OMHSAS designated performance goal of 10.0%.
- PerformCare's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness HEDIS indicators QI 1 and QI 2 were statistically significantly lower than the BH-MCO Averages by 9.8 and 5.6 percentage points. PerformCare reported the lowest results for both QI 1 and QI 2 of all the BH-MCOs evaluated.
- PerformCare's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness PA Specific indicators QI A and QI B were statistically significantly lower than the BH-MCO Averages by 6.9 and 3.2 percentage points. PerformCare reported the lowest results for QI A of all the BH-MCOs evaluated.
- PerformCare's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness HEDIS indicators (QI 1 and QI 2) for ages 6-64 did not meet either the OMHSAS interim goal for MY 2013 or the goal of meeting or exceeding the 75th percentile.

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:



	<p>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.</p> <p>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.</p> <p>HEDIS Follow-Up After Hospitalization Measures– Ages 6-64: At or above 90th percentile.</p> <p><i>BH-MCOs may have internal goals to improve.</i></p>
	<p>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 <u>or</u> 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.</p> <p>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 <u>or</u> 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.</p> <p>HEDIS Follow-Up After Hospitalization Measures– Ages 6-64: At or above 75th and below 90th percentile.</p> <p><i>BH-MCOs may identify continued opportunities for improvement.</i></p>
	<p>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 <u>or</u> 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 <u>or</u> the BH-MCO's MY 2013 rate is statistically significantly above the MY 2013 HealthChoices BH-MCO Average but trends down from MY 2012.</p> <p>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 <u>or</u> 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 <u>or</u> the BH-MCO's MY 2013 rate is statistically significantly below the MY 2013 HealthChoices BH-MCO Average but trends up from MY 2012.</p> <p>HEDIS Follow-Up After Hospitalization Measures– Ages 6-64: N/A</p> <p><i>No action is required although MCOs should identify continued opportunities for improvement.</i></p>
	<p>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 <u>or</u> that the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and trends down from MY 2012.</p> <p>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 <u>or</u> that the BH-MCO's MY 2013 rate is equal to the MY 2013 HealthChoices BH-MCO Average and trends up from MY 2012.</p> <p>HEDIS Follow-Up After Hospitalization Measures– Ages 6-64: At or above 50th and below 75th percentile.</p> <p><i>A root cause analysis and plan of action is required.</i></p>
	<p>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.</p> <p>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.</p> <p>HEDIS Follow-Up After Hospitalization Measures – Ages 6-64: At or below the 50th percentile.</p> <p><i>A root cause analysis and plan of action is required.</i></p>



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

Figure 1.1: Performance Measure Matrix – PerformCare

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

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)	54.2%=	57.4%▲	59.4%=	48.8%▼	55.7%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	72.8%▼	76.7%▲	78.0%=	69.1%▼	72.3%
Readmission within 30 Days of Inpatient Psychiatric Discharge ²	13.0%=	14.8%=	14.1%=	15.5%▲	13.5%

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



PerformCare

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

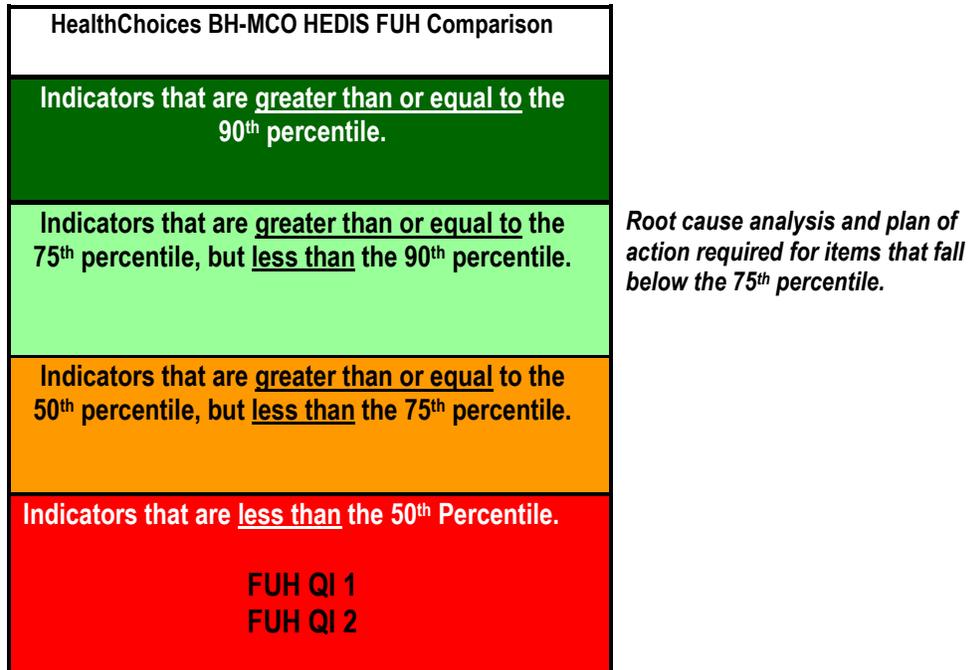


Figure 2.2: HEDIS Follow-Up After Hospitalization (FUH) 7-day/30-day Performance Measure Rates – PerformCare

Quality Performance Measure	MY 2013 Rate	HEDIS MY 2013 Percentile
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day) – Ages 6-64	36.4% Not Met	<i>Below 50th, at or above 25th percentile</i>
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day) – Ages 6-64	61.3% Not Met	<i>Below 50th, at or above 25th percentile</i>



PerformCare

KEY POINTS

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

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

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

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

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

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

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

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

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

- 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
- Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)
- Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)
- Readmission within 30 Days of Inpatient Psychiatric Discharge¹

¹ 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

- PerformCare 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

- PerformCare submitted an initial PIP proposal in 2014.

Performance Measures

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

2012 Opportunities for Improvement MCO Response

- PerformCare provided a response to the opportunities for improvement issued in 2013.

2013 Strengths and Opportunities for Improvement

- Opportunities for improvement were noted for PerformCare in 2013. The BH-MCO will be required to prepare a response for the noted opportunities for improvement in 2014.



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

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Standard 108.2	C/FST budget is sufficient to: hire staff proportionate to HC covered lives, has adequate office space, purchase equipment, travel and attend on-going training.
	Standard 108.5	The C/FST has access to providers and HC members to conduct surveys and employs of a variety of survey mechanisms to determine member satisfaction e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Standard 108.6	The problem resolution process specifies the role of the County, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
	Standard 108.7	The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
	Standard 108.8	The Annual Mailed/Telephonic survey results are representative of HC membership, identify systemic trends and actions have been taken to address areas found deficient, as applicable.
Standard 108.10	The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.	
§438.206 Availability of Service	Standard 1.1	<ul style="list-style-type: none"> • A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages. • Excel or Access data base with the following information: Name of Agency (include satellite sites). Address of Agency (and satellite sites) with zip codes. Level of Care (e.g. Partial Hospitalization, D&A Outpatient, etc). Population served (adult, child & adolescent). Priority Population. Special Population.
	Standard 1.2	100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met.
	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 15 th .
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds



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. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action



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. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.	



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.
§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.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues,



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



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



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



Appendix B: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Second Level Complaints and Grievances		
Complaints	Standard 68.6	The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 68.9	Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.
Grievances and State Fair Hearings	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 71.8	Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.
Enrollee Satisfaction		
Consumer / Family Satisfaction	Standard 108.3	County/BH-MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.
	Standard 108.4	The C/FST Director is responsible for setting program direction consistent with County direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority and directing staff to perform high quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.



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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2013, 11 substandards were considered OMHSAS-specific monitoring standards, and were reviewed. All 11 OMHSAS-specific PEPS Substandards were evaluated for Franklin-Fulton and CABHC HC BH Contractors. The remaining HC BH Contractor Bedford-Somerset – were evaluated on 10 of the substandards. For this HC BH Contractor, there was one Substandard that was not scheduled or not applicable for evaluation for RY 2013. Tables C.1a and C.1b provide a count of these Items, along with the relevant categories.

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

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

Table C.1b OMHSAS-Specific Substandards Reviewed for Bedford-Somerset

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2013	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	Not Reviewed
Complaints (Standard 68)	4	0	0	4	0
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	0
Consumer/Family Satisfaction (Standard 108)	3	0	2	0	1

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

Format

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

Findings

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards³, and all eight substandards were evaluated for PerformCare. PerformCare met seven substandards and partially met on one item, as seen in Table C.2.

³ Beginning with RY 2012, MCO-specific substandards 68.9 and 71.8 were changed to County-specific substandards and renumbered to 68.1 and 78.1 respectively under the County-specific standard set. These changes will be reflected in future reports for applicable RY 2012 findings



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

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

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

PerformCare was “partially met” on Substandard 68.9:

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

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

Table C.3a OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for Bedford-Somerset and Franklin-Fulton

Category	PEPS Item	Review Year	Status by HC BH Contractor		
			Met	Partially Met	Not Reviewed*
Enrollee Satisfaction					
Consumer/Family Satisfaction	Standard 108.3	RY 2012	Franklin-Fulton		Bedford-Somerset
	Standard 108.4	RY 2012	Franklin-Fulton Bedford-Somerset		
	Standard 108.9	RY 2012	Bedford-Somerset	Franklin-Fulton	

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

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

Franklin-Fulton was “partially met” on Substandard 108.9:



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

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

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



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- 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
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 - xx Ibid.
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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.

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