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

2012 External Quality Review Report
Community Behavioral HealthCare Network of Pennsylvania
FINAL REPORT

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REPORT CONTENT

GLOSSARY OF TERMS

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

INTRODUCTION

Purpose and Background

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

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

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

The HealthChoices Behavioral Health is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2012 EQRs for the HealthChoices Behavioral Health (BH) MCOs and to prepare the technical reports. This technical report includes six core sections:

I: Structure and Operations Standards
II: Performance Improvement Projects
III: Performance Measures
IV: 2011 Opportunities for Improvement - MCO Response
V: 2012 Strengths and Opportunities for Improvement
VI: Summary of Activities

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

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

Section IV, 2011 Opportunities for Improvement – MCO Response, includes the BH MCO's responses to opportunities for improvement noted in the 2011 EQR Technical Report, and presents the degree to which the BH MCO addressed each opportunity for improvement.

Section V has a summary of the BH MCO's strengths and opportunities for improvement for this review period (2011) as determined by IPRO, and a "report card" of the BH MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HealthChoices Behavioral Health Managed Care Organization.

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

I: STRUCTURE AND OPERATIONS STANDARDS

This section of the EQR report presents a review by IPRO of the BH MCO Community Behavioral HealthCare Network of Pennsylvania's (CBHNP's) compliance with the structure and operations standards. In Review Year (RY) 2011, 66 PA Counties participated in this compliance evaluation.

Organization of the HealthChoices Behavioral Health Program

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

Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties formed an alliance called Capital Area Behavioral Healthcare (CABHC), which holds a contract with CBHNP. North/Central County Option (NC/CO) Counties – Bedford, Blair, Clinton, Franklin, Fulton, Lycoming, and Somerset – also hold contracts with CBHNP. While Medicaid managed care members may choose a Physical Health (PH) MCO for physical health care services, each HealthChoices enrollee is assigned a BH MCO based on his or her County of residence. IPRO's EQR is based on OMHSAS reviews of CBHNP and the 12 Counties associated with the BH MCO.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CBHNP by OMHSAS monitoring staff within the past three years. These evaluations are performed at the BH MCO and County levels, and the findings are reported in OMHSAS' PEPS review tools for Review Year (RY) 2011. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-County reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year timeframe under consideration, the RAI was provided to IPRO. For those Counties and BH MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review Substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's Program Standards and Requirements (PS&R) are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2012 and entered into the PEPS tools as of October 2012 for RY 2011. Information captured within the PEPS tools informs this report. The PEPS tools are a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each County/BH MCO. Within each standard, the tool specifies the sub-standards or Items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional reviewer comments. Based on the tools, a County/BH MCO is evaluated against substandards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS' more rigorous monitoring criteria.

At the implementation of the PEPS tools in 2004, IPRO evaluated the standards in the tools and created a crosswalk to pertinent BBA regulations. For standards with substandards, all of the substandards within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the substandards required for fulfilling BBA requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS' ongoing monitoring. In the amended crosswalk, the supplemental substandards no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Substandards concerning first level complaints and grievances inform the compliance determination of the BBA categories relating to Federal & State Grievance Systems Standards. All of the PEPS Substandards concerning second level complaints and grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category. As was done for the prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The RY 2011 crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in Appendix A and B, respectively. The review findings for selected OMHSAS-specific Substandards are reported in Appendix C.

Because OMHSAS review of the Counties and their subcontracted BH MCOs expands over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS Substandards from RY 2011, RY 2010, and RY 2009 provided the information necessary for the 2011 assessment. Those standards not reviewed through the PEPS system in RY 2011 were evaluated on their performance based on RY 2010 and/or RY 2009 decisions, or other supporting documentation, if necessary. For those Counties that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed. Since Erie County contracted with two BH MCOs in 2011 and because all applicable standards were reviewed for both BH MCOs within the three-year time frame, Erie County's review findings for RY 2011, RY 2010 and RY 2009 were not included in the assessment of compliance for either BH MCO.

For CBHNP, this year a total of 159 Items were identified as being required for the evaluation of County/BH MCO compliance with the BBA regulations. In addition, 11 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Substandards were relevant to more than one BBA regulation or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS Substandard may contribute more than once to the total number of Items required and/or reviewed. Tables 1.1a and 1.1b provide a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of the CBHNP Counties against the Structure and Operations Standards for this report. In Appendix C, Tables C.1a to C.1c provide a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH MCO and associated Counties against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Items Pertinent to BBA Regulations for CBHNP Counties

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

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	Not Reviewed*
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	5	0	0	7
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	2	4	16	0
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	3	0	0	1
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	2	4	0	0
Quality Assessment and Performance Improvement Program	23	16	7	0	0
Health Information Systems	1	0	1	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	10	0	0	1
General Requirements	14	13	0	0	1
Notice of Action	11	1	0	9	1
Handling of Grievances and Appeals	11	10	0	0	1
Resolution and Notification: Grievances and Appeals	11	10	0	0	1
Expedited Appeals Process	6	5	0	0	1
Information to Providers and Subcontractors	2	2	0	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	5	0	0	1
Effectuation of Reversed Resolutions	6	5	0	0	1

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

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

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	RAI Reviewed in RY 2009	Not Reviewed*
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	5	0	7	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	2	4	16	0
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	3	0	0	1
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	2	4	0	0
Quality Assessment and Performance Improvement Program	23	16	7	0	0
Health Information Systems	1	0	1	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	10	0	0	1
General Requirements	14	13	0	0	1
Notice of Action	11	1	0	9	1
Handling of Grievances and Appeals	11	10	0	0	1
Resolution and Notification: Grievances and Appeals	11	10	0	0	1
Expedited Appeals Process	6	5	0	0	1
Information to Providers and Subcontractors	2	2	0	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	5	0	0	1
Effectuation of Reversed Resolutions	6	5	0	0	1

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

For RY 2011, nine categories, 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements were not directly addressed by the PEPS Substandards reviewed. As per OMHSAS' judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health Program's PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH MCOs. The category of Marketing Activities is Not Applicable because as a result of the Centers for Medicare and Medicaid Services (CMS) HealthChoices waiver, DPW has been granted an allowance to offer only one BH MCO per County.

In evaluations prior to the 2008 report, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all Counties and BH MCOs based only on the

HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. Beginning with the 2008 report, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories by OMHSAS. Hence, Solvency Requirement tracking reports, Encounter Monthly Aggregate Complaint/Grievance records (EMG) and Encounter Monthly Complaint/Grievance Synopsis records (MCG) were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

Determination of Compliance

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

Format

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

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

Findings

For CBHNP and the 12 Counties associated with the BH MCO, 159 PEPS Items were identified as required to fulfill BBA regulations. The 12 Counties were evaluated on 150 PEPS Items during the review cycle. There were nine Items that were not scheduled or not applicable for evaluation for RY 2011.

Subpart C: Enrollee Rights and Protections

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

Table 1.2 Compliance with Enrollee Rights and Protections Regulations

Enrollee Rights and Protections		
Subpart C: Categories	**Compliance**	**Comments**
Enrollee Rights 438.100	Partial	12 substandards were crosswalked to this category. The CABHC Counties were evaluated on 5 substandards and compliant on 5 substandards. The NC/CO Counties were evaluated on 12 substandards. Blair, Bedford, Franklin, Fulton and Somerset Counties were compliant on 12 substandards. Clinton and Lycoming Counties were compliant on 10 substandards and partially compliant on 2 substandards.
Provider-Enrollee Communications 438.102	Compliant	Compliant as per PS&R sections E.4 (p.49) and A.3.a (p.20).
Marketing Activities 438.104	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	Compliant as per PS&R sections A.9 (p.64) and C.2 (p.30).
Cost Sharing 438.108	Compliant	Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	Compliant as per PS&R section 3 (p.34).
Solvency Standards 438.116	Compliant	Compliant as per PS&R sections A.3 (p.59) and A.9 (p.66), and 2011-2012 Solvency Requirements tracking report.

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

Of the 12 PEPS Substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated. The NC/CO Counties were evaluated on 12 substandards. Blair, Bedford, Franklin, Fulton and Somerset Counties were compliant on all 12 substandards. Clinton and Lycoming Counties were compliant on 10 substandards and partially compliant on two substandards. The CABHC Counties (Cumberland, Dauphin, Lancaster Lebanon and Perry) were evaluated on five substandards and were 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

All of the 12 Counties that subcontract with CBHNP were partially compliant with Enrollee Rights due to partial compliance with substandards within PEPS Standard 108.

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

Clinton and Lycoming Counties were partially compliant on two substandards of Standard 108: Substandards 6 and 7 (RY 2009).

> **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.

Subpart D: Quality Assessment and Performance Improvement Regulations

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

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

Table 1.3 Compliance with Quality Assessment and Performance Improvement Regulations

Quality Assessment and Performance Improvement Regulations		
Subpart D: Categories	**Compliance**	**Comments**
Elements of State Quality Strategies 438.204	Compliant	Compliant as per PS&R section G.3 (p.53).
Availability of Services (Access to Care) 438.206	Partial	22 substandards were crosswalked to this category. Each County was evaluated on 22 substandards, compliant on 20 substandards, and partially compliant on 2 substandards.
Coordination and Continuity of Care 438.208	Partial	2 substandards were crosswalked to this category. Each County was evaluated on 2 items and was partially compliant on both.
Coverage and Authorization of Services 438.210	Partial	4 substandards were crosswalked to this category. Each County was evaluated on 3 substandards, and partially compliant on 3 substandards.
Provider Selection 438.214	Compliant	3 substandards were crosswalked to this category. Each County was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	Compliant as per PS&R sections D.2 (p.46), G.4 (p.55) and C.6.c (p.44).

Quality Assessment and Performance Improvement Regulations		
Subpart D: Categories	**Compliance**	**Comments**
Subcontractual Relationships and Delegation 438.230	Compliant	8 substandards were crosswalked to this category. Each County was evaluated on 8 substandards, and compliant on 8 substandards.
Practice Guidelines 438.236	Partial	6 substandards were crosswalked to this category. Each County was evaluated on 6 substandards, compliant on 4 substandards, and partially compliant on 2 substandards.
Quality Assessment and Performance Improvement Program 438.240	Partial	23 substandards were crosswalked to this category. Each County was evaluated on 23 substandards. The CABHC Counties were compliant on 15 substandards and partially compliant on eight substandards. The NC/CO Counties were compliant on 14 substandards and partially compliant on 9 substandards.
Health Information Systems 438.242	Compliant	1 Substandard was crosswalked to this category. Each County was evaluated on 1 Substandard and was compliant on this Item.

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

For this review, 69 Items were crosswalked to Quality Assessment and Performance Improvement Regulations, and all 12 Counties associated with CBHNP were evaluated on 68 Items. There was one Item that was not scheduled or not applicable for evaluation for RY 2011. The CABHC Counties were compliant on 51 Items and partially compliant on 17 Items. The NC/CO Counties were compliant on 50 Items and partially compliant on 18 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. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

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

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

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

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

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

Coordination and Continuity of Care

All 12 Counties associated with CBHNP were partially compliant with Coordination and Continuity of Care due to partial compliance with one substandard 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 12 Counties associated with CBHNP were partially compliant with Coverage and Authorization of Services due to partial compliance with substandards of PEPS Standards 28 and 72.

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

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

All of the CBHNP Counties were partially compliant on one substandard of Standard 72: Substandard 1 (RY 2011).

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

Practice Guidelines

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

PEPS Standard 28: See Standard description and partially compliant substandard determination under Availability of Services (Access to Care) on page 13.

Quality Assessment and Performance Improvement Program

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

PEPS Standard 91: Completeness of the BH-MCO's QM Program Description and QM Work Plan. 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 CBHNP Counties were partially compliant on eight substandards of Standard 91: Substandards 2, 3, 4, 5, 7, 8, 9 and 10 (RY 2011).

> **Substandard 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.
>
> **Substandard 3:** QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.
>
> **Substandard 4:** QM work plan outlines, the joint studies to be conducted.
>
> **Substandard 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)
>
> **Substandard 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).
>
> **Substandard 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).
>
> **Substandard 9:** The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
>
> **Substandard 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

The NC/CO Counties (Bedford, Blair, Clinton, Franklin, Fulton, Lycoming, and Somerset) were partially compliant on one additional substandard of Standard 91: Substandard 12 (RY 2011).

> **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 County/BH MCO's compliance with regulations found in Subpart F. Table 1.4 presents the findings by categories consistent with the regulations.

Table 1.4 Compliance with Federal and State Grievance System Standards

Federal and State Grievance System Standards		
Subpart F: Categories	**Compliance**	**Comments**
Statutory Basis and Definitions 438.400	Partial	11substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 8 substandards, and partially compliant on 2 substandards.
General Requirements 438.402	Partial	14 substandards were crosswalked to this category. Each County was evaluated on 13 substandards, compliant on 11 substandards, and partially compliant on 2 substandards.
Notice of Action 438.404	Partial	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 9 substandards, and partially compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 8 substandards, and partially compliant on 2 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 8 substandards, and partially compliant on 2 substandards.
Expedited Appeals Process 438.410	Partial	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards, compliant on 3 substandards, and partially compliant on 2 substandards.
Information to Providers & Subcontractors 438.414	Compliant	2 substandards were crosswalked to this category. Each County was evaluated on 2 substandards and compliant on both.
Recordkeeping and Recording Requirements 438.416	Compliant	Compliant as per 2011Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.
Continuation of Benefits 438.420	Partial	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards, compliant on 3 substandards, and partially compliant on 2 substandards.
Effectuation of Reversed Resolutions 438.424	Partial	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards, compliant on 3 substandards, and partially compliant on 2 substandards.

There are 10 categories in the Federal and State Grievance System Standards. CBHNP 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 2011 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.

For this review, 78 Items were crosswalked to Federal and State Grievance System Standards, and each CBHNP County was evaluated on 70 Items. There were eight Items that were not scheduled or not applicable for evaluation for RY 2011. Each County was compliant on 55 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 12 CBHNP Counties were deemed partially compliant with eight of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with substandards within PEPS Standards 71 and 72.

PEPS Standard 71: Grievance and 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 CBHNP Counties were partially compliant on one substandard of Standard 71: Substandard 4 (RY 2011).

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

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 14.

II: PERFORMANCE IMPROVEMENT PROJECTS

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH MCO. Under the existing HealthChoices Behavioral Health agreement with OMHSAS, primary contractors (i.e., the Counties), along with the responsible subcontracted entities (i.e., BH MCOs), are required to conduct a minimum of two focused studies per year. The Counties and BH MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, BH MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2012 for 2011 activities.

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

The 2012 EQR is the ninth review to include validation of PIPs. With this PIP cycle, all BH MCOs/Counties share the same baseline period and timeline. To initiate the PIP cycle in 2008, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, remeasurement, and sustained improvement. Direction was given to the BH MCOs/Counties with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness.

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

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

Validation Methodology

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

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

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

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

Review Element Designation/Weighting

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

Table 2.1 Review Element Scoring Designations and Definitions

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

Overall Project Performance Score

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

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

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred through 2011. At the time of the review, a project is reviewed for only the elements that are due, according to the PIP submission schedule. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule.

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

Table 2.2 Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Title, Type, Focus Area	5%
2	Topic Relevance	5%
3	Quality Indicators	0%
4	Baseline Study and Analysis	20%
5	Baseline Study Population and Baseline Measurement Performance	10%
6	Interventions Aimed at Achieving Demonstrable Improvement	20%
7	Demonstrable Improvement	20%
Total Demonstrable Improvement Score		**80%**
1S	Subsequent or modified Interventions Aimed at Achieving Sustained Improvement	5%
2S	Sustained Improvement	15%

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

Findings

As per the timeline distributed by OMHSAS for this review period, BH MCOs were required to submit information for the review elements of Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement. CBHNP submitted the required elements of the FUH PIP for review.

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

Follow-up After Hospitalization for Mental Illness

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

The rationale previously provided for this activity selection included literature citations and root cause analyses based on BH MCO-and County-specific data. CBHNP cited from literature review that an estimated 40-60% of patients fail to connect with outpatient clinicians, but that those who have kept follow-up appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow-up with outpatient care. The BH MCO also referenced research indicating that factors such as socio-demographic, clinical, and service utilization characteristics can be used to predict those at risk for not receiving adequate follow-up care. CBHNP stated that they continue to use these predictors to develop potential next steps and interventions.

CBHNP discussed the BH MCO's rates on the four indicators, noting that all rates remained well below the 90% OMHSAS-established benchmark. CBHNP indicated that they conducted a separate root cause analysis for each of the five County contracts (four of which are joinders) – The Capital Five Counties, Blair County, Bedford/Somerset, Clinton/Lycoming, and Franklin/Fulton. As a result, the MCO observed multiple overarching problem areas, some of which included: 1) Third Party Liability (TPL) issues, specifically cases for which CBHNP is the secondary payer and follow-up visits were completed by providers under the primary insurance, so the claim would not have been captured by CBHNP, 2) use of Out of Network providers, 3) ineffective or lack of appointment outreach calls, 4) limited provider availability, 5) member preferences for unavailable providers, leading to lack of engagement, 6) lack of data reporting capacity, 7) hospital discharge planning issues, and 8) lack of access to transportation. CBHNP also referred to the definition used in the

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

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

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

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

Remeasurement results calculated in 2011 for January 1, 2010 through December 31, 2010 were presented, along with discussion of additional analysis conducted throughout 2010. Remeasurement results show that rates did not increase for any of the indicators. Demonstrable Improvement was not achieved. Additionally, the remeasurement rates did not meet the BH MCO's goals, or the OMHSAS benchmark. The interventions implemented in 2009 do not appear to have had an impact. The timing of the analysis presented indicates

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

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

For the elements of the study evaluated that reflect activities in 2011, CBHNP received no credit for Demonstrable Improvement and partial credit for Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement. Because Sustained Improvement is evaluated for measures for which Demonstrable Improvement was achieved, this measure will not be evaluated for Sustained Improvement in 2013, based on activities conducted in 2012 to assess performance in 2011.

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

Review Element	Compliance Level	Scoring Weight	Final Points Score
1. Project Title, Type, Focus Area	Full	5%	5
2.Topic Relevance	Full	5%	5
3. Quality Indicators	Full	0%	0
4. Baseline Study and Analysis (Calendar Year (CY) 2008, reported in CY 2009)	Full	20%	20
5. Baseline Study Population and Baseline Measurement Performance (CY 2008)	Full	10%	10
6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010)	Full	20%	20
7. Demonstrable Improvement (CY 2010, reported in 2011)	Non-Compliant	20%	0
Total Demonstrable Improvement Score			**60**

Review Element	Compliance Level	Scoring Weight	Final Points Score
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Partial	5%	2.5
2S. Sustained Improvement (CY 2011, reported in 2012)	Not Determined	15%	TBD
Total Sustained Improvement Score			**TBD**
Overall Project Performance Score			**TBD**

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

Project	2008	2009/2010	2010*	2010/2011	Comparison Benchmark for Review Year
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge (QI 1)	42.7%	NA	41.7%	TBD	90%
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	66.7%	NA	65.5%	TBD	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge. (Standard HEDIS Codes and PA codes) (QI A)	55.8%	NA	54.2%	TBD	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge. (Standard HEDIS Codes and PA codes) (QI B)	73.8%	NA	72.8%	TBD	90%
Project Status	Baseline Study	Interventions	Remeasurement #1	Remeasurement #2	

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

III: PERFORMANCE MEASURES

In 2012, OMHSAS and IPRO conducted two EQR studies. Both the Follow-up After Hospitalization for Mental Illness and Readmission within 30 Days of Inpatient Psychiatric Discharge studies were re-measured.

Follow-up After Hospitalization for Mental Illness

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

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

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

For MY 2008, indicator specifications were again aligned to the HEDIS 2009 Volume 2, Technical Specifications. Two Diagnosis Related Group (DRG) codes were removed, and one Universal/Uniform Billing (UB) type of bill code was added to the criteria to identify non-acute care exclusions. Additionally, five

POS codes were added to select CPT codes. Two procedure codes (one CPT and one HCPCS code) to identify eligible follow-up visits were added to the PA-specific measures per suggestions from OMHSAS, the Counties, and the BH MCOs. These codes were added to the existing 17 PA-specific codes, totaling 19 additional service codes that distinguish the PA-specific measure from the HEDIS measure in the MY 2008 study. Furthermore, as requested by OMHSAS, the MY 2008 findings by age are presented as three cohorts: Ages 6-20 years, Ages 21-64 years, and Ages 65 years and over. The Ages 21-64 years cohort was reported as two age ranges (Ages 21-59 years and Ages 60-64 years) in prior studies including MY 2007. As a result, the population previously reported as two cohorts are combined for comparative purposes.

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

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, indicators had very few changes based on the HEDIS 2012 Volume 2: Technical Specifications. One POS code was added to select CPT codes in the criteria to identify outpatient visits. In all, MY 2011 is the fifth re-measurement for QIs A and B, and is the fourth re-measurement for the Counties in the North/Central County and State Options regions across all indicators.

Measure Selection and Description

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

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

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

Eligible Population

The entire eligible population was used for all 67 Counties participating in the MY 2011 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, 2011;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Six years old and over as of the date of discharge; and

- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

I: HEDIS Indicators

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

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

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

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

II: PA-Specific Indicators

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

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

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

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

Quality Indicator Significance

According to the *Global Burden of Disease: 2004 Update* released by the World Health Organization (WHO) in 2008, mental illnesses and mental disorders represent six of the 20 leading causes of disability worldwide. Among developed nations, depression is the leading cause of disability for people ages 0-59 years, followed by drug and alcohol use disorders and psychoses (e.g., bipolar disorder and schizophrenia)[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.

Methodology

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

Performance Goals

Performance goals were set for this review year at the OMHSAS designated gold standard of 90% for all measures. In addition, the HEDIS measures were compared to industry benchmarks, in that the aggregate and BH MCO indicator rates were compared to the *HEDIS 2012 Audit Means, Percentiles and Ratios.* These benchmarks contained means, 10th, 25th, 50th (median), 75th and 90th percentiles, and the enrollment ratios for nearly all HEDIS measures. There were tables published by product line (i.e., Commercial, Medicaid, and Medicare). The appropriate Medicaid benchmarks available for the measurement year were used for comparison. As indicated previously, the PA-specific measures were not comparable to these industry benchmarks.

Data Analysis

The quality indicators were defined as rates, based on a numerator and a denominator. The denominator equaled the number of discharges eligible for the quality indicator, while the numerator was the total number

of members for which the particular event occurred. The overall, or aggregate, performance rate for each indicator was the total numerator divided by the total denominator. The aggregate rate represented the rate derived from the total population of members that qualified for the indicator (i.e., the aggregate value). Year-to-year comparisons to MY 2010 data were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

Findings

BH MCO and County Results

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

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

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

Table 3.1 MY 2011 HEDIS Indicator Rates with Year-to-Year Comparisons

	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
QI 1										
HealthChoices	16,621	36,038	**46.1%**	45.6%	46.6%	45.8%	47.3%	46.1%	0.0	NO
CBHNP	1,796	3,977	**45.2%**	43.6%	46.7%			41.7%	3.4	YES
Bedford	46	113	**40.7%**	31.2%	50.2%			36.8%	3.9	NO
Blair	249	531	**46.9%**	42.6%	51.2%			48.1%	-1.2	NO
Clinton	38	81	***46.9%***	*35.4%*	*58.4%*			43.8%	3.1	NO
Cumberland	127	259	**49.0%**	42.7%	55.3%			42.1%	6.9	NO
Dauphin	319	789	**40.4%**	36.9%	43.9%			35.1%	5.3	NO
Franklin	128	260	**49.2%**	43.0%	55.5%			49.6%	-0.4	NO
Fulton	8	26	***30.8%***	*11.1%*	*50.4%*			46.4%	-15.7	NO
Lancaster	459	1,006	**45.6%**	42.5%	48.8%			40.8%	4.9	NO
Lebanon	213	352	**60.5%**	55.3%	65.8%			48.6%	11.9	YES

	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
Lycoming	121	324	**37.4%**	31.9%	42.8%			38.0%	-0.6	NO
Perry	20	58	***34.5%***	*21.4%*	*47.6%*			51.4%	-16.9	NO
Somerset	68	178	**38.2%**	30.8%	45.6%			38.4%	-0.2	NO
QI 2										
HealthChoices	24,159	36,038	**67.0%**	66.6%	67.5%	66.8%	70.7%	66.9%	0.1	NO
CBHNP	2,781	3,977	**69.9%**	68.5%	71.4%			65.5%	4.4	YES
Bedford	84	113	**74.3%**	65.8%	82.8%			66.3%	8.0	NO
Blair	413	531	**77.8%**	74.1%	81.4%			73.9%	3.9	NO
Clinton	66	81	***81.5%***	*72.4%*	*90.6%*			71.9%	9.6	NO
Cumberland	182	259	**70.3%**	64.5%	76.0%			68.0%	2.3	NO
Dauphin	505	789	**64.0%**	60.6%	67.4%			57.8%	6.2	YES
Franklin	215	260	**82.7%**	77.9%	87.5%			80.1%	2.6	NO
Fulton	14	26	***53.9%***	*32.8%*	*74.9%*			75.0%	-21.2	NO
Lancaster	680	1,006	**67.6%**	64.6%	70.5%			60.4%	7.1	YES
Lebanon	274	352	**77.8%**	73.4%	82.3%			74.6%	3.2	NO
Lycoming	200	324	**61.7%**	56.3%	67.2%			64.4%	-2.6	NO
Perry	33	58	***56.9%***	*43.3%*	*70.5%*			70.0%	-13.1	NO
Somerset	115	178	**64.6%**	57.3%	71.9%			59.6%	5.0	NO

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

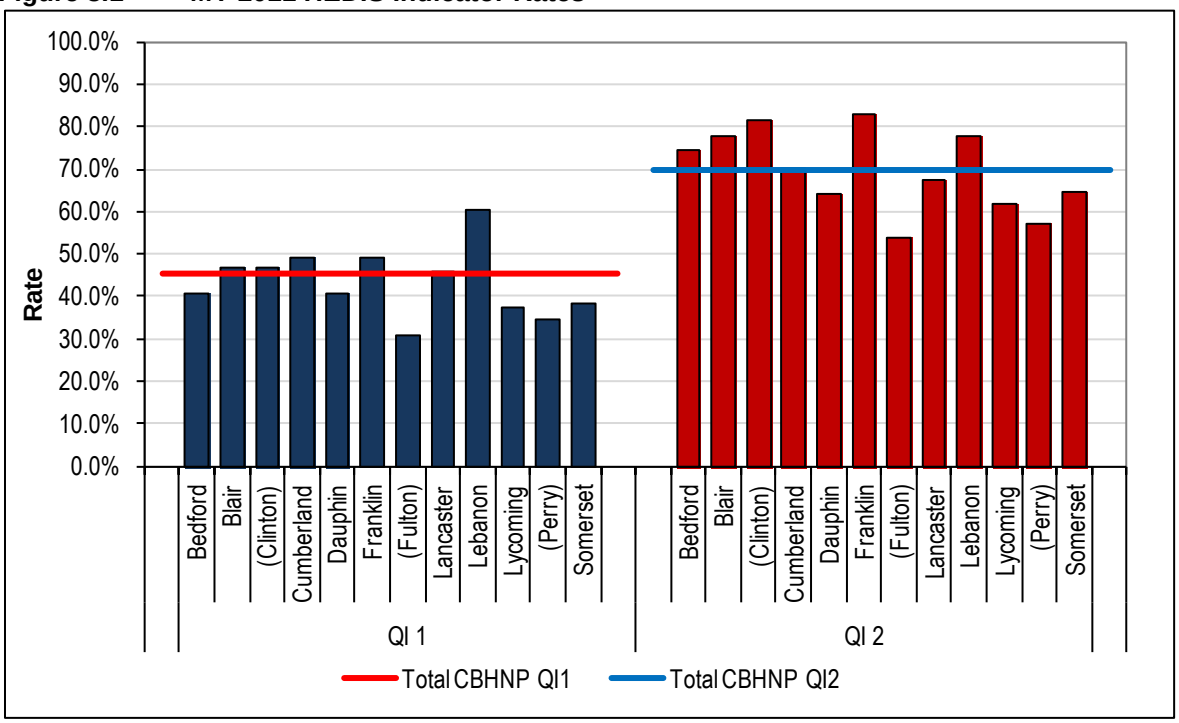
The MY 2011 HealthChoices aggregate rates were 46.1% for QI 1 and 67.0% for QI 2 with no statistically significant differences from the prior year. CBHNP's MY 2011 QI 1 rate was 45.2% and QI 2 rate was 69.9%. Both rates were statistically significantly above the prior year and represented the largest year to year increase among BH MCOs.

The MY 2011 HealthChoices BH MCO Averages for QI 1 and QI 2 were 45.8% and 66.8%, respectively. For MY 2011, although CBHNP's QI 1 rate did differ statistically significantly from the QI 1 HealthChoices BH MCO Average, CBHNP's QI 2 rate was statistically significantly above the QI 2 HealthChoices BH MCO Average by 3.1 percentage points.

As presented in Table 3.1, 12 Counties were contracted with CBHNP in MY 2011. For QI 1, the MY 2011 rate for Lebanon County increased statistically significantly by 11.9 percentage points as compared to the prior measurement year. The MY 2011 QI 1 rates for the remaining 11 CBHNP Counties were not statistically significantly different from the prior year. QI 2 rates for Dauphin and Lancaster Counties were statistically significantly above the MY 2010 rates by 6.2 and 7.1 percentage points respectively. QI 2 rates for the remaining 10 counties were not statistically significantly different from their respective MY 2010 rates.

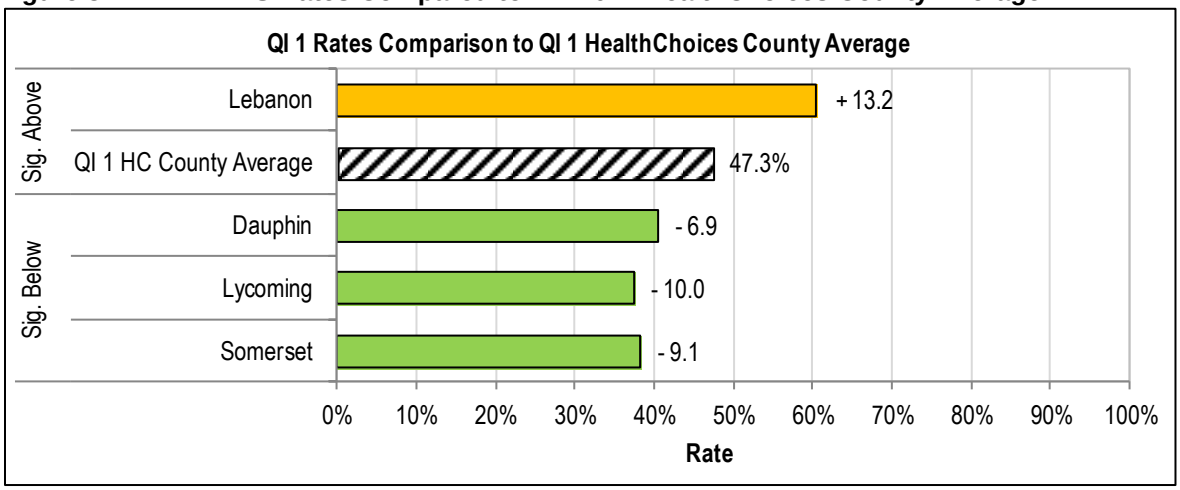
Figure 3.1 displays a graphical representation of the MY 2011 HEDIS follow-up rates for CBHNP and its associated Counties. Figure 3.2 presents the individual CBHNP Counties that performed statistically significantly above or below the HealthChoices County Averages for QI 1 and QI 2.

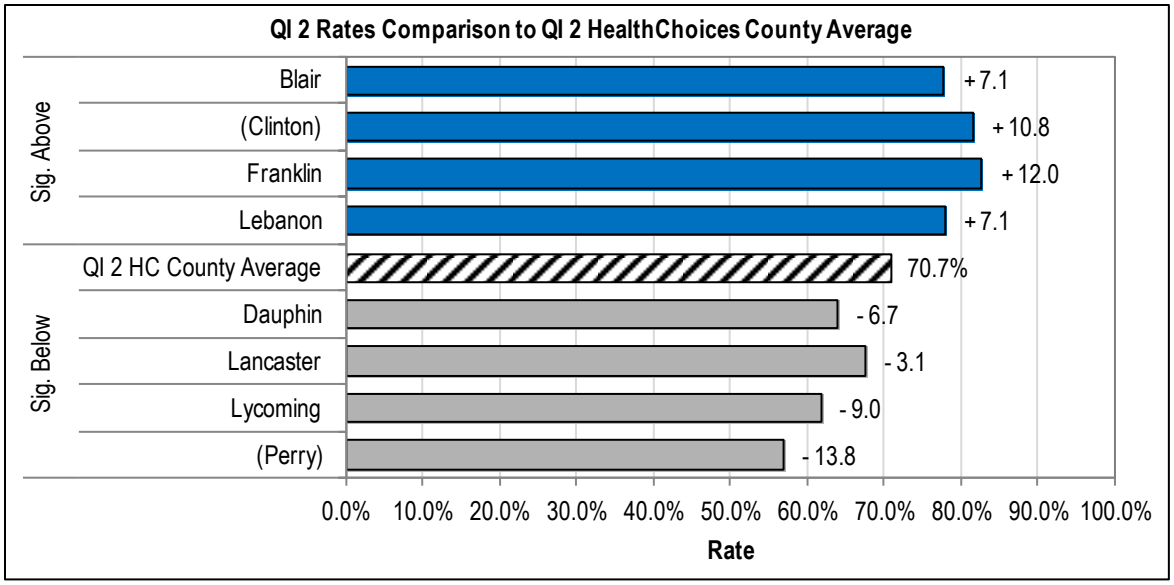
Figure 3.1 MY 2011 HEDIS Indicator Rates



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

Figure 3.2 HEDIS Rates Compared to MY 2011 HealthChoices County Average





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

In MY 2011, the QI 1 rate for Lebanon county was statistically significantly above and the rates for Dauphin, Lycoming, and Somerset Counties were statistically significantly below the MY 2011 QI 1 HealthChoices County Average of 47.3%. For QI 2, the rates for Blair, Clinton, Franklin, and Lebanon Counties were statistically significantly higher, while the rates for Dauphin, Lancaster, Lycoming, and Perry Counties were statistically significantly lower than the MY 2011 QI 2 HealthChoices County Average of 70.7%. Percentage point differences from the respective averages for QI 1 and QI 2 are noted in Figure 3.2.

Table 3.2 MY 2011 PA-Specific Indicator Rates with Year-to-Year Comparisons

	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
QI A										
HealthChoices	20,830	36,038	**57.8%**	57.3%	58.3%	57.6%	58.6%	58.1%	-0.3	NO
CBHNP	2,283	3,977	**57.4%**	55.9%	59.0%			54.2%	3.2	YES
Bedford	69	113	**61.1%**	51.6%	70.5%			55.8%	5.3	NO
Blair	320	531	**60.3%**	56.0%	64.5%			56.9%	3.3	NO
Clinton	50	81	***61.7%***	*50.5%*	*72.9%*			58.4%	3.3	NO
Cumberland	149	259	**57.5%**	51.3%	63.7%			55.4%	2.1	NO
Dauphin	473	789	**60.0%**	56.5%	63.4%			58.4%	1.5	NO
Franklin	168	260	**64.6%**	58.6%	70.6%			60.5%	4.1	NO
Fulton	13	26	***50.0%***	*28.9%*	*71.1%*			53.6%	-3.6	NO
Lancaster	524	1,006	**52.1%**	49.0%	55.2%			48.5%	3.6	NO
Lebanon	242	352	**68.8%**	63.8%	73.7%			57.8%	11.0	YES
Lycoming	159	324	**49.1%**	43.5%	54.7%			46.9%	2.2	NO
Perry	24	58	***41.4%***	*27.8%*	*54.9%*			51.4%	-10.0	NO

	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
Somerset	92	178	**51.7%**	44.1%	59.3%			54.5%	-2.9	NO
QI B										
HealthChoices	26,939	36,038	**74.8%**	74.3%	75.2%	74.7%	77.1%	74.6%	0.1	NO
CBHNP	3,050	3,977	**76.7%**	75.4%	78.0%			72.8%	3.9	YES
Bedford	97	113	**85.8%**	79.0%	92.7%			76.8%	9.0	NO
Blair	434	531	**81.7%**	78.3%	85.1%			77.8%	3.9	NO
Clinton	69	81	***85.2%***	*76.8%*	*93.5%*			78.7%	6.5	NO
Cumberland	196	259	**75.7%**	70.3%	81.1%			74.1%	1.6	NO
Dauphin	604	789	**76.6%**	73.5%	79.6%			74.3%	2.3	NO
Franklin	227	260	**87.3%**	83.1%	91.5%			83.5%	3.9	NO
Fulton	17	26	***65.4%***	*45.2%*	*85.6%*			85.7%	-20.3	NO
Lancaster	721	1,006	**71.7%**	68.8%	74.5%			64.9%	6.8	YES
Lebanon	294	352	**83.5%**	79.5%	87.5%			78.7%	4.8	NO
Lycoming	225	324	**69.4%**	64.3%	74.6%			70.0%	-0.5	NO
Perry	37	58	***63.8%***	*50.6%*	*77.0%*			70.0%	-6.2	NO
Somerset	129	178	**72.5%**	65.6%	79.3%			68.7%	3.8	NO

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

The MY 2011 HealthChoices aggregate rates were 57.8% for QI A and 74.8% for QI B. The year-to-year decrease from MY 2010 was statistically significant for QI A. CBHNP's MY 2011 QI A rate was 57.4% and QI B rate was 76.7%. The QI A rate was a 3.2 percentage point increase from the prior year and the QI B rate was a 3.9 percentage point increase from the prior year which represented statistically significant increases for both measures. These year over year increases noted for CBHNP were the largest increase noted among all MCOs.

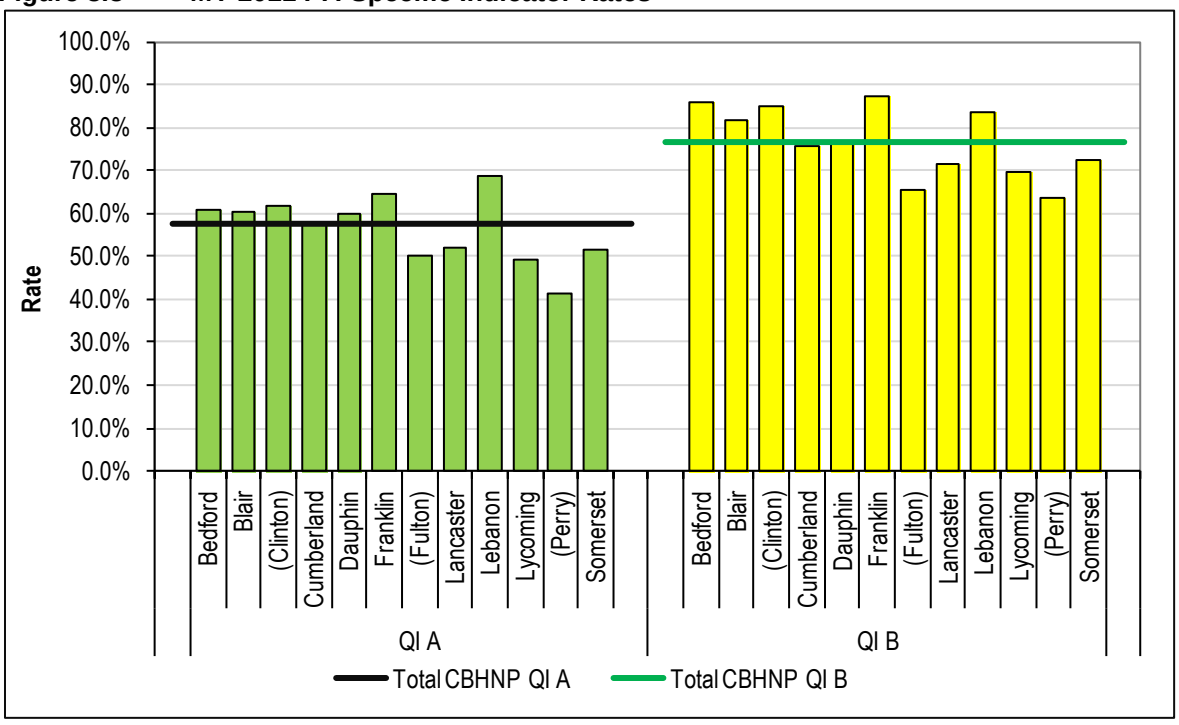
The MY 2011 HealthChoices BH MCO Averages for QI A and QI B were 57.6% and 74.7%, respectively. For MY 2011, although CBHNP's QI A rate did differ statistically significantly from the QI 1 HealthChoices BH MCO Average, CBHNP's QI B rate was statistically significantly above the QI 2 HealthChoices BH MCO Average by 2.0 percentage points.

As presented in Table 3.2, for QI A, the rate for Lebanon County was significantly higher than the prior year rate by 11.0 percentage points, while for QI B, the rate for Lancaster County was statistically significantly higher than the MY 2010 rate by 6.8 percentage points. There were no statistically significant differences for all remaining counties. Figure 3.3 displays a graphical representation of the MY 2011 PA-specific follow-up rates for CBHNP and its respective Counties. Figure 3.4 presents the individual CBHNP Counties that performed statistically significantly above or below the MY 2011 QI A and QI B HealthChoices County Averages.

The QI A rates for Franklin and Lebanon were statistically significantly higher and the rates for Lancaster, Lycoming and Perry Counties were lower than the MY 2011 QI A HealthChoices County Average of 58.6%. The QI A rates for the remaining CBHNP Counties did not differ statistically significantly from the MY 2011 QI A HealthChoices County Average.

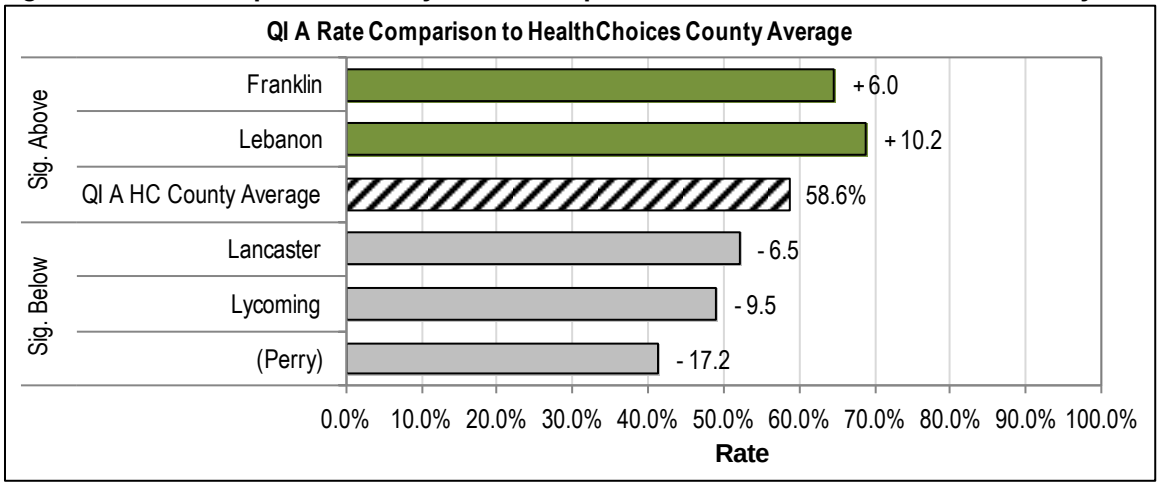
For QI B, the rates for Bedford, Blair, Franklin, and Lebanon Counties were statistically significantly higher and the rates for Lancaster, Lycoming and Perry Counties were statistically significantly lower than the MY 2011 QI B HealthChoices County Average of 77.1%. The QI B rates for the remaining CBHNP Counties did not differ statistically significantly from the MY 2011 QI B HealthChoices County Average.

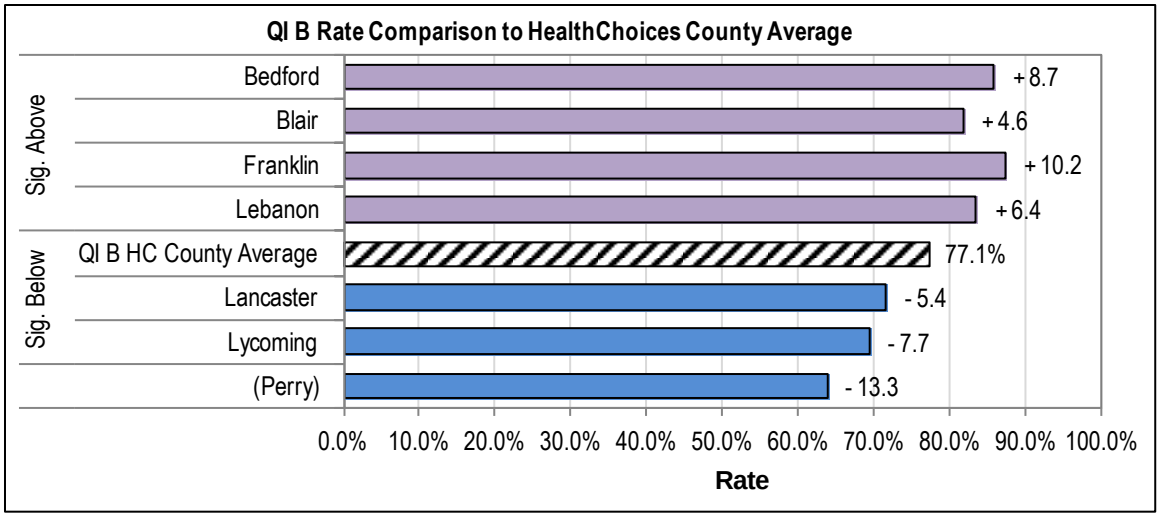
Figure 3.3 MY 2011 PA-Specific Indicator Rates



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

Figure 3.4 PA-Specific County Rates Compared to MY 2011 HealthChoices County Average





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

Comparison to HEDIS® Medicaid Benchmarks

The HealthChoices HEDIS indicator rates and BH MCO rates were compared to the *HEDIS 2012 Audit Means, Percentiles and Ratios* published by NCQA. The reference rates for national normative data contain means, 10th, 25th, 50th, 75th and 90th percentiles, and the enrollment ratios for nearly all HEDIS measures. There are tables by product lines (i.e., Commercial, Medicaid, and Medicare), so that the appropriate Medicaid benchmarks were used for comparison. NCQA's means and percentiles for each product line are generated annually using HMO, POS, and HMO/POS combined products from BH MCOs that underwent a HEDIS Compliance Audit™. Data were included from BH MCOs, regardless of whether the BH MCO did or did not report individual HEDIS rates publicly. The means and percentiles displayed in the *HEDIS 2012 Audit Means, Percentiles and Ratios* tables are based on data from the 2011 measurement year. The benchmark values for Medicaid are presented in Table 3.3.

Table 3.3 HEDIS 2012 Medicaid Benchmarks

MEDICAID	SUMMARY STATISTICS FOR RATES ACROSS MCOS					
	MEAN	10TH %ILE	25TH %ILE	MEDIAN	75TH %ILE	90TH %ILE
Follow-up After Hospitalization for Mental Illness – 7 Days	46.5	24.0	32.2	46.1	57.7	69.6
Follow-up After Hospitalization for Mental Illness – 30 Days	65.0	36.0	57.3	67.7	77.5	84.3

For MY 2011, the HealthChoices rates were 46.1% for QI 1 and 67.0% for QI 2. As compared to the HEDIS 2012 (MY 2011) Medicaid benchmarks, the QI 1 rate fell between the 50th and 75th percentiles, while the QI 2 rate fell between the 25th and 50th percentiles. In previous benchmark comparisons for MY 2010, the rates for both QI 1 and QI 2 fell between the 50th and 75th percentiles.

When comparing the MY 2011 CBHNP rates to the HEDIS 2012 benchmarks, the QI 1 rate of 45.2% fell between the 25th and 50th percentiles, and the QI 2 rate of 69.9% fell between the 50th and 75th percentiles. Similarly, in MY 2010, CBHNP's QI 1 rate of 41.7% also fell between the 25th and 50th percentiles, and the QI 2 rate of 65.5% between the 50th and 75th percentile ranges of the HEDIS 2010 benchmarks.

Conclusion and Recommendations

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.

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the 2012 (MY 2011) Follow-up After Hospitalization for Mental Illness data tables.

In response to the 2012 study, the following general recommendations are applicable to all five participating BH MCOs:

Recommendation 1: The purpose of this re-measurement study is to inform OMHSAS, the Counties and the BH MCOs of the effectiveness of the interventions implemented between MY 2010 and MY 2011 to promote continuous quality improvement with regard to follow-up care after psychiatric hospitalization. The information contained within this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. The Counties and BH MCOs participating in this study should continue to evaluate the current interventions in place with respect to their follow-up rates to assess how these interventions affected change in follow-up rates from the prior measurement years MY 2010 and MY 2009. The Counties and BH MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care, and then implement action and monitoring plans to further increase their rates.

Recommendation 2: The findings of this re-measurement indicate that disparities in rates between demographic populations continue to persist as seen in prior studies. Within each of the demographic populations examined (race, age, gender, ethnicity), results were similar to MY 2010. Statistically significantly lower rates were observed on three or four indicators for: 1) African Americans, 2) members over 21 years old, 3) males, and 4) non-Hispanic members. While OMHSAS contracted Counties and their subcontracted BH MCOs are working to improve their overall follow-up rates, it is also important for these entities to continue to target the demographic populations that do not perform as well as their counterparts. Furthermore, it is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. It is recommended that BH MCOs and Counties continue to focus interventions on populations that continue to exhibit lower follow-up rates (e.g., Black/African American population). Possible reasons for these rate disparities include access, cultural differences and financial factors, which should all be considered and evaluated to determine their potential impact on performance. Additionally, the BH MCOs should be encouraged to initiate targeted interventions to address disparate rates between study populations.

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

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

Readmission within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow up After Hospitalization for Mental Illness, OMHSAS elected to re-measure the Readmission within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Re-measurements were conducted in 2010 and 2011 on MY 2009 and MY 2010 data, respectively. The MY 2011 study conducted in 2012 was the fifth re-

measurement of this indicator, and the indicator specification had no significant changes as compared to MY 2010. This measure continued to be of interest to OMHSAS for the purposes of comparing County and BH MCO rates to the OMHSAS performance goal and to prior rates.

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

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

Eligible Population

The entire eligible population was used for all 67 Counties participating in the MY 2011 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, 2011;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim must be clearly identified as a discharge.

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

Methodology

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

Performance Goals

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

Findings

BH MCO and County Results

The results are presented at the BH MCO and then County level when multiple Counties contract with a single BH MCO. Year-to-year comparisons of MY 2011 to MY 2010 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of

the difference between two independent proportions was determined by calculating the z-ratio. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

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

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

Table 3.4 MY 2011 Readmission Rates with Year-to-Year Comparisons

	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
HealthChoices	5,798	48,312	**12.0%**	11.7%	12.3%	12.3%	9.9%	12.2%	-0.2	NO
CBHNP	829	5,593	**14.8%**	13.9%	15.8%			13.0%	1.8	NO
Bedford	12	145	**8.3%**	3.4%	13.1%			13.4%	-5.1	NO
Blair	111	756	**14.7%**	12.1%	17.3%			8.7%	6.0	NO
Clinton	12	107	**11.2%**	4.8%	17.7%			10.7%	0.5	NO
Cumberland	54	383	**14.1%**	10.5%	17.7%			12.0%	2.1	NO
Dauphin	228	1,182	**19.3%**	17.0%	21.6%			16.4%	2.9	NO
Franklin	48	363	**13.2%**	9.6%	16.8%			11.2%	2.0	NO
Fulton	4	35	***11.4%***	*0.0%*	*23.4%*			6.5%	5.0	NO
Lancaster	193	1,422	**13.6%**	11.8%	15.4%			15.5%	-1.9	NO
Lebanon	70	447	**15.7%**	12.2%	19.1%			9.6%	6.1	NO
Lycoming	55	444	**12.4%**	9.2%	15.6%			9.8%	2.6	NO
Perry	12	80	***15.0%***	*6.6%*	*23.4%*			8.0%	7.0	NO
Somerset	30	229	**13.1%**	8.5%	17.7%			13.1%	0.0	NO

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

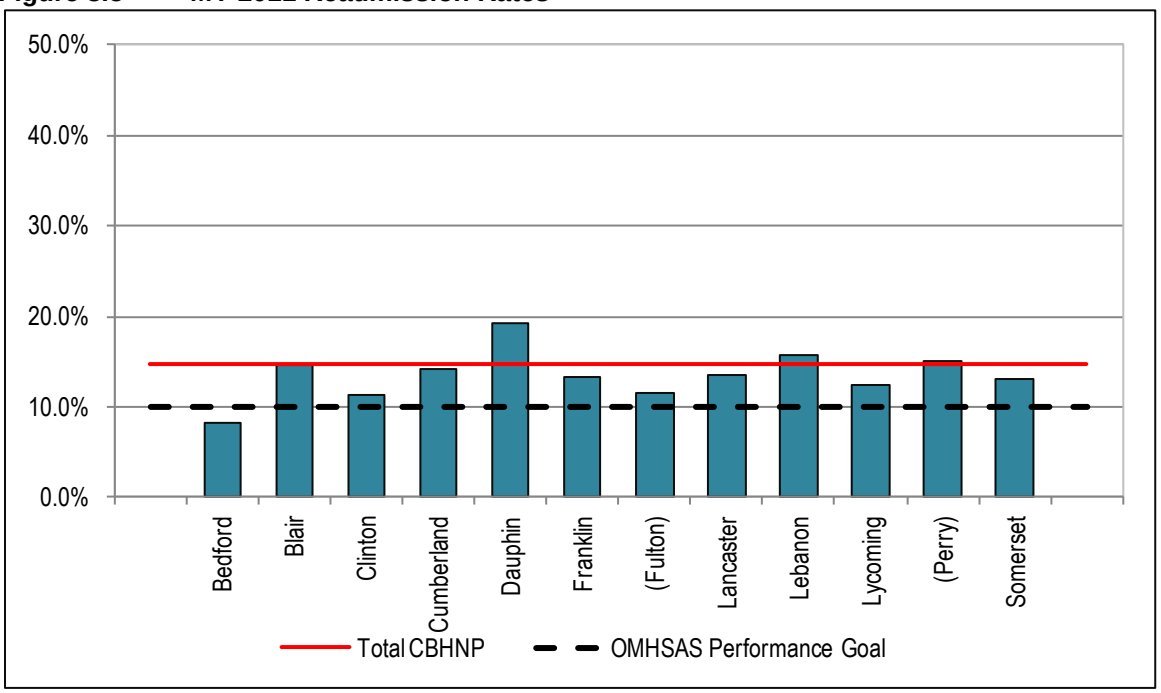
The aggregate MY 2011 HealthChoices readmission rate was 12.0%. CBHNP's readmission rate was 14.8% which was statistically significantly higher than the HealthChoices BH MCO Average of 12.3% and did not meet the designated performance goal of 10%. CBHNP's MY 2011 rate was higher than the MY 2010 rate by 1.8 percentage points which was the largest year over year increase observed among MCOs, but this difference was not statistically significant. Note that this measure is an inverted rate, in that lower rates are preferable.

As presented in Table 3.4, 12 Counties were contracted with CBHNP in MY 2011. None of the County rates changed statistically significantly from MY 2010.

Figure 3.5 displays a graphical representation of the MY 2011 readmission rates for the CBHNP Counties. For MY 2011, the rate for Bedford County met the performance goal of better than or equal to 10.0%. As compared to the MY 2011 HealthChoices County Average of 9.9%, the rate for Blair, Cumberland, Dauphin,

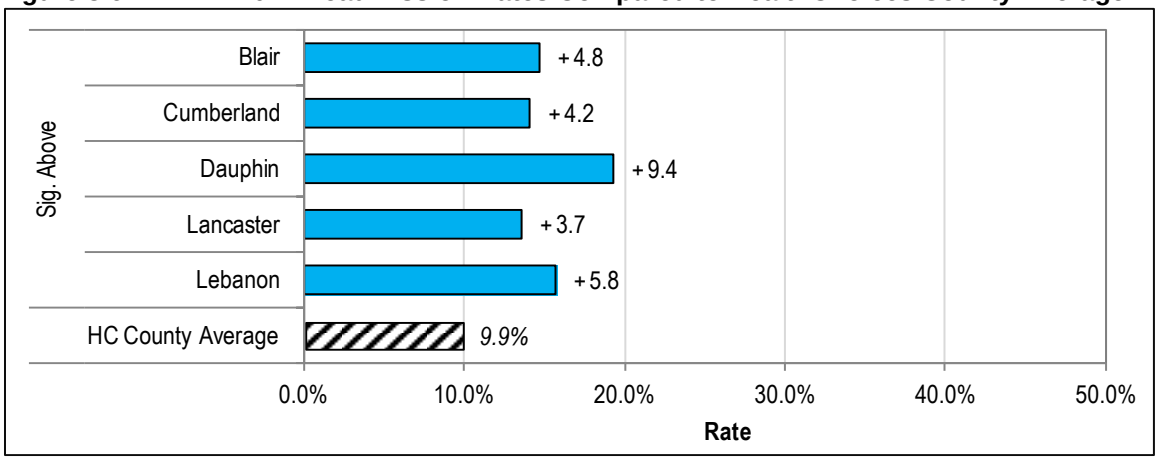
Lancaster and Lebanon Counties were statistically significantly above (poorer than) the average. Note that this measure is an inverted rate, in that lower rates are preferable. Percentage point differences compared to the HealthChoices County Average are noted in Figure 3.6.

Figure 3.5 MY 2011 Readmission Rates



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

Figure 3.6 MY 2011 Readmission Rates Compared to HealthChoices County Average



Conclusion and Recommendations

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

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the 2012 (MY 2011) Readmission within 30 Days of Inpatient Psychiatric Discharge data tables.

In response to the 2012 study, the following general recommendations are applicable to all five participating BH MCOs:

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

IV: 2011 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 2011 EQR Technical Reports, which were distributed in April 2012. The 2012 EQR Technical Report is the fifth report to include descriptions of current and proposed interventions from each BH MCO that address the 2011 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, 2012 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 2012, as well as any additional relevant documentation provided by CBHNP.

Table 4.1 Current and Proposed Interventions: Opportunities for Improvement

Reference Number	Opportunity for Improvement	MCO Response
Structure and Operations Standards		
CBHNP 1	Within Subpart C: Enrollee Rights and Protections Regulations, CBHNP was partially compliant on one out of seven categories – Enrollee Rights.	**Follow Up Actions Taken Through 09/30/12** The Complaint and Grievance Department had 4 staff and 1 supervisor. All new employees receive detailed training on the processes related to Complaints and Grievances, expectations of the processes, and in working with Members and their families. Weekly staff meetings are conducted to review pending issues and provide information and answer questions related to policy and procedures. Annual retraining of processes occurs with staff. Monthly internal auditing occurs to ensure regulatory requirements are met consistently. Ongoing updates to the C&G Department manual occurs as needed to ensure this employee resource is updated appropriately to current processes and expectations. 11/12 Annual retraining with all C&G staff on processes and expectations, with updates provided. Ongoing internal auditing to ensure Member rights are clearly explained during initial contact and documented in the Member's record.
		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 for Members. Ongoing internal auditing of documentation to identify any needed areas of improvement and to provide re-education as necessary.
CBHNP 2	CBHNP was partially compliant on four out of 10 categories within Subpart D:	**Follow Up Actions Taken Through 09/30/12** Network enhancements: 35 new practitioners; 11 Psychiatrists; 4 eligible psychiatrist; 6 Psychologist; 1 Methodone facilitiy; 1 RTF; 1 FQHC; 1 MH OP 1/12- Denial Rubric was revised to capture more accurately information in narrative as to why a service was denied to include behaviors and symptoms.

Reference Number	Opportunity for Improvement	MCO Response
	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	1-9/2012- data captured on returned Denial Rubrics to Clinical Care Manager (CCM) to determine trends. 1-9/12 New treament services offerred, varying by contract. These include Evidence Based Programs of Functional Family Therapy, The Incredible Years, and Parent-Child Interactive Therapy. Others implemented include Brief Treatment Model, Wellness Recovery Action Plans (WRAP) for kids, Crisis Bridge program, and Recovery Oriented Methadone. 3/12 - Release of FBA and BHRS Best Practice Guidelines. 4/12- Provider Relations (PR) moved to an Account Executive model to better assist providers in addressing barriers to access to care and in resolving quality issues. 6/12 - Telepsychiatry fully operational in all contracts. 7/12 - Realigned care manager assignments and roles to provide longitudinal care management. This included the addition of High Risk care managers and Field Care Managers. 8/12 - PA referral guidelines updated to improve the identification and referral of QOC concerns to Physician/Psychologist Advisors (Pas) for consultation. Reports enhanced to monitor CCM compliance. 9/12 - PR developed Community Resource Guides which are updated twice per year and includes any alternative community based options that may be available for Members. 9/ 12 - New Utilization Review (UR) template/assessment developed with addition of prompt for CCM to explore community based diversion, discussion of denial disposition and denial narrative including Appt T and PCPC/ASAM references.
		Future Actions Planned 10/12- Member Monitoring program implemented to provide more intense care management for high profile, complex members. ANSA is utilized for outcomes reporting. 11/12- Report enhancements made to provide better monitoring of access and duration of treatment. 11/12 - BHRS Redesign submitted to OMHSAS for consideration and approval. The plan focuses on approval and access to the appropriate level of treatment. 12/12- Family Based Best Practice Guidelines distributed internally for final review. Should be released in early 2013. 1/13- revise Denial Rubric to capture more detailed information and dates to decrease error in denial letters. 1/13- Explore feasibility of developing and refining system support to eliminate opportunities for human error in denial processing. 1/13- Provider Profiling reports available to identify performance and quality issues. 3/13- Physicians will be re-trained on denial documentation requirements. 3/13- Care manager supervisors will conduct regular oversight of care managers through live call monitoring. The technology for call monitoring will be available in March. 6/13 -Care Management audit tool is being revised to assess the degree of active care management, including the promotion of recovery principles, the promotion of EBP and the identification of QOC issues with appropriate referral to a PA for consultation. Ongoing internal auditing of a sampling of denial letters for accuracy. Continuing supervisory review of decision letters prior to distribution to the Member/family.
CBHNP3	CBHNP was partially compliant on eight out of	**Follow Up Actions Taken Through 09/30/12** Continuing internal auditing of a sampling of acknowledgment and decision letters to

Reference Number	Opportunity for Improvement	MCO Response
	10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions 2) General Requirements 3) Notice of Action 4) Handling of Grievances and Appeals 5) Resolution and Notification: Grievances and Appeals 6) Expedited Appeals Process 7) Continuation of Benefits 8) Effectuation of Reversed Resolutions	be sent to Members. Ongoing supervisory review of decision letters prior to being sent to the Member. Continuing supervisory use of grievance application reports to monitor timeliness of letters sent to Members. Ongoing use of grievance application that mandates use of a template for grievance letters to be sent to Members. Ongoing implementation for CBHNP process for transcribing level two grievances. Continuing use of the internal peer post grievance case reviews with feedback. Continuing use of updated acknowledgment and decision letter templates as per OMHSAS direction. Ongoing use of quality trigger process to identify areas of concern with service provision to ensure clinical involvement. Continuing process for communication with Clinical Care Managers regarding reversed grievance decisions. Ongoing implementation of improved complaint investigations and documentation. Continuing involvement and communication with County Oversights in the complaint and grievance processes. Ongoing use of the updated Expedited Appeal process and Continuation of benefits as per OMHSAS direction. Ongoing use of the developed internal process of clinical coordination when new information is presented during the grievance process that could potentially impact service provision.
		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 use of grievance application reports to monitor timeliness of letters sent to Members and families, as well as the use of the template for grievance letters. Continuing assessment of the processes implemented of post internal peer review cases. Through reviews, areas of re-education need 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, improve 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 concerns.
Performance Measures		
CBHNP4	CBHNP's rate for the MY 2009 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 1 was statistically significantly lower than the QI 1 HealthChoices BH MCO Average by two percentage points.	**Follow Up Actions Taken Through 09/30/12** Updated QI 2011 results showed improvement for Bedford, Somerset, Franklin and Clinton Counties but a decrease in Blair, Dauphin, Lancaster, Lebanon, Cumberland, Perry and Fulton Counties. 1/12- CBHNP received permission from our Privacy Officer to be able to use phone/address information obtained by the admitting Hospital which may offer more updated contact information than what Dept of Public Welfare (DPW) provides to CBHNP. 3/12- Follow Up Specialist began contacting Targeted Case Manager (TCM) by telephone to notify when a Member has not kept an aftercare appointment. 3/12- Member Services provided additional support to Follow Up Specialist activities by contacting Members outside of normal working hours as well as weekends, in an attempt to provide appointment reminders to increase the likelihood of attending outpatient services after discharge. 4/12 -The Crisis Bridge Pilot Program was implemented in Bedford and Somerset

Reference Number	Opportunity for Improvement	MCO Response
		Counties. This pilot involves Somerset Hospital and Bedford/Somerset MHMR (Cornerstone). Bedford/Somerset MHMR is now offering appointments when Members are discharged from Somerset Hospital in order to bridge the gap in service between MH IP discharge and traditional OP follow up. The program was implemented in April 2012. This intervention will impact all four follow up measures. 4/12- Provider Performance Profiles given to providers yearly 6/12 - a regional Performance-Based Contract was initiated with UCBH to improve Routine Access and access to psychiatric evaluations in the Lycoming/Clinton HealthChoices. 6/12 - Two child-adolescent board eligible/certified psychiatrists were added to the regional network in 2012. Another provider is seeking licensure as a MH OP clinic which will provide additional psychiatric coverage in the near future. Conversations with regional providers have continued regarding the feasibility of telepsychiatry as a viable option to improve psychiatric coverage to Franklin/Fulton (FF) CBHNP Members. 7/12 - began discussions with Lancaster County to explore outpatient appointments that can occur as "bridge" appointments post discharge that would enhance Member education and support compliance of meds and follow up appointments. 9/12- Three Capital Area MHOP providers agreed to assist in surveying recently discharged Members about their MH IP discharge experience. Completed surveys to be collected through 12/12. Additional hours were added to the existing services provided by Cornerstone and Nulton Diagnostics in the Bedford/Somerset contract. This also has the potential to impact all four measures. Traditional psychiatric hours were added by Cornerstone and Nulton Diagnostics in 2012. In Blair County a letter to address follow up importance for IP facilities to give Member prior to discharge was developed; Due to the modification in the Member Satisfaction survey, the results were able to improve the follow up appointments. CBHNP is also continuing on working to improve on tracking members who have third party insurance, which makes it difficult to follow up. CBHNP addressed proper discharge planning in both Account Executives (AE) meetings as well as in discussions. Those discussions centered on the Areas of focus for 2013 and this discussion took place in September 2012. In Q1 2012, PHN had continued to see members and assist on follow up with TCM if the member had it.
		Future Actions Planned 10/12 -A meeting was 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. Another meeting is planned for 1/15/13. 10/4/12 - A meeting was held with representatives of The Meadows Psychiatric Center, Lycoming-Clinton HealthChoices, and CBHNP to identify obstacles to coordination, share resources and performance data, and improve communication, discharge-planning, and aftercare coordination. Part of the focus was on improving discharge-planning, ambulatory follow-up, and reducing readmissions. 10/12 - CBHNP and Lycoming-Clinton HealthChoices will confer about the development of a mechanism to access additional assistance (such as the Lycoming-Clinton MH/ID Utilization Manager) when inpatient treatment teams are unable to develop a viable discharge plan.

Reference Number	Opportunity for Improvement	MCO Response
CBHNP5	CBHNP's rate for the MY 2010 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI B rate was a statistically significant decrease of two percentage points from MY 2009.	**Follow Up Actions Taken Through 09/30/12** 1/12 - Ongoing In F/F HealthChoices the local TCM provider is currently providing education to Members while in a local IP unit regarding TCM services. Discussion continued with another MH IP provider that is highly utilized for the region regarding the feasibility of implementing educational sessions via web-based technology or phone. TCM Provider was given contact information for MH IP facility to discuss feasibility of implementing educational sessions. 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. 1/12 –F/F Ongoing-Quarterly review of utilization of Peer Support Services (PSS) and TCM services for Members discharged from MH IP unit. 3/12- Follow Up Specialists began contacting TCM by telephone to notify when a Member has not kept an aftercare appointment. 3/12- Member Services provide additional support to Follow Up Specialist activities by contacting Members outside of normal working hours as well as weekends, in an attempt to provide appointment reminders to increase the likelihood of attending outpatient services after discharge. In Lycoming/Clinton, CBHNP met with TCM provider to improve access and utilization. Efforts are being undertaken to raise community awareness of TCM and Peer Support. 7/12 - Effective 7/1/12, the Lycoming-Clinton region increased the target for a Performance Objective linking adult high-risk Members with TCM to 68%. The target in the previous contract year of 65% was met. On 7/2/12, an email was sent to network inpatient staff with a reminder about the importance of collaborating with TCM in aftercare planning. This email was sent on 10/9/12 to additional inpatient staff who hadn't been on the initial email list.
		Future Actions Planned This goal was met for the 2011-12 Contract Year in L/C contract and the target was raised to 68% for the 2012-13 Contract Year.
CBHNP6	CBHNP's rate for the MY 2010 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 09/30/12** 7/12 – began reviewing data with CABHC in preparation to a Root Cause Analysis (RCA) for Readmission within 30 Days of Inpatient Psychiatric Discharge rates in Dauphin and Lancaster County. 6/12- An increase (of over 10% above projections) of the region's utilization of MH inpatient during the first half of 2012 resulted in the identification and analysis of possible contributing factors. 9/12 - A summary was prepared and shared with CBHNP and the Lycoming-Clinton HealthChoices program (and subsequently, OMHSAS during the Monitoring Meeting on 09/27/2012). Some of the findings were later shared with inpatient staff of Divine Providence Hospital and The Meadows Psychiatric Center with part of the focus on improving discharge-planning, ambulatory follow-up, and reducing readmissions.
		Future Actions Planned 11/12- First meeting with Dauphin County, CBHNP, CABHC and Providers to conduct RCA for Dauphin County 1-2/2013- meet with RCA group again to develop interventions for identified barriers in RCA in order to decrease the 30 day readmission to MH IP rate. Blair: Discussions about the discharge process, follow-up is occurring through Account Executives (AE) and Quality meetings will occur to determine root cause for increase in readmission rate.

Corrective Action Plan

When deficiencies were noted during the PEPS reviews, a Corrective Action Plan response was required from the BH MCO addressing those issues requiring follow-up action. CBHNP was not required to implement any corrective action plans in calendar year 2011.

Root Cause Analysis and Action Plan

The 2012 EQR is the fourth 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 2011 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 2012 EQR, CBHNP was required to prepare a Root Cause Analysis and Action Plan for the following performance measures and quality indicators:

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

CBHNP submitted a Root Cause Analysis and Action Plan in March 2012.

Table 4.2 Root Cause Analysis for CBHNP – Follow-up After Hospitalization for Mental Illness HEDIS 7-Day Quality Indicator 1

<table>
<tr><th colspan="2">Performance Measure</th></tr>
<tr><td colspan="2">Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)</td></tr>
<tr><th colspan="2">Goal Statement</th></tr>
<tr><td colspan="2">Long Term Goal: Increase Num 1 Territory (All 12 Counties combined) Rate for Follow Up after discharge to equal or exceed current interim HEDIS goal of 56.6% by the end of 2014.

Short Term Goal: Increase Num 1 Territory (All 12 Counties combined) Rate for Follow Up after discharge by 7%. The 2010 rate for the Territory was 41.7% and the rate will increase to 44.6% by the end of 2012.</td></tr>
<tr><td>Policies
(e.g., data systems, delivery systems, provider facilities)

1. 1. Provider Network
2. HIPAA
3. HealthChoices Contract Specifications
4. Data Systems</td><td>Initial Response
• Num 1 results for all Counties:

NUM 1 for all Counties
County
BD 36.8%
BL 48.1%
CT 43.8%
CU 42.1%
DA 35.1%
FR 49.6%
FU 46.4%</td></tr>
</table>

LA	40.8%
LB	48.6%
LY	38.0%
PE	51.4%
SO	38.4%
Total	41.7%
Capital	40.3%
NCCO	44.1%

- Current Network of available providers does not appear to impede follow up and are adequately staffed.
- Current practices at CBHNP including credentialing, fee scheduling, policies and procedures do not significantly impact directly on Follow up rates after MH IP discharge
- Ongoing issues with sharing of data at times can challenge providers due to current HIPAA regulations so collaboration is not always available.
- Current CBHNP policy prohibits providers from imposing financial penalties on Members who do not show for a scheduled appointment. Some providers are placing Members on restrictions but Member's tend to change providers instead of dealing with their low level of engagement in treatment. Providers lose schedule availability due to chronic no shows and last minute cancellations.
- Although reporting capabilities have improved slightly during 2011, data that would provide trends and details are limited. The manual handling of data is not feasible for some of the 12 counties due to high admission rates. Currently we are able to trend data based on age, substance abuse history, hospital correlation to follow up and high risk designation; however, we are unable to rely on formal reporting to include details on race, correlations to readmissions, TCM involvement and medication compliance. Through manual data collection we were able to make direct correlations to the follow up results in Provider Profiling which includes Average Length of Stay, Number of Complaints and Readmission rates as well as the Follow up 7 day rate. Additionally, a report that was requested in 2011 and is in development which focuses on all readmissions and medication compliance within 30 days of initial hospitalization.

Provider Profiling for 2010-11:

Hospital	Total D/C	LOS	30 Day Readmit	7-Day Follow up
Chambersburg	196	3.99	12.76%	41.87%
Lancaster General	237	7.94	10.13%	32.00%
Philhaven	714	12.04	12.18%	63.73%
PPI	821	8.62	14.86%	42.14%
ARHS	549	6.06	14.75%	44.67%
Somerset	247	5.56	12.15%	34.07%
Network	5743	10.85	14.09%	40.81%

Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system.

Follow-up Status Response

Procedures (e.g., payment/reimbursement, credentialing/collaboration) 1. QI Auditing Process 2. Transportation of	***Initial Response*** • The MH Inpatient Discharge audit completed by the QI department in 2010 was repeated in 2011 on 18 MH IP Units in the Network. The findings were less than positive despite education; however slight progress was noted in certain areas the second year. Additionally, Recovery practices are slowly being incorporated into most hospitals but are still not meeting the expectations of good practice. Below are the results showing the comparison between the 2010 and 2011.

Members

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

*this indicator was added in 2011 as an action step from the previous RCA.

Clearly, there is a slight increase in collaboration with family and friends with an improvement of 67% to 74%, however this remains below Best Practice standards. Additionally community supports identified at time of discharge doubled from16 to 32%. However this remains well below expectations. Although IP units are addressing barriers to treatment (an increase from 43% to 70%), ironically the follow up rate within 7 days decreased from 77% to 73%. On a positive note the IP Units are reporting that Members were present and in agreement with their aftercare appointments 90% of the time in 2011 which is an increase from 38% in 2010. Last, TCM involvement improved from 61% to 88%. Furthermore, Recovery Practices are more utilized on the MH IP units in 2011. The group schedules reflected at least 3 Recovery Practices or Principles 94% of the time in comparison to 56% seen last year.

- In June 2011 CSS in Capital region initiated a Consumer Survey and completed in February 2012. This survey focused on Members who were Discharged and readmitted. Unfortunately, the number of contacts (15 out of 120) yielded limit results nonetheless, some Members reported they did not have a choice in providers or appointment time and some reported no permanent residence. This seems to correlate with CBHNPs Barrier Survey which was developed in the end of 2011 and will be placed in production this spring.
- Although Franklin and Fulton Counties rates remain below the HEDIS NUM 1 goal of 56.6%, their rates are higher than most other counties in the CBHNP Contract. The QI/Clinical Manager for Franklin/Fulton Counties reports that the success of the follow up rates may be in part due to a positive working relationship with Chambersburg Hospital. Many Members in these two Counties are treated at Chambersburg Hospital and Brooklane Hospitals. Chambersburg hospitals report they have a good working relationship with the local TCM unit. And furthermore a proactive Consumer Support Program through the local Mental Health Association provides a bag with resources and literature on Recovery Principles to all discharges.
- Similar to Franklin and Fulton Counties, Blair and Lebanon Counties also have slightly higher rates than the other counties. Per the QI/Clinical Manager for Blair 75% of the Members are seen at Altoona Regional Health System which partners with Home Nursing Agency (HNA). HNA provides an umbrella of care which makes accessibility easier. Primary Health Network also partners with ARHS offers an appointment within 7 days routinely. These are two positive examples of good collaboration and communication. Lebanon County rates may be influenced by the continuity of care through Philhaven.
- Members continue to report issues with transportation such as too long of a bus ride, vans too early or too late for appointments and sometimes need to cancel their appointment at the last minutes and rural

areas are limited in transportation and have to rely on the family/friends availability.

Root Cause: Best Practice Discharge Processes and Procedures are not completely being followed by many MH IP providers which compounds Member's lack of engagement in aftercare. A clear lack of family involvement, collaboration with other MH OP providers and barriers were not always being addressed prior to discharge which may have led to no shows and cancellations.

Follow-up Status Response

People
(e.g., personnel, provider network, patients)

1. Clinical Case Manager
2. Follow Up Specialist
3. Member
4. QI Clinical/Manager
5. Providers- MH IP, MH OP, TCM

Initial Response

- Clinical Care Managers (CCM) report a steady increase of Members who are new to the system and not necessarily engaged in treatment, homeless or have no phone. Additionally, addresses frequently change and current information may be outdated and outreach becomes difficult. Until recent policy change, CCM were not allowed to use any address or phone number except for the State provided information which limited outreach. Below is a Barriers Report based on what the Member told the CCM when outreach was completed. This report was developed in 2011 and will be in production in spring of 2012. CCM are required to outreach to any Member who was either a no show or cancellation. But unfortunately the response rate to the outreach is poor approximately a 33% response rate; however the data indicates that some Members reported transportation issues, some were readmitted and a fair percentage decided to not continue or begin treatment or did not want to go to the Provider who they had an appointment with. See Table below:

Barriers Identified	# of Mbrs	% of Mbrs
Angry with provider	1	0.12%
Could not/had difficulty utilizing public transportation	2	0.23%
Decided not to continue in/begin treatment	45	5.28%
Decided to follow-up w/ PCP/clergy/other non-MH provider	4	0.47%
Decided to see another MH Provider	40	4.69%
Did not have personal transportation	16	1.88%
Disagreed with referral	4	0.47%
Forgot Appointment	17	1.99%
In Jail	15	1.76%
Insurance Termed	17	1.99%
Moved	14	1.64%
No response to outreach attempts	289	33.88%
Other	279	32.71%
Other party interference	2	0.23%
Problem with scheduled provider	4	0.47%
Provider's hours were not convenient	2	0.23%
Readmission	81	9.50%
Unable to attend due to childcare issues	2	0.23%
Unable to attend due to family reasons	6	0.70%
Unable to attend due to illness	7	0.82%
Unable to attend due to MH Symptoms/issues	3	0.35%
Unable to miss work	3	0.35%
Totals	853	100.00%

*Other usually indicated inability reach Member due to contact or phone issues

- CCM also noted an increase in use of PCP for follow up which is not a covered level of care by BH MCO or blatant refusal for follow up by Member, primarily adults.
- MH IP facilities report difficulty with obtaining accurate contact information to provide BH-MCOs and MH OP providers.
- Follow Up Specialist also noted that MH OP providers often have a different date and or time than what MH IP Unit provided as follow up appointments to the CCM at time of discharge. If documentation of appointment is inconsistent between IP and OP providers, it is most likely inconsistent in the information provided to the Member as well.

	• CBHNP also has available a large sample of Members who were admitted and discharged and if they kept the appointment within 7 days or 30 days or no showed or cancelled. The data provided for 2012 indicated that approximately 2.4% of the Members sought their PCP for follow up, MH OP Providers reported no record of an appointment 2.2% of the time, 9.6% of the Members were "no-shows", 2% had no aftercare scheduled at time of discharge, 2% of the Members declined treatment, 3.6% were readmitted and another 6.6% attended an appointment but was beyond 7 days. Although these rates may seem low individually, the accumulative effect of these categories and others can impact the HEDIS 1 rates. Other contributing factors, albeit low, also affect the overall compliance number such as moved out of the area, jail, SA treatment, and level to level transfers. • A Member(s) reported that they feel the discharge instructions are too confusing, they are not always included in the planning process with no input into times and dates, provider choice of the follow up appointment and day of discharge planning appears rushed. Lastly, some Member's felt the Discharge Planner was "too busy" to talk to them about details or that they needed a family member or natural support person to be present with them when discharge information was reviewed. • QI Clinical/Manager reports the results of the discharge planning audit reveal that family and friends are not documented to be included in the discharge process which can complicate follow up. *Root Cause: Member outreach is complicated by inaccurate Member information making case management and follow up outreach difficult for BH-MCOs and Providers.*
	Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) 1. Provider Education 2. Enrollee Education 3. Provider Profiling	***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 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	***Initial Response***
	None
	Follow-up Status Response
	None

Action and Monitoring Plan		
Action Plan	**Implementation Date**	**Monitoring Plan**
Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system. *Action:* Modifications to current reporting have been requested through IT. Currently, IT is not able to complete the requests for larger reports so the new approach will to break down to smaller reports and request needed information. In 2012. Some data should become available for trending. 1. Quality Improvement QI/Clinical Manager (QCMs) attends scheduled monthly		***Initial Response*** • QCMs will advocate for prioritizing data requests. • QCMS will report quarterly new trends based on new reports/data • QI Project Manager will complete and distribute Provider Profiling and QCM will correlate hospital HEDIS 1 rates to current data of hospitals in their area • QCMS will report follow up results for NUM 1 quarterly and analyze correlations and initiate new action steps in response to the data results. ***Follow-up Status Response***

meetings and will collectively request additional reports from IT that will expand on missing data. 2. QCMs will meet with IT Business Analysis to review reporting changes and requests. 3. QCMs will vet changes and validate reports. 4. QCMs will monitor new reports quarterly and observe for specific trends that may impact follow up. 5. QCMs will review finding in quarterly Performance Improvement Project (PIP).		
Root Cause: Best Practice Discharge Processes and Procedures are not completely being followed by many MH IP providers which compounds Member's lack of engagement in aftercare. A clear lack of family involvement, collaboration with other MH OP providers and barriers were not always being addressed prior to discharge which may have led to no shows and cancellations. *Action:* The QI Department will continue to educate and monitor MH IP units on Best Practice discharge guidelines with a focus specifically on collaboration with family and friends, collaboration with other MH OP providers and the need to address barriers prior to discharge. . 1. Quality Improvement Specialist (QIS) will complete an annual MH IP treatment record review which will include indicators for the discharge processes. 2. CBHNP will create a Barriers Checklist that MH IP providers may incorporate into their processes and provide the results of the Barriers Survey reported by Members. 3. CBHNP will provide information to MH IP providers on Recovery Principles through a specific MH IP Provider Toolkit communications. 4. CBHNP will educate MH IP providers on the significant on		***Initial Response*** • QISs will monitor MH IP treatment record reviews results annually and compare results to previous years • QCMs will measure HEDIS rates NUM 1 quarterly and correlate to each specific hospital • QCMs Repeat Barriers to Treatment Member survey every 6 months. ***Follow-up Status Response***

identifying community and natural supports in aftercare plans through a specific MH IP Toolkit communication. 5. CBHNP Account Executives will be given this clinical information to remind providers during their respective on site visits. 6. Discuss options of collaborations between specific MH IP providers and MH OP providers without impeding on Member Choice where continuity of care is not offered.		
Root Cause: Member outreach is complicated by inaccurate Member information making care management and follow up outreach difficult for BH-MCOs and Providers. Action: Initiate modification of current practices in utilization review care management and encourage MH IP and OP providers to address inaccurate information of Members routinely thus improving the ability to communicate with Members. 1. Alter 2012 practice of URR CCM to include documenting Members most current address and phone number in CBHNP system which is obtained from MH IP Provider. (Previous process did not allow for utilization of any address or phone number not in the State system.) 2. Educate MH IP and MH OP providers to encourage Members to update their current address and contact information at their local County Assistance Office (DPW). Change Follow Up Specialist responsibility to include notifying by telephone the TCM when Member is discharged from MH IP unit and advising the TCM of the aftercare appointments.		***Initial Response*** • QI PM will monitor MH IP audit results based on the same 10 indicators from the record review in 2010. Outcomes will be measured for differences from previous year per provider and for the network system. • QI PM will monitor the Member Survey results on the same 5 indicators from the 2/11 survey and compare and report results and note changes in the data. • QI PM will measure outcomes of success from the pilot based on total number of discharge instruction sheet faxed to CBHNP, to MH OP providers and the accuracy of the information between the fax and verbal discharge information. If successful, the requirement for faxing d/c summaries to all entities will be required. Additional outcomes will be based on the hospital correlation/follow up rate and the Num results by county who are involved which are done quarterly by the Clinical Care Managers. ***Follow-up Status Response***
Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member		***Initial Response*** • QCM will monitor No Shows and Cancellations for trends through Follow Up Report

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. *Action:* Improve MH IP staff understanding of how to engage a Member and motivate a Member to follow through with aftercare. 1. CBHNP will offer a training on motivational interviewing techniques and provide to all MH IP and OP Providers 2. CBHNP will continue to monitor if Members are introduced to Recovery principles through treatment record reviews. 3. CBHNP will continue to offer reimbursement for Recovery Trainings for all providers.		• QCM will measure HEDIS rates NUM 1 quarterly ***Follow-up Status Response***

Table 4.3 Root Cause Analysis for CBHNP – Follow-up After Hospitalization for Mental Illness PA-specific 7-Day Quality Indicator A

Performance Measure	
Follow-up After Hospitalization for Mental Illness QI A (PA-specific 7 Day)	
Goal Statement	
Long Term Goal: Increase Num A Territory (All 12 Counties combined) Rate for Follow Up after discharge to equal or exceed current interim HEDIS goal of 64.2% by the end of 2014. Short Term Goal: Increase Num A Territory (All 12 Counties combined) Rate for Follow Up after discharge by 6%. The 2010 rate for the Territory was 54.2% and the rate will increase to 57.5% by the end of 2012.	
Policies (e.g., data systems, delivery systems, provider facilities) 1. 1. Provider Network 2. HIPAA 3. HealthChoices Contract Specifications 4. Data Systems	***Initial Response*** NUM A for all Counties County / NUM A for all Counties BD 55.8% BL 56.9% CT 58.4% CU 55.4% DA 58.4% FR 60.5% FU 53.6% LA 48.5% LB 57.8% LY 46.9% PE 51.4% SO 54.5% **Total** 54.2% **Capital** 53.7% **NCCO** 55.2% • Current Network of available providers does not appear to impede follow up and are adequately staffed. However, there is limited Peer Support available across the Network. Additionally,

Mobile Psychiatric Nursing is available in the CABHC contract, but limited in Cumberland, Perry and Dauphin Counties which is currently being addressed by CABHC. Currently there is no Mobile Psychiatric Nursing available in the other CBHNP contracts.

- Franklin/Fulton Counties plan to expand services to include Psychiatric Rehab in 2012 and will be added an additional provider for Telepsychiatry.
- Currently Dauphin and Cumberland Counties utilizes a Bridge Appointment and Bedford Somerset Counties began to utilize the Bridge Appointment in January 2012 which may influence NUM A results in the future.
- Current practices at CBHNP including credentialing, fee scheduling, policies and procedures do not significantly impact directly on Follow up rates after MH IP discharge
- Ongoing issues with sharing of data at times can challenge providers due to current HIPAA regulations so collaboration is not always available.
- Current CBHNP policy prohibits providers from imposing financial penalties on Members who do not show for scheduled appointments. Some providers are placing Members on restrictions but Member's tend to change providers instead of dealing with their low level of engagement in treatment. Providers lose schedule availability due to chronic no shows and last minute cancellations.
- Although reporting capabilities have improved slightly during 2011, data that would provide trends and details are limited. The manual handling of data is not feasible for some of the 12 counties due to high admission rates. Currently we are able to trend data based on age, substance abuse history, hospital correlation to follow up and high risk designation; however, we are unable to rely on formal reporting to include details on race, correlations to readmissions, TCM involvement and medication compliance. Through manual data collection we were able to make direct correlations to the follow up results is Provider Profiling which includes Average Length of Stay, Number of Complaints and Readmission rates as well as the Follow up 7 day rate. Additionally, a report that was requested in 2011 and is in development which focuses on all readmissions and medication compliance within 30 days of initial hospitalization.

Provider Profiling for 2010-11:

Hospital	Total D/C	LOS	30 Day Readmit	7-Day Follow up
Chambersburg	196	3.99	12.76%	41.87%
Lancaster General	237	7.94	10.13%	32.00%
Philhaven	714	12.04	12.18%	63.73%
PPI	821	8.62	14.86%	42.14%
ARHS	549	6.06	14.75%	44.67%
Somerset	247	5.56	12.15%	34.07%
Network	5743	10.85	14.09%	40.81%

Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system.

Follow-up Status Response

Procedures (e.g., payment/reimbursement, credentialing/collaboration)

1 QI Auditing Process
2 Transportation of

Initial Response

- The MH Inpatient Discharge audit completed by the QI department in 2010 was repeated in 2011 on 18 MH IP Units in the Network. The findings were less than positive despite education; however slight progress was noted in certain areas the second year. Additionally, Recovery practices are slowly being incorporated into most hospitals but are still not meeting the expectations of good practice. Below are the results showing the comparison between the 2010 and 2011.

	AREAS OF REVIEW	2010 Overall Avg	2011 Overall Avg
1	Was discharge planning initiated within 24 hours of admission?	88%	88%

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

Clearly, there is a slight increase in collaboration with family and friends with an improvement of 67% to 74%, however this remains below Best Practice standards. Additionally community supports identified at time of discharge doubled from16 to 32%.

However this remains well below expectations. Although IP units are addressing barriers to treatment (an increase from 43% to

70%), ironically the follow up rate within 7 days decreased from 77% to 73%. On a positive note the IP Units are reporting that Members were present and in agreement with their aftercare appointments 90% of the time in 2011 which is an increase from 38% in 2010. Last, TCM involvement improved from 61% to 88%. Furthermore, Recovery Practices are more utilized on the MH IP units in 2011. The group schedules reflected at least 3 Recovery Practices or Principles 94% of the time in comparison to 56% seen last year.

- In June 2011 CSS in Capital region initiated a Consumer Survey and completed in February 2012. This survey focused on Members who were Discharged and readmitted. Unfortunately, the number of contacts (15 out of 120) yielded limit results nonetheless, some Members reported they did not have a choice in providers or appointment time and some reported no permanent residence. This seems to correlate with CBHNPs Barrier Survey which was developed in the end of 2011 and will be placed in production this spring.
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- Members continue to report issues with transportation such as too long of a bus ride, vans too early or too late for appointments and sometimes need to cancel their appointment at the last minutes and rural areas are limited in transportation and have to rely on the family/friends availability.

Root Cause: Best Practice Discharge Processes and Procedures are not completely being followed by

	many MH IP providers which compounds Member's lack of engagement in aftercare. A clear lack of family involvement, collaboration with other MH OP providers and barriers were not always being addressed prior to discharge which may have led to no shows and cancellations.
	Follow-up Status Response
People (e.g., personnel, provider network, patients) 1 Clinical Case Manager 2 Follow Up Specialist 3 Member 4 QI Clinical/Manager 5 Providers- MH IP, MH OP, TCM	***Initial Response***

- Clinical Care Managers (CCM) report a steady increase of Members who are new to the system and not necessarily engaged in treatment, homeless or have no phone. Additionally, addresses frequently change and current information may be outdated and outreach becomes difficult. Until recent policy change, CCM were not allowed to use any address or phone number except for the State provided information which limited outreach. Below is a Barriers Report based on what the Member told the CCM when outreach was completed. This report was developed in 2011 and will be in production in spring of 2012. CCM are required to outreach to any Member who was either a no show or cancellation. But unfortunately the response rate to the outreach is poor approximately a 33% response rate; however the data indicates that some Members reported transportation issues, some were readmitted and a fair percentage decided to not continue or begin treatment or did not want to go to the Provider who they had an appointment with. See Table below:

Barriers Identified	# of Mbrs	% of Mbrs
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Could not/had difficulty utilizing public transportation	2	0.23%
Decided not to continue in/begin treatment	45	5.28%
Decided to follow-up w/ PCP/clergy/other non-MH provider	4	0.47%
Decided to see another MH Provider	40	4.69%
Did not have personal transportation	16	1.88%
Disagreed with referral	4	0.47%
Forgot Appointment	17	1.99%
In Jail	15	1.76%
Insurance Termed	17	1.99%
Moved	14	1.64%
No response to outreach attempts	289	33.88%
Other	279	32.71%
Other party interference	2	0.23%
Problem with scheduled provider	4	0.47%
Provider's hours were not convenient	2	0.23%
Readmission	81	9.50%
Unable to attend due to childcare issues	2	0.23%
Unable to attend due to family reasons	6	0.70%
Unable to attend due to illness	7	0.82%
Unable to attend due to MH Symptoms/issues	3	0.35%
Unable to miss work	3	0.35%
Totals	853	100.00%

- CCM also noted an increase in use of PCP for follow up which is not a covered level of care by BH MCO or blatant refusal for follow up by Member, primarily adults.
- MH IP facilities report difficulty with obtaining accurate contact information to provide BH-MCOs and MH OP providers.
- Follow Up Specialist also noted that MH OP providers often have a different date and or time than what MH IP Unit provided as follow up appointments to the CCM at time of discharge. If documentation of appointment is inconsistent between IP and OP providers, it is most likely inconsistent in the information provided to the Member as well.
- CBHNP also has available a large sample of Members who were admitted and discharged and if

	they kept the appointment within 7 days or 30 days or no showed or cancelled. The data provided for 2012 indicated that approximately 2.4% of the Members sought their PCP for follow up, MH OP Providers reported no record of an appointment 2.2% of the time, 9.6% of the Members were "no-shows", 2% had no aftercare scheduled at time of discharge, 2% of the Members declined treatment, 3.6% were readmitted and another 6.6% attended an appointment but was beyond 7 days. Although these rates may seem low individually, the accumulative effect of these categories and others can impact the HEDIS 1 rates. Other contributing factors, albeit low, also affect the overall compliance number such as moved out of the area, jail, SA treatment, and level to level transfers. • A Member(s) reported that they feel the discharge instructions are too confusing, they are not always included in the planning process with no input into times and dates, provider choice of the follow up appointment and day of discharge planning appears rushed. Lastly, some Member's felt the Discharge Planner was "too busy" to talk to them about details or that they needed a family member or natural support person to be present with them when discharge information was reviewed. • QI Clinical/Manager reports the results of the discharge planning audit reveal that family and friends are not documented to be included in the discharge process which can complicate follow up. *Root Cause: Member outreach is complicated by inaccurate Member information making case management and follow up outreach difficult for BH-MCOs and Providers.*
	Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) 1 Provider Education 2 Enrollee Education 3 Provider Profiling	***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 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
	No follow up needed at this time.
Other	***Initial Response***
	None
	Follow-up Status Response
	None

Action and Monitoring Plan

Action Plan	Implementation Date	Monitoring Plan
Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system. Action*:* Modifications to current reporting have been requested through IT. Currently, IT is not able to complete the requests for larger reports so the new approach will to break down to smaller reports and request needed information. In 2012. Some data should become available for trending. 1. Quality Improvement QI/Clinical Manager (QCMs) attends scheduled monthly meetings and will collectively request		***Initial Response*** • QCMs will advocate for prioritizing data requests. • QCMS will report quarterly new trends based on new reports/data • QI Project Manager will complete and distribute Provider Profiling and QCM will correlate hospital HEDIS NUM A rates to current data of hospitals in their area • QCMS will report follow up results for NUM A quarterly and analyze correlations and initiate new action steps in response to the data results. • Continue to monitor utilization of Mobile Psychiatric Nursing, Psychiatric Rehabilitation, Peer Support and Telepsychiatry.

additional reports from IT that will expand on missing data. 2. QCMs will meet with IT Business Analysis to review reporting changes and requests. 3. QCMs will vet changes and validate reports. 4. QCMs will monitor new reports quarterly and observe for specific trends that may impact follow up. 5. QCMs will review finding in quarterly Performance Improvement Project (PIP).		***Follow-up Status Response***
Root Cause: Best Practice Discharge Processes and Procedures are not completely being followed by many MH IP providers which compounds Member's lack of engagement in aftercare. A clear lack of family involvement, collaboration with other MH OP providers and barriers were not always being addressed prior to discharge which may have led to no shows and cancellations. Action: The QI Department will continue to educate and monitor MH IP units on Best Practice discharge guidelines with a focus specifically on collaboration with family and friends, collaboration with other MH OP providers and the need to address barriers prior to discharge. . 1 Quality Improvement Specialist (QIS) will complete an annual MH IP treatment record review which will include indicators for the discharge processes. 2 CBHNP will create a Barriers Checklist that MH IP providers may incorporate into their processes and provide the results of the Barriers Survey reported by Members. 3 CBHNP will provide information to MH IP providers on Recovery Principles through a specific MH IP Provider Toolkit communications. 4 CBHNP will educate MH IP providers on the significant on identifying community and natural supports in aftercare plans through a specific MH IP Toolkit communication. 5 CBHNP Account Executives will be given this clinical information to remind providers during their respective on site visits. 6 Discuss options of collaborations between specific MH IP providers and MH OP providers without impeding on Member Choice where continuity of care is not offered.		***Initial Response*** • QISs will monitor MH IP treatment record reviews results annually and compare results to previous years • QCMs will measure HEDIS rates NUM 1 quarterly and correlate to each specific hospital • QCMs Repeat Barriers to Treatment Member survey every 6 months. ***Follow-up Status Response***
Root Cause: Member outreach is complicated by inaccurate Member information making care management and follow up outreach difficult for BH-MCOs and Providers.		***Initial Response*** • QCMs Repeat Barriers to Treatment Member survey every 6 months • QCM will measure HEDIS rates for NUM 1 Quarterly

Action**:** Initiate modification of current practices in utilization review care management and encourage MH IP and OP providers to address inaccurate information of Members routinely thus improving the ability to communicate with Members. 1 Alter 2012 practice of URR CCM to include documenting Members most current address and phone number in CBHNP system which is obtained from MH IP Provider. (Previous process did not allow for utilization of any address or phone number not in the State system.) 2 Educate MH IP and MH OP providers to encourage Members to update their current address and contact information at their local County Assistance Office (DPW). 3 Change Follow Up Specialist responsibility to include notifying by telephone the TCM when Member is discharged from MH IP unit and advising the TCM of the aftercare appointments. *Root Cause: Limited Peer Support referrals and use of Peer Support Specialist on the MH Inpatient facilities.* Action: Improve MH IP understanding of what a Certified Peer Support Specialist is an advocate for more Peer Support involvement on the MH IP units. 1. CBHNP will provide information to the MH IP Providers on the role of a Certified Peer Support Specialist and the advantages of hiring a Peer Specialist to work on the unit. 2. CBHN P will provide information to the MH OP Providers on the role of a Certified Peer Specialist. 3. CBHNP will provide information to the MH IP and MH OP Providers on the benefits of including a Peer Support Specialist in a Members Treatment Team and how to present this information in an engaging way.		• QCM will measure HEDIS rates for NUM A Quarterly QCM will monitor claims history for number of Peer Support utilized per county. ***Follow-up Status Response***
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. Action*:* Improve MH IP staff understanding of how to engage a Member and motivate a Member to follow through with aftercare. 1. CBHNP will offer a training on motivational interviewing techniques and provide to all		***Initial Response*** • *QCM will monitor No Shows and Cancellations for trends through Follow Up Report* • *QCM will measure HEDIS rates NUM 1 quarterly* ***Follow-up Status Response***

MH IP and OP Providers 2. CBHNP will continue to monitor if Members are introduced to Recovery principles through treatment record reviews. CBHNP will continue to offer reimbursement for Recovery Trainings for all providers.		

Table 4.4 Root Cause Analysis for CBHNP – Follow-up After Hospitalization for Mental Illness HEDIS 30-Day Quality Indicator B

Performance Measure	
Follow-up After Hospitalization for Mental Illness QI B (PA-specific 30 Day)	
Goal Statement	
Long Term Goal: Increase Num B Territory (All 12 Counties combined) Rate for Follow Up after discharge to equal or exceed current interim HEDIS goal of 81.2% by the end of 2014. Short Term Goal: Increase Num B Territory (All 12 Counties combined) Rate for Follow Up after discharge by 6%. The 2010 rate for the Territory was 72.8% and the rate will increase to 76.2% by the end of 2012.	
Policies (e.g., data systems, delivery systems, provider facilities) 1. Provider Network 2. HIPAA 3. HealthChoices Contract Specifications 4. Data Systems	***Initial Response*** NUM B for all Counties County / NUM B for all Counties BD 76.8% BL 77.8% CT 78.7% CU 74.1% DA 74.3% FR 83.5% FU 85.7% LA 64.9% LB 78.7% LY 70.0% PE 70.0% SO 68.7% **Total** 72.8% **Capital** 70.7% **NCCO** 76.2% • Current Network of available providers does not appear to impede follow up and are adequately staffed. However, there is limited Peer Support available across the Network. Additionally, Mobile Psychiatric Nursing is available in the CABHC contract, but limited in Cumberland, Perry and Dauphin Counties which is currently being addressed by CABHC. Currently there is no Mobile Psychiatric Nursing available in the other CBHNP contracts. • Franklin/Fulton Counties plan to expand services to include Psychiatric Rehab in 2012 and will be added an additional provider for Telepsychiatry. • Despite the high rates indicated above, rates fluctuate drastically for Fulton, Perry and Clinton Counties due to the low number of MH IP admissions. • Currently Dauphin and Cumberland Counties utilizes a Bridge Appointment and Bedford Somerset Counties began to utilize the Bridge Appointment in January 2012 which may influence NUM B results in the future. • Current practices at CBHNP including credentialing, fee scheduling, policies and procedures do not significantly impact directly on Follow up rates after MH IP discharge

- Ongoing issues with sharing of data at times can challenge providers due to current HIPAA regulations so collaboration is not always available.
- Current CBHNP policy prohibits providers from imposing financial penalties on Members who do not show for scheduled appointments. Some providers are placing Members on restrictions but Member's tend to change providers instead of dealing with their low level of engagement in treatment. Providers lose schedule availability due to chronic no shows and last minute cancellations.
- Although reporting capabilities have improved slightly during 2011, data that would provide trends and details are limited. The manual handling of data is not feasible for some of the 12 counties due to high admission rates. Currently we are able to trend data based on age, substance abuse history, hospital correlation to follow up and high risk designation; however, we are unable to rely on formal reporting to include details on race, correlations to readmissions, TCM involvement and medication compliance. Through manual data collection we were able to make direct correlations to the follow up results is Provider Profiling which includes Average Length of Stay, Number of Complaints and Readmission rates as well as the Follow up 7 day rate. Additionally, a report that was requested in 2011 and is in development which focuses on all readmissions and medication compliance within 30 days of initial hospitalization.

Provider Profiling for 2010-11:

Hospital	Total D/C	LOS	30 Day Readmit	7-Day Follow up
Chambersburg	196	3.99	12.76%	41.87%
Lancaster General	237	7.94	10.13%	32.00%
Philhaven	714	12.04	12.18%	63.73%
PPI	821	8.62	14.86%	42.14%
ARHS	549	6.06	14.75%	44.67%
Somerset	247	5.56	12.15%	34.07%
Network	5743	10.85	14.09%	40.81%

Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system.

Follow-up Status Response

Procedures
(e.g., payment/reimbursement, credentialing/collaboration)

1. QI Auditing Process
2. Transportation of Members

Initial Response

- The MH Inpatient Discharge audit completed by the QI department in 2010 was repeated in 2011 on 18 MH IP Units in the Network. The findings were less than positive despite education; however slight progress was noted in certain areas the second year. Additionally, Recovery practices are slowly being incorporated into most hospitals but are still not meeting the expectations of good practice. Below are the results showing the comparison between the 2010 and 2011.

	AREAS OF REVIEW	2010 Overall Avg	2011 Overall Avg
1	Was discharge planning initiated within 24 hours of admission?	88%	88%
2	Does the record reflect collaboration with other MH providers at admission?	70%	68%
3	Does the record reflect collaboration with family concerning follow up care?	67%	74%
4	Did follow-up plans identify Natural or Community Supports?	16%	32%
5	Is there documentation in the record that barriers to follow up treatment was discussed with the Member and addressed?	43%	70%
6	Is there documentation that Member was present or in agreement with appointments that were made for follow up?	38%	90%
7	Was the TCM included in the discharge planning process (if applicable)	61%	88%

8	Is there a relapse prevention plan (post-discharge) that reflects what steps a Member should take if symptoms escalate which includes activities based on strengths? This must consist of phone numbers for 1) natural supports, 2) provider(s), and 3) Crisis Intervention.	**64%**	**77%**
9	Was the follow up treatment date within 7 days of discharge?	**77%**	**73%**
10	Was the CBHNP Member letter distributed to our Members at time of discharge? (distributed via Provider Portal 10/7/2010).	**n/a***	**11%**
11	Does the group schedule reflect at least 3 Recovery practices or principles?	**56%**	**94%**

*this indicator was added in 2011 as an action step from the previous RCA.

Clearly, there is a slight in collaboration with family and friends with an improvement of 67% to 74%; however this remains below Best Practice standards. Additionally community supports identified at time of discharge doubled from16 to 32%. However this remains well below expectations. Although IP units are addressing barriers to treatment (in increase from 43% to 70%), ironically the follow up rate within 7 days decreased from 77% to 73%. On a positive note the IP Units are reporting that Members were present and in agreement with their aftercare appointments 90% of the time in 2011 which is an increase from 38% in 2010. Last, TCM involvement improved from 61% to 88%. Furthermore, Recovery Practices are more utilized on the MH IP units in 2011. The group schedules reflected at least 3 Recovery Practices or Principles 94% of the time in comparison to 56% seen last year.

- In June 2011 CSS in CABHC region initiated a Consumer Survey and completed in February 2012. This survey focused on Members who were Discharged and readmitted. Unfortunately, the number of contacts (15 out of 120) yielded limit results nonetheless, some Members reported they did not have a choice in providers or appointment time and some reported no permanent residence. This seems to correlate with CBHNPs Barrier Survey which was developed in the end of 2011 and will be placed in production this spring.
- The highest NUM B HEDIS rates include Franklin, Dauphin, Lebanon and Clinton Counties. In 2010, Clinton County emphasized the need for the increase use of Certified Peer Support by actively educating providers, recruited for Peer Support Providers/specialist and encouraged marketing of the service. Franklin County has an active Peer Support program and TCM. Dauphin and Lebanon Counties may be slightly elevated due to an active CTT program and availability of TCM and Peer Support Services. Lebanon County also has access to Mobile Psychiatric Nursing.
- Members continue to report issues with transportation such as too long of a bus ride, vans too early or too late for appointments and sometimes need to cancel their appointment at the last minutes and rural areas are limited in transportation and have to rely on the family/friends availability.

Root Cause: Best Practice Discharge Processes and Procedures are not completely being followed by many MH IP providers which compounds Member's lack of engagement in aftercare. A clear lack of family involvement, collaboration with other MH OP providers and barriers were not always being addressed prior to discharge which may have led to no shows and cancellations.

Follow-up Status Response

In 2011, the discharge planning/process documentation audit of MHIP is being repeated. Approximately half of the facilities have been reviewed to date and are showing significant improvement in their results. Final results are forthcoming.

The Member Survey is being restructured in attempt to gather more conclusive results and will be repeated in 2011.

See Action Steps for additional information.

People (e.g., personnel, provider network,	***Initial Response***
	• Clinical Care Managers (CCM) report a steady increase of Members who are new to

patients)

1. Clinical Case Manager
2. Follow Up Specialist
3. Member
4. QI Clinical/Manager
5. Providers- MH IP, MH OP, TCM

the system and not necessarily engaged in treatment, homeless or have no phone. Additionally, addresses frequently change and current information may be outdated and outreach becomes difficult. Until recent policy change, CCM were not allowed to use any address or phone number except for the State provided information which limited outreach. Below is a Barriers Report based on what the Member told the CCM when outreach was completed. This report was developed in 2011 and will be in production in spring of 2012. CCM are required to outreach to any Member who was either a no show or cancellation. But unfortunately the response rate to the outreach is poor approximately a 33% response rate; however the data indicates that some Members reported transportation issues, some were readmitted and a fair percentage decided to not continue or begin treatment or did not want to go to the Provider who they had an appointment with. See Table below:

Barriers Identified	# of Mbrs	% of Mbrs
Angry with provider	1	0.12%
Could not/had difficulty utilizing public transportation	2	0.23%
Decided not to continue in/begin treatment	45	5.28%
Decided to follow-up w/ PCP/clergy/other non-MH provider	4	0.47%
Decided to see another MH Provider	40	4.69%
Did not have personal transportation	16	1.88%
Disagreed with referral	4	0.47%
Forgot Appointment	17	1.99%
In Jail	15	1.76%
Insurance Termed	17	1.99%
Moved	14	1.64%
No response to outreach attempts	289	33.88%
Other	279	32.71%
Other party interference	2	0.23%
Problem with scheduled provider	4	0.47%
Provider's hours were not convenient	2	0.23%
Readmission	81	9.50%
Unable to attend due to childcare issues	2	0.23%
Unable to attend due to family reasons	6	0.70%
Unable to attend due to illness	7	0.82%
Unable to attend due to MH Symptoms/issues	3	0.35%
Unable to miss work	3	0.35%
Totals	853	100.00%

*Other usually indicated inability reach Member due to contact or phone issues

- CCM also noted an increase in use of PCP for follow up which is not a covered level of care by BH MCO or blatant refusal for follow up by Member, primarily adults.
- MH IP facilities report difficulty with obtaining accurate contact information to provide BH-MCOs and MH OP providers.
- Follow Up Specialist also noted that MH OP providers often have a different date and or time than what MH IP Unit provided as follow up appointments to the CCM at time of discharge. If documentation of appointment is inconsistent between IP and OP providers, it is most likely inconsistent in the information provided to the Member as well.
- CBHNP also has available a large sample of Members who were admitted and discharged and if they kept the appointment within 7 days or 30 days or no showed or cancelled. The data provided for 2012 indicated that approximately 2.4% of the Members sought their PCP for follow up, MH OP Providers reported no record of an appointment 2.2% of the time, 9.6% of the Members were “no-shows”, 2% had no aftercare scheduled at time of discharge, 2% of the Members declined treatment, 3.6% were readmitted and another 6.6% attended an appointment but was beyond 7

	days. Although these rates may seem low individually, the accumulative effect of these categories and others can impact the HEDIS NUM B rates. Other contributing factors, albeit low, also affect the overall compliance number such as moved out of the area, jail, SA treatment, and level to level transfers. • A Member(s) reported that they feel the discharge instructions are too confusing, they are not always included in the planning process with no input into times and dates, provider choice of the follow up appointment and day of discharge planning appears rushed. Lastly, some Member's felt the Discharge Planner was "too busy" to talk to them about details or that they needed a family member or natural support person to be present with them when discharge information was reviewed. • QI Clinical/Manager reports the results of the discharge planning audit reveal that family and friends are not documented to be included in the discharge process which can complicate follow up. *Root Cause: Member outreach is complicated by inaccurate Member information making case management and follow up outreach difficult for BH-MCOs and Providers.* • CCM also noted a lack of referrals for Peer Support Specialist • MH IP facilities are not actively including Peer Support Specialist (PSS) in treatment team planning as well as introducing the concept of PSS to the Member. Currently there are only two PSS hired in the Extended Acute Facilities and none in the Acute Care Facilities. *Root Cause: Limited Peer Support referrals and use of Peer Support Specialist on the MH Inpatient facilities.*
	Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) 1. Provider Education 2. Enrollee Education 3. Provider Profiling	***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 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
	No follow up needed at this time.
Other	***Initial Response***
	None
	Follow-up Status Response
	None

Action and Monitoring Plan		
Action Plan	**Implementation Date**	**Monitoring Plan**
Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system. Action*:* Modifications to current reporting have been requested through IT. Currently, IT is not able to complete the requests for larger reports so the new approach will to break down to smaller reports and request needed information. In 2012. Some data should become available for trending.		***Initial Response*** • QCMs will advocate for prioritizing data requests. • QCMS will report quarterly new trends based on new reports/data • QI Project Manager will complete and distribute Provider Profiling and QCM will correlate hospital HEDIS NUM B rates to current data of hospitals in their area • QCMS will report follow up results for NUM B quarterly and analyze correlations and initiate new action steps in response to the data results.

1. Quality Improvement QI/Clinical Manager (QCMs) attends scheduled monthly meetings and will collectively request additional reports from IT that will expand on missing data. 2. QCMs will meet with IT Business Analysis to review reporting changes and requests. 3. QCMs will vet changes and validate reports. 4. QCMs will monitor new reports quarterly and observe for specific trends that may impact follow up. QCMs will review finding in quarterly Performance Improvement Project (PIP).		• Continue to monitor utilization of Mobile Psychiatric Nursing, Psychiatric Rehabilitation, Peer Support and Telepsychiatry. ***Follow-up Status Response***
Root Cause: Best Practice Discharge Processes and Procedures are not completely being followed by many MH IP providers which compounds Member's lack of engagement in aftercare. A clear lack of family involvement, collaboration with other MH OP providers and barriers were not always being addressed prior to discharge which may have led to no shows and cancellations. Action: The QI Department will continue to educate and monitor MH IP units on Best Practice discharge guidelines with a focus specifically on collaboration with family and friends, collaboration with other MH OP providers and the need to address barriers prior to discharge. . 1. Quality Improvement Specialist (QIS) will complete an annual MH IP treatment record review which will include indicators for the discharge processes. 2. CBHNP will create a Barriers Checklist that MH IP providers may incorporate into their processes and provide the results of the Barriers Survey reported by Members. 3. CBHNP will provide information to MH IP providers on Recovery Principles through a specific MH IP Provider Toolkit communications. 4. CBHNP will educate MH IP providers on the significant on identifying community and natural supports in aftercare plans through a specific MH IP Toolkit communication. 5. CBHNP Account Executives will be given this clinical information to remind providers during their respective on site visits. 6. Discuss options of collaborations between specific MH IP providers and MH OP providers without impeding on Member Choice where continuity of care is not offered.		***Initial Response*** • QISs will monitor MH IP treatment record reviews results annually and compare results to previous years • QCMs will measure HEDIS rates NUM B quarterly and correlate to each specific hospital • QCMs Repeat Barriers to Treatment Member survey every 6 months. ***Follow-up Status Response***
Root Cause: Member outreach is complicated by inaccurate Member information making care		***Initial Response*** • QCMs Repeat Barriers to Treatment Member

management and follow up outreach difficult for BH-MCOs and Providers. Action**:** Initiate modification of current practices in utilization review care management and encourage MH IP and OP providers to address inaccurate information of Members routinely thus improving the ability to communicate with Members. 1. Alter 2012 practice of URR CCM to include documenting Members most current address and phone number in CBHNP system which is obtained from MH IP Provider.(Previous process did not allow for utilization of any address or phone number not in the State system.) 2 Educate MH IP and MH OP providers to encourage Members to update their current address and contact information at their local County Assistance Office (DPW). 3 Change Follow Up Specialist responsibility to include notifying *Root Cause: Limited Peer Support referrals and use of Peer Support Specialist on the MH Inpatient facilities* Action*:* Improve MH IP understanding of what a Certified Peer Support Specialist is an advocate for more Peer Support involvement on the MH IP units. 1. CBHNP will provide information to the MH IP Providers on the role of a Certified Peer Support Specialist and the advantages of hiring a Peer Specialist to work on the unit. 2. CBHN P will provide information to the MH OP Providers on the role of a Certified Peer Specialist. 3. CBHNP will provide information to the MH IP and MH OP Providers on the benefits of including a Peer Support Specialist in a Members Treatment Team and how to present this information in an engaging way.		survey every 6 months • QCM will measure HEDIS rates for NUM B Quarterly • QCM will measure HEDIS rates for NUM B Quarterly • QCM will monitor claims history for number of Peer Support utilized per county. ***Follow-up Status Response***
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. Action: Improve MH IP staff understanding of how to engage a Member and motivate a Member to follow through with aftercare. 1. CBHNP will offer a training on motivational interviewing techniques and		***Initial Response*** • *QCM will monitor No Shows and Cancellations for trends through Follow Up Report* • *QCM will measure HEDIS rates NUM 1 quarterly* ***Follow-up Status Response***

provide to all MH IP and OP Providers 2. CBHNP will continue to monitor if Members are introduced to Recovery principles through treatment record reviews. 3. CBHNP will continue to offer reimbursement for Recovery Trainings for all providers. in promoting their own Recovery		

V: 2012 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of CBHNP's 2012 (MY 2011) performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH MCO.

Strengths

- CBHNP's rates for the MY 2011 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 1and QI 2 were both statistically significantly above the prior year and represented the largest year to year increase among BH MCOs.

- CBHNP's rate for the MY 2011 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 2 was statistically significantly higher than the QI 2 HealthChoices BH MCO Average by 3.1 percentage points.

- CBHNP's rates for the MY 2011 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI A and QI B were both statistically significantly above the prior year and represented the largest year to year increase among BH MCOs

- CBHNP's rate for the MY 2011 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI B was statistically significantly higher than the QI B HealthChoices BH MCO Average by 2.0 percentage points.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2009, RY 2010, and RY 2011 found CBHNP to be partially compliant with all three Subparts associated with Structure and Operations Standards.
  - Within Subpart C: Enrollee Rights and Protections Regulations, CBHNP was partially compliant on one out of seven categories – Enrollee Rights.
  - CBHNP was partially compliant on five out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Practice Guidelines, and 5) Quality Assessment and Performance Improvement Program.
  - CBHNP was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 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.

- CBHNP submitted one PIP for validation in 2012. CBHNP received no credit for Demonstrable Improvement and partial credit for Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement.

- CBHNP's rate for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.

- CBHNP's rate for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (poorer) than the HealthChoices BH MCO Average by 2.5 percentage points.

Additional strengths and targeted opportunities for improvement can be found in the BH MCO-specific 2012 (MY 2011) Performance Measure Matrix that follows.

PERFORMANCE MEASURE MATRIX

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

- Compares the BH MCO's own measure performance over the two most recent reporting years (Measurement Year (MY) 2011 and MY 2010); and
- Compares the BH MCO's MY 2011 performance measure rates to the MY 2011 HealthChoices BH MCO Average.

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

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

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

The green box (A) indicates that performance is notable. The BH MCO's MY 2011 rate is statistically significantly above the MY 2011 HealthChoices BH MCO Average and trends up from MY 2010.

The light green boxes (B) indicate either that the BH MCO's MY 2011 rate is equal to the MY 2011 HealthChoices BH MCO Average and trends up from MY 2010 or that the BH MCO's MY 2011 rate is statistically significantly above the MY 2011 HealthChoices BH MCO Average but there is no change from MY 2010.

The yellow boxes (C) indicate that the BH MCO's MY 2011 rate is statistically significantly below the MY 2011 HealthChoices BH MCO Average and trends up from MY 2010 or that the BH MCO's MY 2011 rate is equal to the MY 2011 HealthChoices BH MCO Average and there is no change from MY 2010 or that the BH MCO's MY 2011 rate is statistically significantly above the MY 2011 HealthChoices BH MCO Average but trends down from MY 2010. *No action is required although MCOs should identify continued opportunities for improvement.*

The orange boxes (D) indicate either that the BH MCO's MY 2011 rate is statistically significantly below the MY 2011 HealthChoices BH MCO Average and there is no change from MY 2010 or that the BH MCO's MY 2011 rate is equal to the MY 2011 HealthChoices BH MCO Average and trends down from MY 2010. *A root cause analysis and plan of action is required.*

The red box (F) indicates that the BH MCO's MY 2011 rate is statistically significantly below the MY 2011 HealthChoices BH MCO Average and trends down from MY 2010. *A root cause analysis and plan of action is required.*

KEY POINTS

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

Measures that had statistically significantly improvement from MY 2010 to MY 2011 and were statistically significantly above/better than the MY 2011 HealthChoices BH MCO Averages are:

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

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

Measures that had statistically significant improvement from MY 2010 to MY 2011and were equal to the MY 2011 HealthChoices BH MCO Averages are:

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

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

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

Measures that had no statistically significant change from MY 2010 to MY 2011 but were statistically significantly below/poorer than the MY 2011 HealthChoices BH MCO Averages are:

- Readmission within 30 Days of Inpatient Psychiatric Discharge[1]

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

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

Figure 1: Performance Measure Matrix – CBHNP

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

Key to the Performance Measure Matrix Comparison

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

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

Performance measure rates for MY 2009, MY 2010, and MY 2011 are displayed in Figure 2. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

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

Figure 2: Performance Measure Rates – CBHNP

Quality Performance Measure	MY 2009 Rate	MY 2010 Rate	MY 2011 Rate	MY 2011 HC BH MCO Average
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	43.2%	41.7% =	45.2% ▲	45.78%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	66.2%	65.5% =	69.9% ▲	66.81%
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	56.3%	54.2% =	57.4% ▲	57.63%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	74.8%	72.8% ▼	76.7% ▲	74.67%
Readmission within 30 Days of Inpatient Psychiatric Discharge[1]	13.1%	13.0% =	14.8% =	12.34%

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

VI: SUMMARY OF ACTIVITIES

Structure and Operations Standards

- CBHNP was partially compliant on Subparts C, D, and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2011, RY 2010, and RY 2009 were used to make the determinations.

Performance Improvement Projects

- CBHNP submitted one PIP for validation in 2012. CBHNP received no credit for Demonstrable Improvement and partial credit for Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement.

Performance Measures

- CBHNP reported all performance measures and applicable quality indicators in 2012.

2011 Opportunities for Improvement MCO Response

- CBHNP provided a response to the opportunities for improvement issued in 2011, and submitted a root cause analysis and action plan response in 2012.

2012 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CBHNP in 2012. The BH MCO will be required to prepare a response for the noted opportunities for improvement in 2013.

APPENDIX

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

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

BBA Category	PEPS Reference	PEPS Language
	Standard 1.3	Provider Exception report submitted & approved when choice of two providers is not given.
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).
	Standard 1.5	BH-MCO has notified DPW of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.208 Coordination and Continuity of Care	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.210 Coverage and authorization of services	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.2104	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law,

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

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

BBA Category	PEPS Reference	PEPS Language
		measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
§438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality

BBA Category	PEPS Reference	PEPS Language
		Management Denial Summary Report for the respective review year.
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

BBA Category	PEPS Reference	PEPS Language
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the

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

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

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

Appendix B: OMHSAS-Specific PEPS Substandards

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

Category	PEPS Reference	PEPS Language
Hearings		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 CBHNP Counties

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2011, 11 substandards were considered OMHSAS-specific monitoring standards, and were reviewed. All 11 OMHSAS-specific PEPS Substandards were evaluated for Blair, Bedford, and Somerset Counties. Three standards for CABHC counties were not reviewed during the 2011 review year. The remaining NC/CO Counties – Clinton, Franklin, Fulton, and Lycoming – were evaluated on 10 of the substandards. For these counties, there was one Substandard that was not scheduled or not applicable for evaluation for RY 2011. Tables C.1a to C.1c provide a count of these Items, along with the relevant categories.

Table C.1a OMHSAS-Specific Substandards Reviewed for Blair, Bedford, and Somerset Counties

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	Not Reviewed
Complaints (Standard 68)	4	4	0	0	0
Grievances and State Fair Hearings (Standard 71)	4	4	0	0	0
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0

Table C.1b OMHSAS-Specific Substandards Reviewed for the CABHC Counties

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	Not Reviewed
Complaints (Standard 68)	4	4	0	0	0
Grievances and State Fair Hearings (Standard 71)	4	4	0	0	0
Consumer/Family Satisfaction (Standard 108)	3	0	0	0	3

Table C.1c OMHSAS-Specific Substandards Reviewed for Clinton, Franklin, Fulton, and Lycoming Counties

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	Not Reviewed*
Complaints (Standard 68)	4	4	0	0	0
Grievances and State Fair Hearings (Standard 71)	4	4	0	0	0
Consumer/Family Satisfaction (Standard 108)	3	0	0	2	1

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

Format

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

Findings

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

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

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

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

CBHNP was "partially met" on Substandard 68.9:

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

The OMHSAS-specific Substandards relating to Enrollee Satisfaction are County-specific review standards. The CABHC Counties were not reviewed during the 2011 review year. Blair County was

evaluated on three substandards, met two substandards, and partially met on one item. Bedford and Somerset Counties were evaluated on three substandards and compliant on all three. Clinton, Franklin, Fulton, and Lycoming Counties were evaluated on two of the three substandards. Franklin and Fulton Counties met both substandards. Clinton and Lycoming Counties met one item and partially met one item. Tables C.3a and C.3b provide a count of these substandards.

Table C.3a OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for Blair County (A NC/CO County)

Category	PEPS Item	Review Year	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Standard 108.3	RY 2009	Met
	Standard 108.4	RY 2009	Met
	Standard 108.9	RY 2009	Partially Met

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

Category	PEPS Item	Review Year	Status by County		
			Met	Partially Met	Not Reviewed
Enrollee Satisfaction					
Consumer/Family Satisfaction	Standard 108.3	RY 2009	Bedford, Somerset		Franklin, Fulton, Lycoming, Clinton
	Standard 108.4	RY 2009	All remaining NC/CO Counties		
	Standard 108.9	RY 2009	Bedford, Franklin, Fulton, Somerset	Lycoming, Clinton	

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.

Blair, Lycoming and Clinton Counties were "partially met" on Substandard 108.9:

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

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