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

2012 External Quality Review Report
Community Behavioral Health
FINAL REPORT

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REPORT CONTENT

GLOSSARY OF TERMS

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

INTRODUCTION

Purpose and Background

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

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

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

The HealthChoices Behavioral Health is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 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 Health's (CBH'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.

Philadelphia County holds a contract with Community Behavioral Health (CBH). 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. Consequently, members enrolled in the HealthChoices Behavioral Health Program in the Philadelphia County are assigned CBH as their BH MCO. IPRO's EQR is based on OMHSAS reviews of Philadelphia County and CBH.

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 CBH 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 2012 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 CBH, this year a total of 159 Items were identified as being required for the evaluation of County/BH MCO compliance with the BBA regulations. In addition, 11 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Substandards were relevant to more than one BBA regulation or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS Item may contribute more than once to the total number of Items required and/or reviewed. Table 1.1 provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of CBH against the Structure and Operations Standards for this report. In Appendix C, Table C.1 provides a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH MCO and associated Counties against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Items Pertinent to BBA Regulations for CBH and Philadelphia County

Table 1.1 Items Pertinent to BBA Regulations Reviewed for CBH

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	9	3	0	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	17	0	4	1
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	3	0	0	1
Provider Selection	3	3	0	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	8	0
Practice Guidelines	6	2	0	4	0
Quality Assessment and Performance Improvement Program	23	16	0	7	0
Health Information Systems	1	0	0	1	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	1	9	0	1
General Requirements	14	1	12	0	1
Notice of Action	11	10	0	0	1
Handling of Grievances and Appeals	11	1	9	0	1
Resolution and Notification: Grievances and Appeals	11	1	9	0	1
Expedited Appeals Process	6	1	4	0	1
Information to Providers and Subcontractors	2	0	2	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	1	4	0	1
Effectuation of Reversed Resolutions	6	1	4	0	1

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

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

Of the 159 PEPS Items identified as required to fulfill BBA regulations, 149 Items were evaluated for CBH/Philadelphia County, and 10 Items 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. Philadelphia County was evaluated on 12 substandards, compliant on 11 substandards and partially compliant on 1 Item.
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 within Enrollee Rights and Protections Standards. CBH was compliant on five categories and partially compliant on one category. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50-447.60. The remaining category, Solvency Standards, was compliant based on the 2011-2012 Solvency Requirement tracking report. Philadelphia County was evaluated and compliant on 11 PEPS substandards and partially compliant on 1 PEPS substandard that was crosswalked to Enrollee Rights and Protections Regulations, and was deemed partially compliant for the category Enrollee Rights. 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.

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. Philadelphia County was evaluated on 21 substandards, compliant on 18 substandards, and partially compliant on 3 substandards.
Coordination and Continuity of Care 438.208	Partial	2 substandards were crosswalked to this category. Philadelphia County was evaluated on 2 substandards and partially compliant on both substandards.
Coverage and Authorization of Services 438.210	Partial	4 substandards were crosswalked to this category. Philadelphia County was evaluated on 3 substandards and partially compliant on 3 substandards.
Provider Selection 438.214	Compliant	3 substandards were crosswalked to this category. Philadelphia County was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	Compliant as per PS&R sections D.2 (p.46), G.4 (p.55) and C.6.c (p.44).
Subcontractual Relationships and Delegation 438.230	Compliant	8 substandards were crosswalked to this category. Philadelphia County was evaluated on 8 substandards and compliant on 8 substandards.
Practice Guidelines 438.236	Partial	6 substandards were crosswalked to this category. Philadelphia 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. Philadelphia County was evaluated on 23 substandards, compliant on 18 substandards and partially compliant on 5 substandards.
Health Information Systems 438.242	Compliant	1 substandard was crosswalked to this category. Philadelphia County was evaluated on 1 substandard and compliant on this substandard.

Based on the Items reviewed for the 10 categories of Quality Assessment and Performance Improvement Regulations, Philadelphia County was fully compliant on five categories and partially compliant on five categories. Philadelphia County was compliant on the categories Elements of State Quality Strategies and Confidentiality per the HealthChoices PS&R, as these categories were not directly addressed by any PEPS substandards.

Of the 69 PEPS Items crosswalked to Quality Assessment and Performance Improvement regulations, 67 were evaluated for Philadelphia County and 2 Items were not scheduled or not applicable for evaluation for RY 2011. Fifty-two items evaluated were compliant, and 15 Items were partially compliant for Philadelphia County. 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)

Philadelphia County was partially compliant with Availability of Services (Access to Care) due to partial compliance with Substandards 1 and 2 of PEPS Standard 28.

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

> **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

Philadelphia County was partially compliant with Coordination and Continuity of Care due to partial compliance with a substandard of PEPS Standard 28.

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

Coverage and Authorization of Services

Philadelphia County was partially compliant with Coverage and Authorization of Services due to partial compliance with PEPS Standard 28 and Standard 72, Substandard 1.

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.

> **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.

Quality Assessment and Performance Improvement Program

Philadelphia County was partially compliant with Quality Assessment and Performance Improvement Program regulations due to partial compliance with substandards of PEPS Standards 91 and 104.

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

Substandard 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.

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 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 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.

PEPS Standard 104: There is a provision for regular reporting to DPW on accurate and timely QM data.

Substandard 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.

Practice Guidelines

Philadelphia County was partially compliant with Practice Guidelines due to partial compliance with a substandard of PEPS Standard 28.

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

Subpart F: Federal and State Grievance System Standards

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

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

Table 1.4 Compliance with Federal and State Grievance System Standards

Federal and State Grievance System Standards		
Subpart F: Categories	**Compliance**	**Comments**
Statutory Basis and Definitions 438.400	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 10 substandards, compliant on 6 substandards, partially compliant on 3 substandards, and non-compliant on 1 substandard.
General Requirements 438.402	Partial	14 substandards were crosswalked to this category.

Federal and State Grievance System Standards		
Subpart F: Categories	**Compliance**	**Comments**
		Philadelphia County was evaluated on 13 substandards, compliant on 9 substandards, partially compliant on 3 substandards, and non-compliant on 1 substandard.
Notice of Action 438.404	Partial	11 substandards were crosswalked to this category. Philadelphia 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. Philadelphia County was evaluated on 10 substandards, compliant on 6 substandards, partially compliant on 3 substandards, and non-compliant on 1 substandard.
Resolution and Notification: Grievances and Appeals 438.408	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 10 substandards, compliant on 6 substandards, partially compliant on 3 substandards, and non-compliant on 1 substandard.
Expedited Appeals Process 438.410	Partial	6 substandards were crosswalked to this category. Philadelphia 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. Philadelphia County was evaluated on 2 substandards and compliant on 2 substandards.
Recordkeeping and Recording Requirements 438.416	Compliant	Compliant as per 2011 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.
Continuation of Benefits 438.420	Partial	6 substandards were crosswalked to this category. Philadelphia 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. Philadelphia County was evaluated on 5 substandards, compliant on 3 substandards, and partially compliant on 2 substandards.

Based on the Substandards reviewed, Philadelphia County was fully compliant on two of the 10 evaluated categories of Federal and State Grievance System Standards regulations, and partially compliant on the other eight categories. The category Recordkeeping and Recording Requirements was compliant per the 2011 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports. In all, 78 PEPS Items were crosswalked to Federal and State Grievance System Standards, and Philadelphia County was evaluated on 70 Items. Eight Items were not scheduled or not applicable for evaluation for RY 2011. Philadelphia County was fully compliant on 47 Items, partially compliant on 19 Items, and non-compliant on 4 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.

Philadelphia County was rated partially compliant on eight of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with substandards of PEPS Standards 68, 71, and 72.

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

Philadelphia County was non-compliant on one substandard of Standard 68: # Substandard 4 (RY 2010).

> **Substandard 4:** The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.

Philadelphia County was partially compliant on one substandard of Standard 68: Substandard 5 (RY 2010).

> **Substandard 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 files to where the documentation can be obtained for review.

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

Philadelphia County was partially compliant on Substandard 3 of Standard 71: (RY 2010).

> **Substandard 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.

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

II: PERFORMANCE IMPROVEMENT PROJECTS

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

Review Element	Standard	Scoring Weight
1S	Subsequent or modified Interventions Aimed at Achieving Sustained Improvement	5%
2S	Sustained Improvement	15%
Total Sustained Improvement Score		**20%**
Overall Project Performance Score		**100%**

Findings

As per the timeline distributed by OMHSAS for this review period, BH MCOs were required to submit information for the review elements of Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement. CBH 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, CBH 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 was based primarily on a root cause analysis conducted using inpatient data from January 2006 to August 2009. CBH examined patterns among members who were frequent utilizers of inpatient care, reviewing both recidivism and follow-up/utilization. CBH profiled member records in each of four categories according to frequency of inpatient episodes within the period, and calculated follow-up rates within 30 days, average length of stay (ALOS), and total associated costs of stay for each category. The BH MCO also examined the effects of mental health and drug and alcohol (D&A) utilization, crisis response center (CRC) episodes, days in involuntary commitment admissions, extended acute care, intensive care managers (ICMs), resource coordinator utilization, and rehabilitation and detoxification services utilization on the number of days in acute inpatient (AIP) psychiatric care. CBH noted that they used regression modeling to analyze the data, and observed that overall outpatient services did not impact or reduce subsequent inpatient episodes or inpatient days for its membership population.

Given this unexpected finding, and proposing that appropriate follow-up care should reinforce gains from inpatient treatment and reduce the need for additional inpatient stays, CBH conducted additional analyses to examine suboptimal follow-up rates. CBH examined where members go for next level of care after discharge from AIP, analyzing the level of care for members who received follow-up services within seven days of discharge, members who received follow-up services between eight and 30 days, and members who did not receive follow-up services within 30 days of discharge. CBH found that the levels of care ranged from intensive case management (ICM) to individual mental health treatment as examples of services for those who received follow-up within seven days of discharge, whereas CRC evaluations and inpatient (both voluntary and involuntary) admissions were found for those members who did not receive follow-up services within 30 days of discharge. CBH concluded that these findings suggest that the longer clients go without follow-up treatment in the community post-discharge, the more likely they are to receive higher intensity levels of care after discharge.

As a result of these additional analyses, CBH also made a number of other observations about its member population and the services they receive after hospitalization. CBH observed that 14% of members who received follow-up care within 30 days of discharge visited ICMs as the first point of outpatient contact post-discharge. CBH noted that these findings may explain why their PA-specific indicator rates are uniformly higher than the HEDIS indicator rates for the measure, but that the heavy reliance on ICMs is problematic. The BH MCO acknowledged that although timely outpatient connections to resources such as ICMs are associated with positive outcomes, they are not adequate substitutes for ambulatory treatments. Therefore, CBH recognizes the need to improve follow-up rates with respect to active treatment services to avoid readmission to more intensive levels of care. Additionally, CBH noted that a disproportionate number of members with both mental health and substance abuse ("co-occurring") disorders are admitted to acute psychiatric inpatient units where they receive minimal or no attention to their substance abuse issues, and are then discharged with recommendations to follow up at outpatient mental health centers rather than at substance abuse or co-occurring programs. CBH continued that these members are frequently not screened for drug use in the CRCs prior to acute psychiatric inpatient admissions, and are misdiagnosed with primary mental health disorders rather than substance abuse disorders with behavioral symptoms.

Baseline results calculated in 2009 for the period January 1, 2008 through December 31, 2008 were previously presented along with analysis that would lead to interventions initiated in late 2009. The baseline results indicated a rate of 34.8% for QI 1 (HEDIS – seven days), 51.2% for QI 2 (HEDIS – 30 days), 52.0% for QI A (PA-Specific – seven days), and 67.4% for QI B (PA-Specific – 30 days). Rates for all indicators were below the 90% benchmark established by OMHSAS. After review of the validated data and comparison to previous years' rates, the CBH Director of Continuous Quality Improvement (CQI) along with other CQI staff conducted a more detailed analysis of follow-up rates after inpatient hospitalization. This, in conjunction with the root cause analysis, led the CQI Department to look more closely at HEDIS rates. CBH noted that the HEDIS definition allows only outpatient treatment and not intake visits or assessments, which can impact the rates. This issue, however, is not a barrier that can be addressed by the BH MCO, as the national HEDIS definition has been required for use by OMHSAS for QIs 1 and 2. CBH's barrier analysis also examined concerns noted by CQI staff over previous several years regarding members receiving timely intake appointments and then waiting long periods of time for actual therapy to begin. CQI staff noted that during some of those "wait" periods, members were re-hospitalized before they could see a therapist, or that they never attended either intake or therapy sessions. Additionally, CBH outlined several barriers as a result of these analyses, some of which the BH MCO had already identified as part of its root cause analysis. The additional barriers identified by CBH included: 1) variation by provider in obtaining appointments and communicating specific appointment information to CBH, 2) inconsistent use of discharge screen tool by clinical care managers, which made outreach to members regarding follow-up care more difficult, 3) long outpatient wait lists, 4) delays in appropriate discharge planning, 5) inadequate identification of and communication with existing outpatient providers, and 6) members' lack of perceived need for follow-up services. Based on review of baseline results, CBH developed an extensive list of interventions to be implemented in late 2009 and early 2010.

CBH's Interventions Aimed at Achieving Demonstrable Improvement consisted not only of those that were implemented in 2009 and 2010, but also those that were previously implemented and remained

ongoing. The interventions focused primarily on creating risk alerts to aid care managers, provider and care manager education, developing matrices to report performance, and provider profile reports, while continuing root cause and drill down analyses. CBH noted that in 2007, they began the Network for the Improvement of Addiction Treatment (NIATx) process improvement model to decrease wait times for appointments and more timely referrals. CBH noted that they continued the process into 2010, expanding it to reach more providers. CBH observed that its participating providers that applied NIATx practices to reduce wait times in appointment scheduling were able to reduce wait times by 51%. In 2008, CBH implemented Provider Profile Reports, which offer each provider a blinded comparison displaying his/her individual results in comparison to other providers in the network for the specified time period. CBH noted that provider profiling alone was not sufficient, and in 2010 expanded the initiative to include development of pay for performance indicators, measures and financial incentives. Between 2008 and 2009, CBH implemented the use of discharge screens in its information system to allow CBH Member Services to contact members and remind them of scheduled follow-up appointments. CBH observed that by the end of 2009, the number of representatives conducting calls increased five-fold. In 2010, CBH began work with the Crisis Response Centers (CRCs) to increase diversions of co-occurring clients from acute inpatient to substance abuse or co-occurring treatment facilities; the BH MCO noted increases in the achievement of its goal. The BH MCO also began working with providers to increase 24/7 access to drug and alcohol treatment. This process includes identifying providers who are able to take less stable (intoxicated) clients and raising their awareness of the need to accept such clients. Additionally, CBH noted the development of chart audit measures to be added to existing pay for performance process. The BH MCO noted that these audits served to highlight the need for improvements in discharge planning.

Remeasurement results calculated in 2011 for January 1, 2010 through December 31, 2010 were presented. Rates increased for two of the four indicators: QI 1 (HEDIS – seven days) and QI 2 (HEDIS – 30 days). Because of the increases to these indicators, Demonstrable Improvement was achieved. QI 1 increased to 38.8%, while QI2 increased to 55.6%. Although below the OMHSAS benchmark of 90%, both indicators exceeded the BH MCO's goals for remeasurement (38.3% and 50.7%, respectively).

To accompany the remeasurement analysis, CBH provided data for 2010 through the third quarter of 2011. CBH noted that a root cause analysis for both follow-up and readmission was completed in 2010. The root cause, which was provided as part of follow-up discussions with CBH, outlined the factors identified by CBH, as well as dates and progress in implementation of interventions. The Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement outlined by CBH consisted primarily of the previous Interventions Aimed at Achieving Demonstrable Improvement with updates provided as applicable. For example, the NIATx, process was enhanced to include generation and internal reporting of monthly wait times, with additional plans to work on developing a method to safely disseminate information to treatment providers, as well as real time provider submitted availability. As part of the CRC diversion intervention, CBH developed standard reports on high utilizing members, which are shared with the CBH special needs team that works on addressing the needs of the high utilizing CBH member population. As part of its process to increase 24/7 access to drug and alcohol treatment, and in response to the need to abandon efforts to create the "Red Hot Rehabs" that were proposed to provide immediate access to services who presented to CRCs under the influence of substances, CBH developed two new programs in 2011. The Safe Haven Program is a housing first program for mental health/drug and alcohol patients who refuse rehab, with housing diversion and treatment engagement activities as an alternative to inpatient hospitalization and/or drug and alcohol rehabilitation. Additionally, the Journey of Hope was developed as a collaborative effort among Behavioral Health, Addiction Services, and Supportive Housing offices to transform six identified inner city substance abuse residential treatment programs into programs that are equipped to more effectively serve chronically homeless individuals.

CBH received full credit for the elements of the study evaluated that reflect activities in 2011 (Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement). As indicated by the DPW timeline, Sustained Improvement will be evaluated in 2013, based on activities conducted in 2012 to assess performance in 2011. While quality improvement efforts are encouraged for all measures, Sustained Improvement will be evaluated in 2013 for Indicators 1 and 2, as these were the measures for which Demonstrable Improvement was achieved.

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

Review Element	Compliance Level	Scoring Weight	Final Points Score
1. Project Title, Type, Focus Area	Full	5%	5
2.Topic Relevance	Full	5%	5
3. Quality Indicators	Full	0%	0
4. Baseline Study and Analysis (Calendar Year (CY) 2008, reported in CY 2009)	Full	20%	20
5. Baseline Study Population and Baseline Measurement Performance (CY 2008)	Full	10%	10
6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010)	Full	20%	20
7. Demonstrable Improvement (CY 2010, reported in 2011)	Full	20%	20
Total Demonstrable Improvement Score			**80**
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Full	5%	5
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)	34.8%	NA	38.8%[1]	TBD	90%
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	51.2%	NA	55.6%[1]	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)	52.0%	NA	51.2%	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)	67.4%	NA	66.6%	TBD	90%
Project Status	Baseline Study	Interventions	Remeasurement #1	Remeasurement #2	

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

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%	47.4%	46.1%	0.0	NO
CBH/ Philadelphia	2,990	7,642	**39.1%**	38.0%	40.2%			38.8%	0.4	NO
QI 2										
HealthChoices	24,159	36,038	**67.0%**	66.6%	67.5%	66.8%	70.7%	66.9%	0.1	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
CBH/ Philadelphia	4,239	7,642	**55.5%**	54.3%	56.6%			55.6%	-0.2	NO

The MY 2011 HealthChoices aggregate rates were 46.1% for QI 1 and 67.0% for QI 2. CBH's MY 2011 rate was 39.1% for QI 1 and 55.5% for QI 2. There were no statistically significant differences between the MY 2011 and MY 2010 rates for either HealthChoices or CBH.

For MY 2011, CBH's QI 1 rate of 39.1% was statistically significantly lower than the QI 1 HealthChoices BH MCO Average of 45.8% by 6.7 percentage points. CBH's QI 2 rate of 55.5% was also statistically significantly below the QI 2 HealthChoices BH MCO Average of 66.8% by 11.3 percentage points. Overall, as was the case for MY 2010, CBH observed the lowest QI 1 and QI 2 rates among the five BH MCOs evaluated in MY 2011.

For MY 2011, CBH was subcontracted to provide behavioral health services to only one County located in the Southeast region of the Commonwealth: Philadelphia County. Therefore, the CBH performance comprises the BH MCO performance for Philadelphia County alone. Figure 3.1 displays a graphical representation of the MY 2011 HEDIS follow-up rates for Philadelphia County. In MY 2011, Philadelphia (39.1%) performed statistically significantly below the QI 1 HealthChoices County Average of 47.4% by 8.3 percentage points. For QI 2, Philadelphia (55.5%) was statistically significantly below the HealthChoices County Average of 70.7% by 15.2 percentage points.

Figure 3.1 MY 2011 HEDIS Indicator Rates

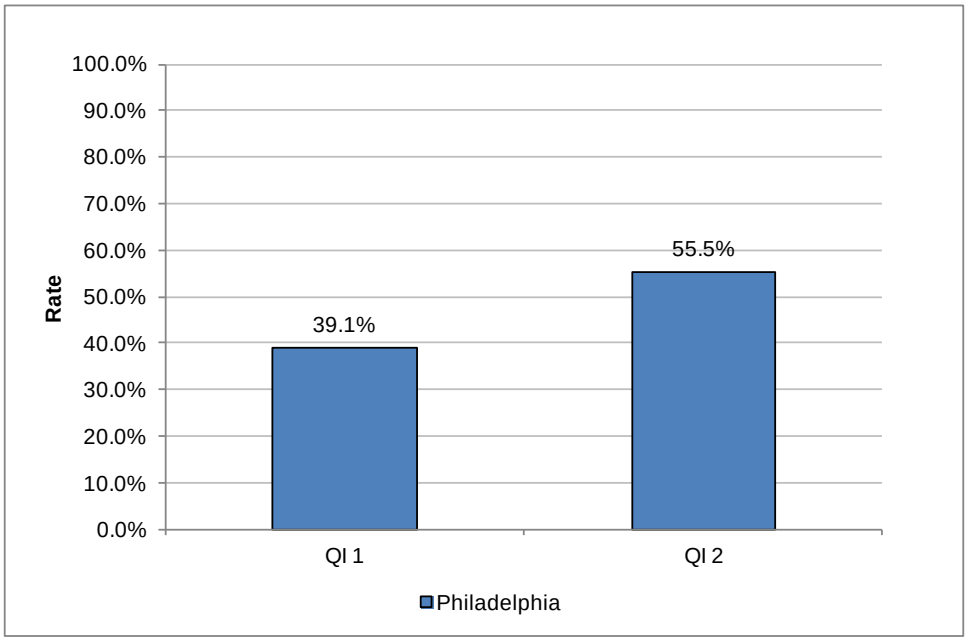


Table 3.2 MY 2011 PA-Specific Indicator Rates with Year-to-Year Comparisons

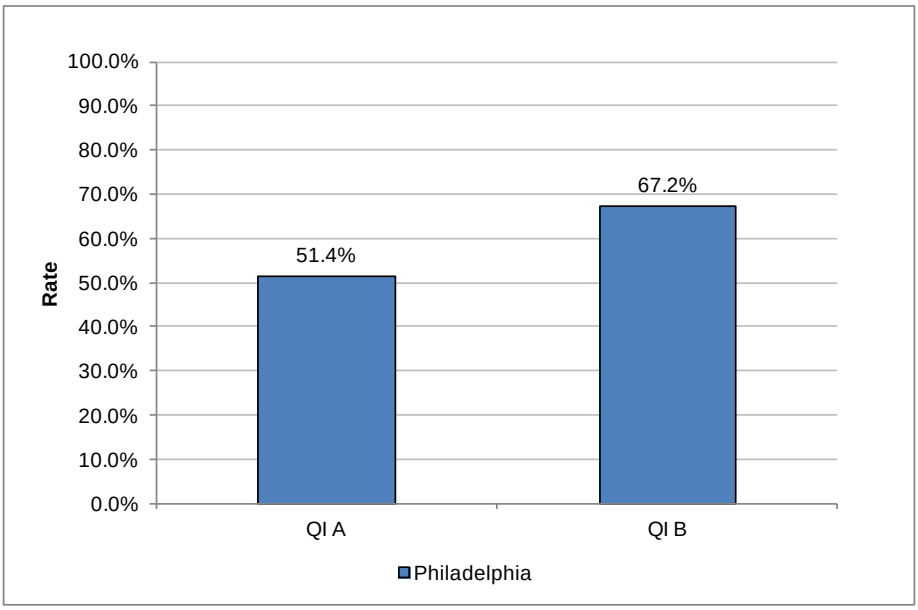
	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
QI A										
HealthChoices	20,830	36,038	**57.8%**	57.3%	58.3%	57.6%	58.6%	58.1%	-0.3	NO
CBH/Philadelphia	3,927	7,642	**51.4%**	50.3%	52.5%			51.2%	0.2	NO
QI B										
HealthChoices	26,939	36,038	**74.8%**	74.3%	75.2%	74.7%	77.1%	74.6%	0.1	NO
CBH/Philadelphia	5,136	7,642	**67.2%**	66.2%	68.3%			66.6%	0.6	NO

The MY 2011 HealthChoices aggregate rates were 57.8% for QI A and 74.8% for QI B. The CBH rate was 51.4% for QI A and 67.2% for QI B. There were no statistically significant differences observed for either measure between MY 2011 and MY 2010 rates for HealthChoices or CBH.

For MY 2011, CBH's QI A rate of 51.4% was statistically significantly lower than the QI A HealthChoices BH MCO Average of 57.6% by 6.2 percentage points. CBH's QI B rate of 67.2% was also statistically significantly below the QI B HealthChoices BH MCO Average of 74.7% by 7.5 percentage points. Overall, as was the case for MY 2010, CBH observed the lowest QI A and QI B rates among the five BH MCOs evaluated in MY 2011.

Figure 3.2 displays a graphical representation of the MY 2011 PA-specific follow-up rates for Philadelphia. At 51.4% for QI A, Philadelphia was statistically significantly below the HealthChoices County Average of 58.6% by 7.2 percentage points. At 67.2% for QI B, Philadelphia was statistically significantly below the HealthChoices County Average of 77.1% by 9.9 percentage points.

Figure 3.2 MY 2011 PA-Specific Indicator Rates



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 HealthChoices rates for both QI 1 and QI 2 fell between the 50th and 75th percentiles.

When comparing the MY 2011 CBH rates to the HEDIS 2012 benchmarks, the QI 1 rate of 39.1% fell between the 25th and 50th percentiles while the BH MCO's MY 2011 rate of 55.5% fell between the 10th and 25th percentiles. In MY 2010, the BH MCO's QI 1 rate and QI 2 rate both fell between the 25th and 50th percentile ranges of the HEDIS 2010 Medicaid 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
CBH/Philadelphia	1,257	10,727	**11.7%**	11.1%	12.3%			13.1%	-1.4	NO

The aggregate MY 2011 HealthChoices readmission rate was 12.0%. CBH/Philadelphia's rate of 11.7% was statistically significantly lower (better) than the HealthChoices BH MCO Average of 12.3% by 0.6 percentage points. Note that this measure is an inverted rate, in that lower rates are preferable. Overall, the rate for CBH/Philadelphia did not meet the performance goal in MY 2011. Although CBH's rate did not statistically significantly change from MY 2010, CBH observed the largest percentage point improvement (decrease) among the five BH MCOs.

Figure 3.3 displays a graphical representation of the MY 2011 readmission rates for CBH/Philadelphia County. Figure 3.4 shows Philadelphia County's rate as compared to the HealthChoices County Average. For MY 2011, the rate for Philadelphia (11.7%) was statistically significantly higher (poorer) than the HealthChoices County Average of 9.9% by 1.8 percentage points.

Figure 3.3 MY 2011 Readmission Rates

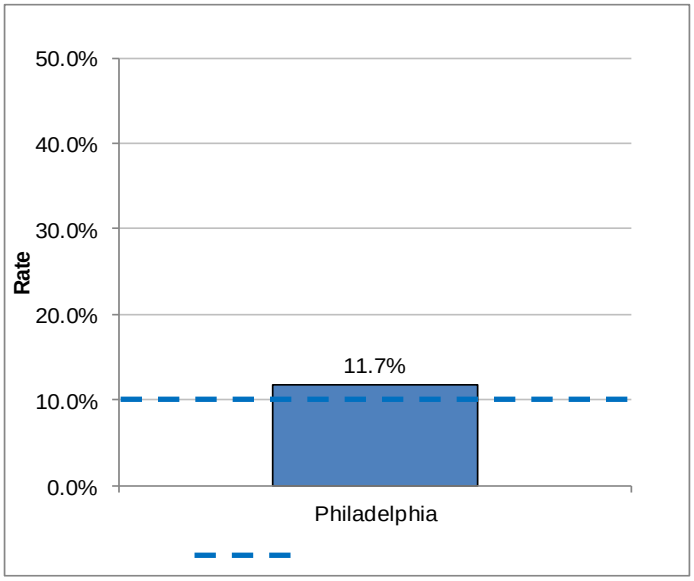
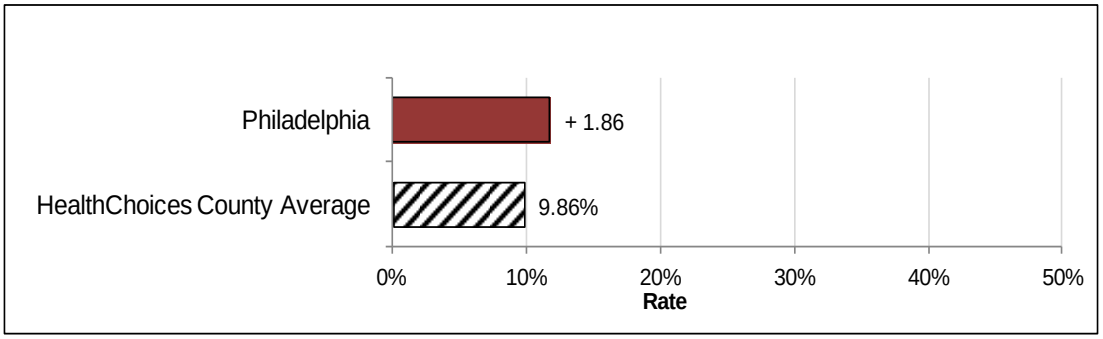


Figure 3.4 MY 2011 Readmission Rates Compared to HealthChoices County Average



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 such as CBH 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 CBH.

Table 4.1 Current and Proposed Interventions: Opportunities for Improvement

Reference Number	Opportunity for Improvement	MCO Response
Structure and Operations Standards		
	Review of compliance with standards conducted by the Commonwealth in RY 2008, RY 2009, and RY 2010 found CBH to be partially compliant with two Subparts associated with Structure and Operations Standards.	Follow Up Actions Taken Through 09/30/12 St.28.2: - Audit tool and process under revision. Implemented results feedback mechanism with increased buy-in from psychologist/psychiatrist staff. Redesigning audit process to increase quality and substance of physician/psychologist notes. Standard 72.1 - Continued monthly audits and inter-rater audits of care management notes with follow up via data and outcomes discussion with all supervisors and coordinators quarterly. - Implementation and evaluation of 'denial module' within the clinical dashboard, including updating policies and designing training for staff on policies and module use.

Reference Number	Opportunity for Improvement	MCO Response
CBH 1	CBH 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) Provider Selection 5) Practice Guidelines.	Follow Up Actions Taken Through 09/30/12 Standard 10.1 "100%" -Implemented credentialing file checklist to ensure all necessary documents are included in each provider's file. Standard 10.3 - Continued development and expansion of the Network Improvement and Accountability Collaborative (NIAC) Department and the Network Inclusion Criteria (NIC) to holistically evaluate agencies. Pay for Performance and Provider Profiling results will be incorporated into NIAC site visits, which will impact the agency's overall network approval status. Future Actions Planned (Specify Dates) Standard 10.3 -Adding additional staff (10/2012)
CBH 2	CBH was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions 2) General Requirements 3) Notice of Action 4) Handling of Grievances and Appeals 5) Resolution and Notification: Grievances and Appeals 6) Expedited Appeals Process 7) Continuation of Benefits 8) Effectuation of Reversed Resolutions	Follow Up Actions Taken Through 09/30/12 St. 71.1 *No action, rated "Fully Compliant" according to CBH records St. 71.2 *No action, rated "Fully Compliant" according to CBH records St. 72.1 Denial Notices (See above) St. 68.7 *No action, grievance process received "Fully Compliant" and it is an identical process. St. 68.8 *No action, grievance process received "Fully Compliant" and it is an identical process. St. 71.5 –Now asking members if they need "any assistance or assistive devices". St. 71.7 Training and feedback to panel participants about verbal identification on tapes. St. 68.4 – Letter of clarification sent to providers, specifying the requirement of supporting documentation for complaints, which are now included in complaint files. (Letter dated 9/15/11) St. 68.5 Representatives and Specialists now can flag quality improvement issues within CBH clinical system, which are tracked and followed up on as necessary. **Future Actions Planned** None

Reference Number	Opportunity for Improvement	MCO Response
CBH 3	CBH's rate for the MY 2010 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 1 was statistically significantly lower than the QI 1 HealthChoices BH MCO Average by 6.6 percentage points. CBH's MY 2010 QI 2 rate was also statistically significantly below the QI 2 HealthChoices BH MCO Average by 11.3 percentage points.	Follow Up Actions Taken Through 09/30/12 1) Development and improvement of AAO meetings for high utilizers 2) Procedural changes increasing oversight of 302 admissions 3) Pilot program to reduce EAC length of stay 4) Continue expansion of ACT teams 5) Monthly Outpatient Provider wait time monitoring 6) Pay for Performance for Inpatient and TCM providers/level of care. 7) Safe haven program – Housing first MH/D&A treatment engagement program 8) Journey of Hope: The Department of Behavioral Health / Intellectual Disability Services (DBHIDS)- Office of Addiction Services (OAS) in collaboration with the Office of Supportive Housing (OSH) have coordinated efforts to transform six identified inner city substance abuse residential treatment programs into programs that are equipped to more effectively serve chronically homeless individuals.
		Future Actions Planned (Specify Dates) 1) Continue to improve AAO meeting process/procedures (ongoing) 2) continue to monitor high utilizers, including cohort analysis (spring 2013) 3) Continue ongoing analysis and monitoring of EAC pilot program (Spring 2013) 4) Initiate notification system for TCM case managers/I.P provider for when member with TCM has inpatient visit. (10/1/2012)
CBH 3	CBH's rate for the MY 2010 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI A was statistically significantly lower than the QI A HealthChoices BH MCO Average by 6.3 percentage points. CBH's MY 2010 QI B rate was also statistically significantly below the QI B HealthChoices BH MCO Average by 7.5 percentage points.	Follow Up Actions Taken Through 09/30/12 **(See above HEDIS actions)**
		Future Actions Planned **(Specify Dates)** **(See above HEDIS actions)**

Reference Number	Opportunity for Improvement	MCO Response
Performance Measures		
CBH 4	CBH'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%.CBH's MY 2010 readmission rate was statistically significantly higher (poorer) than the HealthChoices BH MCO Average by 0.7 percentage points.	Follow Up Actions Taken Through 09/30/12 1) Pay for Performance, OTIP, Practice Guidelines: We have targeted the culture of "inpatient first/inpatient only" system wide via the inpatient provider profile and pay for performance program, along with the TCM provider profile and pay for performance program, which both foster better communication across providers, recovery/prevention based practices, and reduction of inpatient stays, as well as via the DBHIdS Practice Guidelines, which was rolled out along with the Outpatient Transformation Incentive Program, which provided financial incentive to outpatient providers in exchange for their taking on quality improvement projects reflecting the goals of the practice guidelines. The guidelines focus on the patient's perspective on their journey to recovery and stresses clinical and non-clinical (community) supports and treatments. 2) Journey of Hope: The Department of Behavioral Health / Intellectual Disability Services (DBHIDS)- Office of Addiction Services (OAS) in collaboration with the Office of Supportive Housing (OSH) have coordinated efforts to transform six identified inner city substance abuse residential treatment programs into programs that are equipped to more effectively serve chronically homeless individuals. 3) Safe haven program – Housing first MH/D&A treatment engagement program
		Future Actions Planned (Specify Dates) 1) Initiate notification system for TCM case managers/I.P provider for when member with TCM has inpatient visit. (10/1/2012) 2) Incentivize reduction of outpatient provider wait times with 2012 Outpatient Provider Pay for Performance and Provider Profile.

Corrective Action Plan

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

The following Corrective Action Plan was implemented during the calendar year 2011 to address those deficiencies noted by OMHSAS:

Table 4.2 Corrective Action Plan for CBH

Completed: 10/4/12

Recommendation					
Major Action Steps	**Lead Staff Responsible**	**Start Date**	**Planned Completion Date**	**Documented Evidence of Completion**	**Field Office Staff Comments**
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. Recommendation #1: The explanation in the denial letters should include clinical judgment related to the member's current					

Recommendation					
Major Action Steps	**Lead Staff Responsible**	**Start Date**	**Planned Completion Date**	**Documented Evidence of Completion**	**Field Office Staff Comments**
symptoms and behaviors. The explanation should paint a clear picture for the member to understand why he/she is not getting what was requested; If a different service than the one requested is approved, the explanation should explain why the approved service is more appropriate; When the amount of BHRS is decreased, the explanation should identify improvements that will be expected given that services are being decreased. Recommendation #2: The effective date should be correct in 100% of the denial letters reviewed.					
1. All denial notifications will be reviewed by a Clinical Management Supervisor to ensure: a) The clinical explanation is individualized. b) The clinical explanation addresses expected improvements if services have been decreased (particularly for BHRS). c) There is documentation of the clinical judgment related to the member's symptoms and behaviors. d) The effective date is correct.	1. Director of Clinical Management; Clinical Management Clinical Coordinators	07/13/2011	08/31/2012	1. Care Managers send denial notifications to Supervisors via email for review and editing; revised denial notifications are forwarded to administrative staff for formatting and mailing. The Dashboard Denial Letter Template (in production) will require a supervisor's initials after review before which prompts administrative staff to format and generate the denial letter.	
2. A Denial Letter Training will be offered bi-annually. The training will reinforce required timeframes for mailing denial letters, effective dates, clinical justifications, and approving alternative services.	2. Clinical Management Coordinators and Quality Review representative			2. Denial Letter Training PowerPoint (maintained on Clinical Intranet Page); Denial Letter Training sign-in sheets.	
3. Care Management supervisors will a conduct quarterly audit of denial letters. The audit tool will measure the inclusion	3. Director of Clinical Management; Clinical Management Clinical			3. Quarterly audit results forwarded to Director of Clinical Management for review of trends. Audit results will determine what, if any, areas require	

Recommendation					
Major Action Steps	**Lead Staff Responsible**	**Start Date**	**Planned Completion Date**	**Documented Evidence of Completion**	**Field Office Staff Comments**
of medical necessity criteria in the denial decision, the sufficiency of the clinical rationale, compliance with required timeframes and effective dates. In cases where services are decreased, the audit tool will measure that the notification identifies expected improvements in symptoms and behaviors as a result of the decrease in services.	Coordinators			additional training and supervision.	
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. Recommendation #1: Al of the member's complaint issues must be thoroughly investigated at the 1st Level review by the BH-MCO to insure that an informed decision is being made regarding the validity of the complaint. Documentation needs to be obtained from a provider (i.e. medical records, incident reports, policies, etc.) to support their verbal or written response to a complaint. Steps taken by CBH to further investigate a provider's response to a complaint need to be documented in the case file. If a complaint involves a clinical issue, then a clinician needs to be part of the 1st Level committee. The results of the review need to be included in the case file and the decision letter. The complaint case file needs to include documentation of whether or not a member's complaint is substantiated and if any follow-up will occur. Recommendation #2: The respective County should review 1st level complaints from initiation to resolution to determine their satisfaction with the handling of the complaint.					
A letter was sent to providers on 9/15/11 to notify them that documentation is now required to be submitted in conjunction with first level complaints.	Kathleen Painter, Manager of Quality Review	09/15/2011	9/15/11	The template of the notification sent to providers is attached.	CBH submitted a copy of the letter sent to providers on 9/15/11 to OMHSAS Southeast Field Office Staff and QM Staff.

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

CBH submitted a Root Cause Analysis and Action Plan in February 2012. Following discussions with IPRO for related EQR activities, a final follow up call was conducted between IPRO and CBH in December 2012.

* CBH did not include a goal statement within the root cause analysis this year. Within the Performance Improvement Project submission and in subsequent discussion, CBH indicated of a goal of increasing each of the Follow Up After Hospitalization for Mental Illness indicators by five percentage points. CBH was advised to develop goal statements for all applicable measures in the future.

Table 4.3 Root Cause Analysis for CBH – 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	
Policies (e.g., data systems, delivery systems, provider facilities)	***Initial Response***
	*Note: Please find attached at the end of this document, a power point document showing the causal diagram of our Root Cause Analysis. 1.0 Root Cause: Need for better discharge planning Patient may not be reminded by CBH Member Services to seek follow up care due to CBH Member Services not being aware of the need for follow up, due to the reportable field in the CBH information system to record follow up not being used, due to the policy for its use being unclear, 1.1: due to a lack of training due the use of the discharge screen not being actively monitored and 1.2: due to a delay in reporting of discharge information to CBH clinical by the AIP provider, due to a lack of repercussions for delays, due to a lack of a process for actively monitoring submission of discharge paperwork. 10.0 Root Cause: Contact Information is a Dead End CBH Member Services is unable to remind members to seek follow up care when the member's contact information is a dead end. Patient contact information can be a dead end for several reasons.10.1:Their contact phone was shut off, due to the patient's low income (or other reasons) or 10.2: the information given by the patient was false or wrong because the patient's home is transient, due to a lack of available space in homeless shelters, due to a lack of Housing First programs.
	Follow-up Status Response

Procedures (e.g., payment/reimbursement, credentialing/collaboration)	***Initial Response***
	2. Root Cause: Inappropriate admission to inpatient psychiatric care for substance abuse clients Inappropriate treatment results in inappropriate follow-up care (i.e., mental health outpatient when the primary problem may be substance abuse) and leaves substance abuse issues unaddressed. 2.1 Rehab facilities in the CBH provider network frequently do not accept clients for admission on a 24/7 basis, making transfer from Crisis Response Centers difficult. 2.2 Patients are admitted to AIP rather than to rehab because they need to be "clean" for rehab admission. 2.3 Patients are admitted to AIP rather than to rehab because of provider-physician preference to admit to AIP prior to D & A treatment, due to the "clinical culture" amongst physician providers, due to three main causes: 2.3.1: AIP admissions are easier to get than a D&A admission 2.3.2: The D&A admissions process is not accessible 24/7 (as mentioned in Root Cause 2.1) 2.3.3: D&A providers are selective of who they admit. 2.4 Patients are admitted to AIP rather than to rehab because of agency provider preference to admit to AIP, due to financial pressures to keep AIP beds full (supply and demand). 2.5 Patients are admitted to AIP rather than to rehab due to reportable fields in the CBH information systems to record drug screen results not being utilized, due to the CBH policy on its use not being clear to CBH Clinical Services personnel, due to a lack of training on the policies/use of the Drug Screen in the information system. 2.6 Patients are admitted to AIP rather than to rehab because the patient has a preference for AIP admission, due either: 2.6.1 to wanting to avoid detox, while still receiving medical assistance 2.6.2 due to the patient wanting immediate shelter, due to their being out of money or they are seeking sanctuary from their environment due to an unsafe environment due to a lack of "Housing First" options, or 2.6.3 due to the patient preference and/or conditioning to use inpatient psychiatric as their primary symptom relief.
	Follow-up Status Response
	See monitoring plan update below.

People (e.g., personnel, provider network, patients)	***Initial Response***
	3. Root Cause: Lack of perceived need Timely and successful follow-up requires members to be actively engaged in the linkage process in order to complete the transition to outpatient care. 3.1 If a member perceived that his/her inpatient stay was an isolated incident or otherwise feels that outpatient care is not necessary, it is unlikely that follow-up care will occur or continue. Nearly 60% of discharges between January 1, 2006 and June 30, 2009 had three or fewer acute inpatient episodes in that time period; members whose daily lives are relatively stable simply may not see the need for additional services. Data analysis showed this subgroup to have the lowest level of follow-up. 3.2 Clients whose inpatient stays resulted from involuntary commitment (302s) may be particularly resistant to follow-up care and may require psycho-education and additional engagement strategies. Our regression models showed that these involuntarily committed clients did have fewer inpatient days when connected to D&A treatment (suggesting a high incidence of involvement with substance use/abuse for many of these clients). A barrier to psycho-education during inpatient stays for involuntarily committed clients is that they can be released by the courts prior to psycho education taking place. 3.3 One reason for a lack of perceived need of follow up care is that D&A issues were not addressed while in AIP, which is due to either: 1) inappropriate admission to AIP rather than Rehab/Detox (discussed extensively above under root cause #2) or 2) the patient's D&A issues were not the focus of the AIP admission, due to the policy for addressing D&A issues not being followed due to a lack of focus of AIP clinical culture on D&A treatment or because D&A issues were not identified as a presenting problem due to the AIP admission being authorized in the absence of reported drug screen results. 3.4 Patients may lack perceived need for follow up care after an AIP admissions due to the O.P. provider not being aware of a need for follow up because the O.P. provider was not faxed the discharge papers by the AIP, for unknown reasons. 3.5 Patients may lack perceived need for follow up care due to other social crisis taking precedent over outpatient follow up treatment, such as a death or illness in the family. **4. Root Cause: Outpatient wait times** It is a standard for routine appointments to occur within 7 days, per our PEPs standards. Outpatient providers overall had an average wait-time of approximately 7 days, but high volume outpatient providers (i.e., greater than 50 referrals in 2009) average was in excess of 7 days. This information is based on data collected from the CBH Member Services database and where the days from the time the appointment was scheduled to the client's appointment were calculated.
	Follow-up Status Response
Provisions	***Initial Response***

(e.g., screening tools, medical record forms, provider and enrollee educational materials)	**5. Root Cause: Inappropriate clinical assessment of clients for substance abuse** When presenting clients who screen positive for drugs, a qualitative review revealed that substance abuse issues are often overlooked when they are admitted to inpatient psychiatric care. Reports from Appeals Coordinator and discussions with CBH physicians indicated a historical lack of assessment and treatment planning for substance abuse issues, which may be due to a lack of referrals to D&A case management, due to the long waitlist for a D&A case manager.
	Follow-up Status Response
	See monitoring plan update below.
Other	***Initial Response***
	6. Root Cause: Rehab not considered follow up under HEDIS Clients who follow up (not discharged to, but who follow up) with Rehab after an AIP admission, which is not considered follow up under HEDIS criteria.
	Follow-up Status Response

Action and Monitoring Plan		
Action Plan	**Implementation Date**	**Monitoring Plan**
		Initial Response
1.1.1 & 1.1.2 Implement quarterly discharge screen monitoring report for CM supervisors to inform on the use of discharge screens, or possible delays in reporting of discharge paperwork by the inpatient provider.	Quarterly	1.1.1, 1.1.2 Care Management supervisors will be given quarterly reports highlighting the percent of care managers reports that have incomplete discharge information, by care manager, for supervisory as well as quality improvement purposes. Any lags in reporting from the inpatient provider will be noted and brought to the attention of care management executive staff.
4.0 Monthly Outpatient Provider wait time monitoring	Monthly	4.0 Monthly monitoring by provider operations staff of the wait times till intake, first therapist appointment, first psychiatrist appointment, for the majority of outpatient providers (~95% of members served by) with feedback to care management to help disposition members to providers with available appointments. In the future, we hope to make this available as a real time, online resource for inpatient and outpatient providers within our network.
3.1, 3.3, 3.3.2, 3.4: 2011 Pay For Performance for Inpatient and TCM levels of care: Implemented metrics within Inpatient and TCM	Yearly	3.1,3.3, 3.3.2, 3.4 Monitoring of follow-up oriented behaviors via pay-for-performance metrics. 10.0 CBH does not monitor use of free cell phones, or use of contact information

levels of care to monitor/promote Inpatient providers connecting with other care providers during a members inpatient hospitalization, to encourage psycho-education and engagement around Drug and Alcohol treatment issues, as well as a metric to measure submission of discharge paperwork from inpatient provider, and notification of TCM care manager when appropriate. Inpatient and TCM providers are being held accountable for 7 day follow up with TCM provider after inpatient hospitalization. 10.0 Contact information: CBH will continue to promote "free cell phone" programs available to its members, as well as promote an alternative, secondary form of contact, such as a family member or friend, for when member is unable to be contacted. 2.4 Financial pressure to keep beds full: In 2010 DBH announced system wide initiatives to address clinical and financial concerns regarding over-utilization of inpatient psychiatric treatment.	N/A	2.4 Monitor inpatient psychiatric utilization ***Follow-up Status Response***
2.1, 2.2, 2.4.1, 2.4.2, 2.4.3, 2.7, 2.7.1, 2.7.2, 10.0.2: Safe Haven Program: A housing first program for mental health/drug and alcohol patients who refuse rehab, with housing diversion and treatment engagement activities, as an alternative to inpatient hospitalization and/or drug and alcohol rehabilitation 10.0.2: Access to Recovery Grant: is a SAMHSA funded grant initiative, providing adults with alcohol and other drug challenges an array of options and choices to obtain enhanced recovery support service through a voucher program in Philadelphia County. Since many CBH members often need recovery supports (such as emergency housing, vocational training, parent education and many more) in addition to clinical treatment, the ability to link with ATR will provide an opportunity to greatly enhance and sustain individuals' recovery journey.	In progress	***Initial Response*** Measure monthly participation in Safe Haven program, and compare to reductions in inpatient stays with D&A co-morbidities CBH does not monitor the Access to Recovery Grant. ***Follow-up Status Response***
2.1, 2.2, 2.4.1, 2.4.2, 2.4.3, 2.7, 2.7.1, 2.7.2: Journey of Hope: The Department of Behavioral Health / Intellectual Disability Services (DBHIDS)-Office of Addiction Services (OAS) in collaboration with the Office of Supportive Housing (OSH) have		***Initial Response*** Measure monthly participation in Journey of Hope program, and compare to reductions in inpatient stays with D&A co-morbidities ***Follow-up Status Response***

coordinated efforts to transform six identified inner city substance abuse residential treatment programs into programs that are equipped to more effectively serve chronically homeless individuals.		
2.5 Implement quarterly Drug Screen monitoring, with feedback reports to care management supervisors and executive staff	Quarterly	***Initial Response*** Care Management supervisors will be given quarterly reports highlighting the percent of care managers' reports that have incomplete/missing Drug Screen information, by care manager, for supervisory as well as quality improvement purposes ***Follow-up Status Response***

Table 4.4 Root Cause Analysis for CBH – Follow-up After Hospitalization for Mental Illness PA-Specific 30 Day Quality Indicator B

Performance Measure	
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	
Goal Statement	
Policies (e.g., data systems, delivery systems, provider facilities) Please see response for QI A (PA-Specific 7 Day)	***Initial Response*** Please see response for QI A (PA-Specific 7 Day) ***Follow-up Status Response***
Procedures (e.g., payment/reimbursement, credentialing/collaboration) Please see response for QI A (PA-Specific 7 Day)	***Initial Response*** Please see response for QI A (PA-Specific 7 Day) ***Follow-up Status Response***
People (e.g., personnel, provider network, patients) Please see response for QI A (PA-Specific 7 Day)	***Initial Response*** Please see response for QI A (PA-Specific 7 Day) ***Follow-up Status Response***
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) Please see response for QI A (PA-Specific 7 Day)	***Initial Response*** Please see response for QI A (PA-Specific 7 Day) ***Follow-up Status Response***
Other Please see response for QI A (PA-Specific 7 Day)	***Initial Response*** Please see response for QI A (PA-Specific 7 Day) ***Follow-up Status Response***

Action and Monitoring Plan		
Action Plan	**Implementation Date**	**Monitoring Plan**
Please see response for QI A (PA-Specific 7 Day)		***Initial Response*** Please see response for QI A (PA-Specific 7 Day) ***Follow-up Status Response*** None
Please see response for QI A (PA-Specific 7 Day)		***Initial Response*** Please see response for QI A (PA-Specific 7 Day) ***Follow-up Status Response*** None
Please see response for QI A (PA-Specific 7 Day)		***Initial Response*** Please see response for QI A (PA-Specific 7 Day) ***Follow-up Status Response*** None
Please see response for QI A (PA-Specific 7 Day)		***Initial Response*** Please see response for QI A (PA-Specific 7 Day) ***Follow-up Status Response*** None

Table 4.5 Root Cause Analysis for CBH – Readmission within 30 Days of Inpatient Psychiatric Discharge

Performance Measure	
Readmission within 30 Days of Inpatient Psychiatric Discharge	
Goal Statement	
Policies (e.g., data systems, delivery systems, provider facilities)	***Initial Response*** 1.1 Patients may readmit due to a lack of addressing their underlying problems during their initial inpatient episode due to: their drug and alcohol problems not being clinically addressed during their inpatient psychiatric treatment episode, 1.1.1 due to their drug/alcohol problems not being the focus of their inpatient psychiatric treatment episode or 1.1.2 due to the patient having been inappropriately admitted to inpatient psychiatric treatment, rather than Drug and Alcohol Rehabilitation/Detoxification treatment due to either: 1.1.2.1 the barriers associated with traditional rehabilitation programs (lack of 24/7 intake procedures, the need to be clean/stay clean during treatment) or 1.1.2.2 the member not wanting to go to rehab (not ready for treatment, not wanting to have to sober up, patient prioritizes shelter, etc.) 1.2 Patients may readmit due to a lack of addressing their underlying problems during their initial inpatient episode due to: a lack of collaboration by the inpatient provider with the patient's family/supports (or lack of) in the community, and their other treatment providers, due to a lack of clinical culture valuing "social work" aspects of modern patient/recovery focused inpatient psychiatric treatment. 1.3 Patients may readmit due to a lack of addressing their underlying problems during their initial inpatient episode due to: a lack of collaboration between the inpatient psychiatric treatment provider and CBH Clinical Management in addressing the patients treatment history with regards to their inpatient psychiatric treatment episode ***Follow-up Status Response***
Procedures (e.g., payment/reimbursement, credentialing/collaboration)	***Initial Response*** **See 1.3** ***Follow-up Status Response***

People (e.g., personnel, provider network, patients)	***Initial Response*** 2.1 Patient may readmit due to a lack of follow up care, due to a lack of outpatient service provider availability within their desired treatment. 2.2 Patient may readmit due to a lack of follow up care, due to a lack of referrals to drug and alcohol case management due to the long wait list for a D&A case manager. 2.3 Patient may readmit due to a lack of follow up care, due to a lack of perceived need for follow up care, due to the outpatient provider not being aware of the need for follow up, 2.3.1 due to the outpatient provider not being informed by the inpatient provider of admission/discharge or 2.3.2 due to CBH members services not being aware of need to seek follow up care due to member contact information being out of date or inaccurate, due to the member's homelessness or other socioeconomic issues, or 2.3.3 due to the patient being involuntarily committed they do not desire/understand their need for follow up, due to a lack of effective patient education during their inpatient stay, or 2.3.4 due to other social crisis taking precedent in their lives (e.g. death in the family). 3.0 Patient may readmit due to their preference/conditioning from their treatment experience to use inpatient psychiatric treatment as their primary means of symptom (stress) relief.
	Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)	***Initial Response***
	See 2.1
	Follow-up Status Response
Other	***Initial Response***
	See 1.2, 1.3
	Follow-up Status Response

Action and Monitoring Plan		
Action Plan	**Implementation Date**	**Monitoring Plan**
1.2, 2.3.1, 2.3.3 3.0 P4P-IP TCM, OTIP, Practice guidelines 3.0 We have targeted the culture of "inpatient first/inpatient only" system wide via the inpatient provider profile and pay for performance program, along with the TCM provider profile and pay for performance program, which both foster better communication across providers, recovery/prevention based practices, and reduction of inpatient stays, as well as via, and the DBHIdS Practice Guidelines, which was rolled out along with the Outpatient Transformation Incentive Program, which provided financial incentive to outpatient providers in exchange for their taking on quality improvement projects reflecting the goals of the practice guidelines. The guidelines focus on the patient's perspective on their journey to recovery and stresses clinical and non-clinical (community) supports and treatments.	One Time	***Initial Response*** *OTIP projects demonstrating a change of culture, reduced inpatient utilization* ***Follow-up Status Response***
2.1 OP waitlist tracking		***Initial Response***

1.3 Provider Information Portal We have implemented monthly outpatient wait time monitoring, and plan to create a web based information portal for Inpatient providers to have better information for triaging their patients to an outpatient providers with availability. CBH CQI and Clinical Management plan to collaborate and create a provider information/collaboration portal, which would allow providers with secure access to treatment histories, and other pertinent information that CBH has access to via our clinical database, in order to assist them in caring for high risk/high utilizing members, or they can use the CARES database which pulls in data from all city services into one database that can be accessed even in the field by case managers	Monthly/Continuous	*Monthly monitoring by provider operations staff of the wait times till intake, first therapist appointment, first psychiatrist appointment, for the majority of outpatient providers (~95% of members served,) with feedback to care management to help disposition members to providers with available appointments. In the future, we hope to make this available as a real time, online resource for inpatient and outpatient providers within our network. We would monitor the use of the portal by providers.* ***Follow-up Status Response***
1.1.2.1, 1.1.2.2, 2.3.2, Safe Haven: A housing first program for mental health/drug and alcohol patients who refuse rehab, with housing diversion and treatment engagement activities, as an alternative to inpatient hospitalization and/or drug and alcohol rehabilitation		***Initial Response*** *3.1,3.3, 3.3.2, 3.4 Monitoring of follow-up oriented behaviors via pay-for-performance metrics.* ***Follow-up Status Response***
1.1.2.1, 1.1.2.2, Journey of Hope: The Department of Behavioral Health / Intellectual Disability Services (DBHIDS)- Office of Addiction Services (OAS) in collaboration with the Office of Supportive Housing (OSH) have coordinated efforts to transform six identified inner city substance abuse residential treatment programs into programs that are equipped to more effectively serve chronically homeless individuals.		***Initial Response*** *Measure monthly participation in Journey of Hope program, and compare to reductions in inpatient stays with D&A co-morbidities* ***Follow-up Status Response***

Attachments submitted by CBH:

7_30 Day Follow-Up Barriers Flowchart_2(30 Day Recidivism Flowchart_2011 2010_Financial_Presentation

V: 2012 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of CBH'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

- CBH submitted one PIP for validation in 2012 and received full credit for the elements of the study evaluated that reflect activities in 2011 (Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement).
- CBH had the largest improvement (decrease) among the five BH MCOs for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge measure.
- CBH/Philadelphia's rate for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure of 11.7% was statistically significantly lower (better) than the HealthChoices BH MCO Average of 12.3% by 0.6 percentage points.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2009, RY 2010, and RY 2011 found CBH to be partially compliant with all Subparts associated with Structure and Operations Standards.
    - CBH was partially compliant on one of seven categories within Subpart C: Enrollee Rights and Protections Regulations. The partially compliant category was Enrollee Rights.
    - CBH 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.
    - CBH 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.

- CBH's rate for the MY 2011 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI 1 was statistically significantly lower than the QI 1 HealthChoices BH MCO Average by 6.7 percentage points. CBH's QI 2 rate was also statistically significantly below the QI 2 HealthChoices BH MCO Average by 11.3 percentage points.

  CBH's rate for the MY 2011 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI A was statistically significantly lower than the QI A HealthChoices BH MCO Average by 6.2 percentage points. CBH's QI B rate was also statistically significantly below the QI B HealthChoices BH MCO Average by 7.5 percentage points.

- CBH'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%. For MY 2011, the rate for Philadelphia (11.7%) was statistically significantly higher (poorer) than the HealthChoices County Average of 9.9% by 1.8 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 - No CBH performance measure rate fell into this comparison category.**

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

Measure that had no statistically significant change from MY 2010 to MY 2011 but was statistically significantly above/better than the MY 2011 HealthChoices BH MCO Average is:

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

- **C - No CBH performance measure rate fell into this comparison category.**

- **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:

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 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)

- **F - No CBH 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 – CBH

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

Key to the Performance Measure Matrix Comparison

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

Performance measure rates for MY 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 – CBH

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)	34.7%	38.8% ▲	39.1% =	45.78%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	51.1%	55.6% ▲	55.5% =	66.81%
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	52.9%	51.2% ▼	51.4% =	57.63%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	68.0%	66.6% =	67.2% =	74.67%
Readmission within 30 Days of Inpatient Psychiatric Discharge[2]	12.9%	13.1% =	11.7% =	12.34%

[2] 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

- CBH 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

- CBH submitted one PIP for validation in 2012 and received full credit for the elements of the study evaluated that reflect activities in 2011 (Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement).

Performance Measures

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

2011 Opportunities for Improvement MCO Response

- CBH 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 CBH 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 Items to Pertinent BBA Regulations

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

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

BBA Category	PEPS Reference	PEPS Language
§438.2104 Provider Selection	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as, other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.240 Quality assessment and performance improvement program	Standard 91.1	QM program description outlines the ongoing quality assessment and performance improvement activities, Continuous Quality Improvement process and places emphasis on, but not limited to High volume/high-risk services and treatment and Behavioral Health Rehabilitation services.
	Standard 91.2	QM work plan includes goal, aspect of care/ service, scope of activity, frequency, data source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines, the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services, provider network adequacy, penetration rates, appropriateness of service authorizations, inter-rater reliability, complaint, grievance and appeal process, denial rates, grievance upheld and overturn rates and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.

BBA Category	PEPS Reference	PEPS Language
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other HV/HR services).
	Standard 91.8	The QM work plan includes monitoring activities conducted to evaluate the quality and performance of the provider network (quality of individualized service plans and treatment planning, adverse incidents, collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance).
	Standard 91.9	The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	The QM work plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator for : ---Mental Health ---Substance Abuse External Quality Review: ---Follow up After Mental Health Hospitalization QM Annual Summary Report
	Standard 91.11	The identified Performance Improvement Projects must include the following: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality. 3. Evaluation of the effectiveness of the interventions. 4. Planning and initiation of activities for increasing or sustaining improvement. 5. Timeline for reporting status and results of each project to DPW. 6. Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year.
	Standard 91.12	The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.
	Standard 91.13	The BH-MCO has a process for its own evaluation of the impact and effectiveness of its quality management program annually. A report of this evaluation will be submitted to DPW by April 15th.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for Coordination with Other Service Agencies and School.

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

BBA Category	PEPS Reference	PEPS Language
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.

BBA Category	PEPS Reference	PEPS Language
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§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.

BBA Category	PEPS Reference	PEPS Language
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.408 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

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

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

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

Appendix C: Program Evaluation Performance Summary OMHSAS-Specific Substandards for CBH and Philadelphia County

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2011, 11 substandards were considered OMHSAS-specific monitoring standards. Of the 11 OMHSAS-specific PEPS Substandards, nine were evaluated for CBH/Philadelphia County and 2 Substandards were not scheduled or not applicable for evaluation for RY 2011. Table C.1 provides a count of these Items, along with the relevant categories.

Table C.1 OMHSAS-Specific Substandards Reviewed for CBH

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

Format

This document groups the monitoring standards under the subject headings Second Level Complaints and Grievances, and Enrollee Satisfaction. The status of each Substandard is presented as it appears in the PEPS tools submitted by the Commonwealth (i.e., met, partially met, or not met). 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. CBH was evaluated on six of the eight applicable substandards. Of the six substandards evaluated, CBH met two substandards, and partially met four substandards, as seen in Table C.2.

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

Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
Complaints	Standard 68.6	RY 2010	Met
	Standard 68.7	RY 2010	Partially Met
	Standard 68.8	RY 2010	Partially Met
	Standard 68.9	RY 2010	Not Evaluated
Grievances and State Fair Hearings	Standard 71.5	RY 2010	Partially Met
	Standard 71.6	RY 2010	Met
	Standard 71.7	RY 2010	Partially Met
	Standard 71.8	RY 2010	Not Evaluated

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.

CBH was partially met on Substandards 68.7 and 68.8 (RY 2010):

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

Substandard 68.8: A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

PEPS Standard 71: Grievance and Fair Hearing rights and procedures are made known to EAP, members, BH MCO Staff and the provider network through manuals, training, handbooks, etc.

CBH was partially met on Substandards 71.5 and 71.7(RY 2010):

Substandard 71.5: The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.

Substandard 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.

The OMHSAS-specific PEPS Substandards relating to Consumer/Family Satisfaction are County-specific review standards. Of these substandards, three were evaluated for Philadelphia County. Philadelphia County met all three substandards, as seen in Table C.3.

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

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

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