



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

**2012 External Quality Review Report
Community Care Behavioral Health
FINAL REPORT**

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GLOSSARY OF TERMS

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| 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 Care Behavioral Health's (CCBH'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.

Adams, Allegheny, Berks, Chester and York Counties hold contracts with CCBH, and Lackawanna, Luzerne, Susquehanna, Wyoming hold a contract with Northeast Behavioral Health Care Consortium (NBHCC), that in turn holds a contract with CCBH. The North/Central County Option (NC/CO) Counties – Carbon, Monroe, and Pike also hold a contract with CCBH. For the North/Central State Option (NC/SO) Counties – Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne – OMHSAS contracted directly with CCBH to administer services in these Counties. 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. Erie County held a contract with another MCO through June 30, 2011 and contracted with CCBH beginning July 1, 2011. IPRO's EQR is based on OMHSAS reviews of CCBH and the 35 Counties associated with the BH MCO.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CCBH 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 CCBH, 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. Tables 1.1a through 1.1d provide a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of CCBH against the Structure and Operations Standards for this report. In Appendix C, Tables C.1a and C.1b provide a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH MCO and associated Counties against other state-specific Structure and Operations Standards.

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

Table 1.1a Items Pertinent to BBA Regulations Reviewed for Adams, Allegheny, Chester, and York Counties

| 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 | 0 | 3 | 0 |
| Provider-Enrollee Communications | 0 | 0 | 0 | 0 | 0 |
| Marketing Activities | 0 | 0 | 0 | 0 | 0 |
| Liability for Payment | 0 | 0 | 0 | 0 | 0 |
| Cost Sharing | 0 | 0 | 0 | 0 | 0 |
| Emergency and Post-Stabilization Services | 0 | 0 | 0 | 0 | 0 |
| Solvency Standards | 0 | 0 | 0 | 0 | 0 |
| Subpart D: Quality Assessment and Performance Improvement | | | | | |
| Elements of State Quality Strategies | 0 | 0 | 0 | 0 | 0 |
| Availability of Services | 22 | 4 | 18 | 0 | 0 |
| Coordination and Continuity of Care | 2 | 0 | 2 | 0 | 0 |
| Coverage and Authorization of Services | 4 | 1 | 2 | 0 | 1 |
| Provider Selection | 3 | 0 | 3 | 0 | 0 |
| Confidentiality | 0 | 0 | 0 | 0 | 0 |
| Subcontractual Relationships and Delegations | 8 | 8 | 0 | 0 | 0 |
| Practice Guidelines | 6 | 4 | 2 | 0 | 0 |
| Quality Assessment and Performance Improvement Program | 23 | 23 | 0 | 0 | 0 |
| Health Information Systems | 1 | 1 | 0 | 0 | 0 |
| Subpart F: Federal & State Grievance Systems Standards | | | | | |
| Statutory Basis and Definitions | 11 | 1 | 0 | 9 | 1 |
| General Requirements | 14 | 1 | 0 | 12 | 1 |
| Notice of Action | 11 | 1 | 9 | 0 | 1 |
| Handling of Grievances and Appeals | 11 | 1 | 0 | 9 | 1 |
| Resolution and Notification: Grievances and Appeals | 11 | 1 | 0 | 9 | 1 |
| Expedited Appeals Process | 6 | 1 | 0 | 4 | 1 |
| Information to Providers and Subcontractors | 2 | 0 | 0 | 2 | 0 |
| Recordkeeping and Recording Requirements | 0 | 0 | 0 | 0 | 0 |
| Continuation of Benefits Pending Appeal & State Fair Hearings | 6 | 1 | 0 | 4 | 1 |
| Effectuation of Reversed Resolutions | 6 | 1 | 0 | 4 | 1 |

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

Table 1.1b Items Pertinent to BBA Regulations Reviewed for Berks County

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

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

Table 1.1c Items Pertinent to BBA Regulations Reviewed for NBHCC (Lackawanna, Luzerne, Susquehanna, and Wyoming) and the NC/CO (Carbon, Monroe, and Pike) Counties

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

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

Table 1.1d Items Pertinent to BBA Regulations Reviewed for NC/SO Counties (Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne)

| BBA Regulation | Total # of Items | PEPS Reviewed in RY 2011 | PEPS Reviewed in RY 2010 | RAI Reviewed in RY 2009 | Not Reviewed* |
|---|------------------|--------------------------|--------------------------|-------------------------|---------------|
| Subpart C: Enrollee Rights and Protections | | | | | |
| Enrollee Rights | 12 | 2 | 7 | 3 | 0 |
| Provider-Enrollee Communications | 0 | 0 | 0 | 0 | 0 |
| Marketing Activities | 0 | 0 | 0 | 0 | 0 |
| Liability for Payment | 0 | 0 | 0 | 0 | 0 |
| Cost Sharing | 0 | 0 | 0 | 0 | 0 |
| Emergency and Post-Stabilization Services | 0 | 0 | 0 | 0 | 0 |
| Solvency Standards | 0 | 0 | 0 | 0 | 0 |
| Subpart D: Quality Assessment and Performance Improvement | | | | | |
| Elements of State Quality Strategies | 0 | 0 | 0 | 0 | 0 |
| Availability of Services | 22 | 4 | 18 | 0 | 0 |
| Coordination and Continuity of Care | 2 | 0 | 2 | 0 | 0 |
| Coverage and Authorization of Services | 4 | 1 | 2 | 0 | 1 |
| Provider Selection | 3 | 0 | 3 | 0 | 0 |
| Confidentiality | 0 | 0 | 0 | 0 | 0 |
| Subcontractual Relationships and Delegations | 8 | 8 | 0 | 0 | 0 |
| Practice Guidelines | 6 | 4 | 2 | 0 | 0 |
| Quality Assessment and Performance Improvement Program | 23 | 23 | 0 | 0 | 0 |
| Health Information Systems | 1 | 1 | 0 | 0 | 0 |
| Subpart F: Federal & State Grievance Systems Standards | | | | | |
| Statutory Basis and Definitions | 11 | 1 | 0 | 9 | 1 |
| General Requirements | 14 | 1 | 0 | 12 | 1 |
| Notice of Action | 11 | 1 | 9 | 0 | 1 |
| Handling of Grievances and Appeals | 11 | 1 | 0 | 9 | 1 |
| Resolution and Notification: Grievances and Appeals | 11 | 1 | 0 | 9 | 1 |
| Expedited Appeals Process | 6 | 1 | 0 | 4 | 1 |
| Information to Providers and Subcontractors | 2 | 0 | 0 | 2 | 0 |
| Recordkeeping and Recording Requirements | 0 | 0 | 0 | 0 | 0 |
| Continuation of Benefits Pending Appeal & State Fair Hearings | 6 | 1 | 0 | 4 | 1 |
| Effectuation of Reversed Resolutions | 6 | 1 | 0 | 4 | 1 |

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



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

In evaluations prior to the 2008 report, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all Counties and BH MCOs based only on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. Beginning with the 2008 report, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories by OMHSAS. Hence, Solvency Requirement tracking reports, Encounter Monthly Aggregate Complaint/Grievance records (EMG) and Encounter Monthly Complaint/Grievance Synopsis records (MCG) were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

Determination of Compliance

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

Format

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

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

Findings

For CCBH and the 35 Counties associated with the BH MCO included in the structure and operations standards for RY 2011, 159 PEPS Items were identified as required to fulfill BBA regulations. Adams, Allegheny, Chester, York, and NC/SO Counties were evaluated on 150 PEPS Items, with nine Items not scheduled or not applicable for evaluation for RY 2011. Berks, NBHCC, and the NC/CO Counties were evaluated on 149 Items during the review cycle, with 10 Items were not scheduled or not applicable for evaluation for RY 2011.

Subpart C: Enrollee Rights and Protections – Subparts C, D and F

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 | MCO Compliance Status | By County | | Comments |
| | | Fully Compliant | Partially Compliant | |
| Enrollee Rights 438.100 | Partial | Allegheny, Berks, NBHCC, NC/CO, NC/SO | Chester, Adams, York | 12 substandards were crosswalked to this category. Allegheny, Berks, NBHCC, NC/CO and NC/SO Counties were evaluated on 12 substandards and compliant on 12 substandards. Adams, Chester and York Counties were evaluated on 12 substandards, compliant on 11 substandards and partially compliant on 1 substandard. |
| Provider-Enrollee Communications 438.102 | Compliant | All CCBH Counties | | Compliant as per PS&R sections E.4 (p.49) and A.3.a (p.20). |
| Marketing Activities 438.104 | N/A | N/A | N/A | Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH MCOs based on their County of residence. |
| Liability for Payment 438.106 | Compliant | All CCBH Counties | | Compliant as per PS&R sections A.9 (p.64) and C.2 (p.30). |
| Cost Sharing 438.108 | Compliant | All CCBH Counties | | Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60. |
| Emergency and Post-Stabilization Services 438.114 | Compliant | All CCBH Counties | | Compliant as per PS&R section 3 (p.34). |
| Solvency Standards 438.116 | Compliant | All CCBH Counties | | Compliant as per PS&R sections A.3 (p.59) and A.9 (p.66), and 2011-2012 Solvency Requirements tracking report. |



There are seven categories in the Enrollee Rights and Protections Standards. CCBH 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 category Solvency Standards was compliant based on the 2011-2012 Solvency Requirement tracking report.

Allegheny, Berks, NBHCC, NC/CO and NC/SO Counties were compliant on six categories of the Enrollee Rights and Protections Standards. The remaining three Counties – Adams, Chester and York Counties – were compliant on five categories.

Of the 12 PEPS substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated for the CCBH Counties. Allegheny, Berks, NBHCC, NC/CO and NC/SO Counties were compliant on all 12 substandards. Adams, Chester and York Counties were compliant on 11 substandards, and partially compliant on one substandard. Some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Enrollee Rights

Adams, Chester and York Counties were partially compliant with Enrollee Rights due to partial compliance with substandards within PEPS Standard 108.

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

Adams, Chester and York Counties were partially compliant on one substandard of Standard 108: Substandard 10 (RY 2011).

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

Subpart D: Quality Assessment and Performance Improvement Regulations

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

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

Table 1.3 Compliance with Quality Assessment and Performance Improvement Regulations

| Quality Assessment and Performance Improvement Regulations | | | | |
|--|-----------------------|---|---------------------|---|
| Subpart D: Categories | MCO Compliance Status | By County | | Comments |
| | | Fully Compliant | Partially Compliant | |
| Elements of State Quality Strategies 438.204 | Compliant | All CCBH Counties | | Compliant as per PS&R section G.3 (p.53). |
| Availability of Services (Access to Care) 438.206 | Partial | Adams, Allegheny, Berks, Chester, NBHCC, NC /CO, York | NC/SO | <p>22 substandards were crosswalked to this category</p> <p>Adams, Allegheny, Chester and York Counties were evaluated on 22 substandards and compliant on 22 substandards.</p> <p>The Berks, NC/CO, NBHCC, Counties were evaluated on 21 substandards and compliant on 21 substandards.</p> <p>The NC/SO Counties were evaluated on 22 substandards, compliant on 21 substandards, and partially compliant on 1 substandard.</p> |
| Coordination and Continuity of Care 438.208 | Compliant | All CCBH Counties | | <p>2 substandards were crosswalked to this category</p> <p>Each County was 2 substandards and compliant on 2substandards.</p> |
| Coverage and Authorization of Services 438.210 | Compliant | All CCBH Counties | | <p>4 substandards were crosswalked to this category</p> <p>Each County was evaluated on 3 substandards and compliant on 3 substandards.</p> |
| Provider Selection 438.214 | Compliant | All CCBH Counties | | <p>3 substandards were crosswalked to this category.</p> <p>Each County was evaluated on 3 substandards and compliant on 3 substandards.</p> |
| Confidentiality 438.224 | Compliant | All CCBH Counties | | 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 | All CCBH Counties | | <p>8 substandards were crosswalked to this category.</p> <p>Each County was evaluated on 8 substandards and compliant on 8 substandards.</p> |
| Practice Guidelines 438.236 | Compliant | All CCBH Counties | | <p>6 substandards were crosswalked to this category.</p> <p>Each County was evaluated on evaluated on 6 substandards and compliant on 6 substandards.</p> |

| Quality Assessment and Performance Improvement Regulations | | | | |
|--|-----------------------|-------------------|---------------------|--|
| Subpart D: Categories | MCO Compliance Status | By County | | Comments |
| | | Fully Compliant | Partially Compliant | |
| Quality Assessment and Performance Improvement Program 438.240 | Compliant | All CCBH Counties | | 23 substandards were crosswalked to this category. Each County was evaluated on 23 substandards and compliant on 23 substandards. |
| Health Information Systems 438.242 | Compliant | All CCBH Counties | | 1 substandard was crosswalked to this category. Each County was evaluated on 1 substandard and compliant on this substandard. |

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

For this review, 69 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations for all 35 Counties associated with CCBH. Adams, Allegheny, Chester, and York Counties were evaluated on 68 substandards and compliant on 68 substandards. One substandard was not scheduled or not applicable for evaluation for RY 2011 for these Counties. The Berks, NBHCC, NC/CO Counties were evaluated on 67 substandards, and compliant on 67 substandards. Two substandards were not scheduled or not applicable for evaluation for RY 2011 for these Counties. The NC/SO Counties were evaluated on 68 substandards, compliant on 67 substandards and partially compliant on 1 substandard. One substandard was not scheduled or not applicable for evaluation for RY 2011 for these Counties. 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)

The NC/SO Counties were partially compliant with Availability of Services due to partial compliance with one substandard of PEPS Standard 1.

PEPS Standard 1: The Program must include a full array of in-plan services available to adults and children; provider contracts are in place.

The NC/SO Counties were partially compliant on one substandard of Standard 1: Substandard 2 (RY 2010).

Substandard 2: 100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met.

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 | MCO Compliance Status | By County | | Comments |
| | | Fully Compliant | Partially Compliant | |
| Statutory Basis and Definitions 438.400 | Partial | | All CCBH Counties | 11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 8 substandards, and partially compliant on 2 substandards. |
| General Requirements 438.402 | Partial | | All CCBH Counties | 14 substandards were crosswalked to this category Each County was evaluated on 13 substandards, compliant on 11 substandards, and partially compliant on 2 substandards. |
| Notice of Action 438.404 | Compliant | | All CCBH Counties | 11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, and compliant on 10 substandards. |
| Handling of Grievances and Appeals 438.406 | Partial | | All CCBH Counties | 11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 8 substandards, and partially compliant on 2 substandards. |
| Resolution and Notification: Grievances and Appeals 438.408 | Partial | | All CCBH Counties | 11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 8 substandards, and partially compliant on 2 substandards. |
| Expedited Appeals Process 438.410 | Compliant | All CCBH Counties | | 6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards and compliant on 5 substandards. |
| Information to Providers & Subcontractors 438.414 | Compliant | All CCBH Counties | | 2 substandards were crosswalked to this category. Each County was evaluated on 2 substandards and compliant on both. |
| Recordkeeping and Recording Requirements 438.416 | Compliant | All CCBH Counties | | 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 | Compliant | All CCBH Counties | | 6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards and compliant on 5 substandards. |
| Effectuation of Reversed Resolutions 438.424 | Compliant | All CCBH Counties | | 6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards and compliant on 5 substandards. |



There are 10 categories in the Federal and State Grievance System Standards. CCBH was compliant on five and partially compliant on five categories. The category Recordkeeping and Recording Requirements was compliant as per the 2011 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.

For this review, 78 substandards were crosswalked to Federal and State Grievance System Standards for all 35 Counties associated with CCBH. Each County was evaluated on 70 substandards, compliant on 62 substandards, and partially compliant on 8 substandards. Eighteen substandards were not scheduled or not applicable for evaluation for RY 2011. 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.

Each County was partially compliant with four of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with two substandards within PEPS Standard 68.

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.

All of the CCBH Counties were partially compliant on two substandards of Standard 68: Substandard 3 and 5 (RY 2009).

Substandard 3: Complaint decision letters must be written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).

Substandard 5: Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.

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. CCBH 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, CCBH received credit for Topic Selection by attending IPRO's Technical Assistance webinar held on October 5, 2009.

Follow-up After Hospitalization for Mental Illness

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

The rationale previously provided for this activity selection included information regarding the BH MCO's demographics, national research, and the BH MCO's root cause analysis. Referencing literature discussed in the IPRO MY 2008 Follow Up after Hospitalization for Mental Illness report, CCBH indicated that missed appointments are more frequent in those under age 25, and that racial disparities may exist for follow-up. CCBH provided corresponding demographic statistics for the BH MCO's membership, noting that 35% of the BH MCO's members are in the 5-19 age group, 17% are in the 20-34 age group, and 18% identify as African American. CCBH also noted that a total of 12% of the BH MCO's members in treatment have co-occurring mental health and substance abuse disorders. CCBH proposed that these populations, especially those with co-occurring disorders, are at risk for hospitalization and readmission.

CCBH also discussed its review of a number of research articles. CCBH began by stating that published research extensively documents the risk of poor treatment outcomes associated with inadequate treatment follow up after an inpatient mental health hospitalization, and that research indicates that individuals who do not have an outpatient appointment after discharge are two times more likely to be re-hospitalized in the same year than individuals who keep at least one outpatient appointment. Further, CCBH referenced research indicating that stabilization is sustained over time for individuals who keep an

outpatient appointment, and other studies that found a relationship between the length of time between discharge and the first appointment, noting that longer intervals are associated with a higher rate of missed appointments. CCBH cited additional research that found that the strongest predictor of keeping a follow-up appointment within seven and 30 days was receiving clinical treatment in the month before admission. Conversely, CCBH discussed a number of articles that outlined several factors associated with decreased adherence with follow-up appointments. CCBH observed that African American individuals, individuals discharged against medical advice, and individuals with co-occurring substance use disorders appear to be less likely to follow-up within seven and 30 days and therefore more likely to experience poor treatment outcomes. Other factors cited by the BH MCO as related to decreased adherence were: legal status at discharge, poor family support systems, not having an established outpatient clinician, persistent mental illness, having had no prior psychiatric hospitalizations, and having a longer length of stay.

Additionally, CCBH included a discussion of the MCO-conducted root cause analysis, which the BH MCO indicated was initiated to more fully understand the mechanisms influencing whether members kept their initial follow-up appointments after discharge from an inpatient stay and interventions that can address these issues. As a result of the analysis, CCBH observed that: 1) inpatient providers do not make discharge planning an integral part of the hospital stay, 2) inpatient providers are not always aware of the variety of treatment options available to members, 3) maintaining correct member information is difficult, and 4) it is difficult to balance the member's right to choose his/her own recovery plan as it may conflict with ambulatory follow up treatment. Following the analysis, CCBH developed action plans for addressing these issues.

Baseline results were calculated in 2009 for the period January 1, 2008 through December 31, 2008 and were presented along with analysis that would lead to interventions initiated in late 2009. The baseline results indicated a rate of 47.2% for QI 1 (HEDIS – seven days), 68.8% for QI 2 (HEDIS – 30 days), 60.3% for QI A (PA-Specific – seven days), and 76.6% for QI B (PA-Specific – 30 days). All rates fell below the MCO's goal of 90%. CCBH noted that the MCO's goal of 90% was adopted to match the benchmark established by OMHSAS for all BH MCOs. Following baseline, performance rates were analyzed at each individual County's Quality and Care Management Committees (QCMCs), as well as in aggregate at an internal workgroup composed of representatives from CCBH's Senior Management, Quality, and Clinical Departments, Consumer and Provider representatives. As per CCBH, barriers were derived from analysis at the individual QCMCs, the internal workgroup, company-wide outreach intervention efforts, as well as County Member Advisory Committees, Family Advisory Committees and Provider Advisory Committees. The BH MCO noted that performance rates are evaluated quarterly in order to more quickly identify trends and implement interventions in a timelier manner. As a result of these analyses, CCBH outlined numerous barriers at the BH MCO, member, and provider levels.

CCBH implemented numerous Interventions Aimed at Achieving Demonstrable Improvement, some of which had been previously implemented in 2008 and remained ongoing, and several that were implemented following baseline. CCBH implemented interventions to address barriers at the BH MCO, provider, and member levels. Some examples included: 1) medical record reviews of high volume inpatient providers to assess if providers educate members regarding follow-up, 2) collaboration with the Department of Human Services to communicate a child/adolescent member's shelter placement assignment within 24 hours to Care Management to ensure service coordination, 3) collaboration with the physical health (PH) MCO to coordinate care for those with physical and behavioral health diagnoses, 4) increased rates to outpatient service, certified peer specialists, and service coordination providers, 5) expansion of the BH MCO's mobile medication services in rural parts of the network to assist members in adhering to medication use, address barriers that may otherwise prevent medication adherence, and help members learn to self-manage their medications, 6) Annual Provider Benchmarking reports sent to all high volume providers with individualized ambulatory follow up data to inform providers about their follow up rates and compare them to provider network averages, which were enhanced to additionally target underperforming providers for meetings with BH MCO clinical staff, and 7) expansion of the Enhanced Clinical Case Management program, which blends Intensive Case Management and Mobile Outpatient services to better address the needs of members who have difficulty attending traditional post-discharge



care services, or who may require intensive in-home or community support to successfully engage aftercare services.

Remeasurement results calculated in 2011 for January 1, 2010 through December 31, 2010 were presented, with comparisons of MY 2010 rates against the baseline rates and against the goal. Rates increased for all four indicators, and Demonstrable Improvement was achieved. QI 1 increased to 51.3%, QI 2 increased to 73.2%, QIA increased to 62.5%, and QIB increased to 78.9%. All rates remained below the goal of 90%. The validated performance rates for MY 2010 were analyzed at each individual county's Quality and Care Management Committees (QCMC) as well as in aggregate at an internal workgroup. CCBH noted that barriers continue to be identified from analysis at the individual QCMCs, the internal workgroup, company-wide Outreach intervention efforts, as well as County Member Advisory Committees, Family Advisory Committees and Provider Advisory Committees. CCBH noted that the MCO also monitors a similar measure on a quarterly basis in order to more quickly identify trends and implement interventions in a timelier manner, and that many of the previously identified barriers continue to remain relevant. To address these issues, the MCO conducted a series of focus groups with staff at four inpatient facilities and members across the network regarding current and optimal discharge activities to improve timely follow-up. Several themes emerged across the focus groups about activities designed to improve follow-up care, including: 1) Engagement of members and their support networks in the discharge process, 2) Member treatment preferences, 3) Member treatment expectations, 4) Members' education about the mental health system, and 5) Staff knowledge regarding outpatient treatment options.

CCBH noted that the findings from the focus groups were used to inform improvements to the interventions. Some of the previous interventions remained ongoing. Additionally, the MCO included a number of new interventions and/or modifications to existing interventions. Some of these subsequent interventions included: 1) providers of Behavioral Health Rehabilitation Services ((BHRS) Brief Treatment were offered enhanced reimbursement for providing immediate access to services to approved children, including those discharged from inpatient units, 2) members with long inpatient stays were identified in order to focus on barriers to discharge and enhance discharge planning, 3) meetings were initiated with providers based on underperformance on Provider Benchmarking Ambulatory Follow-Up data, volume of members, and previous performance, 4) the MCO expanded mobile and site based Psych Rehab, peer specialists, telepsychiatry, and forensic case management services in rural northern counties, 5) acute case managers were trained on engagement and linkage services, 6) a walk-in crisis center was opened in a rural area to increase access to services, 7) the MCO's care managers began participating in a weekly housing meeting with a large county to identify members ready for discharge to placements and prioritize referrals, 8) the Consent to Release form was revised to allow for MCOs to communicate with each other, 9) quarterly meetings were initiated with Single County Authorities to discuss barriers faced in providing smooth transitions for members back into the community, 10) eight new "discharge planning" Blended Service Coordinator positions were added across the network.

CCBH received full credit for the elements of the study evaluated that reflected 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.

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

| Review Element | Compliance Level | Scoring Weight | Final Points Score |
|---|------------------|----------------|--------------------|
| 1. Project Title, Type, Focus Area | Full | 5% | 5 |
| 2. Topic Relevance | Full | 5% | 5 |
| 3. Quality Indicators | Full | 0% | 0 |
| 4. Baseline Study and Analysis (Calendar Year (CY) 2008, reported in CY 2009) | Full | 20% | 20 |
| 5. Baseline Study Population and Baseline Measurement Performance (CY 2008) | Full | 10% | 10 |

| Review Element | Compliance Level | Scoring Weight | Final Points Score |
|---|------------------|----------------|--------------------|
| 6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010) | Full | 20% | 20 |
| 7. Demonstrable Improvement (CY 2010, reported in 2011) | 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) | 47.2% | NA | 51.3% ¹ | TBD | 90% |
| HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2) | 68.8% | NA | 73.2% 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) | 60.3% | NA | 62.5% ¹ | 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) | 76.6% | NA | 78.9% ¹ | 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 long standing 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. Of note is that the MY 2011 rates for Erie County are based on a six-month time period (July 1, 2011 – December 31, 2011), as Erie's contract with CCBH began on July 1, 2011. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

Findings

BH MCO and County Results

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

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

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

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

| | MY 2011 | | | | | | | MY 2010 | RATE COMPARISON MY 2011 to MY 2010 | |
|----------------------|---------|--------|--------------|-----------------|-----------------|---|---|---------|---------------------------------------|-----|
| | (N) | (D) | % | LOWER 95% CI | UPPER 95% CI | HEALTH- CHOICES BH MCO AVERAGE | HEALTH- CHOICES COUNTY AVERAGE | % | PPD | SSD |
| QI 1 | | | | | | | | | | |
| HealthChoices | 16,621 | 36,038 | 46.1% | 45.6% | 46.6% | 45.8% | 47.3% | 46.1% | 0.0 | NO |
| CCBH | 6,302 | 12,788 | 49.3% | 48.4% | 50.2% | | | 51.3% | -2.0 | YES |
| Adams | 56 | 112 | 50.0% | 40.3% | 59.7% | | | 56.7% | -6.7 | NO |
| Allegheny | 1,805 | 3,650 | 49.5% | 47.8% | 51.1% | | | 49.2% | 0.2 | NO |
| Berks | 622 | 1,131 | 55.0% | 52.1% | 57.9% | | | 54.5% | 0.5 | 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 |
| Bradford | 116 | 217 | 53.5% | 46.6% | 60.3% | | | 44.9% | 8.5 | NO |
| Cameron | 5 | 22 | 22.7% | 2.9% | 42.5% | | | 52.9% | -30.2 | NO |
| Carbon | 73 | 172 | 42.4% | 34.8% | 50.1% | | | 37.6% | 4.8 | NO |
| Centre | 120 | 242 | 49.6% | 43.1% | 56.1% | | | 59.8% | -10.2 | NO |
| Chester | 343 | 673 | 51.0% | 47.1% | 54.8% | | | 54.0% | -3.0 | NO |
| Clarion | 46 | 112 | 41.1% | 31.5% | 50.6% | | | 43.3% | -2.2 | NO |
| Clearfield | 173 | 343 | 50.4% | 45.0% | 55.9% | | | 49.7% | 0.7 | NO |
| Columbia | 114 | 200 | 57.0% | 49.9% | 64.1% | | | 66.8% | -9.8 | NO |
| Elk | 57 | 106 | 53.8% | 43.8% | 63.7% | | | 52.9% | 0.9 | NO |
| Erie* | 190 | 489 | 38.9% | 34.4% | 43.3% | | | NA | NA | NA |
| Forest | 2 | 9 | 22.2% | 0.0% | 54.9% | | | 46.2% | -23.9 | NO |
| Huntingdon | 56 | 126 | 44.4% | 35.4% | 53.5% | | | 50.0% | -5.6 | NO |
| Jefferson | 88 | 233 | 37.8% | 31.3% | 44.2% | | | 51.4% | -13.6 | YES |
| Juniata | 33 | 52 | 63.5% | 49.4% | 77.5% | | | 56.4% | 7.1 | NO |
| Lackawanna | 398 | 714 | 55.7% | 52.0% | 59.5% | | | 57.4% | -1.6 | NO |
| Luzerne | 576 | 1,091 | 52.8% | 49.8% | 55.8% | | | 59.8% | -7.0 | YES |
| McKean | 67 | 154 | 43.5% | 35.4% | 51.7% | | | 34.9% | 8.6 | NO |
| Mifflin | 88 | 191 | 46.1% | 38.7% | 53.4% | | | 55.4% | -9.3 | NO |
| Monroe | 159 | 322 | 49.4% | 43.8% | 55.0% | | | 44.9% | 4.5 | NO |
| Montour | 39 | 59 | 66.1% | 53.2% | 79.0% | | | 63.2% | 2.9 | NO |
| Northumberland | 122 | 260 | 46.9% | 40.7% | 53.2% | | | 51.1% | -4.2 | NO |
| Pike | 26 | 72 | 36.1% | 24.3% | 47.9% | | | 57.3% | -21.2 | NO |
| Potter | 16 | 36 | 44.4% | 26.8% | 62.1% | | | 52.9% | -8.5 | NO |
| Schuylkill | 255 | 598 | 42.6% | 38.6% | 46.7% | | | 42.4% | 0.2 | NO |
| Snyder | 41 | 76 | 54.0% | 42.1% | 65.8% | | | 50.7% | 3.3 | NO |
| Sullivan | 7 | 11 | 63.6% | 30.7% | 96.6% | | | 37.5% | 26.1 | NO |
| Susquehanna | 24 | 46 | 52.2% | 36.6% | 67.7% | | | 64.6% | -12.4 | NO |
| Tioga | 61 | 106 | 57.6% | 47.7% | 67.4% | | | 59.1% | -1.5 | NO |
| Union | 48 | 67 | 71.6% | 60.1% | 83.2% | | | 71.4% | 0.2 | NO |
| Warren | 70 | 138 | 50.7% | 42.0% | 59.4% | | | 51.1% | -0.4 | NO |
| Wayne | 59 | 99 | 59.6% | 49.4% | 69.8% | | | 60.4% | -0.8 | NO |
| Wyoming | 19 | 40 | 47.5% | 30.8% | 64.2% | | | 51.0% | -3.5 | NO |
| York | 328 | 819 | 40.1% | 36.6% | 43.5% | | | 41.1% | -1.1 | NO |
| QI 2 | | | | | | | | | | |

| | 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 | 24,159 | 36,038 | 67.0% | 66.6% | 67.5% | 66.8% | 70.7% | 66.9% | 0.1 | NO |
| CCBH | 9,172 | 12,788 | 71.7% | 70.9% | 72.5% | | | 73.2% | -1.5 | YES |
| Adams | 86 | 112 | 76.8% | 68.5% | 85.1% | | | 77.5% | -0.7 | NO |
| Allegheny | 2,519 | 3,650 | 69.0% | 67.5% | 70.5% | | | 68.7% | 0.3 | NO |
| Berks | 850 | 1,131 | 75.2% | 72.6% | 77.7% | | | 76.2% | -1.1 | NO |
| Bradford | 156 | 217 | 71.9% | 65.7% | 78.1% | | | 73.6% | -1.7 | NO |
| Cameron | 11 | 22 | 50.0% | 26.8% | 73.2% | | | 76.5% | -26.5 | NO |
| Carbon | 115 | 172 | 66.9% | 59.5% | 74.2% | | | 64.5% | 2.3 | NO |
| Centre | 186 | 242 | 76.9% | 71.3% | 82.4% | | | 82.4% | -5.6 | NO |
| Chester | 491 | 673 | 73.0% | 69.5% | 76.4% | | | 70.3% | 2.7 | NO |
| Clarion | 82 | 112 | 73.2% | 64.6% | 81.9% | | | 70.9% | 2.3 | NO |
| Clearfield | 267 | 343 | 77.8% | 73.3% | 82.4% | | | 77.3% | 0.5 | NO |
| Columbia | 146 | 200 | 73.0% | 66.6% | 79.4% | | | 82.9% | -9.9 | YES |
| Elk | 85 | 106 | 80.2% | 72.1% | 88.2% | | | 83.6% | -3.4 | NO |
| Erie* | 316 | 489 | 64.6% | 60.3% | 69.0% | | | NA | NA | NA |
| Forest | 4 | 9 | 44.4% | 6.4% | 82.5% | | | 76.9% | -32.5 | NO |
| Huntingdon | 102 | 126 | 81.0% | 73.7% | 88.2% | | | 84.1% | -3.1 | NO |
| Jefferson | 165 | 233 | 70.8% | 64.8% | 76.9% | | | 78.9% | -8.1 | NO |
| Juniata | 44 | 52 | 84.6% | 73.9% | 95.4% | | | 85.5% | -0.8 | NO |
| Lackawanna | 556 | 714 | 77.9% | 74.8% | 81.0% | | | 79.5% | -1.7 | NO |
| Luzerne | 818 | 1,091 | 75.0% | 72.4% | 77.6% | | | 78.1% | -3.1 | NO |
| McKean | 110 | 154 | 71.4% | 64.0% | 78.9% | | | 73.3% | -1.9 | NO |
| Mifflin | 142 | 191 | 74.4% | 67.9% | 80.8% | | | 81.3% | -6.9 | NO |
| Monroe | 235 | 322 | 73.0% | 68.0% | 78.0% | | | 65.1% | 7.9 | NO |
| Montour | 47 | 59 | 79.7% | 68.5% | 90.8% | | | 86.0% | -6.3 | NO |
| Northumberland | 179 | 260 | 68.9% | 63.0% | 74.7% | | | 71.6% | -2.7 | NO |
| Pike | 47 | 72 | 65.3% | 53.6% | 77.0% | | | 76.8% | -11.5 | NO |
| Potter | 27 | 36 | 75.0% | 59.5% | 90.5% | | | 72.5% | 2.5 | NO |
| Schuylkill | 404 | 598 | 67.6% | 63.7% | 71.4% | | | 69.6% | -2.0 | NO |
| Snyder | 52 | 76 | 68.4% | 57.3% | 79.5% | | | 74.7% | -6.2 | NO |
| Sullivan | 8 | 11 | 72.7% | 41.9% | 100.0% | | | 75.0% | -2.3 | NO |
| Susquehanna | 34 | 46 | 73.9% | 60.1% | 87.7% | | | 73.8% | 0.1 | NO |
| Tioga | 81 | 106 | 76.4% | 67.9% | 85.0% | | | 71.8% | 4.6 | NO |
| Union | 56 | 67 | 83.6% | 74.0% | 93.2% | | | 87.1% | -3.6 | NO |
| Warren | 103 | 138 | 74.6% | 67.0% | 82.3% | | | 76.3% | -1.6 | NO |
| Wayne | 81 | 99 | 81.8% | 73.7% | 89.9% | | | 78.2% | 3.6 | 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 |
| Wyoming | 27 | 40 | 67.5% | 51.7% | 83.3% | | | 76.5% | -9.0 | NO |
| York | 540 | 819 | 65.9% | 62.6% | 69.2% | | | 68.1% | -2.2 | NO |

* The MY 2011 rates for Erie County are based on a six-month time period (July 1, 2011 – December 31, 2011),

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

The MY 2011 HealthChoices aggregate rates were 46.1% for QI 1 and 67.0% for QI 2. Both rates were comparable to (i.e., not statistically significantly different from) MY 2010 rates. CCBH's MY 2011 QI 1 rate was 49.3% and QI 2 rate was 71.7%. Both rates statistically significantly decreased from the respective MY 2010 rate.

For MY 2011, CCBH's QI 1 rate of 49.3% was statistically significantly higher than the MY 2011 QI 1 HealthChoices BH MCO Average of 45.8% by 3.5 percentage points. CCBH's MY 2011 QI 2 rate of 71.7% was also statistically significantly higher than the MY 2011 QI 2 HealthChoices BH MCO Average of 66.8% by 4.9 percentage points.

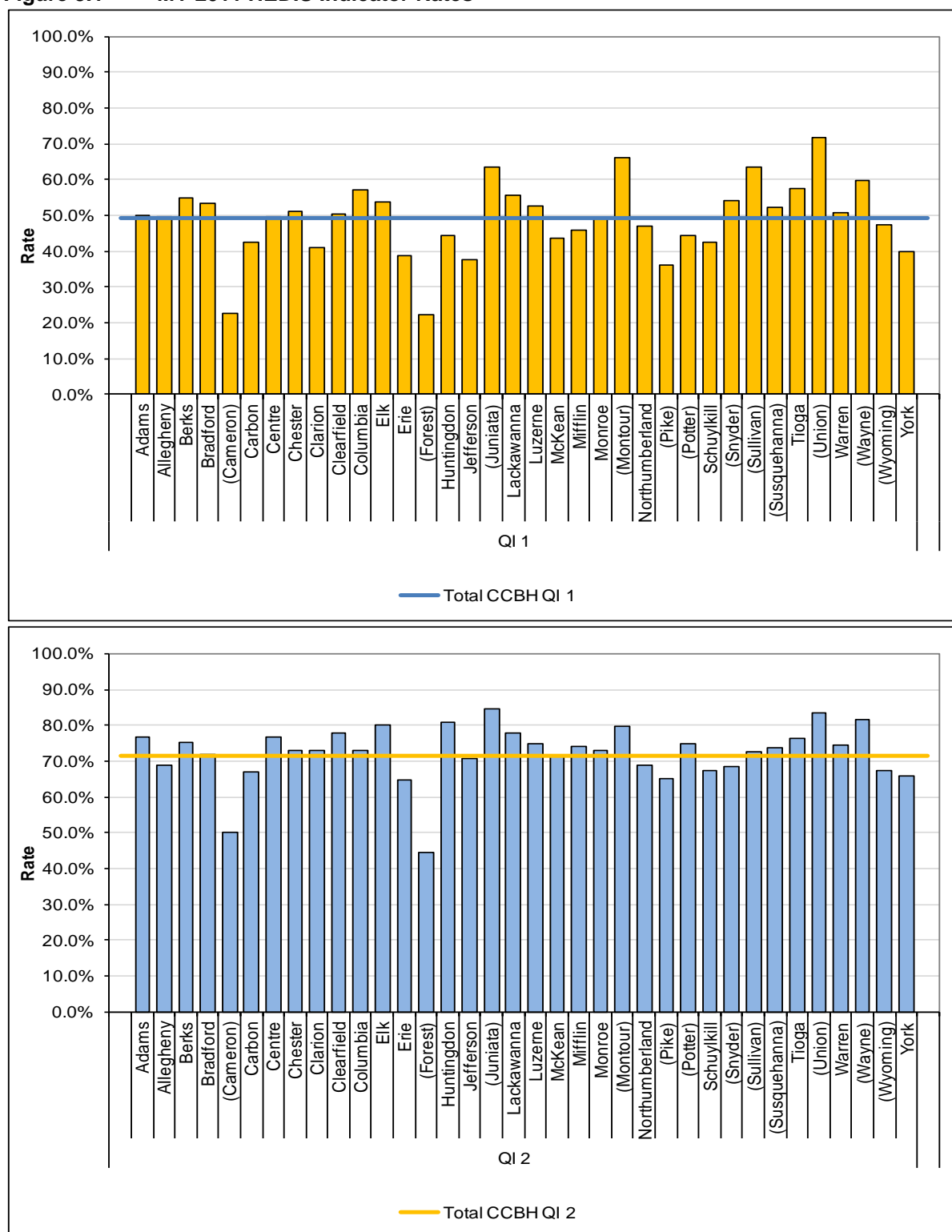
As presented in Table 3.1, the MY 2011 QI 1 rates for Jefferson and Luzerne Counties, and the QI 2 rates for Columbia County, statistically significantly decreased as compared to MY 2010. The MY 2011 QI 1 and QI 2 rates for remaining Counties were not statistically significantly different from MY 2010.

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

In MY 2011, ten CCBH Counties (Allegheny, Berks, Columbia, Juniata, Lackawanna, Luzerne, Montour, Tioga, Union and Wayne) had QI 1 rates statistically significantly higher than the MY 2011 QI 1 HealthChoices County Average of 47.3%, and five Counties (Cameron, Erie, Jefferson, Schuylkill and York) performed statistically significantly below this average. MY 2011 rates for the remaining 21 CCBH Counties did not differ statistically significantly from the QI 1 HealthChoices County Average.

The HealthChoices County Average for QI 2 was 70.7% for MY 2011. Ten Counties (Berks, Centre, Clearfield, Elk, Huntingdon, Juniata, Lackawanna, Luzerne, Union and Wayne) performed statistically significantly above, while three Counties (Allegheny, Erie, and York) were statistically significantly below the MY 2011 QI 2 HealthChoices County Average. MY 2011 QI 2 rates for the remaining 23 CCBH Counties did not differ statistically significantly from the MY 2011 QI 2 HealthChoices County Average.

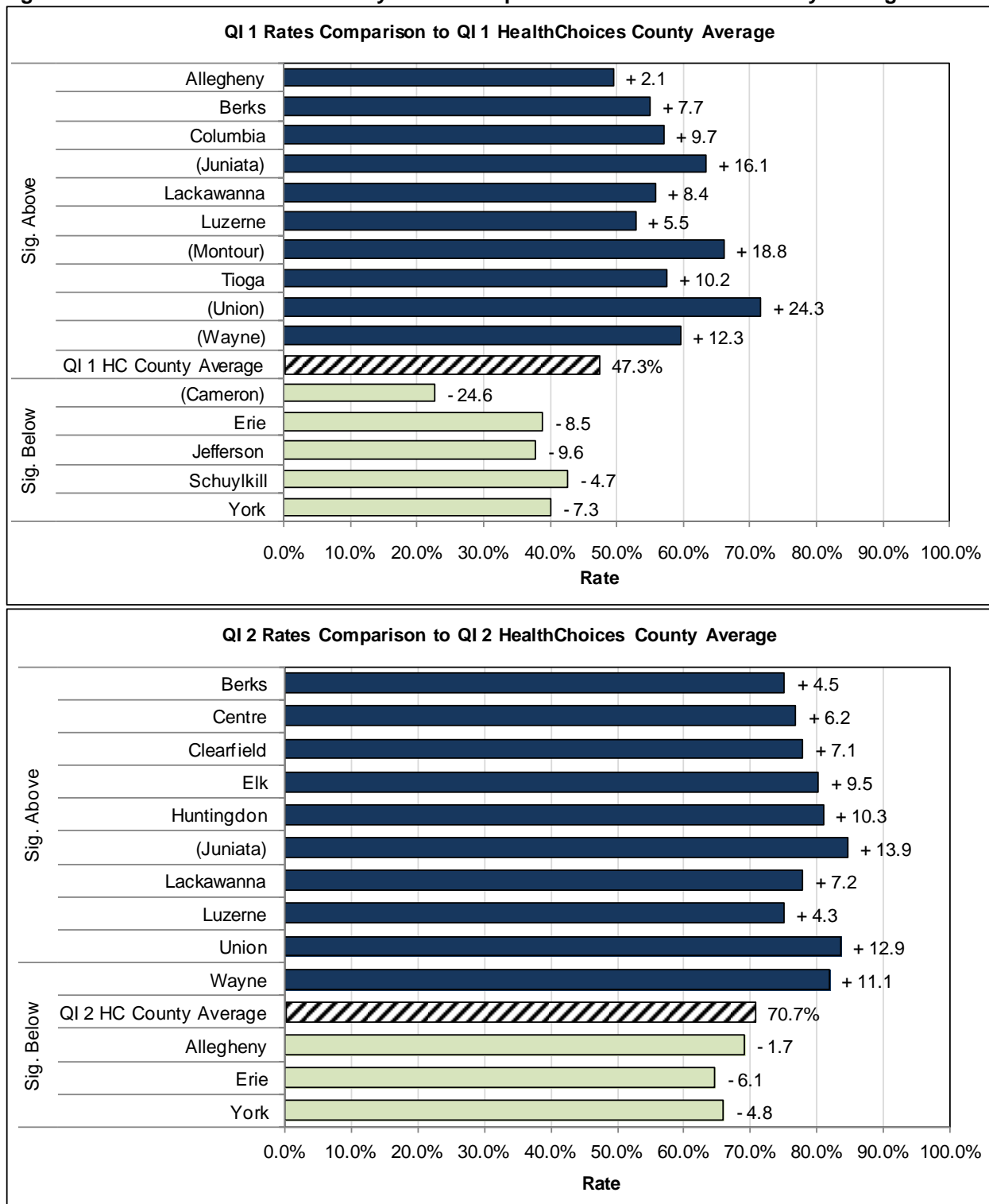
Figure 3.1 MY 2011 HEDIS Indicator Rates



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.

* The MY 2011 rates for Erie County are based on a six-month time period (July 1, 2011 – December 31, 2011),

Figure 3.2 MY 2011 HEDIS County Rates Compared to HealthChoices County Average



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.

* The MY 2011 rates for Erie County are based on a six-month time period (July 1, 2011 – December 31, 2011),

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 |
| CCBH | 7,712 | 12,788 | 60.3% | 59.5% | 61.2% | | | 62.5% | -2.2 | YES |
| Adams | 63 | 112 | 56.3% | 46.6% | 65.9% | | | 61.7% | -5.4 | NO |
| Allegheny | 2,278 | 3,650 | 62.4% | 60.8% | 64.0% | | | 62.0% | 0.4 | NO |
| Berks | 724 | 1,131 | 64.0% | 61.2% | 66.9% | | | 64.7% | -0.7 | NO |
| Bradford | 126 | 217 | 58.1% | 51.3% | 64.9% | | | 56.2% | 1.9 | NO |
| Cameron | 9 | 22 | 40.9% | 18.1% | 63.7% | | | 64.7% | -23.8 | NO |
| Carbon | 87 | 172 | 50.6% | 42.8% | 58.3% | | | 51.6% | -1.0 | NO |
| Centre | 147 | 242 | 60.7% | 54.4% | 67.1% | | | 69.9% | -9.1 | NO |
| Chester | 415 | 673 | 61.7% | 57.9% | 65.4% | | | 64.5% | -2.8 | NO |
| Clarion | 57 | 112 | 50.9% | 41.2% | 60.6% | | | 58.3% | -7.4 | NO |
| Clearfield | 226 | 343 | 65.9% | 60.7% | 71.1% | | | 63.3% | 2.6 | NO |
| Columbia | 137 | 200 | 68.5% | 61.8% | 75.2% | | | 74.9% | -6.4 | NO |
| Elk | 72 | 106 | 67.9% | 58.6% | 77.3% | | | 70.7% | -2.8 | NO |
| Erie* | 264 | 489 | 54.0% | 49.5% | 58.5% | | | NA | NA | NA |
| Forest | 2 | 9 | 22.2% | 0.0% | 54.9% | | | 53.8% | -31.6 | NO |
| Huntingdon | 83 | 126 | 65.9% | 57.2% | 74.5% | | | 70.5% | -4.6 | NO |
| Jefferson | 136 | 233 | 58.4% | 51.8% | 64.9% | | | 70.1% | -11.7 | YES |
| Juniata | 41 | 52 | 78.9% | 66.8% | 90.9% | | | 76.4% | 2.5 | NO |
| Lackawanna | 452 | 714 | 63.3% | 59.7% | 66.9% | | | 64.8% | -1.5 | NO |
| Luzerne | 660 | 1,091 | 60.5% | 57.5% | 63.4% | | | 65.9% | -5.4 | YES |
| McKean | 99 | 154 | 64.3% | 56.4% | 72.2% | | | 55.9% | 8.4 | NO |
| Mifflin | 124 | 191 | 64.9% | 57.9% | 71.9% | | | 75.4% | -10.5 | YES |
| Monroe | 184 | 322 | 57.1% | 51.6% | 62.7% | | | 57.5% | -0.4 | NO |
| Montour | 44 | 59 | 74.6% | 62.6% | 86.5% | | | 82.5% | -7.9 | NO |
| Northumberland | 153 | 260 | 58.9% | 52.7% | 65.0% | | | 62.6% | -3.7 | NO |
| Pike | 31 | 72 | 43.1% | 30.9% | 55.2% | | | 70.7% | -27.7 | YES |
| Potter | 17 | 36 | 47.2% | 29.5% | 64.9% | | | 56.9% | -9.6 | NO |
| Schuylkill | 332 | 598 | 55.5% | 51.5% | 59.6% | | | 54.9% | 0.6 | NO |
| Snyder | 48 | 76 | 63.2% | 51.7% | 74.7% | | | 65.3% | -2.2 | NO |
| Sullivan | 8 | 11 | 72.7% | 41.9% | 100.0% | | | 50.0% | 22.7 | NO |
| Susquehanna | 27 | 46 | 58.7% | 43.4% | 74.0% | | | 67.7% | -9.0 | NO |
| Tioga | 67 | 106 | 63.2% | 53.6% | 72.9% | | | 65.5% | -2.2 | NO |
| Union | 51 | 67 | 76.1% | 65.2% | 87.1% | | | 82.9% | -6.7 | 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 |
| Warren | 86 | 138 | 62.3% | 53.9% | 70.8% | | | 61.2% | 1.2 | NO |
| Wayne | 67 | 99 | 67.7% | 58.0% | 77.4% | | | 70.3% | -2.6 | NO |
| Wyoming | 19 | 40 | 47.5% | 30.8% | 64.2% | | | 51.0% | -3.5 | NO |
| York | 376 | 819 | 45.9% | 42.4% | 49.4% | | | 46.8% | -0.9 | NO |
| QI B | | | | | | | | | | |
| HealthChoices | 26,939 | 36,038 | 74.8% | 74.3% | 75.2% | 74.7% | 77.1% | 74.6% | 0.1 | NO |
| CCBH | 9,917 | 12,788 | 77.6% | 76.8% | 78.3% | | | 78.9% | -1.4 | YES |
| Adams | 88 | 112 | 78.6% | 70.5% | 86.6% | | | 80.0% | -1.4 | NO |
| Allegheny | 2,800 | 3,650 | 76.7% | 75.3% | 78.1% | | | 76.0% | 0.7 | NO |
| Berks | 891 | 1,131 | 78.8% | 76.4% | 81.2% | | | 80.9% | -2.1 | NO |
| Bradford | 161 | 217 | 74.2% | 68.1% | 80.2% | | | 78.1% | -3.9 | NO |
| Cameron | 12 | 22 | 54.6% | 31.5% | 77.6% | | | 76.5% | -21.9 | NO |
| Carbon | 122 | 172 | 70.9% | 63.9% | 78.0% | | | 73.1% | -2.2 | NO |
| Centre | 198 | 242 | 81.8% | 76.8% | 86.9% | | | 85.8% | -4.0 | NO |
| Chester | 521 | 673 | 77.4% | 74.2% | 80.6% | | | 74.8% | 2.6 | NO |
| Clarion | 91 | 112 | 81.3% | 73.6% | 88.9% | | | 78.7% | 2.5 | NO |
| Clearfield | 293 | 343 | 85.4% | 81.5% | 89.3% | | | 82.3% | 3.1 | NO |
| Columbia | 162 | 200 | 81.0% | 75.3% | 86.7% | | | 86.4% | -5.4 | NO |
| Elk | 92 | 106 | 86.8% | 79.9% | 93.7% | | | 87.1% | -0.4 | NO |
| Erie | 360 | 489 | 73.6% | 69.6% | 77.6% | | | NA | NA | NA |
| Forest | 5 | 9 | 55.6% | 17.5% | 93.6% | | | 84.6% | -29.1 | NO |
| Huntingdon | 107 | 126 | 84.9% | 78.3% | 91.6% | | | 89.4% | -4.5 | NO |
| Jefferson | 187 | 233 | 80.3% | 74.9% | 85.6% | | | 86.9% | -6.6 | NO |
| Juniata | 48 | 52 | 92.3% | 84.1% | 100.0% | | | 90.9% | 1.4 | NO |
| Lackawanna | 584 | 714 | 81.8% | 78.9% | 84.7% | | | 82.4% | -0.6 | NO |
| Luzerne | 848 | 1,091 | 77.7% | 75.2% | 80.2% | | | 80.9% | -3.1 | NO |
| McKean | 125 | 154 | 81.2% | 74.7% | 87.7% | | | 80.0% | 1.2 | NO |
| Mifflin | 156 | 191 | 81.7% | 75.9% | 87.4% | | | 89.2% | -7.5 | YES |
| Monroe | 250 | 322 | 77.6% | 72.9% | 82.3% | | | 72.9% | 4.7 | NO |
| Montour | 49 | 59 | 83.1% | 72.6% | 93.5% | | | 93.0% | -9.9 | NO |
| Northumberland | 205 | 260 | 78.9% | 73.7% | 84.0% | | | 79.5% | -0.6 | NO |
| Pike | 50 | 72 | 69.4% | 58.1% | 80.8% | | | 84.1% | -14.7 | NO |
| Potter | 28 | 36 | 77.8% | 62.8% | 92.7% | | | 74.5% | 3.3 | NO |
| Schuylkill | 453 | 598 | 75.8% | 72.2% | 79.3% | | | 77.9% | -2.2 | NO |
| Snyder | 61 | 76 | 80.3% | 70.7% | 89.9% | | | 84.0% | -3.7 | NO |
| Sullivan | 9 | 11 | 81.8% | 54.5% | 100.0% | | | 87.5% | -5.7 | 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 |
| Susquehanna | 35 | 46 | 76.1% | 62.7% | 89.5% | | | 76.9% | -0.8 | NO |
| Tioga | 84 | 106 | 79.3% | 71.1% | 87.4% | | | 80.9% | -1.7 | NO |
| Union | 57 | 67 | 85.1% | 75.8% | 94.3% | | | 92.9% | -7.8 | NO |
| Warren | 112 | 138 | 81.2% | 74.3% | 88.0% | | | 82.7% | -1.6 | NO |
| Wayne | 83 | 99 | 83.8% | 76.1% | 91.6% | | | 85.1% | -1.3 | NO |
| Wyoming | 27 | 40 | 67.5% | 51.7% | 83.3% | | | 76.5% | -9.0 | NO |
| York | 563 | 819 | 68.7% | 65.5% | 72.0% | | | 71.4% | -2.7 | NO |

* The MY 2011 rates for Erie County are based on a six-month time period (July 1, 2011 – December 31, 2011),

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

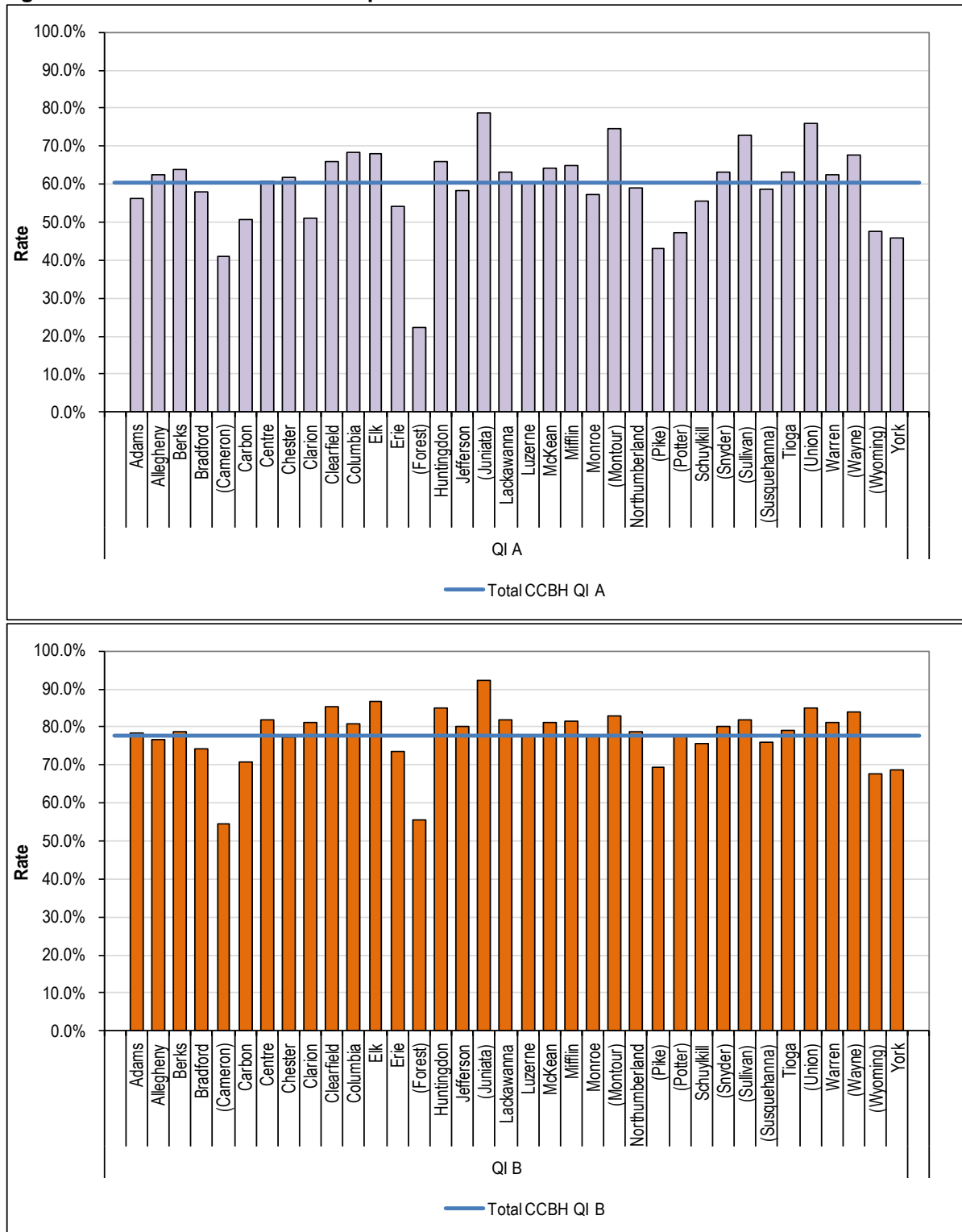
The MY 2011 HealthChoices aggregate rates were 58.1% for QI A and 74.6% for QI B. Both rates were comparable to (i.e., not statistically significantly different from) MY 2010 rates. CCBH's MY 2011 QI A rate was 60.3% and QI B rate was 77.6%. Both rates statistically significantly decreased from MY 2010.

For MY 2011, CCBH's QI A rate of 60.3% was statistically significantly higher than the MY 2011 QI A HealthChoices BH MCO Average of 57.6% by 2.7 percentage points. CCBH's MY 2011 QI B rate of 77.6% was statistically significantly higher than the MY 2011 QI B HealthChoices BH MCO Average of 74.7% by 2.9 percentage points.

As presented in Table 3.2, the MY 2011 QI A rates for Jefferson, Luzerne, Mifflin and Pike Counties had statistically significant decreases when compared to the prior year. For QI B, the rate for Mifflin County statistically significantly decreased between MY 2010 and MY 2011. Year-to-year rate changes for the remaining Counties were not statistically significant.

Figure 3.3 displays a graphical representation of the MY 2011 PA-specific follow-up rates for CCBH and its associated Counties. Figure 3.4 presents the individual CCBH Counties that performed statistically significantly above or below the MY 2011 QI A and QI B HealthChoices County Averages.

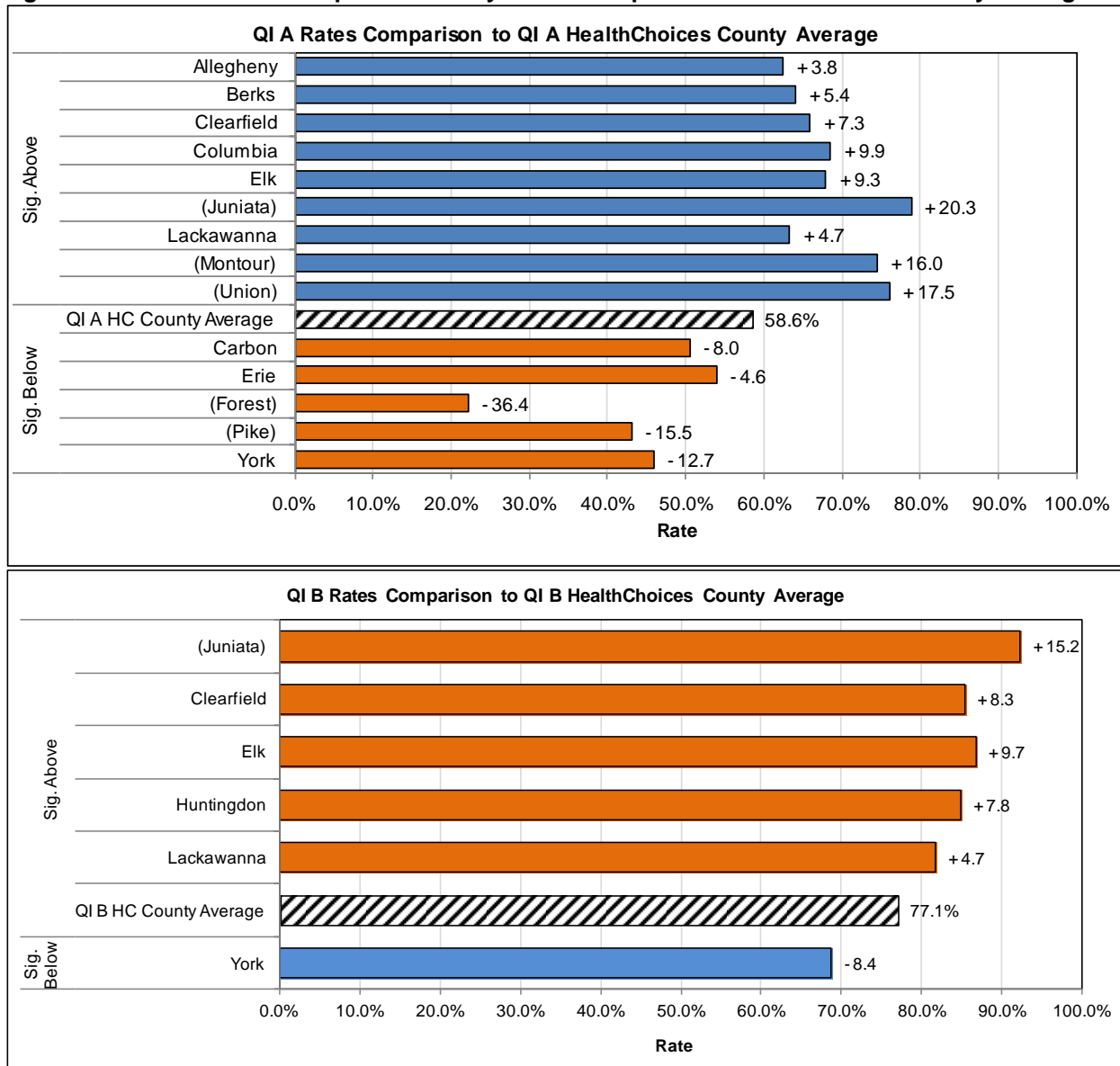
Figure 3.3 MY 2011 CCBH PA-Specific Indicator Rates



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.

* The MY 2011 rates for Erie County are based on a six-month time period (July 1, 2011 – December 31, 2011),

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



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.

* The MY 2011 rates for Erie County are based on a six-month time period (July 1, 2011 – December 31, 2011),

In MY 2011, the QI A rates for nine Counties (Allegheny, Berks, Clearfield, Columbia, Elk, Juniata, Lackawanna, Montour and Union) were statistically significantly above, and the rates for five Counties (Carbon, Erie, Forest, Pike and York) were statistically significantly below the MY 2011 QI A HealthChoices County Average of 58.6%. The MY 2011 QI A rates for the remaining 22 CCBH Counties did not differ statistically significantly from the MY 2011 QI A HealthChoices County Average.

For QI B, the MY 2011 rates for five Counties (Clearfield, Elk, Huntingdon, Juniata and Lackawanna) were statistically significantly above, and the rate for one County (York) was statistically significantly below the MY 2011 QI B HealthChoices County Average of 77.1%. The MY 2011 QI B rate for the remaining 30 CCBH Counties did not differ statistically significantly from the MY 2011 QI B HealthChoices County Average.

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 CCBH rates to the HEDIS 2012 benchmarks, the QI 1 rate of 49.3% and QI 2 rate of 71.7% fell between the 50th and 75th percentiles. This was similar to MY 2010, in which CCBH's QI 1 rate of 51.3% and QI 2 rate of 73.2% fell between the respective 50th and 75th percentiles 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. As with the Follow-up After Hospitalization for Mental Illness measure, the MY 2011 rate for Erie County is based on a six-month time period (July 1, 2011 – December 31, 2011), beginning with the initiation of Erie's contract with CCBH. 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 |
| CCBH | 1,720 | 15,547 | 11.1% | 10.6% | 11.6% | | | 10.8% | 0.3 | NO |
| Adams | 10 | 126 | 7.9% | 2.8% | 13.1% | | | 12.9% | -5.0 | NO |
| Allegheny | 502 | 4,120 | 12.2% | 11.2% | 13.2% | | | 13.0% | -0.9 | NO |
| Berks | 185 | 1,455 | 12.7% | 11.0% | 14.5% | | | 10.6% | 2.1 | NO |
| Bradford | 31 | 257 | 12.1% | 7.9% | 16.2% | | | 10.8% | 1.2 | NO |
| Cameron | 0 | 24 | 0.0% | 0.0% | 2.1% | | | 13.6% | -13.6 | NA |
| Carbon | 17 | 211 | 8.1% | 4.1% | 12.0% | | | 6.1% | 2.0 | NO |
| Centre | 35 | 308 | 11.4% | 7.7% | 15.1% | | | 8.7% | 2.6 | NO |
| Chester | 120 | 865 | 13.9% | 11.5% | 16.2% | | | 10.6% | 3.3 | NO |
| Clarion | 8 | 126 | 6.4% | 1.7% | 11.0% | | | 7.7% | -1.4 | NO |
| Clearfield | 37 | 410 | 9.0% | 6.1% | 11.9% | | | 8.1% | 0.9 | NO |
| Columbia | 21 | 245 | 8.6% | 4.9% | 12.3% | | | 12.8% | -4.2 | NO |
| Elk | 10 | 114 | 8.8% | 3.1% | 14.4% | | | 6.4% | 2.4 | NO |
| Erie* | 79 | 670 | 11.8% | 9.3% | 14.3% | | | NA | NA | NA |
| Forest | 0 | 10 | 0.0% | 0.0% | 5.0% | | | 6.7% | -6.7 | NA |
| Huntingdon | 10 | 149 | 6.7% | 2.4% | 11.1% | | | 10.7% | -3.9 | NO |
| Jefferson | 37 | 294 | 12.6% | 8.6% | 16.6% | | | 12.6% | 0.0 | NO |
| Juniata | 2 | 56 | 3.6% | 0.0% | 9.3% | | | 4.8% | -1.2 | NO |
| Lackawanna | 94 | 889 | 10.6% | 8.5% | 12.6% | | | 10.7% | -0.1 | NO |
| Luzerne | 189 | 1,454 | 13.0% | 11.2% | 14.8% | | | 9.6% | 3.4 | NO |
| McKean | 21 | 182 | 11.5% | 6.6% | 16.5% | | | 12.9% | -1.4 | NO |
| Mifflin | 27 | 247 | 10.9% | 6.8% | 15.0% | | | 13.0% | -2.1 | NO |
| Monroe | 33 | 375 | 8.8% | 5.8% | 11.8% | | | 8.9% | -0.1 | NO |
| Montour | 5 | 69 | 7.3% | 0.4% | 14.1% | | | 3.2% | 4.0 | NO |
| Northumberland | 30 | 328 | 9.2% | 5.9% | 12.4% | | | 10.5% | -1.4 | NO |
| Pike | 5 | 78 | 6.4% | 0.3% | 12.5% | | | 10.0% | -3.6 | NO |
| Potter | 6 | 45 | 13.3% | 2.3% | 24.4% | | | 9.5% | 3.8 | NO |
| Schuylkill | 70 | 750 | 9.3% | 7.2% | 11.5% | | | 7.9% | 1.4 | NO |
| Snyder | 3 | 86 | 3.5% | 0.0% | 8.0% | | | 9.8% | -6.3 | NO |
| Sullivan | 0 | 10 | 0.0% | 0.0% | 5.0% | | | 0.0% | 0.0 | NA |

| | 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 |
| Susquehanna | 6 | 58 | 10.3% | 1.6% | 19.0% | | | 2.6% | 7.8 | NO |
| Tioga | 8 | 133 | 6.0% | 1.6% | 10.4% | | | 10.6% | -4.5 | NO |
| Union | 6 | 78 | 7.7% | 1.1% | 14.2% | | | 14.0% | -6.3 | NO |
| Warren | 6 | 147 | 4.1% | 0.5% | 7.6% | | | 6.8% | -2.8 | NO |
| Wayne | 5 | 117 | 4.3% | 0.2% | 8.4% | | | 11.0% | -6.8 | NO |
| Wyoming | 5 | 57 | 8.8% | 0.5% | 17.0% | | | 6.7% | 2.1 | NO |
| York | 97 | 1,004 | 9.7% | 7.8% | 11.5% | | | 8.5% | 1.2 | NO |

* The MY 2011 rates for Erie County are based on a six-month time period (July 1, 2011 – December 31, 2011),

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

The aggregate MY 2011 HealthChoices readmission rate was 12.0%. CCBH's readmission rate was 11.1% in MY 2011, which did not meet the designated goal, but was statistically significantly lower than the MY 2011 HealthChoices BH MCO Average of 12.3%. Note that this measure is an inverted rate, in that lower rates are preferable. CCBH's MY 2011 rate was not statistically significantly different than the BH MCO's MY 2010 rate.

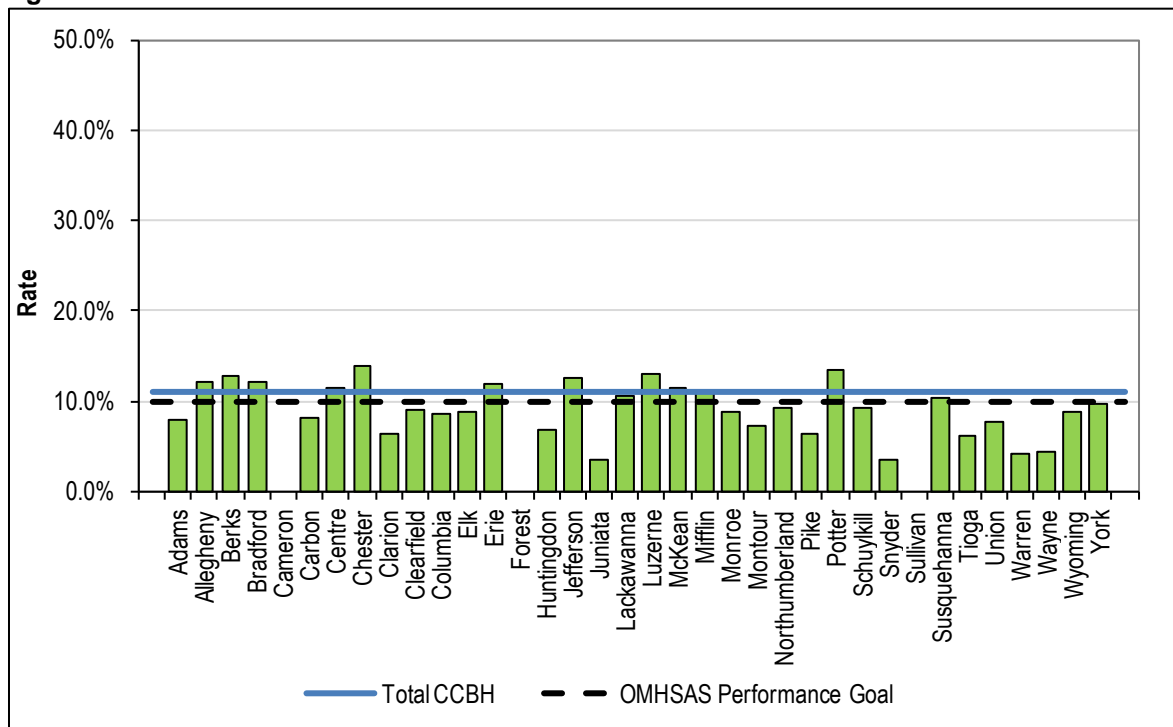
As presented in Table 3.4, 36 Counties were associated with CCBH in MY 2011. Of the 35 Counties with rates for MY 2011, there were no statistically significant differences noted for any Counties when comparing MY 2010 and MY 2011 rates.

For MY 2011, the rates for 23 Counties met the performance goal of 10.0%. These Counties were Adams, Cameron, Carbon, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Juniata, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, Wayne, Wyoming, and York. The rates for Cameron, Forest, Juniata, Montour, Pike, Snyder, Sullivan, Union, and Wyoming Counties, however, were determined by less than 100 eligible discharges.

The MY 2011 rates for Allegheny, Berks, Chester and Luzerne Counties were statistically significantly higher (poorer) than the MY 2011 HealthChoices County Average of 9.9%. As noted previously, this rate is inverted, in that lower rates are preferable. The MY 2011 rates for Cameron, Forest, Juniata, Snyder, Sullivan, Warren and Wayne Counties were statistically significantly below (better than) the MY 2011 HealthChoices County Average. The rates for Cameron, Forest, Juniata, Snyder and Sullivan Counties were determined by less than 100 eligible discharges.

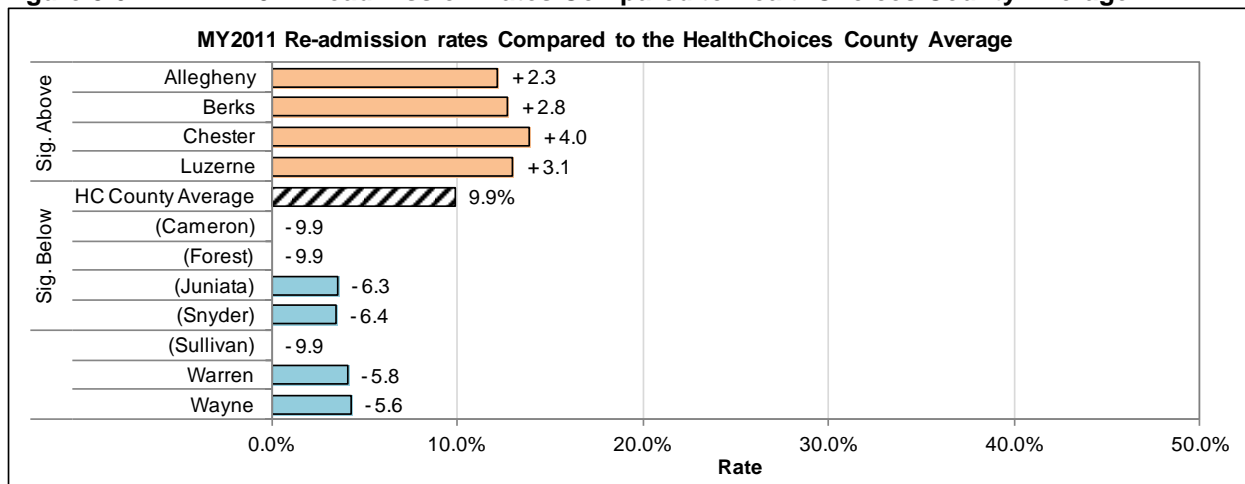
Figure 3.5 provides a graphical presentation of the MY 2011 readmission rates for CCBH and its associated counties. Figure 3.6 displays percentage point differences for the individual CCBH Counties that performed statistically significantly higher or lower than the MY 2011 HealthChoices County Average.

Figure 3.5 MY 2011 Readmission Rates



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.
 * The MY 2011 rates for Erie County are based on a six-month time period (July 1, 2011 – December 31, 2011),

Figure 3.6 MY 2011 Readmission Rates Compared to HealthChoices County Average



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.
 * The MY 2011 rates for Erie County are based on a six-month time period (July 1, 2011 – December 31, 2011),

Conclusion and Recommendations

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



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

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

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

IV: 2011 OPPORTUNITIES FOR IMPROVEMENT MCO RESPONSE

Current and Proposed Interventions






The general purpose of this section is to assess the degree to which each BH MCO has effectively addressed the opportunities for improvement cited by IPRO in the 2011 EQR Technical Reports, which were distributed in April 2012. The 2012 EQR Technical Report is the fifth report to include descriptions of current and proposed interventions from each BH MCO that address the 2011 recommendations.







The BH MCOs are required by OMHSAS to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the Pennsylvania Medicaid BH MCOs. These activities follow a longitudinal format, and are designed to capture information relating to:





- Follow-up actions that the BH MCO has taken through September 30, 2012 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken; and
- The BH MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of the end of 2012, as well as any additional relevant documentation provided by CCBH.

Table 4.1 Current and Proposed Interventions: Opportunities for Improvement

| Reference Number | Opportunity for Improvement | MCO Response |
|---|--|---|
| Structure and Operations Standards | | |
| CCBH 1 | Within Subpart C: Enrollee Rights and Protections Regulations, CCBH was partially compliant on one out of seven categories – Enrollee Rights | <p><u>Follow Up Actions Taken Through 09/30/12</u></p> <p>From RY 2008- York/Adams/Berks: please reference letter indicating no CAP required.</p> <p> Standard 108_Y-A County RY 2008 PEPs</p> <p> Standard 108_Berks County RY 2008 PEPs</p> <p>York/Adams 108.1, 108.4, and 108.8</p> <p> Standard 108_YAB_CAP for PEI108_Attachment A_0</p> <p> Standard 108_YAB_CAP for PEI108_Attachment A_0</p> <p> Standard 108_Attachment B_C</p> |

| Reference Number | Opportunity for Improvement | MCO Response |
|------------------|--|--|
| | | <div data-bbox="873 283 1273 821">  Standard 108_Attachment C.M108_Attachment D. F  Standard 108_Attachment E.4C  Standard 108_Attachment F 20 Berks- 108.10 and 108.4  Standard 108.10_Berks.doc </div> <div data-bbox="873 835 1468 1045"> <p>Future Actions Planned Community Care continues to have monthly meetings with CFST to address any concerns. Contracts are updated annually. Trainings occur annually. Both the Y/A and Berks CFST Directors continue to be involved in the CFST budget, contract reviews, developing surveys and directing CFST staff. No new concerns have been identified.</p> </div> |
| CCBH 2 | CCBH was partially compliant on one out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant category is: Availability of Services (Access to Care). | <p>Follow Up Actions Taken Through 09/30/12 From RY 2010 – PEPS 1.2 NorthCentral (SO) - A waiver (provider exception request) was requested and approved by OMHSAS as the following levels of care did not meet the requirement for a choice of 2 providers within 30/60 miles: IP D&A Detox (Child- ALL 23 counties); IP D&A Detox (Adult – Centre, Clearfield, Huntington, Juniata, Mifflin, Northumberland, Schuylkill, and Snyder); IP D&A Rehab (Child – ALL 23 Counties; Adult – All Counties except – Clarion, Forest, and Warren); Non-hospital D&A Detox (Child-Bradford, Cameron, Centre, Clarion, Elk, Forest, Jefferson, Juniata, McKean, Potter, Snyder, Tioga, and Warren) Non-hospital D&A Detox (Adult- Bradford, Cameron, Elk, McKean, Potter, and Tioga); Non-hospital D&A Rehab (Child-Cameron, Centre, Clarion, Clearfield, Elk, Forest, Huntington, Jefferson, McKean, Potter, Tioga, and Warren); Non-hospital D&A Rehab (Adult-Bradford); D&A Halfway House (Bradford, Clarion, Forest, McKean, Potter, Tioga, Warren); D&A Methadone (Bradford, Cameron, Centre, Columbia, Elk, Juniata, McKean, Northumberland, Potter, Snyder, Sullivan, Tioga, Union, and Wayne).</p> <div data-bbox="873 1753 1414 1871">  HCNC Exception Requests_10.20.10.  DPW_Approval_11.4 .2010.pdf </div> |

| Reference Number | Opportunity for Improvement | MCO Response |
|-----------------------------|---|---|
| | | Future Actions Planned Continue to offer members a choice of 2 or more providers within 30/60 miles. When a member cannot access a provider within the standard drive times, Community Care refers a member to the closest provider possible, approves services to nonparticipating providers, or approves a higher level of care. Providers are also added to the network when possible. |
| CCBH 3 | CCBH was partially compliant on four 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) Handling of Grievances and Appeals 4) Resolution and Notification: Grievances and Appeals. | Follow Up Actions Taken Through 09/30/12 All Counties 68.3; 68.5; 68.6; 68.9   EQR_Standard_68.d Standard 68.5.doc oc  EQR 68.5 & 68.9.docx Future Actions Planned N/A |
| Performance Measures | | |
| CCBH 4 | CCBH's rate for the MY 2010 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%. | Follow Up Actions Taken Through 09/30/12 Please see attached interventions grid.  Readmission Interventions through Future Actions Planned Community Care will continue to conduct barrier analysis and develop interventions to positively impact this measure. |

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:

| Recommendation Corrective Action #1 | | | | | |
|---|------------------------|------------|-------------------------|-----------------------------------|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Develop and implement training for care manager and providers on expedited appeals. <ul style="list-style-type: none"> Mercer uses the term "appeal," but DPW uses the terms expedited review of a complaint and expedited grievance; training will be provided on both terms. | | | | | |
| 1) Annual Training for | Klemens | 09/01/2010 | 12/31/2010 | Agenda | Completed |

| Recommendation Corrective Action #1 | | | | | |
|--|------------------------|------------|-------------------------|--|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Care Managers & Customer Service Representatives on the expedited review of complaints and expedited grievance process. | | | | Curriculum Sign in sheets PEPS response for cells 60, 68, 71, 72 | |
| 2) Community Care will conduct a web ex training for providers related to all levels of the complaint and grievance process. | Klemens | 09/01/2010 | 12/31/2010 | Training materials | Completed |

| Recommendation Corrective Action #2 | | | | | |
|---|------------------------|------------|-------------------------|--|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Increase monitoring of care managers and providers to increase documentation of recovery and resilience, as well as ongoing supervision focused on specific strategies that care managers can use during reviews to promote recovery and resilience. | | | | | |
| 1) Include recovery oriented items on Quality record review tools for providers. | Klanchar | Completed | Completed | Revised record review tool(s) | Completed |
| 2) PsychConsult clinical template contains hard coded prompts to prompt care managers to ask about and document recovery/resiliency discussion. Relevant topics include but are not limited to advance directives, WRAP plans, crisis planning, use of family and other natural supports, identifying member strengths etc. | Doyle | 09/01/2010 | 08/31/2011 | Revised clinical template UM clinical documentation review tool | Completed |
| 3) Incorporate discussion of recovery/resiliency concepts in morning | Taylor/Doyle | 09/01/2010 | 08/31/2011 | PsychConsult documentation Supervision | Completed |

| Recommendation Corrective Action #2 | | | | | |
|---|------------------------|------------|-------------------------|-----------------------------------|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| case review as well as in group and 1:1 supervision. Professional Advisors are documenting their involvement in case review in PsychConsult in the general documents section. | | | | documentation tool | |

| Recommendation Corrective Action #3 | | | | | |
|--|----------------------------|------------|-------------------------|---|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Provide training and regular monitoring and supervision for all service center care managers to: -Increase longitudinal care management in the care management process, including review and use of prior treatment and care management history. -Increase PA consultation for quality of care issues, including medication issues; multiple, changing or unclear diagnoses; co-occurring SA and medical disorders and other quality of care indicators. -Require documentation of meaningful crisis plans for high risk individuals. These plans should identify crisis triggers and define alternatives to the use of the emergency department for crisis diversion. -Address documentation deficiencies noted in the prior section of the report. | | | | | |
| 1) Training for clinical staff on longitudinal care management/UM best practices. | Clinical Managers | 09/01/2010 | 12/31/2010 | Sign in sheets, agenda | Completed |
| 2) Develop protocol for documenting results of morning meetings with PAs. Professional Advisors will document involvement in case review in PsychConsult in a general note. | Clinical Managers | 08/01/2010 | 12/31/2010 | PA documentation protocol | Completed |
| 3) UM Clinical documentation tool includes an indicator for quality consults with PA. | Clinical Managers | completed | completed | UM clinical documentation review tool | Completed |
| 4) Crisis plans are fluid documents in that they are constantly changing. | Clinical Managers Doyle | 09/01/2010 | 08/31/2011 | Revised clinical template Guide for MH continued stay review | Completed |

| Recommendation Corrective Action #3 | | | | | |
|---|------------------------|------------|-------------------------|--|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Focusing on recovery concepts, Community Care expects that the member own their crisis plan and that the treating provider be aware of its contents. Through clinical reviews, the provider is expected to discuss the crisis plan with their designated Case Manager. Community Care also expects that the provider would not direct the member to the ER for crisis diversion as part of that plan. Clinical template will be reviewed to add more specific information about crisis triggers and planning. | | | | UM clinical documentation review tool Provider newsletter article related to developing effective crisis plans with members | |

| Recommendation Corrective Action #4 | | | | | |
|--|------------------------|------------|-------------------------|--|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Assess care manager caseloads for all service centers and develop a plan to ensure that care managers have sufficient time to actively manage care for adults and high risk cases, including: -Review of CMR review findings that differ by county/service center to determine the impact, if any, of care manager caseloads based on the care management model under contract or variability in supervision provided at each service center. | | | | | |
| 1) Complete a point in time analysis by end of August of current CM: Membership ratio by contract and CM:Utilizers ratio by contract. | Clinical Managers | 07/15/2010 | 08/15/2010 | Caseload report | Completed |
| 2) Based on identified need and financial feasibility by contract, recruit and hire additional Care | Taylor | 08/15/2010 | 12/31/2010 | Position posting Hiring care managers | Completed |

| Recommendation Corrective Action #4 | | | | | |
|--|------------------------|------------|-------------------------|-----------------------------------|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Managers. | | | | | |

| Recommendation Corrective Action #5 | | | | | |
|--|---------------------------|------------|-------------------------|---|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Develop and implement required in-service training for CCBHO staff regarding EBP's and consensus-based practices for all population groups including: -Use of detailed FBA results/findings, which was required as of January 1, 2009. -Trauma-informed assessments, diagnostic formulations and treatment options | | | | | |
| 1) Train staff on Evidence Based Practices. Prior training by Elizabeth Campbell, from OMHSAS, occurred at the 9/09 Children's Retreat on Multi-Systemic Therapy/Functional Family Therapy. Additional training topics as applicable to Care Management caseload will include: Motivational Interviewing, Trauma Informed Care/Trauma Assessment, Multi-Dimensional Treatment Foster Care and Assertive Community Treatment. | Wittman/Clinical Managers | 09/01/2010 | 06/30/2011 | Sign in sheets, agenda | Completed |
| 2) Bi-weekly CM Leadership meeting will serve as a venue to discuss upcoming trainings on EBP's to share with Care Management staff. | Clinical Managers | 09/15/2010 | Ongoing | CM Leadership agenda and minutes | Completed |
| 3) Add hard coded prompt to PsychConsult Was FBA completed (y/n) Were the findings | Doyle/Clinical Managers | 09/15/2010 | 12/31/2010 | Revised clinical template for BHRS Revised UM clinical documentation review tool | Completed |

| Recommendation Corrective Action #5 | | | | | |
|---|------------------------|------------|-------------------------|-----------------------------------|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| incorporated into the member's treatment plan (y/n) | | | | | |

| Recommendation Corrective Action #6 | | | | | |
|--|------------------------|------------|-------------------------|--|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Review existing policy on referral indicators for PA consults; monitor compliance with the new policy through documentation audits and call monitoring protocols. As the number of PA reviews increase, additional PA resources may be needed. | | | | | |
| 1) UM Clinical documentation tool includes a check for quality consults with PA. Clinical Managers review 5 cases per care manager per quarter as part of ongoing supervision and to ensure compliance with CM039. | Clinical Managers | completed | completed | UM clinical documentation review tool Supervision tool | Completed |
| 2) Review PA:Membership ratios and PA: Review/Consult ratios quarterly. Increase resources as necessary. | Schuster | 09/01/2010 | 12/31/2010 | Staff FTE to membership report PA review logs | Completed |
| 3) CM039 Peer Advisor Consult and Referral has been reviewed and revised since submission of the desktop materials. The current policy is dated 12/09. | Taylor | completed | completed | Revised CM039 Policy | Completed |
| 4)Add hardcoded prompt within PsychConsult as the reason for PA Consult/Review being quality of care issue | Taylor | 09/01/2010 | 12/31/2010 | Revised clinical template UM clinical documentation review tool | Completed |

| Recommendation Corrective Action #7 | | | | | |
|---|------------------------|------------|-------------------------|---|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Train all clinical staff in the above areas within the next 12 months, with a plan for monitoring adherence to the required training. | | | | | |
| See Corrective Action #1-6 | Taylor/Wittman | 09/01/10 | 8/30/2011 | Training sign in sheets, agendas, materials | Completed |

| Recommendation Corrective Action #8 | | | | | |
|---|------------------------|------------|-------------------------|---|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Develop a plan to address the frequency of prescriber assessments for individuals with ASD and improve treatment plans. The plan should encourage providers to avoid unnecessary and repetitive evaluations that do not add value and to individualize treatment plans at a level that is realistic given the client's strengths, challenges and resources. | | | | | |
| 1) Review one year authorization option for children/adolescents with ASD in BHRS provider meetings. Emphasize individualized approach for members | Clinical Managers | 09/01/2010 | 12/31/2010 | Provider meeting agenda and minutes Provider alert related frequency of evaluations | Completed |
| 2) Review authorization requests for more frequent evaluations for clinical rationale. | BHRS Care Managers | 09/01/2010 | Ongoing | Care Manager documentation within PsychConsult UM clinical documentation review tool | Completed |
| 3) Include treatment plan indicator on Quality record review tools for providers: Does the BHRS plan include therapy or behavioral interventions specific to the treatment of ASD? | Klanchar | 09/01/2010 | 12/31/2010 | Revised record review tool(s) | Completed |

| Recommendation Corrective Action #9 | | | | | |
|--|------------------------|------------|-------------------------|--|-----------------------------|
| Major Action Steps | Lead Staff Responsible | Start Date | Planned Completion Date | Documented Evidence of Completion | Field Office Staff Comments |
| Develop guidance for care managers when medical co-morbidities are identified and train staff to incorporate collaboration in ongoing care management practice. | | | | | |
| 1) Expand use of Physical Health referral protocol – Community Care now has a fax referral form for those members who have complex medical and mental health issues and may need follow up from a special needs case manager. This referral form will be faxed to the identified contact at the physical health plans special needs unit. The referral form provides the members information, the reason for referral and follow up contacts. The expectation is that the physical health plan will follow up with the member. The goal of this communication process is to aid in the referrals to special needs units and help close any gaps between physical health and behavioral health. | Schuster/Taylor | 09/01/2010 | 06/30/2011 | PH referral protocol documentation within PsychConsult | Completed |
| 2) Ongoing training of above referral process and discussion of PH/BH collaboration during weekly team meetings. | Clinical Managers | | | Team meeting agenda and minutes | |



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. CCBH was not required to submit a root cause analysis and action plan in 2012 based on 2011 Performance.

V: 2012 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of CCBH'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

- CCBH's rates for the MY 2011 Follow-up After Hospitalization for Mental Illness HEDIS indicators, QI 1 and QI 2, were statistically significantly higher than the respective MY 2011 HealthChoices BH MCO Averages by 3.5 and 4.9 percentage points.
- CCBH's rates for the MY 2011 Follow-up After Hospitalization for Mental Illness PA-specific indicators, QI A and QI B, were statistically significantly higher than the respective MY 2011 HealthChoices BH MCO Averages by 2.7 and 2.9 percentage points.
- CCBH's rate for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly lower (better) than the MY 2011 HealthChoices BH MCO Average by 1.2 percentage points.
- CCBH submitted one PIP for validation in 2012 and received full credit for the elements of the study evaluated that reflected activities in 2011 (Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement).

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2009, RY 2010, and RY 2011 found CCBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
 - Within Subpart C: Enrollee Rights and Protections Regulations, CCBH was partially compliant on one out of seven categories – Enrollee Rights.
 - CCBH was partially compliant on one out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant category is Availability of Services (Access to Care).
 - CCBH was partially compliant on four 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) Handling of Grievances and Appeals, and 4) Resolution and Notification: Grievances and Appeals.
- CCBH's MY 2011 QI 1 rate and QI 2 rate both statistically significantly decreased from MY 2010.
- CCBH's MY 2011 QI A rate and QI B rate both statistically significantly decreased from MY 2010.
- CCBH'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%.

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.*



Community Care Behavioral Health (CCBH)

KEY POINTS

▪ **A - No CCBH performance measure rate fell into this comparison category.**

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

Measures that did not statistically significantly change from MY 2010 to MY 2011 but were statistically significantly above/better than the MY 2011 HealthChoices BH MCO Averages are:

- Readmission within 30 Days of Inpatient Psychiatric Discharge¹

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

Measures that were statistically significantly lower from MY 2010 to MY 2011 but were statistically significantly above/better 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)

▪ **D - No CCBH performance measure rate fell into this comparison category.**

▪ **F - No CCBH 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 – CCBH

| HealthChoices BH MCO Average Statistical Significance Comparison | | | | |
|--|-----------|-----------------------------|---------|---|
| Year to Year Statistical Significance Comparison | Trend | Below / Poorer than Average | Average | Above / Better than Average |
| | ↑ | C | B | A |
| | No Change | D | C | B Readmission within 30 Days of Inpatient Psychiatric Discharge |
| | ↓ | F | D | C 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) |

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 – CCBH

| 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) | 51.5% | 51.3% = | 49.3% ▼ | 45.78% |
| Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day) | 72.1% | 73.2% = | 71.7% ▼ | 66.81% |
| Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day) | 62.8% | 62.5% = | 60.3% ▼ | 57.63% |
| Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day) | 78.4% | 78.9% = | 77.6% ▼ | 74.67% |
| Readmission within 30 Days of Inpatient Psychiatric Discharge ¹ | 10.7% | 10.8% = | 11.1% = | 12.34% |

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



VI: SUMMARY OF ACTIVITIES

Structure and Operations Standards

- CCBH 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

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

Performance Measures

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

2011 Opportunities for Improvement MCO Response

- CCBH provided a response to the opportunities for improvement issued in 2011.

2012 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CCBH 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 | <ul style="list-style-type: none"> • A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages. • Excel or Access data base with the following information: Name of Agency (include satellite sites). Address of Agency (and satellite sites) with zip codes. Level of Care (e.g. Partial Hospitalization, D&A Outpatient, etc). Population served (adult, child & adolescent). Priority Population. Special Population. |
| | Standard 1.2 | 100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met. |

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

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

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

| BBA Category | PEPS Reference | PEPS Language |
|--|----------------|---|
| | | timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW. |
| | Standard 104.3 | Performance Improvement Plans status reported within the established time frames. |
| §438.242 Health information systems | Standard 120.1 | The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data. |
| §438.400 Statutory basis and definitions | Standard 68.1 | Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External |
| | Standard 68.2 | 100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | Standard 68.3 | Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s). |
| | Standard 68.4 | The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file. |
| | Standard 68.5 | Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review. |
| | Standard 71.1 | Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited |
| | Standard 71.2 | 100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | Standard 71.3 | Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized. |
| | Standard 71.4 | Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review. |
| | Standard 72.1 | Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year. |
| | Standard 72.2 | Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year. |

| BBA Category | PEPS Reference | PEPS Language |
|----------------------------------|----------------|---|
| §438.402 General requirements | Standard 60.1 | Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances. |
| | Standard 60.2 | Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum. |
| | Standard 60.3 | Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum. |
| | Standard 68.1 | Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External |
| | Standard 68.2 | 100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | Standard 68.3 | Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s). |
| | Standard 68.4 | The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file. |
| | Standard 68.5 | Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review. |
| | Standard 71.1 | Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited |
| | Standard 71.2 | 100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | Standard 71.3 | Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized. |
| | Standard 71.4 | Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review. |
| | Standard 72.1 | Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year. |
| §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 |

| BBA Category | PEPS Reference | PEPS Language |
|--|----------------|---|
| | | 5% requirement is met. |
| | Standard 23.3 | List of interpreters is available for non-English Speakers. |
| | Standard 24.1 | BH-MCO provides application includes information about handicapped accessibility. |
| | Standard 24.2 | Provider network data base contains required information for ADA compliance. |
| | Standard 24.3 | BH-MCO phone answering uses TTY or PA telecommunication relay services. |
| | Standard 24.4 | BH-MCO is able to access to interpreter services. |
| | Standard 24.5 | BH-MCO has the ability to accommodate people who are hard of hearing. |
| | Standard 24.6 | BH-MCO can make alternate formats available upon request. |
| | Standard 72.1 | Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year. |
| | Standard 72.2 | Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year. |
| §438.406 Handling of grievances and appeals | Standard 68.1 | Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External |
| | Standard 68.2 | 100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | Standard 68.3 | Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s). |
| | Standard 68.4 | The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file. |
| | Standard 68.5 | Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review. |
| | Standard 71.1 | Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited |
| | Standard 71.2 | 100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | Standard 71.3 | Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized. |
| | Standard 71.4 | Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the 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. |
| §438.408 Resolution and notification: Grievances and appeals | Standard 68.1 | Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External |
| | Standard 68.2 | 100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | Standard 68.3 | Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s). |
| | Standard 68.4 | The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file. |
| | Standard 68.5 | Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review. |
| | Standard 71.1 | Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited |
| | Standard 71.2 | 100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | Standard 71.3 | Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized. |
| | Standard 71.4 | Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review. |
| | Standard 72.1 | Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year. |
| | Standard 72.2 | Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year. |

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

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

Appendix B: OMHSAS-Specific PEPS 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 |

| Category | PEPS Reference | PEPS Language |
|--------------------------------|----------------|---|
| | | 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 CCBH Counties

OMHSAS-specific items are not required to fulfill BBA requirements. In RY 2011, 11 substandards were considered OMHSAS-specific monitoring standards, and were reviewed. Tables C.1a and C.1b provide a count of these items, along with the relevant categories. Each of the CCBH Counties was evaluated on all 11 OMHSAS-specific substandards.

Table C.1a OMHSAS-Specific Substandards Reviewed for Adams, Allegheny, Berks, Chester, York, NBHCC, and NC/CO Counties

| 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 | 0 | 4 | 0 |
| Grievances and State Fair Hearings (Standard 71) | 4 | 0 | 0 | 4 | 0 |
| Enrollee Satisfaction | | | | | |
| Consumer/Family Satisfaction (Standard 108) | 3 | 3 | 0 | 0 | 0 |

Table C.1b OMHSAS-Specific Substandards Reviewed for NC/SO Counties

| 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 | 0 | 4 | 0 |
| Grievances and State Fair Hearings (Standard 71) | 4 | 0 | 0 | 4 | 0 |
| Enrollee Satisfaction | | | | | |
| Consumer/Family Satisfaction (Standard 108) | 3 | 0 | 3 | 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 (i.e., met, partially met, or not met) and/or applicable RAI tools (i.e., complete or pending)



submitted by OMHSAS. This format reflects the goal of this supplemental review, which is to assess the County/BH MCO's compliance on selected ongoing OMHSAS-specific monitoring standards.

Findings

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

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

| Category | PEPS Item | Review Year | Status |
|---|---------------|-------------|---------------|
| Second Level Complaints and Grievances | | | |
| Complaints | Standard 68.6 | RY 2009 | Met |
| | Standard 68.7 | RY 2009 | Met |
| | Standard 68.8 | RY 2009 | Partially Met |
| | Standard 68.9 | RY 2009 | Met |
| Grievances and State Fair Hearings | Standard 71.5 | RY 2009 | Met |
| | Standard 71.6 | RY 2009 | Met |
| | Standard 71.7 | RY 2009 | Met |
| | Standard 71.8 | RY 2009 | Met |

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

CCBH was "partially met" on Substandard 68.8 (RY 2009):

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

The OMHSAS-specific Substandards relating to Enrollee Satisfaction are County-specific review standards. All three substandards crosswalked to this category were evaluated for the 35 CCBH Counties and were compliant on all three substandards. Statuses by County are presented in Tables C.3a and C.3b.

Table C.3a OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for Adams, Allegheny, Berks, Chester, NBHCC, NC/CO and York Counties

| 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 |



Table C.3b OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for NC/SO Counties

| Category | PEPS Item | Review Year | Status |
|------------------------------|----------------|-------------|--------|
| Enrollee Satisfaction | | | |
| Consumer/Family Satisfaction | Standard 108.3 | RY 2010 | Met |
| | Standard 108.4 | RY 2010 | Met |
| | Standard 108.9 | RY 2010 | Met |

REFERENCES

- i World Health Organization. (2008) WHO Global Burden of Disease: 2004 Update. Available from: www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html
- ii Dombrovski A, Rosenstock J (2004) Bridging General Medicine and Psychiatry: Providing General Medical and Preventive Care for the Severely Mentally Ill. *Current Opinion in Psychiatry*, 17(6):523-529
- iii Moran M. (2009) Schizophrenia Patients Show High Rates of Comorbid Illness. *Psychiatric News*, 44(18):22.
- iv Gill SS. (2005). Stable Monotherapy with Clozapine or Olanzapine Increases the Incidence of Diabetes Mellitus in People with Schizophrenia. *Evid Based Ment Health*, 8(1):24.
- v Leslie DL, Rosenheck RA. (2004) Incidence of Newly Diagnosed Diabetes Attributable to Atypical Antipsychotic Medications. *Am J Psychiatry*, 161:1709–11.
- vi Druss BG, Rosenheck, RA, Desai MM, &Perlin, J. B. (2002). Quality of Preventive Medical Care for Patients with Mental Disorders. *Medical Care*, 40(2):129–136.
- vii Desai M, Rosenheck RA, Druss BG, Perlin J.B. (2002) Mental Disorders and Quality of Diabetes Care in Veterans Health Administration. *Am J Psychiatry*, 159:1584-1590
- viii Frayne SM., Halanych JH., Miller D.R., et al. (2005) Disparities in Diabetes Care: Impact of Mental Illness. *Arch Intern Med*, 165(22):2631-8.
- ix Druss BG, Bradford DW, Rosenheck RA et al. (2000) Mental Disorders and Use of Cardiovascular Procedures After Myocardial Infarction *JAMA*, 283(4):506-11.
- x Averyt JM, Kuno E, Rothbard AB, Culhane DP. (1997) Impact of Continuity of Care on Recurrence of Homelessness Following an Acute Psychiatric Episode. *Continuum* 4.3
- xi National Institute of Mental Health — Statistics.
<http://www.nimh.nih.gov/health/topics/statistics/index.shtml>. updated Mar 31,2009. Accessed May 20, 2009.
- xii Insel TR. (2008) Assessing the Economic Costs of Serious Mental Illness. *Am J Psychiatry*, 165:663-65.
- xiii D'Mello DA, Boltz MK, Msibi B. (1995) Relationship between Concurrent Substance Abuse in Psychiatric Patients and Neuroleptic Dosage. *Am J Drug Alcohol Abuse*, 2:257-65.
- xiv National Committee for Quality Assurance (NCQA, 2007). The State of Health Care Quality 2007. Washington, DC: National Committee for Quality Assurance. Available at http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_2007.pdf (Accessed July 12, 2010).
- xv van Walraven C, Mamdani M, Fang J, Austin PC. (2004) Continuity of Care and Patient Outcomes After Discharge. *J Gen Intern Med*, 19:624-31
- xvi Hermann RC. (2000) Quality measures for mental health care: results from a National Inventory. *Medical Care Research and Review*, 57:136-54

xvii Ibid.

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

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

xx Ibid.

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

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

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

xxiv Ibid.