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

2012 External Quality Review Report
Magellan Behavioral Health
FINAL REPORT

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REPORT CONTENT

GLOSSARY OF TERMS

Average (i.e., arithmetic mean or mean)	The sum of all items divided by the number of items in the list. All items have an equal contribution to the calculation; therefore, this is un-weighted.
Confidence Interval	Confidence interval (CI) is a range of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% CI indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would be within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the CI 95 times, or 95% of the time.
HealthChoices Aggregate Rate	The sum of all behavioral health (BH) managed care organization (MCO) numerators divided by the sum of all BH MCO denominators.
HealthChoices BH MCO Average	The sum of the individual BH MCO rates divided by the total number of BH MCOs (five BH MCOs). Each BH MCO has an equal contribution to the HealthChoices BH MCO Average value.
HealthChoices 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 HealthChoices BH 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 Magellan Behavioral Health's (MBH's) compliance with the structure and operations standards. In Review Year (RY) 2011, 66 PA Counties participated in this compliance evaluation.

Organization of the HealthChoices Behavioral Health Program

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

Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. While Medicaid managed care members may choose a Physical Health (PH) MCO for physical health care services, each HealthChoices enrollee is assigned a BH MCO based on his or her County of residence. IPRO's EQR is based on OMHSAS reviews of Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties and MBH.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of MBH by OMHSAS monitoring staff within the past three 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 MBH, 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, 10 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Substandards were relevant to more than one BBA regulation or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS Item may contribute more than once to the total number of Items required and/or reviewed. Table 1.1 provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of the MBH Counties against the Structure and Operations Standards for this report. In Appendix C, Table C.1 provides a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH MCO and associated Counties against other state-specific Structure and Operations Standards.

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

Table 1.1 Items Pertinent to BBA Regulations Reviewed for MBH 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	3	0	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	17	0	4	1
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	3	0	0	1
Provider Selection	3	3	0	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	8	0
Practice Guidelines	6	2	0	4	0
Quality Assessment and Performance Improvement Program	23	16	0	7	0
Health Information Systems	1	0	0	1	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	1	9	0	1
General Requirements	14	1	12	0	1
Notice of Action	11	10	0	0	1
Handling of Grievances and Appeals	11	1	9	0	1
Resolution and Notification: Grievances and Appeals	11	1	9	0	1
Expedited Appeals Process	6	1	4	0	1
Information to Providers and Subcontractors	2	2	0	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	1	4	0	1
Effectuation of Reversed Resolutions	6	1	4	0	1

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

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

Medicaid Services (CMS) HealthChoices waiver, DPW has been granted an allowance to offer only one BH MCO per County.

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

Determination of Compliance

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

Format

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

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

Findings

For MBH and the five Counties that subcontract with the BH MCO, 159 PEPS Items were identified as required to fulfill BBA regulations, and the entities were evaluated on 149 Items. There were 10 Items that were not scheduled or not applicable for evaluation for RY 2011.

Subpart C: Enrollee Rights and Protections

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

Table 1.2 Compliance with Enrollee Rights and Protections Regulations

Enrollee Rights and Protections				
Subpart C: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Compliant	All MBH Counties		12 substandards were crosswalked to this category. Each County was evaluated on 12 substandards and compliant on 12 substandards.
Provider-Enrollee Communications 438.102	Compliant	All MBH 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 MBH Counties		Compliant as per PS&R sections A.9 (p.64) and C.2 (p.30).
Cost Sharing 438.108	Compliant	All MBH 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 MBH Counties		Compliant as per PS&R section 3 (p.34).
Solvency Standards 438.116	Compliant	All MBH Counties		Compliant as per PS&R sections A.3 (p.59) and A.9 (p.66), and 2011-2012 Solvency Requirements tracking report.

Based on the PEPS substandards reviewed, All MBH Counties were compliant on six categories of Enrollee Rights and Protections Regulations as per the HealthChoices PS&R, and one category as per CMS Regulation 42 CFR 447.50-447.60. The category Solvency Standards was also compliant based on the 2011-2012 Solvency Requirement tracking report. One category, Marketing Activities, was Not Applicable.

Of the 12 PEPS substandards that were crosswalked to the category Enrollee Rights, all 12 were evaluated for each County and all MBH Counties were compliant on all 12 Items.

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 MBH Counties		Compliant as per PS&R section G.3 (p.53).
Availability of Services (Access to Care) 438.206	Compliant	All MBH Counties		22 substandards were crosswalked to this category. Each County was evaluated on 21 substandards and compliant on 21 substandards.
Coordination and Continuity of Care 438.208	Compliant	All MBH Counties		2 substandards were crosswalked to this category. Each County was evaluated on 2 substandards and compliant on both.
Coverage and Authorization of Services 438.210	Partial		All MBH Counties	4 substandards were crosswalked to this category. Each County was evaluated on 3 substandards, compliant on 2 substandards and partially compliant on 1 substandard.
Provider Selection 438.214	Compliant	All MBH Counties		3 substandards were crosswalked to this category. Each County was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	All MBH 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 MBH Counties		8 substandards were crosswalked to this category. Each County was evaluated on 8 substandards and compliant on 8 substandards.
Practice Guidelines 438.236	Compliant	All MBH Counties		6 substandards were crosswalked to this category. Each County was evaluated on 6 substandards and compliant on 6 substandards.
Quality Assessment and Performance Improvement Program 438.240	Compliant	All MBH Counties		23 substandards were crosswalked to this category. Each County was evaluated on 23 substandards and compliant on 23 substandards.

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

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

For this review, 69 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations. Each County was evaluated on 67 substandards. There were 2 substandards not scheduled or not applicable for evaluation for RY 2011. All MBH Counties were compliant on 66 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.

Coverage and Authorization of Services

All MBH Counties were partially compliant with Coverage and Authorization of Services due to partial and non-compliance with one of three substandards within PEPS Standard 72: Substandard 1 (RY 2011)

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

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

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 MBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 5 substandards, partially compliant on 4 substandards, and non-compliant on 1 substandard.
General Requirements 438.402	Partial		All MBH Counties	14 substandards were crosswalked to this category. Each County was evaluated on 13 substandards, compliant on 8 substandards, partially compliant on 4 substandards, and non-compliant on 1 substandard.
Notice of Action 438.404	Partial		All MBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards and compliant on 9 substandards and partially compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All MBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 5 substandards, partially compliant on 4 substandards, and non-compliant on 1 substandard.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All MBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 5 substandards, partially compliant on 4 substandards, and non-compliant on 1 substandard.
Expedited Appeals Process 38.410	Partial		All MBH Counties	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards and compliant on 4 substandards and partially compliant on 1 substandard.
Information to Providers & Subcontractors 438.414	Compliant	All MBH Counties		2 substandards were crosswalked to this category. Each County was evaluated on 2 substandards and compliant on both.

Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Recordkeeping and Recording Requirements 438.416	Compliant	All MBH 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	Partial		All MBH Counties	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards and compliant on 4 substandards and partially compliant on 1 substandard.
Effectuation of Reversed Resolutions 438.424	Partial		All MBH Counties	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards and compliant on 4 substandards and partially compliant on 1 substandard.

MBH was evaluated for compliance on the 10 categories of Federal and State Grievance System Standards. The BH MCO as a whole was compliant on two categories and partially compliant on eight categories. The category Recordkeeping and Recording Requirements was compliant per the 2011 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports. Each MBH County was also compliant on two categories and partially compliant on eight categories.

For this review, 78 substandards were crosswalked to this Subpart for all five MBH Counties, and each County was evaluated on 70 substandards. Eight substandards were not scheduled or not applicable for evaluation for RY 2011. The five Counties were compliant on 46 substandards, partially compliant on 20 substandards and non-compliant on four. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

The five MBH Counties were partially compliant with eight of the 10 categories pertaining to Federal State and Grievance System Standards due to partial or non-compliance with substandards within PEPS Standard 68.

PEPS Standard 68: Complaint 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.

Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties were partially compliant on three substandards of Standard 68: Substandard 2, 3 and 5 (RY 2010).

> **Substandard 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.

Substandard 3: The Complaint Case File includes documentation of the steps taken by the BH MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.

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

Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties were non-compliant on one substandard of PEPS Standard 68: Substandard 4 (RY 2010).

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

All MBH Counties were partially compliant with Coverage and Authorization of Services due to partial and non-compliance on one substandard PEPS Standard 72: Substandard 1 (RY 2011)

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

II: PERFORMANCE IMPROVEMENT PROJECTS

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

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

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

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

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

Validation Methodology

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

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

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

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last two relate to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points are

awarded for the two phases of the project noted above, and are combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance.

Review Element Designation/Weighting

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

Table 2.1 Review Element Scoring Designations and Definitions

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

Overall Project Performance Score

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

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

Scoring Matrix

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

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

Table 2.2 Review Element Scoring Weights

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

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

Findings

As per the timeline distributed by OMHSAS for this review period, BH MCOs were required to submit information for the review elements of Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement. MBH 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, MBH 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 performances measure 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 MCO-specific data, information regarding the BH MCO's previous efforts to impact follow-up rates, and information regarding the MBH's identification of areas of concern regarding follow-up care. MBH included baseline rates from previous studies, noting that while their rates for this measure have increased from previous years, the rates still do not meet the standard of 90% established by OMHSAS for all four indicators. MBH pointed out that this issue has been identified as a priority for performance improvement.

MBH also indicated that they recognize, as has been demonstrated in research, the importance of follow-up in reducing the risk of readmission to the hospital and other 24 hour levels of care. MBH noted that, in accordance with PA's Child and Adolescent Service System Program (CASSP) and Community Support Program (CSP) principles, the goal is to work towards treating members at the least restrictive level of cares to the extent possible. According to MBH, doing so supports individuals in their recovery and realizes benefits from both a utilization and cost of care perspective.

MBH emphasized commitment to recovery-focused treatment, detailing a number of clinical management strategies that are in place. MBH indicated that one strategy has been the use of provider/community-

based and MBH-staffed peer support services. Although these services have had varying degrees of success, MBH stated that the MCO remains committed to examining and adapting the programs to meet community needs. Other strategies involve the BH MCO's care managers and care workers, who MBH noted are essential to the follow-up process. MBH indicated that care managers play a critical role in planning for aftercare services by involving the member directly, engaging him/her in treatment that is recovery focused, and ensuring that the aftercare/discharge process is progressing. Care workers are actively involved with the member in attempting to schedule aftercare appointments, which includes discussing barriers with the member and discussing attempts to re-engage the member with providers. For members identified as high risk, MBH noted that their case managers, as part of an intensive case management program supervised by the Clinical Department, work closely with the member and his/her community-based treatment providers to develop inpatient discharge plans that are consistent with the member's identified needs and recovery goals. As a result of these clinical management activities, MBH stated that the BH MCO's care managers identified discharge planning without a recovery focus and without direct member involvement as a significant quality of care concern. Care managers also identified miscommunication between discharging facilities and community-based/outpatient providers as a concern. MBH noted that the BH MCO would seek to address these issues to improve follow-up.

Baseline results calculated in 2009 for the period January 1, 2008 through December 31, 2008 were previously presented along with analysis that led to interventions initiated in late 2009. Baseline results indicated a rate of 52.0% for QI 1 (HEDIS – seven days), 67.7% for QI 2 (HEDIS – 30 days), 62.6% for QI A (PA-Specific – seven days), and 74.7% for QI B (PA-Specific – 30 days). Following review of baseline data, MBH implemented root cause analysis tools including a brainstorming and fishbone diagram session with the BH MCO's Lehigh and Newtown Offices' Clinical and Quality Management staff to first identify barriers, and then opportunities and interventions to improve performance on the measures. Lehigh staff members included the Medical Director, General Manager, Clinical Director, and Quality Improvement Manager. Newtown staff included the Clinical Officer, Clinical Supervisors, Quality Improvement Director and Quality Improvement Clinical Reviewer. Through brainstorming, MBH identified an extensive list of barriers, which the BH MCO subsequently classified into four broader areas of opportunities via the fishbone diagram process. These four areas, some of which related to concerns identified in the rationale, were: 1) the role of the inpatient/discharging provider, 2) outpatient provider access, 3) members with co-occurring disorder diagnosis; and 4) member engagement in recovery. MBH then developed potential interventions to attempt to address these identified areas.

MBH began implementing Interventions Aimed at Achieving Demonstrable Improvement in early 2009 and continued into 2010. MBH's interventions were developed to address each of the MCO's identified barriers, and were aimed at members, providers, and the BH MCO itself. Some of these interventions included: 1) contracting with peer support specialists, 2) enhancing the provider network for members with co-occurring disorders, 3) acute inpatient provider-specific review of follow-up data for subsequent discussion, corrective action plan, or education, 4) increasing member enrollment in MBH high-risk case management programs, 5) partnering with the Network for Improving Addiction Treatment (NIATx) to work with mental health and substance abuse providers to improve processes that would lead to improved outcomes for members, 6) telephonic auditing of MBH care managers, including staff management of the discharge planning process with providers, 7) arranging and participating in conferences/meetings for members, focusing on what is needed to support individuals to remain in the community.

Remeasurement results calculated in 2011 for January 1, 2010 through December 31, 2010 were presented along with additional analysis to compare the MY 2010 rates against the baseline rates, against the statewide HC BH-MCO average, and against the goal. Rates increased for three of the four indicators: QI 2 (HEDIS – 30 days), QI A (PA-Specific – seven days), and QI B (PA-Specific – 30 days). Because of the increases to these indicators, Demonstrable Improvement was achieved. QI 2 increased to 68.45, QIA increased to 62.77%, and QIB increased to 76.04%. Although all rates remained below the OMHSAS benchmark of 90%, QIA and QIB exceeded the MCO's goals for remeasurement (67.74% and 74.65%, respectively). Greater improvements were observed for the 30-day measures. Additionally, MBH noted rates were higher than the statewide HC BH-MCO average for all indicators.

MBH noted that, following review of the 2010 re-measurement results, the barriers identified through the initial brainstorming process were reviewed and were identified as remaining, with no additional barriers identified. MBH's subsequent interventions included ongoing previous interventions aimed at achieving demonstrable improvement, with MBH providing updates for a number of them. MBH continued to contract with additional Certified Peer Support providers. The MCO also increased the number and focus of its provider-specific acute inpatient reviews, which resulted in repeated and additional provider-specific meetings, corrective action plans, and educational sessions. The telephonic auditing process of care managers continued, with the goal for the Care Management Centers (CMCs) to complete five audits per care manager per month. MBH also continued to enroll additional members in its high risk case management programs, and continued its member conferences and meetings. Additionally, the MCO included a number of new interventions, including 1) Mental Health Inpatient Provider Forums to discuss barriers, data trends, areas for improvement, and best practices as well as requested action plans. MBH plans to continue these forums and incorporate Outpatient providers; 2) MBH's Lehigh Care Management Center contracted with Recovery Partnership to offer Certified Peer Specialist (CPS) services to visit members who readmit into IP MH facilities. MBH's Lehigh Care Management Center contracted with Recovery Partnership to offer Certified Peer Specialist (CPS) services to visit members who readmit into IP MH facilities. The CPS conducts the visits for chronic SMI members who prefer not to be seen by MCO staff; 3) The Lehigh CMC worked with a local Outpatient Mental Health provider to develop a Tele-Health program model focusing on the SMI population and on particular members who have a history of readmission; 4) Addition of medical mobile crisis services in the network for Lehigh CMC.

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

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

Review Element	Compliance Level	Scoring Weight	Final Points Score
1. Project Title, Type, Focus Area	Full	5%	5
2.Topic Relevance	Full	5%	5
3. Quality Indicators	Full	0%	0
4. Baseline Study and Analysis (Calendar Year (CY) 2008, reported in CY 2009)	Full	20%	20
5. Baseline Study Population and Baseline Measurement Performance (CY 2008)	Full	10%	10
6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010)	Full	20%	20
7. Demonstrable Improvement (CY 2010, reported in 2011)	Full	20%	TBD
Total Demonstrable Improvement Score			**TBD**
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Full	5%	TBD
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)	52.0%	NA	50.79%	TBD	90%
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	67.7%	NA	68.45%[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)	62.6%	NA	62.77%[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)	74.7%	NA	76.04%[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. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

Findings

BH MCO and County Results

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

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

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

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

	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
QI 1										
HealthChoices	16,621	36,038	**46.1%**	45.6%	46.6%	45.8%	47.4%	46.1%	0.0	NO
MBH	2,749	5,532	**49.7%**	48.4%	51.0%			50.8%	-1.1	NO
Bucks	417	892	**46.8%**	43.4%	50.1%			52.6%	-5.8	NO
Delaware	604	1,167	**51.8%**	48.9%	54.7%			46.4%	5.4	YES
Lehigh	652	1,327	**49.1%**	46.4%	51.9%			50.4%	-1.3	NO
Montgomery	676	1,357	**49.8%**	47.1%	52.5%			51.4%	-1.6	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
Northampton	400	789	**50.7%**	47.1%	54.3%			55.0%	-4.3	NO
QI 2										
HealthChoices	24,159	36,038	**67.0%**	66.6%	67.5%	66.8%	70.7%	66.9%	0.1	NO
MBH	3,757	5,532	**67.9%**	66.7%	69.1%			68.5%	-0.5	NO
Bucks	584	892	**65.5%**	62.3%	68.6%			69.0%	-3.5	NO
Delaware	792	1,167	**67.9%**	65.1%	70.6%			65.7%	2.1	NO
Lehigh	877	1,327	**66.1%**	63.5%	68.7%			67.5%	-1.4	NO
Montgomery	946	1,357	**69.7%**	67.2%	72.2%			70.0%	-0.3	NO
Northampton	558	789	**70.7%**	67.5%	74.0%			70.8%	-0.1	NO

The MY 2011 HealthChoices aggregate rates were 46.1% for QI 1 and 67.0% for QI 2. There were no statistically significant differences between MY 2011 and MY 2010 rates for either measure. MBH's MY 2011 QI 1 rate of 49.7% and QI 2 rate of 67.9% were comparable to (i.e., not statistically significantly different from) MY 2010 rates.

For MY 2011, MBH's QI 1 rate of 49.7% was statistically significantly higher than the MY 2011 QI 1 HealthChoices BH MCO Average of 45.8% by 3.9 percentage points. MBH's MY 2011 QI 2 rate of 67.9% was also higher than the MY 2011 QI 2 HealthChoices BH MCO Average of 66.8% by 1.1 percentage points. This difference was not statistically significant.

As presented in Table 3.1, the QI 1 rate for Delaware County statistically significantly increased between MY 2010 and MY 2011 by 5.4 percentage points. The MY 2011 QI 1 rates for the remaining four Counties, along with the QI 2 rates for all five Counties, did not statistically significantly change as compared to MY 2010 rates.

Figure 3.1 MY 2011 HEDIS Indicator Rates

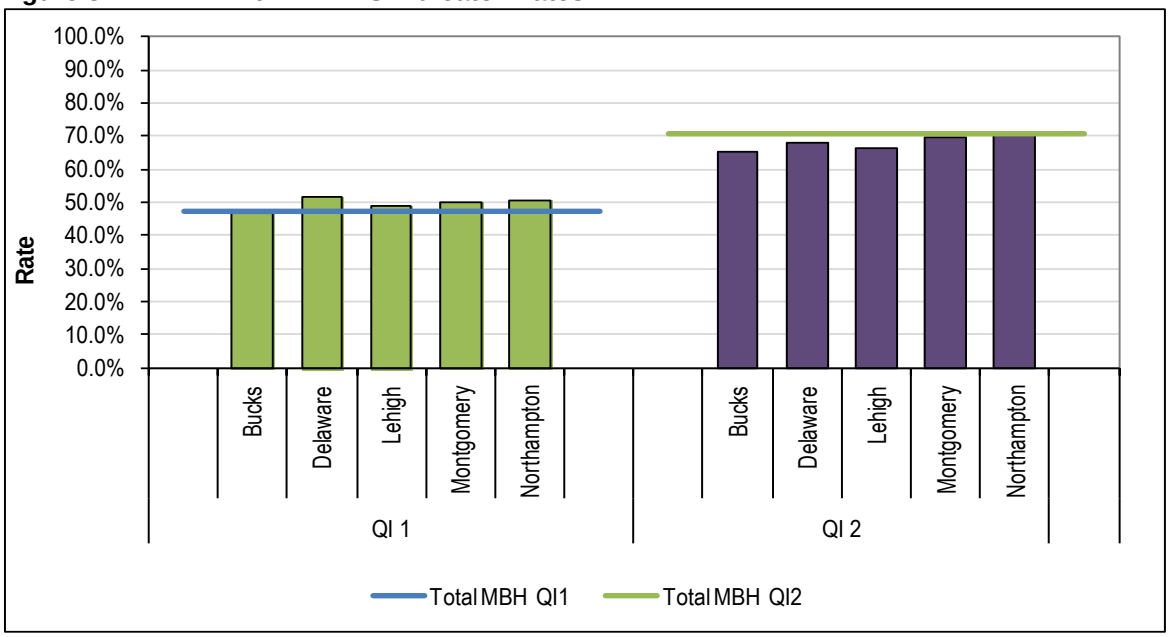


Figure 3.1 displays a graphical representation of the MY 2011 HEDIS follow-up rates for MBH and its associated Counties. Figure 3.2 presents the individual MBH Counties that performed statistically significantly above or below the MY 2011 HealthChoices County Average. In MY 2011, the QI 1 rates for Delaware County performed statistically significantly higher than the MY 2011 QI 1 HealthChoices County Average of 47.3%. Rates for the remaining MBH Counties were not statistically significantly different from the HealthChoices County Average For QI 2, the rates for Bucks, Delaware and Lehigh Counties were statistically significantly below the MY 2011 QI 2 HealthChoices County Average of 70.7%. Rates for the remaining MBH Counties were not statistically significantly different from the HealthChoices County Average.

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

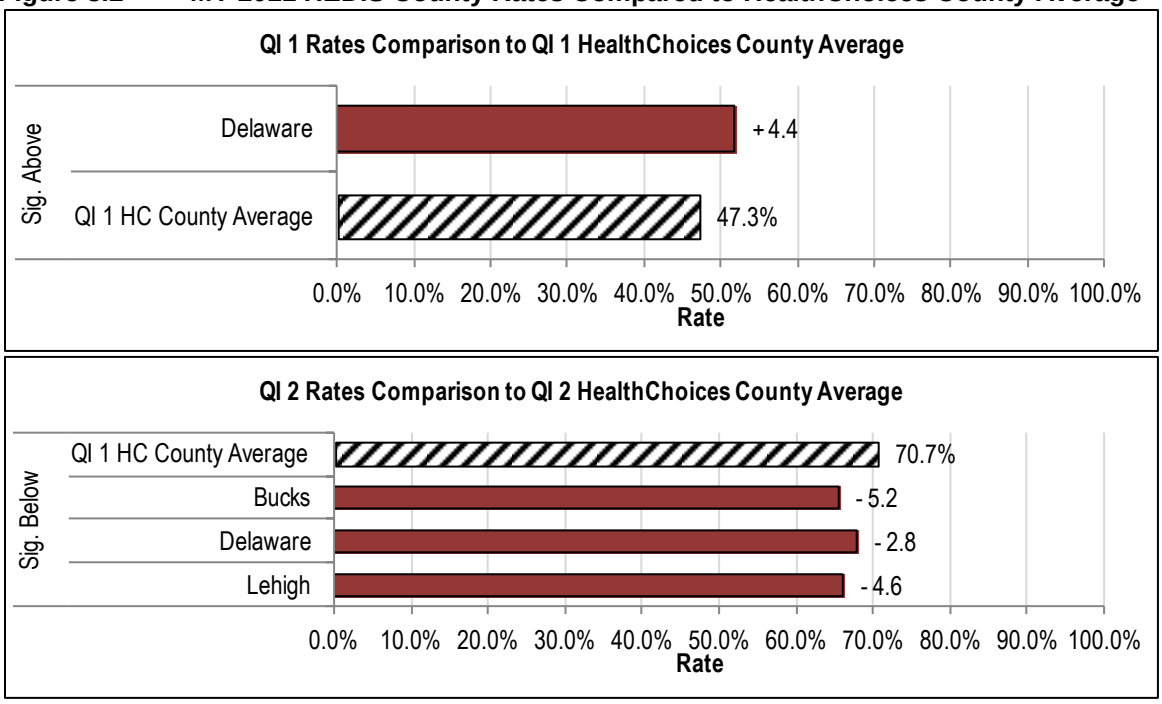


Table 3.2 MY 2011 PA-Specific Indicator Rates with Year-to-Year Comparisons

	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
MBH	3,434	5,532	**62.1%**	60.8%	63.4%			62.8%	-0.7	NO
Bucks	528	892	**59.2%**	55.9%	62.5%			65.6%	-6.4	YES
Delaware	777	1,167	**66.6%**	63.8%	69.3%			61.8%	4.8	YES
Lehigh	786	1,327	**59.2%**	56.5%	61.9%			60.6%	-1.4	NO
Montgomery	845	1,357	**62.3%**	59.7%	64.9%			63.2%	-0.9	NO
Northampton	498	789	**63.1%**	59.7%	66.6%			63.8%	-0.7	NO
QI B										

	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	26,939	36,038	**74.8%**	74.3%	75.2%	74.7%	77.1%	74.6%	0.1	NO
MBH	4,184	5,532	**75.6%**	74.5%	76.8%			76.0%	-0.4	NO
Bucks	654	892	**73.3%**	70.4%	76.3%			77.4%	-4.1	NO
Delaware	897	1,167	**76.9%**	74.4%	79.3%			74.4%	2.4	NO
Lehigh	969	1,327	**73.0%**	70.6%	75.4%			75.1%	-2.1	NO
Montgomery	1,050	1,357	**77.4%**	75.1%	79.6%			77.2%	0.2	NO
Northampton	614	789	**77.8%**	74.9%	80.8%			76.4%	1.5	NO

The MY 2011 HealthChoices aggregate rates were 57.8% for QI A and 74.8% for QI B. There were no statistically significant year-to-year differences between MY2011 and MY 2010 for either measure. MBH's QI A rate of 62.1% and QI B rate of 75.6% for MY 2011 both decreased from MY 2010 rates. These year-to-year differences were not statistically significant.

In MY 2011, MBH's QI A rate of 62.1% was statistically significantly higher than the MY 2011 QI A HealthChoices BH MCO Average of 57.6% by 4.5 percentage points. MBH's QI B rate of 75.6% was higher than the MY 2011 QI B HealthChoices BH MCO Average of 74.7% by 0.9 percentage points. This difference was not statistically significant.

As presented in Table 3.2, QI A MY 2011 rates for Bucks County decreased statistically significantly from MY 2010 to MY 2011 by 6.4 percentage points and increased statistically significantly for Delaware County from MY 2010 to MY 2011 by 4.8 percentage points. There were no statistically significant year-to-year differences observed for QI B County rates. Figure 3.3 displays a graphical representation of the MY 2011 PA-specific follow-up rates for MBH and its associated Counties. Figure 3.4 presents the individual MBH Counties that performed statistically significantly higher or lower than the MY 2011 HealthChoices County Average.

Figure 3.3 MY 2011 PA-Specific Indicator Rates

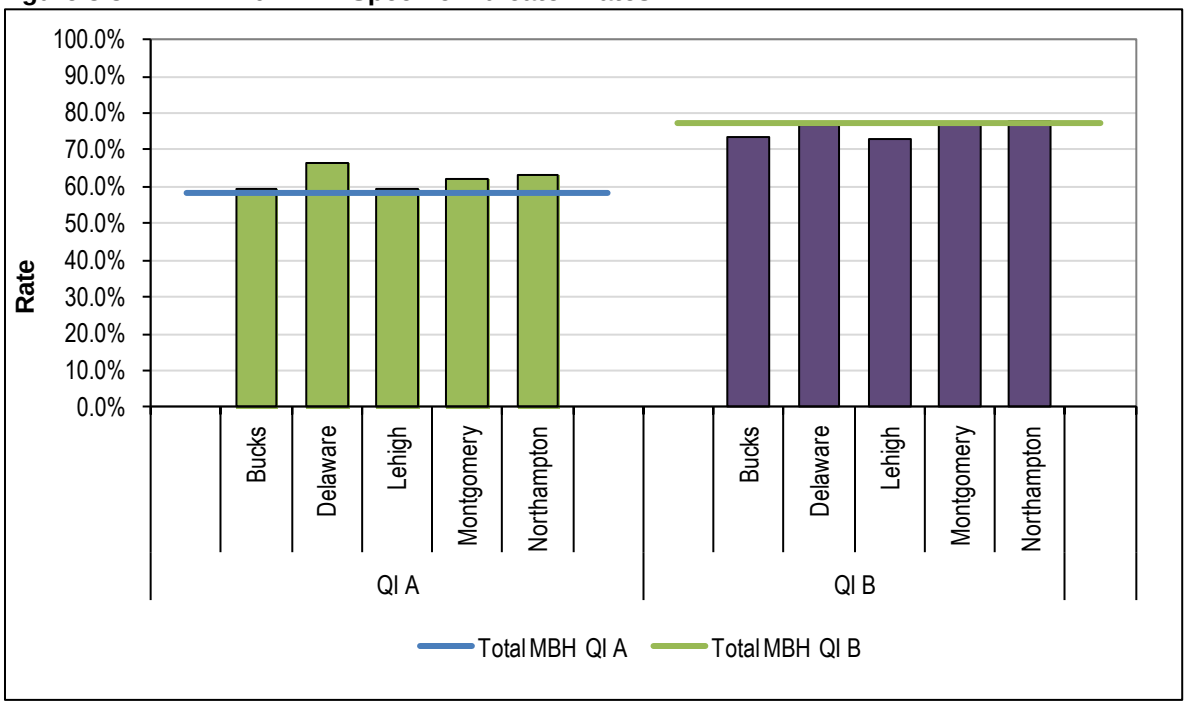
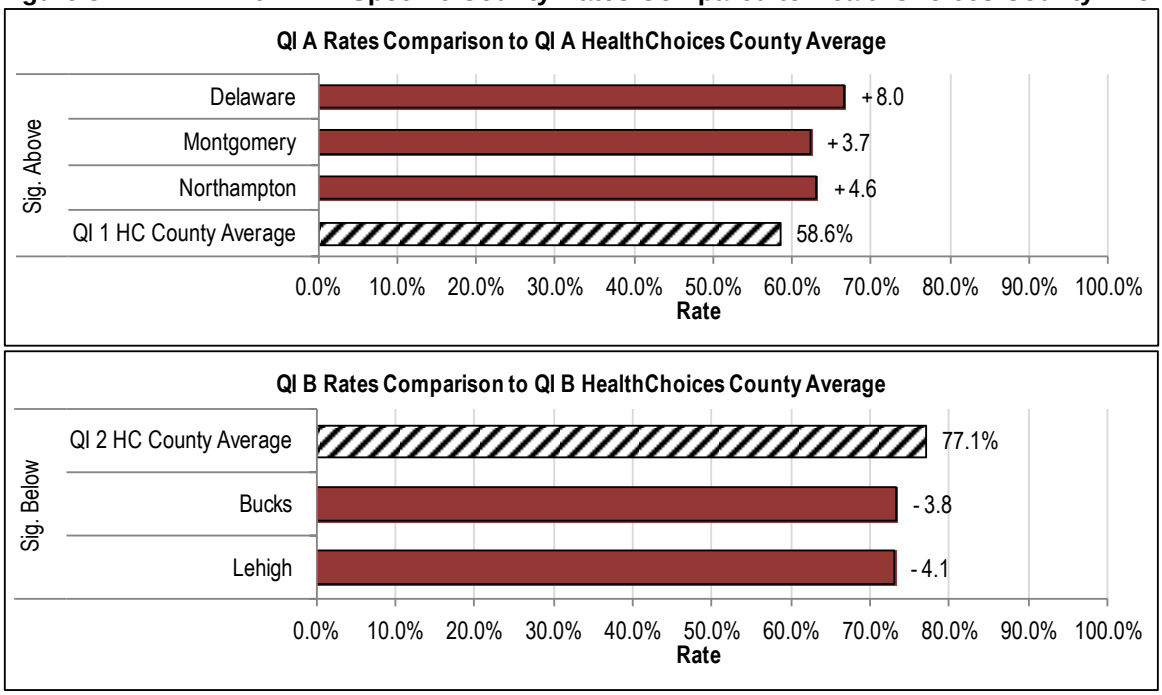


Figure 3.4 MY 2011 PA-Specific County Rates Compared to HealthChoices County Average



For MY 2011, the QI A rates for Delaware, Montgomery and Northampton Counties were statistically significantly higher than the MY 2011 QI A HealthChoices County Average of 58.6%, and the QI B rates for Bucks and Leigh Counties were statistically significantly below the QI B HealthChoices County Average of 77.1%. The rates for the remaining MBH Counties were not statistically significantly different from the respective HealthChoices County Averages.

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
HEDIS 2012 (MY 2011)						
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 MBH rates to HEDIS 2012 benchmarks, the QI 1 rate of 49.7% and QI 2 rate of 67.9% both fell between the 50th and 75th percentile ranges for each respective measure. These findings were consistent with MY 2010 where MBH's QI 1 rate of 50.8% and QI 2 rate of 68.5% also fell between the 50th and 75th percentile ranges HEDIS 2010 Medicaid benchmarks.

Conclusion and Recommendations

Efforts should continue to be made to improve performance with regard to Follow-up After Hospitalization for Mental Illness, particularly for those BH MCOs that performed below the HealthChoices BH MCO Average.

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

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

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

cause and barrier analyses to identify further impediments in receiving follow-up care, and then implement action and monitoring plans to further increase their rates.

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

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

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

Readmission within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow up After Hospitalization for Mental Illness, OMHSAS elected to re-measure the Readmission within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Re-measurements were conducted in 2010 and 2011 on MY 2009 and MY 2010 data, respectively. The MY 2011 study conducted in 2012 was the fifth re-measurement of this indicator, and the indicator specification had no significant changes as compared to MY 2010. This measure continued to be of interest to OMHSAS for the purposes of comparing County and BH MCO rates to the OMHSAS performance goal and to prior rates.

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

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

Eligible Population

The entire eligible population was used for all 67 Counties participating in the MY 2011 study.

Eligible cases were defined as those members in the HealthChoices Behavioral Health Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2011;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim must be clearly identified as a discharge.

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

Methodology

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

Performance Goals

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

Findings

BH MCO and County Results

The results are presented at the BH MCO and then County level when multiple Counties contract with a single BH MCO. Year-to-year comparisons of MY 2011 to MY 2010 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

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

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

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

	MY 2011							MY 2010	RATE COMPARISON MY 2011 to MY 2010	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH-CHOICES BH MCO AVERAGE	HEALTH-CHOICES COUNTY AVERAGE	%	PPD	SSD
HealthChoices	5,798	48,312	**12.0%**	11.7%	12.3%	12.3%	9.9%	12.2%	-0.2	NO
MBH	1,242	8,458	**14.7%**	13.9%	15.4%			14.7%	0.0	NO
Bucks	151	1,388	**10.9%**	9.2%	12.6%			13.1%	-2.2	NO
Delaware	262	1,823	**14.4%**	12.7%	16.0%			12.6%	1.7	NO
Lehigh	313	1,935	**16.2%**	14.5%	17.8%			16.7%	-0.6	NO
Montgomery	364	2,168	**16.8%**	15.2%	18.4%			15.8%	1.0	NO
Northampton	152	1,144	**13.3%**	11.3%	15.3%			14.5%	-1.2	NO

The aggregate MY 2011 HealthChoices readmission rate was 12.0%. MBH's rate of 14.7% was statistically significantly higher than the HealthChoices BH MCO Average of 12.3% by 2.4 percentage points, but did not differ statistically significantly from the MY 2010 rate of 14.7%. Note that this measure is an inverted rate, in that lower rates are preferable. MBH did not meet the performance goal of 10.0% in MY 2011.

As presented in Table 3.4, none of the Counties met the performance goal of 10.0% in MY 2011. The rates for Delaware, Lehigh, Montgomery and Northampton Counties were statistically significantly higher (poorer) than the HealthChoices County Average of 9.9%. Note that this measure is an inverted rate, in that lower rates are preferable.

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

Figure 3.5 MY 2011 Readmission Rates

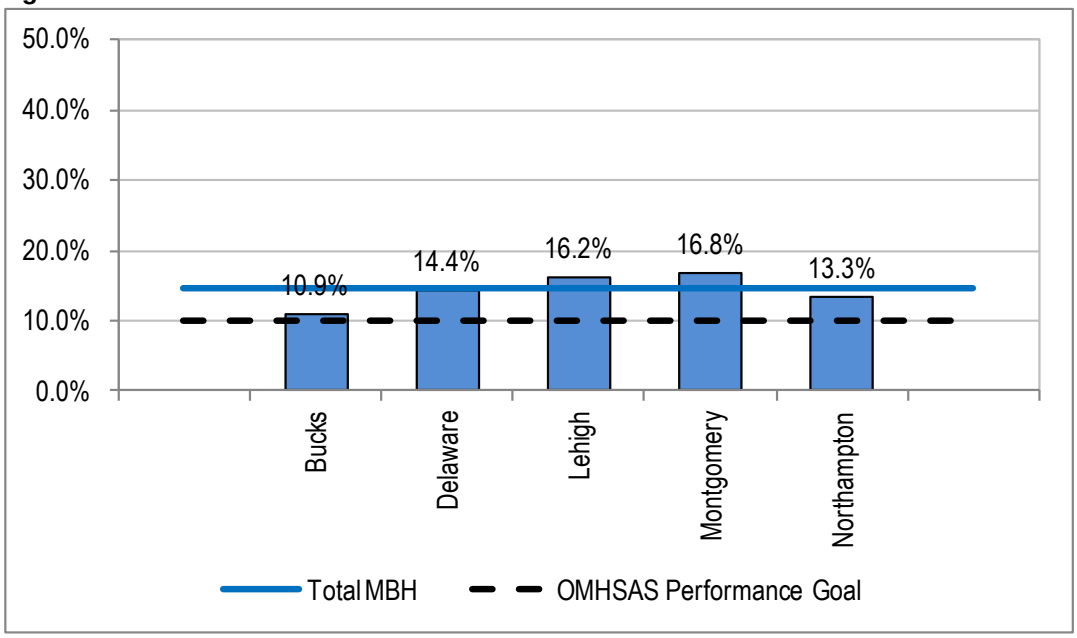
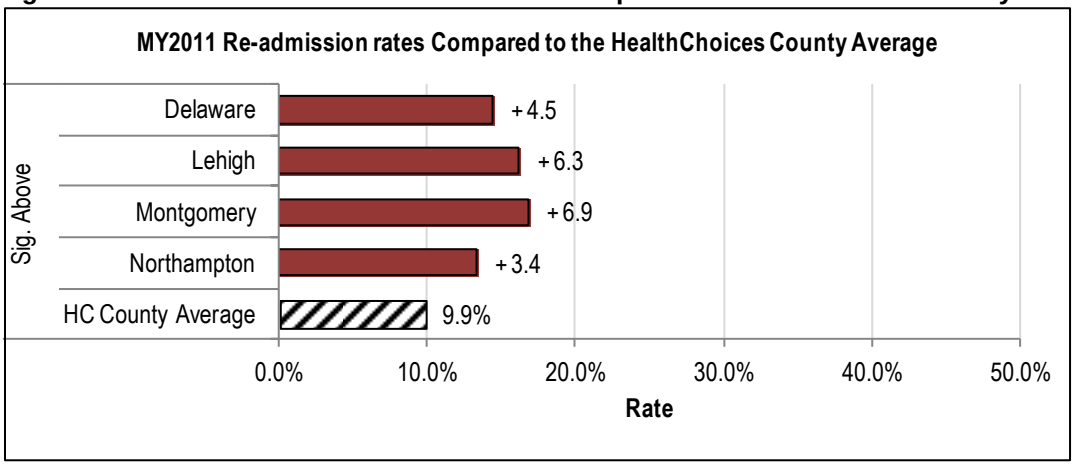


Figure 3.6 MY 2011 Readmission Rates Compared to HealthChoices County Average



Conclusion and Recommendations

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

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

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

- As with MY 2010, no significant improvement was noted for any of the BH MCOs for MY 2011. IPRO recommends that the Counties and BH MCOs participating in this study conduct root cause analyses

to help determine what factors are negatively impacting readmission rates, and develop interventions that target specific barriers to improving the readmission rates.

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

IV: 2011 OPPORTUNITIES FOR IMPROVEMENT MCO RESPONSE

Current and Proposed Interventions

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

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

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

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

Table 4.1 Current and Proposed Interventions: Opportunities for Improvement

Reference Number	Opportunity for Improvement	MCO Response
Structure and Operations Standards		
MBH 1	Within Subpart C: Enrollee Rights and Protections Regulations, MBH was partially compliant on one out of seven categories – Enrollee Rights.	**Follow Up Actions Taken Through 09/30/12** **Enrollee Rights** **Standard 108, Substandard 1 (Lehigh & Northampton)** Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Recovery Partnership (Consumer/ Family Satisfaction Team [CFST]) continues to administer at least 552 satisfaction surveys annually. Magellan also amended their contract in 2011 which includes CFST providing some Certified Peer Support (CPS) Services for Magellan. OMHSAS feedback from the triennial review of this substandard in 2012 for RY2011 indicates that "The HC contractual requirements are met. County/BH-MCO oversight is sufficient." See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012TriennialCFST(108) & Northampton2012TriennialCFST(108)].  Lehigh2012TriennialCFST(108).doc  Northampton2012TriennialCFST(108).doc **Enrollee Rights** **Standard 108, Substandard 2 (Montgomery)**

Reference Number	Opportunity for Improvement	MCO Response
		Please refer to Response to 2010 EQR and attachments submitted on 10/20/11. The actions put into place in response to prior EQR reports have been effective. The embedded document below provides documentation that Montgomery County met this Standard/Substandard in the 2012 review of RY 2011. OMHSAS feedback from the triennial review of this substandard in 2012 for RY2011 indicates that 'Each satisfaction team budget is reviewed quarterly and adjustments are made, if additional or less money is needed. Annually, each satisfaction team also participated in the budget review process in which the Scope of Work is identified and budgets are formulated accordingly.'  2011 PEPS 09 Montgomery Co Trier **Enrollee Rights** **Standard 108, Substandard 2 (Lehigh & Northampton)** Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. CFST was given an increase. Magellan also amended their contract in 2011 which includes CFST providing some Certified Peer Support (CPS) Services for Magellan. OMHSAS feedback from the triennial review of this substandard in 2012 for RY2011 indicates that "C/FST staff and director reports adequate staff and support budget to satisfy requirements of the contract. They are able to complete the majority of surveys face to face which is the gold standard. Lehigh county requires 329 surveys annually. Northampton County requires 223 surveys annually. They are able to obtain ongoing training on a variety of topics." See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012TriennialCFST(108) & Northampton2012TriennialCFST(108)]. **Standard 108, Substandard 3 (Lehigh & Northampton)** Please refer to Response to 2009 EQR and attachments, particularly the workflow attachment, submitted on 10/5/10. Please also see Response to 2010 EQR and attachments, submitted on 10/20/11. Quarterly meetings were held 8/31/11, 11/30/11, 2/29/12, 5/30/12 & 9/26/12 with Recovery Partnership, the Counties and Magellan. Discussion of current processes and workflows is, and will continue to be, a standing agenda item. Please see attached meeting agendas from Aug 2011 through Sept 2012.

Reference Number	Opportunity for Improvement	MCO Response
		 CFST agenda,8.31.11.doc  CFST agenda,11.30.11.doc  CFST agenda,2.29.12.doc  CFST agenda,5.30.12.doc  CFST agenda,9.26.12.doc OMHSAS feedback from the triennial review of this substandard in 2012 for RY2011 indicates that "C/FST staff reports that they are supported, and are included in decision making." See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012 TriennialCFST(108) & Northampton2012 TriennialCFST(108)]. **Standard 108, Substandard 4 (Lehigh & Northampton)** Please refer to Response to 2009 EQR and attachments, particularly the workflow attachment, submitted on 10/5/10. Please also see Response to 2010 EQR and attachments, submitted on 10/20/11. OMHSAS feedback from the triennial review of this substandard in 2012 for RY2011 indicates that "Director reports he is included in all aspects of the survey process. Survey quality is high." See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012 TriennialCFST(108) & Northampton2012 TriennialCFST(108)]. **Enrollee Rights** **Standard 108, Substandard 5 (Lehigh & Northampton)** Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. The number of telephonic surveys has increased; but, the majority of the surveys are conducted face to face, which is the preferred method. The Director of Recovery Partnership reports they do have the capability to conduct focus groups. There is a standing agenda item on the quarterly meeting agenda with Recovery Partnership, Counties and Magellan regarding the survey/audit process, which includes CFST having adequate access to member names—agenda item "Check in regarding audit process workflows, reports, etc."Please see previously attached meeting agendas from Aug 2011 through Sept 2012. See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012TriennialCFST(108) & Northampton2012TriennialCFST(108)], for which this substandard was met. **Enrollee Rights** **Standard 108, Substandard 6 (Montgomery)**

Reference Number	Opportunity for Improvement	MCO Response
		Please refer to Response to 2010 EQR and attachments submitted on 10/20/11. The actions put into place in response to prior EQR reports have been effective. The embedded document below provides documentation that Montgomery County met this Standard/Substandard in the 2012 review of RY 2011. OMHSAS feedback from the review of this Standard/Substandard in 2012 for RY2011 indicates that 'The problem resolution process is clearly defined, and the "closing the loop" process ensures that C/FST staff is assured of the outcomes.' 2011 PEPS 09 Montgomery Co Trier **Enrollee Rights** **Standard 108, Substandard 6 (Lehigh & Northampton)** Please refer to Response to 2009 EQR and attachments submitted on 10/5/10. Any member concerns reported to Recovery Partnership are discussed with Magellan and the Counties, as well as possible solutions. Follow up occurs with appropriate parties. OMHSAS feedback from the triennial review of this substandard in 2012 for RY2011 indicates that "The problem resolution process does specify roles and timely follow up is achieved. C/FST director reports the feedback loop has been closed and they are aware of problems resolution results." See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012TriennialCFST(108) & Northampton2012TriennialCFST(108)]. **Enrollee Rights** **Standard 108, Substandard 7 (Lehigh & Northampton)** Please refer to Response to 2009 EQR and attachments submitted on 10/5/10, particularly the workflow document and discussion of CFST provider specific survey results which are included in the provider overall audit report to which they are held accountable for any areas for improvement with the submission of a corrective action plan. Feedback loop is provided to Recovery Partnership. Actions taken on negative responses are reported at Community HealthCare Alliance (CHA) Meetings to providers and members (meetings occur every 2 mos.) and at the HealthChoices Advisory Board (HAB) Meetings. CFST staff has information regarding how members can file a complaint/grievance, so they can inform members who state they do not know. This information is also available on the Magellan of PA HealthChoices website and trainings were provided at CHA and HAB.

Reference Number	Opportunity for Improvement	MCO Response
		OMHSAS feedback from the triennial review of this substandard in 2012 for RY2011 indicates that "All elements are included in the quarterly reports, including actions taken with providers and any systemic issues that have been identified." See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012TriennialCFST(108) & Northampton2012TriennialCFST(108)]. **Standard 108, Substandard 9 (Lehigh & Northampton)** Magellan does not wait for the results of the profile to act on a trend with providers—they are done on a more frequent basis via treatment record review audits, claims audits, compliance audits, ongoing daily and monthly monitoring and reporting of Quality of Care Concerns (QCCs), adverse incident and claims data trends, etc. Providers are held accountable, via a Corrective Action Plan (CAP), in addressing any areas needing improvement, as a result of the provider specific CFST member satisfaction survey, immediately after the audit is conducted. The 2012 profiles will include provider specific survey results, if applicable to the providers chosen. We have had several providers from various levels of care submit a CAP for an area identified via the survey (majority regarding discharge planning). OMHSAS feedback from the triennial review of this substandard in 2012 for RY2011 indicates that "Surveys may result in a corrective action plan by the provider which are monitored to ensure improvement. C/FST staff are made aware of provider progress toward the corrective action plan." See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012 TriennialCFST(108) & Northampton2012 TriennialCFST(108)]. **Enrollee Rights** **Standard 108, Substandard 10 (Lehigh & Northampton)** Please refer to Response to 2009 EQR and attachments submitted on 10/5/10 and responses to previous substandards regarding improving relationships, increasing responsibility and incorporation of survey findings regarding provider improvements/ accountability. OMHSAS feedback from the triennial review of this substandard in 2012 for RY2011 indicates that "The CFST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement." See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012 TriennialCFST(108) & Northampton2012 TriennialCFST(108)].
		Future Actions Planned **Enrollee Rights** **Standard 108, Substandard 1 (Lehigh & Northampton)**

Reference Number	Opportunity for Improvement	MCO Response
		Continue to have at least quarterly meetings with Counties and Recovery Partnership. Improvements/enhancements to workflow will be discussed on an ongoing basis, if issues/ obstacles arise and also at quarterly meetings with Recovery Partnership, the Counties and Magellan. Regular dialogue and seeking out feedback from Recovery Partnership is ongoing. Expected outcomes include improved services for members as additional areas for improvement will be able to be captured at the provider level of care specific area and providers will be held accountable to address these issues. Contractual requirements will continue to be met. Contracts are reviewed yearly by the General Manager and will continue to be done. Actions are reviewed at the quarterly meetings with Recovery Partnership, the Counties and Magellan and an open line of communication is occurring between Recovery Partnership and Magellan. OMHSAS feedback from the triennial review of this substandard in 2012 for RY2011 indicates that "The HC contractual requirements are met. County/BH-MCO oversight is sufficient." **Enrollee Rights** **Standard 108, Substandard 2 (Montgomery)** As the current interventions met the requirements for this Standard/Substandard in the most recent PEPS review (2012 review of RY 2011), these interventions will remain in place. **Enrollee Rights** **Standard 108, Substandard 2 (Lehigh & Northampton)** Contracts are reviewed yearly by the General Manager and will continue to be done, to ensure appropriate payment for services. Actions are reviewed at the quarterly meetings with Recovery Partner-ship, the Counties and Magellan and an open line of communication is occurring between Recovery Partnership and Magellan. See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012TriennialCFST(108) & Northampton2012TriennialCFST(108)]. **Standard 108, Substandard 3 (Lehigh & Northampton)** Actions are reviewed and will continue to be reviewed at the quarterly meetings with Recovery Partnership, the Counties and Magellan. These meetings can be and are increased to monthly when needed. Counties are always involved in actions and meetings with CFST for monitoring and involvement for feedback. Assessment of new contract amendment with CFST for provision of CPS for Magellan is, and will continue to be, assessed on an ongoing basis. See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012TriennialCFST(108) & Northampton2012TriennialCFST(108)]. **Standard 108, Substandard 4 (Lehigh & Northampton)** Please see response to previous sub-standards as they are all related to the ongoing improved workflows and

Reference Number	Opportunity for Improvement	MCO Response
		involvement which will continue. Quarterly meetings are scheduled to obtain feedback and monitor progress/discuss any barriers. Meetings are held at least quarterly (Feb/May/Aug/Nov). New survey questions will continue to be discussed for addition to survey in the future. See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012 TriennialCFST(108) & Northampton2012 TriennialCFST(108)]. **Enrollee Rights** **Standard 108, Substandard 5 (Lehigh & Northampton)** Continue to use and provide the claims information to Recovery Partnership in order for them to have member information from which to contact them to conduct surveys. Recovery Partnership continues to get information regarding upcoming Magellan audits by provider and level of care and reports they have the ability to conduct focus groups, on site interviews at providers, telephonic surveys and surveys via the computer/internet. This process will continue to be monitored via ongoing communication with Recovery Partnership staff and at the quarterly meetings with CFST, Counties and Magellan. An open line of communication is occurring between Recovery Partnership and Magellan. See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012TriennialCFST(108) & Northampton2012TriennialCFST(108)]. **Enrollee Rights** **Standard 108, Substandard 6 (Montgomery)** As the current interventions met the requirements for this Standard/Substandard in the most recent PEPS review (2012 review of RY 2011), these interventions will remain in place. **Enrollee Rights** **Standard 108, Substandard 6 (Lehigh & Northampton)** Continue to address any issues that arise as a result of responses from CFST satisfaction surveys; continue to meet with CFST and Counties quarterly to discuss survey results, etc. Magellan QI Director coordinates the quarterly meetings with CFST and the Counties. Expected outcome is improvement in satisfaction survey scores; improvement in overall member satisfaction; continuation of quarterly meetings; ongoing communication with CFST and County staff; analysis of quarterly CFST survey results. Continue to utilize workflow and revise, if necessary, in collaboration with CFST and the Counties. An open line of communication is occurring between Recovery Partnership and Magellan. See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012TriennialCFST(108) & Northampton2012TriennialCFST(108)]. **Enrollee Rights** **Standard 108, Substandard 7 (Lehigh & Northampton)**

Reference Number	Opportunity for Improvement	MCO Response
		Continue with the actions mentioned in previous substandard. Continue to report to providers their specific level of care results once received from Recovery Partnership and have them address any areas deemed necessary, via the report from Recovery Partnership. Recovery Partnership is apprised of actions taken with providers and will continue to be, via ongoing communication and during the quarterly meetings held. Continue interventions re: issues that arise and in areas scoring below benchmark. Expected outcome is improvement in satisfaction survey scores; improvement in overall member satisfaction. See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012 TriennialCFST(108) & Northampton2012 TriennialCFST(108)]. **Standard 108, Substandard 9 (Lehigh & Northampton)** Continue to provide audit findings data, which includes survey findings from CFST, as part of the annual provider profiles. Individual provider profile letters will include information regarding results of the provider/ level of care specific member satisfaction survey results for those providers who had an audit conducted in the measurement year. Magellan does not wait for the distribution of the provider profiles to have providers act on any areas for improvement. Providers respond via a CAP, after the audit occurs, which is much more timely. Expected outcome will be increased provider accountability and improved member satisfaction and services, monitoring via corrective action plan reviews and follow-up audits. See attached OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012 TriennialCFST(108) & Northampton2012 TriennialCFST(108)]. **Enrollee Rights** **Standard 108, Substandard 10 (Lehigh & Northampton)** Continue previously mentioned actions, workflows, meetings, oversight and monitoring indicated in the substandards addressed under Standard 108. Expected outcome has been, and will continue to be, increased communication between Magellan/Counties and Recovery Partnership, ease in the ability of CFST to have access to members to conduct surveys, increased number of members surveyed, so that more members are heard and more potential issues can be addressed, and improvement in member satisfaction and services. Monitoring via methods previously mentioned. The positive effects of these actions is seen in the results of the most recent OMHSAS findings regarding Standard 108 review in 2012 of RY2011[Lehigh2012TriennialCFST (108) & Northampton2012TriennialCFST (108)].
MBH 2	MBH 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) Standard 1, Substandard 2 (Montgomery)** Please refer to Response to 2010 EQR and attachments submitted on 10/20/11.

Reference Number	Opportunity for Improvement	MCO Response
	Availability of Services (Access to Care).	The actions put into place in response to prior EQR reports have been effective. The embedded document below provides documentation that Montgomery County met this Standard/Substandard in the 2012 review of RY 2011. OMHSAS feedback from the 2012 review of this Standard/Substandard for RY2011 indicates that 'For Montgomery County in 2011, exception requests were submitted for the following levels of care: Inpatient Detox (4A) and Rehab (4B) and Halfway House.'  2011 PEPS Montgomery 01 Co. T **Availability of Services (Access to Care) Standard 1, Substandard 3 (Montgomery)** Please refer to Response to 2010 EQR and attachments submitted on 10/20/11. The actions put into place in response to prior EQR reports have been effective. The embedded document in the substandard above provides documentation that Montgomery County met this Standard/ Substandard in the 2012 review of RY 2011. OMHSAS feedback from the 2012 review of this Standard/Substandard for RY2011 indicates that 'Exception requests for the above listed levels of care were submitted.'
		Future Actions Planned **Availability of Services (Access to Care) Standard 1, Substandard 2 (Montgomery)** As the current interventions met the requirements for this Standard/Substandard in the most recent PEPS review (2012 review of RY 2011), these interventions will remain in place. **Availability of Services (Access to Care) Standard 1, Substandard 3 (Montgomery)** As the current interventions met the requirements for this Standard/Substandard in the most recent PEPS review (2012 review of RY 2011), these interventions will remain in place.
MBH 3	MBH 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** **Standard 68, Substandard 2 (Bucks, Delaware, Lehigh, Montgomery & Northampton)** Please see following attachment (CAP) submitted to OMHSAS 9/16/11 which address this substandard: CAP_MBH_#60,68,71,72_FINAL_submitted 9 16 11.  CAP_MBH_#60,68,7 1,72_FINAL_submitte

Reference Number	Opportunity for Improvement	MCO Response
		Please also see the following attachment of OMHSAS letter approving CAP: PEP CAP approval (CGD).  PEP CAP approval (CGD).pdf **Standard 68, Substandard 3 (Bucks, Delaware & Montgomery)** Major action steps outlined in the CAP document embedded for Standard 68, Substandard 4 above also address the concerns identified for Standard 68, Substandard 3: • Magellan will review responses submitted by a provider with the provider and obtain documentation as appropriate to support a provider's response to a complaint. • All verbal communication with the provider will be documented in the IP system. • Magellan's IP note will indicate if the member's complaint was substantiated or not through the resolution process. • Additional steps or actions to be taken after the complaint process will also be recorded in IP. **Standard 68, Substandard 3 (Lehigh & Northampton)** Complaint letters are thoroughly investigated and reflect whether or not the member's complaint was substantiated. Lehigh County continues to audit Magellan's 1st level complaint and grievance records on a quarterly basis. Feedback on results of the 1st level audits occurs within a week to ensure timeliness of feedback and any corrective actions that may be needed by Magellan. Northampton County continues to perform 1st level complaint record audits on a regular basis. Timely feedback is given from the County to Magellan, so that any actions can be taken as soon as possible. **Standard 68, Substandard 4 (Bucks, Delaware, Lehigh, Montgomery & Northampton)** Please see embedded documents above (CAP_MBH_#60,68,71,72_FINAL_submitted 9 16 11; & PEP CAP approval (CGD) submitted to OMHSAS on 9/16/11 which address this substandard. **Standard 68, Substandard 5 (Bucks, Delaware & Montgomery)** Please refer to Response to 2010 EQR and attachments submitted on 10/20/11. In addition, it is important to note that the documentation of the complaint resolution, the Magellan staff person resolving the complaint needs to identify if there is a provider

Reference Number	Opportunity for Improvement	MCO Response
		performance concern identified through the work to resolve the member's concerns. If a concern is identified, the staff person initiates a PPIR (Provider Performance Inquiry Review) through the QI department. This process gives the opportunity for targeted action when needed, as well as tracking for trend-level interventions. Identification of a provider performance concern and entry of a PPIR is documented in the complaint record and within the QI system. **Standard 68, Substandard 5 (Lehigh & Northampton)** Discussion occurred with OMHSAS, MBH complaint staff and County oversight staff during the on site interviews. Staff has increased input into the complaint tracking system and member documentation system (IP) regarding any follow-up actions taken, as a result of a complaint investigation. **Standard 68, Substandard 6 (Lehigh)** • Dates of all member contacts and attempts are clearly documented on the Complaint/Grievance case note forms. • Documentation consistently includes that the member was asked/offered a convenient date/time/location for hearing, if there are any special accommodations needed (i.e., ability to get to hearing, 1st floor room needed, etc.), and if any assistive technologies or other assistance is needed (i.e., interpreter, etc.) • LC HC QA Manager reviews complaint/ grievance case notes following a closed case to insure that information is documented as needed. **Standard 68, Substandard 9 (Lehigh & Northampton)** For Northampton County, County QI has been doing first level complaint audits that have continued up to 9/2012 so far. During the audit, Northampton County QI processes whether the complaint deserves more clinical or programmatic attention. No further action was necessary this past calendar year. Also, County QI does a review of all complaint letters on a monthly basis and will call Magellan when any concerns arise. For calendar year 2012, there were no issues seen. For Lehigh County, • LC HC QA Manager conducts quarterly 1st Level Complaint (and Grievance) audits of Magellan records, to insure that complaints are investigated properly and include a review by a clinician, when appropriate. • First Quarterly audit was done, on 1/20/10, for the 4th Quarter 2009. • Quarterly audits in 2012 were completed on 6/1/12, 8/17/12, and 10/26/12. • Any issues identified are discussed and addressed with the Magellan Customer Comment Coordinator and Quality Improvement Director.

Reference Number	Opportunity for Improvement	MCO Response
		Standard 68, Substandard 9 (Bucks, Delaware & Montgomery) As part one of the major action steps outlined in the CAP embedded above, the southeast counties began completing quarterly audits of 1st level complaints in Q4 2011. An audit tool was developed (below) and, each quarter, a 20% randomly chosen sample is sent to the identified county representatives. • Quarterly audits were sent to the county representatives on: 3/20/12, 4/27/12, 7/30/12 and 11/1/12. • Any issues identified were discussed and addressed with the Appeals, Comments and Complaints Supervisor and Quality Improvement Director. Information is shared with Newtown CMC leadership and staff as needed to implement changes based on feedback.  First Level Complaint Audit Tool.docx **Standard 71, Substandard 5 (Lehigh & Northampton)** Northampton County documents every consumer contact in the CareTracker System and can provide all HealthChoices notes for the member, when requested for PEPS. These have been submitted in the past. If more information is needed, please specify. Lehigh County: • Dates of all member contacts and attempts are clearly documented on the Complaint/Grievance case note forms. • Documentation consistently includes that the member was asked/offered a convenient date/time/location for hearing, if there are any special accommodations needed (i.e., ability to get to hearing, 1st floor room needed, etc.), and if any assistive technologies or other assistance is needed (i.e., interpreter, etc.). LC HC QA Manager reviews complaint/ grievance case notes following a closed case, to insure that information is documented as needed.
		Future Actions Planned **Standard 68, Substandard 2 (Bucks, Delaware, Lehigh, Montgomery & Northampton)** Continue efforts/actions outlined in the CAP attached in previous section re: this subsection. **Standard 68, Substandard 3 (Bucks, Delaware & Montgomery)** Will continue quarterly audit of 20% of 1st level complaints by respective county to ensure completeness of review and documentation, as well as compliance with applicable regulations.

Reference Number	Opportunity for Improvement	MCO Response
		Standard 68, Substandard 3 (Lehigh & Northampton) Magellan efforts continue as outlined in the previous section. Northampton County continues to perform 1st level audits on a regular basis, to ensure satisfaction with conduction and completion of the 1st level hearing. Lehigh County continues to audit Magellan's 1st level complaint and grievance records on a quarterly basis. Feedback on results of the 1st level audits occurs within a week to ensure timeliness of feedback and any corrective actions that may be needed by Magellan. This process will continue for oversight and collaboration. **Standard 68, Substandard 4 (Bucks, Delaware, Lehigh, Montgomery & Northampton)** Continue efforts/actions outlined in the CAP attached in previous section re: this subsection. Ongoing monitoring to ensure compliance with this standard. **Standard 68, Substandard 5 (Bucks, Delaware & Montgomery)** Same efforts/action steps will continue. **Standard 68, Substandard 5 (Lehigh & Northampton)** Ongoing monitoring to ensure compliance with this standard and make sure that documentation includes if a complaint was substantiated. **Standard 68, Substandard 6 (Lehigh)** • Once a complaint and grievance coordinator can be identified, LC HC QA Manager will include the above information in training the coordinator to insure that information continues to be conveyed to member and documented as needed (date to be determined due to staffing issues). • LC HC QA Manager will continue to review complaint/grievance case notes following closure of case, to insure that information is documented as needed (ongoing). **Standard 68, Substandard 9 (Lehigh & Northampton)** For the future, Northampton County will keep a log of its reviews stated above and submit with PEPS documentation. Lehigh County: • Quarterly 1st Level Complaint (and Grievance) audits will continue to occur (ongoing). • Feedback will continue to be provided (ongoing). • Corrective Action Plans will be requested if need be (as needed) **Standard 68, Substandard 9 (Bucks, Delaware & Montgomery)** Will continue quarterly audit of 20% of 1st level complaints by respective county to ensure completeness of review and documentation, as well as compliance with applicable

Reference Number	Opportunity for Improvement	MCO Response
		regulations. An annual summary of the audit findings will be completed and presented to Newtown CMC leadership and to the QIC. **<u>Standard 71, Substandard 5 (Lehigh & Northampton)</u>** Northampton County: Continue to track all appropriate documentation in Care Tracker System. Lehigh County: • Once a complaint and grievance coordinator can be identified, LC HC QA Manager will include the above information in training the coordinator, to insure that information continues to be conveyed to the member and documented as needed (date to be determined due to staffing issues). • LC HC QA Manager will continue to review complaint/grievance case notes following closure of case, to insure that information is documented as needed (ongoing).
Performance Measures		
MBH 4	MBH's rate for the MY 2010 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (poorer) than the MY 2010 HealthChoices BH MCO Average by 2.3 percentage points. MBH's rate did not meet the OMHSAS designated performance goal of 10.0%.	Please see Response to 2010 EQR and attachments, submitted on 10/20/11. Root cause analysis (RCA) update regarding Readmission within 30 Days of Inpatient Psychiatric Discharge was completed by Magellan and submitted to IPRO on 2/22/12. An e-mail was received by IPRO on that same day (2/22/12) stating "I have received your document. Thank you for the early submission." See Attached RCA update: 2011 BH PM RCA Response_Magellan_021512.  2011 BH PM RCA Response_Magellan_(Since 9/30/11, Magellan and its five County partners held 1 AIP Provider forum (11/2/11); 1 Community Based Provider forum (6/6/12); and 1 Combined AIP/ Community Based Provider forum (10/17/12). The focus of these forums was decreasing 30 day readmission rate to AIP. See Attached meeting agendas: 20111103_Agenda; 01_Agenda_20120606_final; & Agenda_20121017.  20111103_Agenda.doc  01_Agenda_20120606_final.docx  Agenda_20121017.docx

Reference Number	Opportunity for Improvement	MCO Response
		Overall, the process in working with providers is to gather information regarding ideas on improving the rates from the various break-out groups and overall discussions were compiled by Magellan and then distributed to all providers. Provider contact information was also collected and distributed at and after the combined forums, so that having updated information from various facilities would aid in the coordination of care activities. On an ongoing basis, Magellan continues to provide quarterly readmission and follow-up after hospitalization (FAH) data to AIP providers. In order to provide timely data to providers, an internal Magellan readmission rate methodology is used for the data measurement. Using this methodology, in the first half of 2011 (1/1/11-6/30/11), the combined provider readmission rate was 14.52%. For the second half of 2011 (7/1/11-12/31/11) this rate had decreased to 13.59%. **These data combined for a full 2011 rate of 14.07%, which was a 1.91% decrease from 2010**. These findings are extremely encouraging and offer evidence that our continued work with the mental health inpatient provider community is having an impact. Data from the first half of 2012 shows the continued decrease in readmission rates for members covered by Magellan**. The combined provider Readmission Rate for individuals who discharged from a mental health inpatient facility from 1/1/12-6/30/12 was 13.20%.** On 8/1/1, the Lehigh Valley CMC held a meeting with providers who provide the following levels of care: Assertive Community Treatment, Case Management, & Family Based Services. A meeting was then held 10/3/12, with those providers & Acute Inpatient Mental Health and Emergency Room providers. The goal of the meeting was for the community based and hospital based providers to collaborate more on the HealthChoices members who are frequently seen in the ER and admitted to AIP. Please see attachment "Lehigh Valley CMC Strategies to Reduce 30 Day Readmission Rates" for recent efforts taken by Lehigh Valley CMC to reduce readmission rates.  Lehigh Valley CMC Strategies to Reduce
		Future Actions Planned Magellan will continue efforts outlined in the Root Cause Analysis and continue activities and efforts of the AIP and community based provider forums. We will also continue with the additional efforts outlined above, with the hopes of reducing the 30 day readmission rate to AIP.

Corrective Action Plan

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

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

Table 4.2 Corrective Action Plan for MBH

Recommendation					
Major Action Steps	**Lead Staff Responsible**	**Start Date**	**Planned Completion Date**	**Documented Evidence of Completion**	**Field Office Staff Comments**
Standard 68.2 • All issues identified by the member in the 1st level complaint must be included in the 1st and 2nd level complaint acknowledgement letter and decision letter. • 1st and 2nd level complaints must be resolved within 30 days unless there is documentation in the case file to support the delay 1st level complaints must be thoroughly investigated and should not be closed "due to timeframe"					
• DPW template amended to include section which will report complaint details	• John Bottger / Deema Hadid	10/1/11	10/1/11	Revised templates BU Attachment 2 A-1st Level Standard	**Complete**
• For Newtown CMC-Outlook calendar reminders will be used to remind staff when complaints are due to ensure timely completion	• John Bottger	10/1/11	12/31/11	MN Attachment 2 A 1st Level Standard Cc	
• For Lehigh Valley CMC- Sr. Appeals& Comment Coordinator will track complaints to ensure timely completion via excel tracker	• Deema Hadid	10/1/11	Ongoing	DE 2 A-1st Level Standard Complaint R	
• Bucks County has in place the administrative processes and checks to ensure compliance with the resolution timeliness standards. As the ultimate and overriding goal is to meet the needs of the members in a complete and timely manner, the standard timeframe will only be exceeded if the best interest of the member dictates doing so. For example, accommodating the member's scheduling requirements might lead to resolution outside the standard. In such cases, Bucks County will clearly document the reasons for not meeting the	• Bern McBride	1/1/11	Ongoing	NHAttachment 2 A-1st Level Standard LE Attachment 2 A-1st Level Standard Outlook calendar reminder procedure	**Complete**

Recommendation					
Major Action Steps	**Lead Staff Responsible**	**Start Date**	**Planned Completion Date**	**Documented Evidence of Completion**	**Field Office Staff Comments**
standard. For Lehigh Valley CMC; MBH will resolve 1st level complaints within 30 days unless there is documentation in the case file to support the delay. **Regarding the case that was referenced as closed "due to timeframe" – the wording in the case note states "requested a return call ASAP due to time restraints [sic] to complete the complaint". The complaint was resolved and member's mom did not end up filing a 2nd level complaint. Lehigh County and MBH did not stop resolving a complaint if the 11 business day time frame was reached. The attached e-mail from 2009 illustrates same. Lehigh County and MBH have not, nor will not, stop resolving a complaint because the 30 day time frame has been reached and the file will include accompanying documentation to support the delay.	• Deema Hadid For informational purposes only NA	Immediate NA	Ongoing NA	 Outlook Calendar Complaint Reminder S Excel tracking sheet  LVCMC-Complaint Tracker.xls Updated internal staff complaint training and reference guide  LVCMC-Member Complaint Training G Copy of case note  LVCMC case note.pdf Email documentation	

Recommendation					
Major Action Steps	**Lead Staff Responsible**	**Start Date**	**Planned Completion Date**	**Documented Evidence of Completion**	**Field Office Staff Comments**
				Email Evidence from LE.doc	

Standard 68.4

- All of the member's complaint issues must be thoroughly investigated at the 1st level review by the BH-MCO to insure that an informed decision is being made regarding the validity of the complaint.
- Documentation needs to be obtained from a provider (i.e. medical records, incident reports, policies, etc.) to support their verbal or written response to a complaint.
- Steps taken by MBH to further investigate a provider's response to a complaint need to be documented in the case file.
- If a complaint involves a clinical issue then a clinician needs to be part of the 1st level committee. The results of the review need to be included in the case file and the decision letter.
- The complaint case file needs to include documentation of whether or not a member's complaint is substantiated and if any follow up will occur.

The respective County should review 1st level complaints from initiation to resolution to determine their satisfaction with the handling of the complaint.

• % complaints to 2nd level in 2010 BU= 6% (3 of 47) DE= 7% (4 of 61) LE= 6% (2 out of 33) MN= 6% (5 of 79) NH= 0% (0 out of 14)	For informational purposes only NA; illustrates that members are satisfied with 1st level resolutions and not taking their issue to the next level.	NA	NA	NA	
• Magellan will review responses submitted by a provider with the provider and obtain documentation as appropriate to support a provider's response to a complaint. All verbal communication with the provider will be documented in the IP system. Magellan's IP note will indicate if the member's complaint was substantiated or not through the resolution process. Additional steps or actions to be taken after the complaint process will also be recorded in IP.	• John Bottger / Deema Hadid to train Clinical Staff • Clinical Staff to implement items	10/17/11	10/17/11	Training to occur with Care Managers on September 22, 2011 for Lehigh Valley CMC & October 5, 2011 for Newtown CMC.	**Complete**
• For Lehigh Valley CMC- if a complaint involves a clinical	• Deema Hadid	10/17/11	Ongoing	Training to occur with Care Managers on September	

Recommendation					
Major Action Steps	**Lead Staff Responsible**	**Start Date**	**Planned Completion Date**	**Documented Evidence of Completion**	**Field Office Staff Comments**
issue, it will be forwarded to a clinician for review and resolution. • For Lehigh Valley CMC- ▪ Lehigh County: The above MBH processes have been continuously monitored by Lehigh County QA. Lehigh County HealthChoices reviews all complaint and grievance letters forwarded by Magellan on a weekly basis. In January 2010, Lehigh County began auditing MBH 1st level complaint records from initiation to resolution. Lehigh County continues to audit Magellan's 1st level complaint and grievance records on a quarterly basis. Feedback on results of the 1st level audits occurs within a week (though generally feedback is discussed immediately following the completion of the audit) to ensure timeliness of feedback and any corrective actions that may be needed by Magellan. This process allows Lehigh County HC to insure that members' rights are being upheld as well as the county's satisfaction with how complaints are being handled and ultimately resolved. ▪ Northampton County: Northampton County HealthChoices conducts audits of complaint and grievance files twice per year (every 6 months). Feedback is given immediately after the review and a report is provided to MBH by NH County. Audits began in December 2008. ▪ For Newtown CMC- Starting with Q4 2011	• Deema Hadid • Matthew Bauder – L.C. HC QA Manager • • Tisbine Moussa, N.C. HC QI • John Bottger	Has been ongoing for 2 years Q4 2011	Ongoing Ongoing	22, 2011. • See audit tools and results for both LE and NH Counties LVCMC-1st Level Complaint Audit Tool_ LVCMC-2nd Q 2011 LE 1st Level Complain LVCMC-1st level Complaint Audit Tool_ LVCMC-1st Level Complaint Audit Tool_ LVCMC-NH 1st level complaint audit result	

Recommendation					
Major Action Steps	**Lead Staff Responsible**	**Start Date**	**Planned Completion Date**	**Documented Evidence of Completion**	**Field Office Staff Comments**
Complaints, Magellan will submit a random sample of 20% of all complaints resolved quarterly to the County for review within 30 days of the end of each quarter. An audit tool will be provided for the Counties to complete. The results of the audit will be returned to Magellan in order to provide feedback and input. The complaints & audit tool will be provided to the County staff person who oversees all C&G matters.				• Audit tool to be developed.	

Root Cause Analysis and Action Plan

The 2012 EQR is the fourth for which BH MCOs were required to prepare a Root Cause Analysis and Action Plan for performance measures performing statistically significantly poorer than the BH MCO average and/or as compared to the prior measurement year. The performance measures that were noted as opportunities for improvement in the 2011 EQR Technical Report required that the MCO submit:

- A goal statement;
- Root cause analysis and analysis findings;
- Action plan to address findings;
- Implementation dates; and
- A monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

IPRO reviewed each submission, and offered technical assistance to BH MCO staff. The BH MCOs were given the opportunity to revise and re-submit response forms as needed and as time permitted. For the 2012 EQR, MBH was required to prepare a Root Cause Analysis and Action Plan for the following performance measures and quality indicator:

- Readmission within 30 Days of Inpatient Psychiatric Discharge

MBH submitted a Root Cause Analysis and Action Plan in February 2012.

Table 4.3 Root Cause Analysis for MBH – Readmission within 30 Days of Inpatient Psychiatric Discharge

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

Goal Statement: Decrease 30 day readmission rate by 2 percentage points by the MY 2012 measurement period.

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

Findings

MBH had no statistically significant change from MY 2009 (13.7%) to MY 2010 (14.7%) but was statistically significantly below/poorer than the MY 2010 HealthChoices BH MCO average of 12.4%. The table below provides a comparison of the MY 2009 to MY 2010 performance per County, for MBH and the HC BH MCO average.

30 Day-Readmission		
	MY2009	MY2010
BU	10.68%	13.10%
DE	12.92%	12.64%
LE	14.10%	16.74%
MO	16.36%	15.83%
NH	13.18%	14.47%
Magellan	13.73%	14.69%
HC BH MCO	12.10%	12.40%

Montgomery County demonstrated the only statistically significant decrease out of the 5 counties from MY 2009 to MY 2010. This decrease was not sufficient enough to offset the increases from the 4 other counties.

Based on the findings from the MY 2008 Readmission Rate Report, MBH and its 5 county partners embarked on a CQI process to further analyze the readmission rates and identify/ develop interventions to improve the rates. The details of this CQI process can be found in the Root Cause Analysis and Action Plan – Update submitted to IPRO in October 2010.

As part of the comprehensive analysis conducted by Magellan and its five-county partners for the Readmission Rate Root Cause Analysis, it was determined that the primary intervention to address Readmission Rates would be to engage the Mental Health Inpatient providers directly into the discussion. Involving them directly into the conversation increases their involvement in and responsibility for improvement. There were 3 MH IP Provider Forums held in 2011, each designed to increase providers' awareness of and responsibility for decreasing the rate at which individuals return to MH IP level of care.

The data presented at the most recent MH IP Provider Forum on 11/3/11, was only through 6/30/11 to allow for claims lag. This showed that half of the providers' readmission rates improved and the others did not. The time period analyzed included the initial data analysis and intervention planning process, so it is expected that Q3 and Q4

	outcomes will be more representative of the impact of the interventions. • Data through 10/31/11 is included in the embedded document below (this was not presented to the providers but reviewed for the current RCA). In this data, 13 of the 22 providers have shown improved (decreased) readmission rates and the combined total of these providers decreased by 2.32% from 14.34% in 2010 to 14.02% in 2011 (through 10/31). • Most notable is that the combined provider Readmission Rate through 6/30/11 was 14.52%. The Readmission Rate for this same group from July-October 2011 was 12.89%. Readmission Rates in the following 4 months decreased by enough to impact the year-to-date with a decrease of Readmission Rate by 3.44% from the first 6 months of the year compared with the following 4 months. Although the time periods compared are not equal, this initial finding is encouraging and provides support for the continuation of the efforts of MBH and the counties to engage the providers in addressing readmission.  2011_10_31_provide r data.xlsm
Policies (e.g., data systems, delivery systems, provider facilities) N/A	***Initial Response*** ***Follow-up Status Response*** *<insert follow-up response here; leave blank for initial response submission>*
Procedures (e.g., payment/reimbursement, credentialing/collaboration) 1. AFU information source does not capture data for all AFU appointments kept. 2. In one county, despite multiple years of intervention, the highest volume adult inpatient program has continued to report high readmission rates and an unreliable quality of treatment 3. Closure of Allentown State Hospital	***Initial Response*** 1. Information from AFU appointments kept is limited to those submitted through claims. For many reasons, including when MBH is the secondary payer, claims may not be submitted and therefore although the individual may have received the service, it may not be considered in the AFU rate. 2. For this provider, ongoing quality audits, case-level planning meetings, collaboration between MBH's Medical Director and facility's Medical Director/CEO have not created the outcomes expected. In assessing the minimal amount of return on a significant time and resource investment, consideration of a payment structure based on outcomes and quality needs to be considered. 3. The closure of the Allentown State Hospital by December 2010 led to an increased number of SMI members to be placed in appropriate community services to meet their complex needs. This group of members deals with complex issues requiring a multi-systemic approach. It was noticed that some of these members frequently admit and re-admit as they transition to other community based services. ***Follow-up Status Response***

People (e.g., personnel, provider network, patients) 1. Provider specific readmission rates (consideration of provider specific ALOS in relation to readmission rates as well) 2. Provider specific ambulatory follow-up rates (AFU)	***Initial Response*** • Provider specific readmission rate and AFU data are analyzed and comparisons using available MY2011 data occur on an ongoing basis. County specific and/or regional data are also analyzed to drill down in case more specified actions are needed. • It was discovered that for Lehigh (LE) and Northampton (NH) counties, the providers treating children/adolescents only had the lowest readmission rates for MY2011 so far. While their average length of stay (ALOS) was longer, the costs may be offset by having fewer readmissions. • In the data through 10/31/11 embedded above, of the 13 providers with improved Readmission Rates compared to 2010, 9 (69%) of them had a corresponding increase in ALOS as well. There was a 29% average decrease in Readmission Rates and an average of 15% increase in ALOS. (Please note the average change is based on provider, not weighted by the number of discharges in the period.) • Of those same 13 providers with improved Readmission Rates, only 3 (23%) demonstrated a corresponding increase in AFU rates. ***Follow-up Status Response***
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) 1. Are crisis intervention services for children being utilized effectively to provide needed support and intervention outside the inpatient facility? 2. Are educational materials available and easy to access for providers and members? 3. Do clinical care managers have information needed to offer longitudinal approach to an individual's treatment needs	***Initial Response*** 1. Children's mobile crisis services are offered by 1 provider in Bucks and Montgomery Counties. The service available includes crisis intervention, as well as crisis prevention planning. Analysis of encounter data needs to be enhanced to ensure it provides a comprehensive representation of the services being provided. 2. In various discussions and during meetings with providers, MBH was informed that they are not always aware of and up to date with the latest availability of services (i.e., new providers, levels of care, etc.). MBH also gets told from providers that at times they feel the services they provide may not be known to the community. MBH informs providers that information is on our website but they also need to market themselves in the community. 3. Prior clinical and claims information for individual members is contained within the progress notes and claims records. It is not easily accessible in a comprehensive format for the clinical team to use in daily care management functions. ***Follow-up Status Response***
Other (specify)	***Initial Response*** N/A ***Follow-up Status Response***

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

Complete next page of corresponding action plan.

Measure: *Readmission within 30 Days of Inpatient Psychiatric Discharge** For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2011. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
Policies – N/A		
Procedures 1. Verify members' participation in services following inpatient discharge with providers 2. Explore the development of a Reward for Quality (R4Q) program with Montgomery County's high volume adult inpatient facility. 3. Closure of Allentown State Hospital	January 2010 (ongoing) January 2012 State Hospital closed December 2010 and efforts are ongoing	***Initial Response*** • In the Newtown CMC, the customer service team sends weekly fax confirmation forms to outpatient providers to confirm that the member attended the scheduled aftercare appointment. Data collected through this process is then entered into the clinical record system and used in the calculation of AFU rates in MBH-established methodology. As per discussions with OMHSAS, it is expected that the reporting specifications for the HEDIS and PA-Specific FAH measures will allow for the inclusion of pseudo-claims captured. • MBH will work with Montgomery County to develop a proposal to establish payment incentives for positive outcomes, of which readmission rates will be a primary measure. • Complex case reviews are used as needed to address members who access multiple systems. This will provide MBH with the opportunity to ensure proper collaboration with other service systems such as Children and Youth, the criminal justice system, intellectual disability system, county mental health departments, as well as multiple providers. • The IMPACT program is MBH's high risk care management program, which focuses on members who have special needs or struggle to remain in the community. The IMPACT team meets with the individuals and addresses barriers to remaining in the community and then advocates with providers and community supports. • Members from this group also benefit from all of the other interventions described in this document. ***Follow-up Status Response*** *<insert follow-up response here; leave blank for initial response submission>*
People 1. Provider specific readmission rates and 2. Provider specific ambulatory follow-up rates • provider specific	February 2011 (Ongoing)	***Initial Response*** • As mentioned in the Analysis section, MBH and its partnering Counties hosted 3 MH IP Provider forums in 2011. Planning is occurring for the next phases of the forums which will include the addition of high utilizing

meetings/teleconferences to discuss barriers • hold providers accountable via corrective action plans	July 2011 (Ongoing)	Outpatient providers for discussions on maintaining and improving member engagement in services. MBH will also give the providers their readmission rate and AFU data (blinded) on a quarterly ongoing basis and follow up with MH IP providers who had the most dramatic improvements in their readmission rate data to see what actions were implemented and share with the rest of the group.
• Ongoing education with clinical staff to initiate QCCs/PPCs for providers who are not adhering to adequate discharge planning	July 2011 (Ongoing)	• QI Staff will continuously monitor via quality of care concern (QCC)/provider performance concern (PPC) tracking and tracking of record audits which are ongoing measures and trending. Upon receipt of each QCC/PPC, either the CM supervisor or QI Staff contacts the facility to discuss the issue. When 3 QCCs/PPCs are received within a 3 month period on the same provider regarding similar issues, a CAP is requested of the provider. If issues persist, a meeting is held with the provider (including MBH clinical and QI staff), as well as CAP addendum requirements. From Jan-Dec 2011, MBH did not have to request any corrective action plans from inpatient providers due to insufficient discharge planning of inpatient providers. This is a decrease compared to the previous year when CAPs were requested from 3 providers. Monthly calls did occur with one provider (Devereux Kanner) to address discharge planning issues. At least nine inpatient MH providers had quality of care concerns completed from Jan-Dec 2011 regarding at least one episode of inadequate discharge planning. MBH held several teleconferences with providers to address barriers providers are having.
• Work directly with Lehigh & Northampton County providers to impact readmission and AFU rates, which will change the county's rates for these indicators	July 2011 (Ongoing) January 2012 (Ongoing)	• In Lehigh, the QI Reviewer conducts trainings with clinical staff twice per year to "refresh" them regarding appropriateness of initiating QCCs/ and completeness of QCCs. Trends are discussed with clinical staff during the monthly staff meetings and, if issues arise, also in Clinical Team meetings. Trainings are scheduled each June and December. This process is ongoing; one training occurred on 6/9/11 and the most recent training was on 12/15/11 (Lehigh). • In Newtown, the QI Reviewer conducts training with clinical staff annually to review the PPIR process. This review includes an overview of the purpose of PPIRs to identify concerns with a provider's performance, the trending and analysis conducted and then the work directly with the providers to improve the quality of treatment provided. The most recent training was held 6/22/11. • Clinical staff pulls the 30 day readmission report every Monday to analyze provider and member specific outliers to address in a more timely fashion. The Field

	Case Management (began 2004) & ACT (began 2006)- enhanced data focus in 2011	Care Workers (FCW) or a Peer Support from Recovery Partnership meets with the member while they are still in the hospital to identify barriers to remaining in the community. The information is then given to the Care Manager who is managing the facility to address during discharge planning meetings. The FCW then contacts the member prior to their appointment to determine if they can make the appointment or if they have encountered another barrier. Finally the FCW will meet the member at their appointment and will support them until they go in for their appointment. They will then continue to monitor and be available to the member until they reach 30 days community tenure. This process is discussed with the member while they are still in the hospital and will only be followed if the member is in agreement.
• Work directly with Bucks, Delaware and Montgomery County providers within high intensity services to impact Readmission and AFU rates, which will change the county's rates for these indicators	January 2012 (Ongoing) February 2012	• For the Lehigh CMC, MBH Care Managers conduct telephonic reviews with ACT providers for any ACT members admitted to IP MH. For LE and NH counties the percentage of admissions to IP MH for ACT members is >5% of the ACT population per month, with some of them readmitting. It is hoped that by connecting with the ACT providers, barriers to community tenure can be addressed to prevent future admissions/re-admissions, as well as ensuring that the ACT team is connecting with the IP MH facility regarding treatment and aftercare planning. Monthly monitoring calls also occur with ACT providers who are not consistently meeting expectations or are on a corrective action plan (CAP)
3. Members • At Lehigh CMC, the positions of Follow-Up Specialist (FUS) were converted to Field Care Workers (FCW).	May 2011 (Ongoing)	
• At Newtown CMC, the care management teams will be reorganized to improve longitudinal care management for PH/BH, SMI, co-occurring, and high risk children.		• For MBH's Newtown CMC, ACT and Case Management services are managed through the Partners In Care (PIC) program. This approach includes programmatic management through the data analysis and review with the provider, oversight of best practices and case specific review. A critical component of the data analysis and review is the rate of individuals in the specific programs being admitted to MH IP LOC. By reducing the number of admissions overall, the rate of readmission will also be decreased.
• Lehigh CMC: Contract with Recovery Partnership		• Some of the previous job duties of the FUS were shifted to other staff which allows the FCW to have increased time for them in the community/field to visit with members who are frequent re-admitters to address barriers to engaging in aftercare treatment and maintaining community tenure.
		• In 2012, criteria will be developed to identify individuals' needs which can be met through targeted longitudinal care management approaches; interventions will be designed to improve the longitudinal history to drive current treatment. Incorporation of an individual's history into their current treatment is more likely to

		meet their needs and reduce the need for higher levels of care. • The Lehigh CMC has contracted with Recovery Partnership (our local Consumer and Family Satisfaction Team provider) who offers Certified Peer Specialist (CPS) services to visit members who readmit into IP MH facilities. The CPS conducts the visits for chronic SMI members who prefer not to be seen by "professionals" (i.e., MBH FCW). The series of visits (whether conducted by CPS or FCW) can take 1-2 weeks. The typical course for these series of meetings: ▪ 1st meeting: discuss what leads to admission/readmission (occurs in IP facility) ▪ 2nd meeting: discuss what member needs in the community; does discharge plan as written meet member's needs (occurs in IP facility) ▪ 3rd meeting: discuss if member went to aftercare appointment (occurs in community) ▪ Last meeting: Aftercare planning, etc. (occurs in community). Transition to the IMPACT program (MBH intensive case management program). ***Follow-up Status Response*** *<insert follow-up response here; leave blank for initial response submission>*
Provisions • Increase the use of children's mobile crisis services for children in inpatient facilities to assist with crisis prevention planning. • MagellanofPA.com website • Provider Performance Indicator Dashboard • Member Handbook • Implementation and utilization of programs in the community that are necessary and would hopefully decrease the readmission rate to IP MH	January 2012 July 2011 (Ongoing) July 2011 (Ongoing) July 2011 (Ongoing)	***Initial Response*** • MBH is developing a plan to increase the number of children who are connected to the mobile crisis program while in inpatient facilities. The service to be provided will include crisis prevention, identification of supports and resources for the child and family when a situation is escalating and f/up support in the first 2 weeks after discharge or until aftercare services are fully in place. • The Newtown CMC maintains a website (MagellanofPA.com) and updates, information on a consistent basis, so that members and providers have accurate information such as in network providers, community resources, available trainings, member and provider handbooks, and outcomes data/reports. The Provider Performance Indicator Dashboard can also be accessed via this website, which informs the reader of certain provider's current data on specific indicators based upon level of care. Having more data available to members and providers allows for accountability and ownership for the provider and informed decision making for the members. • MBH is conducting level of care (LOC) trainings for providers throughout the year, so that providers are aware of the available services. A

• Member Profile report to be available for all members	March 2012	LOC training was provided at the provider/ County/MBH/stakeholder meeting in November 2011. More training sessions are scheduled to continue, including an LOC training webinar on 2/17/12. This webinar will be recorded and then available on the MagellanofPA.com website for accessibility by anyone at anytime. • Lehigh CMC ▪ Child/Adolescent Crisis Residential-RHD has been awarded the contract. Currently seeking an appropriate site for the program. Program will open in 2012. ▪ Expansion of telehealth pilot; for consumers who are unable to travel to OP appointments, this will hopefully enable them to connect with the therapist and/or psychiatrist for continuity of care. ▪ Implementation of Behavioral Health-Physical Health (BH-PH) program; this will allow members to obtain mental health and physical health services at one location. ▪ Develop case management and/or psych rehab program for homeless population with local homeless shelter ▪ Increase use of enhanced intensive case management and medical mobile crisis service when appropriate ▪ Explore local IP MH provider interest in obtaining co-occurring competency • The internal member profile report will be accessible to all Clinical staff by March 2012. This report will provide a snapshot of 1 year of the individual's treatment history and diagnosis profile. The report is intended to provide an overview and to offer the CM a direction in which to focus their more detailed case overview. In 2012, workflows and processes will be developed and implemented so this information is incorporated into member's care in an effective and strategic way.
		Follow-up Status Response

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

V: 2012 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of MBH'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

- MBH was fully compliant with all seven categories within the Structure and Operations Standards Subpart C: Enrollee Rights and Protections Regulations.

- MBH's rate for the MY 2011 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 1 was statistically significantly higher than the MY 2011 QI 1 HealthChoices BH MCO Average of 45.8% by 3.9 percentage points.

- MBH's rate for the MY 2011 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI A was statistically significantly higher than the MY 2011 QI A HealthChoices BH MCO Average by 4.5 percentage points.

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

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2009, RY 2010, and RY 2011 found MBH to be partially compliant with two Subparts associated with Structure and Operations Standards.
    - MBH was partially compliant on one out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant category is Coverage and Authorization of Services.
    - MBH was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.

- MBH's rate for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (poorer) than the MY 2011 HealthChoices BH MCO Average by 2.4 percentage points. MBH's rate 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.*

KEY POINTS

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

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

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

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

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

Measures that had no statistically significant changes from MY 2010 to MY 2011 and were not statistically significantly different from the MY 2011 HealthChoices BH MCO Averages are:

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

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

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

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

- **F - No MBH 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 – MBH

		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 Readmission within 30 Days of Inpatient Psychiatric Discharge[1]	C Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day) Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	B Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day) Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)
	⬇	F	D	C

Key to the Performance Measure Matrix Comparison

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

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

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

Figure 2: Performance Measure Rates – MBH

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)	52.2%	50.8% ═	49.7% ═	45.78%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	69.2%	68.5% ═	67.9% ═	66.81%
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	63.4%	62.8% ═	62.1% ═	57.63%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	76.8%	76.0% ═	75.6% ═	74.67%
Readmission within 30 Days of Inpatient Psychiatric Discharge[1]	13.7%	14.7% ═	14.7% ═	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

- MBH was fully compliant on Subpart C and partially compliant on Subparts 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

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

Performance Measures

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

2011 Opportunities for Improvement MCO Response

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

2012 Strengths and Opportunities for Improvement

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

APPENDIX

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

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

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

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

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

BBA Category	PEPS Reference	PEPS Language
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
§438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

BBA Category	PEPS Reference	PEPS Language
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.

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

BBA Category	PEPS Reference	PEPS Language
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.408 Resolution and notification: Grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	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.
§438.410 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.

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

Appendix B: OMHSAS-Specific PEPS Items

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

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

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2011, 11 substandards were considered OMHSAS-specific monitoring standards, and were reviewed. Table C.1 provides a count of these Items, along with the relevant categories. All 11 OMHSAS-specific PEPS substandards were evaluated for the five Counties subcontracting with MBH.

Table 1.5 OMHSAS-Specific Substandards Reviewed for MBH

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

Format

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

Findings

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards. Of the eight substandards evaluated, MBH met five substandards and partially met three substandards, as indicated in Table C.2.

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

Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
Complaints	Standard 68.6	RY 2010	Partially Met
	Standard 68.7	RY 2010	Met
	Standard 68.8	RY 2010	Met
	Standard 68.9	RY 2010	Partially Met
Grievances and State Fair Hearings	Standard 71.5	RY 2010	Partially Met
	Standard 71.6	RY 2010	Met
	Standard 71.7	RY 2010	Met
	Standard 71.8	RY 2010	Met

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

MBH was "partially met" on Substandards 68.6 and 68.9:

> **Substandard 68.6:** The second level complaint case file includes documentation that the member was contacted about the second 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.
>
> **Substandard 68.9:** Where applicable there is evidence of County oversight and involvement in the second level complaint process.

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

MBH was "partially met" on Substandard 71.5:

> **Substandard 71.5:** The second level grievance case file includes documentation that the member was contacted about the second 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.

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

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

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

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