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

2015 External Quality Review Report
PerformCare

FINAL
April 13, 2016

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

Table of Contents

GLOSSARY OF TERMS **4**

INTRODUCTION **5**

I: STRUCTURE AND OPERATIONS STANDARDS **6**

Organization of the HealthChoices Behavioral Health Program 6
Methodology 6
Data Sources 7
Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for PerformCare 8
Determination of Compliance 9
Format 9
Findings 9
Subpart C: Enrollee Rights and Protections *10*
Subpart D: Quality Assessment and Performance Improvement Regulations *12*
Subpart F: Federal and State Grievance System Standards *15*

II: PERFORMANCE IMPROVEMENT PROJECTS **20**

Validation Methodology 21
Review Element Designation/Weighting 21
Overall Project Performance Score 22
Scoring Matrix 22
Findings 22

III: PERFORMANCE MEASURES **24**

Follow-up After Hospitalization for Mental Illness 24
Readmission within 30 Days of Inpatient Psychiatric Discharge 40
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment 43

IV: QUALITY STUDY **54**

V: 2014 OPPORTUNITIES FOR IMPROVEMENT – MCO RESPONSE **56**

Current and Proposed Interventions 56
Corrective Action Plan for Partial and Non-compliant PEPS Standards 68
Root Cause Analysis and Action Plan 68

VI: 2015 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT **121**

Strengths 121
Opportunities for Improvement 121
Performance Measure Matrices 121

VII: SUMMARY OF ACTIVITIES **126**

Structure and Operations Standards 126
Performance Improvement Projects 126
Performance Measures 126
2014 Opportunities for Improvement MCO Response 126
2015 Strengths and Opportunities for Improvement 126

APPENDICES **127**

Appendix A: Crosswalk of Required PEPS Substandards to Pertinent BBA Regulations 127
Appendix B: OMHSAS-Specific PEPS Substandards 149
Appendix C: Program Evaluation Performance Summary: OMHSAS-Specific Substandards for PerformCare Counties 150

REFERENCES **154**

List of Tables and Figures

Table 1: HealthChoices Oversight Entities, HC BH Contractors and Counties 6
Table 2: Substandards Pertinent to BBA Regulations Reviewed for PerformCare 8
Table 3: Compliance with Enrollee Rights and Protections Regulations 10
Table 4: Compliance with Quality Assessment and Performance Improvement Regulations 12
Table 5: Compliance with Federal and State Grievance System Standards 15
Table 6: Review Element Scoring Designations and Definitions 22
Table 7: Review Element Scoring Weights 22
Table 8: MY 2014 HEDIS Follow-up Indicator Rates: 6–64 Years Old 29
Figure 1: MY 2014 HEDIS Follow-up Indicator Rates: 6-64 Years Old 31
Figure 2: HEDIS Follow-up Rates Compared to MY 2014 HealthChoices HC BH Contractor Average: 6-64 Years Old 31
Table 9: MY 2014 HEDIS Follow-up Indicator Rates – Overall Population 32
Figure 3: MY 2014 HEDIS Follow-up Indicator Rates – Overall Population 33
Figure 4: HEDIS Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average – Overall Population 34
Table 10: MY 2014 HEDIS Follow-up Indicator Rates: 6-20 Years Old 34
Figure 5: MY 2014 HEDIS Follow-up Indicator Rates: 6-20 Years Old 36
Figure 6: HEDIS Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average: 6-20 Years Old 36
Table 11: MY 2014 PA-Specific Follow-up Indicator Rates with Year-to-Year Comparisons – Overall Population 37
Figure 7: MY 2014 PA-Specific Follow-up Indicator Rates – Overall Population 38
Figure 8: PA-Specific Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average – Overall Population 39
Table 12: MY 2014 Readmission Rates with Year-to-Year Comparisons 41
Figure 9: MY 2014 Readmission Rates 42
Figure 10: MY 2014 Readmission Rates Compared to HealthChoices HC BH Contractor Average 42
Table 13: MY 2014 IET rates with Year-to-Year Comparisons 45
Figure 11: MY 2014 IET Rates: 13–17 Years Old 47
Figure 12: MY 2014 IET Rates Compared to HealthChoices County Average: 13–17 Years Old 47
Table 14: MY 2014 IET Rates: 18+YearsWith Year-to-Year Comparisons 48
Figure 13: MY 2014 IET Rates – 18+Years 50
Figure 14: MY 2014 IET Rates Compared to HealthChoices HC BH Contractor Average – 18+ Years 50
Table 15: MY 2014 IET Rates – 13+Years with Year-to-Year Comparisons 51
Figure 15: MY 2014 IET Rates: 13+Years 52
Figure 16: MY 2014IET Rates Compared to HealthChoices HC BH Contractor Average: 13+ Years 53
Table 16: Current and Proposed Interventions 57
Table 17: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6–64 Years 69
Table 18: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years 79
Table 19: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day) 87
Table 20: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day) 95
Table 21: RCA and Action Plan – Readmission Within 30 Days of Inpatient Psychiatric Discharge 104
Table 22: BH-MCO Performance and HEDIS Percentiles 122
Table 23: Performance Measure Matrix 123
Table 24: Performance Measure Rates 123
Table 25: HEDIS Follow-up After Hospitalization 7-Day/30-Day Performance Measure Matrix 124
Table 26: HEDIS Follow-up After Hospitalization 7-Day/30-Day Performance Measure Rates Ages 6–64 Years 124
Table 27: Key Points of Performance Measure Comparisons 125
Table C.1: OMHSAS-Specific Substandards Reviewed for PerformCare 150
Table C.2: OMHSAS-Specific Requirements Relating to Care Management 150
Table C.3: OMHSAS-Specific Requirements Relating to Second Level Complaints and Grievances 151
Table C.4: OMHSAS-Specific Requirements Relating to Denials 152
Table C.5: OMHSAS-Specific Requirements Relating to Executive Management 152
Table C.6: OMHSAS-Specific Requirements Relating to Enrollee Satisfaction 152

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 unweighted.
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.
HC BH Contractor Average	The sum of the individual HC BH Contractor rates divided by the total number of HC BH Contractors (34). Each HC BH Contractor has an equal contribution to the HC BH Contractor Average value.
Rate	A proportion indicated as a percentage of members who received services out of the total population of identified eligible members.
Percentage Point Difference	The arithmetic difference between two rates.
Weighted Average	Similar to an arithmetic mean (the most common type of average), where instead of each of the data points contributing equally to the final average, some data points contribute more than others.
Statistical Significance	A result that is unlikely to have occurred by chance. The use of the word "significance" in statistics is different from the standard definition that 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.

HealthChoices Behavioral Health is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2015 EQRs for the HealthChoices Behavioral Health (BH) MCOs and to prepare the technical reports. This technical report includes seven core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures
IV. Quality Study
V. 2014 Opportunities for Improvement - MCO Response
VI. 2015 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the HealthChoices BH-MCOs, the information for the compliance with the Structure and Operations Standards section of the report is derived from monitoring and reviews conducted by OMHSAS of the BH-MCOs, as well as the oversight functions of the county or contracted entity when applicable, against the Commonwealth's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable.

Information for Sections II and III of this report is derived from Island Peer Review Organization's (IPRO's) validation of each BH-MCO's performance improvement projects (PIPs) and performance measure submissions. The Performance Measure validation as conducted by IPRO included a repeated measurement of two Performance Measures – Follow-up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. For the second year, IPRO produced a third Performance Measure, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. The results of this measure are being studied by PA DHS/OMHSAS, and the data presentation is included in the 2015 EQR BBA Technical Report for the first time.

Section IV contains the results of a Quality Study conducted by OMHSAS and IPRO that examines the HealthChoices readmission rate, using both Physical and Behavioral health encounter data, and conducts analysis to determine what factors correlate with an increased 30-day readmission rate. Following Section IV, Section V, 2014 Opportunities for Improvement – MCO Response, includes the BH-MCO's responses to opportunities for improvement noted in the 2014 EQR Technical Report, and presents the degree to which the BH-MCO addressed each opportunity for improvement. Section VI has a summary of the BH-MCO's strengths and opportunities for improvement for this review period (2015) 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. Lastly, Section VII provides a summary of EQR activities for the BH-MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA Regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

I: Structure and Operations Standards

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the structure and operations standards. In review year (RY) 2014, 64 Pennsylvania counties participated in this compliance evaluation.

Organization of the HealthChoices Behavioral Health Program

OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program; the mandatory managed care program that provides Medical Assistance recipients with services to treat mental health and/or substance abuse diagnoses/disorders. Forty-three of the 67 counties have signed agreements using the right of first opportunity and have sub-contracted with a private sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four counties have elected not to enter into a capitated agreement and as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties. In the interest of operational efficiency, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the HC BH Contractors while providing an oversight function of the BH-MCOs. During RY 2013, three Counties, Blair, Clinton, and Lycoming, held a contract with PerformCare through June 30, 2013 and contracted with another BH-MCO as of July 1, 2013.

In some cases the HealthChoices Oversight Entity is the HealthChoices Behavioral Health (HC BH) Contractor, and in other cases multiple HC BH Contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. Operational reviews are completed for each HealthChoices Oversight Entity. The Department holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH Contractors, who in turn, contract with a private sector BH-MCO. The HC BH Contractor is responsible for their regulatory compliance to federal and state regulations, and the HC BH PS&R Agreement compliance. The HC BH PS&R Agreement includes the HC BH Contractor's responsibility for the oversight of BH-MCO's compliance.

Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties formed an HC Oversight Entity called Capital Area Behavioral Health Collaborative (CABHC). The Tuscarora Managed Care Alliance and Behavioral Health Services of Somerset and Bedford Counties (BHSSBC) oversee the HC BH program for Franklin, Fulton, Bedford and Somerset Counties respectively. The latter two HC Oversight Entities hold contracts with PerformCare. **Table 1** shows the name of the HealthChoices Oversight Entity, the associated HealthChoices HC BH Contractor(s), and the county(ies) encompassed by each HC BH Contractor.

Table 1: HealthChoices Oversight Entities, HC BH Contractors and Counties

HealthChoices Oversight Entity	HC BH Contractor	County
Capital Area Behavioral Health Collaborative (CABHC)	Cumberland County	Cumberland County
	Dauphin County	Dauphin County
	Lancaster County	Lancaster County
	Lebanon County	Lebanon County
	Perry County	Perry County
Behavioral Health Services of Somerset and Bedford Counties (BHSSBC)	Behavioral Health Services of Somerset and Bedford Counties (BHSSBC) Otherwise known as Bedford-Somerset for review.	Bedford County
		Somerset County
The Tuscarora Managed Care Alliance	The Tuscarora Managed Care Alliance Otherwise known as Franklin-Fulton for review.	Franklin County
		Fulton County

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of PerformCare by OMHSAS monitoring staff within the past three review years (RYs 2014, 2013, 2012).

These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for RY 2014. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year timeframe under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review Substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's Program Standards and Requirements (PS&R) are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2015 and entered into the PEPS Application as of October 2015 for RY 2014. Information captured within the PEPS Application informs this report. The PEPS Application is a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each HealthChoices Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the substandards 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 PEPS Application, a HealthChoices Oversight Entity/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's more rigorous monitoring criteria.

At the implementation of the PEPS Application in 2004, IPRO evaluated the standards in the Application 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's 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 2014 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's review of the HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS Substandards from RY 2014, RY 2013, and RY 2012 provided the information necessary for the 2015 assessment. Those standards not reviewed through the PEPS system in RY 2014 were evaluated on their performance based on RY 2013 and/or RY 2012 decisions, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed. Because Blair, Clinton, and Lycoming Counties contracted with two BH-MCOs in the review period, and because all applicable standards were reviewed for both BH-MCOs within the three-year time frame, these HealthChoices Oversight Entity review findings were not included in the assessment of compliance for either BH-MCO.

For PerformCare, this year a total of 163 Items were identified as being required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations. In addition, 16 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 2** provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of PerformCare against the Structure and Operations Standards for this report. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH-MCO and associated HealthChoices Oversight Entities against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for PerformCare

Table 2: Substandards Pertinent to BBA Regulations Reviewed for PerformCare

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	PEPS Reviewed in RY 2012	Not Reviewed[1]
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	5	0	7	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	24	7	4	13	0
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	4	0	0	0
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	2	4	0	0
Quality Assessment and Performance Improvement Program	23	16	7	0	0
Health Information Systems	1	0	1	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	11	0	0	0
General Requirements	14	14	0	0	0
Notice of Action	13	7	0	6	0
Handling of Grievances and Appeals	11	11	0	0	0
Resolution and Notification: Grievances and Appeals	11	11	0	0	0
Expedited Appeals Process	6	6	0	0	0
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	6	0	0	0
Effectuation of Reversed Resolutions	6	6	0	0	0

[1] Items "Not Reviewed" were not scheduled or not applicable for evaluation. "Not Reviewed" items, including those that were "Not Applicable," did not substantially affect the findings for any category, if other items within the category were reviewed.

For RY 2014, 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's judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health Program's PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH-MCOs. The category of Marketing Activities is Not Applicable because as a result of the Centers for Medicare and Medicaid Services (CMS) HealthChoices waiver, DHS has been granted an allowance to offer only one BH-MCO per county. Compliance for the Cost Sharing category is not assessed by PEPS Substandards, as any cost sharing imposed on Medicaid enrollees is in accordance with CMS regulation 42 CFR 447.50-447.60.

Before 2008, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all HC BH Contractors and BH-MCOs based on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. In 2008, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories. In this 2015 report, the Solvency tracking reports and the quarterly reporting of Complaint and Grievances data were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

Determination of Compliance

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

Format

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in the *CMS EQR Protocol #1: Assessment of Compliance with Medicaid Managed Care Regulations* ("Quality of Care External Quality Review," 2012). Under each general subpart heading are the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a manner consistent with the three subparts in the BBA regulations explained in the Protocol i.e., Enrollee Rights and Protections, Quality Assessment and Performance Improvement (including access, structure and operation and measurement and improvement standards), and Federal and State Grievance System Standards.

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

Findings

For PerformCare and the seven HC BH Contractors associated with the BH-MCO that were included in the structure and operations standards for RY 2014, 163 PEPS Items were identified as required to fulfill BBA regulations. The seven HC BH Contractors were evaluated on 163 PEPS Items during the review cycle. Because two HC BH Contractors, Blair and Lycoming-Clinton, contracted with two BH-MCOs in the review period, and because all applicable standards were

reviewed for both BH-MCOs within the three-year time frame, these HealthChoices Oversight Entity review findings are not included in the assessment of compliance for either BH-MCO.

Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this subpart is to ensure that each HC BH Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable Federal and State laws that pertain to enrollee rights, and that the HC BH Contractor/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees (42 C.F.R. § 438.100 [a], [b]). **Table 3** presents the findings by categories consistent with the regulations.

Table 3: Compliance with Enrollee Rights and Protections Regulations

Subpart C: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Partial		All PerformCare HC BH Contractors	12 substandards were crosswalked to this category. Cumberland, Dauphin, Lancaster, Lebanon, Perry and Bedford-Somerset were evaluated on 12 substandards, compliant on 10 substandards, and non-compliant on 2 substandards. Franklin-Fulton was evaluated on 12 substandards, compliant on 5 substandards, partially compliant on 5 substandards, and non-compliant on 2 substandards.
Provider-Enrollee Communications 438.102	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R sections E.4 (p.52) and A.4.a (p.20).
Marketing Activities 438.104	N/A	N/A	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH-MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R sections A.9 (p.70) and C.2 (p.32).
Cost Sharing 438.108	Compliant	All PerformCare HC BH Contractors		Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R section 4 (p.37).
Solvency Standards 438.116	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R sections A.3 (p.65) and A.9 (p.70), and 2014-2015 Solvency Requirements tracking report.

N/A: not applicable

There are seven categories within Enrollee Rights and Protections Standards. PerformCare was compliant on five categories and partially compliant on one category. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50-447.60. The remaining category, Solvency Standards, was compliant based on the 2014-2015 Solvency Requirement tracking report.

Of the 12 PEPS Substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated. Cumberland, Dauphin, Lancaster, Lebanon, Perry and Bedford-Somerset evaluated on 12 substandards, compliant on 10 substandards, and non-compliant on two substandards. Franklin-Fulton was compliant on five substandards, partially compliant on five substandards, and non-compliant on two substandards. Some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Enrollee Rights

Franklin-Fulton was partially compliant with Enrollee Rights due to partial compliance with 5 substandards within PEPS Standard 108 and non-compliance on substandards 2 and 3 within PEPS Standard 60.

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

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

Substandard 1: County/BH-MCO oversight of C/FST Program ensures HealthChoices contractual requirements are met.
Substandard 5: The C/FST has access to providers and HealthChoices members to conduct surveys, and employs of a variety of survey mechanisms to determine member satisfaction; e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
Substandard 6: The problem resolution process specifies the role of the County, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
Substandard 7: The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
Substandard 10: The C/FST Program is an effective, independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.

PEPS Standard 60: Complaint/Grievance Staffing. The County Contractor/BH-MCO: a) shall identify a lead person responsible for overall coordination of the complaint and grievance process, including the provision of information and instructions to members; b) shall designate and train sufficient staff responsible for receiving, processing and responding to member complaints and grievances in accordance with the requirements contained in Appendix H; and c) staff shall be educated concerning member rights and the procedure for filing complaints and grievances.

All HC BH Contractors were non-compliant on two substandards of Standard 60: Substandards 2 and 3 (RY 2014).

Substandard 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.
Substandard 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.

Subpart D: Quality Assessment and Performance Improvement Regulations

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

The PEPS documents for each HC BH Contractor include an assessment of the HC BH Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 4** presents the findings by categories consistent with the regulations.

Table 4: Compliance with Quality Assessment and Performance Improvement Regulations

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Elements of State Quality Strategies 438.204	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R section G.3 (p.58).
Availability of Services (Access to Care) 438.206	Partial		All PerformCare HC BH Contractors	24 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 24 substandards, compliant on 21 substandards, and partially compliant on 3 substandards.
Coordination and Continuity of Care 438.208	Partial		All PerformCare HC BH Contractors	2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 items, compliant on 1 substandard, and partially compliant on 1 substandard.
Coverage and Authorization of Services 438.210	Partial		All PerformCare HC BH Contractors	4 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 4 substandards, compliant on 2 substandards, and partially compliant on 2 substandards.
Provider Selection 438.214	Compliant	All PerformCare HC BH Contractors		3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R sections D.2 (p.49), G.4 (p.59) and C.6.c (p.47).
Subcontractual Relationships and Delegation 438.230	Partial		All PerformCare HC BH Contractors	8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards, compliant on 6 substandards, and partially compliant on 2 substandards.
Practice Guidelines 438.236	Partial		All PerformCare HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant on 5 substandards, and partially compliant on 1 substandards.
Quality Assessment and Performance Improvement Program 438.240	Compliant	All PerformCare HC BH Contractors		23 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards, and compliant on 23 substandards.
Health Information	Compliant	All		1 Substandard was crosswalked to this category.

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Systems 438.242		PerformCare HC BH Contractors		Each HC BH Contractor was evaluated on 1 Substandard and was compliant on this Item.

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

For this review, 71 Items were crosswalked to Quality Assessment and Performance Improvement Regulations, and the seven HC BH Contractors associated with PerformCare were evaluated on all 71 Items. All of the PerformCare HC BH Contractors reviewed were compliant on 62 Items and partially compliant on 9 Items. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

All HC BH Contractors associated with PerformCare were partially compliant with Availability of Services (Access to Care) due to partial compliance with substandard 2 substandards within PEPS Standard 23 and substandard 1 within PEPS Standard 28.

PEPS Standard 23: BH-MCO shall make services available that ensure effective communication with non-English speaking populations that include: (a) Oral Interpretation services [Interpreters or telephone interpreter services]; (b) Written Translation services, including member handbooks, consumer satisfaction forms, and other vital documents in the member's primary language (for language groups with 5% or more of the total eligible membership]; (c) Telephone answering procedures that provide access for non-English speaking members. Limited English Proficiency (LEP) Requirements (Section 601 of Title V of the Civil Rights Act of 1964 - 42 U.S.C. Section 200d 3t. seq) must be met by the BH-MCO. An LEP individual is a person who does not speak English as their primary language, and who has a limited ability to read, write, speak or understand English.

All of the PerformCare HC BH Contractors were partially compliant on two substandards of Standard 23: Substandards 4 and 5 (RY 2014).

> **Substandard 4:** BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
> **Substandard 5:** BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)

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

All of the PerformCare HC BH Contractors were partially compliant on one substandard of Standard 28: Substandards 1 (RY 2014).

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

Coordination and Continuity of Care

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

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

Coverage and Authorization of Services

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

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

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

All of the PerformCare HC BH Contractors were partially compliant on one substandard of Standard 72: Substandard 2 (RY 2014).

> **Substandard 2:** The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

Subcontractual Relationships and Delegations

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

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

All PerformCare HC BH Contractors were partially compliant on two substandards of Standard 99, Substandard 6 and Substandard 8 (RY 2013).

> **Substandard 6:** Provider profiles and individual monitoring results are reviewed with providers.
> **Substandard 8:** The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.

Practice Guidelines

All HC BH Contractors associated with PerformCare were partially compliant with Practice Guidelines due to partial compliance with 1 substandard of PEPS Standard 28.

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

Subpart F: Federal and State Grievance System Standards

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances. The PEPS documents include an assessment of the HC BH Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 5** presents the findings by categories consistent with the regulations.

Table 5: Compliance with Federal and State Grievance System Standards

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All PerformCare HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant on 4 substandards, partially compliant on 4 substandards, and non-compliant on 3 substandards.
General Requirements 438.402	Partial		All PerformCare HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards, compliant on 5 substandards, partially compliant on 4 substandards, and non-compliant on 5 substandards.
Notice of Action 438.404	Partial		All PerformCare HC BH Contractors	13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards, compliant on 10 substandards, and partially compliant on 3 substandards.
Handling of Grievances and Appeals 438.406	Partial		All PerformCare HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant on 4 substandards, partially compliant on 4 substandards, and non-compliant on 3 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All PerformCare HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant on 4 substandards, partially compliant on 4 substandards, and non-compliant on 3 substandards.
Expedited Appeals Process 438.410	Partial		All PerformCare HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant on 3 substandards, and partially compliant on 3 substandards.
Information to Providers	Compliant	All		2 substandards were crosswalked to this

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

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

For this review, 80 Items were crosswalked to Federal and State Grievance System Standards, and each PerformCare HC BH Contractor was evaluated on 80 Items. Each HC BH Contractor was compliant on 38 Items, partially compliant on 28 Items, and non-compliant on 14 Items. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

The seven PerformCare HC BH Contractors were deemed partially compliant with 8 of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance or non-compliance with four substandards within PEPS Standard 68, non-compliance with two substandards within PEPS Standard 60, partial compliance with two substandards within PEPS standard 71, and partial compliance with one substandard within PEPS standard 72.

Statutory Basis and Definitions

The seven HC BH Contractors associated with PerformCare were partially compliant with Statutory Basis and Definitions due to non-compliance with 3 substandards within PEPS Standard 68 and partial compliance with 1 substandard within PEPS Standard 68, 2 substandards within PEPS Standards 71, and 1 substandard within PEPS Standard 72.

PEPS Standard 68: Complaints. 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.

All of the PerformCare HC BH Contractors were non-compliant on three substandards of Standard 68: Substandard 2, Substandard 3, and Substandard 4 (RY 2014).

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: Complaint decision letters must be written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
Substandard 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 of the PerformCare HC BH Contractors were partially compliant on one substandard of Standard 68: Substandard 5 (RY 2014).

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.

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

All of the PerformCare HC BH Contractors were partially compliant on two substandards of Standard 71: Substandard 3 and Substandard 4 (RY 2014).

Substandard 3: Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
Substandard 4: Grievance case files must include documentation of any referrals to County/BH- MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.

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

General Requirements
All HC BH Contractors associated with PerformCare were partially compliant with General Requirements due to non-compliance with substandards of Standards 60 and 68 and partial compliance with substandards of Standards 71 and 72.

PEPS Standard 60: See Standard description and partially compliant substandard determination under Enrollee Rights on page 11 of this report.

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

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

Notice of Action
All HC BH Contractors associated with PerformCare were partially compliant with Notice of Action due to partial compliance with Substandards 4 and 5 of Stanrdard 23 and Substandard 1 of Standard 72.

PEPS Standard 23: See Standard description and determination of compliance under the Availability of Services (Access to Care) section on page 13 of this report.

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

Handling of Grievances and Appeals

All HC BH Contractors associated with PerformCare were partially compliant with Handling of Grievances and Appeals due to non-compliance with substandards of Standards 68 and partial compliance with substandards of Standards 68, 71, and 72.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 16 of this report.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

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

Resolution and Notification: Grievances and Appeals

All HC BH Contractors associated with PerformCare were partially compliant with Resolution and Notification non-compliance with substandards of Standards 68 and partial compliance with substandards of Standards 68, 71, and 72.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 16 of this report.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

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

Expedited Appeals Process

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

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

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

Continuation of Benefits

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

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

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

Effectuation of Reversed Resolutions

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

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

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

II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH-MCO. Under the existing HealthChoices Behavioral Health agreement with OMHSAS, HC BH Contractors along with the responsible subcontracted entities (i.e., BH-MCOs), are required to conduct a minimum of two focused studies per year. The HC BH Contractors and BH-MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or re-measurement 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 2015 for 2014 activities.

A new EQR PIP cycle began for BH-MCOs and HC BH Contractors in 2014. For this PIP cycle, OMHSAS selected the topic, "Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis" as the topic for this PIP. The topic was selected because the Aggregate HealthChoices 30-day Readmission Rate has consistently not met the OMHSAS goal of a rate of 10% or less. In addition, all HealthChoices BH-MCOs continue to remain below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS®[1]) Follow-up After Hospitalization (FUH) metrics.

The Aim Statement for this PIP is "Successful transition from inpatient care to ambulatory care for Pennsylvania HealthChoices members hospitalized with a mental health or a substance abuse diagnosis." OMHSAS selected three common objectives for all BH-MCOs:

1. Reduce behavioral health and substance abuse readmissions post-inpatient discharge.
2. Increase kept ambulatory follow-up appointments post-inpatient discharge.
3. Improve medication adherence post-inpatient discharge.

Additionally, OMHSAS is requiring all BH-MCOs to submit the following core performance measures on an annual basis:

1. **Readmission Within 30 Days of Inpatient Psychiatric Discharge (Mental Health Discharges)**
   The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days without a substance abuse diagnosis during the initial stay.
2. **Readmission Within 30 Days of Inpatient Psychiatric Discharge (Substance Abuse Discharges)**
   The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days with a substance abuse diagnosis (primary or secondary) during the initial stay.
3. **Adherence to Antipsychotic Medications for Individuals with Schizophrenia**
   The percentage of members diagnosed with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. This measure is based on the HEDIS measure of the same name.
4. **Components of Discharge Management Planning**
   This measure is based on review of facility discharge management plans, and assesses the following:
   a. The percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses and provider phone numbers.
   b. The percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses and provider phone numbers where at least one of the scheduled appointments occurred.

This PIP project will extend from January 2014 through December 2017, with initial PIP proposals submitted in 2014 and a final report due in June 2018. The non-intervention baseline period was from January 2014 to December 2014. BH-MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. BH-MCOs will be required to submit interim reports in June 2016 and June 2017, as well as a final report in June 2018. BH-MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH Contractor-level and BH-MCO-level data, including clinical history and pharmacy data. This PIP is designed to be a

[1] Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of the National Committee for Quality Assurance (NCQA).

collaboration between the HC BH Contractors and BH-MCOs. The BH-MCOs and each of their HC BH Contractors are required to collaboratively develop a root-cause/barrier analysis that identifies potential barriers at the BH-MCO level of analysis. Each of the barriers identified should include the contributing HC BH Contract level data and illustrate how HC BH Contractor knowledge of their high risk populations contributes to the barriers within their specific service areas. Each BH-MCO will submit the single root-cause/barrier analysis according to the PIP schedule.

This PIP was formally introduced to the BH-MCOs and HC BH Contractors during a Quality Management Directors meeting on June 4, 2014. During the latter half of 2014, OMHSAS and IPRO conducted follow-up calls with the BH-MCOs and HC BH Contractors as needed.

The 2015 EQR is the 12th review to include validation of PIPs. With this PIP cycle, all BH-MCOs/HC BH Contractors share the same baseline period and timeline. To initiate the PIP cycle in 2014, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given to the BH-MCOs/HC BH Contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness. As calendar year 2015 is the first intervention year, the BH-MCOs were expected to implement the interventions that were planned in 2014, monitor the effectiveness of their interventions, and to improve their interventions based on their monitoring results.

The BH-MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with the Centers for Medicare & Medicaid Services (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 for compliance with the ten review elements listed below:

1. Project Topic and Topic Relevance
2. Study Question (Aim Statement)
3. Study Variables (Performance Indicators)
4. Identified Study Population
5. Sampling Methods
6. Data Collection Procedures
7. Improvement Strategies (Interventions)
8. Interpretation of Study Results (Demonstrable Improvement)
9. Validity of Reported Improvement
10. Sustainability of Documented Improvement

The first nine elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. As calendar year 2015 was an intervention year for all BH-MCOs, IPRO reviewed elements 1 through 9 for each BH-MCO.

Review Element Designation/Weighting

Calendar year 2015 was an intervention year; therefore, scoring cannot be completed for all elements. This section describes the scoring elements and methodology that will occur during the sustainability period.

For each review element, the assessment of compliance is determined through the weighted responses to each review item. 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. **Table 6** presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 6: 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; **Table 7**).

PIPs are also reviewed for the achievement of sustained improvement. This has a weight of 20%, for a possible maximum total of 20 points (**Table 7**). The BH-MCO must sustain improvement relative to the baseline after achieving demonstrable improvement. The evaluation of the sustained improvement area has two review elements.

Scoring Matrix

At the time each PIP element is reviewed, a finding is given of "Met," "Partially Met," or "Not Met." Elements receiving a "Met" will receive 100% of the points assigned to the element, "Partially Met" elements will receive 50% of the assigned points, and "Not Met" elements will receive 0%.

Table 7: Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Topic and Topic Relevance	5%
2	Study Question (Aim Statement)	5%
3	Study Variables (Performance Indicators)	15%
4/5	Identified Study Population and Sampling Methods	10%
6	Data Collection Procedures	10%
7	Improvement Strategies (Interventions)	15%
8/9	Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	20%
Total Demonstrable Improvement Score		80%
10	Sustainability of Documented Improvement	20%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

Findings

PerformCare submitted their PIP Final Proposal document in April 2015, and submitted their PIP Year 1 Update document for review in October 2015. As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. The final proposal was reviewed by OMHSAS and IPRO and recommendations were provided to PerformCare. PerformCare was given the opportunity to schedule a technical assistance meeting to review their changes based on the initial review. PerformCare's assistance call occurred in August 2015.

PerformCare's proposal included objectives that align with the proposal objectives, and a rationale for conducting the PIP based on literature review, demographic data, and a readmission analysis for members with Mood Disorders inclusive of Major Depression and Bipolar illness, Schizophrenia inclusive of Unspecified Psychosis, and Drug and Alcohol

Related Conditions. There was limited discussion of BH-MCO data regarding readmission rates and no analysis of medication adherence data. As the final proposal was submitted prior to the availability of complete baseline year (2014) data, no baseline rates or goals were included in the proposal.

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

PerformCare provided a brief description of interventions planned for the PIP, including development of provider education on discharge managements, and expansion of their enhanced care management program. No details were given regarding the implementation of these interventions, nor were any process measurements proposed to measure their effectiveness.

III: Performance Measures

In 2015, OMHSAS and IPRO conducted three EQR studies. Both the Follow-up After Hospitalization for Mental Illness (FUH) and Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were re-measured in 2015. OMHSAS also elected to implement a statewide measure that focuses on substance abuse services, the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) HEDIS measure.

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 continues to be of interest to OMHSAS for the purpose of comparing county, HC BH Contractor, and BH-MCO rates to available national benchmarks and to prior years' rates.

Measurement year (MY) 2002 was the first year follow-up rates were reported. QI 1 and QI 2 utilize the HEDIS methodology for this measure. The PA-specific indicators were added to include services with high utilization in the HealthChoices BH Program that could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits. Each year the QI 1 and QI 2 specifications are aligned with the HEDIS Follow-up After Mental Health Hospitalization measure. The PA-specific codes that are not included in the HEDIS measure are also reviewed for accuracy on an annual basis.

The last major change to the PA-specific follow-up measures was in MY 2006. Codes added to the measures as per suggestions from OMHSAS, the counties, and BH-MCOs changed the measures substantially, and rates for these indicators were no longer comparable to those from preceding MYs. Consequently, these indicators were renamed to QI A and QI B, respectively. As these indicators represented a significant deviation from HEDIS measure specifications, comparisons to HEDIS rates were not made. In addition, for MY 2006 the follow-up measure was collected for the newly implemented HealthChoices Northeast Counties, and these counties were asked to collect data for the six-month time frame that they were in service for 2006.

For MY 2007, all PA local codes previously mapped to standard CPT and HCPCS codes as per HIPAA requirements were retired and removed. Additionally, the measure was initiated for the 23 North/Central State Option Counties implemented in January 2007. As with the Northeast Counties for MY 2006, the North/Central County Option Counties were asked to collect data for the six-month time frame that they were in service for 2007.

For MY 2008 to MY 2012, and in MY 2014 there were only minor changes made to the specifications. The specifications were modified each year to align with the HEDIS measure.

In July 2013, after the BH-MCOs submitted their MY 2012 results, IPRO and OMHSAS conducted an encounter data validation of each BH-MCO. Part of this validation was a complete review of how each MCO produced and validated their performance measures. Based on these reviews, minor inconsistencies were found in how each BH-MCO produces their PM results. It was found that not all BH-MCOs include denied claims in their submission, and there are differences in how BH-MCOs identify transfers. Based on the results of these validations, the following changes were made to the specifications for subsequent years: If a member was known to have multiple member IDs in the MY, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure and that they must use the original procedure and revenue code submitted on the claim.

On January 1, 2013 a number of CPT codes for psychiatry and psychotherapy services were retired and replaced with new codes. The HEDIS follow-up measures for MY 2013 included retired codes in the follow-up specifications, but for MY 2014 the retired CPT codes were removed from all follow-up specifications.

Measure Selection and Description

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

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

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

Eligible Population

The entire eligible population was used for all 34 HC BH Contractors participating in the MY 2014 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, 2014;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Six years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2014, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified, are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 1, 2014. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2015 methodology for the Follow-up After Hospitalization for Mental Illness measure.

HEDIS Follow-up Indicators

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

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

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

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

PA-Specific Follow-up Indicators

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

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

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

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

Quality Indicator Significance

According to the *Global Burden of Disease: 2004 Update* released by the World Health Organization (WHO) in 2008, mental illnesses and mental disorders represent six of the 20 leading causes of disability worldwide. Among developed nations, depression is the leading cause of disability for people ages 0-59 years, followed by drug and alcohol use disorders and psychoses (e.g., bipolar disorder and schizophrenia; World Health Organization, 2008). 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 (Dombrovski & Rosenstock, 2004; Moran, 2009) such as obesity, cardiovascular diseases and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns (Gill, 2005; Leslie & Rosenheck, 2004), reduced use of preventive services (Druss et al., 2002) and substandard medical care that they receive (Desai et al., 2002; Frayne et al., 2005; Druss et al., 2000). Moreover, these patients are five times more likely to become homeless than those without these disorders (Averyt et al., 1997). On the whole, serious mental illnesses account for more than 15 percent of overall disease burden in the U.S. (National Institute of Mental Health, 2009), 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 (Insel, 2008). 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 (D'Mello et al., 1995). 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 (NCQA, 2007). 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 to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments (van Walraven et al., 2004). 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 (Hermann, 2000). 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 (Hermann, 2000).

The difficulty in engaging psychiatric patients after inpatient hospitalization; however, has been a longstanding concern of behavioral health care systems, with some researchers having estimated that 40 to 60 percent of patients fail to connect with an outpatient clinician (Cuffel et al., 2002). 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 (Nelson et al., 2000). 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 (Nelson et al., 2000). 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 (Adair et al., 2005). Patients with higher functioning in turn had significantly lower community costs, and improved provider continuity was associated with lower hospital (Mitton et al., 2005) and Medicaid costs (Chien et al., 2000).

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 (Chien et al., 2000). Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care; therefore, is an important component of comprehensive care, and is an effective means to control the cost and maximize the quality of mental health services.

As noted, this measure and the issue of follow-up have been and remain of interest to OMHSAS, and results are reviewed for potential trends each year. While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Methodology

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

Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. The three-year OMHSAS goal is to achieve the 75th percentile for ages 6 to 64, based on the annual HEDIS published percentiles for 7-day and 30-day FUH by MY 2016. For MY 2013 through MY 2015, BH-MCOs will be given interim goals for the next MY for both the 7-day and 30-day follow-up rates based on their previous years' results.

The interim goals are defined as follows:

1. If a BH-MCO achieves a rate greater than or equal to the NCQA 75th percentile, the goal for the next MY is to maintain or improve the rate above the 75th percentile.
2. If a BH-MCO's rate is within 2% of the 75th percentile and above the 50th percentile, their goal for the next MY is to meet or exceed the 75th percentile.
3. If a BH-MCO's rate is more than 2% below the 75th percentile and above the 50th percentile, their goal for the next MY is to increase their current year's rate by 2%.
4. If a BH-MCO's rate is within 2% of the 50th percentile, their goal for the next MY is to increase their rate by 2%.
5. If a BH-MCO's rate is between 2% and 5% below the 50th percentile, their goal for the next MY is to increase their current year's rate by the difference between their current year's rate and the 50th percentile.
6. If a BH-MCO's rate is greater than 5% below the 50th percentile, their goal for the next MY is to increase their current year's rate by 5%.

Interim goals were provided to the BH-MCOs after the MY 2013 rates were received. The interim goals will be updated from MY 2013 to MY 2015. The interim goals are used the BH-MCOs progress in achieving the OMHSAS goal of the 75th percentile.

HEDIS percentiles for the 7-day and 30-day FUH indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis for these indicators. As noted in Section V of this report, beginning with MY 2012 performance, and continuing through MY 2014, rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request for a root cause analysis.

Data Analysis

The quality indicators were defined as rates, based on a numerator and a denominator. The denominator equaled the number of discharges eligible for the quality indicator, while the numerator was the total number of members for which the particular event occurred. The HealthChoices Aggregate for each indicator was the total numerator divided by the total denominator, which represented the rate derived from the total population of discharges that qualified for the indicator. The aggregate rate represented the rate derived from the total population of members that qualified for the indicator (i.e., the aggregate value). Year-to-year comparisons to MY 2013 data were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the Z-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

HC BH Contractors with Small Denominators

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for all HC BH Contractors. Caution should be exercised when interpreting results for small denominators, as they produce rates that are less stable. Rates produced from small denominators may be subject to greater variability or greater margin of error. A denominator of 100 or greater is preferred for drawing conclusions from performance measure results.

Findings

BH-MCO and HC BH Contractor Results

The HEDIS follow-up indicators are presented for three age groups: ages 6 to 64, ages 6 and older, and ages 6 to 20. The results for the 6 to 64 years old age group are presented to compare the BH-MCOs and HC BH Contractor results to the OMHSAS interim and final goals for this age group. The 6+ years old results are presented to show the follow-up rates for the overall HEDIS population, and the 6-20 year old age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old only.

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

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

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

The HEDIS follow-up results for the 6 to 64 year old age group and the 6+ year old age groups are compared to the MY 2014 HEDIS national percentiles. NCQA produces annual HEDIS Follow-up After Mental Health benchmarks for the 6+ year age band only; therefore results for the 6 to 64 year old age group are compared to percentiles for the 6+ year age bands. The percentile comparison for the 6 to 64 year old age group is presented to show BH-MCO and HC BH Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile by MY 2016. HEDIS percentile comparisons for the 6+ year old age group are presented for illustrative purposes only. The HEDIS follow-up results for the 6 to 20 year old age group are not compared to HEDIS benchmarks for the 6+ age band.

I: HEDIS Follow-up Indicators

(a) Age Group: 6–64 Years Old

As noted in the Performance Goal section, OMHSAS has elected to set a three-year goal for both the HEDIS 7-day and 30-day follow-up measures for members ages 6 to 64 years old. The goal is for all HC BH Contractor and BH-MCO rates to meet or exceed the HEDIS 75th percentile by MY 2015. For MYs 2013 through 2015, BH-MCOs will be given interim goals for the next MY for both the 7-day and 30-day follow-up rates based on their previous years' results. **Table 8** shows the MY 2014 results compared to their MY 2014 goals and HEDIS percentiles.

Table 8: MY 2014 HEDIS Follow-up Indicator Rates: 6–64 Years Old

	MY 2014							MY 2013	Rate Comparison			
Measure	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2014 Goal	2014 Goal Met?	%	PPD: MY 13 to MY 14	% Change: MY 13 to MY 14[1]	SSD: MY 13 to MY 14	HEDIS MY 2015 Medicaid Percentiles
QI 1 – HEDIS 7-Day Follow-up for Ages 6–64 Years Old												
HealthChoices Aggregate	16,736	35,193	**47.6%**	47.0%	48.1%	48.9%	NO	47.9%	-0.4	-0.80%	NO	Above 50th Percentile, Below 75th Percentile
PerformCare[2]	1,488	3,282	**45.3%**	43.6%	47.1%	44.3%	YES	43.4%	1.9	4.46%	NO	Below 50th Percentile, Above 25th Percentile
Bedford-Somerset	114	263	**43.3%**	37.2%	49.5%	40.0%	YES	38.1%	5.2	13.73%	NO	Below 50th Percentile, Above 25th Percentile
Cumberland	157	348	**45.1%**	39.7%	50.5%	42.1%	YES	40.1%	5.1	12.62%	NO	Below 50th Percentile, Above 25th Percentile
Dauphin	328	822	**39.9%**	36.5%	43.3%	42.3%	NO	40.3%	-0.4	-0.98%	NO	Below 50th Percentile, Above 25th Percentile
Franklin-Fulton	151	294	**51.4%**	45.5%	57.2%	49.4%	YES	48.5%	2.9	5.95%	NO	Above 50th Percentile, Below 75th Percentile
Lancaster	516	1,117	**46.2%**	43.2%	49.2%	42.3%	YES	40.8%	5.3	13.09%	YES	Below 50th Percentile, Above 25th Percentile
Lebanon	196	357	**54.9%**	49.6%	60.2%	54.5%	YES	54.2%	0.7	1.38%	NO	Above 50th Percentile, Below 75th Percentile
Perry	26	81	**32.1%**	21.3%	42.9%	37.8%	NO	36.0%	-3.9	-10.75%	NO	Below 50th Percentile, Above 25th Percentile
QI 2 – HEDIS 30-Day Follow-up for Ages 6-64 Years Old												
HealthChoices Aggregate	23,882	35,193	**67.9%**	67.4%	68.3%	69.8%	NO	68.4%	-0.6	-0.85%	NO	Above 50th Percentile, Below 75th Percentile
PerformCare[2]	2,283	3,282	**69.6%**	68.0%	71.2%	67.9%	YES	66.5%	3.0	4.56%	YES	Above 50th Percentile, Below 75th Percentile
Bedford-Somerset	178	263	**67.7%**	61.8%	73.5%	68.5%	NO	67.1%	0.5	0.82%	NO	Above 50th Percentile, Below 75th Percentile
Cumberland	242	348	**69.5%**	64.6%	74.5%	66.2%	YES	64.9%	4.6	7.13%	NO	Above 50th Percentile, Below 75th Percentile
Dauphin	513	822	**62.4%**	59.0%	65.8%	64.6%	NO	62.7%	-0.3	-0.44%	NO	Below 50th Percentile, Above 25th Percentile
Franklin-Fulton	243	294	**82.7%**	78.2%	87.2%	75.9%	YES	75.9%	6.7	8.85%	NO	At or Above 75th Percentile
Lancaster	776	1,117	**69.5%**	66.7%	72.2%	64.6%	YES	63.2%	6.2	9.88%	YES	Above 50th Percentile, Below 75th Percentile
Lebanon	280	357	**78.4%**	74.0%	82.8%	76.8%	YES	76.8%	1.6	2.14%	NO	At or Above 75th Percentile
Perry	51	81	**63.0%**	51.8%	74.1%	63.6%	NO	60.5%	2.4	4.03%	NO	Below 50th Percentile, Above 25th Percentile

[1] Percentage change is the percentage increase or decrease of the MY 2014 rate when compared to the MY 2013 rate. The formula is: (MY 2014 rate – MY 2013 rate)/MY 2013 rate.
[2] As Blair and Lycoming-Clinton ended their contract with PerformCare on June 30, 2013, overall MY 2013 results for PerformCare include discharges for Blair and Lycoming-Clinton that occurred between 1/1/13 and 6/30/13. Individual rates for Blair and Lycoming-Clinton are not shown.
N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval

The MY 2014 HealthChoices Aggregate HEDIS follow-up rates in the 6 to 64 year age group were 47.6% for QI 1 and 67.9% for QI 2 (**Table 8**). These rates were comparable to (i.e. not statistically significantly different from) the HealthChoices Aggregate rates for this age group in MY 2013, which were 47.9% and 68.4% respectively. The HealthChoices Aggregate rates were below the MY 2014 interim goals of 48.9% for QI 1 and 69.8% for QI 2; therefore, both interim goals were not met in MY 2014. Both HealthChoices Aggregate rates were between the NCQA 50th and 75th percentiles; therefore, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2014 for either rate.

The MY 2014 PerformCare QI 1 rate for members ages 6 to 64 was 45.3%, which was comparable to the MY 2013 PerformCare QI 1 rate of 43.4% (**Table 8**). The corresponding QI 2 rate was 69.6%, a statistically significant increase of 3.0 percentage points from the MY 2013 PerformCare QI 2 rate of 66.5%. PerformCare's QI 1 rate for the 6 to 64 year old population was statistically significantly lower than the QI 1 HealthChoices BH-MCO Average of 47.4% by 2.1 percentage points, while its QI 2 rate for this age group was not statistically significantly different from the QI 2 HealthChoices BH-MCO Average of 68.0%. Both the 7-day and the 30-day interim follow-up goals for PerformCare were met in MY 2014, as PerformCare's rates surpassed its target goals of 44.3% for QI 1 and 67.9% for QI 2. Compared to the 2015 HEDIS NCQA percentiles, PerformCare's QI 1 rate was between the 25th and 50th percentiles, and its QI 2 rate was between the 50th and 75th percentiles; therefore, the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by PerformCare in MY 2014 for either rate.

From MY 2013 to MY 2014, HEDIS rates for members 6 to 64 years old statistically significantly increased in Lancaster by 5.3 percentage points for QI 1 and 6.2 percentage points for QI 2 (**Table 8**). Five of PerformCare's seven HC BH Contractors met their MY 2014 interim goals for QI 1, and four Contractors met their QI 2 interim goals. Two HC BH Contractors, Franklin-Fulton and Lebanon, achieved the final OMHSAS goal of meeting or exceeding the NCQA 75th percentile for QI 2.

Figure 1 is a graphical representation of MY 2014 HEDIS follow-up rates in the 6 to 64 year old population for PerformCare and its associated HC BH Contractors. **Figure 2** shows the HC BH Contractor Averages for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rate for Lebanon was statistically significantly above the MY 2014 QI 1 HC BH Contractor Average of 47.6% by 7.3 percentage points, while the QI 1 rates for Dauphin and Perry were statistically significantly lower than the Average by 7.7 and 15.5 percentage points respectively. The QI 2 rates for Lebanon and Franklin-Fulton were significantly higher than the QI 2 HC BH Contractor Average of 69.8% by 8.7 and 12.9 percentage points respectively, while the QI 2 rate for Dauphin was statistically significantly below the average by 7.4 percentage points.

Figure 1: MY 2014 HEDIS Follow-up Indicator Rates: 6-64 Years Old

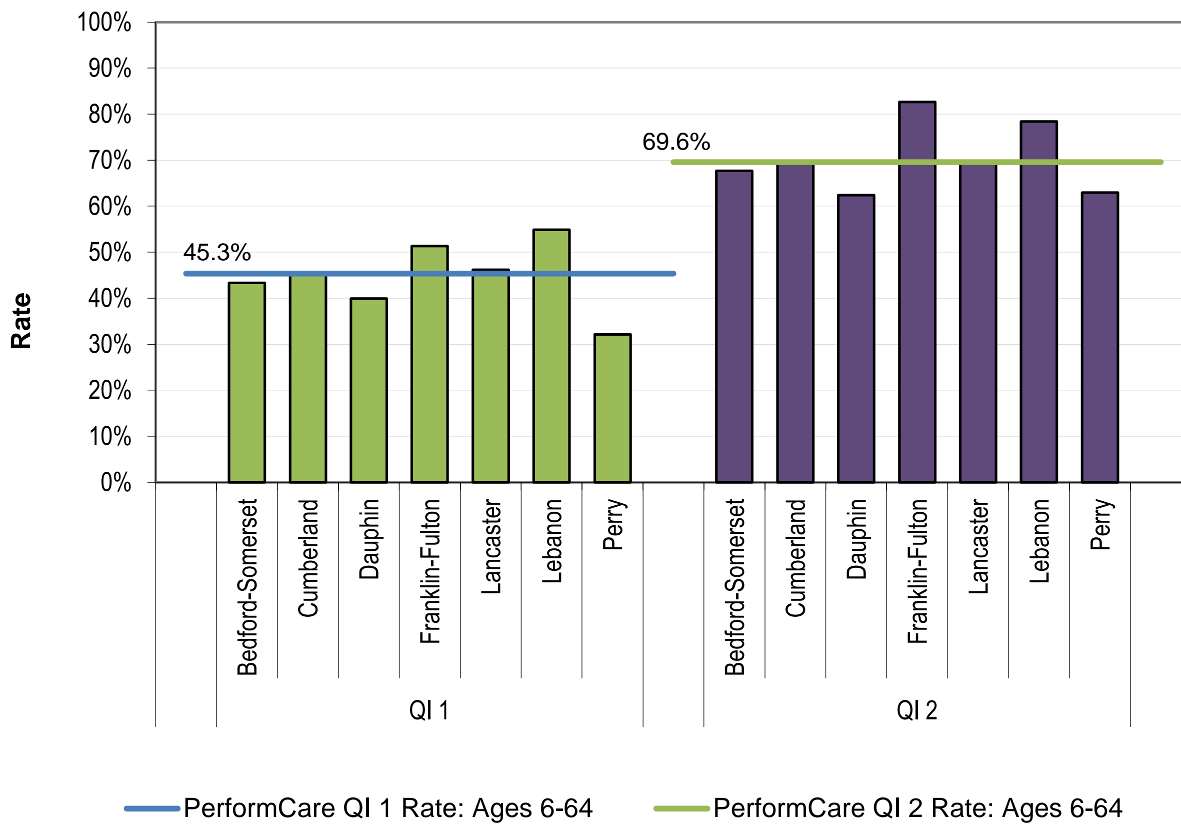
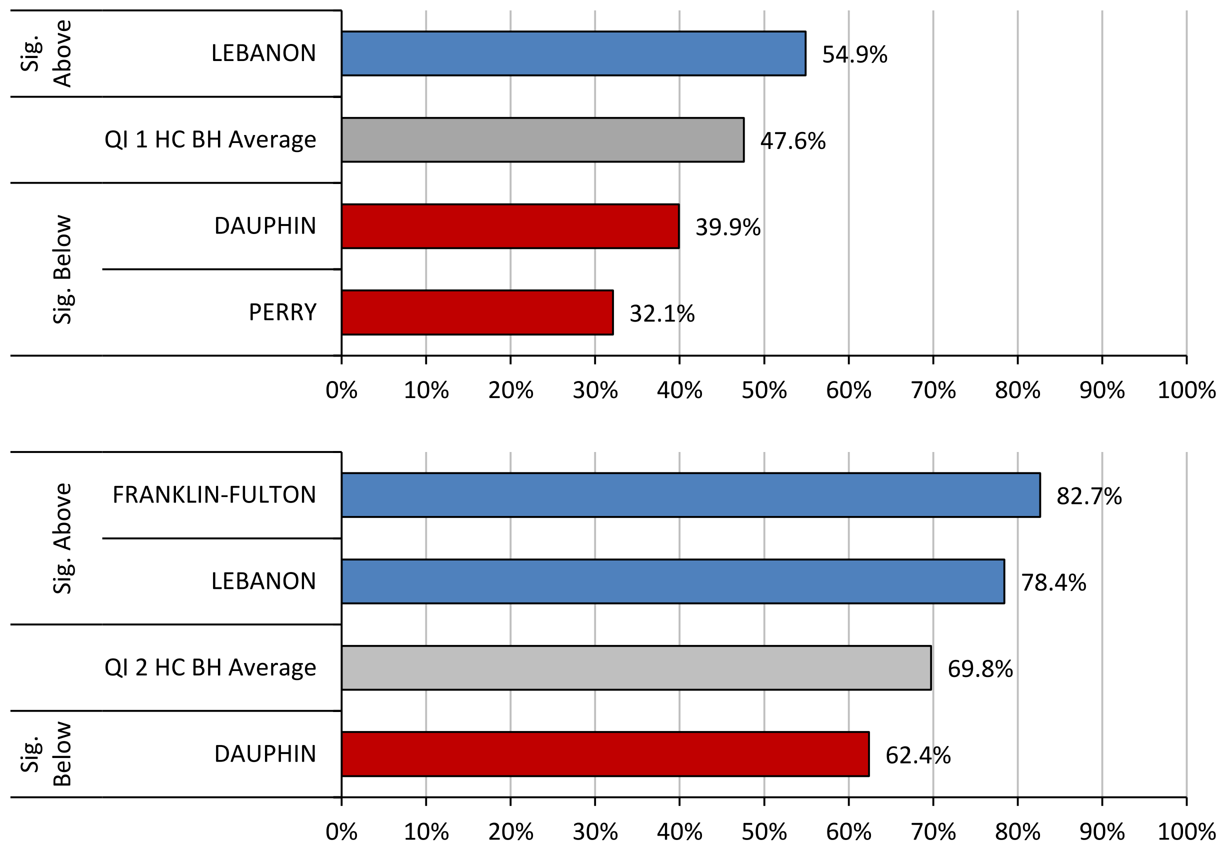


Figure 2: HEDIS Follow-up Rates Compared to MY 2014 HealthChoices HC BH Contractor Average: 6-64 Years Old



(b) Overall Population: 6+ Years Old

Table 9: MY 2014 HEDIS Follow-up Indicator Rates – Overall Population

Measure	MY 2014							MY 2013	Rate Comparison of MY 2014 against:		
									MY 2013		
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	%	PPD	SSD	HEDIS MY 2015 Percentile
QI 1 – HEDIS 7-Day Follow-up for Ages 6+ Years Old											
HealthChoices Aggregate	16,917	35,824	**47.2%**	46.7%	47.7%	47.1%	47.3%	47.7%	-0.4	NO	Above 50th Percentile, Below 75th Percentile
PerformCare[1]	1,499	3,335	**44.9%**	43.2%	46.7%			43.1%	1.8	NO	Below 50th Percentile, Above 25th Percentile
Bedford-Somerset	116	269	**43.1%**	37.0%	49.2%			37.7%	5.4	NO	Below 50th Percentile, Above 25th Percentile
Cumberland	157	355	**44.2%**	38.9%	49.5%			39.7%	4.5	NO	Below 50th Percentile, Above 25th Percentile
Dauphin	330	834	**39.6%**	36.2%	42.9%			40.2%	-0.7	NO	Below 50th Percentile, Above 25th Percentile
Franklin-Fulton	152	301	**50.5%**	44.7%	56.3%			47.8%	2.7	NO	Above 50th Percentile, Below 75th Percentile
Lancaster	521	1,134	**45.9%**	43.0%	48.9%			40.6%	5.4	YES	Below 50th Percentile, Above 25th Percentile
Lebanon	197	361	**54.6%**	49.3%	59.8%			53.8%	0.7	NO	Above 50th Percentile, Below 75th Percentile
Perry	26	81	**32.1%**	21.3%	42.9%			36.0%	-3.9	NO	Below 50th Percentile, Above 25th Percentile
QI 2– HEDIS 30-Day Follow-up for Ages 6+ Years Old											
HealthChoices Aggregate	24,152	35,824	**67.4%**	66.9%	67.9%	67.6%	69.3%	68.1%	-0.7	NO	Above 50th Percentile, Below 75th Percentile
PerformCare[1]	2,302	3,335	**69.0%**	67.4%	70.6%			66.2%	2.9	YES	Above 50th Percentile, Below 75th Percentile
Bedford-Somerset	182	269	**67.7%**	61.9%	73.4%			66.8%	0.9	NO	Above 50th Percentile, Below 75th Percentile
Cumberland	243	355	**68.5%**	63.5%	73.4%			64.6%	3.8	NO	Above 50th Percentile, Below 75th Percentile
Dauphin	517	834	**62.0%**	58.6%	65.3%			62.6%	-0.6	NO	Below 50th Percentile, Above 25th Percentile
Franklin-Fulton	245	301	**81.4%**	76.8%	86.0%			74.9%	6.5	NO	At or Above 75th Percentile
Lancaster	783	1,134	**69.0%**	66.3%	71.8%			62.7%	6.3	YES	Above 50th Percentile, Below 75th Percentile
Lebanon	281	361	**77.8%**	73.4%	82.3%			76.2%	1.6	NO	At or Above 75th Percentile
Perry	51	81	**63.0%**	51.8%	74.1%			60.5%	2.4	NO	Below 50th Percentile, Above 25th Percentile

[1] As Blair and Lycoming-Clinton ended their contract with PerformCare on June 30, 2013, overall MY 2013 results for PerformCare include discharges for Blair and Lycoming-Clinton that occurred between 1/1/13 and 6/30/13. Individual rates for Blair and Lycoming-Clinton are not shown.

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval

The MY 2014 HealthChoices Aggregate HEDIS follow-up rates were 47.2% for QI 1 and 67.4% for QI 2 (**Table 9**). These rates were comparable to the MY 2013 HealthChoices Aggregate rates, which were 47.7% for QI 1 and 68.1% for QI 2. For PerformCare, the MY 2014 QI 1 rate was 44.9%, which was comparable to its MY 2013 QI 1 rate of 43.1%. The corresponding QI 2 rate was 69.0%, a statistically significant increase of 2.9 percentage points from the MY 2013 PerformCare QI 2 rate of 66.2%. The PerformCare QI 1 rate was statistically lower than the QI 1 HealthChoices BH-MCO Average of 47.1% by 2.1 percentage points, while the QI 2 rate was not statistically significantly different from the QI 2 HealthChoices BH-MCO Average of 67.6%. PerformCare had the lowest QI 1 rate of the five BH-MCOs evaluated in MY 2014.

From MY 2013 to MY 2014, both HEDIS rates for Lancaster statistically significantly increased, with improvements of 5.4 percentage points for QI 1 and 6.3 percentage points for QI 2 (**Table 9**). None of the other HC BH Contractors associated with PerformCare had statistically significant changes in HEDIS follow-up rates from MY 2013 to MY 2014.

Figure 3 is a graphical representation of the MY 2014 HEDIS follow-up rates for PerformCare and its associated HC BH Contractors. **Figure 4** shows the HC BH Contractor Averages and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rate for Lebanon was statistically significantly above the MY 2014 QI 1 HC BH Contractor Average of 47.3% by 7.3 percentage points, while the QI 1 rates for Dauphin and Perry were statistically significantly lower than the Average by 7.7 and 15.2 percentage points respectively. The QI 2 rates for Lebanon and Franklin-Fulton were statistically significantly higher than the QI 2 HC BH Contractor Average of 69.3% by 8.5 and12.1 percentage points respectively, while the QI 2 rate for Dauphin was below the Average by 7.3 percentage points.

Figure 3: MY 2014 HEDIS Follow-up Indicator Rates – Overall Population

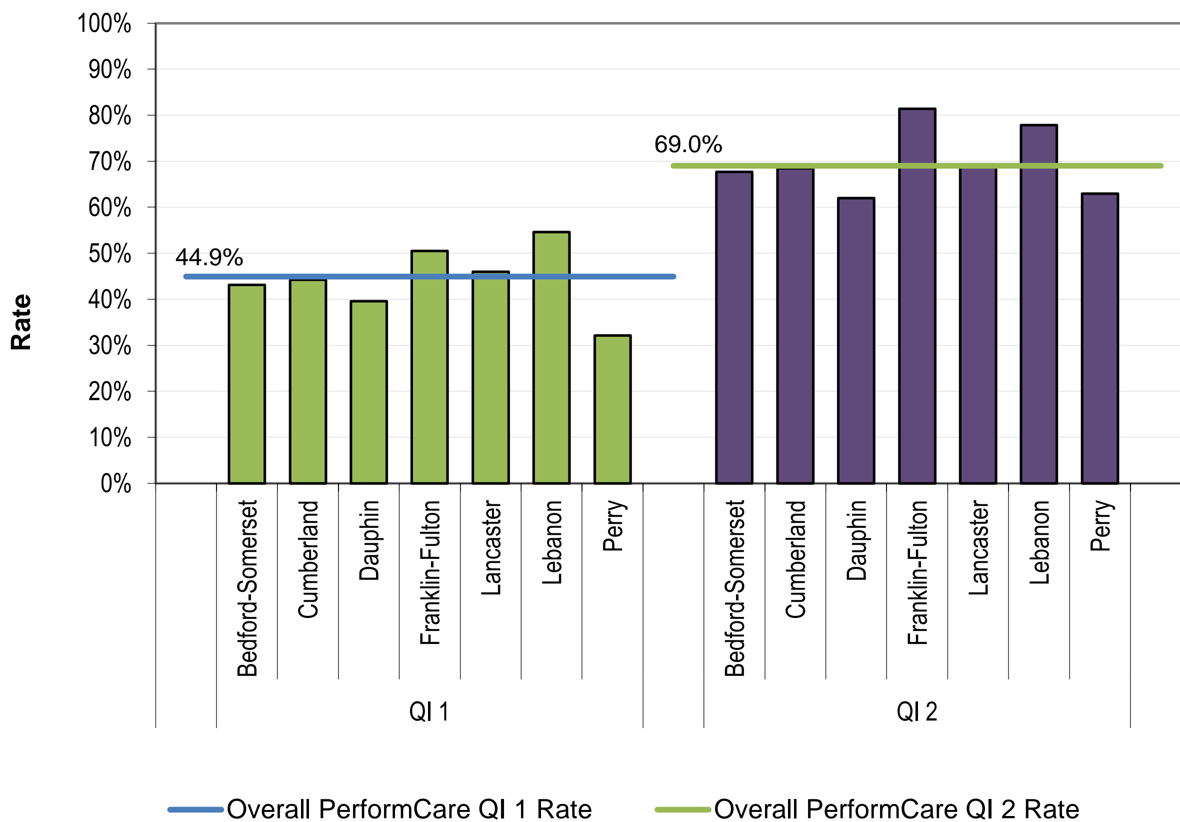
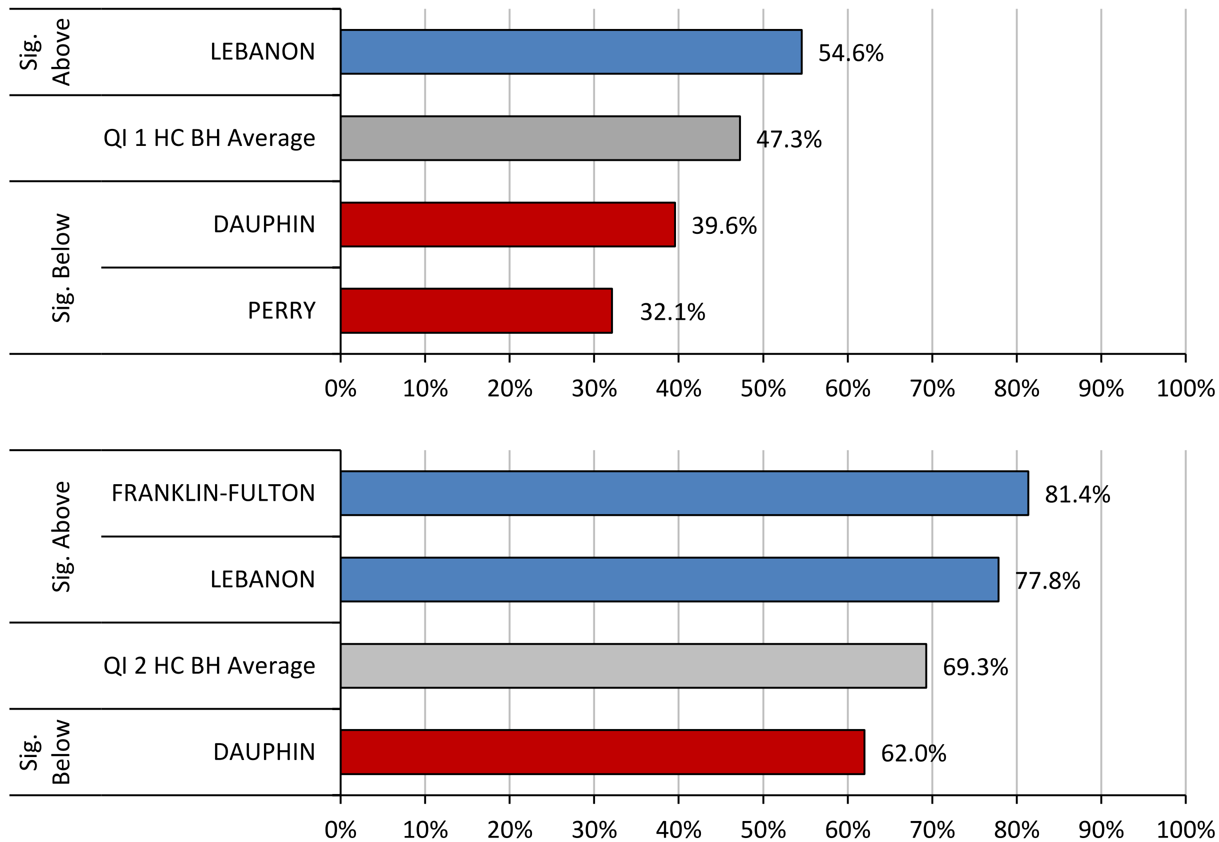


Figure 4: HEDIS Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average – Overall Population



(c) Age Group: 6–20 Years Old

Table 10: MY 2014 HEDIS Follow-up Indicator Rates: 6-20 Years Old

Measure	MY 2014							MY 2013	Rate Comparison: MY 14 vs. MY 13	
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2013 %	PPD	SSD
QI 1 – HEDIS 7-Day Follow-up for Ages 6–20 Years Old										
HealthChoices Aggregate	5,672	10,031	**56.5%**	55.6%	57.5%	56.4%	56.5%	56.9%	-0.3	NO
PerformCare[1]	634	1,126	**56.3%**	53.4%	59.2%			58.8%	-2.5	NO
Bedford-Somerset	42	84	**50.0%**	38.7%	61.3%			49.5%	0.5	NO
Cumberland	65	120	**54.2%**	44.8%	63.5%			50.0%	4.2	NO
Dauphin	126	234	**53.8%**	47.2%	60.4%			60.7%	-6.8	NO
Franklin-Fulton	60	110	**54.5%**	44.8%	64.3%			64.4%	-9.8	NO
Lancaster	234	402	**58.2%**	53.3%	63.2%			57.8%	0.4	NO
Lebanon	98	151	**64.9%**	57.0%	72.8%			71.4%	-6.5	NO
Perry	9	25	**36.0%**	15.2%	56.8%			47.9%	-11.9	NO
QI 2 – HEDIS 30-Day Follow-up for Ages 6-20 Years Old										
HealthChoices Aggregate	7,720	10,031	**77.0%**	76.1%	77.8%	76.6%	78.3%	77.4%	-0.4	NO

Measure	MY 2014							MY 2013		
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2013 %	Rate Comparison: MY 14 vs. MY 13 PPD	SSD
PerformCare[1]	878	1,126	**78.0%**	75.5%	80.4%			79.1%	-1.1	NO
Bedford-Somerset	70	84	**83.3%**	74.8%	91.9%			81.1%	2.3	NO
Cumberland	91	120	**75.8%**	67.8%	83.9%			73.7%	2.1	NO
Dauphin	178	234	**76.1%**	70.4%	81.7%			81.2%	-5.1	NO
Franklin-Fulton	91	110	**82.7%**	75.2%	90.2%			78.2%	4.6	NO
Lancaster	304	402	**75.6%**	71.3%	79.9%			75.8%	-0.2	NO
Lebanon	127	151	**84.1%**	77.9%	90.3%			90.2%	-6.1	NO
Perry	17	25	**68.0%**	47.7%	88.3%			70.8%	-2.8	NO

[1] As Blair and Lycoming-Clinton ended their contract with PerformCare on June 30, 2013, overall MY 2013 results for PerformCare include discharges for Blair and Lycoming-Clinton that occurred between 1/1/13 and 6/30/13. Individual rates for Blair and Lycoming-Clinton are not shown.

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval

The MY 2014 HealthChoices Aggregate HEDIS follow-up rates in the 6 to 20 year age group were 56.5% for QI 1 and 77.0% for QI 2 (**Table 10**). These rates were comparable to the MY 2013 HealthChoices Aggregate rates for the 6 to 20 year age cohort, which were 56.9% and 77.4% respectively. PerformCare's MY 2014 HEDIS follow-up rates for members ages 6 to 20 were 56.3% for QI 1 and 78.0% for QI 2; both rates were lower than PerformCare's MY 2013 rates of 58.8% for QI 1 and 79.1% for QI 2; however, the year-to-year rate differences were not statistically significant for either rate. The HEDIS follow-up rates for PerformCare's 6 to 20 year old population were not statistically different from the HealthChoices BH-MCO Averages of 56.4% for QI 1 and 76.6% for QI 2. In this age cohort, there were no statistically significant year-to-year changes in HEDIS follow-up rates for any of the seven HC BH Contractors associated with PerformCare.

Figure 5 is a graphical representation of the MY 2014 HEDIS follow-up rates in the 6 to 20 year old population for PerformCare and its associated HC BH Contractors. **Figure 6** shows the HC BH Contractor Averages for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rate for Lebanon was statistically significantly higher than the MY 2014 QI 1 HC BH Contractor Average of 56.5% by 8.4 percentage points. For QI 2, none of the seven HC BH Contractors' rates were statistically significantly different from the QI 2 HC BH Contractor Average of 78.3%.

Figure 5: MY 2014 HEDIS Follow-up Indicator Rates: 6-20 Years Old

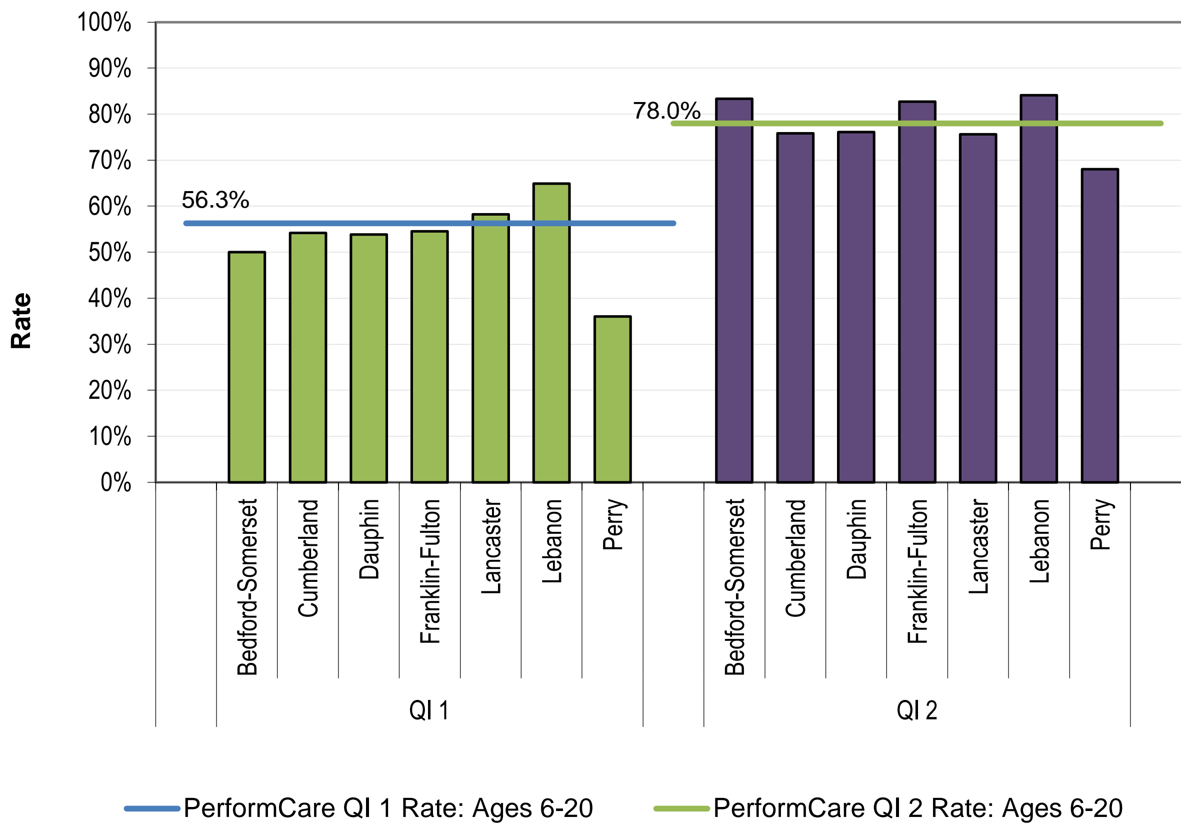
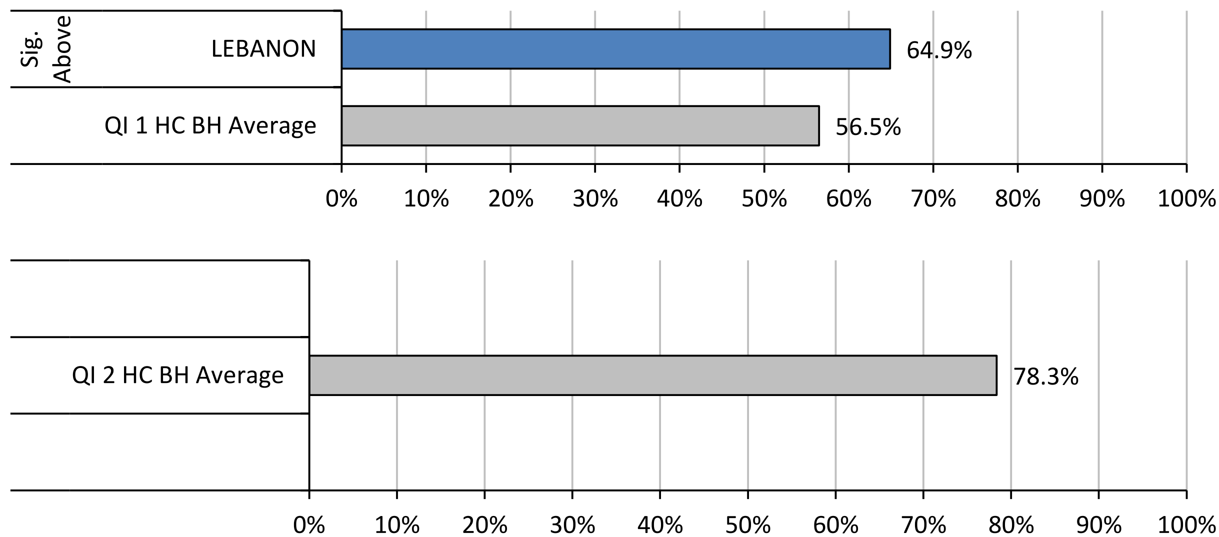


Figure 6: HEDIS Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average: 6-20 Years Old



II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

Table 11: MY 2014 PA-Specific Follow-up Indicator Rates with Year-to-Year Comparisons – Overall Population

Measure	MY 2014							MY 2013		
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2013 %	Rate Comparison of MY 14 vs. MY 13	
									PPD	SSD
QI A – PA-Specific 7-Day Follow-up for Ages 6+										
HealthChoices Aggregate	20,971	35,824	**58.5%**	58.0%	59.1%	58.2%	57.7%	57.6%	1.0	YES
PerformCare[1]	1,899	3,335	**56.9%**	55.2%	58.6%			54.1%	2.8	YES
Bedford-Somerset	152	269	**56.5%**	50.4%	62.6%			48.8%	7.7	NO
Cumberland	183	355	**51.5%**	46.2%	56.9%			49.6%	2.0	NO
Dauphin	510	834	**61.2%**	57.8%	64.5%			58.6%	2.5	NO
Franklin-Fulton	187	301	**62.1%**	56.5%	67.8%			59.9%	2.3	NO
Lancaster	613	1,134	**54.1%**	51.1%	57.0%			49.3%	4.8	YES
Lebanon	220	361	**60.9%**	55.8%	66.1%			58.4%	2.6	NO
Perry	34	81	**42.0%**	30.6%	53.3%			43.0%	-1.0	NO
QI B – PA-Specific 30-Day Follow-up for Ages 6+										
HealthChoices Aggregate	26,814	35,824	**74.8%**	74.4%	75.3%	74.8%	75.5%	73.9%	1.0	YES
PerformCare[1]	2,548	3,335	**76.4%**	74.9%	77.9%			73.1%	3.3	YES
Bedford-Somerset	199	269	**74.0%**	68.5%	79.4%			73.7%	0.3	NO
Cumberland	260	355	**73.2%**	68.5%	78.0%			71.9%	1.4	NO
Dauphin	638	834	**76.5%**	73.6%	79.4%			74.1%	2.3	NO
Franklin-Fulton	256	301	**85.0%**	80.9%	89.2%			79.6%	5.5	NO
Lancaster	839	1,134	**74.0%**	71.4%	76.6%			68.5%	5.5	YES
Lebanon	294	361	**81.4%**	77.3%	85.6%			78.5%	3.0	NO
Perry	62	81	**76.5%**	66.7%	86.4%			68.4%	8.1	NO

[1] As Blair and Lycoming-Clinton ended their contract with PerformCare on June 30, 2013, overall MY 2013 results for PerformCare include discharges for Blair and Lycoming-Clinton that occurred between 1/1/13 and 6/30/13. Individual rates for Blair and Lycoming-Clinton are not shown.

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval

The MY 2014 HealthChoices Aggregate PA-specific follow-up rates were 58.5% for QI A and 74.8% for QI B (**Table 11**). Both of the PA-specific follow-up rates were statistically significantly higher than the MY 2013 HealthChoices Aggregate rates of 57.6% and 73.9% by 1.0 percentage point. PerformCare's MY 2014 PA-specific follow-up rates were 56.9% for QI A and 76.4% for QI B; both rates were statistically significantly higher than PerformCare's MY 2013 rates of 54.1% for QI A (2.8 percentage point difference) and 73.1% for QI B (3.3 percentage point difference). The QI A rate for PerformCare was not statistically significantly different from the QI A HealthChoices BH-MCO Average of 58.2%, while the QI B rate for PerformCare was statistically significantly higher than the QI B HealthChoices BH-MCO Average of 74.8% by 1.6 percentage points.

From MY 2013 to MY 2014, both HEDIS rates for Lancaster statistically significantly increased, with improvements of 4.8 percentage points for QI A and 5.5 percentage points for QI B (**Table 11**). None of the other HC BH Contractors

associated with PerformCare had statistically significant changes in PA-specific follow-up rates from MY 2013 to MY 2014.

Figure 7 is a graphical representation of the MY 2014 PA-specific follow-up rates for PerformCare and its associated HC BH Contractors. **Figure 8** shows the HC BH Contractor Averages and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. QI A rate for Dauphin was statistically significantly above the MY 2014 QI A HC BH Contractor Average of 57.7% by 3.4 percentage points, while the QI A rates for Lancaster, Cumberland and Perry were statistically significantly lower than the Average by 3.7 to 15.8 percentage points. The QI B rates for Lebanon and Franklin-Fulton were statistically significantly above the QI B HC BH Contractor Average of 75.5% by 5.9 and 9.5 percentage points respectively.

Figure 7: MY 2014 PA-Specific Follow-up Indicator Rates – Overall Population

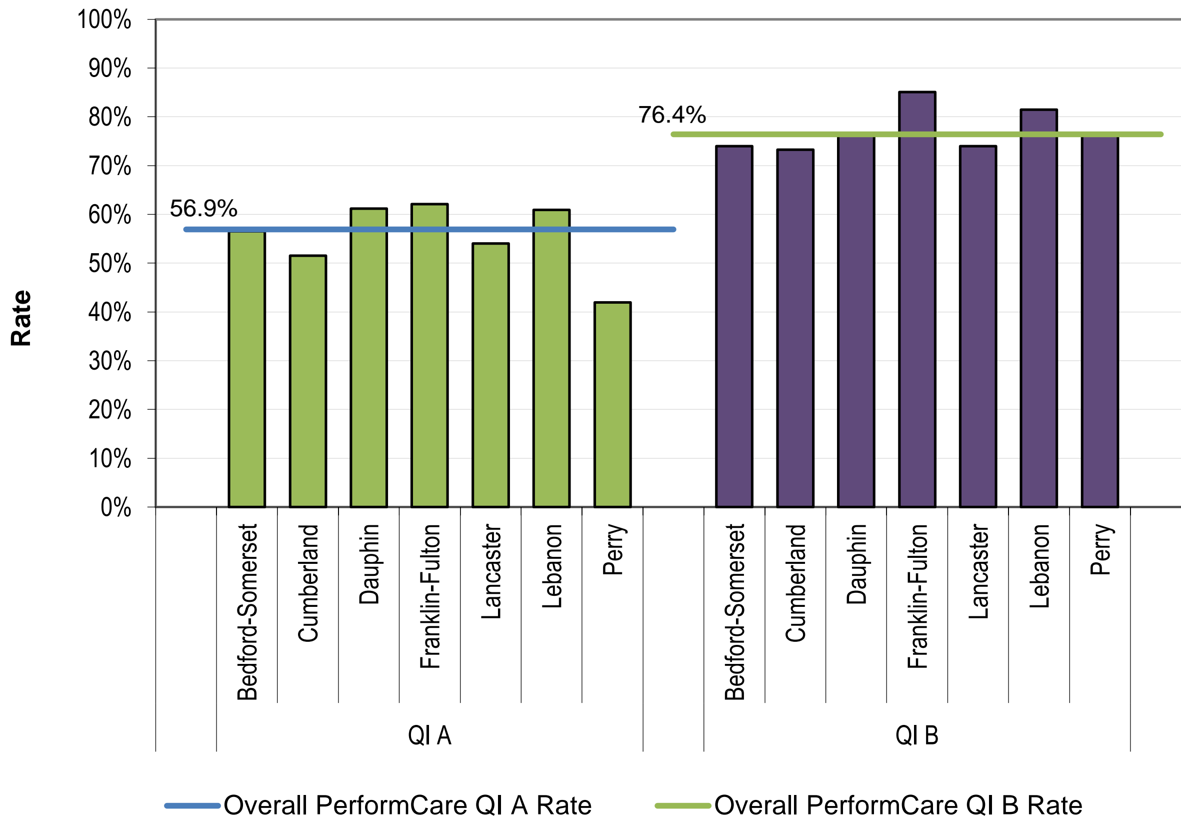
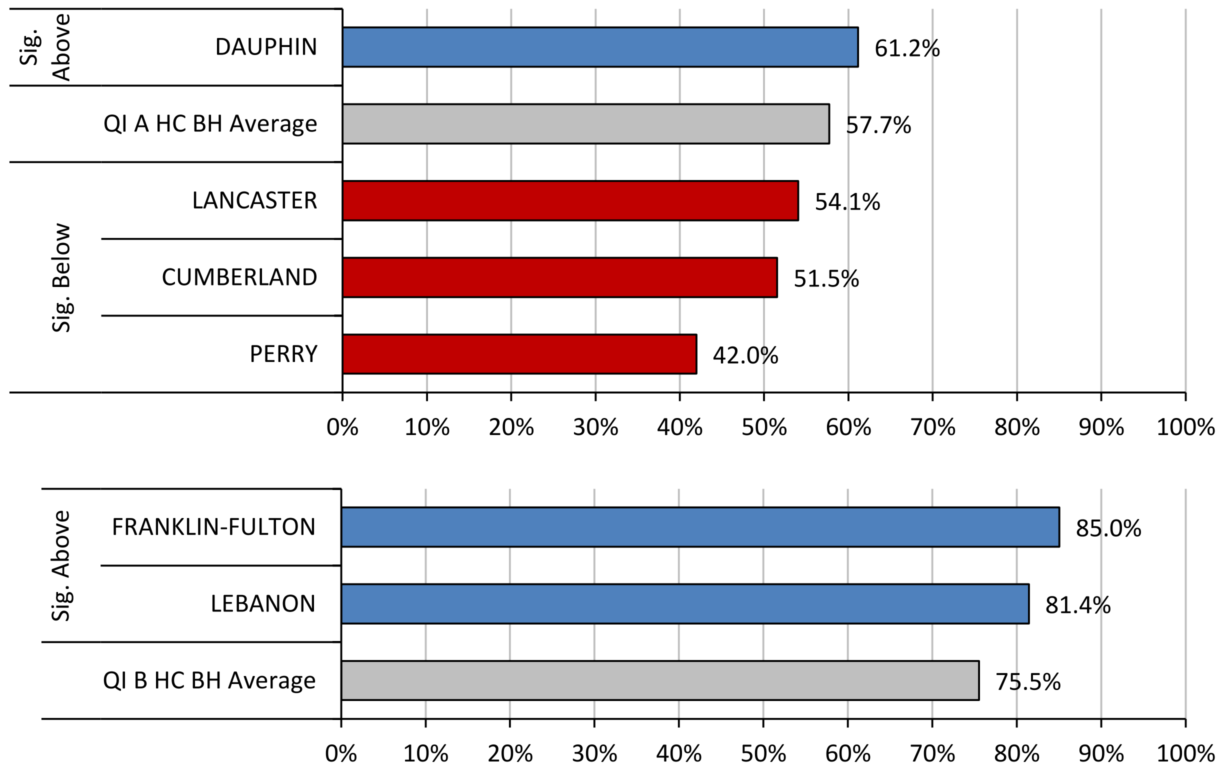


Figure 8: PA-Specific Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average – Overall Population



Conclusion and Recommendations

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

In response to the 2015 study, which included results for MY 2013 and MY 2014, the following general recommendations were made to all five participating BH-MCOs:

- Despite a number of years of data collection and interventions, FUH rates have not increased meaningfully, and FUH for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted, the recommendations may assist in future discussions.
- The purpose of this re-measurement study is to inform OMHSAS, the HC BH Contractors and the BH-MCOs of the effectiveness of the interventions implemented during 2012, 2013 and 2014 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. Although the current cycle of performance improvement projects were in their baseline period for the PIP implemented at the beginning of MY 2015, BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in next few years as a result of the newly implemented interventions. To that end, the HC BH Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving behavioral health follow-up. The HC BH Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across MYs, and applicable to all groups. The findings of this re-measurement indicate that, despite some improvement over the last five MYs, significant rate disparities persist between racial and ethnic groups. It is important for BH-MCOs and HC BH Contractors to

analyze performance rates by racial and ethnic categories and to target the demographic populations that do not perform as well as their counterparts. It is recommended that BH-MCOs and HC BH Contractors continue to focus interventions on populations that exhibit lower follow-up rates (e.g., black/African American population). Further, it is important to examine regional trends in disparities. For instance, the results of this study indicate that African Americans in rural areas have disproportionately low follow-up rates, in contrast to the finding that overall follow-up rates are higher in rural areas than in urban areas. Possible reasons for racial-ethnic disparities include access, cultural competency and community factors; these and other drivers should be evaluated to determine their potential impact on performance.

- BH-MCOs and HC BH Contractors are encouraged to review the findings of the follow-up study in conjunction with inpatient psychiatric readmission rates. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either had or did not have evidence of ambulatory follow-up/aftercare visit(s) during the interim period.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-up After Hospitalization for Mental Illness, OMHSAS elected to retain and re-measure the Readmission Within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Re-measurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2014 study conducted in 2015 was the eighth re-measurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the MY, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish a same day readmission from a transfer to another acute facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH Contractor level for MY 2013.

This measure continued to be of interest to OMHSAS for the purposes of comparing HC BH Contractor, and BH-MCO rates to the OMHSAS performance goal and to prior rates.

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

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

Eligible Population

The entire eligible population was used for all 67 counties and 34 HC BH Contractors participating in the MY 2014 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, 2014;
- 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.

Performance Goals

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

Findings

BH-MCO and HC BH Contractor Results

The results are presented at the BH-MCO and then HC BH Contractor level. Year-to-year comparisons of MY 2014 to MY 2013 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the Z-ratio. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

Individual rates are also compared to the categorical average. Rates statistically significantly above and/or below the average are indicated. Whether or not an individual rate performed statistically significantly above or below average was determined by whether or not that rate's 95% CI included the average for the indicator.

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

Table 12: MY 2014 Readmission Rates with Year-to-Year Comparisons

	MY 2014								MY 2013
Measure	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	BH-MCO Average	BH HC Contractor Average	2014 Goal Met?	%
Inpatient Readmission									
HealthChoices Aggregate	6,510	45,657	**14.3%**	14.0%	14.6%	14.3%	14.0%	NO	13.6%
PerformCare[1]	712	4,478	**15.9%**	14.8%	17.0%			NO	15.5%
Bedford-Somerset	38	318	**11.9%**	8.2%	15.6%			NO	14.1%
Cumberland	73	457	**16.0%**	12.5%	19.5%			NO	13.3%
Dauphin	234	1,208	**19.4%**	17.1%	21.7%			NO	17.9%
Franklin-Fulton	40	374	**10.7%**	7.4%	14.0%			NO	16.0%
Lancaster	225	1,508	**14.9%**	13.1%	16.7%			NO	13.9%
Lebanon	84	495	**17.0%**	13.6%	20.4%			NO	21.1%
Perry	18	118	**15.3%**	8.4%	22.2%			NO	15.0%

[1] As Blair and Lycoming-Clinton ended their contract with PerformCare on June 30, 2013, overall MY 2013 results for PerformCare include discharges for Blair and Lycoming-Clinton that occurred between 1/1/13 and 6/30/13. Individual rates for Blair and Lycoming-Clinton are not shown.
N: numerator; D: denominator; CI: confidence interval

The MY 2014 HealthChoices Aggregate readmission rate was 14.3%, statistically significantly higher than the MY 2013 HealthChoices Aggregate rate of 13.6% by 0.7 percentage points (**Table 12**). The PerformCare MY 2014 readmission rate

of 15.9% is a slight increase from the PerformCare MY 2013 rate of 15.5% by 0.4 percentage points. Note that this measure is an inverted rate, in that the lower rates indicate better performance. The PerformCare MY 2014 readmission rate of 15.9% is statistically significantly higher than the HealthChoices BH-MCO Average of 14.3% by 1.6 percentage points. Overall, PerformCare had the highest readmission rate of the five BH-MCOs evaluated in MY 2014. PerformCare did not meet the OMHSAS performance goal of a readmission rate at or below 10.0% in MY 2014.

As presented in **Table 12**, the readmission rate for one PerformCare HC BH Contractor, Franklin-Fulton, decreased from 16.0% in MY 2013 to 10.7% in MY 2014, a statistically significant decrease of 5.3 percentage points. No statistically significant changes from the prior year were noted for the remaining PerformCare HC BH Contractors. No PerformCare HC BH Contractors met the performance goal of a readmission rate at or below 10.0% in MY 2014.

Figure 9 is a graphical representation of the MY 2014 readmission rates for PerformCare HC BH Contractors compared to the performance measure goal of 10.0%. **Figure 10** shows the Health Choices HC BH Contractor Average readmission rates and the individual PerformCare HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Averages. Dauphin had a readmission rate that was statistically significantly higher (poorer) than the HealthChoices HC BH Contractor average of 14.0% by 5.4 percentage points. Franklin-Fulton's rate of 10.7% was statistically significantly lower than the HC BH Contractor average by 3.3 percentage points.

Figure 9: MY 2014 Readmission Rates

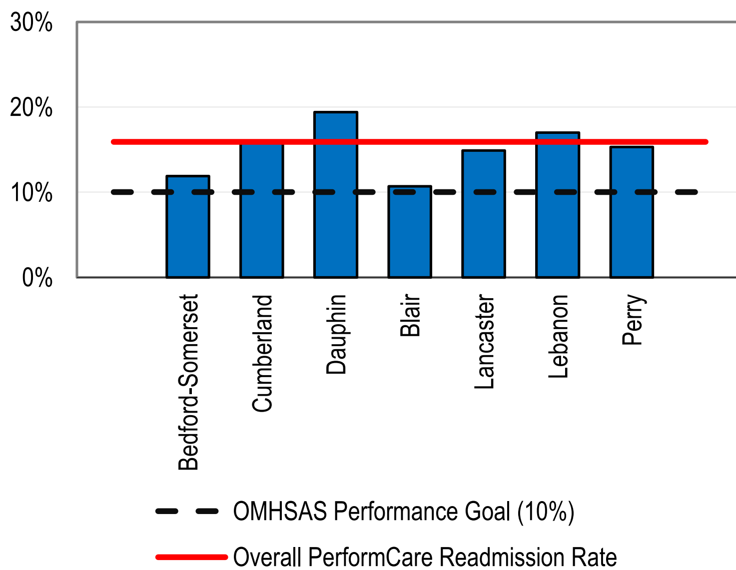
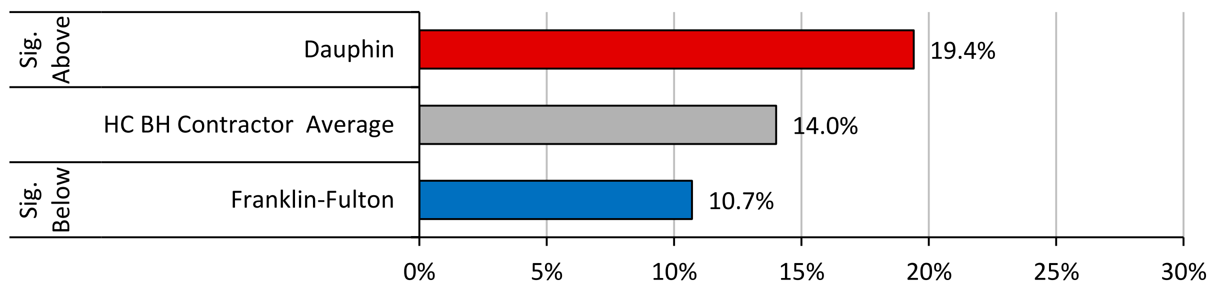


Figure 10: MY 2014 Readmission Rates Compared to HealthChoices HC BH Contractor Average



This measure is an inverted rate, meaning that rates statistically significantly below the HC BH Contractor Average indicate good performance, and rates statistically significantly above the HC BH Contractor Average indicate poor performance.

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 and HC BH Contractors that did not meet the performance goal, and/or performed below the HealthChoices BH-MCO Average.

BH-MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the 2014 (MY 2013) Readmission Within 30 Days of Inpatient Psychiatric Discharge data tables.

Despite a number of years of data collection and interventions, readmission rates have continued to increase. Readmission for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the current performance improvement project cycle, the recommendations may assist in future discussions.

In response to the 2015 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 HC BH Contractors and the BH-MCOs of the effectiveness of the interventions implemented during 2012, 2013 and 2014 to promote continuous quality improvement with regard to mental health discharges that result in a readmission. The information contained within this study should be used to further develop strategies for decreasing the likelihood that at-risk members will be readmitted. Although the current cycle of performance improvement projects were in their baseline period during the MY 2014 review year, BH-MCOs are expected to demonstrate meaningful improvement in behavioral health readmission rates in the next few years as a result of the newly implemented interventions. To that end, the HC BH Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing behavioral health readmissions. The HC BH Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission.

Recommendation 2: It is essential to ensure that improvements are consistent, sustained across MYs, and applicable to all groups. The findings of this re-measurement indicate that there are significant rate disparities between rural and urban settings. It is important for BH-MCOs and HC BH Contractors to target the demographic populations that do not perform as well as their counterparties. It is recommended that the BH-MCOs and HC BH Contractors continue to focus interventions on populations that exhibit higher readmission rates (e.g. urban populations).

Recommendation 3: BH-MCOs and HC BH Contractors are encouraged to review the findings of the behavioral health readmission study in conjunction with follow-up after hospitalization rates. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either had or did not have evidence of ambulatory follow-up/aftercare visit(s) during the interim period.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

As part of the Center for Medicaid and Medicare Services' (CMS) Adult Quality Measure Grant Program, the Department of Health Services (DHS) was required to report the Initiation and Engagement of Alcohol and Other Drug Dependence (IET) measure. Although the grant ended in December 2014, DHS will continue reporting the IET measure as part of CMS' Adult Quality Core Measure set. This measure was reported initially by one county for MY 2012 and expanded to the HealthChoices population in MY 2013. Due to several implementation issues identified with BH-MCO access to all applicable data and at DHS' request, this measure was produced by IPRO. IPRO began development of this measure in 2014 for MY 2013, and continued to produce the measure in 2015 for MY 2014. The measure was produced using HEDIS specifications, using encounter data that was submitted to DHS by the BH-MCOs and the Physical Health MCOs. As directed by OMHSAS, IPRO produced rates for this measure for the HealthChoices population, by BH-MCO, and by BH HC Contractor.

This study examined substance abuse services provided to members participating in the HealthChoices Behavioral Health and Physical Health Programs. For the indicator, the criteria specified to identify the eligible population were

product line, age, enrollment, anchor date, and event/diagnosis. Date of service and diagnosis/procedure codes were used to identify the administrative numerator positives. The denominator and numerator criteria were identical to the HEDIS 2015 specifications. This performance measure assessed the percentage of members who had a qualifying encounter with a diagnosis of alcohol or other drug dependence (AOD) who had an initiation visit within 14 days of the initial encounter, and the percentage of members who also had 2 visits within 30 days after the initiation visit.

Quality Indicator Significance

Substance abuse is a major health issue in the United States. According to the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), 8.5 percent of adults had alcohol use disorder problem, 2 percent met the criteria for a drug use disorder, and 1.1 percent met the criteria for both (U.S. Department of Health & Human Services, 2008). Research shows that people who are dependent on alcohol are much more likely than the general population to use drugs, and vise versa. Patients with co-occurring alcohol and other drug use disorders are more likely to have psychiatric disorders, such as personality, mood, and anxiety disorders, and they are also more likely to attempt suicide and to suffer health problems (Arnaout & Petrakis, 2008).

With appropriate intervention for AOD dependence, the physical and behavioral health conditions of patients can be improved and the use of health care services, such as the emergency departments, will be decreased. In 2009 alone, there were nearly 4.6 million drug-related ED visits nationwide (National Institute on Drug Abuse, 2011). Improvement in the socioeconomic situation of patients and lower crime rates will follow if suitable treatments are implemented.

Eligible Population

The entire eligible population was used for all 34 BH HC Contractors participating in the MY 2014 study. Eligible cases were defined as those members in the HealthChoices Behavioral Health and Physical Health Programs who met the following criteria:

- Members who had an encounter with a primary or secondary AOD diagnosis between January 1 and November 15, 2014;
- Continuously enrolled in both HealthChoices Behavioral Health and Physical Health from 60 days prior to the AOD diagnosis to 44 days after the AOD diagnosis with no gaps in enrollment;
- No encounters with an AOD diagnosis in the 60 days prior to the initial encounter;
- If a member has multiple encounters that meet the criteria, only the first encounter is used in the measure.

This measure is reported for three age cohorts: ages 13 to 17 years old, ages 18+ years old, and ages 13+ years old.

Numerators

This measure has two numerators:

Numerator 1 – Initiation of AOD Treatment: Members who initiate treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization with an AOD diagnosis within 14 days of the diagnosis.

Numerator 2 – Engagement of AOD Treatment: Members who initiated treatment and who had two or more additional inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with a diagnosis of AOD within 30 days of the initiation visit. The engagement numerator was only evaluated for members who passed the initiation numerator.

Methodology

As this measure requires the use both Physical Health and Behavioral Health encounters, only members who were enrolled in both Behavioral Health and Physical Health HealthChoices where included in this measure. The source for all information was administrative data provided to IPRO by the BH-MCOs and PH MCOs. The source for all administrative data was the MCOs' transactional claims systems. As administrative data from multiple sources was needed to produce this measure, the measure was programmed and reported by IPRO. The results of the measure were presented to representatives of each BH-MCO, and the BH-MCOs were given an opportunity to respond to the results of the measure.

Limitations

As physical health encounters with an AOD diagnosis are used in this measure, a BH-MCO does not have complete information of all encounters used in this measure. This will limit the BH-MCOs ability to independently calculate their performance of this measure, and determine the effectiveness of interventions.

Performance Goals

As this is the first year this measure was reported for HealthChoices, no goals were set for MY 2014.

Findings

BH-MCO and HC BH Contractor Results

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

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

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

The performance measure results for the three age cohorts (13 to 17 years old, ages 18+, and ages 13+) are compared to HEDIS national percentiles. NCQA produces annual HEDIS IET benchmarks for these three age bands; therefore, results for each age group are compared to national percentiles for the corresponding age bands.

(a) Age Group: 13–17 Years Old

Table 13: MY 2014 IET rates with Year-to-Year Comparisons

	MY 2014							MY 2013			Rate Comparison MY 2014 to HEDIS Benchmarks
Measure	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH MCO Average	BH HC Contractor Average	%	PPD	SSD	
Age Cohort: 13–17 Years – Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	1,134	3,063	**37.0%**	35.3%	38.7%	34.7%	33.3%	35.4%	1.6	NO	Below 50th, at or above 25th percentile
PerformCare[1]	103	334	**30.8%**	25.7%	35.9%			20.3%	10.5	YES	Below 25th Percentile
Bedford-Somerset	3	8	**37.5%**	0.0%	77.3%			9.1%	28.4	NO	Below 50th, at or above 25th percentile
Cumberland	9	33	**27.3%**	10.6%	44.0%			18.2%	9.1	NO	Below 25th Percentile
Dauphin	33	115	**28.7%**	20.0%	37.4%			21.3%	7.4	NO	Below 25th Percentile

Measure	MY 2014 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH MCO Average	BH HC Contractor Average	MY 2013 %	PPD	SSD	Rate Comparison MY 2014 to HEDIS Benchmarks
Franklin-Fulton	15	28	**53.6%**	33.3%	73.9%			21.4%	32.2	NO	At or above 75th Percentile
Lancaster	27	110	**24.5%**	16.0%	33.0%			17.5%	7.0	NO	Below 25th Percentile
Lebanon	13	33	**39.4%**	21.2%	57.6%			37.5%	1.9	NO	Below 50th, at or above 25th percentile
Perry	3	7	**42.9%**	0.0%	86.7%			14.3%	28.6	NO	Below 75th, at or above 50th percentile
Age Cohort: 13–17 Years – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	791	3,063	**25.8%**	24.2%	27.4%	23.5%	19.7%	24.9%	0.9	NO	Below 25th Percentile
PerformCare[1]	49	334	**14.7%**	10.8%	18.6%			7.1%	7.6	YES	Below 25th Percentile
Bedford-Somerset	0	8	**0.0%**	0.0%	6.3%			0.0%	0.0	NO	Below 25th Percentile
Cumberland	7	33	**21.2%**	5.7%	36.7%			0.0%	21.2	NO	Below 25th Percentile
Dauphin	19	115	**16.5%**	9.3%	23.7%			9.3%	7.2	NO	Below 25th Percentile
Franklin-Fulton	8	28	**28.6%**	10.1%	47.1%			0.0%	28.6	NO	Below 25th Percentile
Lancaster	12	110	**10.9%**	4.6%	17.2%			11.1%	-0.2	NO	Below 25th Percentile
Lebanon	2	33	**6.1%**	0.0%	15.8%			0.0%	6.1	NO	Below 25th Percentile
Perry	1	7	**14.3%**	0.0%	47.4%			0.0%	14.3	NO	Below 25th Percentile

[1] As Blair and Lycoming-Clinton ended their contract with PerformCare on June 30, 2013, overall MY 2013 results for PerformCare include discharges for Blair and Lycoming-Clinton that occurred between 1/1/13 and 6/30/13. Individual rates for Blair and Lycoming-Clinton are not shown.

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval

The MY 2014 HealthChoices Aggregate rates in the 13-17 year age group were 37.0% for Initiation and 25.8% for Engagement (**Table 13**). These rates were comparable to the MY 2013 13-17 year old HealthChoices Aggregate rates of 35.4% and 24.9%, respectively. The HealthChoices Aggregate rate for Initiation was between the HEDIS percentiles for the 25th and 50th percentile, while the HealthChoices Aggregate rate for Engagement was at or above the 75th percentile.

The PerformCare MY 2014 13-17 year old Initiation rate of 30.8% statistically significantly increased from the MY 2013 rate of 20.3% by 10.5 percentage points, and the Engagement rate of 14.7% statistically significantly increased from the MY 2013 rate of 7.1% by 7.6 percentage points (**Table 13**). The PerformCare MY 2014 Initiation rate was not statistically significantly different from the HealthChoices BH-MCO Initiation Average of 34.7% for the 13-17 age group, while the Engagement rate of 14.7% was statistically significantly lower than the HealthChoices BH-MCO Engagement Average of 23.5% by 8.8 percentage points. PerformCare's Initiation rate and Engagement rates were both below the HEDIS 2015 25th percentile for the 13-17 age group.

As presented in **Table 13**, none of the HC BH Contractors had statistically significant rate changes from MY 2013 to MY 2014. For Initiation rates, three HC BH Contractors (Cumberland, Dauphin, and Lancaster) were below the HEDIS 2015 25th percentile, two HC BH Contractors (Bedford-Somerset and Lebanon) were between the HEDIS 2015 25th and 50th percentile, Perry was between the 50th and 75th percentile, and Franklin-Fulton was above the 75th percentile. All HC BH Contractors' Engagement rates were below the HEDIS 25th percentile.

Figure 11 is a graphical representation of the 13-17 year old MY 2014 HEDIS Initiation and Engagement rates for PerformCare and its associated HC BH Contractors. **Figure 12** shows the HealthChoices HC BH Contractor Average rates for this age cohort and the individual PerformCare HC BH Contractor rates that were statistically significantly higher or lower than the HealthChoices HC BH Contractor Average. The Initiation rate for Lancaster was statistically significantly lower than the MY 2014 HC BH Contractor Initiation Average of 33.3% by 8.8 percentage points, while the Initiation rate for Franklin Fulton was above the Average by 20.3 percentage points. The Engagement rates for Lancaster, Lebanon and Bedford-Somerset were statistically significantly lower than the HC BH Contractor Engagement Average of 19.7% by 8.8 to 19.7 percentage points.

Figure 11: MY 2014 IET Rates: 13–17 Years Old

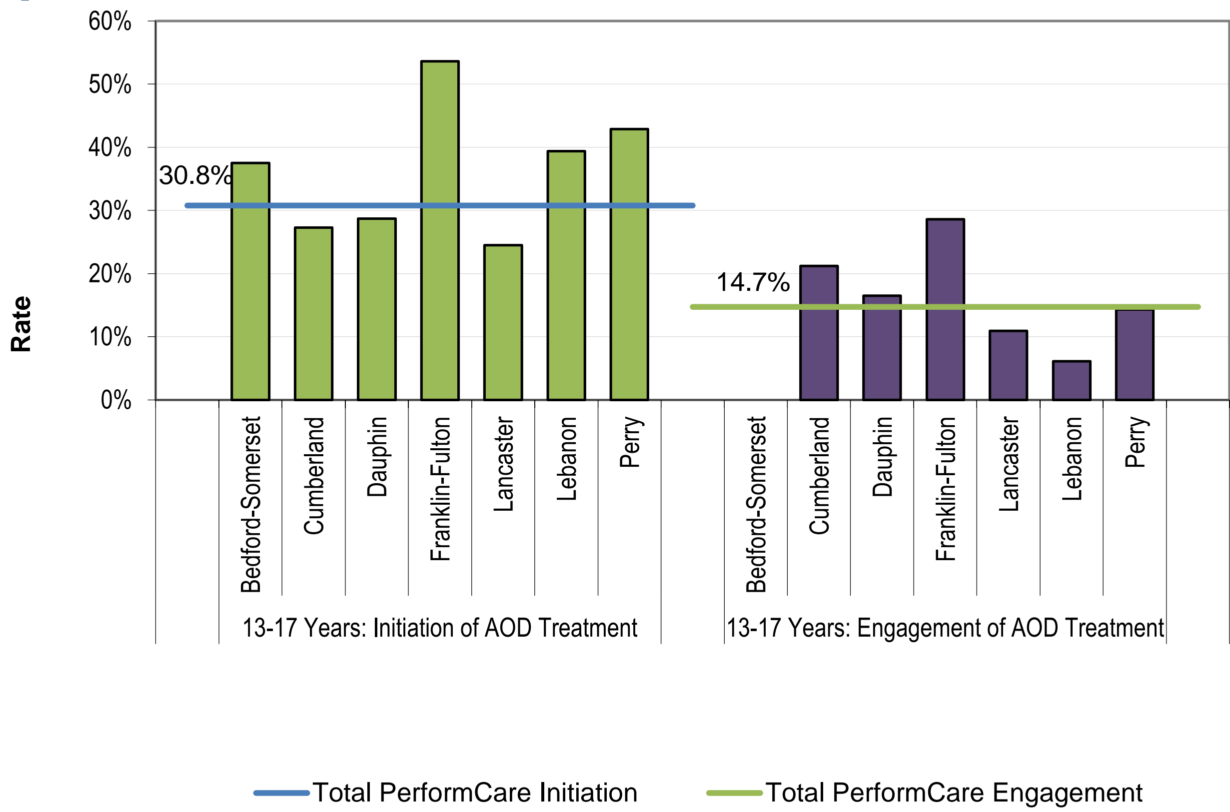
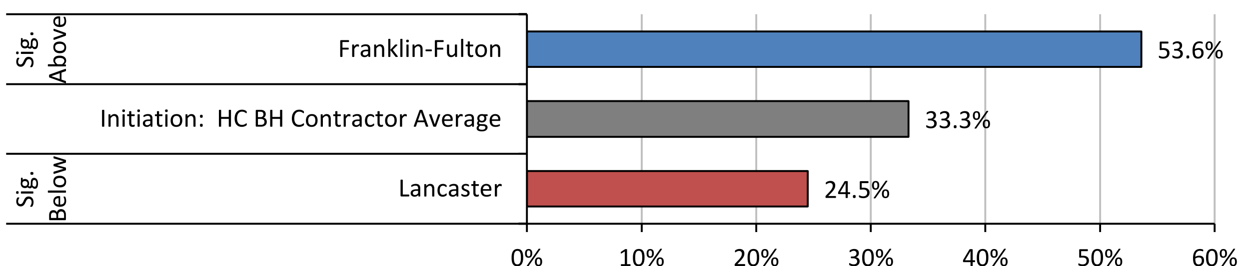
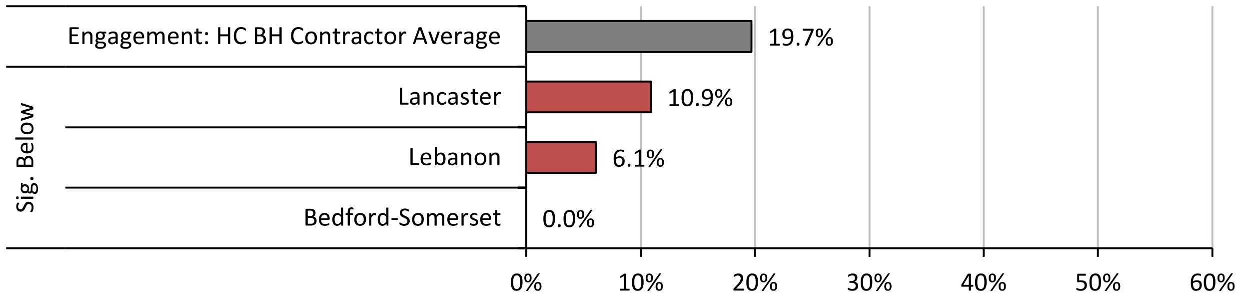


Figure 12: MY 2014 IET Rates Compared to HealthChoices County Average: 13–17 Years Old





(b) Age Group: 18+ Years Old

Table 14: MY 2014 IET Rates: 18+YearsWith Year-to-Year Comparisons

Measure	MY 2014 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	MY 2013 %	PPD	SSD	Rate Comparison MY 2014 to HEDIS Benchmarks
Age Cohort: 18+ Years –Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	11,616	39,023	**29.8%**	29.3%	30.3%	28.7%	28.3%	29.4%	-3.5	NO	Below 25th Percentile
PerformCare[1]	805	3,014	**26.7%**	25.1%	28.3%			20.5%	-20.5	NO	Below 25th Percentile
Bedford-Somerset	65	339	**19.2%**	14.9%	23.5%			26.2%	-6.1	NO	Below 25th Percentile
Cumberland	66	264	**25.0%**	19.6%	30.4%			21.9%	-8.1	NO	Below 25th Percentile
Dauphin	190	725	**26.2%**	22.9%	29.5%			18.4%	-10.7	NO	Below 25th Percentile
Franklin-Fulton	70	239	**29.3%**	23.3%	35.3%			14.5%	-1.2	NO	Below 25th Percentile
Lancaster	313	1,129	**27.7%**	25.0%	30.4%			21.9%	-8.0	YES	Below 25th Percentile
Lebanon	80	237	**33.8%**	27.6%	40.0%			17.8%	0.6	NO	Below 50th, at or above 25th percentile
Perry	21	81	**25.9%**	15.7%	36.1%			18.2%	-4.9	NO	Below 25th Percentile
Age Cohort: 18+ Years – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	7,842	39,023	**20.1%**	19.7%	20.5%	18.8%	18.0%	20.3%	-0.2	NO	At or above 75th Percentile
PerformCare[1]	417	3,014	**13.8%**	12.6%	15.0%			9.3%	4.5	YES	Below 75th, at or above 50th percentile
Bedford-Somerset	26	339	**7.7%**	4.7%	10.7%			12.8%	-5.1	NO	Below 50th, at or above 25th percentile
Cumberland	35	264	**13.3%**	9.0%	17.6%			7.8%	5.5	NO	Below 75th, at or above 50th percentile

Measure	MY 2014							MY 2013			Rate Comparison MY 2014 to HEDIS Benchmarks
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	%	PPD	SSD	
Dauphin	101	725	**13.9%**	11.3%	16.5%			8.1%	5.8	YES	Below 75th, at or above 50th percentile
Franklin-Fulton	44	239	**18.4%**	13.3%	23.5%			6.8%	11.6	YES	At or above 75th Percentile
Lancaster	150	1,129	**13.3%**	11.3%	15.3%			10.2%	3.1	YES	Below 75th, at or above 50th percentile
Lebanon	50	237	**21.1%**	15.7%	26.5%			7.5%	13.6	YES	At or above 75th Percentile
Perry	11	81	**13.6%**	5.5%	21.7%			13.6%	0.0	NO	Below 75th, at or above 50th percentile

[1] As Blair and Lycoming-Clinton ended their contract with PerformCare on June 30, 2013, overall MY 2013 results for PerformCare include discharges for Blair and Lycoming-Clinton that occurred between 1/1/13 and 6/30/13. Individual rates for Blair and Lycoming-Clinton are not shown.

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval

The MY 2013 HealthChoices Aggregate Initiation rate for the 18 and older age group was 29.8%, falling below the HEDIS 2015 Medicaid 25th percentile benchmark (**Table 14**). The MY 2014 HealthChoices Aggregate Engagement rate in this age cohort was at or above the HEDIS 75th percentile with a rate of 20.1%.

The PerformCare Initiation rate of 26.7% in the 18+ year age group was statistically significantly lower than the HealthChoices BH-MCO Average of 28.7% by 2.0 percentage points (**Table 14**). The PerformCare Engagement rate of 13.8% in this age cohort was statistically significantly lower than the HealthChoices BH-MCO Average rate of 18.8% by 5.0 percentage points. Compared to the HEDIS 2015 benchmarks for the 18+ year old age cohort, the Initiation rate for PerformCare was below the 25th percentile, while the Engagement rate was between the 50th and 75th percentile.

As presented in **Table 14**, Initiation rates in the 18+ age group were below the 25th percentile for six of seven PerformCare HC BH Contractors, with Lebanon's Initiation rate between the 25th and 50th percentile. Engagement rates in this age group were at or above the 75th percentile for two HC BH Contractors (Franklin-Fulton and Lebanon), between the 50th and 75th percentile for five HC BH Contractors (Cumberland, Dauphin, Lancaster, and Perry), and between the 25th and 50th percentile for Bedford-Somerset.

Figure 13 is a graphical representation MY 2014 IET rates for PerformCare and its associated HC BH Contractors for the 18+ age group. **Figure 14** shows the HealthChoices HC BH Contractor Average rates and individual PerformCare HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. The Initiation rate for Bedford-Somerset was statistically significantly lower than the HealthChoices HC BH Contractor Average Initiation rate of 28.3% by 9.1 percentage points. The Engagement rates for Dauphin, Cumberland, Lancaster, and Bedford-Somerset were statistically significantly lower than the HC BH Contractor Average of 18.0% by 4.1 to 10.3 percentage points.

Figure 13: MY 2014 IET Rates – 18+Years

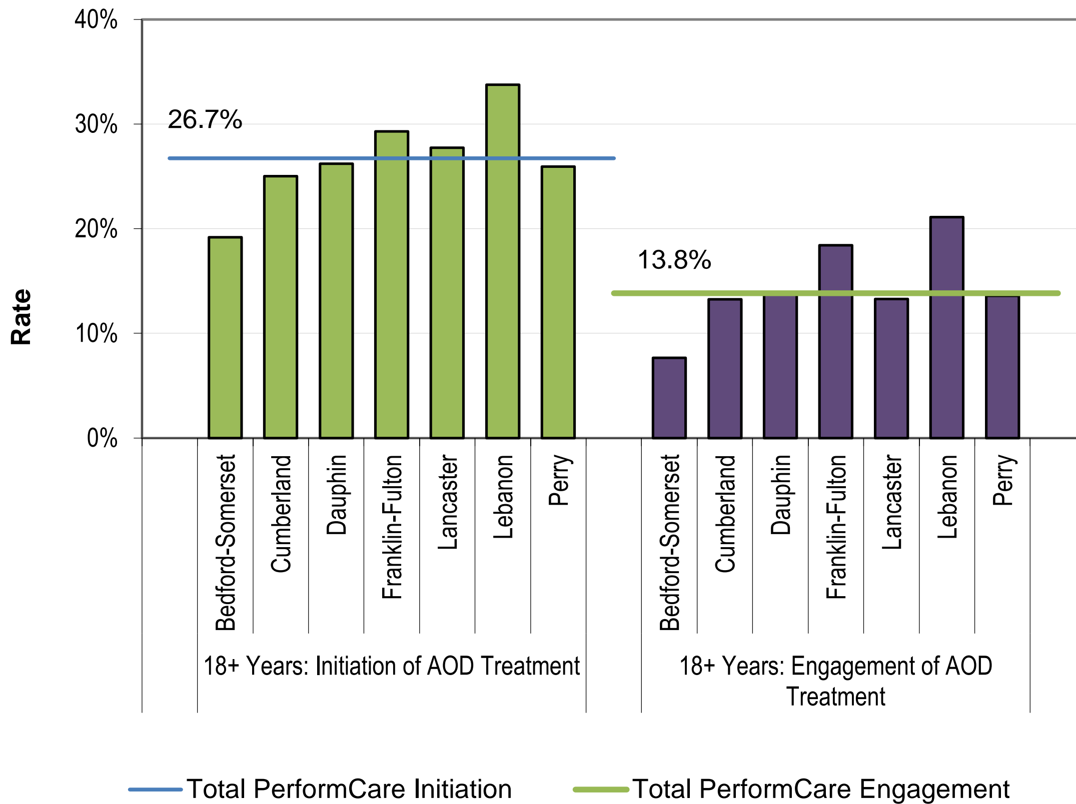
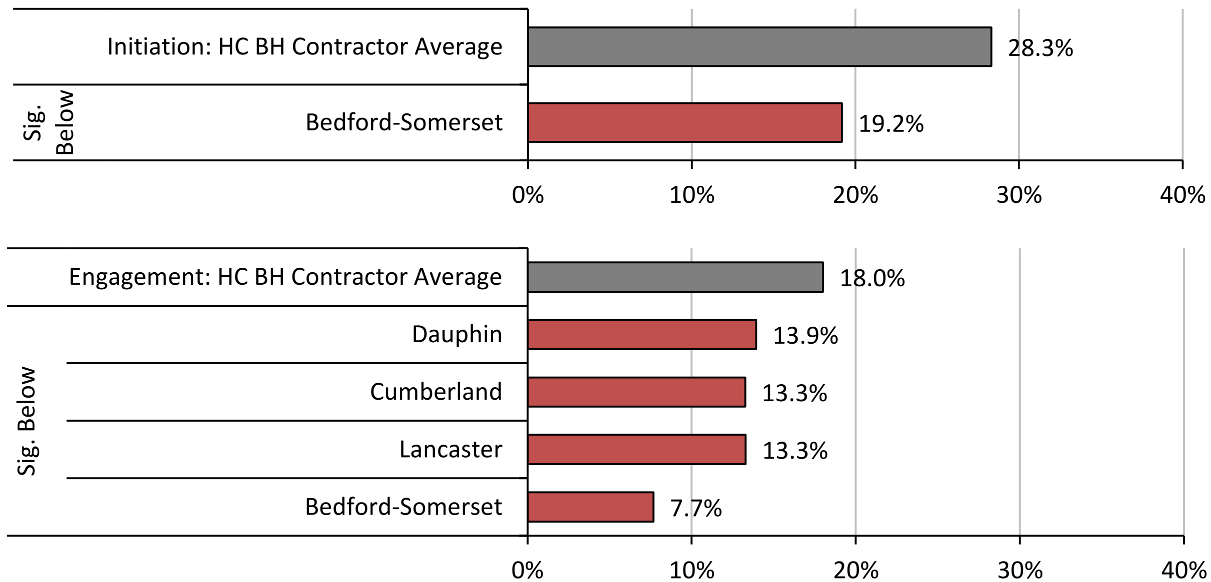


Figure 14: MY 2014 IET Rates Compared to HealthChoices HC BH Contractor Average – 18+ Years



(c) Age Group: 13+ Years Old

Table 15: MY 2014 IET Rates – 13+Years with Year-to-Year Comparisons

Measure	MY 2014							MY 2013			Rate Comparison MY 2014 to HEDIS Benchmarks
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	%	PPD	SSD	
Age Cohort: Total – Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	12,750	42,086	**30.3%**	29.9%	30.7%	29.1%	28.7%	29.9%	0.4	NO	Below 25th Percentile
PerformCare[1]	908	3,348	**27.1%**	25.6%	28.6%			21.7%	5.4	YES	Below 25th Percentile
Bedford-Somerset	68	347	**19.6%**	15.3%	23.9%			25.1%	-5.5	NO	Below 25th Percentile
Cumberland	75	297	**25.3%**	20.2%	30.4%			21.6%	3.7	NO	Below 25th Percentile
Dauphin	223	840	**26.5%**	23.5%	29.5%			18.7%	7.8	YES	Below 25th Percentile
Franklin-Fulton	85	267	**31.8%**	26.0%	37.6%			15.3%	16.5	YES	Below 25th Percentile
Lancaster	340	1,239	**27.4%**	24.9%	29.9%			21.7%	5.7	YES	Below 25th Percentile
Lebanon	93	270	**34.4%**	28.5%	40.3%			18.7%	15.7	YES	Below 50th, at or above 25th percentile
Perry	24	88	**27.3%**	17.4%	37.2%			17.8%	9.5	NO	Below 25th Percentile
Age Cohort: Total – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	8,633	42,086	**20.5%**	20.1%	20.9%	19.1%	18.2%	20.6%	-0.1	NO	At or above 75th Percentile
PerformCare[1]	466	3,348	**13.9%**	12.7%	15.1%			10.4%	3.5	YES	Below 75th, at or above 50th percentile
Bedford-Somerset	26	347	**7.5%**	4.6%	10.4%			12.0%	-4.5	NO	Below 50th, at or above 25th percentile
Cumberland	42	297	**14.1%**	10.0%	18.2%			7.1%	7.0	YES	Below 75th, at or above 50th percentile
Dauphin	120	840	**14.3%**	11.9%	16.7%			8.2%	6.1	YES	Below 75th, at or above 50th percentile
Franklin-Fulton	52	267	**19.5%**	14.6%	24.4%			6.1%	13.4	YES	At or above 75th Percentile
Lancaster	162	1,239	**13.1%**	11.2%	15.0%			10.3%	2.8	YES	Below 75th, at or above 50th percentile
Lebanon	52	270	**19.3%**	14.4%	24.2%			7.1%	12.2	YES	At or above 75th Percentile
Perry	12	88	**13.6%**	5.9%	21.3%			12.3%	1.3	NO	Below 75th, at or above 50th percentile

[1] As Blair and Lycoming-Clinton ended their contract with PerformCare on June 30, 2013, overall MY 2013 results for PerformCare include discharges for Blair and Lycoming-Clinton that occurred between 1/1/13 and 6/30/13. Individual rates for Blair and Lycoming-Clinton are not shown.

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval

The MY 2014 HealthChoices Aggregate Initiation rate for the total population was 30.3%, falling below the HEDIS 2015 Medicaid 25th percentile benchmark (**Table 15**). The MY 2014 HealthChoices Aggregate Engagement rate was at or above the HEDIS 75th percentile with a rate of 20.5%.

The total PerformCare Initiation rate of 27.1% was statistically significantly lower than the HealthChoices BH-MCO Average of 29.1% by 2.0 percentage points (**Table 15**). The PerformCare Engagement rate of 13.9% was statistically significantly lower than the HealthChoices BH-MCO Average rate of 19.1% by 5.2 percentage points. Compared to the HEDIS 2015 benchmarks, the Initiation rate for PerformCare was below the 25th percentile, while the Engagement rate was between the 50th and 75th percentile.

As presented in **Table 15**, Initiation rates were below the 25th percentile for all PerformCare HC BH Contractors, except Lebanon, which had a rate between the 25th and 50th percentile. Engagement rates were at or above the 75th percentile for two HC BH Contractors (Franklin-Fulton and Lebanon), between the 50th and 75th percentile for four HC BH Contractors (Cumberland, Dauphin, Lancaster, and Perry), and between the 25th and 50th percentile for Bedford-Somerset.

Figure 15 is a graphical representation MY 2014 IET rates for PerformCare and its associated HC BH Contractors. **Figure 16** shows the HealthChoices HC BH Contractor Average rates and individual PerformCare HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. The Initiation rate for Bedford-Somerset was statistically significantly lower than the HealthChoices HC BH Contractor Average Initiation rate of 28.7% by 9.1 percentage points. The Engagement rates for Dauphin, Lancaster, and Bedford-Somerset were statistically significantly lower than the HC BH Contractor Average of 18.2% by 3.9 to 10.7 percentage points.

Figure 15: MY 2014 IET Rates: 13+Years

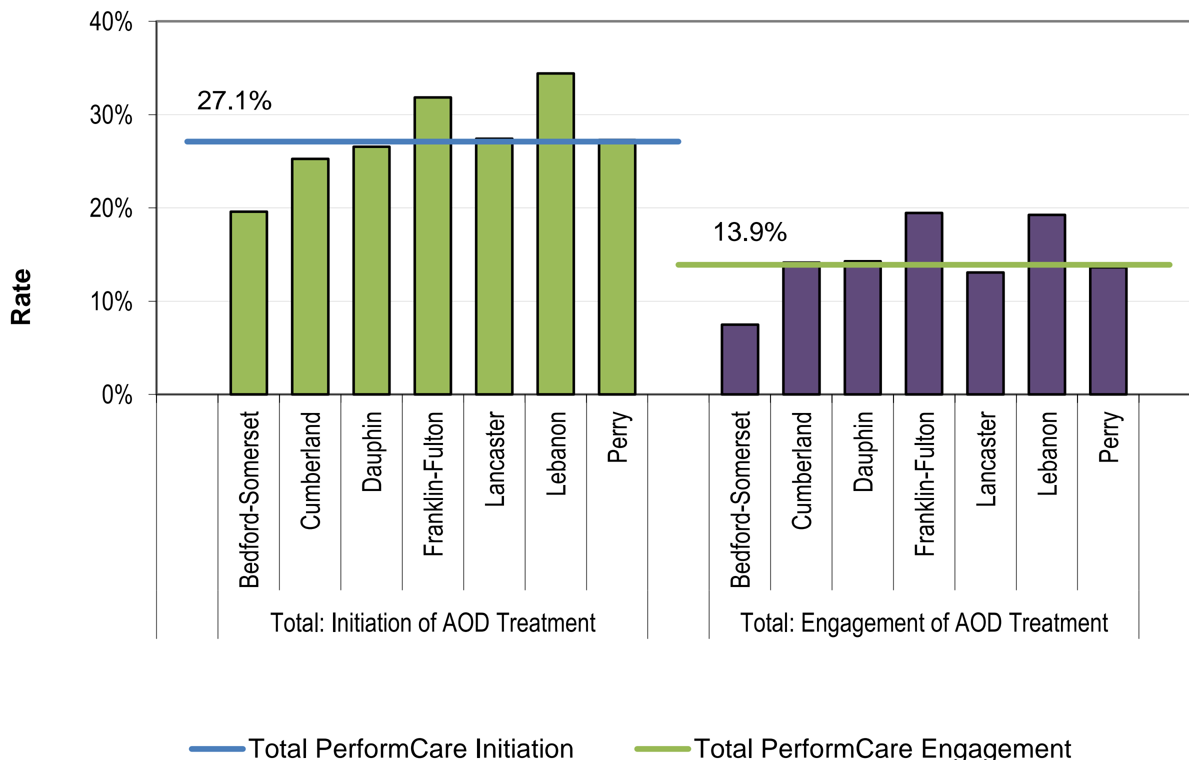
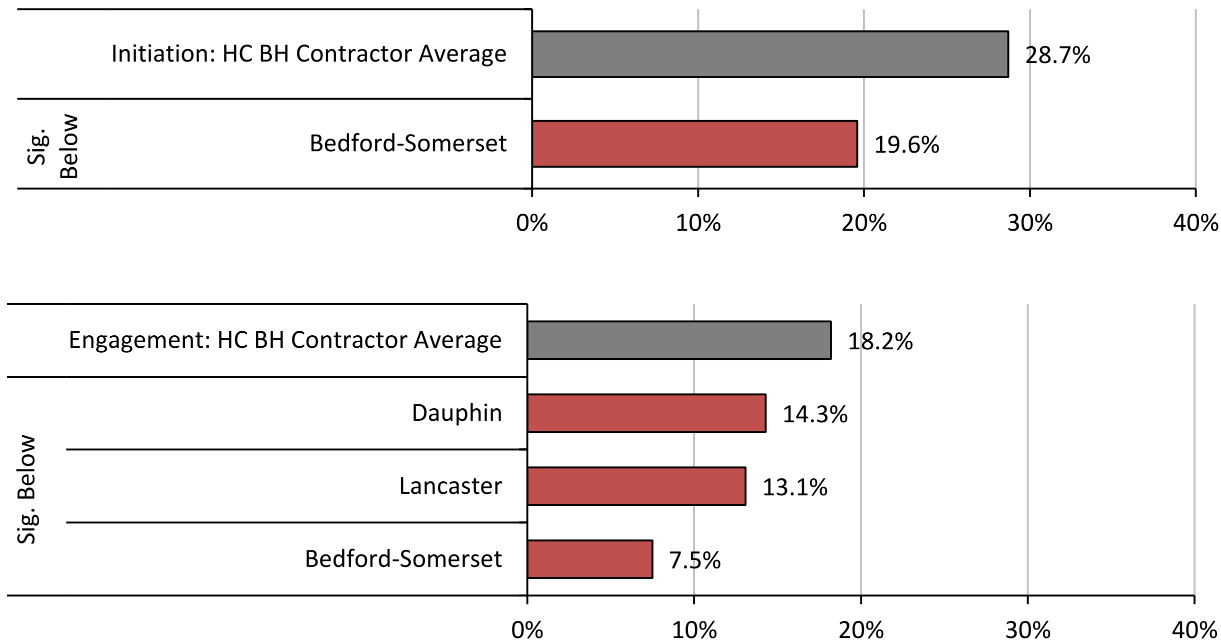


Figure 16: MY 2014IET Rates Compared to HealthChoices HC BH Contractor Average: 13+ Years



Conclusion and Recommendations

For MY 2014, the aggregate HealthChoices rate for the Initiation numerator was 30.3%, and the Engagement rate was 20.5%. The Initiation rate was below the HEDIS 25th percentile while the Engagement rate was at or above the 75th percentile. There was no statistically significant difference for Initiation and Engagement from MY 2013. As seen with other performance measures, there is significant variation between the HC BH Contractors. The following general recommendations are applicable to all five participating BH-MCOs:

- BH-MCOs should begin to implement programs to report this measure for their population on a regular basis. This will allow BH-MCOs to identify specific subpopulations with low performance for future interventions.
- BH-MCOs should identify high performing subpopulations to determine if any best practices exist for increasing the Initiation and Engagement rates.
- When developing reporting and analysis programs, BH-MCOs should focus on the Initiation rate, as four of the five BH-MCOs had a rate below the HEDIS 25th percentile for this numerator.

IV: Quality Study

The purpose of this section is to describe a quality study performed between 2014 and 2015 for the HealthChoices population. The study is included in this report as an optional EQR activity which occurred during the Review Year (42 CFR §438.358 (c)(5)).

Overview/Study Objective

DHS commissioned IPRO to conduct a study to identify risk factors for acute inpatient readmissions among members enrolled in the Pennsylvania Medicaid Behavioral Health HealthChoices program. The objective of this study was to combine physical health and behavioral health encounter data to identify risk factors across both domains of care. IPRO and DHS developed a claims based study to determine what demographic and clinical factors are correlated with increased readmission rates. The goal of this study was to provide data to guide targeted quality improvement interventions by identifying subpopulations with high readmission rates. Emphasis was placed on identifying factors across domains of care, i.e. physical health comorbidities that correlate with increased BH readmission rates and vice versa.

Data Collection and Analysis

This study was a claims based analysis of acute inpatient behavioral and physical health admissions between 12/2/2010 and 12/1/2011. The primary source of data was claims that were submitted to and accepted by the DHS PROMISe encounter system. One BH-MCO had significant data loss during the study period. For this BH-MCO, the Person Level Event (PLE) files that the BH-MCO submitted to OMHSAS for rate setting purposes were used in place of PROMISe data for this BH-MCO. Any claims not submitted to or not accepted by PROMISe are not included in this study. For the BH-MCO with data loss, any encounters not included in their PLE files are not included in this study. The analysis consisted of comparisons of 30-day readmission rates for various subpopulations. Subpopulations were distinguished by member demographics, diagnosis prior to and during the admission, and the number and type of encounters before and after the inpatient stay. Finally, regression analyses were done to identify what factors or combinations of factors correlate with a high readmission rate.

Results/Conclusions

There were a total of 17,245 behavioral health admissions and 64,222 physical health included in this study. The 30-day readmission rate for behavioral health admissions was 10.8%, and physical health readmissions had a readmission rate of 9.6%. The study was completed in September of 2015, and distributed to the BH-MCOs and HC BH Contractors in December 2015.

There were a number of demographic factors that were statistically significantly correlated with an increased readmission rate for behavioral health admissions. African Americans had a higher readmission rate than white members, and members in an urban county had a higher readmission rate than members in a rural county. Members with a history of mental health and/or substance abuse diagnosis within one year prior to their admission had significantly higher readmission rates than members without a history of these diagnoses. Alcohol-induced mental disorders, schizophrenic disorders and other nonorganic psychoses had the highest BH readmission rates (17.5%, 16.5% and 16.2%, respectively).

An analysis of physical health co-morbidities for behavioral health readmission showed that asthma, cardiovascular disease, developmental disability, diabetes and gastrointestinal disease co-morbidity are associated with significantly higher BH readmission rates. Members who had a follow-up visit with a behavioral health provider did not have statistically significant different readmission rates than members who did not. However, members who had a follow-up visit with a physical health provider had statistically significant lower readmission rates than members who did not.

For physical health readmission rates, African American members had significantly higher readmission rates than index stays for white members. Index stays for members receiving SSI benefits had statistically significantly higher readmissions rates compared to admissions for members receiving Temporary Assistance for Needy Families (TANF). The highest readmission rates are noted for hepatitis (30.6%) and liver disease (25.3%) admissions. Admissions for COPD, cardiovascular disease, gastrointestinal disease, and HIV all had readmission rates between 15% and 20%. Admissions for obstetric conditions have the lowest readmission rates, with a rate of 1.0% for admissions due to delivery

complications, 1.7% for admissions due to normal delivery, and 3.1% for admissions due to pregnancy complications. The presence of behavioral health co-morbidity is associated with significantly higher rates of physical health readmission; admissions with a behavioral health co-morbidity had a physical health readmission rate of 11.2%, while the rate is 7.6% for index stays without a behavioral health co-morbidity.

The results of the study were distributed to the BH-MCOs and HC BH Contractors in December 2015. The findings of the study assisted in the development of an integrated care project which is intended to increase the utilization and analysis of behavioral health data by physical health MCOs and vice versa.

V: 2014 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 2014 EQR Technical Reports, which were distributed in April 2015. The 2015 EQR Technical Report is the eighth report to include descriptions of current and proposed interventions from each BH-MCO that address the 2014 recommendations.

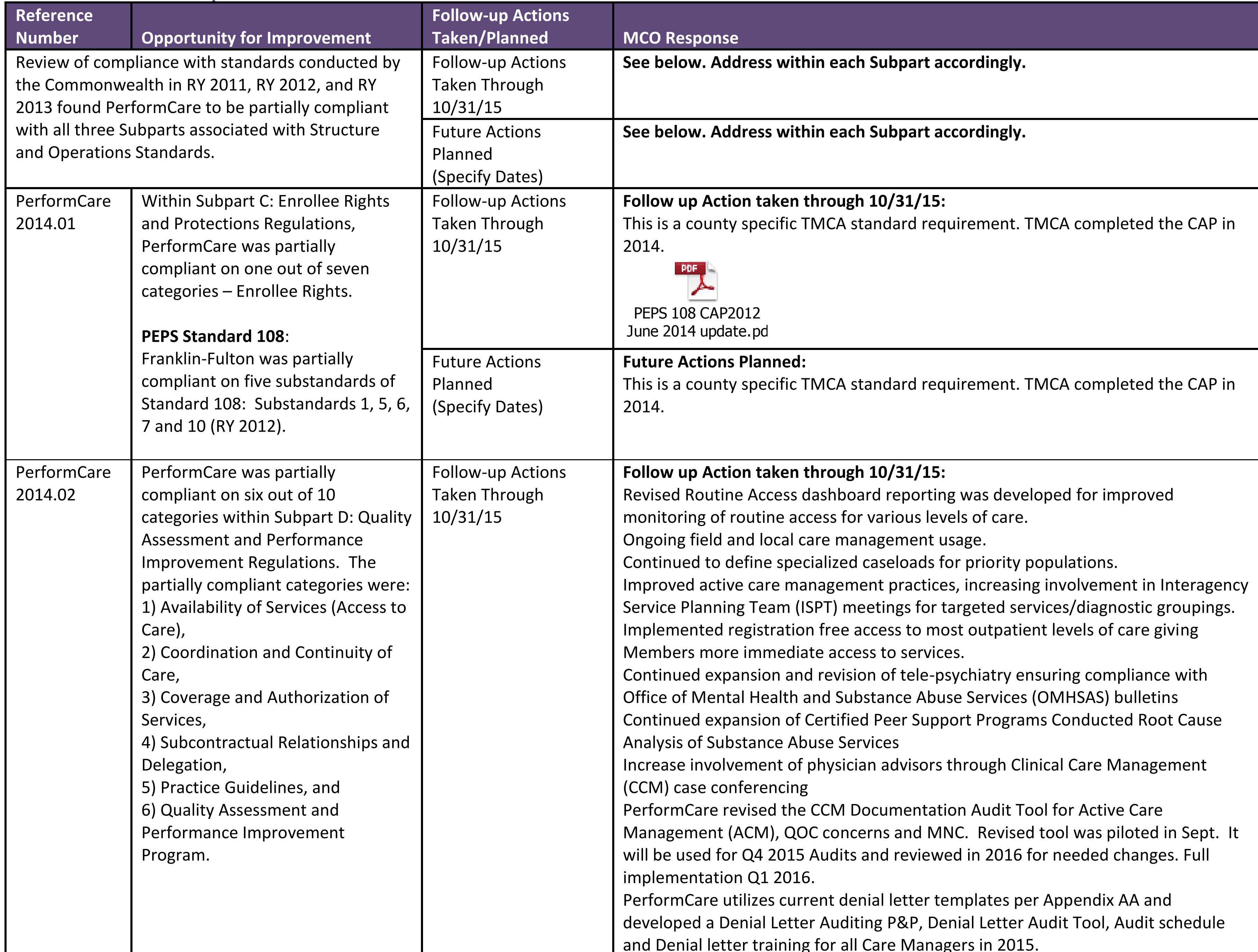
The BH-MCOs are required by OMHSAS to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the Pennsylvania Medicaid BH-MCOs. These activities follow a longitudinal format, and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

- follow-up actions that the BH-MCO has taken through September 30, 2015 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 2015, as well as any additional relevant documentation provided by the BH-MCO.

Table 16 presents PerformCare's responses to opportunities of improvement cited by IPRO in the 2014 EQR Technical Report, detailing current and proposed interventions.

Table 16: Current and Proposed Interventions



Reference Number	Opportunity for Improvement	Follow-up Actions Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in RY 2011, RY 2012, and RY 2013 found PerformCare to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Follow-up Actions Taken Through 10/31/15	**See below. Address within each Subpart accordingly.**
		Future Actions Planned (Specify Dates)	**See below. Address within each Subpart accordingly.**
PerformCare 2014.01	Within Subpart C: Enrollee Rights and Protections Regulations, PerformCare was partially compliant on one out of seven categories – Enrollee Rights. **PEPS Standard 108**: Franklin-Fulton was partially compliant on five substandards of Standard 108: Substandards 1, 5, 6, 7 and 10 (RY 2012).	Follow-up Actions Taken Through 10/31/15	**Follow up Action taken through 10/31/15:** This is a county specific TMCA standard requirement. TMCA completed the CAP in 2014. PEPS 108 CAP2012 June 2014 update.pd
		Future Actions Planned (Specify Dates)	**Future Actions Planned:** This is a county specific TMCA standard requirement. TMCA completed the CAP in 2014.
PerformCare 2014.02	PerformCare was partially compliant on six out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Subcontractual Relationships and Delegation, 5) Practice Guidelines, and 6) Quality Assessment and Performance Improvement Program.	Follow-up Actions Taken Through 10/31/15	**Follow up Action taken through 10/31/15:** Revised Routine Access dashboard reporting was developed for improved monitoring of routine access for various levels of care. Ongoing field and local care management usage. Continued to define specialized caseloads for priority populations. Improved active care management practices, increasing involvement in Interagency Service Planning Team (ISPT) meetings for targeted services/diagnostic groupings. Implemented registration free access to most outpatient levels of care giving Members more immediate access to services. Continued expansion and revision of tele-psychiatry ensuring compliance with Office of Mental Health and Substance Abuse Services (OMHSAS) bulletins Continued expansion of Certified Peer Support Programs Conducted Root Cause Analysis of Substance Abuse Services Increase involvement of physician advisors through Clinical Care Management (CCM) case conferencing PerformCare revised the CCM Documentation Audit Tool for Active Care Management (ACM), QOC concerns and MNC. Revised tool was piloted in Sept. It will be used for Q4 2015 Audits and reviewed in 2016 for needed changes. Full implementation Q1 2016. PerformCare utilizes current denial letter templates per Appendix AA and developed a Denial Letter Auditing P&P, Denial Letter Audit Tool, Audit schedule and Denial letter training for all Care Managers in 2015.

			Completion of 2014 QI/UM Annual Program Evaluation in April 2015. Post submission to OMHSAS, a meeting was held, on April 29, 2015 with each individual contract, between OMHSAS and PerformCare to discuss OMHSAS recommendations to refine goals in relation to the 2015 Annual Work Plan to correlate with findings outlined in the Program Evaluation.
		Future Actions Planned (Specify Dates) 2015-2016 2016 May 2016	**Future Actions Planned:** Ongoing: Continued development of service alternatives which are evidence based, person-centered and recovery oriented. Expansion of peer support services. Monitor the utilization of services on at least a quarterly basis through QI/UM. Evidence of completion is addition of services and increased use of existing services. Review and adoption of additional practice guidelines. Evidence of completion is revision and adoption of practice guidelines as documented by the Provider Advisory Committee. PerformCare is developing a process to Audit Longitudinal Care Management in 2016 and will be incorporated in CCM 2016 Training plan. Evidence of completion is the documented process and inclusion in the training plan. Completion of training will be tracked through centralized tracking system. PerformCare is developing a Psychiatric/Psychologist Advisor (PA) documentation template and Audit tool for MNC, QOC, and Treatment consultations. Evidence of completion is finalization and implementation of template and audit tool. PerformCare will revise Denial Notice P&P to reflect current Appendix AA requirements and incorporate Denial Letter standards into annual Care Manager training plan in 2016. Evidence of completion is revised and approved P&P and training plan. The 2014 and 2015 Annual Program Evaluation findings will be utilized to assist with the development of the 2016 Annual Work Plan goals. Evidence of completion is completed and approved 2016 Annual Work Plan submitted to OMHSAS.
PerformCare 2014.03	PerformCare was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 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,	Follow-up Actions Taken Through 10/31/15	**Follow up Action taken through 10/31/15:** Continued internal auditing of a sampling of acknowledgment and decision letters to be sent to Members. Supervisory review of decision letters prior to being sent to the Member. Continued the following: Grievance application reports to monitor timeliness of letters sent to Members. Use of grievance application that mandates use of a template for grievance letters to be sent to Members. Improvement of PerformCare process for transcribing Level Two grievances. Internal peer post grievance case reviews with feedback. Use of updated acknowledgment and decision letter templates, as per OMHSAS direction. Use of PerformCare's quality trigger process to identify areas of concern with service provision to ensure clinical involvement.

	6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.		Communication process with Clinical Care Managers regarding reversed grievance decisions. Implementation of improved Complaint investigations and documentation. Involvement and communication with County Oversights in the Complaint and Grievance processes. Use of the updated Expedited Appeal process and Continuation of benefits, as per OMHSAS direction. Use of the internal process of clinical coordination when new information is presented during the grievance process that could potentially impact service provision. Revised the Compliant and Grievance Policies and Procedures (P&P) – revised into a separate policy and procedure for complaints and a separate policy and procedure for grievances. Revised Complaint and Grievance desktop processes.
		Future Actions Planned (Specify Dates) 12/31/15 2016	**Future Actions Planned:** Implementation of standardized training roster, a centralized training tracking system, training curriculum and training presentations. Evidence of completion is standardized roster, tracking system, curriculum and presentations completed and implemented. Conduct the following activities at the established time intervals: Internal auditing of a sampling of acknowledgment and decision letters for accuracy and to ensure proper templates and Member driven rights are documented. Supervisory review of decision letters prior to distribution to the Member/family. Supervisory review of grievance application reports to monitor timeliness of letters sent to Members and families, as well as the use of the grievance template letters. Assessment of the processes implemented of post internal peer review cases to identify areas requiring re-education. Assessment of the quality indicator process to ensure the expectations of the process are met, specifically to continue to reduce grievances, improve prescribing practices and the quality of service provision, and increase clinical involvement in the grievance process. Assessment of grievance volume to occur on a monthly basis to determine if additional initiatives need to be implemented to address presenting concerns. Annual employee training and new employee orientation in accordance with the Annual Training Plan. Evidence of completion is documentation of audits, assessments and training. Monitoring will be coordinated with PerformCare Quality Department.
PerformCare 2013.04	PerformCare's rate for the MY 2013 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher	Follow-up Actions Taken Through 10/31/15 7/23/14 and 2015	**Follow up Action taken through 10/31/15** PerformCare completed a network wide barrier analysis for 30- day readmissions as part of the 2014 Performance Improvement Project.

	(worse) than the BH-MCO average by 2.0 percentage points. PerformCare's rate did not meet the OMHSAS designated performance goal of 10.0%.	2013 Ongoing 2015 Ongoing 2014-2015 Ongoing Ongoing Ongoing	PerformCare conducted a RCA with Dauphin County for 30-day readmission rates. Key actions included Member profiling which revealed Members diagnosed with personality disorders to have experienced a higher rate of readmissions. Initiated grand rounds case conferencing with Pennsylvania Psychiatric Institute (PPI) – the primary inpatient facility service this county. The Crisis Bridge Pilot Program was implemented in Bedford and Somerset Counties. This pilot involves Somerset Hospital and Bedford/Somerset Mental Health Mental Retardation (MHMR) (Cornerstone). Bedford/Somerset MHMR is offering appointments when Members are discharged from Somerset Hospital in order to bridge the gap in service between Mental Health Inpatient (MH IP) discharge and traditional OP follow up. The program was implemented in April 2012 and is being utilized currently. Utilization of this service has not been as high as originally projected. Meetings with the Provider of this service and Somerset Hospital occur every six months to review Outcomes and utilization. The Crisis Bridge program is an "opt out" service rather than "opt in" service. Outcomes and utilization review. This intervention has the potential to impact all four follow up measures. Bedford/Somerset: **Comprehensive, Continuous, Integrated System of Care** (**CCISC**) implementation continued throughout 2015. Co-Occurring Disorder (COD) Workgroup meetings are occurring quarterly. Change Agent meetings are occurring bi-monthly. Providers have completed COMPASS-EZ assessments and action plans have been submitted. The COD Workgroup completed the CO-Fit and created an action plan based on the identified opportunities. Franklin/Fulton (FF) County regional office, in conjunction with Tuscarora Managed Care Alliance (TMCA) and various Providers, implemented a MH IP Readmission Work Group in early 2013 and meetings continue to occur on an as needed basis. Findings were utilized and discussed in the PIP barrier analysis work group to assist with the development of the Successful Transition to Ambulatory Care Performance Improvement Plan. Tele-psychiatry expansion continued within the region in an effort to improve access. Tele-psychiatry services expanded in 2015 in the BESO region. Franklin/Fulton Counties continued to work to add additional Tele-psychiatry Providers; one provider joined the network in 2015. Due to concerns with access to MH OP and Psychiatry TMCA formed an Outpatient access workgroup that has utilized various methods to survey Providers in an effort to evaluate access. The workgroup has looked at data from Providers regarding number of patient hours scheduled per week for each doctor, payer mix, no-show rates etc. They facilitated a "secret shopper" survey. The workgroup determined that access issues in the region are not due to a capacity issue but due to ineffective management of resources at the provider level. PerformCare has engaged national consultants to come to the region offer consultation to MH OP providers that wish to develop open access and just in time prescriber scheduling models.

		Ongoing 2014-2015 2013 – 2015 Ongoing 2014-2015 Ongoing 2015 Ongoing	Continued Member and Provider education of specialized services available within the Franklin/Fulton region: Adams Hanover Counseling began to offer DBT groups in Fulton County in late 2012. Three regional Providers were certified in EMDR in 2012 due to scholarship funding from PerformCare and TMCA. In 2014, Parent Child Interactive Therapy and specialized JSO FBMHS and MH OP Therapy. Additionally, certification training was held for Trauma Focused CBT in which eleven clinicians from the Franklin/Fulton region attended. Franklin\Fulton regional CCISC initiative continued through October 2015. The training series on improving Co-Occurring Competency was offered to Providers in the region; CCISC implementation team meetings occur bi-monthly; the Change Agent meetings and training series continued in 2015; Providers have completed COMPASS-EZ and action plans have been submitted; Provider involvement continues to grow in the initiative; and CCISC Implementation team completed the COMPASS-Exec and developed a work plan to address deficiencies identified in the network. A COD work group subcommittee developed a Co-Occurring Competency audit tool to be utilized for Co-Occurring Competency Certification of providers. This certification qualifies providers to bill an enhanced rate. Five providers voluntarily participated in the audit, with two providers successfully completing the audit with a passing score. Additionally, those providers receiving an enhanced rate agreed to participate in the Outcomes Survey. Franklin\Fulton and BESO PerformCare regional staff continue to provide Member and Provider education on Peer Support services and Psychiatric Rehabilitation Services (PRS) offered within the region. A Franklin/Fulton local Targeted Case Management (TCM) Provider (Service Access Management) is currently providing education to Members while in a local IP unit regarding TCM services. This TCM Provider is working closely with MH IP units to improve Member access to TCM services by offering to complete intake prior to Member discharging from MH IP. Discussions continue with local TCM Provider on possible ways to increase referrals for ICM/RC services. Efforts to raise Member, community, and Provider awareness of TCM services will continue. Through Capital Area Behavioral Health Collaborative (CABHC) re-investment dollars, Peer Support Specialists were hired embedded in MH IP units. Began the development and availability of specialized services such as Dialectical Behavioral Therapy (DBT) through use of reinvestment funding. Participated in Department of Human Services (DHS - previously known as Department of Public Welfare), Drug Utilization Review (DUR) Board Meetings to support the standardization of prior authorization criteria for medications (including second generation anti-psychotic medications). Assessed the availability and the potential expansion of Providers who offer injection clinics to support the growing demand for injectable medications. Continued quality Treatment Record Review (TRR) every three years based on the re-credentialing cycle. Increased the benchmark for performance to 80%. Any Provider with scores below 80% will be asked to complete a Quality Improvement Plan (QIP). Once the Quality Improvement Plan has been accepted, the Provider

			will be monitored every three months for improvements.
			The Clinical Department developed a list of high utilizers will be used to screen for: • Internal care management • External community case management through Base Service Units (BSU) • Community programming [Peer Support, Mobile psych nursing, psych rehab, outpatient (OP), medication management, etc.]
		2015	Identified Members who do not have enhanced care management (ECM) to be screened and assigned to the appropriate Mental Health or Substance Abuse (SA)/Co-Occurring ECM. Member, TCM and Community Support outreach will begin to develop a plan for engagement and recovery/resiliency based services and services plans within 2 weeks of ECM designation.
		2015	Identified Members will have individualized member alerts placed in their electronic medical record (EMR) to assist CCMs with follow up and coordination of services.
		Ongoing	Developed and implemented a Recovery Management Plan for Members eligible for ECM.
			Pyramid Healthcare has expanded existing services within the FF contract to include a dually licensed Mental Health/Substance Abuse (MH/SA) OP Clinic.
			Family Behavioral Resources added MH OP Clinic services in 2015 by opening MH OP Clinics in Fulton, Franklin, and Bedford Counties.
			PerformCare obtained and distributed a recovery board game to Mental Health Inpatient Facilities to use in group education on recovery.
			Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex need.
		2014-2015 Ongoing	Monitored utilization of Brief Treatment Model (BTM), Functional Family Therapy (FFT), Incredible Years (IY), and Parent Child Intensive Therapy (PCIT) (evidence-based programming). Utilization is monitored monthly through Quality Improvement/Utilization Management (QI/UM). BTM and FFT utilization increased, PCIT has had a slow start up in BESO with low utilization, and a switch occurred in the IY, for children ages 4 to 8 years, Provider, referrals have been low and it is anticipated that a new advertising campaign will increase the referrals.
			A regional OP clinic added Mobile-Mental Health to their services in September 2014 in Franklin/Fulton Counties and continued throughout 2015.
		2014-2015	Capital Contract continued to use Assertive Community Treatment (ACT), Mobile Mental Health Team (MMHT) and Mobile Psychiatric Nurse (MPN) services to provide in-home/community services.
			PerformCare Contact Center continued to provide Medical Assistance Transportation Program (MATP) information and contact numbers.
			Completed Training: <u>BHSSBC</u> Mental health recovery and WRAP July 29, 2014 and August 5, 2014 WRAP facilitator 7/29/14, 8/5/14. 8/18 to 8/22/15, 3/25/15,3/24/15, 6/15/15 and 6/19/15 Proactive Counseling September 22, 2014 and September 23, 2014

		2015 2015	Community Data Roundtable meeting on the CANS on 9/9/2014 WRAP on 2/17/2015 and 2/27/2015, 5/19/15, 5/26/15, 10/1/15, and 10/16/15 CANS certification on 4/15/15 CABHC ICD-10 & DSM-5 on July 22, 2014 EMDR General Overview on August 27, 2014 EMDR General Overview on August 28, 2014 CANS Algorithm on January 29. 2015 CANS on April 15, 2015 CANS Kickoff on June 8, 2015 TMCA Engaging individuals with COD throughout treatment on April 17, 2015 CCISC No Wrong Day Networking day on June 19, 2015 Treatment planning for COD on September 8, 2015 Treatment Record Review SA OP Treatment Record Review on January 15 and January 16. 2015 MH IP/EAC webinar on August 26, 2015 TRR tool changes and updates webinar for 2016 on August 27, 2015 MH OP Treatment Record Review webinar on August 28, 2015 Initiated Discharge Management Plan auditing as part of the 2104 PIP, gathered and analyzed data for the four pilot facilities, held meetings with facilities and began the development of interventions for each facility.
		Future Actions Planned (Specify Dates) 12/8/15 3/8/16 4/1/16 & 4/29/16 6/14/16 2015-2016	**Future Actions Planned:** Training Opportunities: Substance Abuse treatment plan MH Clinical Service Providers Motivational Interviewing parts 1 and 2 Motivational Interviewing Advanced Skill Building Evidence of completion is training roster and documentation of training completion. Expansion of Mobile Services Team (MST) and mobile – psych nursing in counties where the services are not available currently. Evidence of completion is implementation of the expanded services and increased utilization. Create and Distribute survey to individuals that have been readmitted within 30 days to gather information related to discharge process and planning and available supports within the community. The survey is an intervention developed for the 2014 Performance Improvement Project and will be monitored through that process quarterly. Exploration and implementation of alternative in-home services; exploration of alternative options for in-home services for the adult population. PerformCare is making improvements to outcomes reporting specific to level of care and Provider. The outcomes reports will give detailed information on Provider Performance.

		12/2015 2016	Expansion of Discharge Management Planning to 7 additional inpatient facilities. Expansion of Recovery Management Planning to Members at risk for re-admission to inpatient treatment at time of first re-admission episode. Inter-Rater Reliability testing expansion to Physician Advisors A meeting with MH OP Providers within the TMCA region to discuss the MTM Open Access and Just in Time Prescriber Scheduling Models. Evidence of completion is completion of meeting and attendance record. Physician Advisor (PA) education regarding his/her role in recidivism and follow up training. Outreach to external county base service units (BSU) and single county authorities (SCA), mental health inpatient Providers, mental health and substance abuse outpatient Providers, and Crisis Providers. Evidence of completions is documentation of training and meetings with the identified stakeholders.
PerformCare 2014.05	PerformCare's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness HEDIS indicators QI 1 and QI 2 were statistically significantly lower than the BH-MCO Averages by 9.8 and 5.6 percentage points. PerformCare reported the lowest results for both QI 1 and QI 2 of all the BH-MCOs evaluated. PerformCare's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness PA Specific indicators QI A and QI B were statistically significantly lower than the BH-MCO Averages by 6.9 and 3.2 percentage points. PerformCare reported the lowest results for QI A of all the BH-MCOs evaluated. PerformCare's rates for the MY 2013 Follow-up After Hospitalization for Mental Illness HEDIS indicators (QI 1 and QI 2) for ages 6-64 did not meet either the OMHSAS interim goal for MY 2013 or the goal of meeting or exceeding the 75th percentile.	Follow-up Actions Taken Through 10/31/15 7/23/14 and 2015 2013 Ongoing 2015 Ongoing 2014-2015 Ongoing	**Follow-up Actions Taken** PerformCare completed a network wide barrier analysis for 30-day readmissions as part of the 2014 Performance Improvement Project. PerformCare conducted a RCA with Dauphin County for 30-day readmission rates. Key actions included Member profiling which revealed Members diagnosed with personality disorders to have experienced a higher rate of readmissions. Initiated grand rounds case conferencing with Pennsylvania Psychiatric Institute (PPI) – the primary inpatient facility service this county. The Crisis Bridge Pilot Program was implemented in Bedford and Somerset Counties. The Crisis Bridge program is an "opt out" service rather than "opt in" service. Outcomes and utilization review. This intervention has the potential to impact all four follow up measures. Bedford/Somerset: **Comprehensive, Continuous, Integrated System of Care** (**CCISC**) implementation continued throughout 2015. Franklin/Fulton (FF) County regional office, in conjunction with Tuscarora Managed Care Alliance (TMCA) and various Providers, implemented a MH IP Readmission Work Group in early 2013 and meetings continue to occur on an as needed basis. Tele-psychiatry expansion continued. Due to concerns with access to MH OP and Psychiatry TMCA formed an Outpatient access workgroup that has utilized various methods to survey Providers in an effort to evaluate access. The workgroup has looked at data from Providers regarding number of patient hours scheduled per week for each doctor, payer mix, no-show rates etc. They facilitated a "secret shopper" survey. The workgroup determined that access issues in the region are not due to a capacity issue but due to ineffective management of resources at the provider level. PerformCare has engaged national consultants to come to the region offer consultation to MH OP providers that wish to develop open access and just in time prescriber scheduling

			models. Continued Member and Provider education of specialized services available within the Franklin/Fulton region and the regional CCISC initiative continued through October 2015.
		Ongoing 2014-2015 2013 – 2015 Ongoing 2014-2015 Ongoing 2015 Ongoing 2015 Ongoing 2015 Ongoing	Franklin\Fulton and BESO PerformCare regional staff continue to provide Member and Provider education on Peer Support services and Psychiatric Rehabilitation Services (PRS) offered within the region. A Franklin/Fulton local Targeted Case Management (TCM) Provider (Service Access Management) is currently providing education to Members while in a local IP unit regarding TCM services. Discussions continue with local TCM Provider on possible ways to increase referrals for ICM/RC services. Through Capital Area Behavioral Health Collaborative (CABHC) re-investment dollars, Peer Support Specialists were hired embedded in MH IP units. Began the development and availability of specialized services such as Dialect Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR) through use of reinvestment funding. Assessed the availability and the potential expansion of Providers who offer injection clinics to support the growing demand for injectable medications. Continued quality Treatment Record Review (TRR) every three years based on the re-credentialing cycle. Increased the benchmark for performance to 80%. Any Provider with scores below 80% will be asked to complete a Quality Improvement Plan (QIP). Once the Quality Improvement Plan has been accepted, the Provider will be monitored every three months for improvements. The Clinical Department developed a list of high utilizers will be used to screen for: • Internal care management • External community case management through Base Service Units (BSU) • Community programming [Peer Support, Mobile psych nursing, psych rehab, outpatient (OP), medication management, etc.] Identified Members who do not have enhanced care management (ECM) to be screened and assigned to the appropriate Mental Health or Substance Abuse (SA)/Co-Occurring ECM. Member, TCM and Community Support outreach will begin to develop a plan for engagement and recovery/resiliency based services and services plans within 2 weeks of ECM designation.
		     2015 Ongoing 2015	Identified Members will have individualized member alerts placed in their electronic medical record (EMR) to assist CCMs with follow up and coordination of services. Developed and implemented a Recovery Management Plan for Members eligible for ECM. Pyramid Healthcare has expanded existing services within the FF contract to include a dually licensed Mental Health/Substance Abuse (MH/SA) OP Clinic. Family Behavioral Resources added MH OP Clinic services in 2015 by opening MH

		2015 2015 Ongoing 2014-2015 Ongoing April 2015 2015	OP Clinics in Fulton, Franklin, and Bedford Counties. PerformCare obtained and distributed a recovery board game to Mental Health Inpatient Facilities to use in group education on recovery. Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex need. Monitored utilization of Brief Treatment Model (BTM), Functional Family Therapy (FFT), Incredible Years (IY), and Parent Child Intensive Therapy (PCIT) (evidence-based programming). Utilization is monitored monthly through Quality Improvement/Utilization Management (QI/UM). BTM and FFT utilization increased, PCIT has had a slow start up in BESO with low utilization, and a switch occurred in the IY, for children ages 4 to 8 years, Provider, referrals have been low and it is anticipated that a new advertising campaign will increase the referrals. A regional OP clinic added Mobile-Mental Health to their services in September 2014 in Franklin/Fulton Counties and continued throughout 2015. Capital Contract continued to use Assertive Community Treatment (ACT), Mobile Mental Health Team (MMHT) and Mobile Psychiatric Nurse (MPN) services to provide in-home/community services. PerformCare Contact Center continued to provide Medical Assistance Transportation Program (MATP) information and contact numbers. Generated report identifying Provider HEDIS scores. Members Services Specialist began resuming Member follow up after discharge. Initiated Discharge Management Plan auditing as part of the 2104 PIP, gathered and analyzed data for the four pilot facilities, held meetings with facilities and began the development of interventions for each facility.
		Future Actions Planned (Specify Dates) 12/8/15 3/8/16 4/1/16 & 4/29/16 6/14/16 2015-2016	**Future Actions Planned** Training Opportunities: Substance Abuse treatment plan MH Clinical Service Providers Motivational Interviewing parts 1 and 2 Motivational Interviewing Advanced Skill Building Evidence of completion is training roster and documentation of training completion. Expansion of Mobile Services Team (MST) and mobile – psych nursing in counties where the services are not available currently. Evidence of completion is implementation of the expanded services and increased utilization. Create and Distribute survey to individuals that have been readmitted within 30 days to gather information related to discharge process and planning and available supports within the community. The survey is an intervention developed for the 2014 Performance Improvement Project and will be monitored through that process quarterly. Exploration and implementation of alternative in-home services; exploration of alternative options for in-home services for the adult population.

		12/2015 2016	PerformCare is making improvements to outcomes reporting specific to level of care and Provider. The outcomes reports will give detailed information on Provider Performance. Expansion of Discharge Management Planning to 7 additional inpatient facilities. Expansion of Recovery Management Planning to Members at risk for re-admission to inpatient treatment at time of first re-admission episode. Inter-Rater Reliability testing expansion to Physician Advisors A meeting with MH OP Providers within the TMCA region to discuss the MTM Open Access and Just in Time Prescriber Scheduling Models. Evidence of completion is completion of meeting and attendance record. Physician Advisor (PA) education regarding his/her role in recidivism and follow up training. Outreach to external county base service units (BSU) and single county authorities (SCA), mental health inpatient Providers, mental health and substance abuse outpatient Providers, and Crisis Providers. Evidence of completion is documentation of training and meetings with the identified stakeholders.

Corrective Action Plan for Partial and Non-compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2013, PerformCare began to address opportunities for improvement related to Standards 28, 71, 72, 78, 91 and 108. Proposed actions and evidence of actions taken by PerformCare were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring PerformCare into compliance with the relevant Standards.

Root Cause Analysis and Action Plan

The 2015 EQR is the seventh for which BH-MCOs are 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 MY. For performance measures that were noted as opportunities for improvement in the 2014 EQR Technical Report, BH-MCOs are required to 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 2015 EQR, PerformCare was required to prepare a Root Cause Analysis and Action Plan for the following performance measures and quality indicators:

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6–64 Years (**Table 17**)
- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years (**Table 18**)
- Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day; **Table 19**)
- Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day; **Table 20**)
- Readmission Within 30 Days of Inpatient Psychiatric Discharge (**Table 21**)

Table 17: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6–64 Years

Instructions: **For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.**		
Managed Care Organization (MCO): *PerformCare (formerly Community Behavioral HealthCare Network of Pennsylvania, CBHNP)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) Ages 6-64*	***Response Date:*** *October 9, 2015*
Goal Statement: **(Please specify individual goals for each measure):** ***Short-Term Goal: Increase QI 1 HEDIS 7-Day Performance to 50% (minimum performance goal plus 1%) by the end of Measurement Year (MY) 2015.*** ***Long-Term Goal: Increase QI 1 HEDIS 7-Day Performance to 52% (2015 benchmark plus 1%) by the end of MY 2016.*** *Please see Attachment 1: 2014 Ambulatory Follow-up & Re-admission Fishbone.*		
***Analysis*:** **What factors contributed to poor performance?** **Please enter "N/A" if a category of factors does not apply.**	***Findings*** *PerformCare's rate for MY 2014 for Q1 HEDIS 7-Day was 44.9%, an increase from PerformCare's rate for MY 2013 which was 42% (re-stated).* *PerformCare's rate was 47.2% in MY 2012 and 45.2% in MY 2011 (inclusive of Blair and Lycoming/Clinton contracts).*	
Policies (e.g., data systems, delivery systems, provider facilities) 1. Provider Network 2. HealthChoices Contract Specifications 3. Health Insurance Portability and Accountability Act (HIPAA) of 1996	***Initial Response*** • While performing quality control of PerformCare's measurement year 2014 Follow-up rates PerformCare identified that numerator compliant codes were not being captured. This information was presented to the programmer responsible for preparing the outbound files. • Research revealed that the SQL code was silent for 8 National Codes: 90832, 90833, 90834, 90836, 90837, 90838, 90839 and 90840. The SQL code was amended to contain these codes. • Further research uncovered that the SQL code used to produce the measurement year 2013 outbound files was also silent for these National Codes. • The measurement year 2013 code was reopened and amended to include the missing codes. • This error manifested itself as an apparent significant drop in PerformCare's rates from MY 2012. This perceived "population problem" has further resulted in requests for barrier analyses, and a corrective action plan from one of our contracts. • PerformCare is interested in full disclosure of this error and its associated impacts. • Current Network of psychiatric service providers may impede follow up. There is a shortage of psychiatrists and the rural counties of Bedford, Fulton and Somerset have been issued a Professional Shortage Designation with the Department of Health. While tele-psychiatry has been developed throughout the network, opportunities to expand this resource should continue through Network Operations. • Current practices at Performcare including credentialing, fee scheduling, enhanced rates, policies and procedures do not directly impact follow up rates after MH IP discharge. • If the Member refuses to sign a release to share information with the aftercare Provider, collaboration becomes difficult. Substance Abuse (SA) Providers face unique challenges related to more stringent regulations regarding release of Member information. • Although reporting capabilities have improved through the development and expansion of an Informatics department, timely and efficient data handling to support the identification of trends and details related to ambulatory follow up is limited. Additional attention should be focused on improving the clinical documentation system (eCura®). • Currently we are unable to rely on formal reporting to include details on race, correlations to readmissions, TCM	

- involvement, and medication compliance.
- Currently, data collection to support Provider Profiling is limited by the data stored within the clinical documentation system (eCura®); however, we were able to review provider-specific follow-up rates, average length of stay, and readmission rates.

Root Cause: PerformCare does not consistently use available data for continuous quality improvement. There is a shortage of psychiatrists across the network.

Follow-up Status Response

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

1. Quality Improvement (QI) Auditing Process
2. Discharge Management Planning.

Initial Response

The treatment record review process for Mental Health Inpatient providers include a section related to adequate discharge planning and adherence to recovery principles. Results from 2014 reveal providers are still in need of education regarding discharge planning best practice. Indicators remaining below the 80% target appear below:

Discharge Summary:	2012	2013	2014
Is there a relapse prevention plan (post-discharge) that reflects what steps the Member should take if symptoms escalate which includes activities based on strengths. (must consist of phone numbers for all) A) natural supports, B) provider(s), and C) Crisis Intervention.)	0%	31%	44%
Is there documentation in the record that the PerformCare Member letter was offered to Member at time of discharge?	0%	11%	17%
Are the discharge instructions recovery-oriented (not medical model)? (include Member words, recovery principles, relapse management)	0%	32%	66%
Recovery Orientation (all sections)			
Is there evidence of person-centered language?	0%	26%	52%
Are member strengths incorporated into all areas of treatment (intake, treatment plans, recovery/crisis plans, groups)?	0%	8%	28%

- PerformCare conducted a structured audit of discharge management plans from inpatient facilities in four different hospitals. The hospitals were chosen because we were prompted by IPRO to identify four hospitals for the Successful Transitions to Ambulatory Care PIP, and we thus sought out hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our network. Then, to ensure that we were generating data relevant to contracts outside of the Capital Area, we chose large hospitals in two of our other contracts, Chambersburg Hospital for Franklin/Fulton counties, and Somerset Community Hospital for Bedford/Somerset. The DMP audit tool included an analysis on medication reconciliation. The findings were:

	a. Only 17.3% of 120 reviewed charts in the four identified Providers, demonstrated correct medicine reconciliation. b. These scores are low, and as we see from the literature IPRO provides, low scores could be one of the profound negative impacts on our recidivist rates. Intervention here would be helpful, and could be tracked (Details below.) c. PerformCare does not pay for injectable medication (J-codes) therefore we do not have claims data on this treatment. • The Successful Transition to Ambulatory Care Performance Improvement Plan revealed a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. ***Root Cause: Best Practice Discharge procedures are not completely being followed by many MH IP providers. This could lead to Member's lack of engagement in aftercare. Providers are not identifying barriers and taking steps to resolve prior to discharge.***
	Follow-up Status Response
People (e.g., personnel, provider network, patients) 1. Member 2. Quality Care Manager 3. Providers	***Initial Response*** • The group discussed the importance of having clear discharge instructions, that the Member be present for arranging aftercare appointments that barriers are addressed, and the times/dates are convenient for the Member. • The Franklin/Fulton MH IP Readmission Work Group completed a full analysis of adult Members who had a readmission episode in SFY 2012 and 2013 in order to determine if any commonalities/trends existed within the population and to identify possible barriers to aftercare treatment. This analysis showed that although the majority of Members with a readmission episode had a subsequent follow-up appointment within 7 days; however, readmission episodes still occurred. • There appears to be a lack of provider education on how to engage the Member into treatment by motivating the Member while on the MH IP unit. Some providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way. • There appears to be a lack of Member understanding of Recovery principles, treatment options and necessity of follow up to avoid relapse. • The Successful Transition to Ambulatory Follow up Performance Improvement Plan process revealed an underutilization of community based recovery services, a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there was a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay. There is a lack of active discharge planning. There are insufficient protocols by the providers on the needs and time frames for medication reconciliation, engagement in recovery services, and successful scheduling of follow up visits. • Fractured discharge/transition programs – as IPRO's literature review notes, a clinically sound discharge/transition program is essential for successful transitions to ambulatory care. In our analysis, we have found that the bridge programs in our network are lacking in the following areas: Communication & follow-through deficits through the inpatient and transition processes i. Within PerformCare – there is no one, central document where a discharge management plan of a consumer is developed and tracked over time. While every client has a chart in PerformCare's EMR (eCura®), each event is distinct. While the notes can be looked at back and forth, one central Recovery Management Plan

	(RMP) document located in PerformCare's EMR that is developed over time would allow us to better manage the communication within our organization (and without, as we discuss below) in regards to cases transitioning to ambulatory care. ii. Beyond PerformCare – if communication within PerformCare is fractured, amongst different entities (case management firms, the hospital, psychiatric outpatient Providers, etc.) working with one Member is even more fractured. For instance, through the focus groups we learned that it is not uncommon for a treatment team meeting to come to a conclusion on a Member's discharge, which is then not communicated to the case manager leading the discharge (because of shift changes in the hospital, different case managers come in and out, and communication can be porous). Thus, a centralized RMP that is built with all relevant parties while a Member is in the hospital and that PerformCare can then use to track the client's progress through his/her inpatient stay and beyond, and prompt all Providers to adhere to, would significantly improve communication. ***Root Cause:*** ***1) Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.*** ***2) Due to limited transportation options, scheduling, inadequate discharge instructions and availability of accessible in-home services, follow up has been at a less than desired rate.***
	Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) 1. Provider Education 2. Enrollee Education	***Initial Response***
	• There appears to be a lack of provider education on how to engage the Member into treatment by motivating the Member while on the MH IP unit. Some providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way. • There appears to be a lack of Member understanding of Recovery principles, treatment options and necessity of follow up to avoid relapse. • The Successful Transition to Ambulatory Follow up Performance Improvement Plan process revealed underutilization of community based recovery services, a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there is a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay. ***Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.***
	Follow-up Status Response
Other (specify) ***N/A***	***Initial Response***
	Follow-up Status Response

Complete next page of corresponding action plan.		
Measure: *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) Ages 6-64*		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	Monitoring Plan How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system. There is a shortage of psychiatrists across the network.		***Initial Response***
Action:		
1. Existing Crisis Bridge Programs will be monitored and promoted so utilization may increase.	Ongoing	*1.* BHSSBC and PerformCare will continue to meet with Cornerstone and Somerset Hospital to evaluate the Crisis Bridge Program. Data is presented by PerformCare and Somerset Hospital at these meetings which occur every 6 months. In the fall of 2014, as result of the presentation of data and the above discussions, the Bedford/Somerset model was adjusted so that participation shifted from an Option-In approach to an Option-Out approach.
2. Expand tele-psychiatry and psychiatric services across the network.	Start 2014 Ongoing Fall 2014	*2.* The total number of tele-psychiatry providers increased in 2014 and 2015 and will be monitored through various meetings. Access to psychiatry will be monitored monthly through QI/UM. Bedford/Somerset expanded to two new providers in 2015. Franklin/Fulton Counties added 4 additional providers of Telepsychiatry to the network in 2013 and 2014 and an additional provider was added in 2015.Discussions with additional providers will occur as interest increases. Family Behavioral Resources opened three OP clinics, one in Franklin County, one in Fulton County, and one in Somerset County in 2015. Pyramid Healthcare opened an additional OP clinic in Franklin County (dually licensed) in 2015. CQI folder has a spreadsheet for telepsychiatry and current providers The Capital region added three telepsychiatry providers since in FY 2014/2015. Fourteen new psychiatrists were added to the Capital network during the same time period.
3. Work with providers to brainstorm ideas related to bringing more psychiatrists to rural areas through the Professional Shortage Designation. [Bedford/Somerset (BESO) and Franklin/Fulton (FF) Counties]	2014	*3.* A partnership between TrueNorth Wellness and the Federally Qualified Health Center (FQHC) located in Fulton County is being expanded which will target an increase in Member knowledge regarding MH services available. One provider became an accepted site in Bedford and Somerset Counties and one is waiting to hear if they have been accepted.

4. Create and Distribute survey to individuals that have been readmitted within 30 days to gather information related to discharge process and planning and available supports within the community. 5. Engage inpatient facilities in follow up (CABHC CAP) 6. Add enhancement to follow up resources	2015 April 1, 2015	*4.* The survey is an intervention developed for the Readmission Performance Improvement Project and will be monitored through that process quarterly Franklin and Fulton Counties are moving forward with survey development and will be conducting the survey as planned in 2015. *5.* A report identifying Provider HEDIS scores will be developed. Starting in April, 2015 this report will be sent to providers during a six month rapid experimentation phase to see if receiving information related to HEDIS scores improves provider score. PerformCare has generated the initial report and the report is awaiting approval to move forward. The six month rapid experimentation phase has not been fully implemented. 6. MSS will be resuming Member FU after discharge and ECM's will be responsible for completing their own Member follow up with assistance from AH CCM. A six month rapid experimentation phase will begin in April, 2015, ending in Oct 2015 to assess if this intervention improves the PerformCare (PC) HEDIS scores. Enhanced Care Management Follow-up activities continue. Six month rapid experimentation phase continues with this increased outreach. HEDIS scores continue to be monitored.
		Follow-up Status Response
Root Cause: Best Practice Discharge procedures are not completely being followed by many MH IP providers. This could lead to Member's lack of engagement in aftercare. There is a lack of family involvement, collaboration with MH OP/substance abuse providers at times. Providers are not identifying barriers and taking steps to resolve prior to discharge. **Action:** 1. Continue Quality Treatment Record review every three years based on the re-credentialing cycle. Providers with Quality Improvement Plans will be monitored every three months for improvements. 2. Perform Care is making	Ongoing 2014	***Initial Response*** *1.* Quality Treatment Record reviews are conducted every three years based on the re-credentialing cycle. The benchmark for performance is 80%. Any provider with scores below 80% is asked to complete a Quality Improvement Plan. Once the Quality Improvement Plan has been accepted, the provider will be monitored every three months for improvements. *2.* Preliminary outcomes reporting has been developed and implemented and is being operationalized

improvements to outcomes reporting specific to level of care and provider. The outcomes reports will give detailed information on Provider Performance. 3. Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex needs 4. Comprehensive Continuous Integrated System of Care (CCISC) Implementation has occurred in Bedford/Somerset and Franklin/Fulton Counties. 5. CCISC meetings and Change Agent Meetings/Trainings have occurred and are ongoing. 6. Pyramid Healthcare expansion 7. Discharge Management Educational Meetings 8. Franklin/Fulton Co-occurring competency credential	2014 2011 Ongoing 2015 July 2015 July-August 2015	through Quality Improvement/Utilization Management (QI/UM) Committee for monitoring so further interventions can be planned. The report is still being refined for the inpatient level of care. 3. Local Care Managers are continuing to expand their caseloads. Active Care Management strategies continue for PerformCare Clinical Care Managers through Enhanced Care Management (ECM) PerformCare achieved a 100% score on the NCQA accreditation survey. 4. The clinical department continues to utilize Member Monitoring to conduct Member outreach and follow-up to Members who do not meet the criteria for ECM. The goal of Member Monitoring is to increase Member stabilization within the community and for early intervention prior to a Member meeting the criteria for ECM. 5. CCISC meeting continue in the North Central Contracts. Change Agent Meetings continue in the North Central contracts. There was a Complex condition training completed on 2/20/14 in the Franklin/Fulton region, level of care specific treatment plan trainings are scheduled through 2015 and Motivational Interviewing trainings scheduled for April and June 2016. 6. Pyramid Healthcare expanded existing services within the FF contract to include a dually licensed Mental Health/Substance Abuse (MH/SA) OP Clinic. 7. PerformCare conducted meetings with all 4 hospitals selected for the Discharge Management Plan Audits in July and August of 2015 to review the results of the DMP audit, to review opportunities for improvement, and to review expectations. The DMP audit will be repeated to measure improvement and evaluate the effectiveness of this intervention. 8. This is a provider incentive program, in which MH OP providers must pass the COD audit with a score of 75% in all three rating areas in order to be certified for an enhanced rate. Additionally, the provider must agree to use the COD outcomes tool in order to qualify as well. Two out of 5 providers audited received a passing score and will get an enhanced rate. ***Follow-up Status Response***
Root Cause: Due to transportation issues and other factors, Members are not following up due to lack of clear discharge instructions and availability of accessible in-home services. **Action:**		***Initial Response***

1. Monitor utilization of BTM, FFT, IY, and PCIT (evidence-based programming). **2.** Consider implementation of MST and mobile –psych nursing in counties where the services are not available currently (BESO, Franklin/Fulton**)** **3.** Monitor utilization of ACT, MMHT, and MPN within the Capital region. **4.** A regional OP clinic added Mobile-Mental Health to their services in September 2014 in Franklin/Fulton Counties. **5.** Make MATP contact information readily available. **6.** Implement a Recovery Management Plan for Members who are discharged from Inpatient. **7.** Data analysis of UCBH Partial Hospitalization closure/PHP work group.	Ongoing monthly 2014/2015 2015 and Ongoing monthly 2014 Ongoing 2015 and Ongoing as needed August/Sept 2015, Ongoing as needed	*1.* Utilization is monitored monthly through QI/UM. Brief Treatment Model (BTM) utilization has increased, along with Functional Family Therapy (FFT). Parent Child Intensive Therapy (PCIT) had a slow start up in BESO with one provider with low utilization. An additional provider has been added in Somerset County and utilization has started to increase in 2015. Franklin/Fulton has two providers of PCIT and referrals have been slow for these providers as well. PerformCare anticipates the continued expansion of the PCIT which provides an evidence base practice alternative to more restrictive levels of care. The Incredible Years has not had a cohort for two years and this program is not currently running in Bedford/Somerset region. *2.* Exploration and implementation of alternative in-home services has been added to the fiscal year (FY) 2014/2015 service initiatives for BESO. Bedford/Somerset has selected MST and will be implementing this program in 2016. FF region continues to explore alternative options for in-home services for the adult population. *3.* Capital Counties continue to use Assertive Community Treatment (ACT) and Mobile Psychiatric Nurse (MPN) services for in-home services. *4.* A regional OP clinic added Mobile Mental Health to their services in 2014 in Franklin/Fulton Counties. *5.* Medical Assistance Transportation Program (MATP) information and contact numbers are available through the PerformCare Contact Center. *6.* Overall Intervention Description: In summary, PerformCare plans to create a Recovery Management Plan for all of our Members who are discharged from inpatient. This plan will assure that all those being discharged have means to successfully avoid recidivism. Built into the RMP is a trigger list that will identify those Members who should be referred to our Enhanced Care Management (ECM) program for more active care management, which can help overcome the barriers to successful transition. While this process is going on within our care management program, we will also do increased outreach to our hospitals on issues related to recidivism, especially increasing their medication reconciliation processes with Members through their inpatient stay, as well work to get more pharmacy options to our consumers who have difficulty getting their medications after discharge. *7.* Due to the closure of the UCBH Partial Hospitalization program in Franklin County, serving Franklin and Fulton Members, TMCA conducted a full analysis of utilization of the UCBH partial program including diagnosis, ALOS, and other factors. TMCA and PerformCare have had discussions with regional providers to determine if it has had a significant impact on services. No issues have been identified. TMCA developed a workgroup to identify gaps in services and develop a plan to address unmet needs due to the Partial closure.

		Follow-up Status Response
Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery. **Action**: 1. Provider trainings have been/ will be offered to support the recovery initiative, discharge planning.	Started 2013 and Ongoing	***Initial Response*** . 1. Provider Training: • Wellness Recovery Action Plan (WRAP) training and WRAP facilitator training series took place in Franklin/Fulton Counties June 5 and 6, 2014 and in September 2014. • A mental health recovery and WRAP 1 training was held on July 29, 2014 and August 5, 2014 for Bedford and Somerset providers. • A WRAP facilitators training took place August 18, 2014 – August 22, 2014 for Bedford and Somerset providers. • Proactive Counseling training was held on September 22, 2014 and September 23, 2014 for Bedford/Somerset providers. • There were WRAP facilitator training on 7/29/14 and 8/5/14, 3/23/15, 3/24/15, 6/15/15, and 6/19/15 in the Bedford/Somerset region. • There was a Community Data Roundtable meeting on the CANS on 9/9/2014in Bedford/Somerset region. • There was WRAP training on 2/17/2015 and 2/27/2015, 5/19/15, 5/26/15, 10/1/15, and 10/16/15 in the Bedford/Somerset region. • There was CANS certification training on 4/15/15 in the Bedford/Somerset region. • There as SA OP Treatment Record Review training on January 15 and January 16. 2015, a MH IP/EAC webinar on August 26, 2015, a TRR tool changes and updates webinar for 2016 on August 27, 2015, and MH OP Treatment Record Review webinar on August 28, 2015. • Capital Area training sessions included: ○ ICD-10 & DSM-5 on July 22, 2014 ○ EMDR General Overview on August 27, 2014 ○ EMDR General Overview on August 28, 2014 ○ CANS Algorithm training on January 29. 2015 ○ CANS training on April 15, 2015 ○ CANS Kickoff Training on June 8, 2015 • In Franklin/Fulton region, On April 17, 2015 there was training on Engaging individuals with COD throughout treatment. • A CCISC No Wrong Day Networking day was held on June 19, 2015 in the Franklin/Fulton region. The event was for all human service professionals to learn more about what services are available for individuals served within the Franklin/Fulton Community.

2. Educate Providers on pre-discharge planning meetings that involve Member and team input for after care plans to be in place prior to discharge (CABHC)	TBD	• Training was held on September 8, 2015, for treatment planning training for COD for community support providers in Franklin/Fulton region. • A training will be held on December 8, 2015 for SA providers on treatment plan training in the Franklin/Fulton Region • Training will be held March 8, 2016 for MH clinical service providers in the Franklin/Fulton region. • Motivational Interviewing parts 1 and 2 will be held for Franklin/Fulton providers on April 1, 2016 and April 29, 2016. • Motivational Interviewing Advanced Skill Building training will be held in Franklin/Fulton region on June 14, 2016. 2. The four Providers with lowest HEDIS scores will be identified and targeted for PC intervention. Identified PC parties will provide Provider outreach and education about discharge resources and barriers to discharge planning. A six month rapid experimentation of targeting providers and offering intervention will occur between 4/1/15-10/1/15 to see if this education improves the scores of Providers. As of now, the four providers have not been identified; this action step is on hold due to limited resources.
		Follow-up Status Response

Table 18: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years

<table>
<tr><td colspan="3"><u>Instructions</u>: For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.</td></tr>
<tr><td><u>Managed Care Organization (MCO):</u>
PerformCare (formerly Community Behavioral HealthCare Network of Pennsylvania, CBHNP)</td><td><u>Measure:</u>
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) Ages 6-64</td><td><u>Response Date:</u>
October 9, 2015</td></tr>
<tr><td colspan="3"><u>Goal Statement:</u> (Please specify individual goals for each measure):
Short-Term Goal: Increase QI 2 HEDIS 30-Day Performance to 74.25% (minimum performance goal plus 1%) by the end of 2015.
Long-Term Goal: Increase QI 2 HEDIS 30- Day Performance to 75.25% (2015 benchmark plus 1%) by the end of 2016.
Please see Attachment 1: 2014 Ambulatory Follow-up & Re-admission Fishbone.</td></tr>
<tr><td><u>Analysis</u>:
What factors contributed to poor performance?
Please enter "N/A" if a category of factors does not apply.</td><td colspan="2"><u>Findings</u>
PerformCare's rate for MY 2014 for QI 2 HEDIS 30-Day was 69.0%, an increase from PerformCare's rate for MY 2013 which was 65.5% (re-stated).
PerformCare's rate was 71.5% in MY 2012 and 69.9% in MY 2011 (inclusive of Blair and Lycoming/Clinton contracts).</td></tr>
<tr><td>Policies
(e.g., data systems, delivery systems, provider facilities)

1. Provider Network
2. HealthChoices Contract Specifications
3. HIPAA</td><td colspan="2">Initial Response
• While performing quality control of PerformCare's measurement year 2014 Follow-up rates PerformCare identified that numerator compliant codes were not being captured. This information was presented to the programmer responsible for preparing the outbound files.
• Research revealed that the SQL code was silent for 8 National Codes: 90832, 90833, 90834, 90836, 90837, 90838, 90839 and 90840. The SQL code was amended to contain these codes.
• Further research uncovered that the SQL code used to produce the measurement year 2013 outbound files was also silent for these National Codes.
• The measurement year 2013 code was reopened and amended to include the missing codes.
• This error manifested itself as an apparent significant drop in PerformCare's rates from MY 2012. This perceived "population problem" has further resulted in requests for barrier analyses, and a corrective action plan from one of our contracts.
• PerformCare is interested in full disclosure of this error and its associated impacts.
• Current Network of psychiatric service providers may impede follow up. There is a shortage of psychiatrists and the rural counties of Bedford, Fulton and Somerset have been issued a Professional Shortage Designation with the Department of Health. While tele-psychiatry has been developed throughout the network, opportunities to expand this resource should continue through Network Operations.
• Current practices at PerformCare including credentialing, fee scheduling, enhanced rates, policies and procedures do not directly impact follow up rates after MH IP discharge.
• If the Member refuses to sign a release to share information with the aftercare Provider, collaboration becomes difficult. Substance Abuse (SA) Providers face unique challenges related to more stringent regulations regarding release of Member information.
• Although reporting capabilities have improved through the development and expansion of an Informatics department, timely and efficient data handling to support the identification of trends and details related to ambulatory follow up is limited. Additional attention should be focused on improving the clinical documentation system (eCura®).
• Currently we are unable to rely on formal reporting to include details on race, correlations to readmissions, TCM involvement, and medication compliance.</td></tr>
</table>

	• Currently, data collection to support Provider Profiling is limited by the data stored within the clinical documentation system (eCura®); however, we were able to review provider-specific follow-up rates, average length of stay, and readmission rates. ***Root Cause: PerformCare does not consistently use available data for continuous quality improvement. There is a shortage of psychiatrists across the network.***
	Follow-up Status Response
Procedures (e.g., payment/reimbursement, credentialing/collaboration) 1. QI Auditing Process ***2.*** Discharge Management Planning Process	***Initial Response***
	• The treatment record review process for Mental Health Inpatient providers include a section related to adequate discharge planning and adherence to recovery principles. Results from 2014 reveal providers are still in need of education regarding discharge planning best practice. Indicators remaining below the 80% target appear below:

Discharge Summary:	2012	2013	2014
Is there a relapse prevention plan (post-discharge) that reflects what steps the Member should take if symptoms escalate which includes activities based on strengths. (must consist of phone numbers for all) A) natural supports, B) provider(s), and C) Crisis Intervention.)	0%	31%	44%
Is there documentation in the record that the PerformCare Member letter was offered to Member at time of discharge?	0%	11%	17%
Are the discharge instructions recovery-oriented (not medical model)? (include Member words, recovery principles, relapse management)	0%	32%	66%
Recovery Orientation (all sections)			
Is there evidence of person-centered language?	0%	26%	52%
Are member strengths incorporated into all areas of treatment (intake, treatment plans, recovery/crisis plans, groups)?	0%	8%	28%

• PerformCare conducted a structured audit of discharge management plans from inpatient facilities in four different hospitals. The hospitals were chosen because we were prompted by IPRO to identify four hospitals for the Successful Transitions to Ambulatory Care PIP, and we thus sought out hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our network. Then, to ensure that we were generating data relevant to contracts outside of the Capital Area, we chose large hospitals in two of our other contracts, Chambersburg Hospital for Franklin/Fulton counties, and Somerset Community Hospital for Bedford/Somerset. The DMP audit tool included an analysis on medication reconciliation. The findings were:

1. Only 17.3% of 120 reviewed charts in the four identified Providers, demonstrated correct medicine reconciliation.

	2. These scores are low, and as we see from the literature IPRO provides, low scores could be one of the profound negative impacts on our recidivist rates. Intervention here would be helpful, and could be tracked (Details below.) 3. PerformCare does not pay for injectable medication (J-codes) therefore we do not have claims data on this treatment. • The Successful Transition to Ambulatory Care Performance Improvement Plan revealed a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. ***Root Cause: Best Practice Discharge procedures are not completely being followed by many MH IP providers. This could lead to Member's lack of engagement in aftercare. Providers are not identifying barriers and taking steps to resolve prior to discharge.***
	Follow-up Status Response
People (e.g., personnel, provider network, patients) 1. Member 2. Quality Care Manager 3. Providers	***Initial Response***
	• The group discussed the importance of having clear discharge instructions, that the Member be present for arranging aftercare appointments that barriers are addressed, and the times/dates are convenient for the Member. • The Franklin/Fulton MH IP Readmission Work Group completed a full analysis of adult Members who had a readmission episode in SFY 2012 and 2013 in order to determine if any commonalities/trends existed within the population and to identify possible barriers to aftercare treatment. This analysis showed that although the majority of Members with a readmission episode had a subsequent follow-up appointment within 7 days; however, readmission episodes still occurred. • There appears to be a lack of provider education on how to engage the Member into treatment by motivating the Member while on the MH IP unit. Some providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way. • There appears to be a lack of Member understanding of Recovery principles, treatment options and necessity of follow up to avoid relapse. • The Successful Transition to Ambulatory Follow up Performance Improvement Plan process revealed an underutilization of community based recovery services, a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there was a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay. There is a lack of active discharge planning. There are insufficient protocols by the providers on the needs and time frames for medication reconciliation, engagement in recovery services, and successful scheduling of follow up visits. • Fractured discharge/transition programs – as IPRO's literature review notes, a clinically sound discharge/transition program is essential for successful transitions to ambulatory care. In our analysis, we have found that the bridge programs in our network are lacking in the following areas: Communication & follow-through deficits through the inpatient and transition processes i. Within PerformCare – there is no one, central document where a discharge management plan of a consumer is developed and tracked over time. While every client has a chart in PerformCare's EMR (eCura®), each event is distinct. While the notes can be looked at back and forth, one central Recovery Management Plan (RMP) document located in PerformCare's EMR that is developed over time would allow us to better manage the communication within our organization (and without, as we discuss below) in regards to cases transitioning to ambulatory care. ii. Beyond PerformCare – if communication within PerformCare is fractured, amongst different entities (case management firms, the hospital, psychiatric outpatient Providers, etc.) working with one Member is even more

	fractured. For instance, through the focus groups we learned that it is not uncommon for a treatment team meeting to come to a conclusion on a Member's discharge, which is then not communicated to the case manager leading the discharge (because of shift changes in the hospital, different case managers come in and out, and communication can be porous). Thus, a centralized RMP that is built with all relevant parties while a Member is in the hospital and that PerformCare can then use to track the client's progress through his/her inpatient stay and beyond, and prompt all Providers to adhere to, would significantly improve communication. ***Root Cause:*** ***1) Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.*** ***2) Due to limited transportation options, scheduling, inadequate discharge instructions and availability of accessible in-home services, follow up has been at a less than desired rate.***
	Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) 1. Provider Education 2.. Enrollee Education	***Initial Response***
	• There appears to be a lack of provider education on how to engage the Member into treatment by motivating the Member while on the MH IP unit. Some providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way. • There appears to be a lack of Member understanding of Recovery principles, treatment options and necessity of follow up to avoid relapse. • The Successful Transition to Ambulatory Follow up Performance Improvement Plan process revealed underutilization of community based recovery services**,** a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there is a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay. ***Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.***
	Follow-up Status Response
Other (specify) ***N/A***	***Initial Response***
	Follow-up Status Response

<u>Measure:</u> *Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)Ages 6-64*

For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014. Documentation of actions should be continued on additional pages as needed.

Action Include those planned as well as already implemented.	***<u>Implementation Date</u>*** Indicate start date (month, year)	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.

	duration and frequency (e.g., Ongoing, Quarterly)	
Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system. There is a shortage of psychiatrists across the network.		***Initial Response***
1. Existing Crisis Bridge Programs will be monitored and promoted so utilization may increase.	Ongoing	*1.* BHSSBC and PerformCare will continue to meet with Cornerstone and Somerset Hospital to evaluate the Crisis Bridge Program. Data is presented by PerformCare and Somerset Hospital at these meetings which occur every 6 months. In the fall of 2014, as result of the presentation of data and the above discussions, the Bedford/Somerset model was adjusted so that participation shifted from an Option-In approach to an Option-Out approach.
2. Expand tele-psychiatry and psychiatric services across the network.	Start 2014 Ongoing	*2.* The total number of tele-psychiatry providers increased in 2014 and 2015 and will be monitored through various meetings. Access to psychiatry will be monitored monthly through QI/UM. Bedford/Somerset expanded to two new providers in 2015. Franklin/Fulton Counties added 4 additional providers of Telepsychiatry to the network in 2013 and 2014 and an additional provider was added in 2015.Discussions with additional providers will occur as interest increases. Family Behavioral Resources opened three OP clinics, one in Franklin County, one in Fulton County, and one in Somerset County in 2015. Pyramid Healthcare opened an additional OP clinic in Franklin County (dually licensed) in 2015. CQI folder has a spreadsheet for telepsychiatry and current providers The Capital region added three telepsychiatry providers since in FY 2014/2015. Fourteen new psychiatrists were added to the Capital network during the same time period.
3. Work with providers to brainstorm ideas related to bringing more psychiatrists to rural areas through the Professional Shortage Designation. [Bedford/Somerset (BESO) and Franklin/Fulton (FF) Counties].	Fall 2014	*3.* A partnership between TrueNorth Wellness and the Federally Qualified Health Center (FQHC) located in Fulton County is being expanded which will target an increase in Member knowledge regarding MH services available. One provider became an accepted site in Bedford and Somerset Counties and one is waiting to hear if they have been accepted.
4. Create and Distribute survey to individuals that have been readmitted within 30 days to gather information related to	2014	*4.* The survey is an intervention developed for the Readmission Performance Improvement Project and will be monitored through that process quarterly Franklin and Fulton Counties are moving forward with survey development and will be conducting the survey as planned in 2015.
	2015	*5.* A report identifying Provider HEDIS scores will be developed. Starting in April, 2015 this report will be sent to

discharge process and planning and available supports within the community. 5. Engage inpatient facilities in follow up (CABHC CAP). 6. Add enhancement to follow up resources	April 1, 2015	providers during a six month rapid experimentation phase to see if receiving information related to HEDIS scores improves provider score. PerformCare has generated the initial report and the report is awaiting approval to move forward. The six month rapid experimentation phase has not been fully implemented. *6.* MSS will be resuming Member FU after discharge and ECM's will be responsible for completing their own Member follow up with assistance from AH CCM. A six month rapid experimentation phase will begin in April, 2015, ending in Oct 2015 to assess if this intervention improves the PerformCare (PC) HEDIS scores. Enhanced Care Management Follow-up activities continue. Six month rapid experimentation phase continues with this increased outreach. HEDIS scores continue to be monitored.
		Follow-up Status Response
Root Cause: Best Practice Discharge procedures are not completely being followed by many MH IP providers. This could lead to Member's lack of engagement in aftercare. There is a lack of family involvement, collaboration with MH OP/substance abuse providers at times. Providers are not identifying barriers and taking steps to resolve prior to discharge. **Action:** 1. Continue Quality Treatment Record review every three years based on the re-credentialing cycle. Providers with Quality Improvement Plans will be monitored every three months for improvements. 2. Perform Care is making improvements to outcomes reporting specific to level of care and provider. The outcomes reports will give detailed information on Provider Performance.	Ongoing 2014 2014 2011	***Initial Response*** 1. Quality Treatment Record reviews are conducted every three years based on the re-credentialing cycle. The benchmark for performance is 80%. Any provider with scores below 80% is asked to complete a Quality Improvement Plan. Once the Quality Improvement Plan has been accepted, the provider will be monitored every three months for improvements. 2. Preliminary outcomes reporting has been developed and implemented and is being operationalized through Quality Improvement/Utilization Management (QI/UM) Committee for monitoring so further interventions can be planned. The report is still being refined for the inpatient level of care. 3. Local Care Managers are continuing to expand their caseloads. Active Care Management strategies continue for PerformCare Clinical Care Managers through Enhanced Care Management (ECM) PerformCare achieved a 100% score on the NCQA accreditation survey.

3. Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex needs 4. Comprehensive Continuous Integrated System of Care (CCISC) Implementation has occurred in Bedford/Somerset and Franklin/Fulton Counties. 5. CCISC meetings and Change Agent Meetings/Trainings have occurred and are ongoing. 6. Pyramid Healthcare expansion 7. Discharge Management Educational Meetings 8. Franklin/Fulton Co-occurring competency credential.	Ongoing 2015 July 2015 July/August 2015	4. The clinical department continues to utilize Member Monitoring to conduct Member outreach and follow-up to Members who do not meet the criteria for ECM. The goal of Member Monitoring is to increase Member stabilization within the community and for early intervention prior to a Member meeting the criteria for ECM. 5. CCISC meeting continue in the North Central Contracts. Change Agent Meetings continue in the North Central contracts. There was a Complex condition training completed on 2/20/14 in the Franklin/Fulton region, level of care specific treatment plan trainings are scheduled through 2015 and Motivational Interviewing trainings scheduled for April and June 2016. 6. Pyramid Healthcare expanded existing services within the FF contract to include a dually licensed Mental Health/Substance Abuse (MH/SA) OP Clinic. 7. PerformCare conducted meetings with all 4 hospitals selected for the Discharge Management Plan Audits in July and August of 2015 to review the results of the DMP audit, to review opportunities for improvement, and to review expectations. The DMP audit will be repeated to measure improvement and evaluate the effectiveness of this intervention. 8. This is a provider incentive program, in which MH OP providers must pass the COD audit with a score of 75% in all three rating areas in order to be certified for an enhanced rate. Additionally, the provider must agree to use the COD outcomes tool in order to qualify as well. Two out of 5 providers audited received a passing score and will get an enhanced rate. ***Follow-up Status Response***
Root Cause: Due to transportation issues and other factors, Members are not following up due to lack of clear discharge instructions and availability of accessible in-home services. **Action:**	Ongoing monthly	***Initial Response*** *1.* Utilization is monitored monthly through QI/UM. Brief Treatment Model (BTM) utilization has increased, along with Functional Family Therapy (FFT). Parent Child Intensive Therapy (PCIT) had a slow start up in BESO with one

<table>
<tr><td>1. Monitor utilization of BTM, FFT, IY, and PCIT (evidence-based programming).</td><td></td><td>provider with low utilization. An additional provider has been added in Somerset County and utilization has started to increase in 2015. Franklin/Fulton has two providers of PCIT and referrals have been slow for these providers as well. PerformCare anticipates the continued expansion of the PCIT which provides an evidence base practice alternative to more restrictive levels of care. The Incredible Years has not had a cohort for two years and this program is not currently running in Bedford/Somerset region.</td></tr>
<tr><td>2. Consider implementation of MST and mobile –psych nursing in counties where the services are not available currently (BESO, Franklin/Fulton)</td><td>2014/2015</td><td>2. Exploration and implementation of alternative in-home services has been added to the fiscal year (FY) 2014/2015 service initiatives for BESO. Bedford/Somerset has selected MST and will be implementing this program in 2016. FF region continues to explore alternative options for in-home services for the adult population.</td></tr>
<tr><td>3. Monitor utilization of ACT and MPN within the Capital region.</td><td>2015 and Ongoing monthly</td><td>3. Capital Counties continue to use Assertive Community Treatment (ACT) and Mobile Psychiatric Nurse (MPN) services for in-home services.</td></tr>
<tr><td>4. A regional OP clinic added Mobile-Mental Health to their services in September 2014 in Franklin/Fulton Counties.</td><td>2014</td><td>4. A regional OP clinic added Mobile Mental Health to their services in 2014 in Franklin/Fulton Counties.</td></tr>
<tr><td>5. Make MATP contact information readily available.</td><td>Ongoing</td><td>5. Medical Assistance Transportation Program (MATP) information and contact numbers are available through the PerformCare Contact Center.</td></tr>
<tr><td>6. Implement a Recovery Management Plan for Members who are discharged from Inpatient.</td><td>2015 and Ongoing as needed</td><td>6. Overall Intervention Description: In summary, PerformCare plans to create a Recovery Management Plan for all of our Members who are discharged from inpatient. This plan will assure that all those being discharged have means to successfully avoid recidivism. Built into the RMP is a trigger list that will identify those Members who should be referred to our Enhanced Care Management (ECM) program for more active care management, which can help overcome the barriers to successful transition. While this process is going on within our care management program, we will also do increased outreach to our hospitals on issues related to recidivism, especially increasing their medication reconciliation processes with Members through their inpatient stay, as well work to get more pharmacy options to our consumers who have difficulty getting their medications after discharge.</td></tr>
<tr><td>7. Data analysis of UCBH Partial Hospitalization closure/PHP work group.</td><td>August/Sept 2015, Ongoing as needed</td><td>7. Due to the closure of the UCBH Partial Hospitalization program in Franklin County, serving Franklin and Fulton Members, TMCA conducted a full analysis of utilization of the UCBH partial program including diagnosis, ALOS, and other factors. TMCA and PerformCare have had discussions with regional providers to determine if it has had a significant impact on services. No issues have been identified. TMCA developed a workgroup to identify gaps in services and develop a plan to address unmet needs due to the Partial closure.</td></tr>
<tr><td></td><td></td><td>Follow-up Status Response</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

Table 19: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)

<table>
<tr><td colspan="3"><u>Instructions</u>: For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure</td></tr>
<tr><td><u>Managed Care Organization (MCO):</u>
PerformCare (formerly Community Behavioral HealthCare Network of Pennsylvania, CBHNP)</td><td><u>Measure:</u>
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)</td><td><u>Response Date:</u>
October 9, 2015</td></tr>
<tr><td colspan="3"><u>Goal Statement:</u> (Please specify individual goals for each measure):
Short-Term Goal: Increase QI A PA-Specific 7-Day Performance to 59.5% (minimum performance goal plus 1%) by the end of 2015.
Long-Term Goal: Increase QI A PA-Specific 7-Day Performance to 60.5% (2015 benchmark plus 1%) by the end of 2016.
Please see Attachment 1: 2014 Ambulatory Follow-up & Re-admission Fishbone.</td></tr>
<tr><td><u>Analysis</u>:
What factors contributed to poor performance?
Please enter "N/A" if a category of factors does not apply.</td><td colspan="2"><u>Findings</u>
PerformCare's rate for MY 2014 for QI A PA-Specific 7-Day was 56.9%, an increase from MY 2013 which was 53.2 %(restated). PerformCare's rate was 59.4% in MY 2012 and 57.4% in MY 2011 (inclusive of Blair and Lycoming/Clinton contracts).</td></tr>
<tr><td>Policies
(e.g., data systems, delivery systems, provider facilities)

1. Provider Network
2. HealthChoices Contract Specifications
3. HIPAA</td><td colspan="2">Initial Response
While performing quality control of PerformCare's measurement year 2014 Follow-up rates PerformCare identified that numerator compliant codes were not being captured. This information was presented to the programmer responsible for preparing the outbound files.
Research revealed that the SQL code was silent for 8 National Codes: 90832, 90833, 90834, 90836, 90837, 90838, 90839 and 90840. The SQL code was amended to contain these codes.
Further research uncovered that the SQL code used to produce the measurement year 2013 outbound files was also silent for these National Codes.
The measurement year 2013 code was reopened and amended to include the missing codes.
This error manifested itself as an apparent significant drop in PerformCare's rates from MY 2012. This perceived "population problem" has further resulted in requests for barrier analyses, and a corrective action plan from one of our contracts.
PerformCare is interested in full disclosure of this error and its associated impacts.
Current Network of psychiatric service providers may impede follow up. There is a shortage of psychiatrists and the rural counties of Bedford, Fulton and Somerset have been issued a Professional Shortage Designation with the Department of Health. While tele-psychiatry has been developed throughout the network, opportunities to expand this resource should continue through Network Operations.
Current practices at Performcare including credentialing, fee scheduling, enhanced rates, policies and procedures do not directly impact follow up rates after MH IP discharge.
If the Member refuses to sign a release to share information with the aftercare Provider, collaboration becomes difficult. Substance Abuse (SA) Providers face unique challenges related to more stringent regulations regarding release of Member information.
Although reporting capabilities have improved through the development and expansion of an Informatics department, timely and efficient data handling to support the identification of trends and details related to ambulatory follow up is limited. Additional attention should be focused on improving the clinical documentation system (eCura®).
Currently we are unable to rely on formal reporting to include details on race, correlations to readmissions, TCM involvement, and medication compliance.</td></tr>
</table>

- Currently, data collection to support Provider Profiling is limited by the data stored within the clinical documentation system (eCura®); however, we were able to review provider-specific follow-up rates, average length of stay, and readmission rates.

Root Cause: PerformCare does not consistently use available data for continuous quality improvement. There is a shortage of psychiatrists across the network.

Follow-up Status Response

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

1. Quality Improvement (QI) Auditing Process
2. Discharge Management Planning Process

Initial Response

The treatment record review process for Mental Health Inpatient providers include a section related to adequate discharge planning and adherence to recovery principles. Results from 2014 reveal providers are still in need of education regarding discharge planning best practice. Indicators remaining below the 80% target appear below:

Discharge Summary:	2012	2013	2014
Is there a relapse prevention plan (post-discharge) that reflects what steps the Member should take if symptoms escalate which includes activities based on strengths. (must consist of phone numbers for all) A) natural supports, B) provider(s), and C) Crisis Intervention.)	0%	31%	44%
Is there documentation in the record that the PerformCare Member letter was offered to Member at time of discharge?	0%	11%	17%
Are the discharge instructions recovery-oriented (not medical model)? (include Member words, recovery principles, relapse management)	0%	32%	66%
Recovery Orientation (all sections)			
Is there evidence of person-centered language?	0%	26%	52%
Are member strengths incorporated into all areas of treatment (intake, treatment plans, recovery/crisis plans, groups)?	0%	8%	28%

- PerformCare conducted a structured audit of discharge management plans from inpatient facilities in four different hospitals. The hospitals were chosen because we were prompted by IPRO to identify four hospitals for the Successful Transitions to Ambulatory Care PIP, and we thus sought out hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our network. Then, to ensure that we were generating data relevant to contracts outside of the Capital Area, we chose large hospitals in two of our other contracts, Chambersburg Hospital for Franklin/Fulton counties, and Somerset Community Hospital for Bedford/Somerset. The DMP audit tool included an analysis on medication reconciliation. The findings were:
  a. Only 17.3% of 120 reviewed charts in the four identified Providers, demonstrated correct medicine reconciliation.
  b. These scores are low, and as we see from the literature IPRO provides, low scores could be one of the profound

	negative impacts on our recidivist rates. Intervention here would be helpful, and could be tracked (Details below.) c. PerformCare does not pay for injectable medication (J-codes) therefore we do not have claims data on this treatment. • The Successful Transition to Ambulatory Care Performance Improvement Plan revealed a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. ***Root Cause: Best Practice Discharge procedures are not completely being followed by many MH IP providers. This could lead to Member's lack of engagement in aftercare. Providers are not identifying barriers and taking steps to resolve prior to discharge.***
	Follow-up Status Response
People (e.g., personnel, provider network, patients) ***1.*** Member ***2.*** Quality Care Managers ***3.*** Providers	***Initial Response*** • The group discussed the importance of having clear discharge instructions, that the Member be present for arranging aftercare appointments that barriers are addressed, and the times/dates are convenient for the Member. • The Franklin/Fulton MH IP Readmission Work Group completed a full analysis of adult Members who had a readmission episode in SFY 2012 and 2013 in order to determine if any commonalities/trends existed within the population and to identify possible barriers to aftercare treatment. This analysis showed that although the majority of Members with a readmission episode had a subsequent follow-up appointment within 7 days; however, readmission episodes still occurred. • There appears to be a lack of provider education on how to engage the Member into treatment by motivating the Member while on the MH IP unit. Some providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way. • There appears to be a lack of Member understanding of Recovery principles, treatment options and necessity of follow up to avoid relapse. • The Successful Transition to Ambulatory Follow up Performance Improvement Plan process revealed an underutilization of community based recovery services, a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there was a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay. There is a lack of active discharge planning. There are insufficient protocols by the providers on the needs and time frames for medication reconciliation, engagement in recovery services, and successful scheduling of follow up visits. • Fractured discharge/transition programs – as IPRO's literature review notes, a clinically sound discharge/transition program is essential for successful transitions to ambulatory care. In our analysis, we have found that the bridge programs in our network are lacking in the following areas: Communication & follow-through deficits through the inpatient and transition processes iii. Within PerformCare – there is no one, central document where a discharge management plan of a consumer is developed and tracked over time. While every client has a chart in PerformCare's EMR (eCura®), each event is distinct. While the notes can be looked at back and forth, one central Recovery Management Plan (RMP) document located in PerformCare's EMR that is developed over time would allow us to better manage the communication within our organization (and without, as we discuss below) in regards to cases transitioning to ambulatory care. iv. Beyond PerformCare – if communication within PerformCare is fractured, amongst different entities (case

	management firms, the hospital, psychiatric outpatient Providers, etc.) working with one Member is even more fractured. For instance, through the focus groups we learned that it is not uncommon for a treatment team meeting to come to a conclusion on a Member's discharge, which is then not communicated to the case manager leading the discharge (because of shift changes in the hospital, different case managers come in and out, and communication can be porous). Thus, a centralized RMP that is built with all relevant parties while a Member is in the hospital and that PerformCare can then use to track the client's progress through his/her inpatient stay and beyond, and prompt all Providers to adhere to, would significantly improve communication. ***Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.*** ***Root Cause: Due to limited transportation options, scheduling, inadequate discharge instructions and availability of accessible in-home services, follow up has been at a less than desired rate.***
	Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) ***1.*** Provider Education ***2.*** Enrollee Education	***Initial Response***
	• There appears to be a lack of provider education on how to engage the Member into treatment by motivating the Member while on the MH IP unit. Some providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way. • There appears to be a lack of Member understanding of Recovery principles, treatment options and necessity of follow up to avoid relapse. • The Successful Transition to Ambulatory Follow up Performance Improvement Plan process revealed underutilization of community based recovery services, a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there is a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay. ***Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.***
	Follow-up Status Response
Other (specify) ***N/A***	***Initial Response***
	Follow-up Status Response

Measure: *Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)*

For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014. 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	Monitoring Plan How will you know if this action is working? What will you measure and how often?

	(month, year) duration and frequency (e.g., Ongoing, Quarterly)	Include what measurements will be used, as applicable.
Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system. There is a shortage of psychiatrists across the network.		***Initial Response***
Action: 1. Existing Crisis Bridge Programs will be monitored and promoted so utilization may increase.	Ongoing	1. BHSSBC and PerformCare will continue to meet with Cornerstone and Somerset Hospital to evaluate the Crisis Bridge Program. Data is presented by PerformCare and Somerset Hospital at these meetings which occur every 6 months. In the fall of 2014, as result of the presentation of data and the above discussions, the Bedford/Somerset model was adjusted so that participation shifted from an Option-In approach to an Option-Out approach.
2. Expand tele-psychiatry and psychiatric services across the network.	Start 2014 Ongoing	2. The total number of tele-psychiatry providers increased in 2014 and 2015 and will be monitored through various meetings. Access to psychiatry will be monitored monthly through QI/UM. Bedford/Somerset expanded to two new providers in 2015. Franklin/Fulton Counties added 4 additional providers of Telepsychiatry to the network in 2013 and 2014 and an additional provider was added in 2015.Discussions with additional providers will occur as interest increases. Family Behavioral Resources opened three OP clinics, one in Franklin County, one in Fulton County, and one in Somerset County in 2015. Pyramid Healthcare opened an additional OP clinic in Franklin County (dually licensed) in 2015. CQI folder has a spreadsheet for telepsychiatry and current providers The Capital region added three telepsychiatry providers since in FY 2014/2015. Fourteen new psychiatrists were added to the Capital network during the same time period.
3. Work with providers to brainstorm ideas related to bringing more psychiatrists to rural areas through the Professional Shortage Designation. [Bedford/Somerset (BESO) and Franklin/Fulton (FF) Counties]	Fall 2014	3. A partnership between TrueNorth Wellness and the Federally Qualified Health Center (FQHC) located in Fulton County is being expanded which will target an increase in Member knowledge regarding MH services available. One provider became an accepted site in Bedford and Somerset Counties and one is waiting to hear if they have been accepted.
4. Create and Distribute survey to individuals that have been readmitted within 30 days to gather information related to discharge process and planning and available supports within the community.	2015	4. The survey is an intervention developed for the Readmission Performance Improvement Project and will be monitored through that process quarterly Franklin and Fulton Counties are moving forward with survey development and will be conducting the survey as planned in 2015.
5. Engage inpatient facilities in follow up (CABHC CAP) 6. Add enhancement to follow up resources	April 1, 2015	5. A report identifying Provider HEDIS scores will be developed. Starting in April, 2015 this report will be sent to providers during a six month rapid experimentation phase to see if receiving information related to HEDIS scores improves provider score. PerformCare has generated the initial report and the report is awaiting approval to move forward. The six month rapid experimentation phase has not been fully implemented

	3/15/2015	6. MSS will be resuming Member FU after discharge and ECM's will be responsible for completing their own Member follow up with assistance from AH CCM. A six month rapid experimentation phase will begin in April, 2015, ending in Oct 2015 to assess if this intervention improves the PerformCare (PC) HEDIS scores. Enhanced Care Management Follow-up activities continue. Six month rapid experimentation phase continues with this increased outreach. HEDIS scores continue to be monitored
		Follow-up Status Response
Root Cause: Best Practice Discharge procedures are not completely being followed by many MH IP providers. This could lead to Member's lack of engagement in aftercare. There is a lack of family involvement, collaboration with MH OP/substance abuse providers at times. Providers are not identifying barriers and taking steps to resolve prior to discharge.		***Initial Response***
Action: 1. Continue Quality Treatment Record review every three years based on the re-credentialing cycle. Providers with Quality Improvement Plans will be monitored every three months for improvements.	Ongoing	1. Quality Treatment Record reviews are conducted every three years based on the re-credentialing cycle. The benchmark for performance is 80%. Any provider with scores below 80% is asked to complete a Quality Improvement Plan. Once the Quality Improvement Plan has been accepted, the provider will be monitored every three months for improvements.
	2014	2. Preliminary outcomes reporting has been developed and implemented and is being operationalized through Quality Improvement/Utilization Management (QI/UM) Committee for monitoring so further interventions can be planned. The report is still being refined for the inpatient level of care.
	2014	3. Local Care Managers are continuing to expand their caseloads. Active Care Management strategies continue for PerformCare Clinical Care Managers through Enhanced Care Management (ECM) PerformCare achieved a 100% score on the NCQA accreditation survey.
2. Perform Care is making improvements to outcomes reporting specific to level of care and provider. The outcomes reports will give detailed information on Provider Performance.	2011	4. The clinical department continues to utilize Member Monitoring to conduct Member outreach and follow-up to Members who do not meet the criteria for ECM. The goal of Member Monitoring is to increase Member stabilization within the community and for early intervention prior to a Member meeting the criteria for ECM.
3. Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex needs	Ongoing	5. CCISC meeting continue in the North Central Contracts. Change Agent Meetings continue in the North Central contracts. There was a Complex condition training completed on 2/20/14 in the Franklin/Fulton region, level of care specific treatment plan trainings are scheduled through 2015 and Motivational Interviewing trainings scheduled for April and June 2016.
4. Comprehensive Continuous	2015	6. Pyramid Healthcare expanded existing services within the FF contract to include a dually licensed Mental Health/Substance Abuse (MH/SA) OP Clinic.

Integrated System of Care (CCISC) Implementation has occurred in Bedford/Somerset and Franklin/Fulton Counties. 5. CCISC meetings and Change Agent Meetings/Trainings have occurred and are ongoing. 6. Pyramid Healthcare expansion 7. Discharge Management Educational Meetings 8. Franklin/Fulton Co-occurring competency credential	2014 July-August 2015	7. PerformCare conducted meetings with all 4 hospitals selected for the Discharge Management Plan Audits in July and August of 2015 to review the results of the DMP audit, to review opportunities for improvement, and to review expectations. The DMP audit will be repeated to measure improvement and evaluate the effectiveness of this intervention. 8. This is a provider incentive program, in which MH OP providers must pass the COD audit with a score of 75% in all three rating areas in order to be certified for an enhanced rate. Additionally, the provider must agree to use the COD outcomes tool in order to qualify as well. Two out of 5 providers audited received a passing score and will get an enhanced rate. ***Follow-up Status Response***
Root Cause: Due to transportation issues and other factors, Members are not following up due to lack of clear discharge instructions and availability of accessible in-home services. **Action:** 1. Monitor utilization of BTM, FFT, IY, and PCIT (evidence-based programming). 2. Consider implementation of MST and mobile –psych nursing in counties where the services are not available currently (BESO, Franklin/Fulton**)** 3. Monitor utilization of ACT, MMHT, and MPN within the Capital region. 4. A regional OP clinic added Mobile-Mental Health to their services in September 2014 in Franklin/Fulton Counties. 5. Make MATP contact information	Ongoing monthly 2014/2015 2015 and Ongoing monthly 2014 Ongoing	***Initial Response*** 1. Utilization is monitored monthly through QI/UM. BTM utilization has increased, along with Functional Family Therapy (FFT). Parent Child Intensive Therapy (PCIT) had a slow start up in BESO with one provider with low utilization. An additional provider has been added in Somerset County and utilization has started to increase in 2015. Franklin/Fulton has two providers of PCIT and referrals have been slow for these providers as well. The Incredible Years has not had a cohort for two years and this program is not currently running in Bedford/Somerset region. 2. Exploration and implementation of alternative in-home services has been added to the fiscal year (FY) 2014/2015 service initiatives for BESO. Bedford/Somerset has selected MST and will be implementing this program in 2016. FF region continues to explore alternative options for in-home services for the adult population. 3. Capital Counties continue to use Assertive Community Treatment (ACT), Mobile Mental Health Team (MMHT) and Mobile Psychiatric Nurse (MPN) services for in-home services 4. A regional OP clinic added Mobile Mental Health to their services in 2014 in Franklin/Fulton Counties. *5.* Medical Assistance Transportation Program (MATP) information and contact numbers are available through the PerformCare Contact Center

readily available. 6. Implement a Recovery Management Plan for Members who are discharged from Inpatient. ***7.*** Data analysis of UCBH Partial Hospitalization closure/PHP work group	2015, Ongoing as needed August/Sept 2015, Ongoing as needed	*6.* Overall Intervention Description: In summary, PerformCare plans to create a Recovery Management Plan for all of our Members who are discharged from inpatient. This plan will assure that all those being discharged have means to successfully avoid recidivism. Built into the RMP is a trigger list that will identify those Members who should be referred to our Enhanced Care Management (ECM) program for more active care management, which can help overcome the barriers to successful transition. While this process is going on within our care management program, we will also do increased outreach to our hospitals on issues related to recidivism, especially increasing their medication reconciliation processes with Members through their inpatient stay, as well work to get more pharmacy options to our consumers who have difficulty getting their medications after discharge *7.* Due to the closure of the UCBH Partial Hospitalization program in Franklin County, serving Franklin and Fulton Members, TMCA conducted a full analysis of utilization of the UCBH partial program including diagnosis, ALOS, and other factors. TMCA and PerformCare have had discussions with regional providers to determine if it has had a significant impact on services. No issues have been identified. TMCA developed a workgroup to identify gaps in services and develop a plan to address unmet needs due to the Partial closure.
		Follow-up Status Response

Table 20: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)

<table>
<tr><td colspan="3"><u>Instructions</u>: For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.</td></tr>
<tr><td><u>Managed Care Organization (MCO):</u>
PerformCare (formerly Community Behavioral HealthCare Network of Pennsylvania, CBHNP)</td><td><u>Measure:</u>
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)</td><td><u>Response Date:</u>
October 9, 2015</td></tr>
<tr><td colspan="3"><u>Goal Statement:</u> (Please specify individual goals for each measure):
Short-Term Goal: Increase QI B PA-Specific 30-Day Performance to 78.0% (MY 2012 rate) by the end of 2015.
Long-Term Goal: Increase QI B PA-Specific 30-Day Performance to 80.0% (2015 goal plus 2%) by the end of 2016.
Please see Attachment 1: 2014 Ambulatory Follow-up & Re-admission Fishbone.</td></tr>
<tr><td><u>Analysis</u>:
What factors contributed to poor performance?
Please enter "N/A" if a category of factors does not apply.</td><td colspan="2"><u>Findings</u>
Perform Care's rate for MY 2014 for QI B PA-Specific 30-Day was 76.4%, an increase from MY 2013 which was 72.6 %(restated). Perform Care's rate was 78.0% in MY 2012 and 76.7% in MY 2011 (inclusive of Blair and Lycoming/Clinton contracts).</td></tr>
<tr><td>Policies
(e.g., data systems, delivery systems, provider facilities)

1. Provider Network
2. HC Contract Specifications
3. HIPAA</td><td colspan="2">Initial Response
• While performing quality control of PerformCare's measurement year 2014 Follow-up rates PerformCare identified that numerator compliant codes were not being captured. This information was presented to the programmer responsible for preparing the outbound files.
• Research revealed that the SQL code was silent for 8 National Codes: 90832, 90833, 90834, 90836, 90837, 90838, 90839 and 90840. The SQL code was amended to contain these codes.
• Further research uncovered that the SQL code used to produce the measurement year 2013 outbound files was also silent for these National Codes.
• The measurement year 2013 code was reopened and amended to include the missing codes.
• This error manifested itself as an apparent significant drop in PerformCare's rates from MY 2012. This perceived "population problem" has further resulted in requests for barrier analyses, and a corrective action plan from one of our contracts.
• PerformCare is interested in full disclosure of this error and its associated impacts.
• Current Network of psychiatric service providers may impede follow up. There is a shortage of psychiatrists and the rural counties of Bedford, Fulton and Somerset have been issued a Professional Shortage Designation with the Department of Health. While tele-psychiatry has been developed throughout the network, opportunities to expand this resource should continue through Network Operations.
• Current practices at PerformCare including credentialing, fee scheduling, enhanced rates, policies and procedures do not directly impact follow up rates after MH IP discharge.
• If the Member refuses to sign a release to share information with the aftercare Provider, collaboration becomes difficult. Substance Abuse (SA) Providers face unique challenges related to more stringent regulations regarding release of Member information.
• Although reporting capabilities have improved through the development and expansion of an Informatics department, timely and efficient data handling to support the identification of trends and details related to ambulatory follow up is limited. Additional attention should be focused on improving the clinical documentation system (eCura®).
• Currently we are unable to rely on formal reporting to include details on race, correlations to readmissions, TCM involvement, and medication compliance.</td></tr>
</table>

	• Currently, data collection to support Provider Profiling is limited by the data stored within the clinical documentation system (eCura®); however, we were able to review provider-specific follow-up rates, average length of stay, and readmission rates. • ***Root Cause: PerformCare does not consistently use available data for continuous quality improvement. There is a shortage of psychiatrists across the network.***
	Follow-up Status Response
Procedures (e.g., payment/reimbursement, credentialing/collaboration) 1. QI Auditing Process 2. Discharge Management Planning Process	***Initial Response***

- The treatment record review process for Mental Health Inpatient providers include a section related to adequate discharge planning and adherence to recovery principles. Results from 2014 reveal providers are still in need of education regarding discharge planning best practice. Indicators remaining below the 80% target appear below:

Discharge Summary:	2012	2013	2014
Is there a relapse prevention plan (post-discharge) that reflects what steps the Member should take if symptoms escalate which includes activities based on strengths. (must consist of phone numbers for all) A) natural supports, B) provider(s), and C) Crisis Intervention.)	0%	31%	44%
Is there documentation in the record that the PerformCare Member letter was offered to Member at time of discharge?	0%	11%	17%
Are the discharge instructions recovery-oriented (not medical model)? (include Member words, recovery principles, relapse management)	0%	32%	66%
Recovery Orientation (all sections)			
Is there evidence of person-centered language?	0%	26%	52%
Are member strengths incorporated into all areas of treatment (intake, treatment plans, recovery/crisis plans, groups)?	0%	8%	28%

- PerformCare conducted a structured audit of discharge management plans from inpatient facilities in four different hospitals. The hospitals were chosen because we were prompted by IPRO to identify four hospitals for the Successful Transitions to Ambulatory Care PIP, and we thus sought out hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our network. Then, to ensure that we were generating data relevant to contracts outside of the Capital Area, we chose large hospitals in two of our other contracts, Chambersburg Hospital for Franklin/Fulton counties, and Somerset Community Hospital for Bedford/Somerset. The DMP audit tool included an analysis on medication reconciliation. The findings were:
  a. Only 17.3% of 120 reviewed charts in the four identified Providers, demonstrated correct medicine reconciliation.

b. These scores are low, and as we see from the literature IPRO provides, low scores could be one of the profound negative impacts on our recidivist rates. Intervention here would be helpful, and could be tracked (Details below.)

c. PerformCare does not pay for injectable medication (J-codes) therefore we do not have claims data on this treatment.

- The Successful Transition to Ambulatory Care Performance Improvement Plan revealed a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. The treatment record review process for Mental Health Inpatient providers include a section related to adequate discharge planning and adherence to recovery principles. Results from 2014 reveal providers are still in need of education regarding discharge planning best practice. Indicators remaining below the 80% target appear below:

Discharge Summary:	2012	2013	2014
Is there a relapse prevention plan (post-discharge) that reflects what steps the Member should take if symptoms escalate which includes activities based on strengths. (must consist of phone numbers for all) A) natural supports, B) provider(s), and C) Crisis Intervention.)	0%	31%	44%
Is there documentation in the record that the PerformCare Member letter was offered to Member at time of discharge?	0%	11%	17%
Are the discharge instructions recovery-oriented (not medical model)? (include Member words, recovery principles, relapse management)	0%	32%	66%
Recovery Orientation (all sections)			
Is there evidence of person-centered language?	0%	26%	52%
Are member strengths incorporated into all areas of treatment (intake, treatment plans, recovery/crisis plans, groups)?	0%	8%	28%

- PerformCare conducted a structured audit of discharge management plans from inpatient facilities in four different hospitals. The hospitals were chosen because we were prompted by IPRO to identify four hospitals for the Successful Transitions to Ambulatory Care PIP, and we thus sought out hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our network. Then, to ensure that we were generating data relevant to contracts outside of the Capital Area, we chose large hospitals in two of our other contracts, Chambersburg Hospital for Franklin/Fulton counties, and Somerset Community Hospital for Bedford/Somerset. The DMP audit tool included an analysis on medication reconciliation. The findings were:

d. Only 17.3% of 120 reviewed charts in the four identified Providers, demonstrated correct medicine reconciliation.

e. These scores are low, and as we see from the literature IPRO provides, low scores could be one of the profound negative impacts on our recidivist rates. Intervention here would be helpful, and could be tracked (Details below.)

f. PerformCare does not pay for injectable medication (J-codes) therefore we do not have claims data on this treatment.

	• The Successful Transition to Ambulatory Care Performance Improvement Plan revealed a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. ***Root Cause: Best Practice Discharge procedures are not completely being followed by many MH IP providers. This could lead to Member's lack of engagement in aftercare. Providers are not identifying barriers and taking steps to resolve prior to discharge.***
	Follow-up Status Response
People	***Initial Response***
(e.g., personnel, provider network, patients) 1. Member 2. Quality Care Manager 3. Providers	• The group discussed the importance of having clear discharge instructions, that the Member be present for arranging aftercare appointments that barriers are addressed, and the times/dates are convenient for the Member. • The Franklin/Fulton MH IP Readmission Work Group completed a full analysis of adult Members who had a readmission episode in SFY 2012 and 2013 in order to determine if any commonalities/trends existed within the population and to identify possible barriers to aftercare treatment. This analysis showed that although the majority of Members with a readmission episode had a subsequent follow-up appointment within 7 days; however, readmission episodes still occurred. • There appears to be a lack of provider education on how to engage the Member into treatment by motivating the Member while on the MH IP unit. Some providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way. • There appears to be a lack of Member understanding of Recovery principles, treatment options and necessity of follow up to avoid relapse. • The Successful Transition to Ambulatory Follow up Performance Improvement Plan process revealed an underutilization of community based recovery services, a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there was a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay. There is a lack of active discharge planning. There are insufficient protocols by the providers on the needs and time frames for medication reconciliation, engagement in recovery services, and successful scheduling of follow up visits. • Fractured discharge/transition programs – as IPRO's literature review notes, a clinically sound discharge/transition program is essential for successful transitions to ambulatory care. In our analysis, we have found that the bridge programs in our network are lacking in the following areas: Communication & follow-through deficits through the inpatient and transition processes i. Within PerformCare – there is no one, central document where a discharge management plan of a consumer is developed and tracked over time. While every client has a chart in PerformCare's EMR (eCura®), each event is distinct. While the notes can be looked at back and forth, one central Recovery Management Plan (RMP) document located in PerformCare's EMR that is developed over time would allow us to better manage the communication within our organization (and without, as we discuss below) in regards to cases transitioning to ambulatory care. ii. Beyond PerformCare – if communication within PerformCare is fractured, amongst different entities (case management firms, the hospital, psychiatric outpatient Providers, etc.) working with one Member is even more fractured. For instance, through the focus groups we learned that it is not uncommon for a treatment team meeting to come to a conclusion on a Member's discharge, which is then not communicated to the case manager leading the discharge (because of shift changes in the hospital, different case managers come in and

<table>
<tr><td></td><td>out, and communication can be porous). Thus, a centralized RMP that is built with all relevant parties while a Member is in the hospital and that PerformCare can then use to track the client's progress through his/her inpatient stay and beyond, and prompt all Providers to adhere to, would significantly improve communication.
Root Cause:
1) Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.
2) Due to limited transportation options, scheduling, inadequate discharge instructions and availability of accessible in-home services, follow up has been at a less than desired rate.</td></tr>
<tr><td></td><td>Follow-up Status Response</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Provisions
(e.g., screening tools, medical record forms, provider and enrollee educational materials)

1. Provider Education
2. Enrollee Education</td><td>Initial Response</td></tr>
<tr><td></td><td>• There appears to be a lack of provider education on how to engage the Member into treatment by motivating the Member while on the MH IP unit. Some providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way.
• There appears to be a lack of Member understanding of Recovery principles, treatment options and necessity of follow up to avoid relapse.
• The Successful Transition to Ambulatory Follow up Performance Improvement Plan process revealed underutilization of community based recovery services, a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there is a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay.

Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.</td></tr>
<tr><td></td><td>Follow-up Status Response</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Other (specify)
N/A</td><td>Initial Response</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td>Follow-up Status Response</td></tr>
<tr><td></td><td></td></tr>
</table>

<table>
<tr><td colspan="3"><u>Measure:</u> Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)</td></tr>
<tr><td colspan="3">For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014. Documentation of actions should be continued on additional pages as needed.</td></tr>
<tr><td>Action
Include those planned as well as already implemented.</td><td><u>Implementation Date</u>
Indicate start date (month, year) duration and</td><td>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.</td></tr>
</table>

	frequency (e.g., Ongoing, Quarterly)	
Root Cause: Limited reportable data to trend and allow correlations to guide appropriate interventions or make changes in the system. There is a shortage of psychiatrists across the network.		***Initial Response***
Action: 1. Existing Crisis Bridge Programs will be monitored and promoted so utilization may increase.	Ongoing	1. BHSSBC and PerformCare will continue to meet with Cornerstone and Somerset Hospital to evaluate the Crisis Bridge Program. Data is presented by PerformCare and Somerset Hospital at these meetings which occur every 6 months. In the fall of 2014, as result of the presentation of data and the above discussions, the Bedford/Somerset model was adjusted so that participation shifted from an Option-In approach to an Option-Out approach.
2. Expand tele-psychiatry and psychiatric services across the network.	Start 2014 Ongoing	2. The total number of tele-psychiatry providers increased in 2014 and 2015 and will be monitored through various meetings. Access to psychiatry will be monitored monthly through QI/UM. Bedford/Somerset expanded to two new providers in 2015. Franklin/Fulton Counties added 4 additional providers of Telepsychiatry to the network in 2013 and 2014 and an additional provider was added in 2015.Discussions with additional providers will occur as interest increases. Family Behavioral Resources opened three OP clinics, one in Franklin County, one in Fulton County, and one in Somerset County in 2015. Pyramid Healthcare opened an additional OP clinic in Franklin County (dually licensed) in 2015. CQI folder has a spreadsheet for telepsychiatry and current providers The Capital region added three telepsychiatry providers since in FY 2014/2015. Fourteen new psychiatrists were added to the Capital network during the same time period.
3. Work with providers to brainstorm ideas related to bringing more psychiatrists to rural areas through the Professional Shortage Designation. [Bedford/Somerset (BESO) and Franklin/Fulton (FF) Counties]	Fall 2014	3. A partnership between TrueNorth Wellness and the Federally Qualified Health Center (FQHC) located in Fulton County is being expanded which will target an increase in Member knowledge regarding MH services available. One provider became an accepted site in Bedford and Somerset Counties and one is waiting to hear if they have been accepted.
4. Create and Distribute survey to individuals that have been readmitted within 30 days to gather information related to discharge process and planning and available supports within the community.	2015	4. The survey is an intervention developed for the Readmission Performance Improvement Project and will be monitored through that process quarterly Franklin and Fulton Counties are moving forward with survey development and will be conducting the survey as planned in 2015.
5. Engage inpatient facilities in follow up (CABHC CAP)	April 1, 2015	5. A report identifying Provider HEDIS scores will be developed. Starting in April, 2015 this report will be sent to providers during a six month rapid experimentation phase to see if receiving information related to HEDIS scores improves provider score. PerformCare has generated the initial report and the report is awaiting approval to move forward. The six month rapid experimentation phase has not been fully implemented.
6. Add enhancement to follow up resources	3/15/2015	6. MSS will be resuming Member FU after discharge and ECM's will be responsible for completing their own Member follow up with assistance from AH CCM. A six month rapid experimentation phase will begin in April, 2015, ending in Oct 2015 to assess if this intervention improves the PerformCare (PC) HEDIS scores.

		Enhanced Care Management Follow-up activities continue. Six month rapid experimentation phase continues with this increased outreach. HEDIS scores continue to be monitored
		Follow-up Status Response
Root Cause: Best Practice Discharge procedures are not completely being followed by many MH IP providers. This could lead to Member's lack of engagement in aftercare. There is a lack of family involvement, collaboration with MH OP/substance abuse providers at times. Providers are not identifying barriers and taking steps to resolve prior to discharge.		***Initial Response***
Action: 1. Continue Quality Treatment Record review every three years based on the re-credentialing cycle. Providers with Quality Improvement Plans will be monitored every three months for improvements. 2. Perform Care is making improvements to outcomes reporting specific to level of care and provider. The outcomes reports will give detailed information on Provider Performance. 3. Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex needs 4. Comprehensive Continuous Integrated System of Care (CCISC) Implementation has occurred in Bedford/Somerset	Ongoing \ 2014 2014 2011 Ongoing 2015 2014	1. Quality Treatment Record reviews are conducted every three years based on the re-credentialing cycle. The benchmark for performance is 80%. Any provider with scores below 80% is asked to complete a Quality Improvement Plan. Once the Quality Improvement Plan has been accepted, the provider will be monitored every three months for improvements. 2. Preliminary outcomes reporting has been developed and implemented and is being operationalized through Quality Improvement/Utilization Management (QI/UM) Committee for monitoring so further interventions can be planned. The report is still being refined for the inpatient level of care. 3. Local Care Managers are continuing to expand their caseloads. Active Care Management strategies continue for PerformCare Clinical Care Managers through Enhanced Care Management (ECM) PerformCare achieved a 100% score on the NCQA accreditation survey. 4. The clinical department continues to utilize Member Monitoring to conduct Member outreach and follow-up to Members who do not meet the criteria for ECM. The goal of Member Monitoring is to increase Member stabilization within the community and for early intervention prior to a Member meeting the criteria for ECM. 5. CCISC meeting continue in the North Central Contracts. Change Agent Meetings continue in the North Central contracts. There was a Complex condition training completed on 2/20/14 in the Franklin/Fulton region, level of care specific treatment plan trainings are scheduled through 2015 and Motivational Interviewing trainings scheduled for April and June 2016. 6. Pyramid Healthcare expanded existing services within the FF contract to include a dually licensed Mental Health/Substance Abuse (MH/SA) OP Clinic. 7. PerformCare conducted meetings with all 4 hospitals selected for the Discharge Management Plan Audits in July and August of 2015 to review the results of the DMP audit, to review opportunities for improvement,

and Franklin/Fulton Counties. 5. CCISC meetings and Change Agent Meetings/Trainings have occurred and are ongoing. 6. Pyramid Healthcare expansion 7. Discharge Management Educational Meetings 8. Franklin/Fulton Co-occurring competency credential	July-August 2015	and to review expectations. The DMP audit will be repeated to measure improvement and evaluate the effectiveness of this intervention. 8. This is a provider incentive program, in which MH OP providers must pass the COD audit with a score of 75% in all three rating areas in order to be certified for an enhanced rate. Additionally, the provider must agree to use the COD outcomes tool in order to qualify as well. Two out of 5 providers audited received a passing score and will get an enhanced rate. ***Follow-up Status Response***
Root Cause: Due to transportation issues and other factors, Members are not following up due to lack of clear discharge instructions and availability of accessible in-home services. **Action:** 1. Monitor utilization of BTM, FFT, IY, and PCIT (evidence-based programming). 2. Consider implementation of MST and mobile –psych nursing in counties where the services are not available currently (BESO, Franklin/Fulton**)** 3. Monitor utilization of ACT, MMHT, and MPN within the Capital region. 4. A regional OP clinic added Mobile-Mental Health to their services in September 2014 in Franklin/Fulton Counties. 5. Make MATP contact information readily available.	Ongoing monthly 2014/2015 2015 and Ongoing monthly 2014 Ongoing	***Initial Response*** 1. Utilization is monitored monthly through QI/UM. Brief Treatment Model (BTM) utilization has increased, along with Functional Family Therapy (FFT). Parent Child Intensive Therapy (PCIT) had a slow start up in BESO with one provider with low utilization. An additional provider has been added in Somerset County and utilization has started to increase in 2015. Franklin/Fulton has two providers of PCIT and referrals have been slow for these providers as well. 2. PerformCare anticipates the continued expansion of the PCIT which provides an evidence base practice alternative to more restrictive levels of care. The Incredible Years has not had a cohort for two years and this program is not currently running in Bedford/Somerset region. 3. Exploration and implementation of alternative in-home services has been added to the fiscal year (FY) 2014/2015 service initiatives for BESO. Bedford/Somerset has selected MST and will be implementing this program in 2016. FF region continues to explore alternative options for in-home services for the adult population. Capital Counties continue to use Assertive Community Treatment (ACT) and Mobile Psychiatric Nurse (MPN) services for in-home services 4. A regional OP clinic added Mobile Mental Health to their services in 2014 in Franklin/Fulton Counties. *5.* Medical Assistance Transportation Program (MATP) information and contact numbers are available through the PerformCare Contact Center.

6. Implement a Recovery Management Plan for Members who are discharged from Inpatient. ***7.*** Data analysis of UCBH Partial Hospitalization closure/PHP work group	2015, Ongoing as needed August/Sept 2015, Ongoing as needed	*6.* Overall Intervention Description: In summary, PerformCare plans to create a Recovery Management Plan for all of our Members who are discharged from inpatient. This plan will assure that all those being discharged have means to successfully avoid recidivism. Built into the RMP is a trigger list that will identify those Members who should be referred to our Enhanced Care Management (ECM) program for more active care management, which can help overcome the barriers to successful transition. While this process is going on within our care management program, we will also do increased outreach to our hospitals on issues related to recidivism, especially increasing their medication reconciliation processes with Members through their inpatient stay, as well work to get more pharmacy options to our consumers who have difficulty getting their medications after discharge *7.* Due to the closure of the UCBH Partial Hospitalization program in Franklin County, serving Franklin and Fulton Members, TMCA conducted a full analysis of utilization of the UCBH partial program including diagnosis, ALOS, and other factors. TMCA and PerformCare have had discussions with regional providers to determine if it has had a significant impact on services. No issues have been identified. TMCA developed a workgroup to identify gaps in services and develop a plan to address unmet needs due to the Partial closure.
		Follow-up Status Response

Table 21: RCA and Action Plan – Readmission Within 30 Days of Inpatient Psychiatric Discharge

Instructions: For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.

Managed Care Organization (MCO): *PerformCare (formerly Community Behavioral HealthCare Network of Pennsylvania, CBHNP)*	***Measure:*** *Readmission Within 30 Days of Inpatient Psychiatric Discharge*	***Response Date:*** ***October 9, 2015***

Goal Statement: **(Please specify individual goals for each measure):**
Short Term goal: Decrease 30-day readmission rate by 0.5% per quarter
Long Term goal: Decrease 30-day readmission rate by 2% over the next measurement year
Please see Attachment 1: 2014 Ambulatory Follow-up & Re-admission Fishbone.

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

Policies
(e.g., data systems, delivery systems, provider facilities)

1. Data Systems

Initial Response

Current reporting is reviewed quarterly; however, it lacks the detail necessary to determine trends, identify barriers or Member specific details. Detail is reviewed manually and is not always feasible for the volume of Members served in all contracts. The data that is collected is based on claims and is therefore not considered to be "real time" reporting.

- The MY 2011, MY2012 ,MY 2013, and MY 2014 Readmission rates for all counties are as follows:

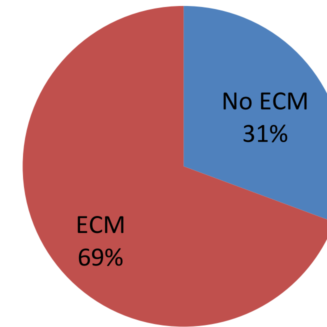
County	MY 2011	MY 2012	MY 2013	MY 2014
Bedford	**8.3%**	**5.9%**	**15.1%**	**14%**
Blair	**14.7%**	**12.4%**	**15.2%**	**N/A**
Clinton	**11.2%**	***13.0%***	***6.6%***	**N/A**
Cumberland	**14.1%**	**12.5%**	**13.3%**	**16%**
Dauphin	**19.3%**	**17.0%**	**17.9%**	**19.4%**
Franklin	**13.2%**	**19.3%**	**16.3%**	**10.8%**
Fulton	**11.4%**	***4.3%***	***12.5%***	***8.7%***
Lancaster	**13.6%**	**12.3%**	**13.9%**	**14.9%**
Lebanon	**15.7%**	**20.5%**	**21.1%**	**17%**
Lycoming	**12.4%**	**9.7%**	**11.0%**	**N/A**
Perry	**15.0%**	**18.0%**	**15.0%**	**15.3%**
Somerset	**13.1%**	**6.8%**	**13.7%**	**10.7%**
Network	**14.8%**	**14.1%**	**15.5%**	**15.9%**

*** Caution should be exercised when interpreting results for small populations because large differences in rates do not necessarily mean there is a statistically significant difference in rates.**

- The trend across the four year period, MY 2011 to MY 2014, shows an overall increase in readmission rate for the network from MY 2011 (14.8%) to MY 2014 (15.9%).

	• The County specific data indicates that there is a mixture of increases and decreases amongst the individual counties across the four year period (MY 2011 to 2014): • Bedford, Franklin, Fulton, and Somerset show a rate decrease from 2013 to 2014. • Cumberland, Dauphin, Lancaster, Lebanon, and Perry showed increased readmission rates from 2013 to 2014. • To ensure active care management, inpatient discharges are reviewed daily by clinical management to identify Members to be referred to the Enhanced Case Management (ECM) program and other Member Monitoring initiatives. • Analysis of recidivists in regards to appropriate profiling and active care managing Recognizing our problematic numbers in regards to recidivism, PerformCare wanted to do an analysis to better understand if we are identifying Members and managing Members appropriately within our care management programs. Thus we did an analysis on our current care management profiling, and how good of a job we are doing in identifying recidivists. ▪ A preliminary analysis done on SMI Members with an inpatient readmit within 30 days of last discharge in the 120 day period prior, PerformCare found that all such Members are in Enhanced Care Management (N=38) – thus while this population is a driver of readmits, it is not being missed by ECM staff. ▪ We then did the analysis all Adult Members with Inpatient Readmit within 30 days of last discharge in the 120 day period prior; are they being care managed at our most active care management level (Enhanced Care Management)? We identified 172 Members with at least one 30-day recidivist episode in the last 120 days, and then checked how many of them are in any of our care management programs. We found that 63% of such people are in no ECM program. ▪ Next, we looked at Adult (21 and over) Members with 3 or More MHIP Admits in 1 year period prior to end date, and looked to see if they are receiving any level of ECM. We found that 31% of Members with this profile are not receiving any ECM services.

Adults with 3 Admits in 1 Year Receiving ECM Services (n=75)



- Our conclusion is that ECM services are not getting to the people who are driving our recidivism rates, and we need to improve our system of profiling and getting people into the program.

- Qualitative analysis of member profiling barriers - The IPRO literature review demonstrates that good Member profiling helps identify people in need of intervention, and allows for quick and successful intervention. At this point, however, PerformCare's profiling system in regards to recidivism poses barriers.
  - Deficits on when we profile – In the baseline year, PerformCare only did an annual profile of recidivists. This list of names is then given to care managers to add to our enhanced care management program. This process is too slow and disjunctive from the real world realities of these Members who need to be identified right when they hit an inpatient setting, and managed appropriately while they are in crisis, not 12 months later.
  - Deficits of who/how we are profiling - In the baseline year, our logic for who gets on the list to be managed more intensely was limited (we primarily looked at Members hospitalized 3 times over the last year.) This is insufficient. We need to identify people who have the deficits as noted above (transportation deficits, D&A use, housing deficits, medication adherence problems, etc.) and instantly begin to address their needs and document in our PerformCare Recovery Management Plan (discussed below). Further, our profiling should not just be claims based, but must be based on information picked up during the authorization process, so that we can instantly start working with Members to help them have a successful discharge.
  - Deficits on what we do with profiled information. In the baseline year, our profiled patients were referred for an enhanced care management program that is not necessarily connected to managing their transition out of inpatient care. We need to have an active case management

	program that begins when someone is in the inpatient setting, and then follows them out into the community and to their ambulatory transition. ▪ Business Review meetings are occurring monthly at a Director level. Quality indicators are reviewed and interventions are planned. ***Root Cause: PerformCare does not consistently use available data for continuous quality improvement.***
	Follow-up Status Response
Procedures (e.g., payment/reimbursement, credentialing/collaboration) 1. Adequate providers with the appropriate training, certification and license to provide specialized services such as DBT, TF-CBT, EMDR and Co-Occurring disorders ***1.***	***Initial Response*** • MH IP units report that there are not adequate providers to provide specialized services such as DBT, TF-CBT, and EMDR for Members. • Lack of co-occurring competent providers in the network. ***Root Cause: There are an inadequate number of Providers who are certified to provide specialized services such as Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), TF-CBT, and providers who are Co-occurring competent in the provider network. Without specialized services available to address specific issues such as trauma and substance abuse Members may not receive adequate treatment needed to stay in the community.***
	Follow-up Status Response
People (e.g., personnel, provider network, patients) 1. Clinical Case Manager 2. Follow Up Specialist 3. Member ***4.*** QI Clinical/Manager ***5.*** Providers- MH IP, MH OP, TCM ***6.*** Peer Support Specialist in MH IP units	***Initial Response*** • Member(s) reported that they feel the discharge instructions are too confusing, they are not always included in the planning process with no input into times and dates, provider choice of the follow up appointment and day of discharge planning appears rushed. Lastly, some Members felt the Discharge Planner was "too busy" to talk to them about details or that they needed a family member or natural support person to be present with them when discharge information was reviewed. • There is a lack of identified EBP initiatives to address the needs of this population; a potential barrier to reducing readmissions. • Results of the MH IP audits indicate: ○ Collaboration with other MH provider at the time of admission is occurring but not 100% of the time ○ Member strengths and barriers to follow up are not always identified/addressed ○ Discharge planning lacks collaboration and coordination ○ Crisis planning needs to be more inclusive of the Member's support system and supportive of recovery

Discharge Summary:	2012	2013	2014
Were aftercare and follow-up plans identified including Natural Supports?	63%	63%	87%
Is there documentation that the Member was present and in agreement with appointments that were made for follow up?	90%	74%	86%

Was the TCM (Targeted Case Management) included in the discharge planning process (if currently involved)?	100%	59%	79%
Is there a relapse prevention plan (post-discharge) that reflects what steps the Member should take if symptoms escalate which includes activities based on strengths. (must consist of phone numbers for all) A) natural supports, B) provider(s), and C) Crisis Intervention.)	0%	31%	44%
Was the follow up treatment date within 7 days of discharge?	88%	65%	78%
Is there documentation in the record that the PerformCare Member letter was offered to Member at time of discharge?	0%	11%	17%
Are the discharge instructions recovery-oriented (not medical model)? (include Member words, recovery principles, relapse management)	0%	32%	66%
Recovery Orientation (all sections)			
Is there evidence of person-centered language?	0%	26%	52%
Is there evidence of clinician as consultant and Member as expert?	11%	67%	N/A- removed from tool
Is progress defined by Member/family?	0%	59%	86%
Have efforts been made to strengthen natural supports?	100%	72%	83%
Is the focus not simply on symptom reduction (i.e. addresses needs of Member; improves quality of life, etc.)?	100%	58%	90%
Are member strengths incorporated into all areas of treatment (intake, treatment plans, recovery/crisis plans, groups)?	0%	8%	28%
Is there documentation that educational/vocational options/strategies were discussed with the Member?	100%	69%	76%

- A review of the audit data over the above three year period indicates that improvements have been made in the areas of documentation of Member's barriers to follow up, the initiation of discharge planning at admission, inclusion of Natural Supports in aftercare and follow up, and Member involvement/agreement

	in discharge planning. PerformCare conducted a structured audit in 2014 of discharge management plans from inpatient facilities as part of the Successful Transitions to Ambulatory Care Performance Improvement Project in four different hospitals. The hospitals were chosen because we were prompted by IPRO to identify four hospitals for the Successful Transitions to Ambulatory Care PIP, and we thus sought out hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our network. Then, to ensure that we were generating data relevant to contracts outside of the Capital Area, we chose large hospitals in two of our other contracts, Chambersburg Hospital for Franklin/Fulton counties, and Somerset Community Hospital for Bedford/Somerset. The DMP audit tool included an analysis on medication reconciliation. The findings were: • Only 17.3% of 120 reviewed charts in the four identified Providers, demonstrated correct medicine reconciliation. • These scores are low, and as we see from the literature IPRO provides, low scores could be one of the profound negative impacts on our recidivist rates. Intervention here would be helpful, and could be tracked (Details below.) • PerformCare does not pay for injectable medication (J-codes) therefore we do not have claims data on this treatment. • The Successful Transition to Ambulatory Care Performance Improvement Plan revealed a lack of clinically sound discharge management plans created by Mental Health Inpatient providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. o Deficits in medication reconciliation from entry to exit of the hospital. • PerformCare conducted a structured audit of discharge management plans from inpatient facilities in four different hospitals. The hospitals were chosen because we were prompted by IPRO to identify four hospitals for the Successful Transitions to Ambulatory Care PIP, and we thus sought out hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our network. Then, to ensure that we were generating data relevant to contracts outside of the Capital Area, we chose large hospitals in two of our other contracts, Chambersburg Hospital for Franklin/Fulton counties, and Somerset Community Hospital for Bedford/Somerset. • The DMP audit tool included an analysis on medication reconciliation, see the above findings. o Deficits in the utilization of sub-acute mental health programs (AKA “Recovery Services”) that help with achieving successful transitions to ambulatory care. PerformCare has worked hard to help develop a whole continuum of services we refer to as “recovery services.” These are services that provide Members supports so that they can function well in the community without the need for re-hospitalization. For our purposes here, these services include: • D&A ICM • D&A Recovery Specialist/Recovery Services • Peer Support Services • Medication services:

- Community Treatment Teams
    - Assertive Community Treatment
    - Mobile Psychiatric Nursing
- Targeted Case Management:
    - Resource Coordination
    - Intensive Case Management
    - Blended Case Management
- Crisis Bridge/Hotline programs

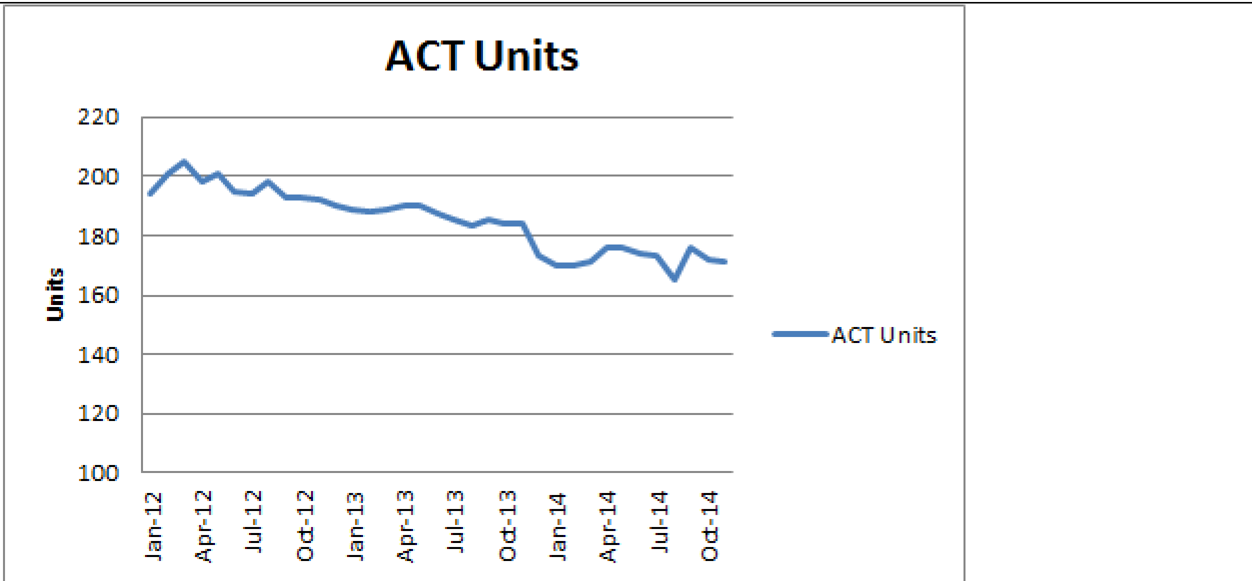
PerformCare did an analysis to see why these programs are not having the expected impact on recidivism. Here are some of our findings:

i. Under referral by inpatient facilities of Peer Support Services (PSS). In only 20% of reviewed mental health inpatient charts, was there evidence that peer support services were discussed with a Member, and a referral was made.
    1. This table below shows the volume of Peer Support Utilization for those Members recently hospitalized, by days after admission. It demonstrates the low numbers of PSS use, considering the numbers of admissions to MH IP in our network (3,850 mental health inpatient discharges in 2013, with 561 mental health inpatient readmissions – a rate of 15.9%):

Days after hospitalization	Member Count
30 Days after admission	30
60 days after admission	22
90 days after admission	19
180 days after admission	24
Greater than 180 days after admission	24

    2. The fact that so many people are starting PSS more than 30 days after inpatient discharge (i.e. 75% of post MHIP PSS service starts are beyond 30 days) shows that there is sustained demand for the service, but something is blocking a successful, immediate, hand-off.

ii. ACT and CTT Data shows that it is underused. There has been a steady, though slow, reduction in use of comprehensive community based mental health services like CTT (and ACT, which is a hi-fidelity version of CTT that is evidence-based). It is important to note that there has been no concomitant reduction in population, and in fact population of covered lives for PerformCare has gone up during this time.



iii. Crisis bridge program – the Crisis Bridge program allows crisis intervention units to follow up with consumers for the 30 days after discharge. It is available in our BHSSBC contract. Of the 252 unique BHSSBC Member discharges in 2014, only 22 utilized the Crisis Bridge service. Of those who did receive the service, 90% received it within 7 days (demonstrating that the program can have a quick turnaround). Increased use of this program would get acute Members support quickly to help with successful transitions.

iv. Mobile psych nursing – mobile psych nursing is a program that targets SMI Members. It utilizes an RN that goes to Members' homes and administers medication and provides education. Over the last year, its utilization has remained stable (approximately 2055 units a month). And it is unclear if the "right" Members are getting this service, so that our recidivism numbers would be impacted.

v. Drug and Alcohol Sub-acute recovery services. PerformCare has been working with its counties and oversights to develop innovative sub-acute options for Members who have acute drug and alcohol treatment needs, but who could be given these supports outside of the hospital setting, and thus have a more successful transition to ambulatory care. These programs are currently being supported by PerformCare and its partner counties through other funding streams than MA, because they are still pilot programs utilizing grant and/or reinvestment funds. These programs are having their outcomes monitored, to see which are successful, and which thus should be brought into the fee structure. These programs include:

1. Substance Abuse Supportive Housing – There are a number of individuals who, when completing non-hospital rehabilitation or halfway house services for the treatment of substance abuse issues, require some form of transitional housing to support their recovery. This may include individuals who are homeless or whose prior living situation would have undermined their recovery efforts. A

	local network of Recovery Houses is being developed to provide a living environment that reinforces recovery. Capital Area Behavioral Health Collaborative (CABHC) has been issuing scholarships to assist eligible individuals. 2. D&A Recovery Specialists – Targets individuals in the five-county Capital Area who are in need of one-on-one recovery coaching to assist them with overcoming obstacles that otherwise may keep them from succeeding in the process of recovering from substance abuse. Program participants are matched with a Recovery Specialist who meets with them regularly and assists them in learning the skills necessary to live successfully and maintain their sobriety. 3. Drug and Alcohol Recovery Services - These target MA eligible adults (18 years or older) who are experiencing a substance abuse disorder. These are peer operated programs that offer support and sober recreation services, but not treatment. ***Root Cause:*** ***1) Utilization of Certified Peer Support (PSS) in the community and MH IP units is poor. PSS are able to assist Members with discharge planning and connecting with natural supports in the community setting that can lead to better involvement with follow-up treatment and decrease readmission to MH IP. Additionally there may be an inadequate pool of certified peer specialists who are actively looking for employment. This needs to be reviewed and examined to rule out as a possible cause.*** ***2) Best Practice Discharge Processes and Procedures are not completely being followed by many MH IP providers which compounds Member's lack of engagement. Lack of Recovery Practices during MH IP admissions further prohibits engagement in treatment.***
	Follow-up Status Response
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) ***1.*** Provider Education 2. Enrollee Education 3. Provider Profiling	***Initial Response***
	• Results of discharge planning audit continue to also reveal that some MH IP providers do not provide education on Recovery tools such as WRAP at discharge. • There appears to be a lack of Member understanding of Recovery principles, treatment options and necessity of follow up to avoid relapse • Providers are in need of training regarding discharge management planning. ***Root Cause: Providers are not thoroughly informed about Recovery Principles and/or are not encouraging Members to develop a Crisis Plan which leads to poor crisis intervention and ultimately can lead to Member readmission.***
	Follow-up Status Response
Other (specify) ***N/A***	***Initial Response***
	Follow-up Status Response

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 2014. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
Root Cause: PerformCare does not consistently use available data for continuous quality improvement. ***Action:*** 1. Modifications to current reporting will be requested through IT. Currently all reporting is claims based and real time data cannot be extrapolated. 2. QI staff will advocate the need for real time reporting at meetings with IT Department. QI staff will continue to meet with IT business analysts to review current reports and discuss possible need for additional data. QI staff will monitor reporting quarterly. **Action Plan Items:** 1. Identify and provide data re: Members with at least one readmission in Calendar Year 2014 2. A. The list of high utilizers will be used to screen for: • Internal care management	Ongoing Ongoing 2/13/15 3/1/2015 Completed 2/16/15 Completed 3/1/15	***Initial Response*** Quality Management will continue to advocate for the completion of requests for more real time reportable data • Quality Clinical Managers will continue to review readmission rates quarterly, correlate data manually, and initiate new action steps in response to the data results. • QI Management will complete Provider Profiling for both Inpatient and Outpatient levels of care on an annual basis and develop a Provider scorecard to provide periodic reports to Providers • Quality Management will support the assessment of access & availability of psychiatrist, psychologists, CRNPs and mental health outpatient clinics throughout the network to ensure the capacity of outpatient services which may reduce readmission rates • Account Executives will utilize reporting to share with High Volume Providers during quarterly meetings. • Clinical Managers will continue to review daily discharges to triage Members to the most appropriate level of care management needed (ECM, Member • Monitoring, Local Care Management, Field Care Management). 1. Detailed list of 2014 Recidivists provided to Clinical Care Manager (CCM) supervisor Completed 2/16/15 2 A. By 3/1/15, all names and internal IDs will be identified and ready to be explored further re: internal and external services Completed 3/1/15; the list of high utilizers has been assessed for the appropriate level of intervention. 2B. By 3/18/15, those recidivists not in higher level internal programming will be assigned to the higher level of programming. Documentation of services and service plans 3/18/15 Members have been assigned to the appropriate level of programming. 2C. ECMs remain engaged with identified members and review opportunities for diversion and barrier concerns when members experience a 30-day readmission.

• External community case management through Base Service Units (BSU) • Community programming [Peer Support, Mobile psych nursing, psych rehab, outpatient (OP), medication management, etc.] B. Identified Members who do not have enhanced care management (ECM) will be screened and assigned to the appropriate Mental Health or Substance Abuse (SA)/Co-Occurring ECM. Member, TCM and Community Support outreach will begin to develop a plan for engagement and recovery/resiliency based services and services plans within 2 weeks of ECM designation. C. Diversion/Recovery plans will be reviewed by team when a 30-day readmission occurs to determine opportunities to improve diversion plans and address barriers 3. The above identified Members will have individualized member alerts placed in their electronic medical record (EMR) indicating the following: • Pertinent clinical information regarding current functioning • Individualized	Completed 3/18/15 Ongoing 2016 2016 July 2015 Ongoing 2016	3. By 3/8/15, all identified Members will have individualized member alerts in EMR indicating that the member has recidivism history and other specifics surrounding readmissions Completed 3/8/15; alerts will be done on an as needed basis in the future. 4. Training documentation 5A. In person meetings with at least two TCM units will be scheduled to review and discuss: • Informatics, CCM Supervisors and Senior CCMs roles/responsibilities • Potential Community Service Providers • Consumer advocate • County specific recidivism numbers and Members requiring diversion plans • Community base programming that should be utilized as part of the diversion plan • Discussion of BSU feedback regarding barriers encountered with engagement of Member in the community; ways to collaboratively address the barriers • Subsequent meetings will be scheduled with additional TCM units, as well as ACT/CTT. 5B. CCM supervisors will outreach to MH Inpatient providers schedule and document in person meetings to discuss: • Recidivism and follow up scores - individually and rank amongst PC providers. • Informatics, CCM supervisors and senior CCMs roles and responsibilities • Potential community service providers • Consumer advocate There will be an ongoing outreach plan. 6. Starting 2/16/15, report will be run at a minimum of once per week to identify any new 30-day readmissions; when this occurs, they will go through the above steps re: identification, assignment, and outreach to county CM if applicable. July 2015 – Care Management report developed and being pulled weekly to identify new 30-day readmissions. 7. CCM supervisors will outreach to at least crisis providers to schedule in person meetings to discuss recidivism, provide specific member names and develop diversion plan for each; there will be an ongoing outreach plan to all providers
		Follow-up Status Response

diversion plan • Current recovery/resiliency based services being received • Identified barriers ***4.*** Clinical leadership, along with medical director, will collaborate to provide training to physician advisors regarding the Physician Advisor (PA) role in recidivism and new action steps being taken to address follow up after inpatient and Readmission to inpatient. 5. A. Outreach to external county base service units B. Outreach to Mental Health Inpatient (MH IP) Providers: PerformCare will identify 4 facilities with the highest recidivism and lowest rates of follow up per HEDIS measures and outreach/schedule in person meetings 6. Early Identification 7. Outreach to crisis providers		
Root Cause: There are an inadequate number of Providers who are certified to provide specialized services such as Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR) and providers who are Co-occurring competent in the provider network. Without specialized services available to address specific issues such as trauma and substance		***Initial Response***

abuse Members may not receive adequate treatment needed to stay in the community. ***Action:*** There may not be adequate resources within provider operations to provide DBT and/or EMDR. 1. CCMs will continue to encourage MH IP discharge planner to choose a provider that meets the Member's needs. 2. Continued Stipend program which enables providers to obtain training on trauma and co-occurring treatment and be monetarily reimbursed by PerformCare. 3. Account Executives will educate providers on importance of trauma informed care. 4. Continue to monitor outcome of CCISC in Franklin/Fulton and Bedford Somerset to see if readmission rates decrease and more Members are identified as receiving co-occurring treatment. 5. Monitor the success of specialized (evidence based) services implemented by reviewing re-admission rates. 6. Provide Bi-Polar D/O education to Providers and promote EBP matches. 7. TFCBT TRAINING 8. Franklin/Fulton Co-occurring competency credential	Ongoing Ongoing Ongoing Ongoing Ongoing Start 2015 Start 2015 July-August 2015	1. Network Operations will monitor network capacity of providers who are specialized in trauma informed care and specialization such as DBT and EMDR. 2. PerformCare will continue to offer stipends for providers to attend trainings in the several areas including trauma informed care and co-occurring treatment and be reimbursed monetarily by PerformCare. 3. Quality Improvement Manager will explore incentive options for providers who develop and implement specialized outpatient services which are more effective in meeting Member needs. 4. Quality Improvement Staff will monitor the number of providers who utilize training stipends and will promote the use of these funds so that providers are adequately informed to develop specialized services. 5. PerformCare will continue to support the development of CCISC practices to meet the individual needs of each contract through the local participation in the various CCISC workgroups. 6. TF-CBT training and certification for Bedford, Somerset, Franklin, and Fulton providers occurred in 2015 for 24 providers. Case consultations are still ongoing. 7. This is a provider incentive program, in which MH OP providers must pass the COD audit with a score of 75% in all three rating areas in order to be certified for an enhanced rate. Additionally, the provider must agree to use the COD outcomes tool in order to qualify as well. Two out of 5 providers audited received a passing score and will get an enhanced rate. ***Follow-up Status Response***
Root Cause: Best Practice Discharge Processes and procedures are not completely being followed by many MH IP providers which compound Member's lack of engagement. Lack of		***Initial Response*** 1. QMS will monitor MH IP treatment record review results annually and compare results to previous results. When trends are noted and results do not improve, MH IP facilities will be asked to submit a quality improvement plan. 2. Quality Management staff will continue to monitor Readmission Rates and correlate to each specific hospital.

Recovery Practices during MH IP admissions further prohibits engagement in treatment. ***Action:*** The QI Department will continue to educate and monitor MH IP units during treatment record auditing on Best Practice discharge guidelines with a focus on Recovery Principals and collaboration with family, natural supports and aftercare providers. 1. Quality Management Specialist will complete MH IP treatment record review which includes indicators for discharge process. 2. PerformCare Account Executives will be given clinical information in the form a report card to remind providers during their respective visits of importance of follow-up and Recovery Principals. 3. PerformCare Contact Center will conduct enhanced Member outreach to explore Member Wellness, engage and confirm accuracy of discharge information, identify any barriers to follow-up appointments and offer any assistance that might be needed. 4. PerformCare will continue to explore the development of Crisis Bridge Programs that encourage the coordination of efforts for follow-up care. 5. Enhanced Care Management will define high risk case management, substance abuse care management, and member monitoring in addition	Ongoing 01/15 Started: 9/13 Ongoing Ongoing Ongoing 2014 2014	This information will be shared with High Volume providers in a report card format by Account Executives during quarterly meetings. 3. Contact Center Staff will monitor the accuracy of discharge planning. They will gather information when speaking with Members during follow-calls that will be initiated when Member is discharged from a MH IP facility. 4. Clinical care management will fully define care management options and will recommend adjustment to caseloads to meet the needs of Members. 5. Clinical care managers will develop mobile onsite teams. 6. Account Executives will begin to use report card/benchmark report format to MH IP providers in quarterly meetings that will include information on the importance of follow-up and recovery principles. 7. PerformCare will continue to encourage the development of Crisis Bridge Programs with MH IP units. Development of Recovery Management Plan (RMP) with built in Trigger list a. This change in process is facilitated by the development of a document within PerformCare called the Recovery Management Plan (RMP). The RMP is the plan for all Members who are inpatient, to ensure they leave hospital with the supports necessary to have a successful discharge. i. There are 5 items in the RMP that trigger a referral to ECM. These are items that link to high risk for recidivism, and that can be addressed with more active care management. These items were identified by a literature review. Here is a basic summary of the items, and the logic for how they were chosen: 1. MH IP readmission within 30 days (Yes/No) 2. SA readmission within 60 days (Yes/No) 3. MH/SA Comorbidities (Yes/No) 4. Barriers to follow through with attending aftercare appointments present? (Yes/No) 5. Takes medications as prescribed (Yes/No) 8. In looking at development of a five item trigger list for ECM, the important areas that need to be assessed include: quick readmission to mental health inpatient treatment, non-compliance with prescribed medications, untreated or concurrent issues with substance abuse, lack of timely follow up from last inpatient treatment and non-engagement in aftercare plans following an inpatient stay. There are several factors that lead to a re-admission, with the top three being medication non-compliance (Weiden, Kozma, Grogg & Locklear, 2004), lack of engagement in outpatient services (Nelson, 2000) and concurrent substance abuse (Raven, Doran, Kostrowski, Gillespie & Elbel, 2011).
		Follow-up Status Response

to field care management and local care management to enhance improvement. 6. Clinical care managers will implement a pilot project to establish mobile on-site teams who will work on site at inpatient units to improve discharge planning and member engagement efforts. 7. Director of Clinical Outcomes will develop a report card or benchmarking report to communicate outcome results to inpatient providers.		
Root Cause: Utilization of Certified Peer Support (PSS) in the community and MH IP units is poor. PSS are able to assist Members with discharge planning and connecting with natural supports in the community setting that can lead to better involvement with follow-up treatment and decrease readmission to MH IP. Additionally there may be an inadequate pool of certified peer specialists who are actively looking for employment. This needs to be reviewed and examined to rule out as a possible cause. ***Action***: PerformCare will continue to encourage the implementation of PSS into the network MH IP units. 1. Encourage MH IP units to utilize PSS/Recovery Specialist in the MH IP unit. 2. Monitor the Capital Reinvestment plan to place certified peer specialist In MH IP units. 3. Monitor the number of PSS in the network actively seeking employment to determine if there is adequate peer support	Started:10/13 Ongoing Started: 12/13 Ongoing Started: 10/13 Ongoing Started:10/13 Ongoing	***Initial Response*** 1. Monitor the readmission rates for the four MH IP units that will have the PSS on staff compare to those MH IP facilities that do not have PSS staff. 2. QI Staff will continue to participate in the PSS workgroup at CABHC. 3. QI will continue to monitor the utilization of Peer Support Services in the QI/UM meetings. 4. Network Operations will monitor the capacity of Peer Support Providers in the network. ***Follow-up Status Response***

certified and available. 4. PerformCare will explore the feasibility of recommended documentation guidelines for PSS and engage all contracts in the review of proposed guidelines. 5. Increase capacity of Providers of Peer Support Services	Ongoing	
Root Cause: There is inadequate provider next day appointments available for diversion of MH IP stays which leads emergency room physicians to admit the Member to an inpatient unit. ***Action:*** PerformCare will continue to encourage and monitor the development of diversion programs that can offer next day appointments. 1. Monitor the NHS program utilizing a PCP, Nurse Navigators and a Peer Support Specialist as a possible means of diverting from a MH IP stay. Members will be seen the next day by a team member. 2. Discuss with additional providers to determine if other providers are interested in this type of diversion. 3. PerformCare will explore Rapid Access diversion to MH inpatient 4. Measure programs individual outcomes created to determine the success of the program. 5. PerformCare will share the complied outcome data with the other contracts for consideration of diversion programs	Started:1/14 Ongoing Ongoing Ongoing Ongoing 2015	***Initial Response*** 1. Quality Improvement will measure the outcomes set forth by each provider for the program that will include how many Members were seen and how many were diverted. 2. Programs currently being explored by PerformCare include: o Lancaster Transformation Model o Dauphin Co. Same day Diversion proposal o PPI-Evidence Based Proposal of discharge nurse dispensing medication. ***Follow-up Status Response***

Root Cause: Providers are not thoroughly informed about Recovery Principles and/or are not encouraging Members to develop a Crisis Plan which leads to poor crisis intervention and ultimately can lead to Member readmission.		***Initial Response***
		8. QI Staff will continue to monitor through the quality treatment record reviews to determine if providers are incorporating Crisis Planning in their discharge. *9.* QI staff will review data through reporting by MSS if Member had a Crisis Plan and if it was used to divert from inpatient admissions.
		Follow-up Status Response
Action: Address the lack of Crisis Plans with both Providers and Members and stress the importance of utilization of the plans to avoid readmission when possible.	Ongoing	
1. UR CCM will continue to encourage MH IP and PHP Providers during utilization reviews to utilize the development of a Crisis Plan prior to discharge.	Ongoing Started: 9/13	
2. QI will continue to maintain the Crisis Plan as part of treatment plan audit tool	Ongoing	
3. Contact Center will conduct follow-up calls to Members upon discharge from a MH IP discharge to identify any barriers to follow up and inquire if Member has a Crisis Plan.	Started:12/13 Ongoing Ongoing	
4. The Capital Area Counties will continue with the reinvestment plan to add PSS to MH IP units to encourage Members and educate staff and promote on recovery principles		
5. Encourage Mental Health Providers to adopt and integrate Recovery Principles.		

Note: The PerformCare contract with Blair, Clinton and Lycoming Counties terminated in 2013; therefore, this RCA does not apply to these counties.

VI: 2015 Strengths and Opportunities for Improvement

The review of PerformCare's 2015 (MY 2014) 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

- PerformCare's rate for the MY 2014 Follow-up After Hospitalization for Mental Illness PA Specific indicator QI B was statistically significantly above the BH-MCO Average by 1.6 percentage points.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2012, RY 2013, and RY 2014 found PerformCare to be partially compliant with all three Subparts associated with Structure and Operations Standards.
    - Within Subpart C: Enrollee Rights and Protections Regulations, PerformCare was partially compliant on one out of seven categories – Enrollee Rights.
    - PerformCare was partially compliant on five out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Subcontractual Relationships and Delegation, and 5) Practice Guidelines.
    - PerformCare was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.
- PerformCare's rate for the MY 2014 Readmission Within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (worse) than the BH-MCO average by 1.6 percentage points. PerformCare's rate did not meet the OMHSAS designated performance goal of 10.0%.
- PerformCare's rates for the MY 2014 Follow-up After Hospitalization for Mental Illness HEDIS indicators QI 1 (Total Population) was statistically significantly lower than the BH-MCO Average by 2.1 percentage points. PerformCare reported the lowest result for QI 1 of all the BH-MCOs evaluated.
- PerformCare's rates for the MY 2014 Follow-up After Hospitalization for Mental Illness HEDIS indicators (QI 1 and QI 2) for ages 6-64 did not meet the goal of meeting or exceeding the 75th percentile.

Additional strengths and targeted opportunities for improvement can be found in the BH-MCO-specific 2015 (MY 2014) Performance Measure Matrices that follow.

Performance Measure Matrices

The Performance Measure (PM) Matrices provide a comparative look at quality indicators (QIs) included in the External Quality Review (EQR) evaluation for Quality Performance of the HealthChoices BH-MCO. The comparisons are presented in matrices that are color-coded to indicate when the findings for these measures are notable and whether there is cause for action as described in **Table 22**.

Table 22: BH-MCO Performance and HEDIS Percentiles

Color Code	Definition
	PA-specific Follow-up After Hospitalization Measures: Indicates that the BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average and trends up from MY 2013. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Indicates that the BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average and trends down from MY 2013. HEDIS Follow-up After Hospitalization Measures– Ages 6–64: At or above 90th percentile. BH-MCOs may have internal goals to improve.
	PA-specific Follow-up After Hospitalization Measures: Either the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and trends up from MY 2013 or that the BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average but there is no change from MY 2013. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and trends down from MY 2013 or that the BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average but there is no change from MY 2013. HEDIS Follow-up After Hospitalization Measures– Ages 6–64: At or above 75th and below 90th percentile. BH-MCOs may identify continued opportunities for improvement.
	PA-specific Follow-up After Hospitalization Measures: The BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average and trends up from MY 2013 or the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and there is no change from MY 2013 or the BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average but trends down from MY 2013. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** The BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average and trends down from MY 2013 or the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and there is no change from MY 2013 or the BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average but trends up from MY 2013. HEDIS Follow-up After Hospitalization Measures– Ages 6–64: N/A No action is required although MCOs should identify continued opportunities for improvement.
	PA-specific Follow-up After Hospitalization Measures: Either the BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average and there is no change from MY 2013 or that the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and trends down from MY 2013. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average and there is no change from MY 2013 or that the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and trends up from MY 2013. HEDIS Follow-up After Hospitalization Measures– Ages 6–64: At or above 50th and below 75th percentile. A root cause analysis and plan of action is required.
	PA-specific Follow-up After Hospitalization Measures: the BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average and trends down from MY 2013. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** the BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average and trends up from MY 2013. HEDIS Follow-up After Hospitalization Measures – Ages 6–64: At or below the 50th percentile. A root cause analysis and plan of action is required.

Table 23 is a three-by-three matrix depicting the horizontal comparison between the BH-MCO's performance and 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.

Table 23: Performance Measure Matrix

Year to Year Statistical Significance Comparison	HealthChoices BH-MCO Average Statistical Significance Comparison		
Trend	Below / Poorer than Average	Average	Above / Better than Average
⬆	C	B FUH QI A	A FUH QI B
No Change	D REA[1]	C	B
⬇	*F*	D	C

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

Letter Key: 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.

Color Key: See **Table 22.**

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

Table 24 represents the BH-MCO's performance for each measure in relation to prior year's rates for the same indicator for MY 2011 to MY 2014. The BH-MCO's rate can be statistically significantly higher than the prior year's rate (▲), have no change from the prior year, or be statistically significantly lower than the prior year's rate (▼). 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.

Table 24: Performance Measure Rates

Quality Performance Measure	MY 2011 Rate	MY 2012 Rate	MY 2013 Rate	MY 2014 Rate	MY 2014 HC BH-MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)	57.4%▲	59.4%═	54.1%▼	56.9%▲	58.2%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)	76.7%▲	78.0%═	73.1%▼	76.4%▲	74.8%
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	14.8%=	14.1%═	15.5% ▲	15.9% ═	14.3%

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

Table 25 is a four-by-one matrix that represents the BH-MCO's performance as compared to the HEDIS 90th, 75th, 50th and 25th percentiles for the Follow-up After Hospitalization 7-Day/30-Day metrics (FUH7/FUH30). A root cause analysis and plan of action is required for items that fall below the 75th percentile.

Table 25: HEDIS Follow-up After Hospitalization 7-Day/30-Day Performance Measure Matrix

HealthChoices BH-MCO HEDIS FUH Comparison[1]
Indicators that are greater than or equal to the 90th percentile.
Indicators that are greater than or equal to the 75th percentile, but less than the 90th percentile. (*Root cause analysis and plan of action required for items that fall below the 75th percentile.)*
Indicators that are greater than or equal to the 50th percentile, but less than the 75th percentile. **FUH QI 2**
Indicators that are less than the 50th percentile. **FUH QI 1**

[1] Rates shown are for ages 6–64 years. These rates are slightly higher than the overall rate.
FUH QI 1: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) FUH QI 2: Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)

Table 26 illustrates the rates achieved compared to the HEDIS 75th percentile goal. Results are not compared to the prior year's rates.

Table 26: HEDIS Follow-up After Hospitalization 7-Day/30-Day Performance Measure Rates Ages 6–64 Years

Quality Performance Measure	MY 2014		HEDIS MY 2014 Percentile
	Rate[1]	Compliance	
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day)	45.3%	Not Met	Below 50th and at or above 25th percentile
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	69.6%	Not Met	Below 75th and at or above 50th percentile

[1] Rates shown are for ages 6–64 years. These rates are slightly higher than the overall rate.

Table 27 summarizes the key points based on the findings of the performance measure matrix comparisons.

Table 27: Key Points of Performance Measure Comparisons

A – Performance is notable. No action required. BH-MCOs may have internal goals to improve.
• Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)
B – No action required. BH-MCO may identify continued opportunities for improvement.
• Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)
C – No action required although BH-MCO should identify continued opportunities for improvement.
• No PerformCare performance measure rate fell into this comparison category.
D – Root cause analysis and plan of action required.
• Readmission Within 30 Days of Inpatient Psychiatric Discharge[1] • Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day – 6 to 64 years)
F – Root cause analysis and plan of action required.
• Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day – 6 to 64 years)

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

VII: Summary of Activities

Structure and Operations Standards

- PerformCare was partially compliant on Subparts C, D and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2014, RY 2013, and RY 2012 were used to make the determinations.

Performance Improvement Projects

- PerformCare submitted an final PIP proposal and Year One Updatein 2015.

Performance Measures

- PerformCare reported all performance measures and applicable quality indicators in 2015.

2014 Opportunities for Improvement MCO Response

- PerformCare provided a response to the opportunities for improvement issued in 2014.

2015 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for PerformCare in 2015. The BH-MCO will be required to prepare a response for the noted opportunities for improvement in 2016.

Appendices

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

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DHS.
	Standard 104.2	The BH-MCO must submit to the DHS data specified by the DHS 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 DHS.
	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, have 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. 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

BBA Category	PEPS Reference	PEPS Language
		urban/rural met.
	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 the Department 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 provide instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of oral interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Standard 24.2	Provider network database 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: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, and Consumer satisfaction.
§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.

BBA Category	PEPS Reference	PEPS Language
§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 according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§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: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, and Consumer satisfaction.
§438.240 Quality	Standard 91.1	QM program description outlines ongoing quality assessment, performance improvement activities, a continuous quality improvement process, and places

BBA Category	PEPS Reference	PEPS Language
assessment and performance improvement program		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 processes; denial rates; upheld and overturned grievance rates; and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other high volume/high risk 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: Mental Health; and, 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 DHS. 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 DHS 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: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates,

BBA Category	PEPS Reference	PEPS Language
		Follow up after hospitalization rates, and Consumer satisfaction.
	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 schools.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DHS.
	Standard 104.2	The BH-MCO must submit to the DHS data specified by the DHS 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 DHS.
	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 decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must b 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 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.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: • BBA Fair Hearing • 1st level • 2nd level

BBA Category	PEPS Reference	PEPS Language
		• 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 according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§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 • Expedited
	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 decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must 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 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

BBA Category	PEPS Reference	PEPS Language
		documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and 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 according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§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 provide instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of oral interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Standard 24.2	Provider network database 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 according to required timeframes and use the

BBA Category	PEPS Reference	PEPS Language
		required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§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 decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must 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 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.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and 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 according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand

BBA Category	PEPS Reference	PEPS Language
		and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§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 decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must 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 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.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and 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 according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services;

BBA Category	PEPS Reference	PEPS Language
		contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.410 Expedited resolution of appeals	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and 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 according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§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	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and 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	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: • BBA Fair Hearing

BBA Category	PEPS Reference	PEPS Language
MCO or PIHP appeal and the State fair hearing are pending		• 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 according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.424 Effectuation of reversed appeal resolutions	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and 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 according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

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.
	Standard 1.3	Provider Exception report submitted & approved when choice of two providers is not given.

BBA Category	PEPS Reference	PEPS Language
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).
	Standard 1.5	BH-MCO has notified DPW of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that was provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that was provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational/vocational status and Changes in living status.
§438.208 Coordination and Continuity of Care	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.210 Coverage and	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.

BBA Category	PEPS Reference	PEPS Language
authorization of services	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.2104 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	Re-credentialing 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	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

BBA Category	PEPS Reference	PEPS Language
improvement program		source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines, the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services, provider network adequacy, penetration rates, appropriateness of service authorizations, inter-rater reliability, complaint, grievance and appeal process, denial rates, grievance upheld and overturn rates and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other HV/HR services).
	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,

BBA Category	PEPS Reference	PEPS Language
		Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational/vocational status and Changes in living status.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH-MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for Coordination with Other Service Agencies and School.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline 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

BBA Category	PEPS Reference	PEPS Language
		• 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.
§438.402 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

BBA Category	PEPS Reference	PEPS Language
		• 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	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

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

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

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

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

Appendix B: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Care Management		
Care Management (CM) Staffing	Standard 27.7	Other: Significant onsite review findings related to Standard 27.
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
Second Level Complaints and Grievances		
Complaints	Standard 68.6	The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 68.9	Where applicable there is evidence of county oversight and involvement in the 2nd level complaint process.
Grievances and State Fair Hearings	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 71.8	Where applicable there is evidence of county oversight and involvement in the 2nd level grievance process.
Denials		
Denials	Standard 72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to **Appendix AA** requirements.
Executive Management		
County Executive Management	Standard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Standard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/ Family Satisfaction	Standard 108.3	County/BH-MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.
	Standard 108.4	The C/FST Director is responsible for setting program direction consistent with county direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority and directing staff to perform high quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2014, 16 substandards were considered OMHSAS-specific monitoring standards. Of the 16 OMHSAS-specific PEPS Substandards, 16 were evaluated for PerformCare and the seven HC BH Contractors contracting with PerformCare. **Table C.1** provides a count of these Items, along with the relevant categories.

Table C.1: OMHSAS-Specific Substandards Reviewed for PerformCare

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	PEPS Reviewed in RY 2012	Not Reviewed
Care Management					
Care Management (CM) Staffing (Standard 27)	1	1	0	0	0
Longitudinal Care Management (and Care Management Record Review) (Standard 28)	1	1	0	0	0
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	4	0	0	0
Grievances and State Fair Hearings (Standard 71)	4	4	0	0	0
Denials					
Denials (Standard 72)	1	1	0	0	0
Executive Management					
County Executive Management (Standard 78)	1	1	0	0	0
BH-MCO Executive Management (Standard 86)	1	1	0	0	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0

Format

This document groups the monitoring standards under the subject headings Care Management, Second Level Complaints and Grievances, Denials, Executive Management and Enrollee Satisfaction. The status of each substandard is presented as it appears in the PEPS Review Application (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 Care Management are MCO-specific review standards. These two substandards were added to the PEPS Application for RY 2014. Of the two substandards, PerformCare met one substandard and partially met one substandard. The status for these substandards is presented in **Table C.2**.

Table C.2: OMHSAS-Specific Requirements Relating to Care Management

Category	PEPS Item	Review Year	Status
Care Management			
Care Management (CM) Staffing	Standard 27.7	RY 2014	Partially Met
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	RY 2014	Met

PEPS Standard 27: Care management staffing is sufficient to meet member needs. Appropriate supervisory staff, including access to senior clinicians (peer reviewers, physicians, etc.) is evident.

PerformCare partially met the criteria for compliance on Substandard 27.7 (RY 2014).

Substandard 27.7: Other: Significant onsite review findings related to Standard 28.

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards[2]. Of the seven substandards evaluated, PerformCare met one substandard, partially met two substandards, and did not meet five substandards, as indicated in **Table C.3**.

Table C.3: OMHSAS-Specific Requirements Relating to Second Level Complaints and Grievances

Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
Complaints	Standard 68.1	RY 2014	Partially Met
	Standard 68.6	RY 2014	Not Met
	Standard 68.7	RY 2014	Not Met
	Standard 68.8	RY 2014	Not Met
Grievances and State Fair Hearings	Standard 71.1	RY 2014	Met
	Standard 71.5	RY 2014	Partially Met
	Standard 71.6	RY 2014	Not Met
	Standard 71.7	RY 2014	Not Met

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

PerformCare partially met the criteria for compliance on Substandards 68.1 and did not meet the criteria for compliance on Substandards 68.6, 68.7, and 68.8 (RY 2014).

Substandard 68.1: Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.
Substandard 68.6: The second level complaint case file includes documentation that the member was contacted about the second level complaint meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
Substandard 68.7: Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.
Substandard 68.8: A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

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

PerformCare partially met the criteria for compliance on Substandards 71.5 and did not meet the criteria for compliance on Substandards 71.6 and 71.7 (RY 2014).

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

[2] Beginning with RY 2012, MCO-specific substandards 68.9 and 71.8 were changed to county-specific substandards and renumbered to 68.1 and 78.1 respectively under the county-specific standard set.

Substandard 71.6: Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.

Substandard 71.7: A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2014. PerformCare was evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

Table C.4: OMHSAS-Specific Requirements Relating to Denials

Category	PEPS Item	Review Year	Status
Denials			
Denials	Standard 72.3	RY 2014	Met

There are two OMHSAS-specific PEPS substandards relating to Executive Management; the County Executive Management substandard is a county-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. These substandards were added to the PEPS Application during RY 2014. PerformCare met the criteria for compliance for substandard 78. 5 and partially met the criteria for compliance for substandard 86.3. The status for these substandards is presented in **Table C.5**.

Table C.5: OMHSAS-Specific Requirements Relating to Executive Management

Category	PEPS Item	Review Year	Status
Care Management			
County Executive Management	Standard 78.5	RY 2014	Met
BH-MCO Executive Management	Standard 86.3	RY 2014	Partially Met

PEPS Standard 86: Required duties and functions are in place. The BH-MCO's table of organization depicts organization relationships of the following functions/ positions: Chief Executive Office; the appointed Medical Director is a board certified psychiatrist licensed in Pennsylvania with at least five years experience in mental health and substance abuse; Chief Financial Office; Director of Quality Management; Director of Utilization Management; Management Information Systems; Director of Prior/service authorization; Direcotr of member Services; and Director of Provider Services.

PerformCare partially met the criteria for compliance on Substandards 86.3 RY 2014).

Substandard 86.3: Significant onsite review findings related to Standard 86.

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are county-specific review standards. All three substandards crosswalked to this category were evaluated for PerformCare counties. Counties contracted with PerformCare met two substandards, and partially met one substandard. The status for these is presented in **Table C.6**.

Table C.6: OMHSAS-Specific Requirements Relating to Enrollee Satisfaction

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

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

PerformCare partially met the criteria for compliance on Substandards 108.9 (RY 2012).

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

References

Adair C.E., McDougall, G.M., & Mitton, C.R. (2005). Continuity of Care and Health Outcomes Among Persons with Severe Mental Illness. *Psychiatric Services, 56(9)*, 1061-1069.

Arnaout, B., & Petrakis, I. (2008). Diagnosing Co-Morbid Drug Use in Patients With Alcohol Use Disorders. *Alcohol Research & Health, 31(2)*, 148–154.

Averyt, J.M., Kuno, E., Rothbard, A.B., & Culhane, D.P. (1997). Impact of Continuity of Care on Recurrence of Homelessness Following an Acute Psychiatric Episode. *Continuum* 4.3

Chien, C., Steinwachs, D.M., Lehman, A.F., et al. (2000). Provider Continuity and Outcomes of Care for Persons with Schizophrenia. *Mental Health Services Research, 2*, 201-211.

Cuffel, B.J., Held, M., & Goldman, W. (2002). Predictive Models and the Effectiveness of Strategies for Improving Outpatient Follow-up Under Managed Care. *Psychiatric Services, 53*, 1438-1443.

D'Mello, D.A., Boltz, M.K., & Msibi, B. (1995). Relationship between Concurrent Substance Abuse in Psychiatric Patients and Neuroleptic Dosage. *American Journal of Drug and Alcohol Abuse, 2, 257-265*.

Desai, M., Rosenheck, R.A., Druss, B.G., & Perlin, J.B. (2002) Mental Disorders and Quality of Diabetes Care in Veterans Health Administration. *American Journal of Psychiatry, 159*, 1584-1590.

Dombrovski A.,& Rosenstock, J. (2004). Bridging General Medicine and Psychiatry: Providing General Medical and Preventive Care for the Severely Mentally Ill. *Current Opinion in Psychiatry*, *17(6)*, 523-529.

Druss, B.G., Bradford, D.W., Rosenheck, R.A., et al. (2000). Mental Disorders and Use of Cardiovascular Procedures After Myocardial Infarction. *Journal of the American Medical Association, 283(4)*, 506-511.

Druss B.G., Rosenheck, R.A., Desai, M.M., & Perlin, J. B. (2002). Quality of Preventive Medical Care for Patients with Mental Disorders. *Medical Care, 40(2)*, 129–136.

Frayne, S.M., Halanych, J.H., Miller, D.R., et al. (2005). Disparities in Diabetes Care: Impact of Mental Illness. *Archive of Internal Medicine, 165(22)*, 2631-2638.

Gill, S.S. (2005). Stable Monotherapy with Clozapine or Olanzapine Increases the Incidence of Diabetes Mellitus in People with Schizophrenia. *Evidence Based Mental Health*, *8(1)*, 24.

Hermann, R.C. (2000) Quality measures for mental health care: results from a National Inventory. *Medical Care Research and Review, 57*, 136-154.

Insel, T.R. (2008). Assessing the Economic Costs of Serious Mental Illness. *American Journal of Psychiatry, 165*, 663-665.

Leslie, D.L., & Rosenheck, R.A. (2004). Incidence of Newly Diagnosed Diabetes Attributable to Atypical Antipsychotic Medications. *American Journal of Psychiatry, 161*, 1709–1711.

Mitton, C.R., Adair, C.E., McDougall, G.M., & Marcoux, G. (2005) Continuity of Care and Health Care Costs Among Persons with Severe Mental Illness. *Psychiatric Services, 56(9)*, 1070-1076.

Moran, M. (2009). Schizophrenia Patients Show High Rates of Comorbid Illness. *Psychiatric News*, *44(18)*, 22.

National Committee for Quality Assurance (2007). The State of Health Care Quality 2007. Retrieved from http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_2007.pdf.

National Institute on Drug Abuse (2011). DrugFacts: Drug-Related Hospital Emergency Room Visits. Retrieved from http://www.drugabuse.gov/publications/drugfacts/drug-related-hospital-emergency-room-visits.

National Institute of Mental Health — Statistics (2009). Retrieved from http://www.nimh.nih.gov/health/topics/statistics/index.shtml.

Nelson, E.A., Maruish, M.E., & Axler, J.L. (2000). Effects of Discharge Planning and Compliance with Outpatient Appointments on Readmission Rates. *Psychiatric Services, 51*, 885-889.

Quality of Care External Quality Review (EQR). (2012, September 1.) Retreived from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

U.S. Department of Health & Human Services (2008). Alcohol Alert. National Institute on Alcohol Abuse and Alcoholism, July 2008. Retrieved from http://pubs.niaaa.nih.gov/publications/AA76/AA76.htm.

van Walraven, C., Mamdani, M., Fang, J., & Austin, P.C. (2004). Continuity of Care and Patient Outcomes After Discharge. *Journal of General Internal Medicine, 19*, 624-631.

World Health Organization (2008). WHO Global Burden of Disease: 2004 Update. Retrieved from www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html