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

2016 External Quality Review Report
Community Care Behavioral Health

DRAFT
April 28, 2017

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

List of Tables and Figures

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 2016 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. 2015 Opportunities for Improvement - MCO Response
VI. 2016 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 three Performance Measures – Follow-up After Hospitalization for Mental Illness, Readmission Within 30 Days of Inpatient Psychiatric Discharge, and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

Section V, 2015 Opportunities for Improvement – MCO Response, includes the BH-MCO's responses to opportunities for improvement noted in the 2015 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 (2016) 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) 2015, 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.

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. During RY 2013, three counties, Blair, Clinton, and Lycoming, held a contract with another BH-MCO through June 30, 2013 and contracted with Community Care Behavioral Health (CCBH) as of July 1, 2013.

Adams, Allegheny, Berks, Chester and York Counties hold contracts with CCBH. The North/Central County Option (NC/CO) Counties – Carbon, Monroe, and Pike – also hold a contract with CCBH. Lackawanna, Luzerne, Susquehanna and Wyoming hold a contract with Northeast Behavioral Health Care Consortium (NBHCC), which in turn holds a contract with CCBH. The Department contracts directly with CCBH to manage the HC BH program for the North/Central State Option (NCSO) Counties – Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren and Wayne. **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
Allegheny HealthChoices, Inc. (AHCI)	Allegheny County	Allegheny County
Berks County	Berks County	Berks County
Central Pennsylvania Behavioral Health Collaborative (d/b/a Blair HealthChoices)	Blair HealthChoices	Blair County
Carbon/Monroe/Pike Joinder Board (NC/CO)	Carbon/Monroe / Pike Joinder Board (CMP)	Carbon County
		Monroe County
		Pike County
Chester County	Chester County	Chester County
Erie County	Erie County	Erie County
Lycoming-Clinton Joinder Board	Lycoming-Clinton Joinder Board	Clinton County
		Lycoming County
Northeast Behavioral Health Care Consortium (NBHCC)	Northeast	Lackawanna County

HealthChoices Oversight Entity	HC BH Contractor	County
	Behavioral Health Care Consortium (NBHCC)	Luzerne County
		Susquehanna County
		Wyoming County
PA Department of Human Services – OMHSAS	Community Care Behavioral Health Organization Otherwise known as North/Central State Option (NCSO) for this review	Bradford County
		Cameron County
		Centre County
		Clarion County
		Clearfield County
		Columbia County
		Elk County
		Forest County
		Huntingdon County
		Jefferson County
		Juniata County
		McKean County
		Mifflin County
		Montour County
		Northumberland County
		Potter County
		Schuylkill County
		Snyder County
		Sullivan County
		Tioga County
		Union County
		Warren County
		Wayne County
York/Adams MH/MR Program	Adams County	Adams County
	York County	York 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 CCBH by OMHSAS monitoring staff within the past three review years (RYs 2015, 2014, 2013). 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 2015. 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 2016 and entered into the PEPS Application as of October 2016 for RY 2015. 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 2015 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 2015, RY 2014, and RY 2013 provided the information necessary for the 2016 assessment. Those standards not reviewed through the PEPS system in RY 2015 were evaluated on their performance based on RY 2014 or RY 2013 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 2013, and because all applicable standards were reviewed for both BH-MCOs within the three-year time frame, review findings for these HealthChoices Oversight Entities were not included in the 2016 assessment of compliance for either BH-MCO.

For CCBH, 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 CCBH 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 CCBH

Table 2: Substandards Pertinent to BBA Regulations Reviewed for CCBH

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2015	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	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[2]	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.

[2] There was one substandard (Standard 1, Substandard 7: Confirm FQHC providers) in Availability of Services that was deemed "Not Reviewed" for the NBHCC and Carbon-Monroe-Pike Contractors due to no contracted FQHCs. For these HC BH Contractors, 12 Items were reviewed in RY 2013, and 23 Items were reviewed in total.

For RY 2015, 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 HealthChoices Oversight Entities 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 2016 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 HealthChoices Oversight Entity's 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 CCBH and the 10 HealthChoices Oversight Entities with the BH-MCO who were included in the structure and operations standards for RY 2015, 163 PEPS Items were identified as required to fulfill BBA regulations. Because 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. Adams, Berks, Allegheny, Chester, NCSO, Erie and York HC BH Contractors were evaluated on 163 PEPS Items. One substandard (Substandard 7 of PEPS Standard 1) was not applicable for NBHCC or Carbon-Monroe-Pike during the review cycle; therefore, these HealthChoices Oversight Entities were evaluated on 162 PEPS items.

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	Not Compliant	
Enrollee Rights 438.100	Compliant	All CCBH HC BH Contractors			12 substandards were crosswalked to this category. Each HC BH Contractors was evaluated on 12 substandards and was compliant with 12 substandards.
Provider-Enrollee Communications 438.102	Compliant	All CCBH 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 HC BH Contractor of residence.
Liability for Payment 438.106	Compliant	All CCBH HC BH Contractors			Compliant as per PS&R sections A.9 (p.70) and C.2 (p.32).
Cost Sharing 438.108	Compliant	All CCBH 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 CCBH HC BH Contractors			Compliant as per PS&R section 4 (p.37).
Solvency Standards 438.116	Compliant	All CCBH HC BH Contractors			Compliant as per PS&R sections A.3 (p.65) and A.9 (p.70), and 2015-2016 Solvency Requirements tracking report.

N/A: not applicable

There are seven categories in the Enrollee Rights and Protections Standards. CCBH was compliant with six categories. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the six 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 Solvency Standards category was compliant based on the 2015-2016 Solvency Requirement tracking report.

Of the 12 PEPS substandards that were crosswalked to Enrollee Rights and Protections regulations, all 12 were evaluated. Each HC BH Contractor was evaluated on 12 substandards, and compliant on 12 substandards.

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	Not Compliant	
Elements of State Quality Strategies 438.204	Compliant	All CCBH HC BH Contractors			Compliant as per PS&R section G.3 (p.58).
Availability of Services (Access to Care) 438.206	Partial		All CCBH HC BH Contractors		24 substandards were crosswalked to this category Adams, Allegheny, Chester, Berks, NCSO, Erie and York were evaluated on 24 substandards, compliant with 18 substandards, partially compliant with 4 substandards and non-compliant with 2 substandards. The Carbon-Monroe-Pike and NBHCC HC BH Contractors were evaluated on 23 substandards, compliant with 17 substandards, partially compliant with 4 substandards and non-compliant with 2 substandards.
Coordination and Continuity of Care 438.208	Non-Compliant			All CCBH HC BH Contractors	2 substandards were crosswalked to this category Each HC BH Contractor was evaluated on 2 substandards and non-compliant with 2 substandards.
Coverage and Authorization of Services 438.210	Partial		All CCBH HC BH Contractors		4 substandards were crosswalked to this category Each HC BH Contractor was evaluated on 4 substandards, partially compliant with 2 substandards and non-compliant with 2 substandards.
Provider Selection 438.214	Compliant	All CCBH HC BH Contractors			3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards and

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor			Comments
		Fully Compliant	Partially Compliant	Not Compliant	
					compliant with 3 substandards.
Confidentiality 438.224	Compliant	All CCBH 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 CCBH HC BH Contractors		8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards, compliant with 6 substandards and partially compliant with 2 substandards.
Practice Guidelines 438.236	Partial		All CCBH HC BH Contractors		6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on evaluated on 6 substandards, compliant with 3 substandards, partially compliant with 1 substandard and non-compliant with 2 substandards.
Quality Assessment and Performance Improvement Program 438.240	Partial		All CCBH HC BH Contractors		23 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards, compliant with 22 substandards and partially compliant with 1 substandard.
Health Information Systems 438.242	Compliant	All CCBH HC BH Contractors			1 substandard was crosswalked to this category. Each HC BH Contractor was evaluated on 1 substandard and compliant with this substandard.

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

For this review, 71 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations for all HC BH Contractors associated with CCBH. One substandard was not reviewed for Carbon-Monroe-Pike and NBHCC due to no contracted FQHCs in Review Year 2013. Carbon-Monroe-Pike and NBHCC were compliant with 56 substandards, partially compliant with 6 substandards, and non-compliant with 8 substandards. All other HC BH Contractors were compliant with 57 substandards, partially compliant with 6 substandards and non-compliant with 8 substandards. 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 of the CCBH HC BH Contractors were partially compliant with Availability of Services due to partial or non-compliance with substandards of PEPS Standards 24, 28, and 93.

PEPS Standard 24: Americans with Disabilities Act (ADA). Policies and procedures for, and demonstrated compliance with, the Americans with Disabilities Act, including: a. Physical Disabilities (i.e. identifying handicapped accessibility for all services for persons with physical handicaps). b. Deaf (i.e. providing interpreter services, including American Sign Language and listing of interpreters, and providing alternative methods of phone communication, including availability of Text Telephone Typewriter (TTY) and/or Pennsylvania Telecommunication relay services). c. Hard of hearing (i.e. providing assisted listening devices). d. Blind (i.e. providing Braille/audio tapes).

All of the CCBH HC BH Contractors were partially compliant with one substandard of PEPS Standard 24 (Substandard 3) in RY 2013.

> **Substandard 3:** BH-MCO phone answering uses TTY or PA telecommunication relay services.

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 CCBH HC BH Contractors were non-compliant with two substandards of PEPS Standard 28: Substandards 1 and 2 (RY 2015):

> **Substandard 1:** Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
> **Substandard 2:** The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.

PEPS Standard 93: The BH-MCO Evaluates the Effectiveness of Services received by Members. The quality of care and the effectiveness of the services received by members are evaluated in the following areas: changes made to service access; provider network adequacy; appropriateness of service authorization; inter-rater reliability; complaint, grievance and appeal processes; and treatment outcomes.

All of the CCBH HC BH Contractors were partially compliant on one substandard of Standard 93: Substandard 1 (RY 2014).

> **Substandard 1:** The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.

Coordination and Continuity of Care

All of the CCBH HC BH Contractors were non-compliant with Coordination and Continuity of Care due to non-compliance with two substandards of PEPS Standard 28.

PEPS Standard 28: See Standard description and compliance determination under Availability of Services (Access to Care) on page 15 of this report.

Coverage and Authorization of Services

All of the CCBH HC BH Contractors were partially compliant with Coverage and Authorization of Services due to non-compliance with two substandards of PEPS Standard 28.

PEPS Standard 28: See Standard description and compliance determination under Availability of Services (Access to Care) on page 15 of this report.

Subcontractual Relationships and Delegations

All of the CCBH HC BH Contractors were partially compliant with Subcontractual Relationships and Delegations due to partial compliance with two substandards of PEPS Standard 99.

PEPS Standard 99: 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 of the CCBH HC BH Contractors were partially compliant on two substandards of Standards 99: Substandards 1 and 2 (RY 2014).

> **Substandard 1:** The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning.
> **Substandard 2:** The BH-MCO reports monitoring results for adverse incidents.

Practice Guidelines

All of the CCBH HC BH Contractors were partially compliant with Practice Guidelines due to non-compliance with two substandards of PEPS Standard 28 and partial compliance with one substandard of PEPS Standard 93.

PEPS Standard 28: See Standard description and compliance determination under Availability of Services on page 15 of this report.

PEPS Standard 93: See Standard description and non-compliant standard determination under Availability of Services on page 15 of this report.

Quality Assessment and Performance Improvement

All of the CCBH HC BH Contractors were partially compliant with Quality Assessment and Performance Improvement due to partial compliance with one substandard of PEPS Standard 93.

PEPS Standard 91: Completeness of the BH-MCO's Quality Management (QM) Program Description and QM Work Plan. The BH-MCO has a quality management program that includes a plan for ongoing quality assessment and performance improvement. The BH-MCO conducts performance improvement projects (PIPs) that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The QM plans emphasize high-volume and high-risk services and treatment and BHRS.

All of the CCBH HC BH Contractors were partially compliant with one substandard of Standard 91: Substandard 1 (RY 2014).

> **Substandard 1:** QM program description outlines ongoing quality assessment, performance improvement activities, a continuous quality improvement process, and places emphasis on, but not limited to, high-volume/high-risk services and treatment and Behavioral Health Rehabilitation Services.

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 CCBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 7 substandards, and partially compliant with 4 substandards.
General Requirements 438.402	Partial		All CCBH HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards, compliant with 10 substandards, and partially compliant with 4 supstandards.
Notice of Action 438.404	Partial		All CCBH HC BH Contractors	13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards, compliant with 12 substandards and partially compliant with 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All CCBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 7 substandards, and partially compliant with 4 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All CCBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 7 substandards, and partially compliant with 4 substandards.
Expedited Appeals Process 438.410	Partial		All CCBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 5 substandards and partially compliant with 1 substandard.
Information to Providers & Subcontractors 438.414	Compliant		All CCBH HC BH Contractors	2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards, and compliant with 2 substandards.
Recordkeeping and Recording Requirements 438.416	Compliant	All CCBH HC BH Contractors		Compliant as per the required quarterly reporting of complaint and grievances data
Continuation of Benefits 438.420	Partial		All CCBH HC BH Contractors	6 substandards were crosswalked to this category.

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
				Each HC BH Contractor was evaluated on 6 substandards, compliant with 5 substandards and partially compliant with 1 substandard.
Effectuation of Reversed Resolutions 438.424	Partial		All CCBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 5 substandards and partially compliant with 1 substandard.

There are 10 categories in the Federal and State Grievance System Standards. CCBH was compliant with two categories and partially compliant with eight categories. The Recordkeeping and Recording Requirements category was compliant as per the quarterly reporting of Complaint and Grievances data.

For this review, 80 substandards were crosswalked to Federal and State Grievance System Standards for all HC BH Contractors associated with CCBH and included in the review. Each HC BH Contractor was evaluated on 80 substandards, compliant with 60 substandards, and partially compliant with 20 substandards. 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.

All HC BH Contractors associated with CCBH were partially compliant with eight of the ten categories pertaining to Federal State and Grievance System Standards due to partial or non-compliance with substandards within PEPS Standards 24, 68 and 71.

Statutory Basis and Definitions

All HC BH Contractors associated with CCBH were partially compliant with Statutory Basis and Definitions due to partial compliance with substandards of PEPS Standards 68 and 71.

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

All CCBH HC BH Contractors were partially compliant with three substandards of Standards 68: Substandards 3, 4 and 5 (RY 2015).

> **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.
> **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 complaint/grievance 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: Grievances 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 CCBH HC BH Contractors were partially compliant with one substandard of Standards 71: Substandard 4 (RY 2015).

> **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.

General Requirements

All HC BH Contractors associated with CCBH were partially compliant with General Requirements due to partial compliance with substandards of Standards 68 and 71.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 18 of this report.

PEPS Standard 71: See Standard description and partially compliant substandard determination under Statutory Basis and Definitions on page 18 of this report.

Notice of Action

All HC BH Contractors associated with CCBH were partially compliant with Notice of Action due to partial compliance with one substandard of Standards 24.

PEPS Standard 24: See Standard description and determination of compliance under Availability of Services on page 15 of this report.

Handling of Grievances and Appeals

All HC BH Contractors associated with CCBH were partially compliant with Handling of Grievances and Appeals due to partial compliance with substandards of Standards 68 and 71.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

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

Resolution and Notification: Grievances and Appeals

All HC BH Contractors associated with CCBH were partially compliant with Resolution and Notification due to partial compliance with substandards of Standards 68 and 71.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 18 of this report.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 18 of this report.

Expedited Appeals Process

All HC BH Contractors associated with CCBH were partially compliant with Expedited Appeals Process due to partial compliance with a substandard of Standards 71.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 18 of this report.

Continuation of Benefits

All HC BH Contractors associated with CCBH were partially compliant with Continuation of Benefits due to partial compliance with a substandard of Standards 71.

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

Effectuation of Reversed Resolutions

All HC BH Contractors associated with CCBH were partially compliant with Effectuation of Reversed Resolutions due to partial compliance with a substandard of Standards 71.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 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 2016 for 2015 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. In 2016, OMHSAS elected to add an additional intervention year to the PIP cycle to allow sufficient time for the demonstration of outcomes. 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 2019. BH-MCOs are required to develop performance indicators and implement interventions based on

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

evaluations of HC BH Contractor-level and BH-MCO-level data, including clinical history and pharmacy data. This PIP is designed to be a 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 2016 EQR is the 13th 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. 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

In 2016, OMHSAS elected to begin conducting quarterly PIP review calls with each BH-MCO. The purpose of these calls was discuss ongoing monitoring of PIP activity, discuss the status of implementing planned interventions, and to provide a forum for technical assistance as necessary. Plans were asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, BH-MCOs were asked to submit only one PIP interim report in 2016, rather than two semi-annual submissions.

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. 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 compliance. As calendar year 2016 was an intervention year for all BH-MCOs, IPRO reviewed elements 1 through 9 for each BH-MCO.

Review Element Designation/Weighting

Calendar year 2016 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
Met	Met or exceeded the element requirements	100%
Partially Met	Met essential requirements, but is deficient in some areas	50%
Not Met	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

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

CCBH submitted their Year 1 PIP Update document for review in June 2016. As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. IPRO provided feedback and comments to CCBH on this submission. **Table 8** presents the PIP scoring matrix for the June 2016 Submission.

For the core outcome measures, CCBH identified the population to be measured, including the facilities selected for the DMP measure and a rationale for their selection. CCBH provided full definitions and of the populations to be included in each of the process measures designed to monitor the interventions. CCBH provided a description of eligible members for each indicator. CCBH also provided an estimate of the number of members included. Regarding process measures, CCBH updated the intervention methodology to provide greater detail about how process measures are evaluated. Examples of collection tools were provided. CCBH made several changes that improved the clarity of the PIP in general.

CCBH evaluates the impact of key interventions on readmission and follow-up rates by comparing eligible members who receive the intervention to eligible members who do not. For these interventions, the plan addressed potential confounding by testing for statistically significant differences between control and intervention populations for key variables, and adjusted for any significant differences with logistic regression analysis.

IPRO identified opportunities for improvement for Review Element 2, specifically related to goal-setting. CCBH assigned a uniform goal of 80% for all rates related to the Discharge Management Planning measure, regardless of baseline performance. It is recommended that goals be assigned based on baseline performance. Another opportunity for improvement relates to CCBH's expansion of DMP-focused interventions beyond pilot facilities. Expansion facilities were undergoing their baseline year while the pilot facilities were undergoing their first intervention year, therefore there should be different short-term goals for the two phases. While there may be a benefit to expanding the initial intervention, performance results for the two groups of facilities should not be combined.

Table 8: PIP Scoring Matrix: Successful Transition from Inpatient to Ambulatory Care

Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**77.5**
Review Element 10 – Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			**20%**	**N/A**
OVERALL PROJECT PERFORMANCE SCORE			**100%**	**N/A**

M – Met (100 points); PM – Partially Met (50 points); NM – Not Met (0 points); N/A – Not Applicable

III: Performance Measures

In 2016, 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 2015 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, 2015;
- 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, 2015, 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, 2015. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2016 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 measurement year 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 measurement year 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 measurement year 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 measurement year 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 measurement year 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 measurement year is to increase their current year's rate by 5%.

Interim goals were provided to the BH-MCOs after the MY 2014 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 2015, 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 2014 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 2015 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 ages 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 ages 6+ years 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 9** shows the MY 2015 results compared to their MY 2015 goals and HEDIS percentiles.

Table 9: MY 2015 HEDIS Follow-up Indicator Rates: 6–64 Years Old

	MY 2015							MY 2014	Rate Comparison			
Measure	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2015 Goal	2015 Goal Met?	%	PPD: MY 14 to MY 15	% Change: MY 14 to MY 15[1]	SSD: MY 14 to MY 15	HEDIS MY 2015 Medicaid Percentiles
QI 1 – HEDIS 7-Day Follow-up for Ages 6–64 Years Old												
HealthChoices Aggregate	16,896	36,949	**45.7%**	45.2%	46.2%	48.5%	NO	47.6%	-1.8	-3.84%	YES	Above 50th Percentile, Below 75th Percentile
CCBH	7,078	14,871	**47.6%**	46.8%	48.4%	48.7%	NO	47.7%	-0.1	-0.24%	NO	Above 50th Percentile, Below 75th Percentile
Adams	70	156	**44.9%**	36.7%	53.0%	47.3%	NO	46.4%	-1.5	-3.22%	NO	Above 50th Percentile, Below 75th Percentile
Allegheny	1,659	3,668	**45.2%**	43.6%	46.9%	45.3%	NO	43.1%	2.1	4.89%	NO	Above 50th Percentile, Below 75th Percentile
Berks	579	1,190	**48.7%**	45.8%	51.5%	51.5%	NO	50.5%	-1.8	-3.65%	NO	Above 50th Percentile, Below 75th Percentile
Blair	292	566	**51.6%**	47.4%	55.8%	56.8%	NO	57.2%	-5.6	-9.81%	NO	Above 50th Percentile, Below 75th Percentile
CMP	274	605	**45.3%**	41.2%	49.3%	46.6%	NO	45.7%	-0.4	-0.94%	NO	Above 50th Percentile, Below 75th Percentile
Chester	315	682	**46.2%**	42.4%	50.0%	49.8%	NO	48.8%	-2.6	-5.32%	NO	Above 50th Percentile, Below 75th Percentile
Erie	496	1,058	**46.9%**	43.8%	49.9%	51.4%	NO	50.4%	-3.5	-6.96%	NO	Above 50th Percentile, Below 75th Percentile
Lycoming-Clinton	218	469	**46.5%**	41.9%	51.1%	46.2%	YES	44.5%	2.0	4.47%	NO	Above 50th Percentile, Below 75th Percentile
NBHCC	962	1,873	**51.4%**	49.1%	53.7%	51.8%	NO	50.7%	0.6	1.24%	NO	Above 50th Percentile, Below 75th Percentile
NCSO	1,814	3,562	**50.9%**	49.3%	52.6%	52.3%	NO	51.3%	-0.3	-0.67%	NO	Above 50th Percentile, Below 75th Percentile
York	399	1,042	**38.3%**	35.3%	41.3%	38.4%	NO	36.5%	1.7	4.78%	NO	Below 50th Percentile, Above 25th Percentile
QI 2 – HEDIS 30-Day Follow-up for Ages 6-64 Years Old												
HealthChoices Aggregate	24,408	36,949	**66.1%**	65.6%	66.5%	69.2%	NO	67.9%	-1.8	-2.65%	YES	Above 50th Percentile, Below 75th Percentile
CCBH	10,106	14,871	**68.0%**	67.2%	68.7%	69.9%	NO	68.5%	-0.6	-0.85%	NO	Above 50th Percentile, Below 75th Percentile
Adams	108	156	**69.2%**	61.7%	76.8%	66.6%	YES	64.5%	4.7	7.26%	NO	Above 50th Percentile, Below 75th Percentile
Allegheny	2,320	3,668	**63.2%**	61.7%	64.8%	65.3%	NO	62.2%	1.0	1.63%	NO	Below 50th Percentile, Above 25th Percentile
Berks	817	1,190	**68.7%**	66.0%	71.3%	68.7%	NO	67.4%	1.3	1.89%	NO	Above 50th Percentile, Below 75th Percentile
Blair	415	566	**73.3%**	69.6%	77.1%	75.3%	NO	77.5%	-4.1	-5.33%	NO	At or Above 75th Percentile

Measure	MY 2015							MY 2014	Rate Comparison			
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2015 Goal	2015 Goal Met?	%	PPD: MY 14 to MY 15	% Change: MY 14 to MY 15[1]	SSD: MY 14 to MY 15	HEDIS MY 2015 Medicaid Percentiles
CMP	416	605	**68.8%**	65.0%	72.5%	73.5%	NO	72.1%	-3.3	-4.62%	NO	Above 50th Percentile, Below 75th Percentile
Chester	457	682	**67.0%**	63.4%	70.6%	68.3%	NO	67.0%	0.0	0.03%	NO	Above 50th Percentile, Below 75th Percentile
Erie	704	1,058	**66.5%**	63.7%	69.4%	70.6%	NO	69.2%	-2.6	-3.80%	NO	Above 50th Percentile, Below 75th Percentile
Lycoming-Clinton	309	469	**65.9%**	61.5%	70.3%	69.0%	NO	67.6%	-1.8	-2.60%	NO	Above 50th Percentile, Below 75th Percentile
NBHCC	1,347	1,873	**71.9%**	69.9%	74.0%	75.3%	NO	74.5%	-2.5	-3.42%	NO	Above 50th Percentile, Below 75th Percentile
NCSO	2,599	3,562	**73.0%**	71.5%	74.4%	74.5%	NO	73.0%	-0.1	-0.08%	NO	At or Above 75th Percentile
York	614	1,042	**58.9%**	55.9%	62.0%	62.5%	NO	59.5%	-0.6	-1.03%	NO	Below 50th Percentile, Above 25th Percentile

[1] Percentage change is the percentage increase or decrease of the MY 2015 rate when compared to the MY 2014 rate. The formula is: (MY 2015 rate – MY 2014 rate)/MY 2014 rate.

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option

The MY 2015 HealthChoices Aggregate HEDIS follow-up rates in the 6 to 64 year age group were 45.7% for QI 1 and 66.1% for QI 2 (**Table 9**). These rates were statistically significantly lower than the HealthChoices Aggregate rates for this age group in MY 2014, which were 47.6% and 67.9% respectively. The HealthChoices Aggregate rates were below the MY 2015 interim goals of 48.5% for QI 1 and 69.2% for QI 2; therefore, both interim goals were not met in MY 2015. Both HealthChoices Aggregate rates were between the NCQA 50th and 75th percentile; therefore, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2015 for either rate.

The MY 2015 CCBH QI 1 rate for members ages 6 to 64 was 47.6%, a 0.1 percentage point decrease from the MY 2014 rate of 47.7% (**Table 9**). The corresponding QI 2 rate was 68.0%, a 0.6 percentage point decrease from the MY 2014 rate of 67.9%. Both rates were comparable to (i.e. not statistically significantly different from) the prior year. The CCBH QI 1 rate for the 6 to 64 year old population was statistically significantly higher than the QI 1 HealthChoices BH-MCO Average of 45.1% by 2.5 percentage points, and the CCBH QI 2 rate for this age group was statistically significantly higher than the QI 2 HealthChoices BH-MCO Average of 65.8% by 2.2 percentage points. CCBH's rates were below its target goals of 48.7% for QI 1 and 69.9% for QI 2, therefore both interim follow-up goals were not met in MY 2015. Both HEDIS rates for this age group were between the HEDIS 2016 50th and 75th percentiles; therefore, the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by CCBH in MY 2015 for either rate.

From MY 2014 to MY 2015, none of the individual HC BH Contractors demonstrated statistically significant QI 1 or QI 2 rate changes (**Table 9**). Of the individual HC BH Contractors, Lycoming-Clinton met their MY 2015 interim goal for QI 1, and Adams met their MY 2015 interim QI 2 goal. Blair and the North/Central State Option (NSCSO) achieved the final OMHSAS goal of meeting or exceeding the NCQA 75th percentile for QI 2.

Figure 1 is a graphical representation of MY 2015 HEDIS follow-up rates in the 6 to 64 year old population for CCBH 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 rates for Berks, NCSO, the Northeast Behavioral Health Care Consortium (NBHCC), and Blair were statistically significantly above the MY 2015 QI 1 HC BH Contractor Average of 45.4%, with differences ranging from 3.2 percentage points above the Average

for Berks to 6.2 percentage points above for Blair. The QI 1 rate for York was statistically significantly lower than the Average by 7.1 percentage points. The QI 2 rates for NBHCC, NCSO and Blair were statistically significantly higher than the QI 2 HC BH Contractor Average of 67.4% by 4.6 to 6.0 percentage points, while the rates for Allegheny and York were statistically significantly below the Average by 4.1 and 8.4 percentage points respectively.

Figure 1: MY 2015 HEDIS Follow-up Indicator Rates: 6-64 Years Old

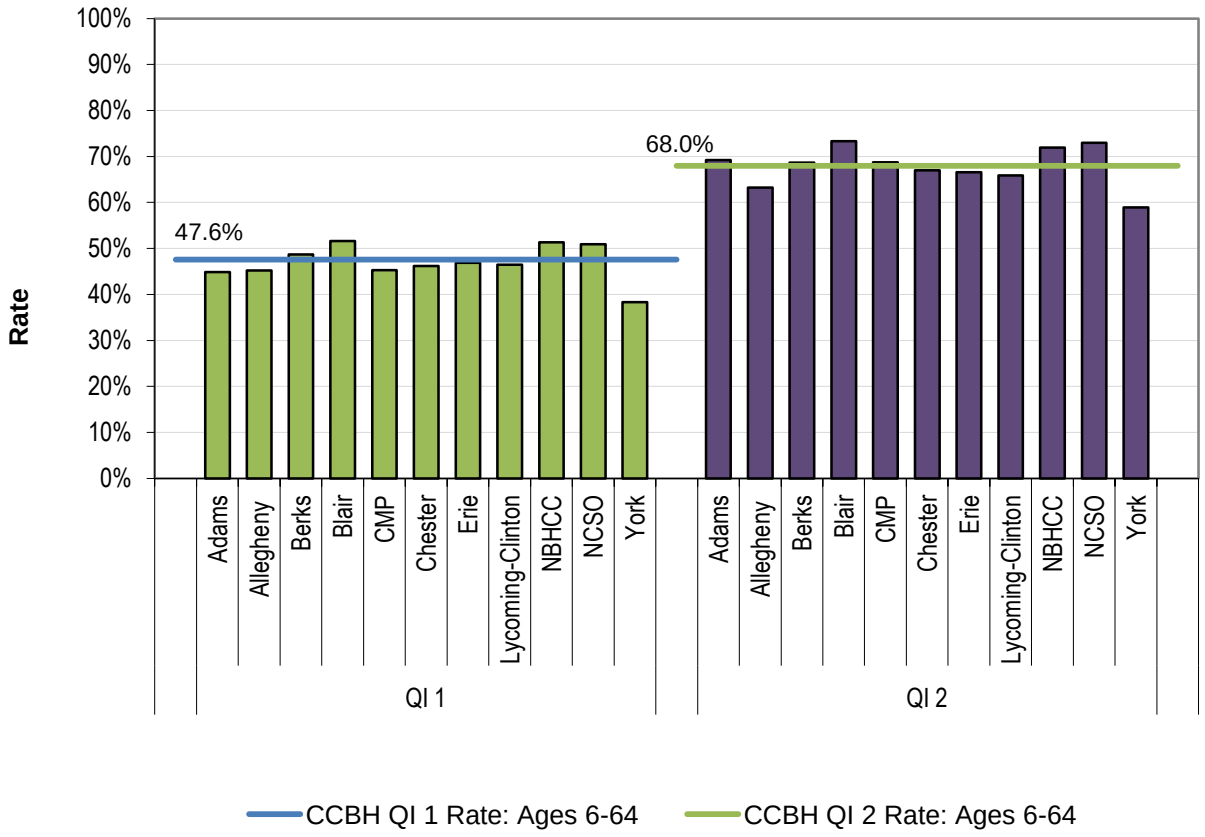
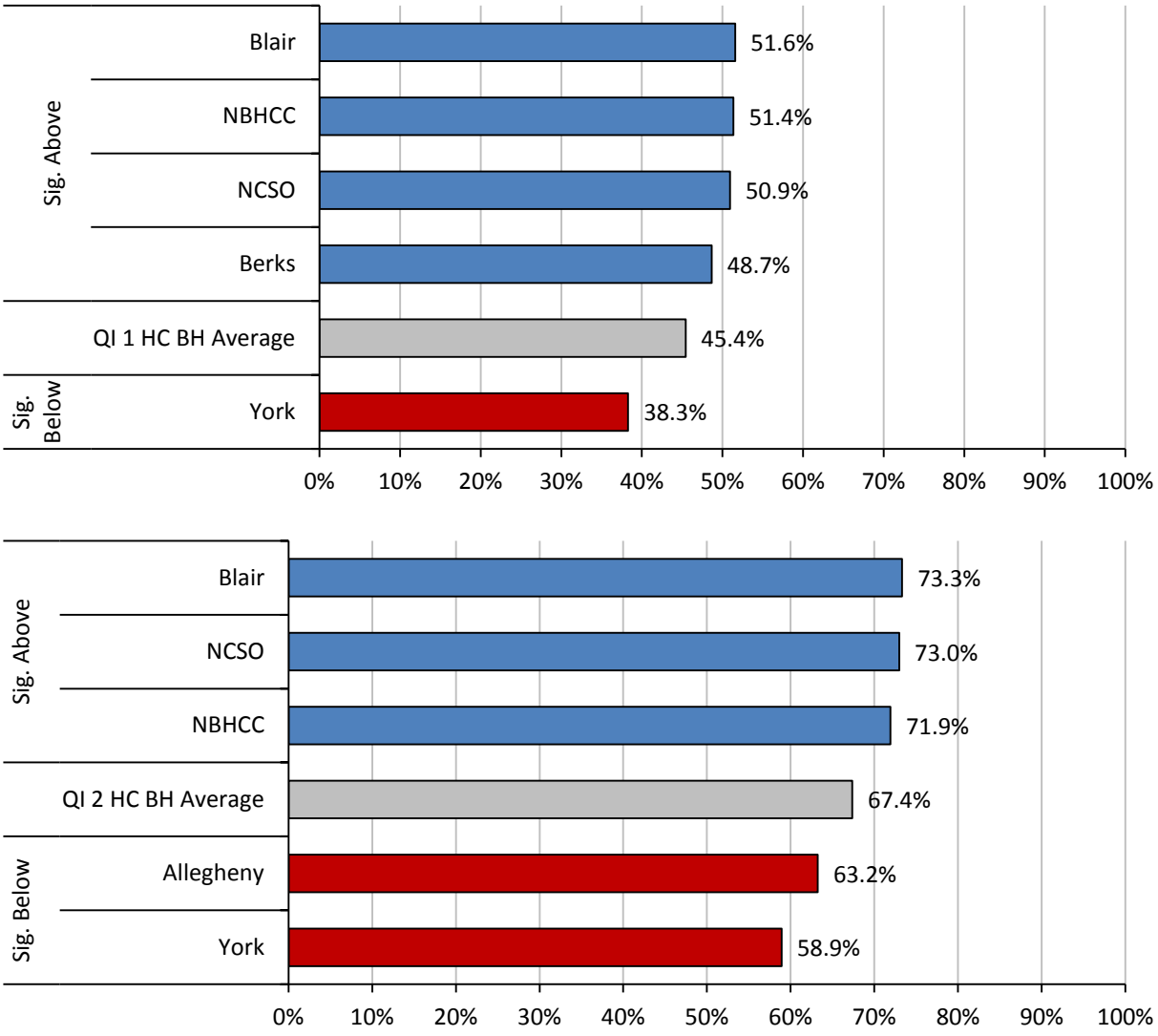


Figure 2: HEDIS Follow-up Rates Compared to MY 2015 HealthChoices HC BH Contractor Average: 6-64 Years Old



(b) Overall Population: 6+ Years Old

Table 10: MY 2015 HEDIS Follow-up Indicator Rates – Overall Population

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	MY 2015 Lower 95% CI	MY 2015 Upper 95% CI	MY 2015 BH-MCO Average	MY 2015 HC BH Contractor Average	MY 2014 %	Rate Comparison of MY 2015 against: MY 2014 PPD	MY 2014 SSD	HEDIS MY 2015 Percentile
QI 1 – HEDIS 7-Day Follow-up for Ages 6+ Years Old (Overall Population)											
HealthChoices Aggregate	17,076	37,505	**45.5%**	45.0%	46.0%	44.9%	45.2%	47.2%	-1.7	YES	Above 50th Percentile, Below 75th Percentile
CCBH	7,151	15,072	**47.4%**	46.6%	48.2%			47.4%	0.1	NO	Above 50th Percentile, Below 75th Percentile
Adams	71	160	**44.4%**	36.4%	52.4%			45.5%	-1.2	NO	Above 50th Percentile, Below 75th Percentile
Allegheny	1,684	3,744	**45.0%**	43.4%	46.6%			42.8%	2.2	NO	Above 50th Percentile, Below 75th Percentile
Berks	584	1,210	**48.3%**	45.4%	51.1%			50.3%	-2.0	NO	Above 50th Percentile, Below 75th Percentile
Blair	293	570	**51.4%**	47.2%	55.6%			56.9%	-5.5	NO	Above 50th Percentile,

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	MY 2015 Lower 95% CI	MY 2015 Upper 95% CI	MY 2015 BH-MCO Average	MY 2015 HC BH Contractor Average	MY 2014 %	Rate Comparison of MY 2015 against: MY 2014 PPD	MY 2014 SSD	HEDIS MY 2015 Percentile
											Below 75th Percentile
CMP	276	615	**44.9%**	40.9%	48.9%			45.1%	-0.2	NO	Above 50th Percentile, Below 75th Percentile
Chester	320	692	**46.2%**	42.5%	50.0%			48.2%	-1.9	NO	Above 50th Percentile, Below 75th Percentile
Erie	500	1,070	**46.7%**	43.7%	49.8%			50.2%	-3.5	NO	Above 50th Percentile, Below 75th Percentile
Lycoming-Clinton	218	470	**46.4%**	41.8%	51.0%			44.1%	2.3	NO	Above 50th Percentile, Below 75th Percentile
NBHCC	973	1,894	**51.4%**	49.1%	53.7%			50.6%	0.8	NO	Above 50th Percentile, Below 75th Percentile
NCSO	1,830	3,598	**50.9%**	49.2%	52.5%			50.9%	0.0	NO	Above 50th Percentile, Below 75th Percentile
York	402	1,049	**38.3%**	35.3%	41.3%			36.2%	2.1	NO	Below 50th Percentile, Above 25th Percentile
QI 2– HEDIS 30-Day Follow-up for Ages 6+ Years Old (Overall Population)											
HealthChoices Aggregate	24,662	37,505	**65.8%**	65.3%	66.2%	65.4%	67.0%	67.4%	-1.7	YES	Above 50th Percentile, Below 75th Percentile
CCBH	10,209	15,072	**67.7%**	67.0%	68.5%			68.2%	-0.4	NO	Above 50th Percentile, Below 75th Percentile
Adams	109	160	**68.1%**	60.6%	75.7%			64.3%	3.8	NO	Above 50th Percentile, Below 75th Percentile
Allegheny	2,354	3,744	**62.9%**	61.3%	64.4%			61.8%	1.1	NO	Below 50th Percentile, Above 25th Percentile
Berks	824	1,210	**68.1%**	65.4%	70.8%			67.2%	0.9	NO	Above 50th Percentile, Below 75th Percentile
Blair	417	570	**73.2%**	69.4%	76.9%			77.2%	-4.1	NO	At or Above 75th Percentile
CMP	420	615	**68.3%**	64.5%	72.1%			71.3%	-3.0	NO	Above 50th Percentile, Below 75th Percentile
Chester	462	692	**66.8%**	63.2%	70.3%			66.1%	0.6	NO	Above 50th Percentile, Below 75th Percentile
Erie	710	1,070	**66.4%**	63.5%	69.2%			69.0%	-2.7	NO	Above 50th Percentile, Below 75th Percentile
Lycoming-Clinton	310	470	**66.0%**	61.6%	70.3%			67.0%	-1.1	NO	Above 50th Percentile, Below 75th Percentile
NBHCC	1,364	1,894	**72.0%**	70.0%	74.1%			74.4%	-2.4	NO	Above 50th Percentile, Below 75th Percentile
NCSO	2,622	3,598	**72.9%**	71.4%	74.3%			72.6%	0.3	NO	At or Above 75th Percentile
York	617	1,049	**58.8%**	55.8%	61.8%			59.3%	-0.5	NO	Below 50th Percentile, Above 25th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option

The MY 2015 HealthChoices Aggregate HEDIS follow-up rates were 45.5% for QI 1 and 65.8% for QI 2 (**Table 10**). These rates were statistically significantly lower than the HealthChoices Aggregate rates in MY 2014, which were 47.2% and 67.4% respectively. For CCBH, the MY 2015 QI 1 rate was 47.4%, and remained unchanged from the prior year. The CCBH QI 2 rate was 67.7%, which was not statistically significantly different from the MY 2014 QI 2 rate. The CCBH QI 1

and QI 2 rates were both statistically significantly higher than the Health Choices BH-MCO Averages of 44.9% for QI 1 and 65.4% for QI 2. CCBH had the highest QI 1 rate of the five BH-MCOs evaluated in MY 2015. None of the individual HC BH Contractors demonstrated statistically significant QI 1 or QI 2 rate changes from MY 2014 to MY 2015.

Figure 3 is a graphical representation of the MY 2015 HEDIS follow-up rates for CCBH 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 rates for Berks, NCSO, NBHCC and Blair were statistically significantly above the MY 2015 QI 1 HC BH Contractor Average of 45.2%, with differences ranging from 3.1 percentage points above the Average for Berks to 6.2 percentage points above for Blair and NBHCC. The QI 1 rate for York was statistically significantly lower than the Average by 6.8 percentage points. The QI 2 rates for NBHCC, NCSO and Blair were statistically significantly higher than the QI 2 HC BH Contractor Average of 67.0% by 5.1 to 6.2 percentage points, while the rates for Allegheny and York were statistically significantly below the Average by 4.1 and 8.1 percentage points respectively.

Figure 3: MY 2015 HEDIS Follow-up Indicator Rates – Overall Population

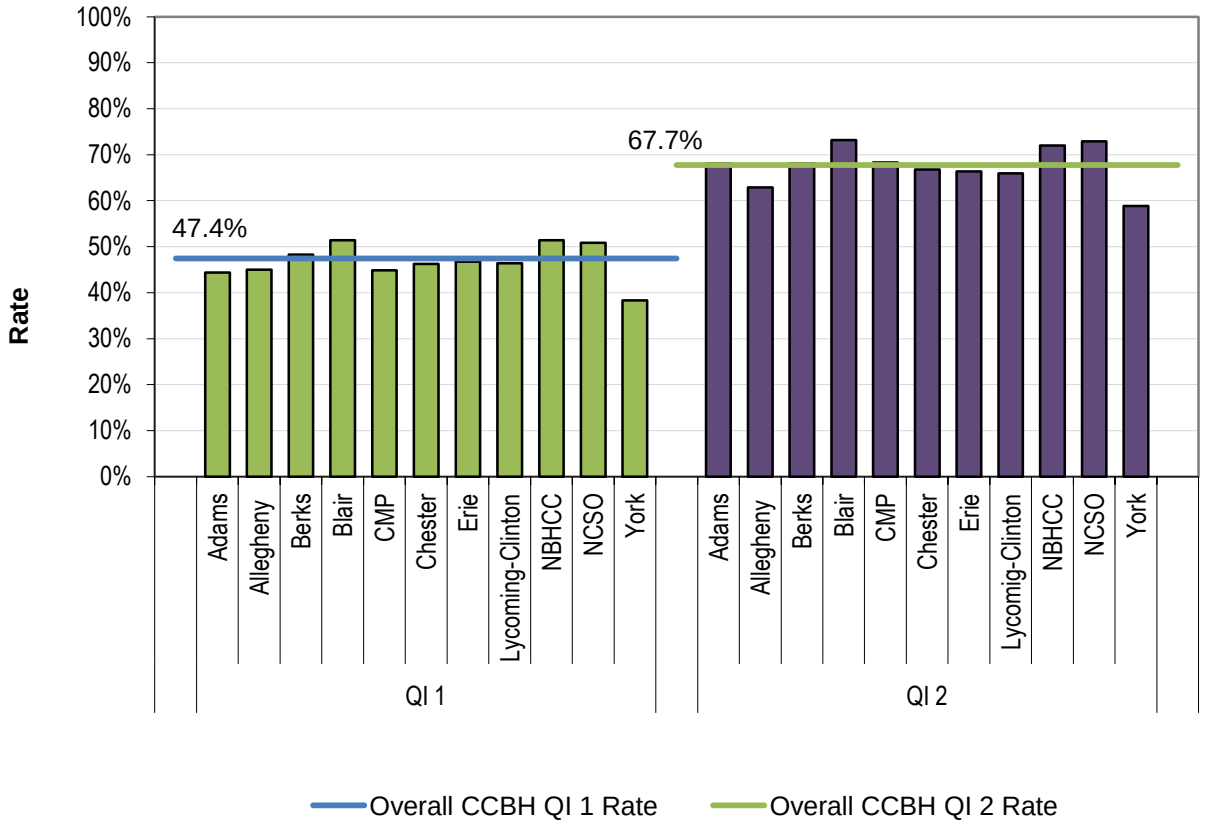
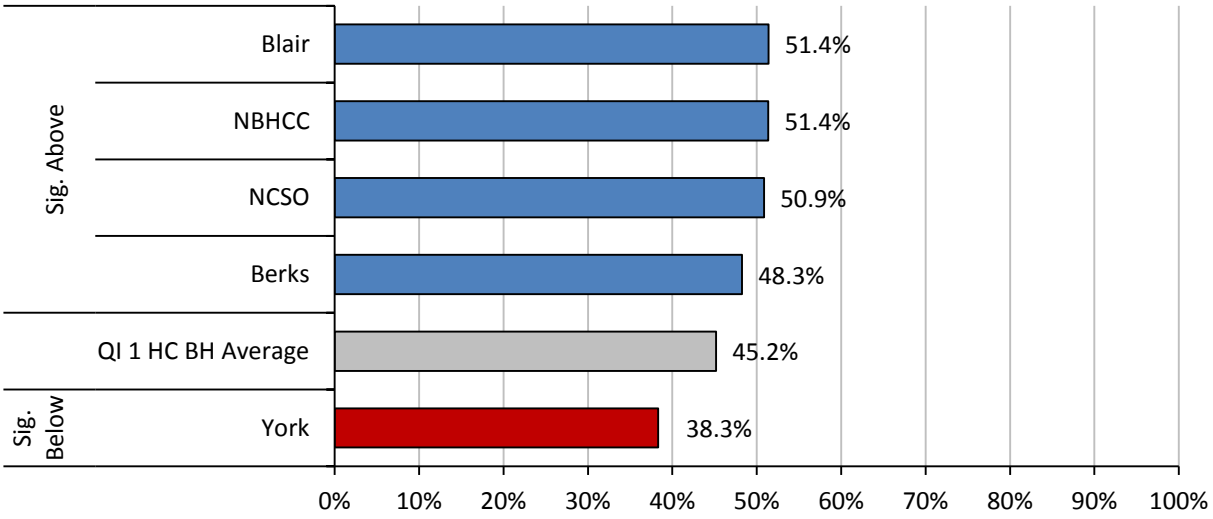
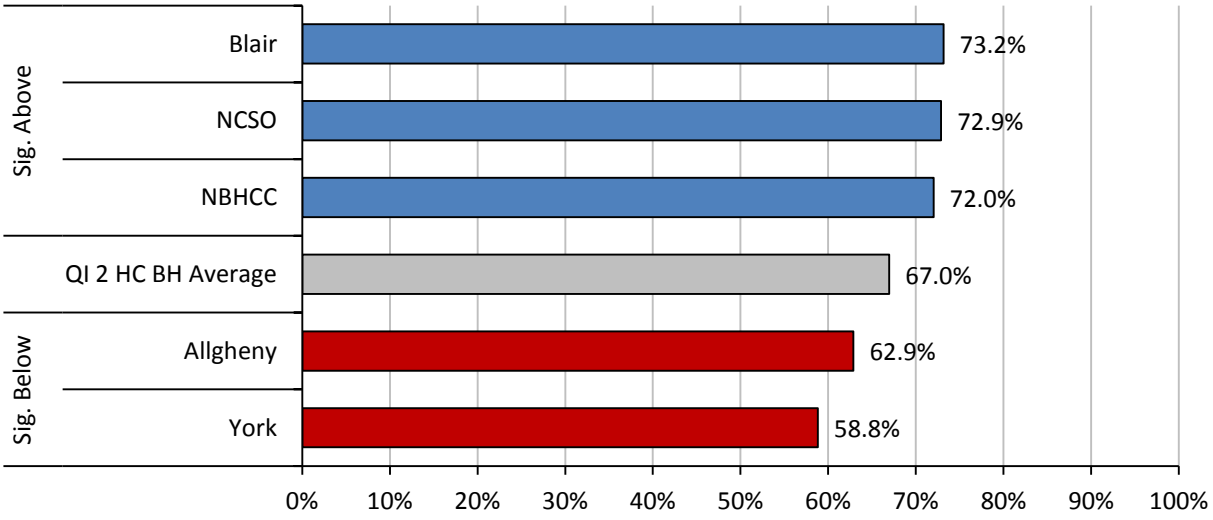


Figure 4: HEDIS Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average – Overall Population





(c) Age Group: 6–20 Years Old

Table 11: MY 2015 HEDIS Follow-up Indicator Rates: 6-20 Years Old

Measure	MY 2015 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2014 MY 2014 %	Rate Comparison: MY 15 vs. MY 14 PPD	SSD
QI 1 – HEDIS 7-Day Follow-up for Ages 6–20 Years Old										
HealthChoices Aggregate	5,736	10,108	**56.7%**	55.8%	57.7%	56.1%	64.1%	56.5%	0.2	NO
CCBH	2,391	4,082	**58.6%**	57.1%	60.1%			56.7%	1.9	NO
Adams	37	67	55.2%	42.6%	67.9%			57.1%	-1.9	NO
Allegheny	437	755	57.9%	54.3%	61.5%			52.6%	5.3	YES
Berks	191	317	60.3%	54.7%	65.8%			59.4%	0.9	NO
Blair	119	192	62.0%	54.9%	69.1%			68.3%	-6.3	NO
CMP	108	205	52.7%	45.6%	59.8%			48.8%	3.9	NO
Chester	126	219	57.5%	50.8%	64.3%			63.3%	-5.7	NO
Erie	145	236	61.4%	55.0%	67.9%			56.5%	4.9	NO
Lycoming-Clinton	84	138	60.9%	52.4%	69.4%			54.2%	6.6	NO

Measure	MY 2015							MY 2014		
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2014 %	Rate Comparison: MY 15 vs. MY 14	
									PPD	SSD
NBHCC	314	510	61.6%	57.2%	65.9%			60.3%	1.3	NO
NCSO	653	1,107	59.0%	56.0%	61.9%			58.8%	0.1	NO
York	177	336	52.7%	47.2%	58.2%			47.5%	5.2	NO
QI 2 – HEDIS 30-Day Follow-up for Ages 6-20 Years Old										
HealthChoices Aggregate	7,780	10,108	77.0%	76.1%	77.8%	76.4%	81.6%	77.0%	0.0	NO
CCBH	3,230	4,082	79.1%	77.9%	80.4%			78.0%	1.1	NO
Adams	47	67	70.1%	58.4%	81.9%			77.6%	-7.4	NO
Allegheny	599	755	79.3%	76.4%	82.3%			73.9%	5.5	YES
Berks	249	317	78.5%	73.9%	83.2%			77.5%	1.1	NO
Blair	156	192	81.3%	75.5%	87.0%			85.5%	-4.3	NO
CMP	156	205	76.1%	70.0%	82.2%			77.0%	-0.9	NO
Chester	175	219	79.9%	74.4%	85.4%			80.6%	-0.7	NO
Erie	190	236	80.5%	75.2%	85.8%			80.5%	0.0	NO
Lycoming-Clinton	109	138	79.0%	71.8%	86.1%			76.1%	2.9	NO
NBHCC	415	510	81.4%	77.9%	84.8%			81.1%	0.2	NO
NCSO	883	1,107	79.8%	77.4%	82.2%			79.0%	0.7	NO
York	251	336	74.7%	69.9%	79.5%			74.1%	0.6	NO

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option

The MY 2015 HealthChoices Aggregate rates in the 6 to 20 year age group were 56.7% for QI 1 and 77.0% for QI 2 (**Table 11**). These rates were comparable to the MY 2014 HealthChoices Aggregate rates for the 6 to 20 year age cohort, which were 56.5% and 77.0% respectively. The CCBH MY 2015 HEDIS rates for members ages 6 to 20 were 58.6% for QI 1 and 79.1% for QI 2; both rates were higher than CCBH's corresponding MY 2014 rates of 56.7% for QI 1 (1.9 percentage point difference) and 78.0% for QI 2 (1.1 percentage point difference); these year-to-year rate differences were not statistically significant for either rate (**Table 11**). The CCBH MY 2015 QI 1 rate for the 6 to 20 year old population was statistically significantly higher than the QI 1 HealthChoices BH-MCO Average of 56.1% by 2.4 percentage points, while the QI 2 rate was statistically significantly higher than the QI 2 HealthChoices BH-MCO Average of 76.4% by 2.8 percentage points. As presented in **Table 11**, MY 2015 QI 1 and QI 2 rates statistically significantly increased from the prior year for Allegheny by 5.3 percentage points for QI 1 and 5.5 percentage points for QI 2.

Figure 5 is a graphical representation of the MY 2015 HEDIS follow-up rates in the 6 to 20 year old population for CCBH 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 rates for NCSO and NBHCC were statistically significantly above the MY 2015 QI 1 HC BH Contractor Average of 55.7%, with differences ranging from 3.3 percentage points above the Average for NCSO to 5.9 percentage points above for NBHCC. QI 2 rates for NCSO and NBHCC were statistically significantly above the MY 2015 QI 2 HC BH Contractor Average of 76.8%, with differences ranging from 3.0 to 4.6 percentage points over the Average.

Figure 5: MY 2015 HEDIS Follow-up Indicator Rates: 6-20 Years Old

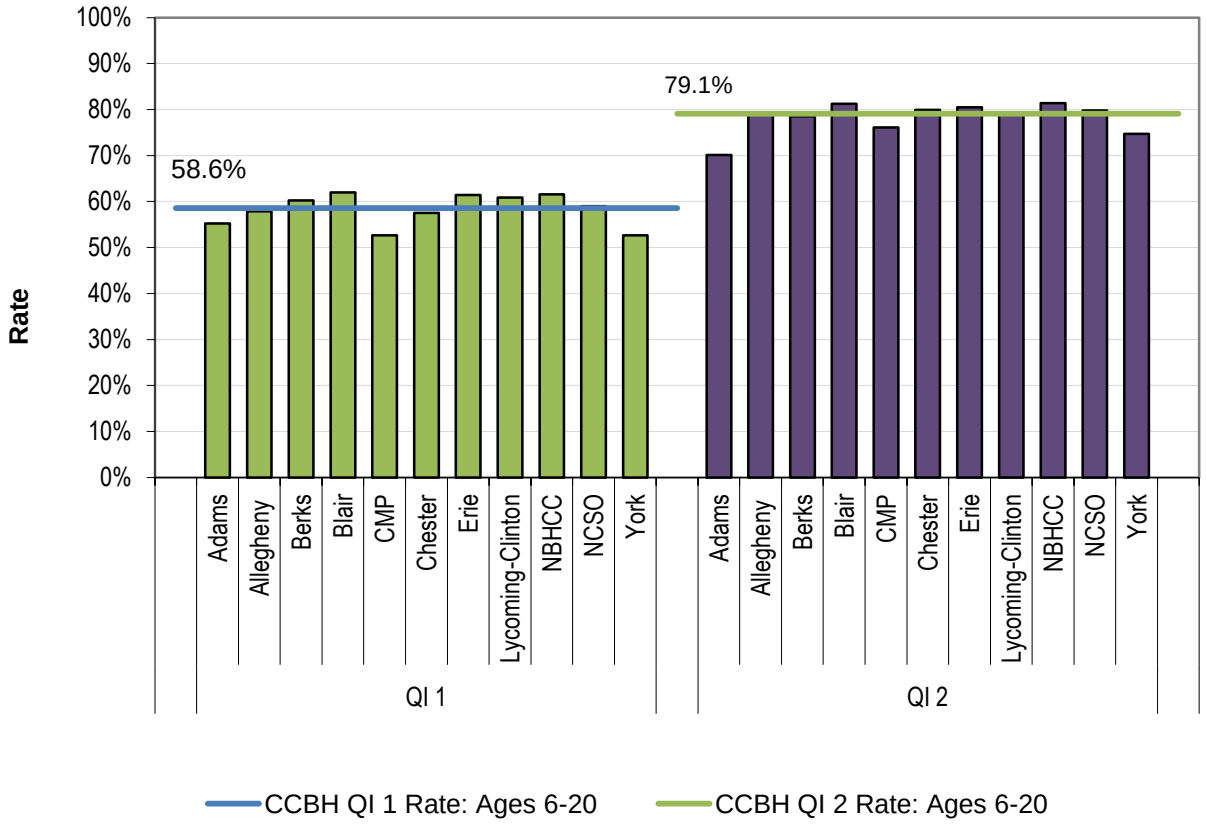
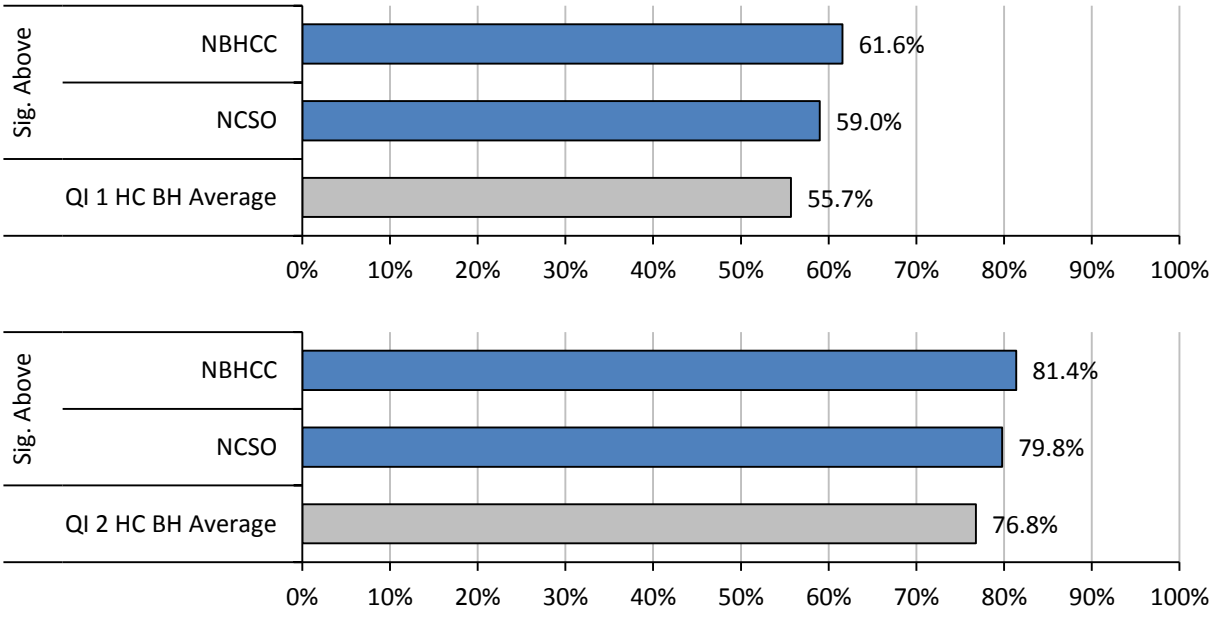


Figure 6: HEDIS Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average: 6-20 Years Old



II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

Table 12: MY 2015 PA-Specific Follow-up Indicator Rates with Year-to-Year Comparisons – Overall Population

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	MY 2015 Lower 95% CI	MY 2015 Upper 95% CI	MY 2015 BH-MCO Average	MY 2015 HC BH Contractor Average	MY 2014 MY 2014 %	Rate Comparison of MY 15 vs. MY 14 PPD	Rate Comparison of MY 15 vs. MY 14 SSD
QI A – PA-Specific 7-Day Follow-up for Ages 6+ (Overall Population)										
HealthChoices Aggregate	21,216	37,505	**56.6%**	56.1%	57.1%	55.8%	55.7%	58.5%	-2.0	YES
CCBH	9,005	15,072	**59.7%**	59.0%	60.5%			59.6%	0.1	NO
Adams	84	160	**52.5%**	44.4%	60.6%			53.6%	-1.1	NO
Allegheny	2,320	3,744	**62.0%**	60.4%	63.5%			60.5%	1.5	NO
Berks	706	1,210	**58.3%**	55.5%	61.2%			58.7%	-0.3	NO
Blair	354	570	**62.1%**	58.0%	66.2%			66.7%	-4.6	NO
CMP	322	615	**52.4%**	48.3%	56.4%			50.5%	1.9	NO
Chester	393	692	**56.8%**	53.0%	60.6%			58.6%	-1.8	NO
Erie	646	1,070	**60.4%**	57.4%	63.4%			61.8%	-1.4	NO
Lycoming-Clinton	285	470	**60.6%**	56.1%	65.2%			55.2%	5.4	NO
NBHCC	1,115	1,894	**58.9%**	56.6%	61.1%			58.6%	0.3	NO
NCSO	2,267	3,598	**63.0%**	61.4%	64.6%			62.9%	0.1	NO
York	513	1,049	**48.9%**	45.8%	52.0%			51.3%	-2.4	NO
QI B – PA-Specific 30-Day Follow-up for Ages 6+ (Overall Population)										
HealthChoices Aggregate	27,371	37,505	**73.0%**	72.5%	73.4%	72.7%	73.5%	74.8%	-1.9	YES
CCBH	11,348	15,072	**75.3%**	74.6%	76.0%			75.8%	-0.5	NO
Adams	120	160	**75.0%**	68.0%	82.0%			68.8%	6.3	NO
Allegheny	2,821	3,744	**75.3%**	74.0%	76.7%			74.0%	1.3	NO
Berks	901	1,210	**74.5%**	72.0%	77.0%			72.7%	1.8	NO
Blair	449	570	**78.8%**	75.3%	82.2%			81.4%	-2.6	NO
CMP	444	615	**72.2%**	68.6%	75.8%			74.0%	-1.8	NO
Chester	498	692	**72.0%**	68.5%	75.4%			72.9%	-0.9	NO
Erie	794	1,070	**74.2%**	71.5%	76.9%			76.3%	-2.1	NO
Lycoming-Clinton	346	470	**73.6%**	69.5%	77.7%			71.9%	1.7	NO
NBHCC	1,430	1,894	**75.5%**	73.5%	77.5%			78.4%	-2.9	YES
NCSO	2,837	3,598	**78.8%**	77.5%	80.2%			79.3%	-0.5	NO
York	708	1,049	**67.5%**	64.6%	70.4%			71.0%	-3.5	NO

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option

The MY 2015 HealthChoices Aggregate rates were 56.6% for QI A and 73.0% for QI B (**Table 12**). Both rates demonstrated statistically significant decreases from the MY 2014 PA-specific follow-up rates: the QI A rate decreased from the MY 2014 rate of 58.5% by 1.9 percentage points, while the QI B rate decreased from the MY 2014 rate of 74.8% percentage points by 1.8 percentage points. The MY 2015 CCBH QI A rate was 59.7%, which represents a 0.1 percentage point increase from the prior year, and the CCBH QI B rate was 75.3%, which represents a 0.5 percentage point decrease from the prior year. These year-to-year changes were not statistically significant. The QI A rate for CCBH was statistically significantly higher than the QI A HealthChoices BH-MCO Average of 55.8% by 3.9 percentage points, and the QI B rate for CCBH was statistically significantly higher than the QI B HealthChoices BH-MCO Average of 72.7% by 2.6 percentage points. CCBH had the highest QI A rate of the five BH-MCOs evaluated in MY 2015.

From MY 2014 to MY 2015, none of the individual HC BH Contractors demonstrated statistically significant QI A rate changes (**Table 12**). For QI B, NBHCC demonstrated a statistically significant rate increase of 2.9 percentage points from MY 2014 to MY 2015.

Figure 7 is a graphical representation of the MY 2015 PA-specific follow-up rates for CCBH 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 rates for NBHCC, Erie, Lycoming-Clinton, Allegheny, Blair and NCSO were statistically significantly above the MY 2015 QI A HC BH Contractor Average of 55.7%, with differences ranging from 3.2 percentage points above the Average for NBHCC to 7.3 percentage points above for NCSO. The QI A rate for York was statistically significantly lower than the Average by 6.8 percentage points. QI B rates for Allegheny, NBHCC, Blair and NCSO were statistically significantly higher than the QI B HC BH Contractor Average of 73.5%, with differences ranging from 1.9 to 5.4 percentage points. The QI B rate for York was statistically significantly lower than the Average by 6.0 percentage points.

Figure 7: MY 2015 PA-Specific Follow-up Indicator Rates – Overall Population

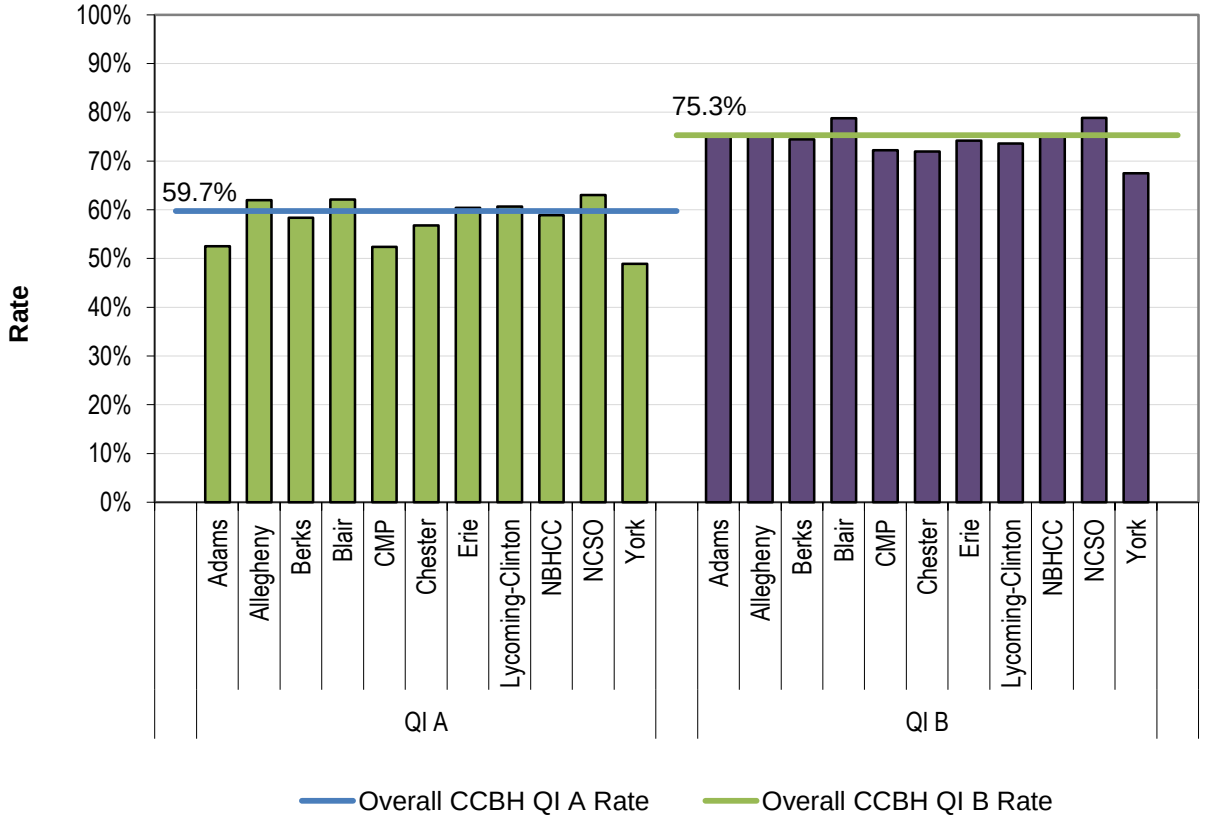
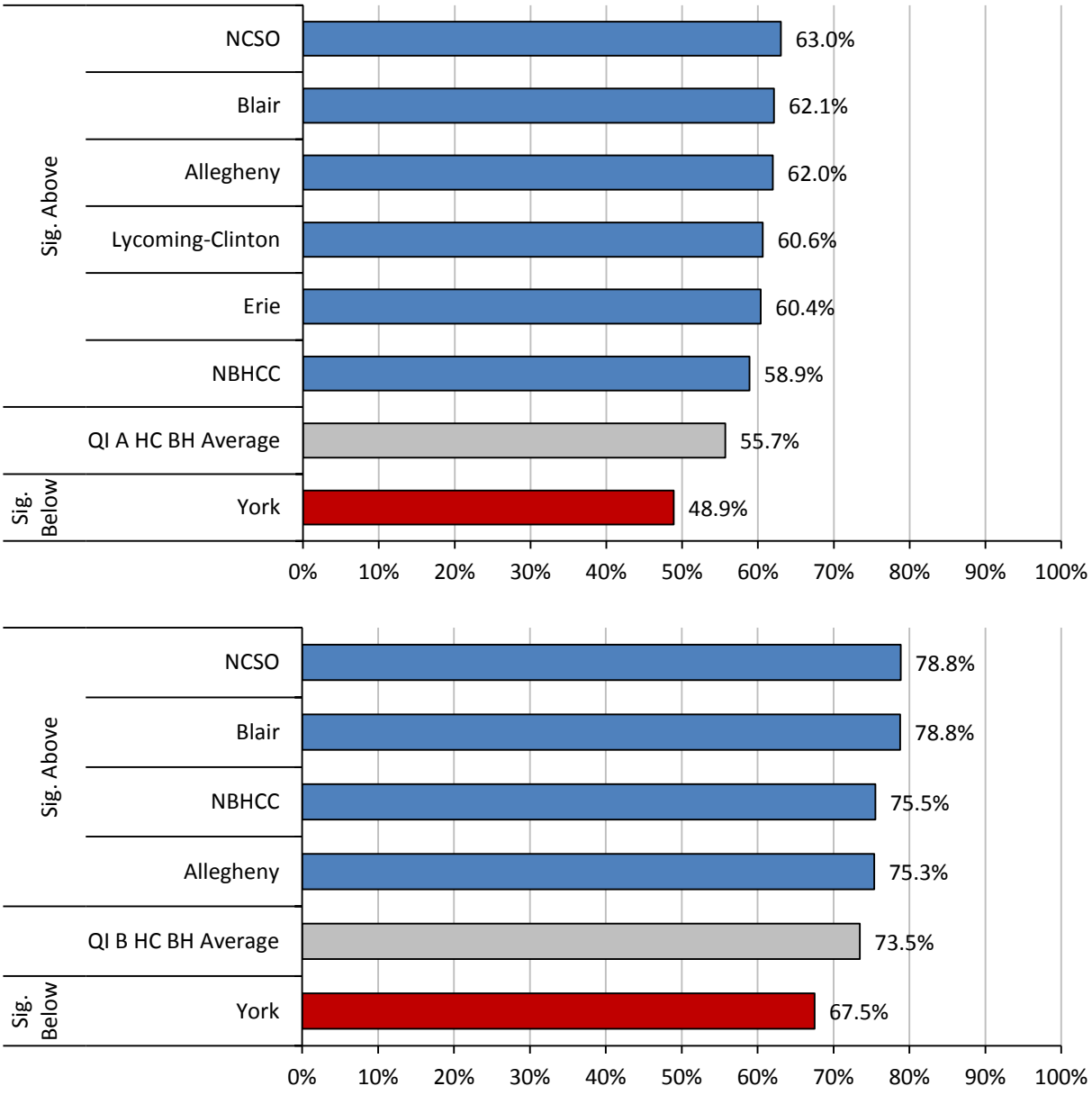


Figure 8: PA-Specific Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average – Overall Population



Conclusion and Recommendations

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

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

- 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 MY2015, 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 measurement years, and applicable to all groups. The findings of this re-measurement indicate that, despite some improvement over the last five measurement years, 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 2015 study conducted in 2016 was the ninth 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 measurement year, 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 2015. 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 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 2015 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, 2015;
- 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. **For this measure, lower rates indicate better performance.**

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 2015 to MY 2014 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 13: MY 2015 Readmission Rates with Year-to-Year Comparisons

	MY 2015							MY 2014		
									Rate Comparison of MY 15 vs. MY 14	
Measure	(N)	(D)	%[1]	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	%	PPD	SSD
Inpatient Readmission										
HealthChoices Aggregate	6,737	48,239	**14.0%**	13.7%	14.3%	14.0%	13.4%	14.3%	-0.3	NO
CCBH	2,670	19,038	**14.0%**	13.5%	14.5%			14.8%	-0.8	YES
Adams	26	198	**13.1%**	8.2%	18.1%			10.1%	3.1	NO
Allegheny	651	4,724	**13.8%**	12.8%	14.8%			15.4%	-1.7	YES
Berks	265	1,584	**16.7%**	14.9%	18.6%			21.2%	-4.5	YES
Blair	98	708	**13.8%**	11.2%	16.5%			15.8%	-1.9	NO
CMP	100	761	**13.1%**	10.7%	15.6%			14.6%	-1.5	NO
Chester	147	876	**16.8%**	14.2%	19.3%			18.5%	-1.7	NO
Erie	234	1,349	**17.3%**	15.3%	19.4%			17.4%	-0.1	NO
Lycoming-Clinton	53	561	**9.4%**	6.9%	12.0%			8.8%	0.7	NO
NBHCC	348	2,491	**14.0%**	12.6%	15.4%			13.5%	0.4	NO
NCSO	529	4,398	**12.0%**	11.1%	13.0%			12.0%	0.1	NO
York	219	1,388	**15.8%**	13.8%	17.7%			13.8%	2.0	NO

[1]The OMHSAS-designated performance measure goal is a readmission rate at or below 10%.
N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option

The MY 2015 HealthChoices Aggregate readmission rate was 14.0%, and represents a decrease from the MY 2014 HealthChoices Aggregate rate of 14.3% by 0.3 percentage points (**Table 13**); this difference was not statistically significant. The CCBH MY 2015 readmission was 14.0%, which was a statistically significantly decrease from the MY 2014 rate of 14.8%. Note that for this measure, lower rates indicate better performance. The CCBH readmission rate was not statistically significantly different from the HealthChoices BH-MCO Average of 14.0%. CCBH did not meet the performance goal of a readmission rate at or below 10.0% in MY 2015.

From MY 2014 to MY 2015, two HC BH Contractors demonstrated statistically significant improvement. The readmission rate for Allegheny decreased 1.7 percentage points from 15.4% to 13.8%, and the readmission rate for Berks decreased 4.5 percentage points from 21.2% to 16.7%. Despite these improvements, neither rate was below the OMHSAS performance goal of 10.0%. One HC BH Contractor, Lycoming-Clinton, met the OMHSAS performance goal with a MY 2015 readmission rate of 9.4%.

Figure 9 is a graphical representation of the MY 2015 readmission rates for CCBH HC BH Contractors compared to the OMHSAS performance goal of 10.0%. **Figure 10** shows the Health Choices HC BH Contractor Average readmission rates and the individual CCBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Averages. NCSO and Lycoming-Clinton had readmission rates that were statistically significantly lower (better) than the HealthChoices HC BH Contractor Average of 13.4% by 1.4 and 4.0 percentage points, respectively. York, Chester, Berks and Erie demonstrated readmission rates that were statistically significantly higher than the Average, with differences that ranged from 2.4 percentage points in York to 3.9 percentage points in Erie.

Figure 9: MY 2015 Readmission Rates

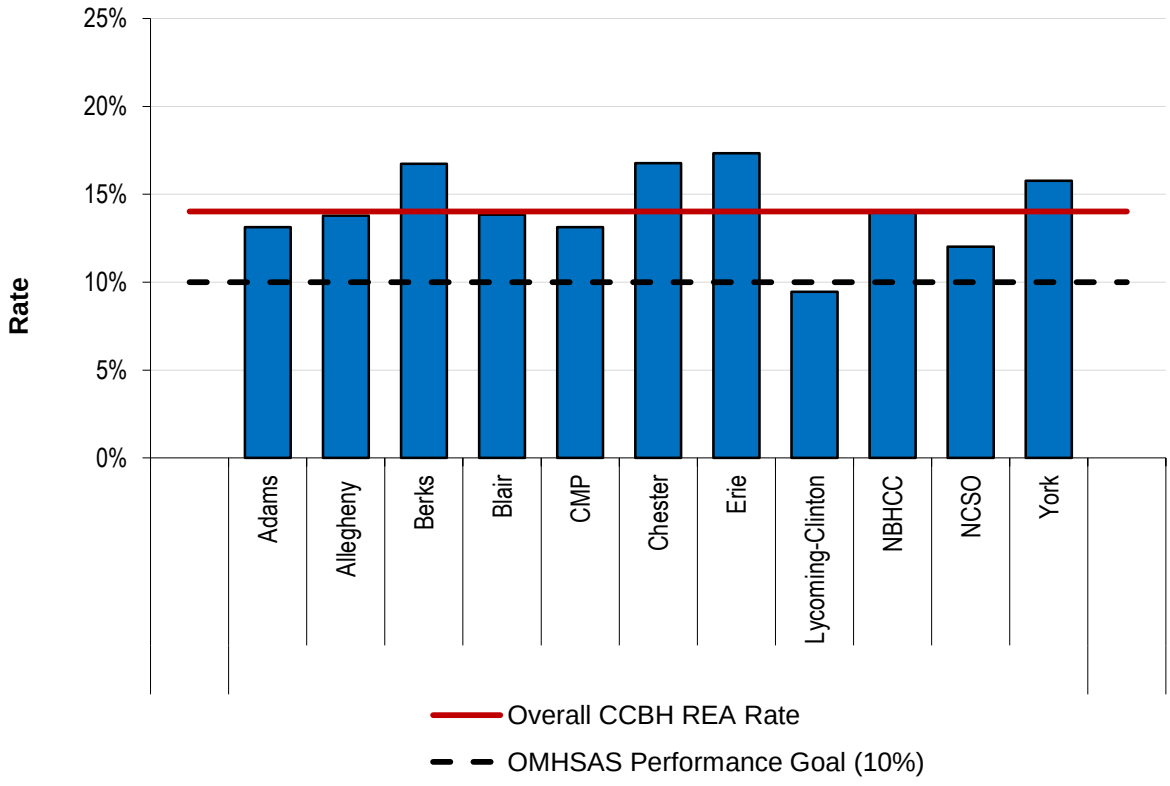
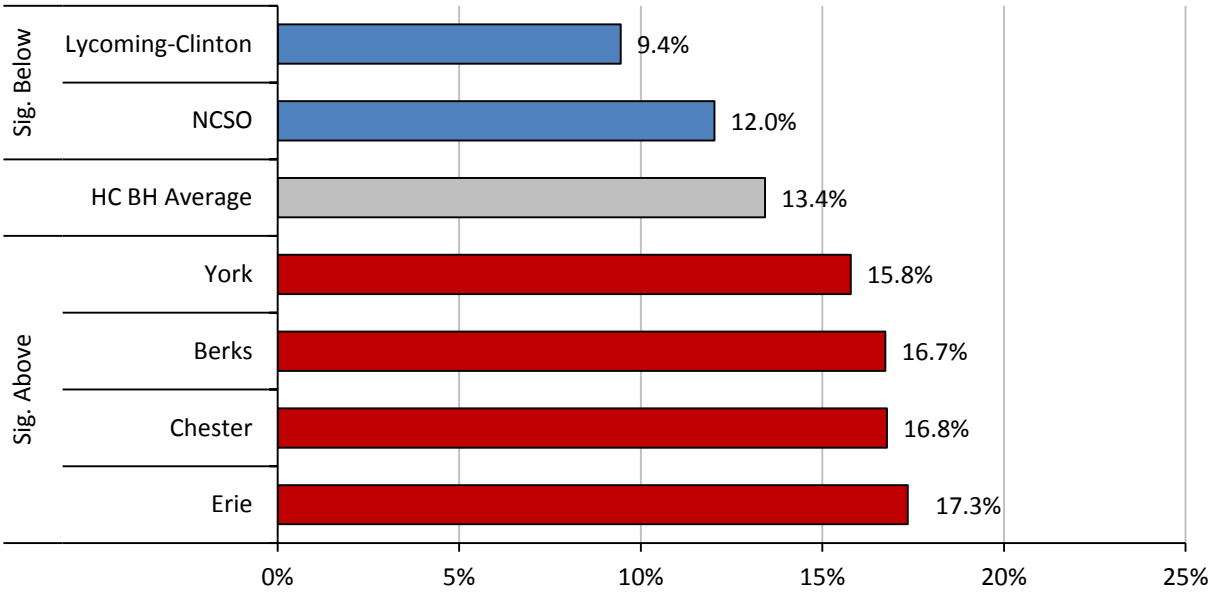


Figure 10: MY 2015 Readmission Rates Compared to HealthChoices HC BH Contractor Average



Conclusion and Recommendations

Continued efforts should be made to improve performance with regard to Readmission Within 30 Days of Inpatient Psychiatric Discharge, particularly for those BH-MCOs 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 2015 (MY 2014) 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 2016 study, the following general recommendations are applicable to all five participating BH-MCOs:

- 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.
- It is essential to ensure that improvements are consistent, sustained across measurement years, 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).

- 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 and 2016. The measure was produced according to HEDIS 2016 specifications. The data source was encounter data submitted to DHS by the BH-MCOs and the Physical Health MCOs (PH-MCOs). As directed by OMHSAS, IPRO produced rates for this measure for the HealthChoices population, by BH-MCO, and by HC BH 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 used 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 2016 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 HC BH Contractors participating in the MY 2015 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, 2015;
- 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.

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 14: MY 2015 IET rates with Year-to-Year Comparisons

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	MY 2015 Lower 95% CI	MY 2015 Upper 95% CI	MY 2015 BH-MCO Average	MY 2015 BH HC Contractor Average	MY 2014 %	MY 2014 PPD	MY 2014 SSD	Rate Comparison MY 2015 to HEDIS Benchmarks
Age Cohort: 13–17 Years – Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	924	2,513	**36.8%**	34.9%	38.7%	33.6%	29.3%	37.0%	-0.3	NO	Below 50th Percentile, Above 25th Percentile
CCBH	437	1,075	**40.7%**	37.7%	43.6%			38.8%	1.8	NO	Below 50th Percentile, Above 25th Percentile
Adams	5	12	**41.7%**	9.6%	73.7%			35.7%	6.0	NO	Below 50th Percentile, Above 25th Percentile
Allegheny	151	320	**47.2%**	41.6%	52.8%			42.1%	5.1	NO	Above 50th Percentile, Below 75th Percentile
Berks	43	99	**43.4%**	33.2%	53.7%			25.8%	17.6	YES	Above 50th Percentile, Below 75th Percentile
Blair	41	72	**56.9%**	44.8%	69.1%			39.0%	17.9	NO	At or Above 75th Percentile
CMP	11	41	**26.8%**	12.0%	41.6%			47.4%	-20.5	NO	Below 25th Percentile
Chester	20	43	**46.5%**	30.4%	62.6%			43.9%	2.6	NO	Above 50th Percentile, Below 75th Percentile
Erie	21	72	**29.2%**	18.0%	40.4%			29.6%	-0.5	NO	Below 25th Percentile
Lycoming-Clinton	16	33	**48.5%**	29.9%	67.1%			51.9%	-3.4	NO	Above 50th Percentile, Below 75th Percentile
NBHCC	64	166	**38.6%**	30.8%	46.3%			46.0%	-7.5	NO	Below 50th Percentile, Above 25th Percentile
NCSO	47	160	**29.4%**	22.0%	36.7%			36.6%	-7.2	NO	Below 25th Percentile
York	18	57	**31.6%**	18.6%	44.5%			23.6%	8.0	NO	Below 25th Percentile
Age Cohort: 13–17 Years – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	645	2,513	**25.7%**	23.9%	27.4%	23.1%	18.9%	25.8%	-0.2	NO	At or Above 75th Percentile
CCBH	303	1,075	**28.2%**	25.5%	30.9%			27.4%	0.8	NO	At or Above 75th Percentile
Adams	2	12	**16.7%**	0.0%	41.9%			7.1%	9.5	NO	Above 50th Percentile, Below 75th Percentile
Allegheny	115	320	**35.9%**	30.5%	41.4%			36.0%	0.0	NO	At or Above 75th Percentile
Berks	27	99	**27.3%**	18.0%	36.6%			10.5%	16.8	YES	At or Above 75th Percentile
Blair	29	72	**40.3%**	28.3%	52.3%			9.8%	30.5	YES	At or Above 75th Percentile
CMP	6	41	**14.6%**	2.6%	26.7%			33.3%	-18.7	NO	Above 50th Percentile, Below 75th Percentile
Chester	12	43	**27.9%**	13.3%	42.5%			36.6%	-8.7	NO	At or Above 75th Percentile
Erie	19	72	**26.4%**	15.5%	37.3%			25.9%	0.5	NO	At or Above 75th Percentile
Lycoming-Clinton	11	33	**33.3%**	15.7%	50.9%			38.5%	-5.1	NO	At or Above 75th Percentile
NBHCC	39	166	**23.5%**	16.7%	30.2%			28.9%	-5.4	NO	At or Above 75th Percentile
NCSO	32	160	**20.0%**	13.5%	26.5%			25.2%	-5.2	NO	Above 50th Percentile, Below 75th Percentile
York	11	57	**19.3%**	8.2%	30.4%			12.5%	6.8	NO	Above 50th Percentile, Below 75th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option

The MY 2015 HealthChoices Aggregate rates in the 13-17 year age group were 36.8% for Initiation and 25.7% for Engagement (**Table 14**). These rates were comparable to the MY 2014 13-17 year old HealthChoices Aggregate rates of 37.0% and 25.8%, respectively. The HealthChoices Aggregate rate for Initiation was between the HEDIS percentiles for the 25th and 50th percentiles, while the HealthChoices Aggregate rate for Engagement was above the 75th percentile.

The CCBH MY 2015 13-17 year old Initiation rate was 40.7%, which was not statistically significantly higher than the MY 2014 CCBH rate of 38.8% (**Table 14**). Similarly, the CCBH MY 2015 13-17 year old Engagement rate was 28.2%, and was not statistically significantly higher than the MY 2014 rate of 27.4%. Compared to the HealthChoices BH-MCO Average of 33.6% for Initiation, the CCBH Initiation rate was statistically significantly higher by 7.1 percentage points. The Engagement rate for CCBH was statistically significantly higher than the HealthChoices BH-MCO Average of 23.1% by 5.1 percentage points. The CCBH Initiation rate was between the HEDIS 25th and 50th percentiles and the CCBH Engagement rate was above the HEDIS 75th percentile.

As presented in **Table 14**, there was statistically significant improvement in the Initiation rate for Berks, which had a rate increase of 17.6 percentage points from 25.8% in MY 2014 to 43.4% in MY 2015. For the Engagement rate, Berks and Blair demonstrated statistically significant improvement of 16.8 and 30.5 percentage points, respectively, from the prior year. Eight of the eleven CCBH HC BH Contractors reported Initiation rates for the 13-17 year age group below the HEDIS 50th percentile, and four HC BH Contractors reported rates between the 50th and 75th percentiles. Blair reported an Initiation rate above the 75th percentile. For Engagement, nine CCBH HC BH Contractors reported rates above the 75th percentile, and four HC BH Contractors reported rates between the 50th and 75th percentiles. None of the CCBH HC BH Contractors reported Engagement rates below the HEDIS 50th percentile.

Figure 11 is a graphical representation of the 13-17 year old MY 2015 HEDIS Initiation and Engagement rates for CCBH and its associated HC BH Contractors. **Figure 12** shows the HealthChoices HC BH Contractor Average rates for this age cohort and the individual CCBH HC BH Contractor rates that were statistically significantly higher or lower than the HealthChoices HC BH Contractor Average. The Initiation rates for NBHCC, Blair, Berks, Chester, Allegheny and Lycoming-Clinton were statistically significantly above the MY 2015 Initiation HC BH Contractor Average of 29.3% with percentage point differences ranging from 9.2 in NBHCC and Blair to 19.2 percentage points for Lycoming-Clinton. None of the HC BH Contractors had an Initiation rate significantly lower than the Average. Engagement rates for Allegheny and Blair were statistically significantly higher than the Engagement HC BH Contractor Average of 18.9% by 17.0 and 21.4 percentage points, respectively.

Figure 11: MY 2015 IET Rates: 13–17 Years Old

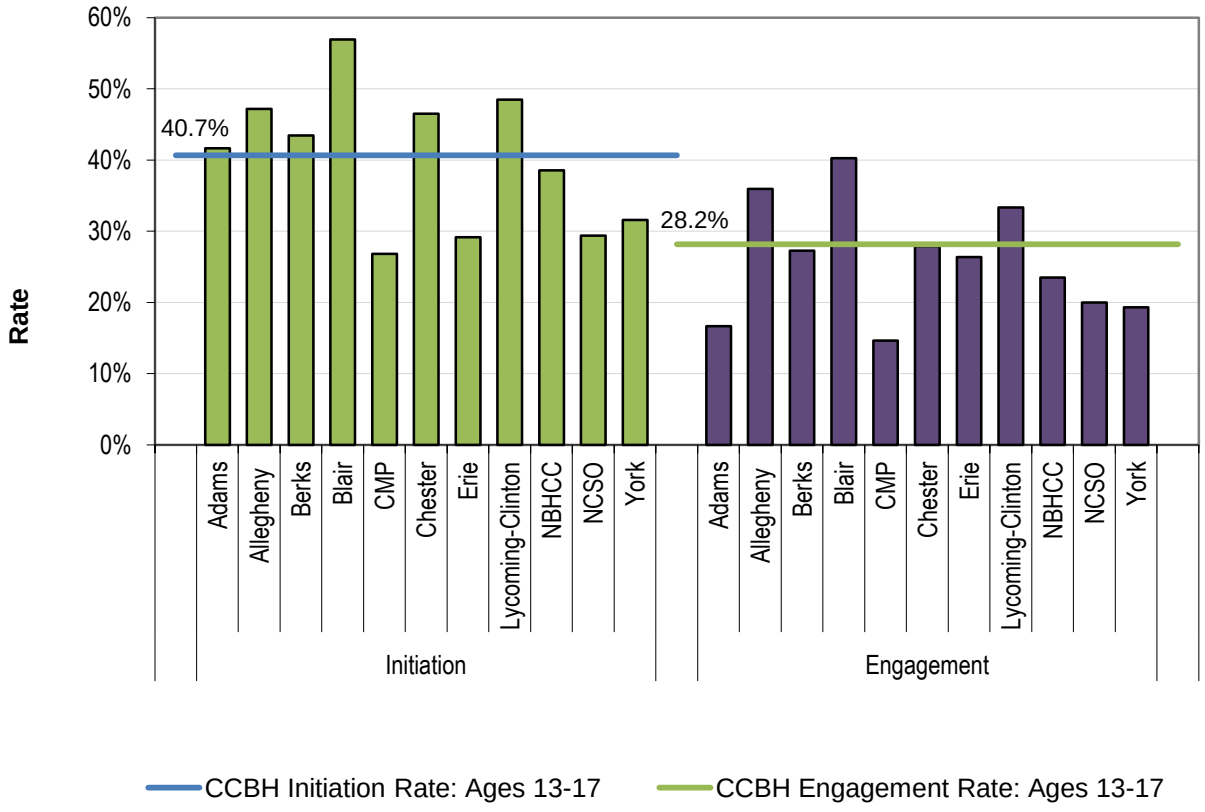
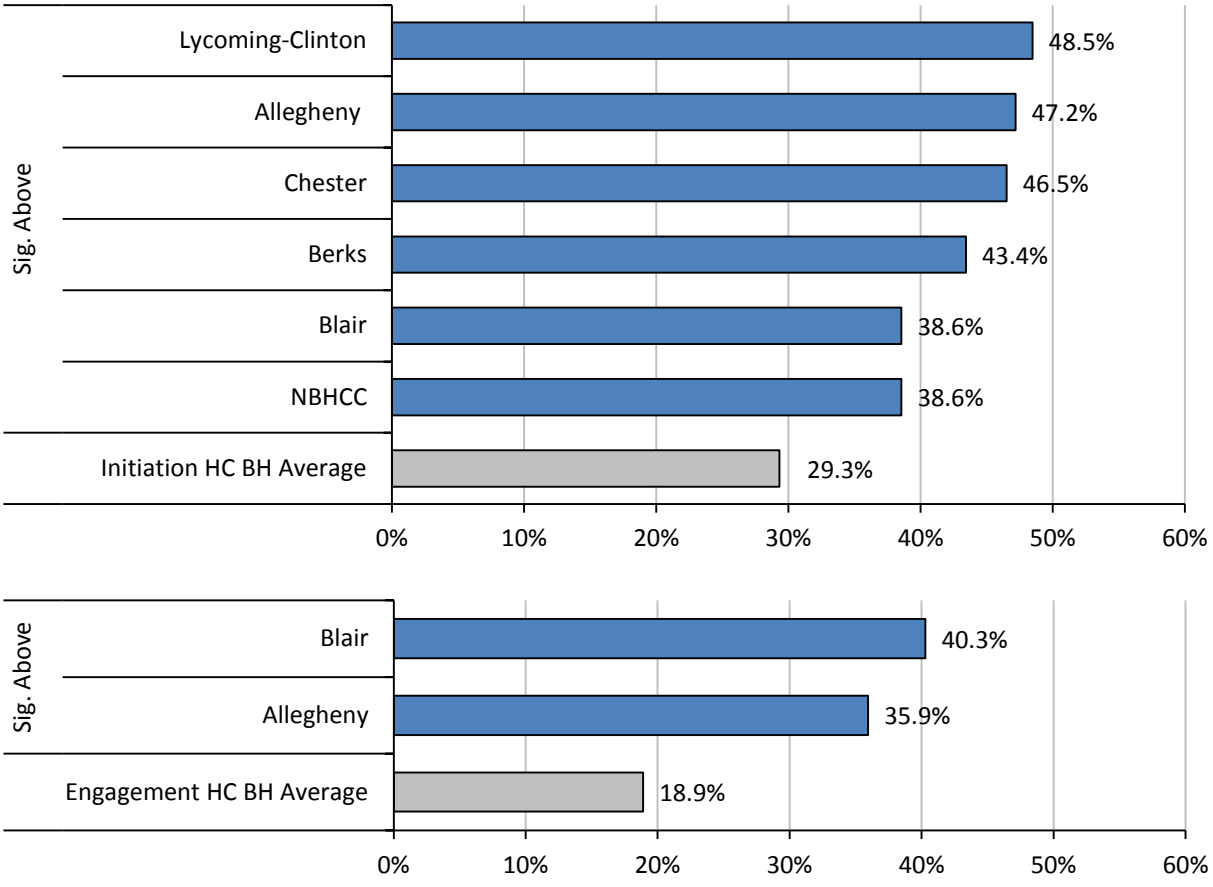


Figure 12: MY 2015 IET Rates Compared to HealthChoices County Average: 13–17 Years Old



(b) Age Group: 18+ Years Old

Table 15: MY 2015 IET Rates: 18+YearsWith Year-to-Year Comparisons

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	MY 2015 Lower 95% CI	MY 2015 Upper 95% CI	MY 2015 BH-MCO Average	MY 2015 BH HC Contractor Average	MY 2014 %	MY 2014 PPD	MY 2014 SSD	Rate Comparison MY 2015 to HEDIS Benchmarks
Age Cohort: 18+ Years –Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	8,493	31,768	**26.7%**	26.2%	27.2%	26.7%	27.7%	29.8%	-3.0	YES	Below 25th Percentile
CCBH	3,119	11,243	**27.7%**	26.9%	28.6%			29.7%	-1.9	YES	Below 25th Percentile
Adams	25	98	**25.5%**	16.4%	34.7%			28.0%	-2.5	NO	Below 25th Percentile
Allegheny	896	3,375	**26.5%**	25.0%	28.1%			29.8%	-3.2	YES	Below 25th Percentile
Berks	207	770	**26.9%**	23.7%	30.1%			23.9%	3.0	NO	Below 25th Percentile
Blair	172	473	**36.4%**	31.9%	40.8%			47.3%	-11.0	YES	Below 50th Percentile, Above 25th Percentile
CMP	155	558	**27.8%**	24.0%	31.6%			22.4%	5.4	YES	Below 25th Percentile
Chester	179	495	**36.2%**	31.8%	40.5%			30.9%	5.3	NO	Below 50th Percentile, Above 25th Percentile
Erie	191	614	**31.1%**	27.4%	34.9%			28.6%	2.5	NO	Below 25th Percentile
Lycoming-Clinton	157	388	**40.5%**	35.5%	45.5%			46.2%	-5.7	NO	Below 50th Percentile, Above 25th Percentile
NBHCC	409	1,605	**25.5%**	23.3%	27.6%			26.8%	-1.3	NO	Below 25th Percentile
NCSO	539	2,028	**26.6%**	24.6%	28.5%			29.7%	-3.1	YES	Below 25th Percentile
York	189	839	**22.5%**	19.6%	25.4%			27.4%	-4.9	YES	Below 25th Percentile
Age Cohort: 18+ Years – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	5,899	31,768	**18.6%**	18.1%	19.0%	18.3%	19.4%	20.1%	-1.5	YES	Above 50th Percentile, Below 75th Percentile
CCBH	2,094	11,243	**18.6%**	17.9%	19.3%			19.3%	-0.6	NO	Above 50th Percentile, Below 75th Percentile
Adams	21	98	**21.4%**	12.8%	30.1%			17.6%	3.8	NO	Above 50th Percentile, Below 75th Percentile
Allegheny	587	3,375	**17.4%**	16.1%	18.7%			19.8%	-2.4	YES	Above 50th Percentile, Below 75th Percentile
Berks	140	770	**18.2%**	15.4%	21.0%			14.5%	3.7	YES	Above 50th Percentile, Below 75th Percentile
Blair	127	473	**26.8%**	22.8%	30.9%			35.8%	-8.9	YES	At or Above 75th Percentile
CMP	96	558	**17.2%**	14.0%	20.4%			12.4%	4.8	YES	Above 50th Percentile, Below 75th Percentile
Chester	133	495	**26.9%**	22.9%	30.9%			20.8%	6.1	YES	At or Above 75th Percentile
Erie	142	614	**23.1%**	19.7%	26.5%			18.9%	4.2	NO	At or Above 75th Percentile
Lycoming-Clinton	113	388	**29.1%**	24.5%	33.8%			34.1%	-5.0	NO	At or Above 75th Percentile
NBHCC	245	1,605	**15.3%**	13.5%	17.1%			16.8%	-1.5	NO	Above 50th Percentile, Below 75th Percentile
NCSO	366	2,028	**18.0%**	16.3%	19.7%			18.5%	-0.4	NO	Above 50th Percentile, Below 75th Percentile
York	124	839	**14.8%**	12.3%	17.2%			15.8%	-1.0	NO	Above 50th Percentile, Below 75th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option

The MY 2015 HealthChoices Aggregate rates in the 18 and older age group were 26.7% for Initiation and 18.6% for Engagement (**Table 15**). Both rates were statistically significantly lower than the corresponding MY 2014 rates: the HealthChoices Aggregate Initiation rate decreased by 3.1 percentage points and the Engagement rate decreased by 1.5 percentage points from the prior year. The MY 2015 HealthChoices Aggregate Initiation rate in this age cohort was below the HEDIS 2016 25th percentile, while the Engagement rate was between the 50th and 75th percentiles.

The CCBH MY 2015 Initiation rate for the 18+ population was 27.7% (**Table 15**). This rate was below the HEDIS 2016 25th percentile, and was statistically significantly lower than the MY 2014 rate by 2.0 percentage points. Compared to the HealthChoices BH-MCO Average of 26.7% for Initiation, the CCBH Initiation rate was statistically significantly higher by 1.0 percentage points. The CCBH MY 2015 Engagement rate for this age cohort was 18.6%, and was between the HEDIS 2016 50th and 75th percentiles. The CCBH Engagement rate for this age group was not statistically significantly lower than the MY 2014 rate of 19.3%, and it was not statistically significantly different from the BH-MCO Average of 18.3%.

As presented in **Table 15**, there was statistically significant improvement in the Initiation rate for Carbon/Monroe/Pike (CMP), which had a rate increase of 5.4 percentage points from 22.4% in MY 2014 to 27.8% in MY 2015. Statistically significant Initiation rate decreases were noted for NSCO, Allegheny, York and Blair, with year-to-year declines ranging from 3.1 percentage points for NSCO to 10.9 percentage points for Blair. Initiation rates in the 18+ age group were below the 25th percentile for eight of the eleven CCBH HC BH Contractors. For the Engagement rate, statistically significant improvement was noted for Berks, CMP and Chester, with percentage point increases ranging from 3.7 for Berks to 6.1 for Chester. Engagement rates statistically significantly decreased in Allegheny and Blair, with percentage point decreases of 2.4 and 9.0, respectively. Seven CCBH HC BH Contractors demonstrated Engagement rates between the HEDIS 50th and 75th percentiles, and the remaining four HC BH Contractors were above the 75th percentile.

Figure 13 is a graphical representation MY 2015 IET rates for CCBH and its associated HC BH Contractors for the 18+ age group. **Figure 14** shows the HealthChoices HC BH Contractor Average rates and individual CCBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. The Initiation rates for Chester, Blair and Lycoming-Clinton were statistically significantly higher than the HealthChoices HC BH Contractor Average of 27.7%, with differences from the Average ranging from 8.5 percentage points for Chester to 12.8 percentage points for Lycoming-Clinton. Initiation rates for NBHCC and York were statistically significantly lower than the HC BH Contractor Average by 2.2 and 5.2 percentage points, respectively. The Engagement rates for Erie Blair, Chester and Lycoming-Clinton were statistically significantly higher than the HC BH Contractor Average of 19.4%, with differences ranging from 3.7 percentage points for Erie to 9.7 percentage points for Lycoming-Clinton. Engagement rates for Allegheny, NBHCC and York were statistically significantly lower than the HC BH Contractor Average, with differences ranging from 2.0 to 4.6 percentage points.

Figure 13: MY 2015 IET Rates – 18+Years

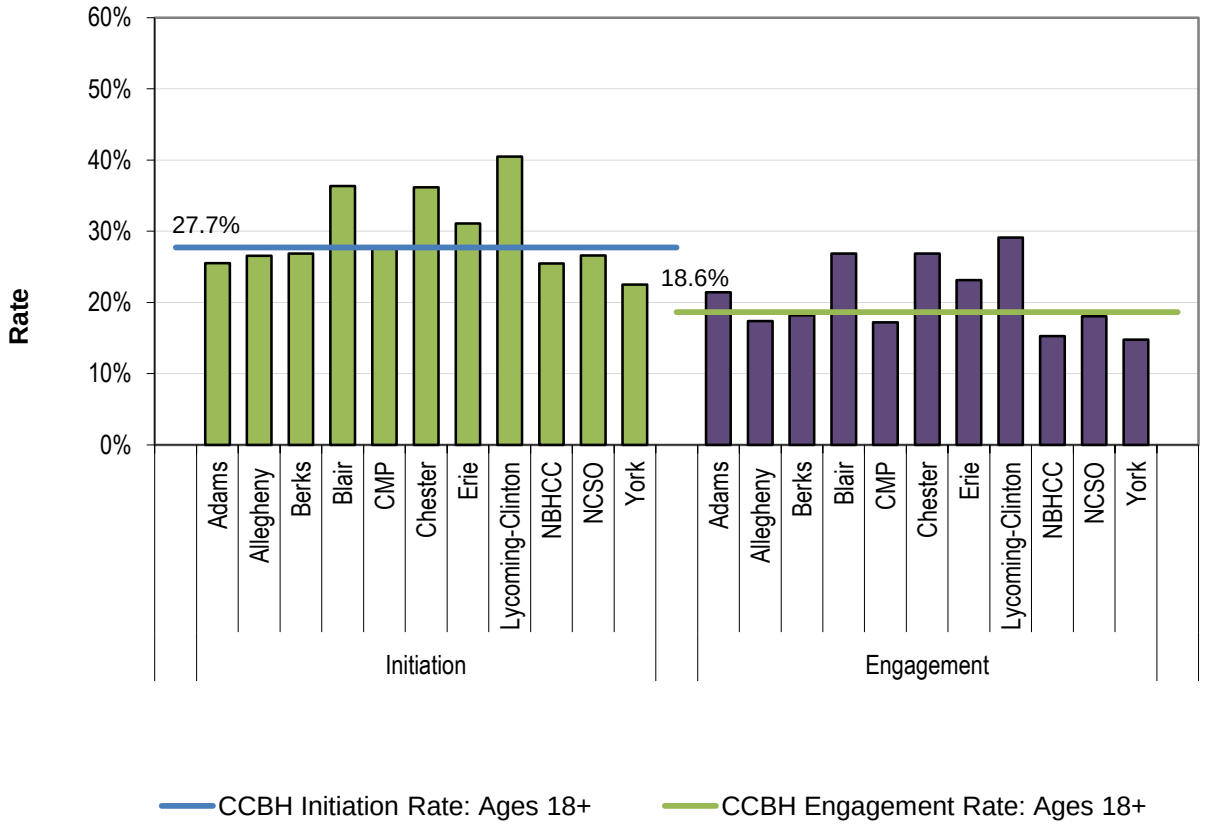
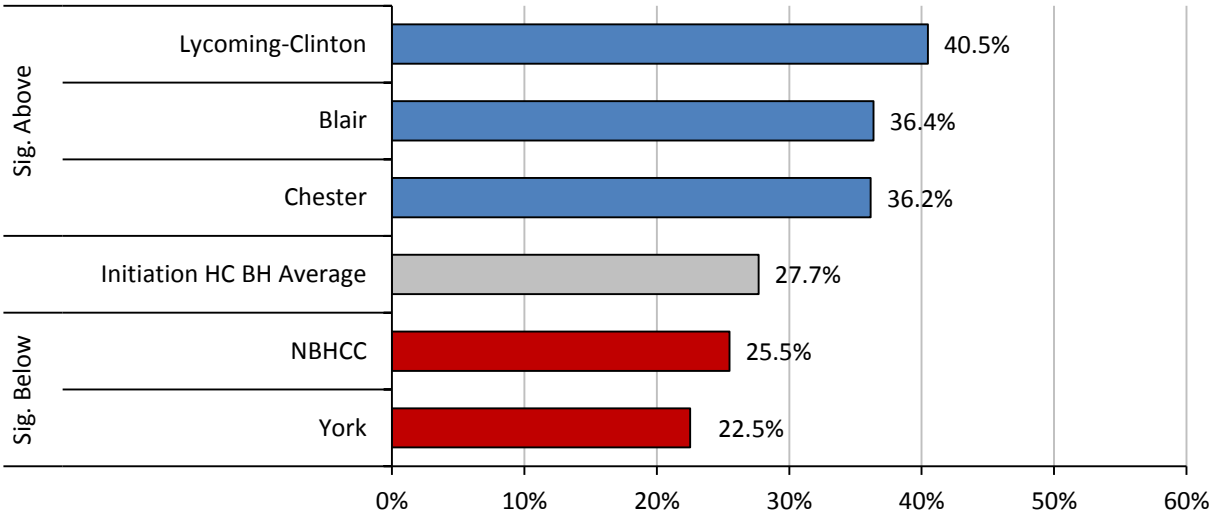
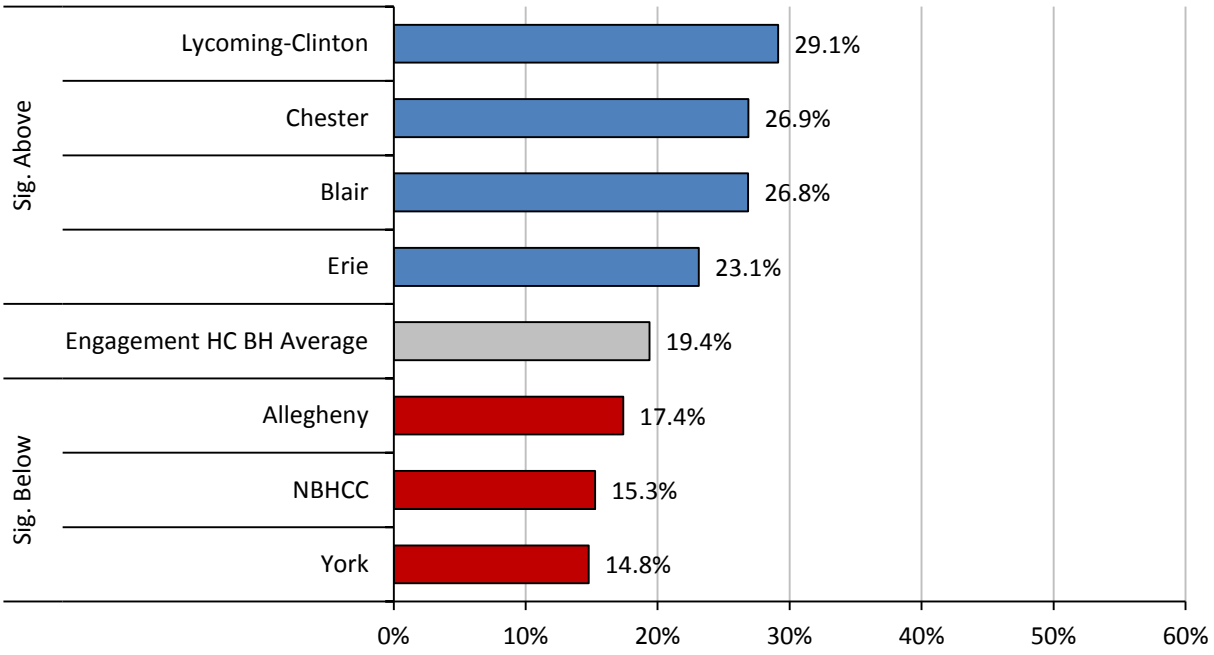


Figure 14: MY 2015 IET Rates Compared to HealthChoices HC BH Contractor Average – 18+ Years





(c) Age Group: 13+ Years Old

Table 16: MY 2015 IET Rates – 13+Years with Year-to-Year Comparisons

Measure	MY 2015 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	MY 2014 %	PPD	SSD	Rate Comparison MY 2015 to HEDIS Benchmarks
Age Cohort: Total – Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	9,417	34,281	**27.5%**	27.0%	27.9%	27.2%	28.0%	30.3%	-2.8	YES	Below 25th Percentile
CCBH	3,556	12,318	**28.9%**	28.1%	29.7%			30.5%	-1.6	NO	Below 25th Percentile
Adams	30	110	**27.3%**	18.5%	36.1%			28.8%	-1.5	NO	Below 25th Percentile
Allegheny	1,047	3,695	**28.3%**	26.9%	29.8%			30.7%	-2.4	NO	Below 25th Percentile
Berks	250	869	**28.8%**	25.7%	31.8%			24.1%	4.6	NO	Below 25th Percentile
Blair	213	545	**39.1%**	34.9%	43.3%			46.7%	-7.7	NO	Above 50th Percentile, Below 75th Percentile
CMP	166	599	**27.7%**	24.0%	31.4%			24.5%	3.3	NO	Below 25th Percentile
Chester	199	538	**37.0%**	32.8%	41.2%			31.8%	5.2	NO	Below 50th Percentile, Above 25th Percentile
Erie	212	686	**30.9%**	27.4%	34.4%			28.7%	2.2	NO	Below 25th Percentile
Lycoming-Clinton	173	421	**41.1%**	36.3%	45.9%			46.7%	-5.6	NO	Above 50th Percentile, Below 75th Percentile
NBHCC	473	1,771	**26.7%**	24.6%	28.8%			28.8%	-2.1	NO	Below 25th Percentile
NCSO	586	2,188	**26.8%**	24.9%	28.7%			30.2%	-3.5	NO	Below 25th Percentile
York	207	896	**23.1%**	20.3%	25.9%			27.2%	-4.1	NO	Below 25th Percentile
Age Cohort: Total – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	6,544	34,281	**19.1%**	18.7%	19.5%	18.7%	19.5%	20.5%	-1.4	YES	At or Above 75th Percentile
CCBH	2,397	12,318	**19.5%**	18.8%	20.2%			20.0%	-0.5	NO	At or Above 75th Percentile
Adams	23	110	**20.9%**	12.9%	29.0%			16.5%	4.4	NO	At or Above 75th Percentile
Allegheny	702	3,695	**19.0%**	17.7%	20.3%			21.1%	-2.1	NO	At or Above 75th Percentile
Berks	167	869	**19.2%**	16.5%	21.9%			14.1%	5.1	NO	At or Above 75th Percentile
Blair	156	545	**28.6%**	24.7%	32.5%			33.9%	-5.3	NO	At or Above 75th Percentile
CMP	102	599	**17.0%**	13.9%	20.1%			14.1%	2.9	NO	At or Above 75th Percentile
Chester	145	538	**27.0%**	23.1%	30.8%			21.8%	5.1	NO	At or Above 75th Percentile
Erie	161	686	**23.5%**	20.2%	26.7%			19.7%	3.8	NO	At or Above 75th Percentile
Lycoming-Clinton	124	421	**29.5%**	25.0%	33.9%			34.5%	-5.0	NO	At or Above 75th Percentile
NBHCC	284	1,771	**16.0%**	14.3%	17.8%			18.1%	-2.0	NO	At or Above 75th Percentile
NCSO	398	2,188	**18.2%**	16.6%	19.8%			19.0%	-0.9	NO	At or Above 75th Percentile
York	135	896	**15.1%**	12.7%	17.5%			15.6%	-0.5	NO	At or Above 75th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option

The MY 2015 HealthChoices Aggregate rates in the 13 and older age group were 27.5% for Initiation and 19.1% for Engagement (**Table 16**). The Initiation rate was statistically significantly lower than the MY 2014 Initiation rate by 2.8 percentage points, and the Engagement rate was statistically significantly lower than the MY 2014 Engagement rate by 1.4 percentage points. The MY 2015 HealthChoices Aggregate Initiation rate was below the HEDIS 2016 25th percentile, while the Engagement rate was above and 75th percentile.

The CCBH MY 2015 Initiation rate for the 13+ population was 28.9% (**Table 16**). This rate was below the HEDIS 2016 25th percentile, and was statistically significantly lower than the MY 2014 rate by 1.6 percentage points. Compared to the HealthChoices BH-MCO Average of 27.2% for Initiation, the CCBH rate was statistically significantly higher by 1.7 percentage points. The CCBH MY 2015 Engagement rate was 19.5%, and was above the HEDIS 2016 75th percentile. The CCBH Engagement rate was not statistically significantly different from the MY 2014 rate of 20.0%, and it was statistically significantly higher than the BH-MCO Average of 18.7% by 0.8 percentage points. CCBH had the highest Initiation rate of the five BH-MCOs evaluated in MY 2015.

As presented in **Table 16**, there was statistically significant improvement in the Initiation rate for Berks, which had a rate increase of 4.7 percentage points from 24.1% in MY 2014 to 28.8% in MY 2015. Statistically significant Initiation rate decreases were noted for Allegheny, NCSO, York and Blair, with year-to-year declines ranging from 2.4 percentage points for Allegheny to 7.6 percentage points for Blair. Initiation rates in the 13+ age group were below the 25th percentile for eight of the eleven CCBH HC BH Contractors, and one was between the 25th and 50th percentiles. Two HC BH Contractors, Blair and Lycoming-Clinton, had rates above the HEDIS 50th percentile. For the Engagement rate, there was statistically significant improvement in Berks, which had a rate increase of 5.1 percentage points from 14.1% in MY 2014 to 19.2% in MY 2015. The Engagement rate in Allegheny statistically significantly decreased 2.1 percentage points from 21.1% in MY 2014 to 19.0% in MY 2015. Engagement rates for all individual HC BH Contractors were above the 75th percentile.

Figure 15 is a graphical representation MY 2015 IET rates for CCBH and its associated HC BH Contractors for the 18+ age group. **Figure 16** shows the HealthChoices HC BH Contractor Average rates and individual CCBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. The Initiation rates for Chester, Blair and Lycoming-Clinton were statistically significantly higher than the HealthChoices HC BH Contractor Average of 28.0%, with differences from the Average ranging from 9.0 percentage points for Chester to 13.1 percentage points for Lycoming-Clinton. The Initiation rate for York was statistically significantly below the HC BH Contractor Average by 4.8 percentage points. The Engagement rates for Erie, Chester, Blair and Lycoming-Clinton were statistically significantly higher than the HC BH Contractor Average of 19.5%, with differences ranging from 4.0 percentage points for Erie to 10.0 percentage points for Lycoming-Clinton. Engagement rates for NBHCC and York were statistically significantly lower than the HC BH Contractor Average by 3.4 and 4.4 percentage points, respectively.

Figure 15: MY 2015 IET Rates: 13+Years

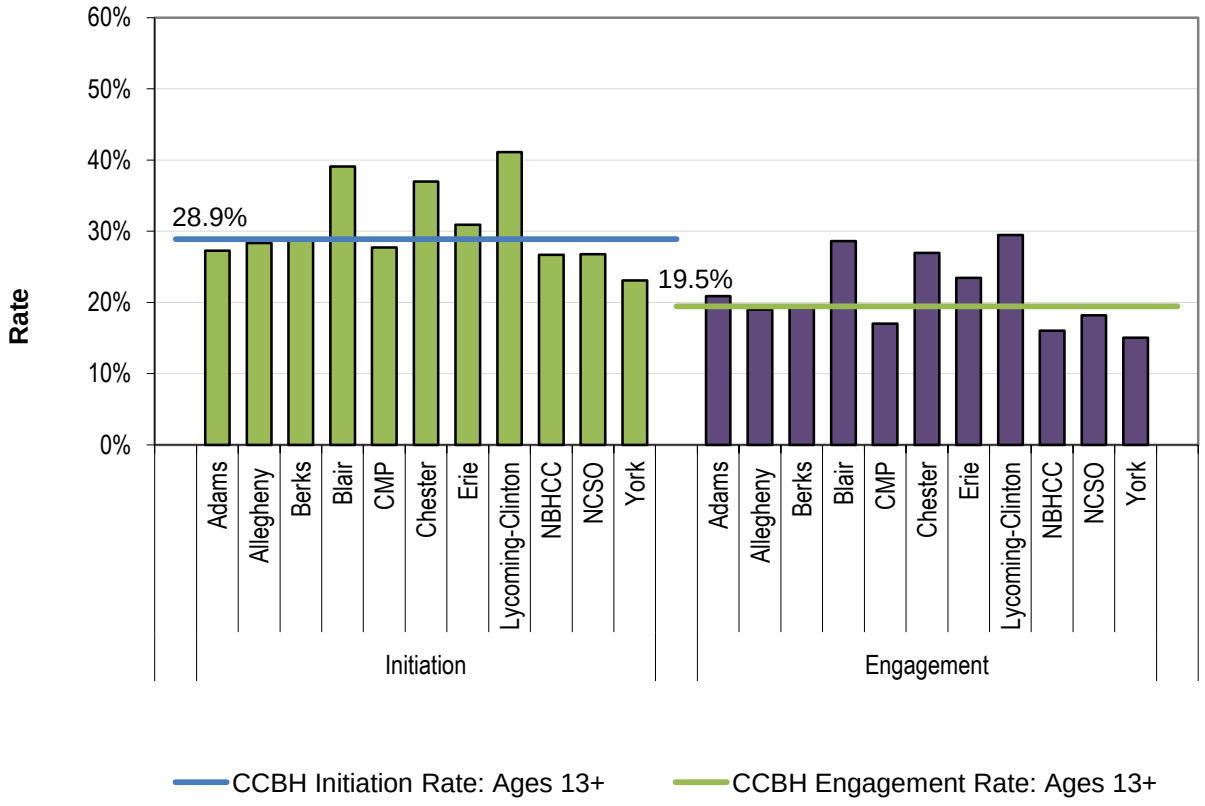
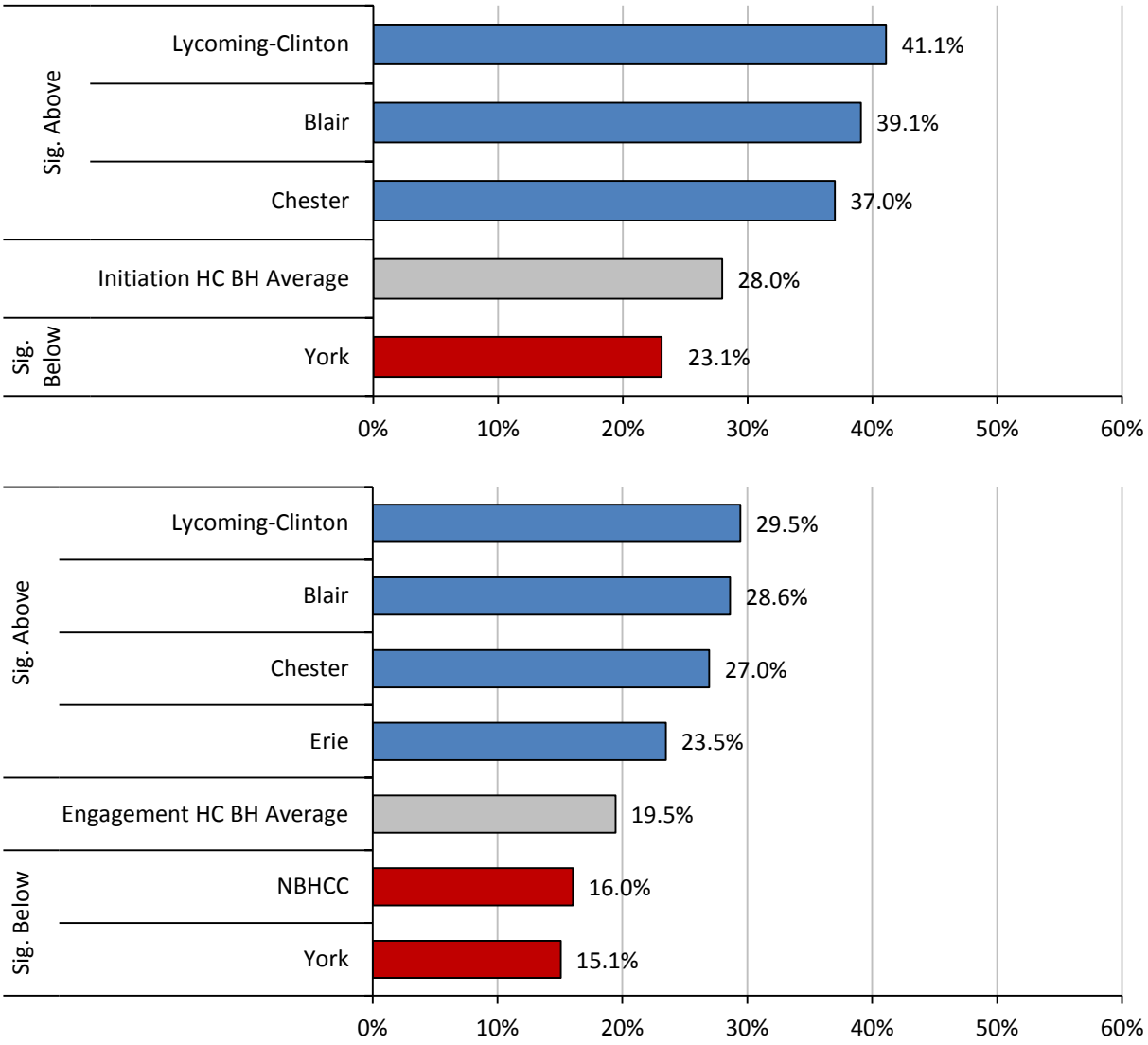


Figure 16: MY 2015 IET Rates Compared to HealthChoices HC BH Contractor Average: 13+ Years



Conclusion and Recommendations

For MY 2015, the aggregate HealthChoices rate in the 13+ population (overall population) was 27.5% for the Initiation rate and 19.1% for the Engagement rate. The Initiation rate was below the HEDIS 25th percentile while the Engagement rate was above the 75th percentile. The Initiation and the Engagement rates both statistically significantly decreased from MY 2014 rates. 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 all 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 2015 and 2016 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 factors associated with initiation and engagement rates among members enrolled in the Pennsylvania Medicaid Behavioral Health HealthChoices program who had a diagnosis of opioid abuse. A claims-based study was developed to determine what demographic and clinical factors are associated with lower initiation and engagement rates, with an objective of combining physical health and behavioral health encounter data to identify factors across both domains of care. The goal of this study was to provide data to guide targeted quality improvement interventions by identifying subpopulations with low initiation and engagement rates. Emphasis was placed on identifying factors across domains of care, i.e. physical and behavioral co-morbidities that are associated with lower initiation and engagement rates, and vice versa.

Data Collection and Analysis

This study analyzed behavioral and physical health encounter data for inpatient, outpatient, partial hospitalization, and intensive outpatient services for members with a primary or secondary diagnosis of opioid abuse between 1/1/14 and 11/15/14 in order to measure the percentage of members who receive these services after the opioid abuse diagnosis (defined as the index event). The primary source of data was claims that were submitted to and accepted by the DHS PROMISe encounter system through 10/28/15 and received by IPRO. Any claims not submitted to or not accepted by PROMISe were not included in this study. Additional analyses compared initiation and engagement rates for various subpopulations. Subpopulations were distinguished by member demographics, opioid diagnosis details, co-occurring substance abuse, and type of encounters/level of care, stratified by the behavioral and physical health domains. Analyses were done to identify what factors or combinations of factors correlate with the index event type, medication-assisted treatment for opioid dependence, and time to service initiation.

Results/Conclusions

There were a total of 10,829 members that met the denominator criteria that were included in this study, of which all had physical health and behavioral health encounters. The overall initiation rate for MY 2014 was 40.68%, and the overall engagement rate was 28.29%.

There were a number of demographic factors that were statistically significantly correlated with lower initiation and engagement rates. For both initiation and engagement, members from urban settings had lower rates than members from rural settings, African American members had lower rates than white members, and males had lower rates than females. It is noted that rates declined for both genders, though this was only statistically significant for initiation. The highest rates were for members aged 25-40.

Although opioid usage details were unspecified for about 85% of the sample, those with a continuous opioid diagnosis had lower initiation and engagement rates than members with any unspecified diagnosis, and lower initiation rates than members with any episodic opioid diagnosis. Members with a diagnosis of opioid dependence have higher initiation and engagement rates than those diagnosed with non-dependent abuse. Opioid diagnosis was the primary diagnosis for 74.6% members; these members had significantly higher rates than those with a non-opioid primary diagnosis (31.9% higher for initiation, and 26.0% higher for engagement). A co-occurring substance abuse diagnosis was associated with lower rates than opioid abuse alone (4.9% lower for initiation and 0.2% lower for engagement). Alcohol, cannabis, and cocaine were the most frequently co-diagnosed drugs; of these, alcohol had the lowest rates (34.3% for initiation and 24.1% for engagement).

Of the five types of index events (inpatient, emergency department, detoxification, outpatient/alternative levels of care, and outpatient/alternative levels of care stratified into behavioral and physical health encounters), intensive outpatient and methadone services had the highest initiation rates (86.7% and 85.4%, respectively) and engagement rates (80.1% and 68.8%, respectively). Members with a primary diagnosis of opioid abuse for the index event have higher initiation and engagement rates (31.9% and 26.0%, respectively) than members with a secondary diagnosis of opioid abuse.

Members with no active prescriptions for medication-assisted treatment for opioid dependence have an initiation rate 24.1% lower than those with an active prescription, and an engagement rate 21.7% lower. Members that initiated treatment within one week of the index event had a higher percentage of engagement than members who initiated treatment during the second week for all services except methadone.

V: 2015 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 2015 EQR Technical Reports, which were distributed in April 2016. The 2016 EQR Technical Report is the ninth report to include descriptions of current and proposed interventions from each BH-MCO that address the 2015 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 May 30, 2016 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 2016, as well as any additional relevant documentation provided by the BH-MCO.

Table 17 presents CCBH's responses to opportunities of improvement cited by IPRO in the 2015 EQR Technical Report, detailing current and proposed interventions.

Table 17: Current and Proposed Interventions

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found CCBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 5/30/16/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
CCBH 2015.01	Within Subpart C: Enrollee Rights and Protections Regulations, CCBH was partially compliant on one out of seven categories – Enrollee Rights.	Follow-up Actions Taken through 5/30/16: QM001 was submitted to OMHSAS on 3/23/16.	Enrollee Rights: PEPS Standard 104.2 (RY2014) The QM Program Description (QM001) was revised to include the timelines for submission of the QM Program Description, Work Plan, and member satisfaction. The change is located on page 16 of QM001 and reads as follows: "Data are shared with the county(ies) and oversight agencies through the QCMC, or are submitted as required contractually. Examples of routinely submitted reports include: • Annual Work Plan (March 1st) • Annual program evaluation (March 1st) • Quarterly PEPS summaries (15th of month after end of quarter) • CFST questions (15th of month after end of quarter) • Annual Performance Measures (as requested by OMHSAS/IPRO) • Successful Transitions PIP measures (as requested by OMHSAS/IPRO)"
		Future Actions Planned: OMHSAS approved the policy on 6/29/16.	Describe one future action. Leave blank if none.
CCBH 2015.02	Within Subpart D: Quality Assessment and Performance Improvement Regulations, CCBH was partially compliant with five out of 10 categories, and non-compliant with one category. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of	Follow-up Actions Taken through 5/30/16: January-December 2015 Data	1) Access to Care: PEPS Standard 23.4 (RY2014) Community Care has Spanish Speaking Customer service representatives and also uses Language Line and Global Arena for oral interpreter services. Information is provided by contract.  Standard 23_Spanish Speakin  Standard_23_Langu age_Output_by_Cor  Standard_23_Globa lArena_Translation_S
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
	Services, 3) Subcontractual Relationships and Delegation, 4) Practice Guidelines, and 5) Quality Assessment and Performance Improvement Program. The non-compliant category was: 1) Coordination and Continuity of Care.	Follow-up Actions Taken through 5/30/16: January-December 2015 Data	1) Access to Care: PEPS Standard 23.5 (RY2014) Community Care uses Global Arena for written translation services. Information is provided by contract.  Standard_23_GlobalArena_Translation_S
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: TTY Training through February 2016	1) Access to Care: PEPS Standard 24.3 (RY2014) Information on the TTY service and training information.  Standard 24_Language Line-T  Standard_24_Lang_Speech_Hearing_Pol  Standard 24_Language Line T  Copy of Standard 24_Global Arena_TTY  Copy of Standard 24_Global Arena_TTY
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: Actions taken through June 2014	1) Access to Care and 1) Coordination of Care (COC) and 2) Coverage and Authorization of Services and 4)Practice Guidelines: PEPS Standard 28.1 (RY2013)  Response to Cells 28.1_28.2.docx  PEPS_Cell28_CM Documentation Audit  PEPS_CELL28_CM Documentation Webe  Std 28 Item 1i IRR and Levels of Severit  Std 28 Item 1k BHRS MH Medical N  Std 28 Item 1q Recovery and Resilier
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: Actions taken through June 2014	1) Access to Care and 1) COC and 2) Coverage and Authorization of Services and 4) Practice Guidelines: PEPS Standard 28.2 (RY2013) See response to PEPS Standard 28.1 above.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		Follow-up Actions Taken through 5/30/16: Actions completed by January 1, 2016	1) Access to Care and 4) Practice Guidelines and 5) Quality Assessment and Performance Improvement Program: PEPS Standard 93.1 (RY2014) Recommendations from the PEPs for 93.1 were: (a) CCBH conducts a formal monitoring process specific to routine access of care to its members with a goal of 7 calendar days reported annually. (b) CCBH ensures a plan of action in reducing the number of exceptions is either documented in either the Annual Evaluation or Monitoring Meetings. Community Care implemented the following to address the PEPs recommendations: (a) A new critical performance measure was added to all 2016 work plans to measure routine access. The data source is the member satisfaction survey. Questions #5, 6, and 7 are questions that relate to routine access. Question #6 is considered the routine access measure for BQIC. Each contract will set their own goal or use the BQIC goal. (b) Some of the typical levels of care requiring exceptions have been removed from reporting. QMs address this in annual evaluations.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: Actions completed by January 1, 2016	3) Subcontractual Relationships and Delegation: PEPS Standard 99.1 (RY2013) The BH_MCO reports monitoring results for the quality of individualized service plans and treatment planning. Recommendation for PEPs 99.1 was to improve measurements in RTF Quality Reviews that can accurately demonstrate the improvement or decline in clinical delivery and reduction or increase in negative outcomes. Community Care made changes to the RTF quality review goal for the 2016 work plan. The goal was revised as follows: 100% QIPs received, 80% on record review indicators, 100% all safety concerns addressed immediately.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: Actions completed by March 1, 2016	3) Subcontractual Relationships and Delegation: PEPS Standard 99.2 (RY2013) Recommendation for PEPs standard 99.2 was to report out on all follow-up activities associated with SMIs to include, but not limited to:

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			documentation reviews, on-site reviews, QIP and Red Flag meetings, for all contracts. Community Care responded by indicating: documentation reviews, on-site reviews, and QIPs are reflected in the annual evaluation report on SMIs. The number of Red Flag meetings is contained in the annual evaluation introduction section.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: QM001 was submitted to OMHSAS on 3/23/16.	5) Quality Assessment and Performance Improvement Program: PEPS Standard 91.1 (RY 2014)  PEPS_Standard_91.1 .docx
		Future Actions Planned: OMHSAS approved the policy on 6/29/16.	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: QM001 was submitted to OMHSAS on 3/23/16.	5) Quality Assessment and Performance Improvement Program: PEPS Standard 104.2 (RY2014) The QM Program Description (QM001) was revised to include the timelines for submission of the QM Program Description, Work Plan, and member satisfaction. The change is located on page 16 of QM001 and reads as follows: "Data are shared with the county(ies) and oversight agencies through the QCMC, or are submitted as required contractually. Examples of routinely submitted reports include: • Annual Work Plan (March 1st) • Annual program evaluation (March 1st) • Quarterly PEPS summaries (15th of month after end of quarter) • CFST questions (15th of month after end of quarter) • Annual Performance Measures (as requested by OMHSAS/IPRO) • Successful Transitions PIP measures (as requested by OMHSAS/IPRO)"
		Future Actions Planned: OMHSAS approved the policy on 6/29/16.	Describe one future action. Leave blank if none.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
CCBH 2015.03	CCBH was partially compliant on nine 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) Information to Providers and Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.	Follow-up Actions Taken through 5/30/16: Community Care completed all quality improvement plans around standard 68.1 and received confirmation in the most recent PEPs review.	1) Statutory Basis and Definitions and 2) General Requirements and 4) Handling of Grievances and Appeals and 5) Resolution of Notification: Grievances and Appeals and 7)Information to Providers and Subcontractors: PEPS Standard 68.1 (RY2012)  Response to Cells 68.1_68.3_68.4_68.!  PEPS 68.1_2015-level1-cor  PEPS_68.1_2015-lev el2-complaint-meetinç **Note: Community Care has been working on standard 68.1 since RY 2012. The most recent review, RY2015 found this standard no longer required a corrective action plan.**  PEPS_RY2015Feedb ack_Std_68.1_68.3_6
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: Community Care completed all quality improvement plans around standard 68.4 and received confirmation in the most recent PEPs review.	1) Statutory Basis and Definitions and 2) General Requirements and 4) Handling of Grievances and Appeals and 5) Resolution of Notification: Grievances and Appeals : PEPS Standard 68.4 (RY2012)  Response to Cells 68.1_68.3_68.4_68.!  Std 68.4 (Items 1-6) and 68.5 (Items 1-5)  Std 68.4 (Items 1-6) and 68.5 (Items 1-5) **Note: Community Care has been working on standard 68.4 since RY2012. The most recent review, RY2015 found this standard no longer required a corrective action plan.**  PEPS_RY2015Feedb ack_Std_68.1_68.3_6
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: Community Care completed all quality improvement plans around standard 68.3	1) Statutory Basis and Definitions and 2) General Requirements and 4) Handling of Grievances and Appeals and 5) Resolution of Notification: Grievances and Appeals: PEPS Standard 68.3 (RY2012)

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		and received confirmation in the most recent PEPs review.	Response to Cells 68.1_68.3_68.4_68.! 68.3_L1C ack ltr to mbr.docx 68.3_L1C decision ltr.docx 68.3_L1C ack ltr for Action Complaints.do 68.3_L1C decision ltr for Action Complaints 68.3_L2C ack ltr to mbr.docx 68.3_L2C decision ltr.docx **Note: Community Care has been working on standard 68.3 since RY2012. The most recent review, RY2015 found this standard no longer required a corrective action plan.** PEPS_RY2015Feedback_Std_68.1_68.3_6
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: Community Care completed all quality improvement plans around standard 68.5 and received confirmation in the most recent PEPs review.	1) Statutory Basis and Definitions and 2) General Requirements and 4) Handling of Grievances and Appeals and 5) Resolution of Notification: Grievances and Appeals: PEPS Standard 68.5 (RY2012) Response to Cells 68.1_68.3_68.4_68.! Std 68.4 (Items 1-6) and 68.5 (Items 1-5) Std 68.4 (Items 1-6) and 68.5 (Items 1-5) Std 68.5 Item 6a Complaint Trending P **Note: Community Care has been working on standard 68.5 since RY2012. The most recent review, RY2015 found this standard no longer required a corrective action plan.**

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			PEPS_RY2015Feedback_Std_68.1_68.3_6
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: Community Care completed all quality improvement plans around standard 71.3 and received confirmation in the most recent PEPs review.	1) Statutory Basis and Definitions and 2) General Requirements and 4) Handling of Grievances and Appeals and 5) Resolution of Notification: Grievances and Appeals and 6) Expedited Appeals Process and 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions: PEPS Standard 71.3 (RY2012) Response to Cell_71.3_71.4.docx Psychologist agenda 3-11-14.docx MD Meeting Minutes 3-12-14.docx **Note: Community Care has been working on standard 71.3 since RY2012. The most recent review, RY2015 found this standard no longer required a corrective action plan.** PEPS_RY2015Feedback_Std_71.3_71.4_C
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: Community Care completed all quality improvement plans around standard 71.4 and received confirmation in the most recent PEPs review.	1) Statutory Basis and Definitions and 2) General Requirements and 4) Handling of Grievances and Appeals and 5) Resolution of Notification: Grievances and Appeals 6) Expedited Appeals Process and 8) Continuation of Benefits and 9) Effectuation of Reversed Resolutions : PEPS Standard 71.4 (RY2012) Response to Cell_71.3_71.4.docx Psychologist agenda 3-11-14.docx MD Meeting Minutes 3-12-14.docx 71.4_PPI Process and Trending Method **Note: Community Care has been working on standard 71.4 since RY2012.**

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			The most recent review, RY2015 found this standard no longer required a corrective action plan.  PEPS_RY2015Feedback_Std_71.3_71.4_C
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: January-December 2015 Data	3) Notice of Action: PEPS Standard 23.4 (RY2014) Community Care has Spanish Speaking Customer service representatives and also uses Language Line and Global Arena for oral interpreter services. Information is provided by contract.    Standard 23_Spanish Speakin Standard_23_Language_Output_by_Cor Standard_23_GlobalArena_Translation_S
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: January-December 2015 Data	3) Notice of Action: PEPS Standard 23.5 (RY2014) Community Care uses Global Arena for written translation services. Information is provided by contract.  Standard_23_GlobalArena_Translation_S
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow-up Actions Taken through 5/30/16: TTY Training through February 2016	3) Notice of Action: PEPS Standard 24.3 (RY2014) Information on the TTY service and training information.    Standard 24_Language Line-T Standard_24_Lang_Speech_Hearing_Pol Standard 24_Language Line T   Copy of Standard 24_Global Arena_TTY Copy of Standard 24_Global Arena_TTY
		Future Actions Planned	Describe one future action. Leave blank if none.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		(Specify Dates)	
CCBH 2015.04	CCBH's rate for the MY 2014 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.	Follow Up Actions Taken Through 5/30/16	Please find Community Care's actions to address follow up and readmission.  Aggregate_Interventions_for_Readmissi
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
CCBH 2015.05	CCBH's overall rate for the MY 2014 30-Day Follow-up After Hospitalization for Mental Illness – HEDIS Indicator (QI 2) statistically significantly decreased from their MY 2013 rate of 69.8% by 1.7 percentage points. CCBH's rate for the MY 2014 30-Day Follow-up After Hospitalization for Mental Illness – PA Indicator (QI B) statistically significantly decreased from their MY 2013 rate of 77.0% by 1.2 percentage points. CCBH'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 OMHSAS interim goals, nor did they meet the goal of achieving or exceeding the 75th percentile.	Follow Up Actions Taken Through 5/30/16	For PA Indicator (QIB) refer to the document in the readmission section (CCBH 2.15.04). PA Specific follow up interventions are designated in the document with an *. For QI 1 and QI 2 refer to the embedded Root Cause Analysis.  Frm_2015 BH PM Root Cause Request
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.

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 2014, CCBH began to address opportunities for improvement related to Standards 23, 24, 28, 68, 71, 91, 93, 99 and 104. Proposed actions and evidence of actions taken by CCBH 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 CCBH into compliance with the relevant Standards.

Root Cause Analysis and Action Plan

The 2016 EQR is the eighth 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 measurement year. For performance measures that were noted as opportunities for improvement in the 2015 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.

For the 2016 EQR, CCBH 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 18**)
- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years (**Table 19**)

Table 18: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6–64 Years

RCA: Follow-Up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day – Ages 6-64)		
***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): *Community Care Behavioral Health Organization (Community Care)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day – Ages 6-64)*	***Response Date:*** ***7-29-16***
Goal Statement: **(Please specify individual goals for each measure):** Short term goal: Increase 7-day Follow-up HEDIS rates by 2 percentage points Long term goal: Increase 7-day Follow-up HEDIS rates to meet and/or exceed the 75th percentile		
***Analysis*:** **What factors contributed to poor performance?** **Please enter "N/A" if a category of factors does not apply.**	***Findings*** ***Policies Root Cause 1*: Discharge planning is not always as comprehensive or as individualized as required by the members' needs (Raven, 2010).** ***Policies Root Cause 2:* Data information systems (i.e., communication or telecommunication) have not kept pace with advances in technology (e.g., cell phones, go phones, email vs US mail) to maintain contact with the member.** ***Policies Root Cause 3:* Coordination between systems is fragmented.** ***Procedures Root Cause 1:* Measurement parameters/exclusions limit the data capture.** ***Procedures Root cause 2*: Payment delivery systems (CMS/insurance companies) reimburse "acute, stabilization" inpatient stays.** ***People Root Cause 1:* Difficult to balance the member's right to choose non-traditional services, supports or treatment with encouraging traditional follow up treatment.** ***People Root Cause 2:* Members have complex psychosocial stressors that take precedence over keeping follow up appointments.** ***People Root Cause 3*: Some members do not feel comfortable with many providers due to a lack of cultural diversity, specifically a lack of African American providers.** ***People Root Cause 4:* There is a shortage of psychiatrists.** ***Provisions Root Cause 1:* Discharge planning is not always as comprehensive**	

RCA: Follow-Up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day – Ages 6-64)	
	or as individualized as required by the members' needs (Raven, 2010). ***<u>Provisions Root Cause 2:</u> Coordination between systems is fragmented.*** ***<u>Provisions Root Cause 3:</u> Inpatient providers may not communicate materials/information in a way that members can understand. (Health Literacy)***
<u>Policies (1)</u> (e.g., data systems, delivery systems, provider facilities) • Members are not involved in discharge planning; interviews with members readmitted to an inpatient unit beginning in 2015 indicated that 20% of members did not have a discharge plan from their previous hospital stay. • Some providers may not schedule aftercare appointments for members; our most recent member satisfaction data indicates 14% of adults and 15% of children do not have appointments scheduled at the time of discharge. • Members may be referred to ambulatory providers that only offer open access appointments and may not receive services within 7 days; some open access providers cannot accommodate members on the same day. Some members may not be able to wait long periods for their turn in an open access setting or members may not return to an open access clinic if they are not seen on the first day that they go there. • Member is not given a follow up appointment; our most recent member satisfaction data indicates 14% of adults and 15% of children do not have appointments scheduled at the time of discharge. Member interviews in 2015 with readmitted members found that 24% of members did not have a follow up appointment scheduled at the time of discharge. • Members discharged against medical advice (AMA) are frequently not provided follow up or refuse to accept a follow up; our most recent member satisfaction survey found 15% of our adult members signed out of inpatient treatment AMA. • Members discharged during off hours may not leave with a follow up appointment date. • Some members are new to behavioral health or to inpatient treatment and may be less aware of the importance of follow up, less familiar with aftercare treatment or need additional engagement strategies. In MY 2014 this was the first admission for 37% of members that did not attend a follow up service after their inpatient stay. • Inpatient providers do not account for psycho social stressors or social determinants in discharge management planning. The top five reasons reported by readmitted members interviewed in 2015 for their readmission reported they were readmitted due to their mental health symptoms (37%), substance use (30%), housing issues (25%), medications	***Initial Response*** ***<u>Policies Root Cause 1</u>: Discharge planning is not always as comprehensive or as individualized as required by the members' needs (Raven, 2010).*** *.*

(25%), and conflicts with others/lack of supports (14%). • Lack of service choices in some areas limits referral opportunities specifically in rural communities (Robinson et al., 2012).	***Follow-up Status Response***
Policies (2) (e.g., data systems, delivery systems, provider facilities) • Contact information (address, phone number provided by the DHS feed) is often incorrect and providers and managed care organizations (MCO) are not able to contact members to encourage appointment attendance. • Maintaining accurate member contact information is difficult. • Providers are unclear on using electronic technology while also maintaining member confidentiality.	***Initial Response*** ***Policies Root Cause 2: Data information systems (i.e., communication or telecommunication) have not kept pace with advances in technology (e.g., cell phones, go phones, email vs US mail) to maintain contact with the member.*** ***Follow-up Status Response***
Policies (3) (e.g., data systems, delivery systems, provider facilities) • Outpatient providers have indicated inpatient providers do not provide timely notification of a member's discharge which creates challenges when scheduling appointments within 7 days; this may be due to doctor's discharging a member over the weekend when case managers are not working or when members leave AMA. • Communication on the inpatient unit between physicians and other staff is also fragmented. • There is a lack of communication between inpatient and outpatient providers; inpatient providers do not communicate with current treatment providers; treating providers indicate they are often not aware that a member was admitted and are then not involved in planning for discharge. • Transition from inpatient (IP) to ambulatory care is not seamless if discharging provider is different from receiving provider. • Receiving provider does not have complete or accurate clinical picture.	***Initial Response*** ***Policies Root Cause 3: Coordination between systems is fragmented.*** ***Follow-up Status Response***
Procedures (1) (e.g., payment/reimbursement, credentialing/collaboration) • HEDIS methodology does not capture services commonly used by and specifically developed for the Medicaid population, such as community based and mobile treatment options. • For members that did not follow up with services, 50% these members had co-occurring	***Initial Response*** ***Procedures Root Cause 1: Measurement parameters/exclusions limit the data capture.***

<table>
<tr><th colspan="2">RCA: Follow-Up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day – Ages 6-64)</th></tr>
<tr><td>disorders; these members may have followed up with clinically indicated services that are not mental health follow up services and not included in the methodology. Members with co-occurring issues may also seek traditional supports like AA and NA for follow up care, these types of follow up are not be included in the methodology.
• Members who utilize their primary insurance for follow up will not be captured in our follow up rates since we are unable to capture claims for follow up services that are paid for by the primary insurer; 20% of members in the MY 2014 data that did not have a follow up visit had other primary insurance. These members may have received follow up services through their primary insurance however we did not receive a claim.
• Our ability to intervene with providers is limited if we are not the primary payer as we often are not notified of the discharge in a timely manner or involved in the discharge planning process.</td><td>Follow-up Status Response</td></tr>
<tr><td><u>Procedures (2)</u>
(e.g., payment/reimbursement, credentialing/collaboration)
• The inpatient delivery system provides “acute stabilization”; inpatient providers are not prioritizing aftercare planning with members and providers.
• Doctor time to coordinate care (through telephone calls) with outpatient physicians/CNPs/nurses is not reimbursable.
• Providers are not incentivized (financially or otherwise) to provide a greater focus on discharge planning and coordination of care.
• Pay for performance programs have not been used to decrease readmission or improve follow up.</td><td>Initial Response
<u>Procedures Root cause 2</u>: Payment delivery systems (CMS/insurance companies) reimburse “acute, stabilization” inpatient stays.
Follow-up Status Response</td></tr>
<tr><td><u>People (1)</u>
(e.g., personnel, provider network, patients)
• Member does not keep follow up appointment. Member satisfaction surveys indicate approximately 10% of members do not keep scheduled follow up appointments; interviews with members readmitted in 2015 indicated that 51% of MH members did not attend their aftercare appointment. The reasons members reported they did not keep their follow up appointment included: readmission before the appointment (36%), relapse before the appointment (25%), chose not to attend their follow up appointment (15%), and forgot their appointment (4%).
• Member refuses follow up appointment; attitudinal member belief that they can handle their problem without help or that they don’t need help (Chen et al., 2013; Andrade et al., 2014).</td><td>Initial Response
<u>People Root Cause 1:</u> Difficult to balance the member’s right to choose non-traditional services, supports or treatment with encouraging traditional follow up treatment.</td></tr>
</table>

RCA: Follow-Up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day – Ages 6-64)	
• 27% of members chose not to take medication according to interviews with members readmitted in 2015. Members may not attend follow up appointments around medication if they choose not to continue medications post discharge. • Some members are new to behavioral health or to inpatient treatment and may be less aware of the importance of follow up, less familiar with aftercare treatment or need additional engagement strategies. In MY 2014 this was the first admission for 37% of members that did not attend a follow up service after their inpatient stay.	***Follow-up Status Response***
People (2) (e.g., personnel, provider network, patients) • Member is homeless/lacks stable housing; inpatient interviews found that 23% of members interviewed in 2015 reported housing issues leading to their readmission. • Member lacks social supports. • Member family/friends are not involved in discharge planning. Member satisfaction survey information indicates 32% of members did not have their family/friends included in discharge planning; direct interviews with members readmitted in 2015 indicate 61% report no family/friends involvement. • Transportation issues limit availability to keep appointments.	***Initial Response*** ***People Root Cause 2: Members have complex psychosocial stressors that take precedence over keeping follow up appointments.*** ***Follow-up Status Response***
People (3) (e.g., personnel, provider network, patients) • Racial/ethnic disparities have been identified in participation in ambulatory care: two of our counties have a large African American population and one county has a large Hispanic population. African Americans have lower rates of outpatient mental health penetration. • "African Americans are more likely to leave MH programs early" (Snowden, 2001). • Some racial/ethnic groups do not seek treatment due to stigma (Gary, 2005). • In MY 2014, the Black/African American population were statistically significantly lower than rates for the White population (DHS OMHSAS, 2014). • A focus group including approximately 25 Community Care members of color identified the following barriers to seeking outpatient treatment: feelings of embarrassment/stigma, lack of trust in medical professionals, and lack of trust that professionals could help them.	***Initial Response*** ***People Root Cause 3: Some members do not feel comfortable with many providers due to a lack of cultural diversity, specifically a lack of African American providers.*** ***Follow-up Status Response***
People (4) (e.g., personnel, provider network, patients)	***Initial Response*** ***People Root Cause 4: There is a shortage of psychiatrists.*** ***Follow-up Status Response***

RCA: Follow-Up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day – Ages 6-64)	
• Psychiatrists have limited time to spend with patients.	
Provisions (1) (e.g., screening tools, medical record forms, provider and enrollee educational materials) • Discharge management plans are inadequate and may not contain all the information members need for their follow up appointment. Information from our discharge management planning chart abstraction measure found that only 58% of charts had adequate follow up information for members regarding a follow up appointment within seven days. • Providers do not do adequate medication reconciliation for members upon discharge; information from our discharge management planning chart abstraction measure found only 3% of members had adequate medication reconciliation at discharge. • Interviews with members found that 52% of members with frequent readmissions report they did not have a recovery plan, including crisis information; results of our discharge management planning chart abstraction measure found that 54% of members did not have a crisis plan at the time of discharge that was individualized, clearly documented, and included specific interventions for the member and families.	***Initial Response*** ***Provisions Root Cause 1: Discharge planning is not always as comprehensive or as individualized as required by the members' needs (Raven, 2010).*** ***Follow-up Status Response***
Provisions (2) (e.g., screening tools, medical record forms, provider and enrollee educational materials) • Transmission of discharge information to receiving provider can be delayed if receiving provider is different from discharging provider. • Increased focus on confidentiality is placing new restrictions on information being released. • Release of Information (ROI) can be difficult to obtain from member.	***Initial Response*** ***Provisions Root Cause 2: Coordination between systems is fragmented.*** ***Follow-up Status Response***
Provisions (3) (e.g., screening tools, medical record forms, provider and enrollee educational materials) • Patients are disconnected or may not understand their discharge plan. • Members may not understand the importance of their follow up treatment.	***Initial Response*** ***Provisions Root Cause 3: Inpatient providers may not communicate materials/information in a way that members can understand. (Health Literacy)*** ***Follow-up Status Response***
Complete next page of corresponding action plan.	

Action Plan: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day – Ages 6-64)		
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.
Action Embedded please find the actions and interventions Community Care implemented from July 2015 through May 2016.  RCA_and_Interventi ons_for_Readmissio		***Initial Response*** Monitoring Plan is included in the document. ***Follow-up Status Response***

Table 19: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years

RCA: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day – Ages 6-64)		
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): *Community Care Behavioral Health (CCBH)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day – Ages 6-64)*	***Response Date:*** ***7-29-16***
Goal Statement: **(Please specify individual goals for each measure):** Short term goal: Increase 30-day Follow-up HEDIS rates by 2 percentage points. Long term goal: Increase 30-day Follow-up HEDIS rates to meet and/or exceed the 75th percentile.		
Analysis*:** **What factors contributed to poor performance?** **Please enter "N/A" if a category of factors does not apply.** ***The same factors that were identified for the 7 day HEDIS follow up were also identified for the 30 day HEDIS follow up. Please refer to the 7 day follow up analysis.	***Findings*** ***Policies Root Cause 1: Discharge planning is not always as comprehensive or as individualized as required by the members' needs (Raven, 2010).*** ***Policies Root Cause 2: Data information systems (i.e., communication or telecommunication) have not kept pace with advances in technology (e.g., cell phones, go phones, email vs US mail) to maintain contact with the member.*** ***Policies Root Cause 3: Coordination between systems is fragmented.*** ***Procedures Root Cause 1: Measurement parameters/exclusions limit the data capture.*** ***Procedures Root cause 2: Payment delivery systems (CMS/insurance companies) reimburse "acute, stabilization" inpatient stays.*** ***People Root Cause 1: Difficult to balance the member's right to choose non-traditional services, supports or treatment with encouraging traditional follow up treatment.*** ***People Root Cause 2: Members have complex psychosocial stressors that take precedence over keeping follow up appointments.*** ***People Root Cause 3: Some members do not feel comfortable with many providers due to a lack of cultural diversity, specifically a lack of African American providers.*** ***People Root Cause 4: There is a shortage of psychiatrists.*** ***Provisions Root Cause 1: Discharge planning is not always as comprehensive or as individualized as required by the members' needs (Raven, 2010).*** ***Provisions Root Cause 2: Coordination between systems is fragmented.*** ***Provisions Root Cause 3: Inpatient providers may not communicate materials/information in a way that members can understand. (Health Literacy)***	
Complete next page of corresponding action plan.		

<table>
<tr><th colspan="3">Action Plan: Follow-up After Hospitalization for Mental Illness QI 2 (30-Day – Ages 6-64)</th></tr>
<tr><td colspan="3"><u>Measure:</u> Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day – Ages 6-64)</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 frequency
(e.g., Ongoing, Quarterly)</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>
<tr><td rowspan="4">Action

Refer to the actions and interventions attachment in the HEDIS 7 day follow up section as these were the same action and interventions identified for HEDIS 30 day follow up.</td><td rowspan="4"></td><td>Initial Response</td></tr>
<tr><td>Monitoring plan is identified in the document.</td></tr>
<tr><td>Follow-up Status Response</td></tr>
<tr><td></td></tr>
</table>

References for **Tables 17–18**:

Andrade LH, Alonso J, Mneimneh Z, Wells JE, Al-Hamzawi A et al. (2014). Barriers to Mental Health Treatment: Results from the WHO World Mental Health Surveys. Psychological Medicine 44, 1303–1317.

Chen LY, Crum RM, Martins SS, Kaufmann CN, Strain EC, Mojtabai R. (2013). Service Use and Barriers to Mental Health Care Among Adults with Major Depression and Comorbid Substance Dependence. Psych Services, 64, 863-870.

Gary, FA. (2005). Stigma: Barrier to mental health care among ethnic minorities. Issues in Mental Health Nursing, 26, 979-999.

Commonwealth of Pennsylvania Department of Health Services Office of Mental Health and Substance Abuse Services (DHS OMHSAS) (2014). Follow-Up After Hospitalization for Mental Illness - External Quality Review, Performance Measure Validation, and Reporting Measurement Year 2014.

Kozubal, D.E., Samus, Q.M., Bakare, A.A., Trecker, C.C., Wong, H.W., Guo, H., Cheng, J., Allen, P. X., Mayer, L.S., Kay R. Jamison, K.R., Kaplin, A.I. (2013). Separate May Not Be Equal: A preliminary Investigation of the Clinical Correlates of Electronic Psychiatric Record Accessibility in Academic Medical Centers. International Journal of Medical Informatics, 82, 260-267.

Loveland, D. (2015). Engaging Clients, Family Members, and their Habits. Community Care Care Management Training.

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(7), 885-889.

Raven MC, Carrier ER, Lee J, et al. (2010). Substance Use Treatment Barriers for Patients with Frequent Hospital Admissions. Journal of Substance Abuse Treatment, 38, 22-30.

Robinson WD, Springer, R, Bischoff R, Geske J, Backer E, Olson M, Jarzynka K, Swinton J. (2012). Rural Experiences with Mental Illness: Through the Eyes of Patients and Their Families. Families, Systems, & Health, 30(4), 308-321.

Snowden LR. (2001). Barriers to Effective Mental Health Services for African Americans. Mental Health Services Research, 3, 181-187.

VI: 2016 Strengths and Opportunities for Improvement

The review of CCBH's 2016 (MY 2015) performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH-MCO.

Strengths

- CCBH's rate for the MY 2015 7-Day Follow-up After Hospitalization for Mental Illness – PA Indicator (QI A) measure was statistically significantly higher than the MY 2015 HealthChoices BH-MCO Average of 55.8% by 3.9 percentage points.
- CCBH's rate for the MY 2015 30-Day Follow-up After Hospitalization for Mental Illness – PA Indicator (QI B) measure was statistically significantly higher than the MY 2015 HealthChoices BH-MCO Average of 72.7% by 2.6 percentage points.
- CCBH's rate for the MY 2015 7-Day Follow-up After Hospitalization for Mental Illness (QI 1) measure for the overall poulation was statistically significantly higher than the MY 2015 HealthChoices BH-MCO Average of 44.9% by 2.6 percentage points
- CCBH's rate for the MY 2015 30-Day Follow-up After Hospitalization for Mental Illness (QI 2) measure for the overall population was statistically significantly higher than the MY 205 HealthChoices BH-MCO Average of 65.4% by 2.3 percentage points.
- CCBH's rate for the Readmission Within 30 Days of Inpatient Psychiatric Discharge measure statistically significantly decreased (improved) from the prior year by 0.8 percentage points.
- CCBH's rate for the MY 2015 Initiation of AOD Treatment performance measure for ages 13+ was statistically significantly higher than the MY 2015 HealthChoices BH-MCO Average of 27.2% by 1.7 percentage points.
- CCBH's rate for the MY 2015 Engagement of AOD Treatment performance measure for ages 13+ was statistically significantly higher than the MY 2015 HealthChoices BH-MCO Average of 18.7% by 0.8 percentage points.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2013, RY 2014, and RY 2015 found CCBH to be partially compliant with two Subparts associated with Structure and Operations Standards.
    - CCBH was partially compliant with five out of 10 categories and non-compliant with one category within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care) 2) Coverage and Authorization of Services 3) Subcontractual Relationships and Delegation 4) Practice Guidelines 5) Quality Assessment and Performance Improvement Project. The non-compliant category is: Coordination and Continuity of Care.
    - CCBH was partially compliant with 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.
- CCBH's rates for the MY 2015 Follow-up After Hospitalization for Mental Illness HEDIS Follow-up indicators (QI 1 and QI 2) for ages 6-64 did not meet the OMHSAS interim goals for MY 2015, nor did they achieve the goal of meeting or exceeding the 75th percentile.
- CCBH did not meet the OMHSAS designated performance goal of 10.0% for the Readmission Within 30 Days of Inpatient Psychiatric Discharge performance measure.

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 20**.

Table 20: BH-MCO Performance and HEDIS Percentiles

Color Code	Definition
	PA-specific Follow-up After Hospitalization Measures: Indicates that the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Indicates that the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014. **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 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014 or that the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average but there is no change from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014 or that the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average but there is no change from MY 2014. **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 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014 or the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average but trends down from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** The BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014 or the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average but trends up from MY 2014. **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 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or that the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or that the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014. **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 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014. **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 21 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 21: Performance Measure Matrix

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

[1]For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in 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 20.**
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); REA: Readmission Within 30 Days of Inpatient Psychiatric Discharge

Table 22 represents the BH-MCO's performance for each measure in relation to prior year's rates for the same indicator for MY 2012 to MY 2015. 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 22: Performance Measure Rates

Quality Performance Measure	MY 2012 Rate	MY 2013 Rate	MY 2014 Rate	MY 2015 Rate	MY 2015 HC BH-MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)	61.1% =	60.3% =	59.6% =	59.7% =	55.8%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)	77.7% =	77.0% =	75.8% ▼	75.3% =	72.7%
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	12.2% =	14.4% ▲	14.8% =	14.0% ▼	14.0%

[1]For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.

Table 23 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 (QI 1/QI 2). A root cause analysis and plan of action is required for items that fall below the 75th percentile.

Table 23: HEDIS Follow-up After Hospitalization 7-Day/30-Day Performance Measure Matrix: Ages 6-64 Years

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 1** **FUH QI 2**
Indicators that are less than the 50th percentile.

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

Table 24: HEDIS Follow-up After Hospitalization 7-Day/30-Day Performance Measure Rates Ages 6–64 Years

Quality Performance Measure	MY 2015		HEDIS MY 2015 Percentile
	Rate[1]	Compliance	
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day): Ages 6-64 Years	47.6%	Not Met	Below 75th and at or above 50th percentile
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day): Ages 6-64 Years	68.0%	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 25 summarizes the key points based on the findings of the performance measure matrix comparisons.

Table 25: Key Points of Performance Measure Comparisons

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

[1] For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.

VII: Summary of Activities

Structure and Operations Standards

- CCBH was compliant with Subpart C and partially compliant with Subparts D and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2015, RY 2014, and RY 2013 were used to make the determinations.

Performance Improvement Projects

- CCBH submitted a Year 1PIP Update in 2016. CCBH participated in quarterly meetings with OMHSAS and IPRO throughout 2016 to discuss ongoing PIP activities.

Performance Measures

- CCBH reported all performance measures and applicable quality indicators in 2016.

2015 Opportunities for Improvement MCO Response

- CCBH provided a response to the opportunities for improvement issued in 2015.

2016 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CCBH in 2016. 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

Category	PEPS Reference	PEPS Language
		content and priority and directing staff to perform high quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2015, 16 substandards were considered OMHSAS-specific monitoring standards. Of the 16 OMHSAS-specific PEPS Substandards, all were evaluated for CCBH and the counties subcontracting with CCBH. **Table C.1** provides a count of these Items, along with the relevant categories.

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

Category (PEPS Standard)	Total Items	PEPS Reviewed in RY 2015	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	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	0	0	4	0
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	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. There are two substandards crosswalked to this category, and CCBH and its HC BH Contractors were compliant with all eight substandards. 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 by HC BH Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Standard 27.7	RY 2015		All HC BH Contractors	
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	RY 2015		All HC BH Contractors	

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

All HC BH Contractors partially met the criteria for compliance with Substandard 27 (RY 2015).

Substandard 27.7: Other: Significant onsite review findings related to Standard 27.

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

All HC BH Contractors partially met the criteria for compliance with Substandard 28.3 (RY 2015)

Substandard 28.3: Other: Significant onsite review findings related to Standard 28.

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO and HC BH Contractor-specific review standards. Eight substandards were evaluated for all HC BH Contractors during RY 2015. CCBH was compliant with each of the substandards croswalked to this category. Findings are presented **Table C.3**.

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

Category	PEPS Item	Review Year	Status by HC BH Contractor		
			Met	Partially Met	Not Met
Second Level Complaints and Grievances					
Complaints	Standard 68.1	RY 2015	All HC BH Contractors		
	Standard 68.6	RY 2015	All HC BH Contractors		
	Standard 68.7	RY 2015	All HC BH Contractors		
	Standard 68.8	RY 2015	All HC BH Contractors		
Grievances and State Fair Hearings	Standard 71.1	RY 2015	All HC BH Contractors		
	Standard 71.5	RY 2015	All HC BH Contractors		
	Standard 71.6	RY 2015	All HC BH Contractors		
	Standard 71.7	RY 2015	All HC BH Contractors		

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. CCBH 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 2015	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. CCBH was evaluated for both substandards in RY 2015. 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 by HC BH Contractor			
			Met	Partially Met	Not Met	Not Evaluated
Executive Management						
County Executive Management	Standard 78.5	RY 2015	Blair, Northcentral 23	Allegheny, Erie, Lycoming-Clinton, York/Adams	Berks, Carbon/ Monroe/Pike	Chester, NBHCC
BH-MCO Executive Management	Standard 86.3	RY 2015			All HC BH Contractors	

PEPS Standard 78: County Executive Management. Evidence exists of the County's oversight of functions and activities delegated to the BH-MCO including: a. County Table of Organization showing a clear organization structure for oversight of BH-MCO functions. b. In the case of a multi-county contract, the Table of Organization shows a clear relationship among and between Counties' management structures, as it relates to the BH-MCO oversight. c. The role of the Single County Authority (SCA) in oversight is clear in the oversight structure. d. Meeting schedules and attendee minutes reflect County oversight of the BH-MCO (e.g., adequate staff with appropriate skills and knowledge that regularly attend meetings and focus on monitoring the contract and taking appropriate action, such as CAPs. f. Documentation of the County's reviews and/or audits of quality and accuracy of the major BH-MCO functions, including: 1) Care Management 2) Quality Assurance (QA) 3) Financial Programs 4) MIS 5) Credentialing 6) Grievance System 7) Consumer Satisfaction 8) Provider Satisfaction 9) Network development, provider rate negotiation, and 10) Fraud, Waste, Abuse (FWA).

Allegheny, Erie, Lycoming-Clinton and York/Adams partially met the criteria for compliance with Substandard 78.5, while Berks and Carbon/Monroe/Pike were did not meet the criteria for compliance with Substandard 78.5 (RY 2015).

Substandard 78.5: Other: Significant onsite review findings related to Standard 78.

PEPS Standard 86: BH-MCO Executive Management. Required duties and functions are in place. The BH-MCO's table of organization depicts organization relationships of the following functions/ positions: Chief Executive Officer; 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 Officer; Director of Quality Management; Director of Utilization Management; Management Information Systems; Director of Prior/service authorization; Director of Member Services; Director of Provider Services

CCBH and its HC BH Contractors did not meet the criteria for compliance with Substandard 86.3 (RY 2015).

Substandard 86.3: Other: 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 the CCBH HC BH Contractors, and all Contractors were compliant on the three substandards. The status for these substandards is presented in **Table C.6**.

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

Category	PEPS Item	Review Year	Status by HC BH Contractor		
			Met	Partially Met	Not Met
Enrollee Satisfaction					
Consumer/Family Satisfaction	Standard 108.3	RY 2013	All HC BH Contractors		
	Standard 108.4	RY 2013	All HC BH Contractors		
	Standard 108.9	RY 2013	All HC BH Contractors		

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