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

2017 External Quality Review Report
Community Behavioral Health

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Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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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 (HC) Behavioral Health (HB) 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 (Island Peer Review Organization) as its EQRO to conduct the 2017 EQRs for HC 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. 2016 Opportunities for Improvement - MCO Response
VI. 2017 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the HC 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 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, 2016 Opportunities for Improvement – MCO Response, includes the BH-MCO's responses to opportunities for improvement noted in the 2016 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 (2017) 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) 2016, 67 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.

The City of Philadelphia and Philadelphia County share a common border. As such, the City of Philadelphia is the HealthChoices Oversight Entity and the HC BH Contractor that holds an agreement with Community Behavioral Health (CBH). CBH is a county-operated BH-MCO. Members enrolled in the HealthChoices Behavioral Health Program in Philadelphia County are assigned CBH as their BH-MCO. The EQR for structure and operations standards is based on OMHSAS reviews of Philadelphia County and CBH.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CBH by OMHSAS monitoring staff within the past three review years (RYs 2016, 2015, 2014). 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 2016. 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 2017 and entered into the PEPS Application as of October 2017 for RY 2016. 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 review findings for selected OMHSAS-specific Substandards are reported in **Appendix A**. The RY 2016 crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in **Appendix B** and **C**, respectively.

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 2016, RY 2015, and RY 2014 provided the information necessary for the 2017 assessment. Those standards not reviewed through the PEPS system in RY 2016 were evaluated on their performance based on RY 2015 and/or RY 2014 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.

For CBH, a total of 163 substandards were applicable for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2014-2016). In addition, 16 OMHSAS-specific substandards 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 substandard may contribute more than once to the total number of BBA categories required and/or reviewed. In **Appendix A**, **Table A.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 the associated HealthChoices Oversight Entity against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for CBH

Table 1.1 tallies the PEPs substandards used to evaluate the HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2014-2016). Because compliance categories (first column) may contain substandards that are either annually or triennially reviewed, the total number of PEPS substandards applicable to this year's (RY 2016) evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations for any given category may not equal the sum of those substandard counts.

Table 1.1: Tally of Substandards Pertinent to BBA Regulations Reviewed for CBH

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
	Total	NR	RY 2016	RY 2015	RY 2014
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	0	5	2	9
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	N/A	N/A	N/A	N/A	N/A
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	24	0	7	9	18
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	0	4	2	2
Provider Selection	3	0	0	0	3
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	8	0
Practice Guidelines	6	0	2	4	0
Quality Assessment and Performance Improvement Program	23	0	16	23	16
Health Information Systems	1	0	0	1	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	0	11	2	2
General Requirements	14	0	14	2	2
Notice of Action	13	0	7	7	13
Handling of Grievances and Appeals	11	0	11	2	2
Resolution and Notification: Grievances and Appeals	11	0	11	2	2
Expedited Appeals Process	6	0	6	2	2
Information to Providers and Subcontractors	2	0	2	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	0	6	2	2
Effectuation of Reversed Resolutions	6	0	6	2	2
Total	163	0	110	70	75

[1] The total number of required substandards required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations. Any PEPS substandards not reviewed indicate retired substandards previously used to evaluate the BH-MCO.

[2] The number of substandards that came under active review during the cycle specific to the review year. Due to substandards coming under active review both annually and triennially for each review year, the sum of the substandards that came under review in RY 2016, 2015, and 2014 may not equate to the total number of applicable PEPS substandards for evaluation of the BH-MCO (163 in RY 2016).

RY: Review Year.

NR: Not reviewed.

N/A: Not applicable.

For RY 2016, nine categories, 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements were not directly addressed by the PEPS Substandards reviewed. As per OMHSAS's judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health Program's PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH-MCOs. The category of Marketing Activities is Not Applicable because, as a result of the Centers for Medicare and Medicaid Services (CMS) HealthChoices waiver, DHS has been granted an allowance to offer only one BH-MCO per county. Compliance for

the Cost Sharing category is not assessed by PEPS Substandards, as any cost sharing imposed on Medicaid enrollees is in accordance with CMS regulation 42 CFR 447.50-447.60.

Before 2008, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all HC BH Contractors and BH-MCOs based on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. In 2008, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories. In this 2017 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 with individual provisions, IPRO grouped the required and relevant monitoring substandards by provision, and evaluated the HC BH Contractors' and BH-MCO's compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of met, partially met or not met in the PEPS Application submitted by the Commonwealth. If a substandard was not evaluated for a particular HealthChoices Oversight Entity/BH-MCO, it was assigned a value of Not Determined. Compliance with the BBA provisions was then determined based on the aggregate results across the three-year period of the PEPS Items linked to each provision. If all Items were met, the HealthChoices Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as partially compliant. If all Items were not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as non-compliant. If no crosswalked Items were evaluated for a given provision, and no other source of information was available to determine compliance, a value of Not Applicable ('N/A') was assigned for that provision. A value of Null was assigned to a provision when none of the existing PEPS Substandards directly covered the Items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results for all provisions within a given category were aggregated to arrive at a summary compliance status for the category. For example, all provisions relating to enrollee rights are summarized under Enrollee Rights - 438.100.

Format

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

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

Findings

Of the 163 PEPS substandards that were used to evaluate CBH and Philadelphia County compliance of BBA regulations in RY 2016, 110 substandards were under active review in RY 2016.

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 1.2** presents the findings by categories.

Table 1.2: Compliance with Enrollee Rights and Protections Regulations

Subpart C: Categories	MCO Compliance Status	Comments
Enrollee Rights 438.100	Partial	12 substandards were crosswalked to this category. Philadelphia County was evaluated on 12 substandards, compliant with 10 substandards and non-compliant with 2 substandards.
Provider-Enrollee Communications 438.102	Compliant	Compliant as per PS&R sections E.4 (p.52) and A.4.a (p.20).
Marketing Activities 438.104	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH-MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	Compliant as per PS&R sections A.9 (p. 70) and C.2 (p.32).
Cost Sharing 438.108	Compliant	Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	Compliant as per PS&R section 4 (p.37).
Solvency Standards 438.116	Compliant	Compliant as per PS&R sections A.3 (p.65) and A.9 (p. 70), and 2016-2017 Solvency Requirements tracking report.

N/A: not applicable

There are seven categories within Enrollee Rights and Protections Standards. CBH was compliant with five categories and partially compliant with one category. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50-447.60. The remaining category, Solvency Standards, was compliant based on the 2016-2017 Solvency Requirement tracking report. Of the substandards that were crosswalked to Enrollee Rights and Protections Regulations, Philadelphia County was evaluated and compliant with 10 PEPS substandards and non-compliant with 2 substandards. Overall, Philadelphia County was deemed partially compliant for the category Enrollee Rights. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Enrollee Rights

Philadelphia County was partially compliant with Enrollee Rights and Protections due to non-compliance with Substandards of PEPS Standard 60 (RY 2016).

PEPS Standard 60: Complaint/Grievance Staffing. The BH-MCO shall identify a lead person responsible for overall coordination of the complaint and grievance process, including the provision of information and instructions to members. (Responsibility includes HIPAA Privacy duties related to complaints and mechanisms for tracking and reporting of HIPAA related complaints.) The BH-MCO shall designate and train sufficient staff responsible for receiving, processing and responding to member complaints and grievances in accordance with the requirements contained in Appendix H. All BH-MCO staff shall be educated concerning member rights and the procedure for filing complaints and grievances.

Philadelphia County was non-compliant with Substandards 2 and 3 of Standard 60 (RY 2016).

> **PEPS Standard 60, Substandard 2:** Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.

PEPS Standard 60, Substandard 3: Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.

Subpart D: Quality Assessment and Performance Improvement Regulations

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

The PEPS documents for each HC BH Contractor include an assessment of the HC BH Contractors/BH-MCO's compliance with regulations found in Subpart D. Based on the Items reviewed for the 10 categories of Quality Assessment and Performance Improvement Regulations, Philadelphia County was fully compliant with six categories, partially compliant with three categories, and non-compliant with one category. Philadelphia County was evaluated through and deemed compliant with the categories Elements of State Quality Strategies and Confidentiality per the HealthChoices Program Standards and Requirements (PS&R), as these categories were not directly addressed by any PEPS substandards.

Of the 71 PEPS Items crosswalked to Quality Assessment and Performance Improvement regulations, 71 were evaluated for Philadelphia County for RY 2016. CBH and Philadelphia County were compliant with 62 PEPS Items, partially compliant with 1 PEPS item, and non-compliant with 8 PEPS items. **Table 1.3** presents the findings by categories consistent with the regulations.

Table 1.3: Compliance with Quality Assessment and Performance Improvement Regulations

Subpart D: Categories	MCO Compliance Status	Comments
Elements of State Quality Strategies 438.204	Compliant	Compliant as per PS&R section G.3 (p.58).
Availability of Services (Access to Care) 438.206	Partial	24 substandards were crosswalked to this category. Philadelphia County was evaluated on 24 substandards, compliant with 22 substandards, and non-compliant with 2 substandards.
Coordination and Continuity of Care 438.208	Non-compliant	2 substandards were crosswalked to this category. Philadelphia County was evaluated on 2 substandards and non-compliant with 2 substandards.
Coverage and Authorization of Services 438.210	Partial	4 substandards were crosswalked to this category. Philadelphia County was evaluated on 4 substandards, compliant with one 1 substandard, partially compliant with 1 substandard, and non-compliant with 2 substandards.
Provider Selection 438.214	Compliant	3 substandards were crosswalked to this category. Philadelphia County was evaluated on 3 substandards and compliant with 3 substandards.
Confidentiality 438.224	Compliant	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	Compliant	8 substandards were crosswalked to this category. Philadelphia County was evaluated on 8 substandards and compliant with 8 substandards.
Practice Guidelines 438.236	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant with 4 substandards, and non-compliant with 2 substandards.
Quality Assessment and Performance Improvement Program 438.240	Compliant	23 substandards were crosswalked to this category. Philadelphia County was evaluated on 23 substandards and compliant with 23 substandards.
Health Information Systems 438.242	Compliant	1 substandard was crosswalked to this category. Philadelphia County was evaluated on 1 substandard and compliant with this substandard.

As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

Philadelphia County was partially compliant with Availability of Services (Access to Care) due to non-compliance with Substandards of PEPS Standard 28 (RY 2016).

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.

Philadelphia County was non-compliant with Substandards 1 and 2 of Standard 28 (RY 2016).

> **PEPS Standard 28, 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.

PEPS Standard 28, Substandard 2: The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.

Coordination and Continuity of Care

Philadelphia County was non-compliant with Coordination and Continuity of Care due to non-compliance with Substandards of PEPS Standard 28 (RY 2016).

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care; above). Philadelphia County was non-compliant with Substandards 1 and 2 of Standard 28 (RY 2016).

Coverage and Authorization of Services

Philadelphia County was partially compliant with Coverage and Authorization of Services due to non-compliance with substandards of PEPS Standard 28 and partial compliance with a substandard of PEPS Standard 72 (RY 2016).

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 11 of this report. Philadelphia County was non-compliant with Substandards 1 and 2 of Standard 28 (RY 2016).

PEPS Standard 72: Denials. Denials or reduction of services are provided, in writing, to the member, parent/custodian of a child/adolescent, and/or county child and youth agency for children in substitute care. The denial note includes: a) specific reason for denial, b) service approved at a lesser rate, c) service approved for a lesser amount than requested, d) service approved for shorter duration than requested, e) service approved using a different service or Item than requested and description of the alternate service, if given, f) date decision will take effect, g) name of contact person, h) notification that member may file a grievance and/or request a DHS Fair Hearing, and i) if currently receiving services, the right to continue to receive services during the grievance and/or DHS Fair Hearing process.
Philadelphia County was partially compliant with Substandard 2 of PEPS Standard 72 (RY 2016).

PEPS Standard 72, Substandard 2: The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

Practice Guidelines

Philadelphia County was partially compliant with Practice Guidelines due to non-compliance with substandards of PEPS Standard 28 (RY 2016).

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 11 of this report. Philadelphia County was non-compliant with Substandards 1 and 2 of Standard 28 (RY 2016).

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. Based on the Substandards reviewed, Philadelphia County was fully compliant with 2 of the 10 evaluated categories of Federal and State Grievance System Standards regulations, and partially compliant with the other 8 categories. The category Recordkeeping and Recording Requirements was compliant per quarterly reporting of complaints and grievances. In all, 80 PEPS Items were crosswalked to Federal and State Grievance System Standards, and Philadelphia County was evaluated on 80 Items. Philadelphia County was fully compliant with 40 Items, partially compliant with 30 Items, and non-compliant with 10 Items. **Table 1.4** presents the findings by categories consistent with the regulations.

Table 1.4: Compliance with Federal and State Grievance System Standards

Subpart F: Categories	MCO Compliance Status	Comments
Statutory Basis and Definitions 438.400	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 11 substandards, compliant with 4 substandards, partially compliant with 5 substandards, and non-compliant with 2 substandards.
General Requirements 438.402	Partial	14 substandards were crosswalked to this category. Philadelphia County was evaluated on 14 substandards, compliant with 5 substandards, partially compliant with 5 substandards, and non-compliant with 4 substandards.
Notice of Action 438.404	Partial	13 substandards were crosswalked to this category. Philadelphia County was evaluated on 13 substandards, compliant with 12 substandards, and partially compliant with 1 substandard.
Handling of Grievances and Appeals 438.406	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 11 substandards, compliant with 4 substandards, partially compliant with 5 substandards, and non-compliant with 2 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 11 substandards, compliant with 4 substandards, partially compliant with 5 substandards, and non-compliant with 2 substandards.
Expedited Appeals Process 438.410	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant with 3 substandards, and partially compliant with 3 substandards.
Information to Providers & Subcontractors 438.414	Compliant	2 substandards were crosswalked to this category. Philadelphia County was evaluated on 2 substandards, and compliant with 2 substandards.
Recordkeeping and Recording Requirements 438.416	Compliant	Compliant as per the required quarterly reporting of complaint and grievances data.
Continuation of Benefits 438.420	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant with 3 substandards, and partially compliant with 3 substandards.
Effectuation of Reversed Resolutions 438.424	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant with 3 substandards, and partially compliant with 3 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.

Statutory Basis and Definitions

Philadelphia County was partially compliant with Statutory Basis and Definitions due to non-compliance and partial compliance with substandards of PEPS Standards 68, 71 and 72 (RY 2016).

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.
Philadelphia County was non-compliant with Substandards 2 and 5, and partially compliant with Substandards 3 and 4, of Standard 68 (RY 2016).

> **PEPS Standard 68, Substandard 2:** 100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

PEPS Standard 68, 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).

PEPS Standard 68, 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.

PEPS Standard 68, Substandard 5: Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.

PEPS Standard 71: 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.

Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 71, Substandard 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.

PEPS Standard 71, Substandard 4: Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.

PEPS Standard 72: See Standard and partially compliant substandard descriptions under Coverage and Authorization of Services on page 13 of this report. Philadelphia County was partially compliant with Substandard 2 of PEPS Standard 72 (RY 2016).

General Requirements

Philadelphia County was partially compliant with General Requirements due to partial and non-compliance with substandards of PEPS Standards 60, 68, 71 and 72 (RY 2016).

PEPS Standard 60: See descriptions of Standard and non-compliant substandards under Enrollee Rights and Protections (Enrollee Rights), on page 10 of this report. Philadelphia County was non-compliant with Substandards 2 and 3 of Standard 60 (RY 2016).

PEPS Standard 68: See descriptions of Standard, partially compliant substandards, and non-compliant substandards under Statutory Basis and Definitions on page 14 of this report. Philadelphia County was non-compliant with Substandards 2 and 5, and partially compliant with Substandards 3 and 4, of Standard 68 (RY 2016).

PEPS Standard 71: See Standard and partially compliant substandards descriptions under Statutory Basis and Definitions, above. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See descriptions of Standard and partially compliant substandard under Coverage and Authorization of Services on page 13 of this report. Philadelphia County was partially compliant with Substandard 2 of PEPS Standard 72 (RY 2016).

Notice of Action

Philadelphia County was partially compliant with Notice of Action due to partial compliance with a substandard of PEPS Standard 72.

PEPS Standard 72: See descriptions of Standard and partially compliant substandard under Coverage and Authorization of Services on page 13 of this report. Philadelphia County was partially compliant with Substandard 2 of PEPS Standard 72 (RY 2016).

Handling of Grievances and Appeals

Philadelphia County was partially compliant with Handling of Grievances and Appeals due to partial and non-compliance with substandards of PEPS Standards 68, 71 and 72.

PEPS Standard 68: See descriptions of Standard, partially compliant substandards, and non-compliant substandards under Statutory Basis and Definitions on page 14 of this report. Philadelphia County was non-compliant with Substandards 2 and 5, and partially compliant with Substandards 3 and 4, of Standard 68 (RY 2016).

PEPS Standard 71: See Standard and partially compliant substandards descriptions under Statutory Basis and Definitions, above. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See descriptions of Standard and partially compliant substandard under Coverage and Authorization of Services on page 13 of this report. Philadelphia County was partially compliant with Substandard 2 of PEPS Standard 72 (RY 2016).

Resolution and Notification: Grievances and Appeals

Philadelphia County was partially compliant with Resolution and Notification of Grievances and Appeals due to partial and non-compliance with substandards of PEPS Standards 68, 71 and 72.

PEPS Standard 68: See descriptions of Standard, partially compliant substandards, and non-compliant substandards under Statutory Basis and Definitions on page 14 of this report. Philadelphia County was non-compliant with Substandards 2 and 5, and partially compliant with Substandards 3 and 4, of Standard 68 (RY 2016).

PEPS Standard 71: See Standard and partially compliant substandards descriptions under Statutory Basis and Definitions on page 14 of this report. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See descriptions of Standard and partially compliant substandard under Coverage and Authorization of Services on page 13 of this report. Philadelphia County was partially compliant with Substandard 2 of PEPS Standard 72 (RY 2016).

Expedited Appeals Process

Philadelphia County was partially compliant with Expedited Appeals process due to partial compliance with substandards of PEPS Standards 71 and 72.

PEPS Standard 71: See Standard and partially compliant substandards descriptions under Statutory Basis and Definitions on page 14 of this report. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See descriptions of Standard and partially compliant substandard under Coverage and Authorization of Services on page 13 of this report. Philadelphia County was partially compliant with Substandard 2 of PEPS Standard 72 (RY 2016).

Continuation of Benefits

Philadelphia County was partially compliant with Continuation of Benefits due to partial compliance with substandards of PEPS Standards 71 and 72.

PEPS Standard 71: See Standard and partially compliant substandards descriptions under Statutory Basis and Definitions on page 14 of this report. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See descriptions of Standard and partially compliant substandard under Coverage and Authorization of Services on page 13 of this report. Philadelphia County was partially compliant with Substandard 2 of PEPS Standard 72 (RY 2016).

Effectuation of Reversed Resolutions

Philadelphia County was partially compliant with Effectuation of Reversed Resolutions due to partial compliance with substandards of PEPS Standards 71 and 72.

PEPS Standard 71: See Standard and partially compliant substandards descriptions under Statutory Basis and Definitions on page 14 of this report. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See descriptions of Standard and partially compliant substandard under Coverage and Authorization of Services on page 13 of this report. Philadelphia County was partially compliant with Substandard 2 of PEPS Standard 72 (RY 2016).

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 2017 for 2016 activities.

Background

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 2018, with initial PIP proposals submitted in 2014 and a final report due in June 2019. 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 were required to submit interim reports in June 2016 and June 2017. BH-MCOs will be required to submit an additional interim report in June 2018, as well as a final report in June 2019. BH-MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH Contractor-

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

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 addressing 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 2017 EQR is the 14th 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 to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing 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 and 2017, 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. As calendar year 2016 was an intervention year for all BH-MCOs (which was then extended into 2017, as well), IPRO reviewed elements 1 through 7 for each BH-MCO, and provided preliminary feedback and guidance on elements 8 and 9.

Review Element Designation/Weighting

Calendar year 2017 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 2.1** presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 2.1: Review Element Scoring Designations and Definitions

Element Designation	Definition	Weight
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 2.2**).

Table 2.2: 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%

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 2.2**). 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%.

Findings

CBH submitted their Year 2 PIP Update document for review in June 2017. IPRO provided feedback and comments to CBH on this submission. **Table 2.3** presents the PIP scoring matrix for the June 2017 Submission, which corresponds to the key findings of the review described in the following paragraphs.

Table 2.3: 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)	M	100	5%	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	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**N/A**
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

As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. Baseline and projected measurements were described. Short term and long term goals were provided from baseline year of intervention. All goals for the update reflected positive outcomes and demonstrated meaningful improvement. Desired measurements at the conclusion of the PIP were addressed in consideration of benchmarks and averages, and were clearly presented. Further barrier analyses through survey methodology addressed barriers to the objectives and root cause analyses improved validity and reliability of indicators. In light of issues with the reMind intervention and the new vendor, as well as other new interventions/pilots, any changes or impacts to goals should be clarified in subsequent PIP Updates, and the study question and aim statement reframed, as appropriate.

CBH defined the outcome and process measures that will be completed for the PIP. Indicators were outcome-oriented, sufficiently defined, measurable, and time-specific. Definitions of core outcome and process measures, intervention monitoring outcome measures and supplemental process measures used in tracking performance for the PIP were provided. The methodology section provided a description of each measure, identifying the interventions linked to each measure and the denominator and numerator criteria. Descriptions of data sources and of individuals responsible for producing the measures were provided. Each measure was numbered to enable cross-referencing among tables. Additional information was provided regarding sampling, data collection, and analysis methods following updates to the initial proposal, specifically scope expansion, and processes and institutions to methodology based on barrier analyses. A timeline provided by CBH reflected the increased frequency of reporting and additional timeframes of measures. CBH should continue to provide this level of detail and update the methodology and timeline as appropriate for subsequent PIP Updates, and should also continue to reinforce the linkage demonstrating that each of the intervention tracking measures correspond to the activities described in the intervention.

The methodology section provides clear descriptions of the measures used in the PIP. CBH clearly defined the population for each performance indicator. The at-risk population was defined in terms of the aims and relevant indicators. Enrollment criteria were explained. The BH-MCO provided rationale for selection the population at risk, as well as expanding scope, in the rationale section of the update. Descriptions of the populations impacted by each intervention were also provided. For changed interventions, the target scope was clearly defined and a rationale for scope expansion was provided. Expansion aimed to capture additional members with eligibility. CBH discussed the chart sampling and abstraction procedure (systematic random sampling) as well as the IRR and reviewer training procedure. Samples were identified with CBH's data for enrollee characteristics relevant to outcomes associated with the interventions' specific objectives. Samples were identified using best practices and IRR was used appropriately. No charts fell below 90% in

CY2016. CBH employed valid and reliable sampling techniques that protected against bias. Systematic exclusions are justified in rationale section or performance indicator definitions.

The study design clearly specified the sources of data. Data sources varied considerably, and included validated claims, DMP chart audit data, program tracking sheets/logs, internal clinical information systems, clinical logs, and program data. Pharmacy data integrated into the BH-MCOs warehouse had been integrated for improved reporting on performance. The methodology section was very clearly presented, with each performance indicator listing a data source. Changes from the initial proposal submission and subsequent updates described steps taken to improve quality of source data. Data was valid, reliable, and systematically collected in accordance with the study design. Completeness and accuracy of data sources for performance measures was described. This update and the previous update included improved data collection methodology to maximize quality following identification of barriers/problems. Following identification of quality issues, re-implementation incorporated improved data collection methodology. For each indicator, the type of data (manual or automatic) was described.

CBH provided a detailed data analysis plan (DAP). The DAP listed each measurement (linked to tables for the associated timeline, data collection, sampling methodology, and overview of the performance indicator), enabling the analytics to be contextualized, resulting in a robust and comprehensive DAP. CBH provided an analysis schedule specific to each performance indicator, including specific dates for running measures, and analysis, and the timeframe of data to be analyzed. The methodology is conducive to reporting performance through repeated measurements over comparable time periods. CBH increased the frequency of reporting to quickly identify issues with interventions. Most analyses have annual or semi-annual reporting which was reflected in the update. Timeframes of barrier analyses, survey methodology, and changed intervention components have improved, though CBH could provide further detail. CBH includes and expands upon the Long Acting Injectables intervention, the telephonic discharge pilot, and the development of a quarterly self-administered medication reconciliation audit tool.

CBH addressed causes and barriers to improvement through data analysis and quality improvement processes. Rationales for changes from initial proposal submission were sufficiently explained. This update included key findings of a readmission survey, which were integrated into the PIP. CBH consistently identified quality improvement shortcomings and conducted appropriate root cause and barrier analyses following insufficient performance. Mechanisms were established to reconcile data integrity during re-implementation or expansion of interventions. CBH should continue to develop additional intervention components or scope expansions to ensure that a larger number of to the target population are reached.

III: Performance Measures

In 2017, 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 2016. OMHSAS also elected to implement a statewide measure that focuses on substance abuse services, based on 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 2016 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, 2016;
- A principal ICD-9- or ICD-10-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, 2016, 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, 2016. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2017 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 was 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 2016, BH-MCOs were 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 (Note: If any of the following rules generate a goal lower than the previous year's goal, then the new goal = last year's goal, even if this amounts to a greater than 5% improvement):

1. If the yearly rate is below the HEDIS Quality Compass 50th percentile, then:
   a. If rate >=5 percentage points (PPs) below the HEDIS Quality Compass 50th percentile, then new goal = last year's rate + 5% improvement over last year's rate
   b. If rate >=2PPs and <5PPs below the HEDIS Quality Compass 50th percentile, then new goal = last year's rate + 5% improvement over last year's rate, or the HEDIS Quality Compass 50th percentile, whichever is less.
   c. If rate <2PPs below the HEDIS Quality Compass 50th percentile, then new goal = the HEDIS Quality Compass 50th percentile.
2. If the yearly rate is rate is above or equal to the HEDIS Quality Compass 50th percentile & below the 75th percentile, then:
   a. If rate >=2PPs below the HEDIS Quality Compass 75th percentile, then new goal = last year's rate + 2% improvement over last year's rate
   b. If rate <2PPs below the HEDIS Quality Compass 75th percentile, then new goal = last year's rate + 2% improvement over last year's rate, or the HEDIS Quality Compass 75th percentile, whichever is less
3. If rate is above or equal to the HEDIS Quality Compass 75th percentile, then new goal = last year's goal.

Interim goals were provided to the BH-MCOs after the MY 2015 rates were received. The interim goals were updated from MY 2013 to MY 2016. 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 2016, 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 of qualifying events or members and a denominator of qualifying events or members, defined according to the specifications of the measure. The HealthChoices Aggregate (Statewide) for each indicator was the total numerator divided by the total denominator, which represented the rate derived for the Statewide population of denominator-qualifying events or members. Year-to-year comparisons to MY 2015 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a z-statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

$$\hat{p} = \frac{\mathrm{N1} + \mathrm{N2}}{\mathrm{D1} + \mathrm{D2}}$$

Where:

N1= Current year (MY 2016) numerator
N2= Prior year (MY 2015) numerator
D1= Current year (MY 2016) denominator
D2= Prior year (MY 2015) denominator

The single proportion estimate was then used for estimating the standard error (SE).

Z test-statistic was obtained by dividing the difference between the proportions by the standard error of the difference. Analysis that uses the Z-test assumes that the data and their test statistics approximate a normal distribution. To correct for approximation error, the Yates correction for continuity was applied:

$$z - statistic = \frac{ABS(p1 - p2) - 0.5(\frac{1}{D1} + \frac{1}{D2})}{\sqrt{\hat{p}(1 - \hat{p})[\frac{1}{D1} + \frac{1}{D2}]}}$$

Where:

p1= Current year (MY 2016) quality indicator rate
p2= Prior year (MY 2015) quality indicator rate

Two-tailed statistical significant tests were conducted at p-value=0.05 to test the null hypothesis of:

$$H_0: p1 = p2.$$

Percentage point difference (PPD), as well as 95% Confidence intervals for difference between the two proportions were also calculated. Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

It should be noted that Pennsylvania continued its Medicaid expansion under the Affordable Care Act in 2016. Due to data quality concerns with identifying the Medicaid expansion subpopulation, however, the decision was made not to compare rates for this subpopulation. Thus any potential impacts on rates from the Medicaid expansion were not evaluated for MY 2016. The plan is to incorporate this analysis in next year's BBA report.

Limitations

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for HC BH Contractors. Caution should be exercised when interpreting results for small denominators. A denominator of 100 or greater is preferred for drawing conclusions from Z-score tests of the performance measure results. In addition, the above analysis assumes that the proportions being compared come from independent samples. To the extent that this is not the case, the findings should be interpreted with caution.

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. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (and HC BH Contractor 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 Aggregate (Statewide) rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HealthChoices BH Statewide rates 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 Statewide rate for the indicator. Statistically significant BH-MCO differences are noted.

HC BH Contractor-specific rates were also compared to the HealthChoices BH Statewide rates 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 BH Statewide rate 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 2016 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 aged 6 to 64 years old. The goal was for all HC BH Contractor and BH-MCO rates to meet or exceed the HEDIS 75th percentile by MY 2016. For MYs 2013 through 2016, BH-MCOs were 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 3.1** shows the MY 2016 results compared to their MY 2016 goals and HEDIS percentiles, as well as to MY 2015.

Table 3.1: MY 2016 HEDIS FUH 7- and 30-Day Follow-up Indicators (6–64 Years)

	MY 2016							MY 2015	MY 2016 Rate Comparison		
				95% CI		Goal			To MY 2015		To MY 2016 HEDIS
Measure	(N)	(D)	%	Lower	Upper	%	Met?	%	PPD	SSD	Medicaid Percentiles
QI 1 – HEDIS 7-Day Follow-up (6–64 Years)											
HealthChoices (Statewide)	17,235	39,448	**43.7%**	43.2%	44.2%	48.5%	No	45.7%	-2.0	YES	Below 50th Percentile, Above 25th Percentile
CBH	3,196	7,748	**41.2%**	40.1%	42.4%	47.0%	No	41.8%	-0.6	NO	Below 50th Percentile, Above 25th Percentile
Philadelphia	3,196	7,748	**41.2%**	40.1%	42.4%	47.0%	No	41.8%	-0.6	NO	Below 50th Percentile, Above 25th Percentile
QI 2 – HEDIS 30-Day Follow-up (6–64 Years)											
HealthChoices (Statewide)	25,062	39,448	**63.5%**	63.1%	64.0%	69.2%	No	66.1%	-2.5	YES	Below 50th Percentile, Above 25th Percentile
CBH	4,425	7,748	**57.1%**	56.0%	58.2%	65.7%	No	60.1%	-3.0	YES	Below 50th Percentile, Above 25th Percentile
Philadelphia	4,425	7,748	**57.1%**	56.0%	58.2%	65.7%	No	60.1%	-3.0	YES	Below 50th Percentile, Above 25th Percentile

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

The HEDIS 7-Day Follow-up (6–64 Years) for HealthChoices (Statewide) was 43.7% for QI 1 and 63.5% for QI 2 (**Table 3.1**). These rates were statistically significantly lower than the HealthChoices (Statewide) rates for this age group in MY 2015, which were 45.7% and 66.1% respectively. The HealthChoices (Statewide) rates were below the MY 2016 interim goals of 48.5% for QI 1 and 69.2% for QI 2; therefore, neither of the interim goals were met in MY 2016. Both HealthChoices (Statewide) rates were between the NCQA 25th and 50th percentile; therefore, the OMHSAS goal of

meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2016 for either rate.

For MY 2016, CBH was subcontracted to provide behavioral health services to only one county located in the Southeast region of the commonwealth, Philadelphia County; therefore, the CBH performance comprises the BH-MCO performance for Philadelphia County alone.

The MY 2016 CBH/Philadelphia QI 1 rate for members age 6 to 64 was 41.2%. The QI 1 rate was not statistically significantly lower than the MY 2015 CBH/Philadelphia QI 1 rate by 0.6 percentage points, and was statistically significantly lower than the HealthChoices (Statewide) rate of 43.7% by 2.5 percentage points. The MY 2016 CBH/Philadelphia QI 2 rate for this age group was 57.1%. The QI 2 rate was statistically significantly lower than the MY 2015 CBH/Philadelphia QI 2 rate by 3 percentage points, and was statistically significantly lower than the QI 2 HealthChoices (Statewide) rate of 63.5% by 6.4 percentage points. Both CBH rates were below the MY 2016 goals of 47.0% for QI 1 and 65.7% for QI 2; therefore both interim follow-up goals were not met in MY 2016. Both HEDIS rates for this age group were between the HEDIS 2017 25th and 50th percentiles; therefore the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by CBH in MY 2016 for either rate.

Figure 3.1 is a graphical representation of the MY 2016 HEDIS follow-up rates in the 6 to 64 year old population for CBH and its associated HC BH Contractor

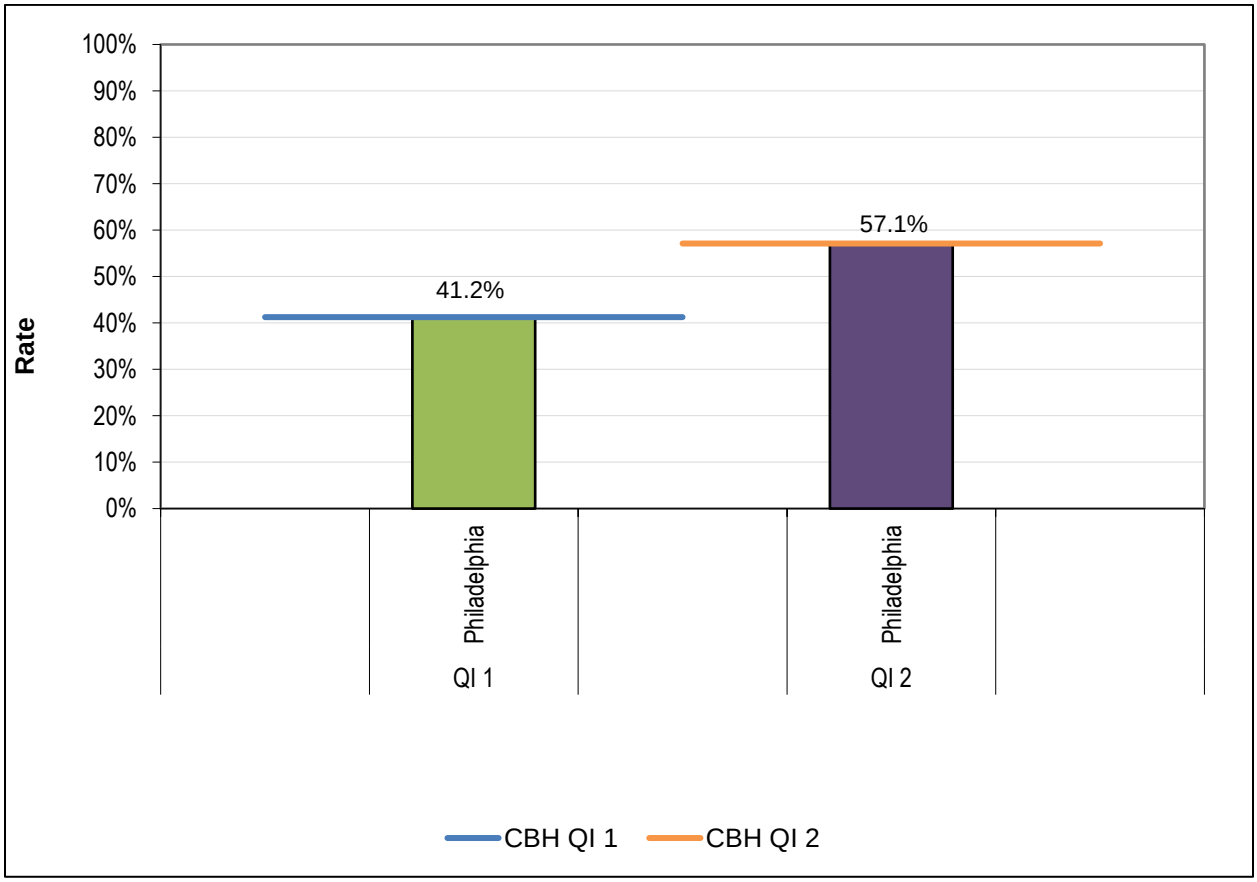

Figure 3.1: MY 2016 HEDIS FUH 7- and 30-Day Follow-up Rates (6–64 Years)

Figure 3.2 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. The QI 1 rate for Philadelphia County was statistically significantly below the MY 2016 QI 1 HC BH Contractor Average of 43.7% by 2.5 percentage points. The QI 2 rate for Philadelphia was statistically significantly lower than the QI 2 HealthChoices (Statewide) rate of 63.5% by 6.4 percentage points.

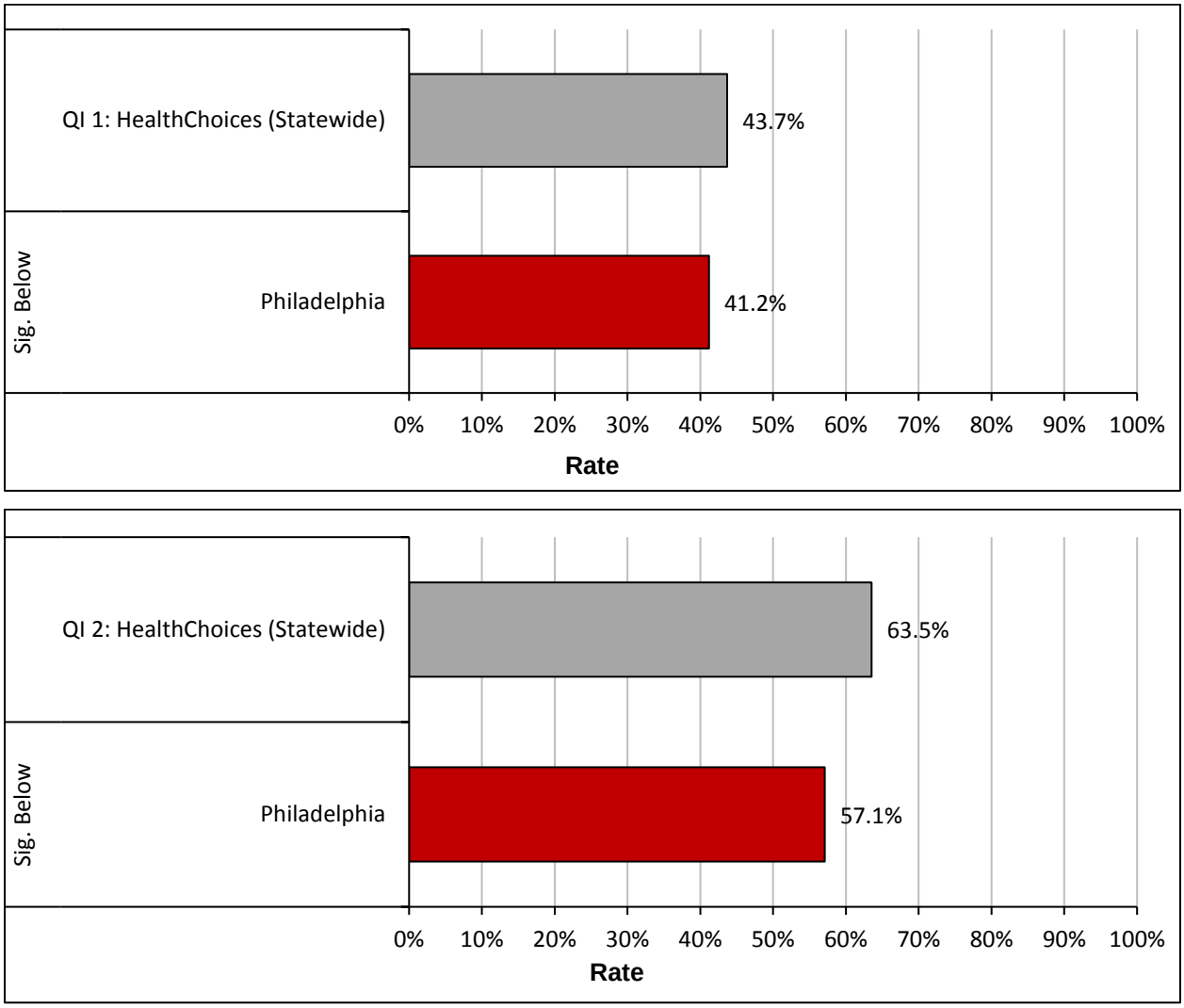

Figure 3.2: Comparison of CBH MY 2016 HEDIS FUH Follow-up Rates (6–64 Years) versus HealthChoices (Statewide) MY 2016 HEDIS FUH Follow-up Rates (6-64 Years)

(b) Overall Population: 6+ Years Old

The MY 2016 HealthChoices Aggregate HEDIS follow-up rates were 43.5% for QI 1 and 63.2% for QI 2 (Table 3.2). These rates were statistically significantly lower than the HealthChoices Aggregate rates in MY 2015, which were 45.5% and 65.8% respectively. For CBH/Philadelphia, the MY 2016 HEDIS rates were 41.1% for QI 1 and 56.8% for QI 2; both rates were lower, albeit not statistically significantly for QI 1, than the corresponding MY 2015 rates by 0.6 percentage points for QI 1 and 2.9 percentage points for QI 2. The CBH QI 1 rate was statistically significantly lower than the QI 1 HealthChoices (Statewide) rate of 43.5% by 2.4 percentage points, while the QI 2 rate was lower than the QI 2 HealthChoices (Statewide) rate of 63.2% by 6.4 percentage points.

Table 3.2: MY 2016 HEDIS FUH 7- and 30-Day Follow-up Indicators (Overall)

Measure	MY 2016					MY 2015 %	MY 2016 Rate Comparison		
				95% CI			To MY 2015		To MY 2016 HEDIS
	(N)	(D)	%	Lower	Upper		PPD	SSD	Medicaid Percentiles
QI 1 – HEDIS 7-Day Follow-up (overall)									
HealthChoices (Statewide)	17479	40225	**43.5%**	43.0%	43.9%	45.5%	-2.1	YES	Below 50th Percentile, Above 25th Percentile
CBH	3266	7956	**41.1%**	40.0%	42.1%	41.6%	-0.6	NO	Below 50th Percentile, Above 25th Percentile
Philadelphia	3266	7956	**41.1%**	40.0%	42.1%	41.6%	-0.6	NO	Below 50th Percentile, Above 25th Percentile
QI 2– HEDIS 30-Day Follow-up (overall)									
HealthChoices (Statewide)	25441	40225	**63.2%**	62.8%	63.7%	65.8%	-2.5	YES	Below 50th Percentile, Above 25th Percentile
CBH	4516	7956	**56.8%**	55.7%	57.9%	59.7%	-2.9	YES	Below 50th Percentile, Above 25th Percentile
Philadelphia	4516	7956	**56.8%**	55.7%	57.9%	59.7%	-2.9	YES	Below 50th Percentile, Above 25th Percentile

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

Figure 3.3 is a graphical representation of the MY 2016 HEDIS follow-up rates in the overall population for CBH and its associated HC BH Contractor

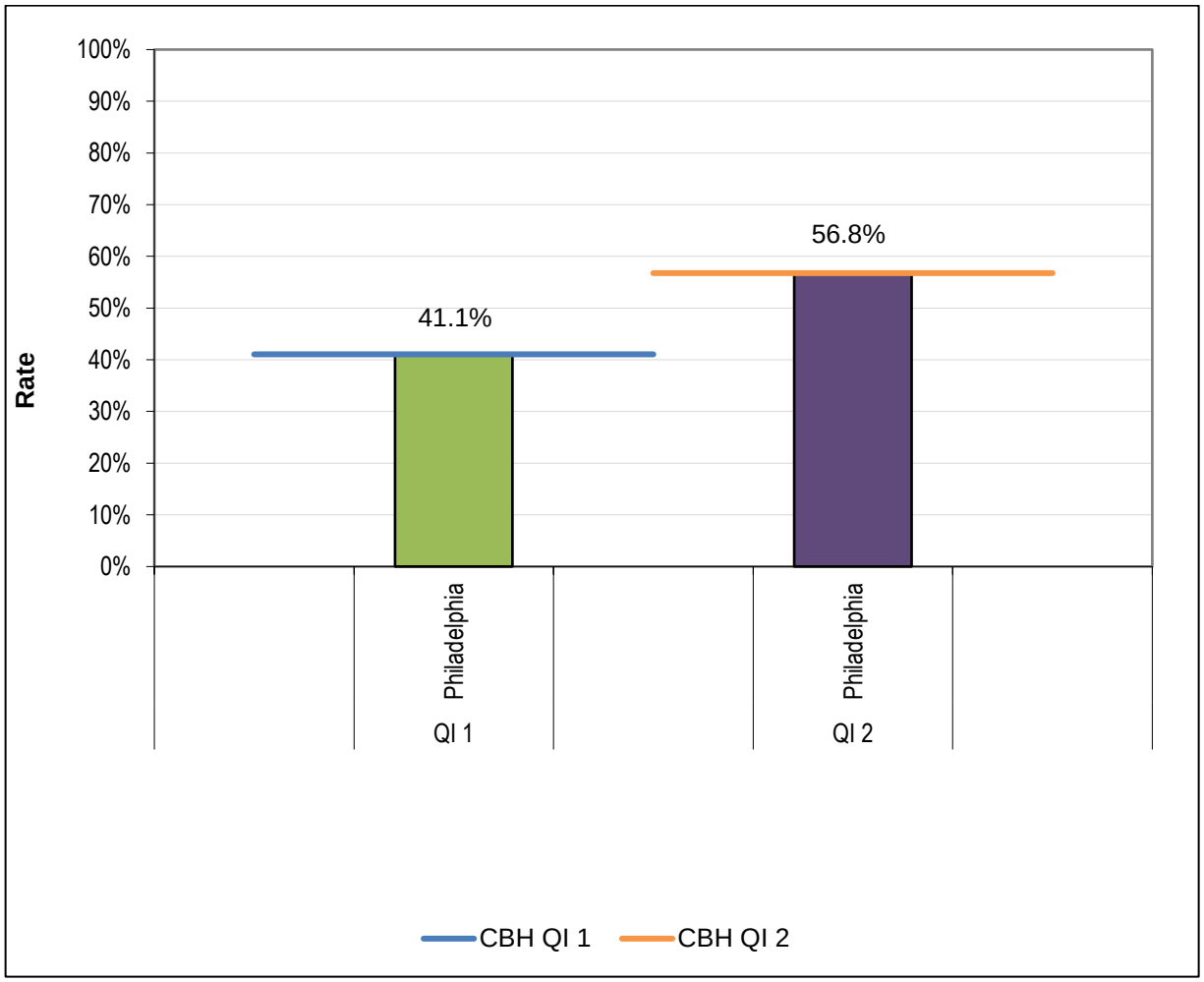

Figure 3.3: MY 2016 HEDIS FUH 7- and 30-Day Follow-up Rates (Overall)

Figure 3.4 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. The QI 1 rate for Philadelphia was statistically significantly

below the MY 2016 QI 1 HC BH Contractor Average of 43.5% by 2.4 percentage points. The QI 2 rate for Philadelphia was statistically significantly lower than the QI 2 HC BH Contractor Average of 63.2% by 6.4 percentage points.

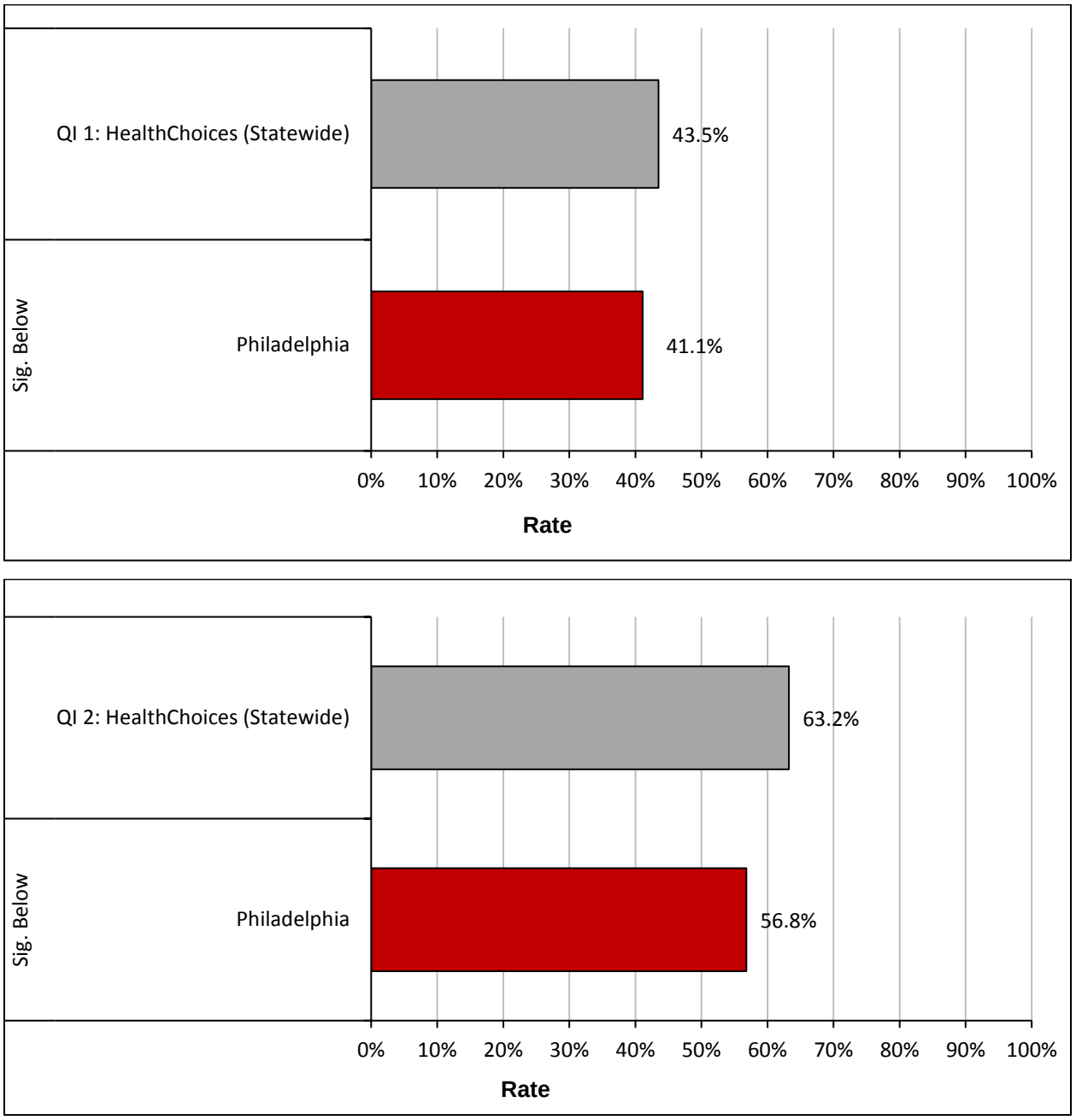

Figure 3.4: Comparison of CBH MY 2016 HEDIS FUH Follow-up Rates (Overall) versus HealthChoices (Statewide) MY 2016 HEDIS FUH Follow-up Rates (Overall)

(c) Age Group: 6–20 Years Old

The MY 2016 HealthChoices Aggregate rates in the 6 to 20 year age group were 56.1% for QI 1 and 77.4% for QI 2 (**Table 3.3**). These rates were comparable to the MY 2015 HealthChoices Aggregate rates for the 6 to 20 year age cohort, which were 56.7% and 77.0%, respectively. The CBH MY 2016 HEDIS follow-up rates for members ages 6 to 20 were 56.7% for QI 1 and 75.9% for QI 2. Only the QI 2 rate was higher than CBH's MY 2015 rates; however, the year-to-year rate differences were not statistically significant for either rate. The CBH MY 2016 follow-up rates for the 6 to 20 year old

population were not statistically different from the HealthChoices BH-MCO Average of 56.1% for QI 1 and 77.4% for QI 2.

Table 3.3: MY 2016 HEDIS FUH 7- and 30-Day Follow-up Indicators (6-20 Years)

Measure	MY 2016					MY 2015	MY 2016 Rate Comparison To MY 2015	
				95% CI				
	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI 1 – HEDIS 7-Day Follow-up (6–20 Years)								
HealthChoices (Statewide)	5,226	9,321	**56.1%**	55.1%	57.1%	56.7%	-0.7	NO
CBH	765	1,350	**56.7%**	54.0%	59.3%	57.5%	-0.8	NO
Philadelphia	765	1,350	**56.7%**	54.0%	59.3%	57.5%	-0.8	NO
QI 2 – HEDIS 30-Day Follow-up (6-20 Years)								
HealthChoices (Statewide)	7,217	9,321	**77.4%**	76.6%	78.3%	77.0%	0.5	NO
CBH	1,025	1,350	**75.9%**	73.6%	78.2%	75.8%	0.1	NO
Philadelphia	1,025	1,350	**75.9%**	73.6%	78.2%	75.8%	0.1	NO

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

Figure 3.5 is a graphical representation of the MY 2016 HEDIS follow-up rates in the 6 to 20 year old population for CBH and its associated HC BH Contractor.

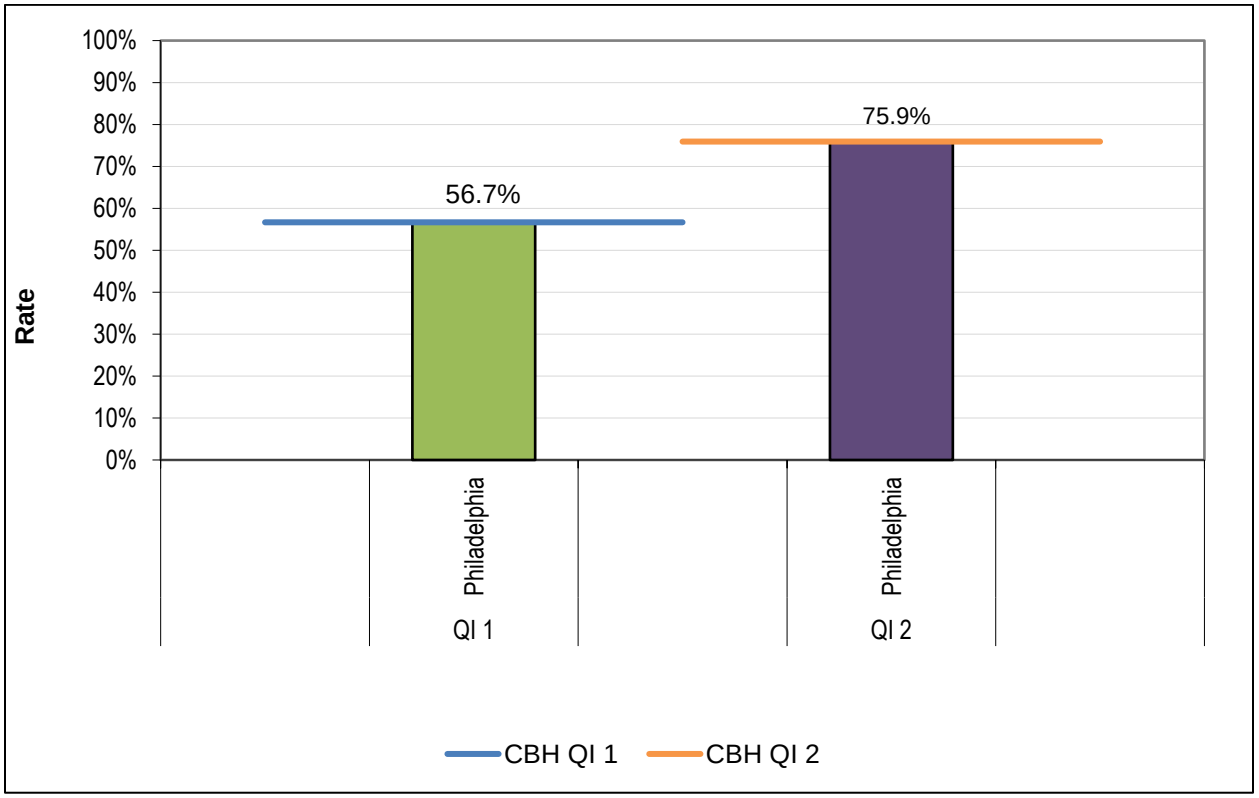

Figure 3.5: MY 2016 HEDIS FUH 7- and 30-Day Follow-up Rates (6-20 Years)

Figure 3.6 shows that the follow-up rates for Philadelphia were not statistically significantly different from the MY 2016 HC BH Contractor Averages of 56.1% for QI 1 and 77.4% for QI 2.

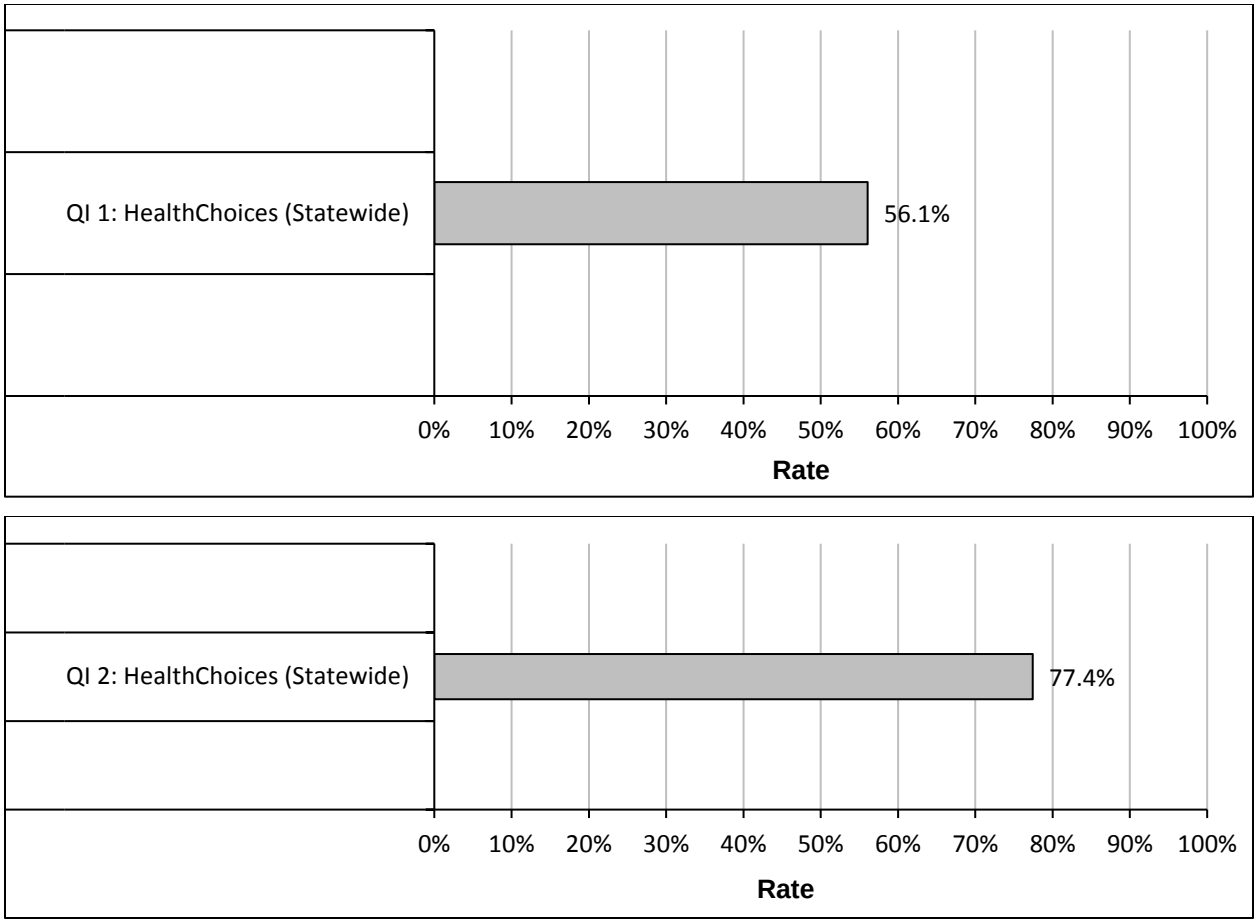

Figure 3.6: Comparison of CBH MY 2016 HEDIS FUH Follow-up Rates (6-20 Years) versus HealthChoices (Statewide) MY 2016 HEDIS FUH Follow-up Rates (6-20 Years)

II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

The MY 2016 HealthChoices Aggregate rates were 53.8% for QI A and 70.4% for QI B (**Table 3.4**). Both rates demonstrated statistically significant decreases from the MY 2015 PA-specific follow-up rates: the QI A rate decreased from the MY 2015 rate of 56.6% by 2.8 percentage points, while the QI B rate decreased from the MY 2015 rate of 73% percentage points by 2.5 percentage points. The CBH MY 2016 PA-specific follow-up rates were 50.1% for QI A and 64.7% for QI B; Only QI B rate was statistically significantly lower than CBH's MY 2015 rate by 2.7 percentage points. The CBH MY 2016 PA-specific follow- up rate for QI A was lower than CBH's MY 2015 rate by 1 percentage points, although this change was not statistically significant.

Table 3.4: MY 2016 PA-Specific FUH 7- and 30-Day Follow-up Indicators (Overall)

Measure	MY 2016 (N)	MY 2016 (D)	MY 2016 %	MY 2016 95% CI Lower	MY 2016 95% CI Upper	MY 2015 %	MY 2016 Rate Comparison To MY 2015 PPD	MY 2016 Rate Comparison To MY 2015 SSD
QI A – PA-Specific 7-Day Follow-up (Overall)								
HealthChoices (Statewide)	21,743	40,428	**53.8%**	53.3%	54.3%	56.6%	-2.8	YES
CBH	3,986	7,956	**50.1%**	49.0%	51.2%	51.1%	-1.0	NO
Philadelphia	3,986	7,956	**50.1%**	49.0%	51.2%	51.1%	-1.0	NO
QI B – PA-Specific 30-Day Follow-up (Overall)								
HealthChoices (Statewide)	28,474	40,428	**70.4%**	70.0%	70.9%	73.0%	-2.5	YES
CBH	5,150	7,956	**64.7%**	63.7%	65.8%	67.4%	-2.7	YES
Philadelphia	5,150	7,956	**64.7%**	63.7%	65.8%	67.4%	-2.7	YES

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

Figure 3.7 is a graphical representation of the MY 2016 HEDIS follow-up rates in the overall population for CBH and its associated HC BH Contractor.

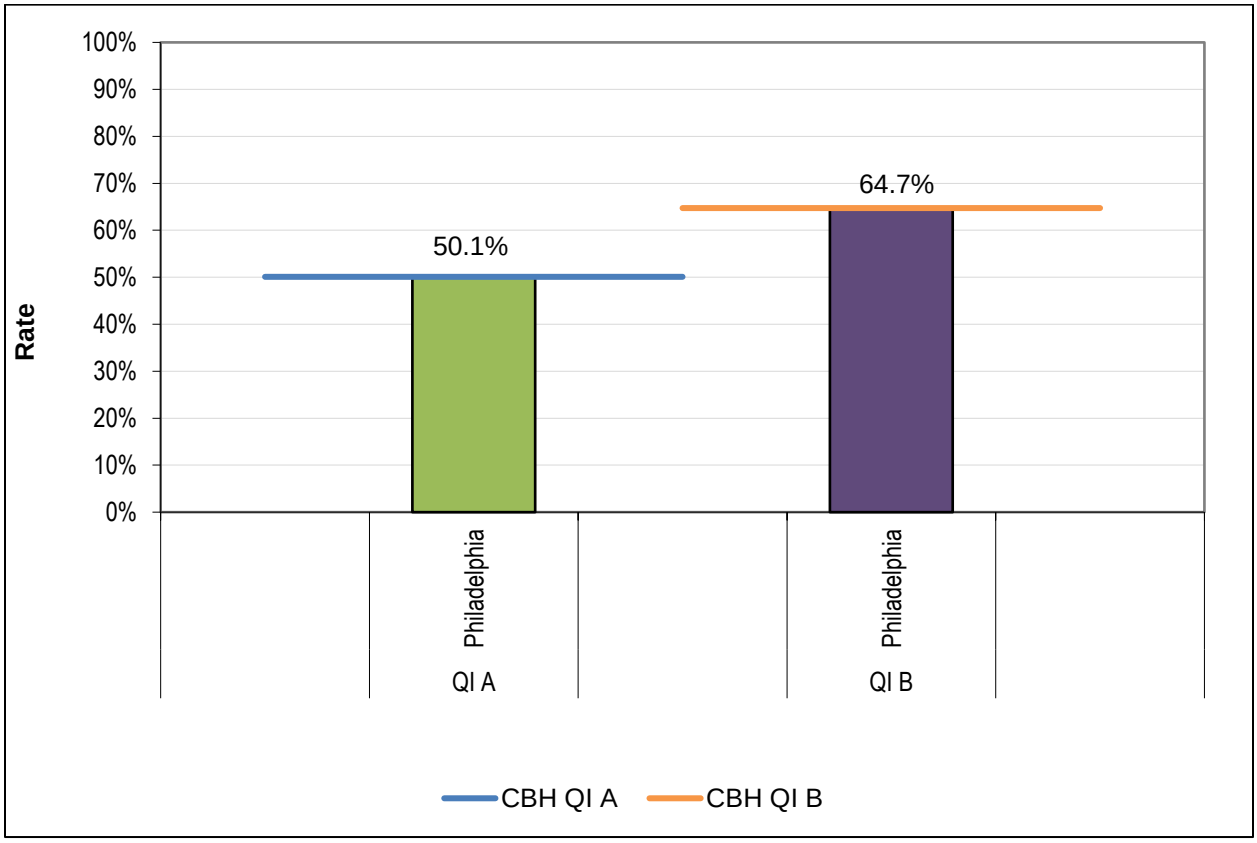

Figure 3.7: MY 2016 PA-Specific FUH 7- and 30-Day Follow-up Rates (Overall)

Figure 3.8 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. The QI A rate for Philadelphia was statistically significantly lower than the QI A HC BH Contractor Average of 53.8% by 3.7 percentage points, and the QI B rate for Philadelphia was statistically significantly lower than the QI B HC BH Contractor Average of 70.4% by 5.7 percentage points.

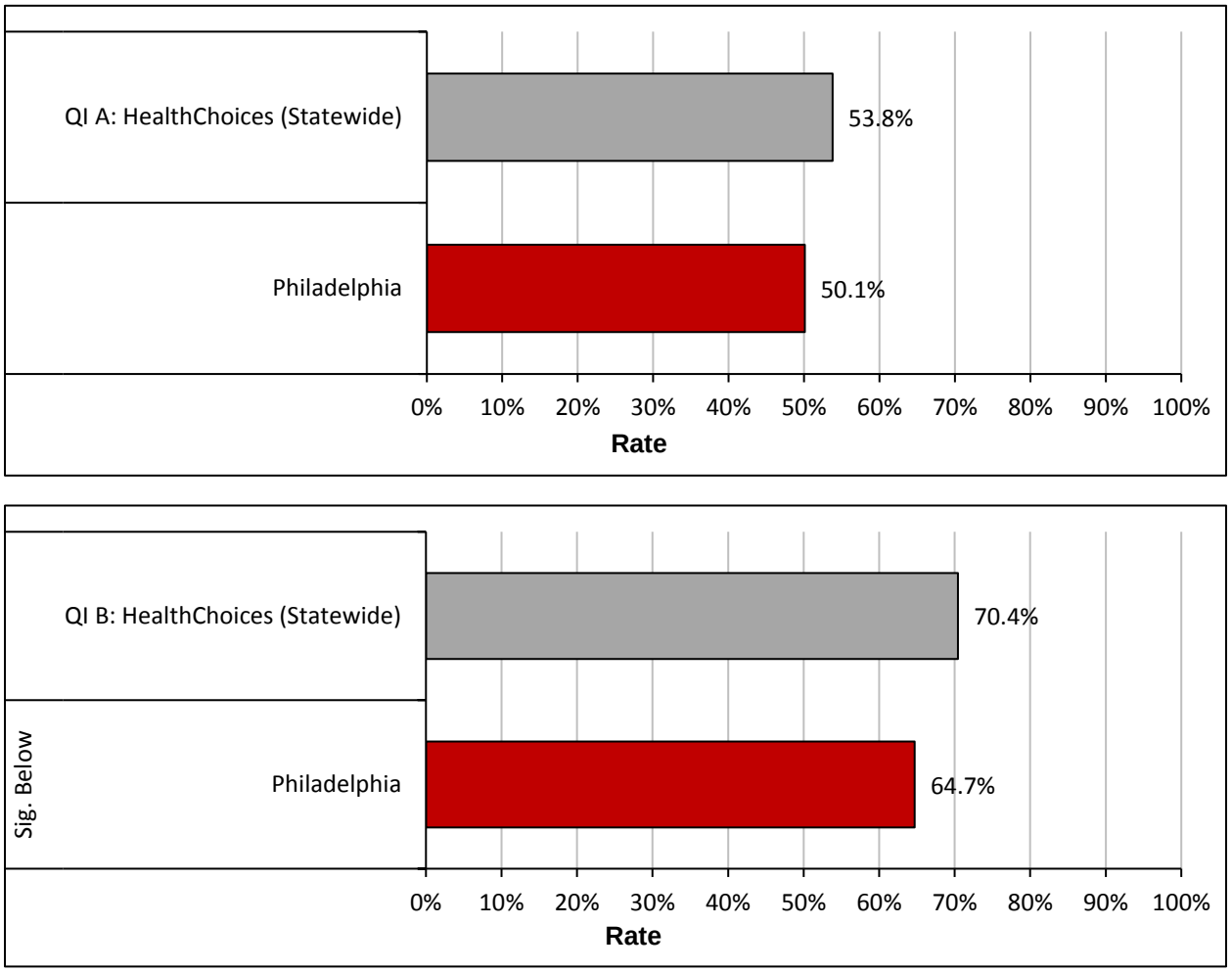

Figure 3.8: Comparison of CBH MY 2016 PA-Specific FUH Follow-up Rates (Overall) versus HealthChoices (Statewide) MY 2016 PA-Specific FUH Follow-up Rates (Overall)

Conclusion and Recommendations

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 Statewide rate. Following are recommendations that are informed by both the MY 2016 review as well as by the 2015 follow-up (care) study, which included results for MY 2014 and MY 2015:

- 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 between 2012 and 2015, which included the first year of the current PIP cycle, to promote continuous quality improvement with regard to timely 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. BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in the next few years as a result of their 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 care 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. OMHSAS's shift in 2017 to a prospective RCA and CAP process should assist with this.

- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. This year's findings indicate that, with some notable HC BH Contractor exceptions, FUH rates have for the most part decreased (worsened), both for the State and for the BH-MCO. In some cases, the change was a continuation or even acceleration of existing trends. As previously noted, this analysis was not able to carry out more detailed examination of rates associated with the Medicaid expansion sub-population. The potential impact on rates from the Medicaid expansion in 2016 could not be evaluated in this report. However, BH-MCOs and HC BH Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For one, 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. Further, it is important to examine regional trends in disparities. For instance, previous studies indicate that African Americans in rural areas have disproportionately low follow-up rates, which stands in contrast to the finding that overall follow-up rates are generally 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 did or did not receive 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 2016 study conducted in 2017 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 (Statewide) level for MY 2016. 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. In order to identify the administrative numerator-positives, date-of-service, and diagnosis/procedure code criteria were outlined, as well as were 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 2016 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, 2016;
- A principal ICD-9- or ICD-10-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 2016 to MY 2015 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-score. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

Individual rates were 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 were 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.

The MY 2016 HealthChoices Aggregate (Statewide) readmission rate was 13.9%, which represents a decrease from the MY 2015 HealthChoices Aggregate rate of 14% by 0.1 percentage points (**Table 3.5**); this difference was not statistically significant. The CBH/Philadelphia County MY 2016 rate of 13.5% was not statistically significantly different from the MY 2015 rate of 13.7%. The CBH readmission rate was not statistically significantly different from the MY 2016 HealthChoices BH-MCO Average of 13.9%.

Table 3.5: MY 2016 REA Readmission Indicators

Measure	MY 2016						MY 2015	MY 2016 Rate Comparison To MY 2015	
	(N)	(D)	%	95% CI Lower	95% CI Upper	Goal Met?[1]	%	PPD	SSD
Inpatient Readmission									
HealthChoices (Statewide)	7,440	53,638	**13.9%**	13.6%	14.2%	No	14.0%	-0.1	NO
CBH	1,353	10,038	**13.5%**	12.8%	14.2%	No	13.7%	-0.3	NO
Philadelphia	1,353	10,038	**13.5%**	12.8%	14.2%	No	13.7%	-0.3	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.

Figure 3.9 is a graphical representation of the MY 2016 readmission rates for CBH and its associated HC BH Contractor relative to the performance goal of 10%. CBH and Philadelphia County did not meet the performance goal of a readmission rate below 10.0% in MY 2016.

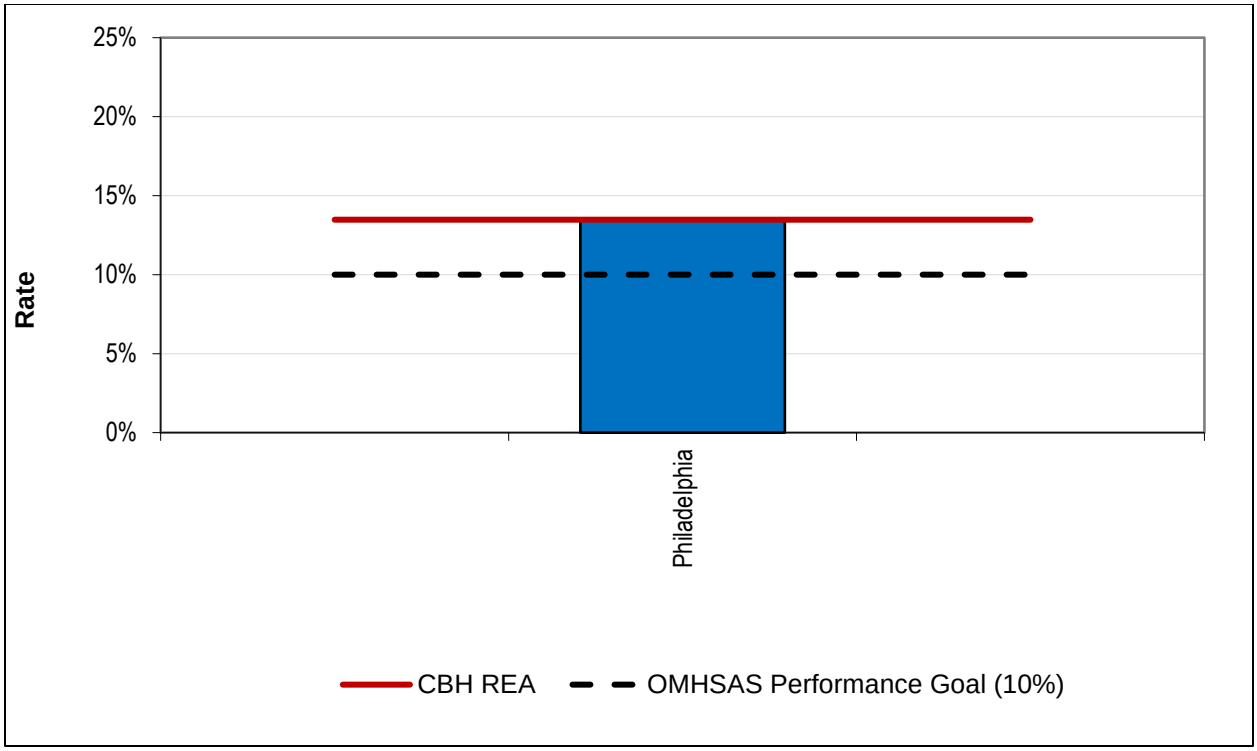

Figure 3.9: MY 2016 REA Readmission Rates for CBH

Figure 3.10 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that would be statistically significantly higher or lower than the statewide benchmark. The Philadelphia County rate of 13.5% was not statistically significantly different from the HC BH Contractor Average of 13.9%.

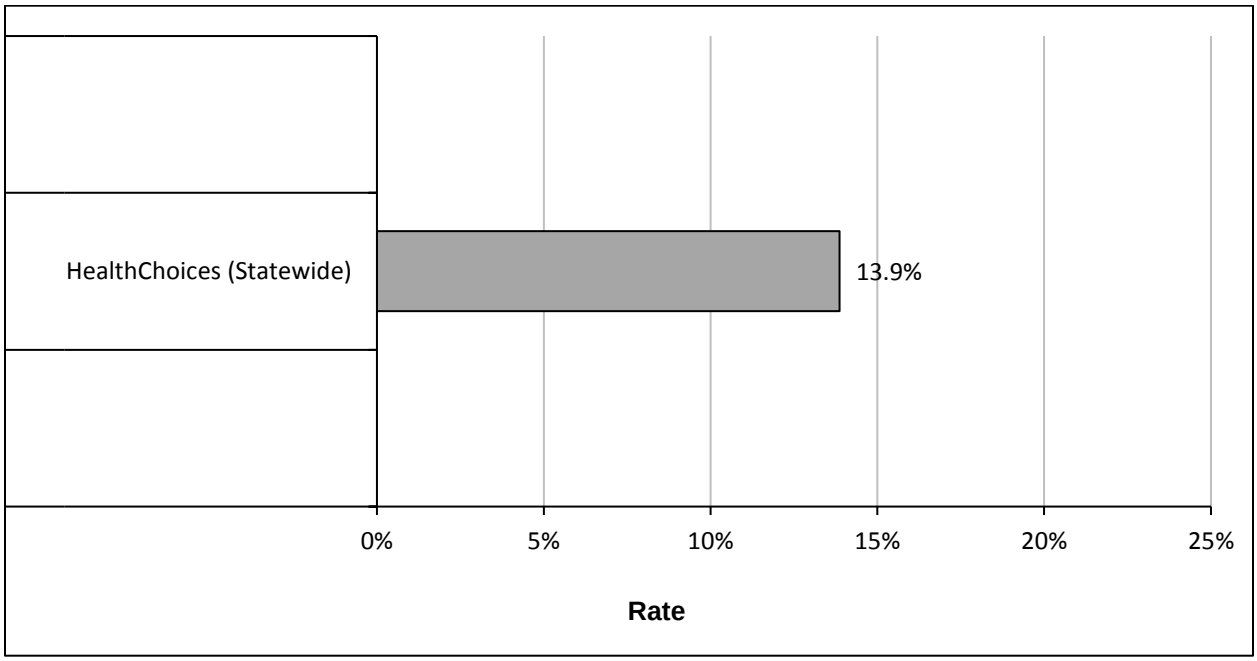

Figure 3.10: Comparison of CBH MY 2016 REA Readmission Rates (Overall) versus HealthChoices (Statewide) MY 2016 REA Readmission Rates (Overall)

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 Statewide rate.

Despite a number of years of data collection and interventions, readmission rates after psychiatric discharge have for the most part not improved and, for some BH-MCOs and their Contractors, rates have worsened (increased). The HC BH

Statewide rate showed a nominal decrease of 0.1 percentage points in 2016, but the change was not statistically significant. 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 2017 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 between 2012 and 2015 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. Building on the current cycle of performance improvement projects, which entered its first (non-baseline) year in 2016, 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. It is important for BH-MCOs and HC BH Contractors to target the demographic populations that do not perform as well as their counterparts. 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 did or did not receive 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 2016 and 2017. The measure was produced according to HEDIS 2017 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 2017 specifications, with one modification: members must be enrolled in the same PH and BH MCO during the continuous enrollment period (60 days prior to the index event, to 44 days after the index event). 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 an 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 vice 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). The opioid crisis has only added to the urgency. Deaths from opioid overdoses alone reached 28,647 in 2014 (The Surgeon General's Report on Alcohol, Drugs, and Health, 2017).

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). Social determinants of health are also themselves impacted by AOD. 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 2016 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, 2016;
- 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 in the measurement year 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 a primary or secondary 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 primary or secondary 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 on 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 Contractor. For each of these rates, the 95% Confidence Interval (CI) was reported. The HealthChoices BH Statewide rate was also calculated for this measure for each age group.

BH-MCO-specific rates were compared to the HealthChoices Statewide rate 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 differences in BH-MCO rates are noted.

HC BH Contractor-specific rates were compared to the HealthChoices BH Statewide rate 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 differences in HC BH Contractor-rates 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

The MY 2016 HealthChoices Aggregate (Statewide) rates in the 13-17 year age group were 38.5% for Initiation and 26% for Engagement (**Table 3.6**). These rates were comparable to the MY 2015 13-17 year old HealthChoices Aggregate rates of 36.8% and 25.7%, respectively. In MY 2016, 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 at or above the 75th percentile. The CBH MY 2016 13-17 year old Initiation rate was 45.0%, which was not statistically significantly different than the MY 2015 CBH rate of 47.6%. Similarly, the CBH MY 2016 13-17 year old Engagement rate was 30.9%, which was comparable to the MY 2015 rate of 35.5% by 4.6. CBH's Initiation rate for MY 2016 was between the HEDIS 50th and 75th percentiles, while the CBH's Engagement rate was at or above the HEDIS 75th percentile.

Table 3.6: MY 2016 IET Initiation and Engagement Indicators (13-17 Years)

Measure	MY 2016					MY 2015	MY 2016 Rate Comparison		
				95% CI			To MY 2015		To MY 2016 HEDIS
	(N)	(D)	%	Lower	Upper	%	PPD	SSD	Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (13–17 Years)									
HealthChoices (Statewide)	908	2,360	**38.5%**	36.5%	40.5%	36.8%	1.7	NO	Below 50th Percentile, Above 25th Percentile
CBH	198	440	**45.0%**	40.2%	49.8%	47.6%	-2.6	NO	Above 50th Percentile, Below 75th Percentile
Philadelphia	198	440	**45.0%**	40.2%	49.8%	47.6%	-2.6	NO	Above 50th Percentile, Below 75th Percentile
Numerator 2: Engagement of AOD Treatment (13–17 Years)									
HealthChoices (Statewide)	614	2,360	**26.0%**	24.2%	27.8%	25.7%	0.4	NO	At or Above 75th Percentile
CBH	136	440	**30.9%**	26.5%	35.3%	35.5%	-4.6	NO	At or Above 75th Percentile
Philadelphia	136	440	**30.9%**	26.5%	35.3%	35.5%	-4.6	NO	At or Above 75th Percentile

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

Figure 3.11 is a graphical representation of the MY 2016 HEDIS follow-up rates in the 13 – 17 year old population for CBH and its associated HC BH Contractor.

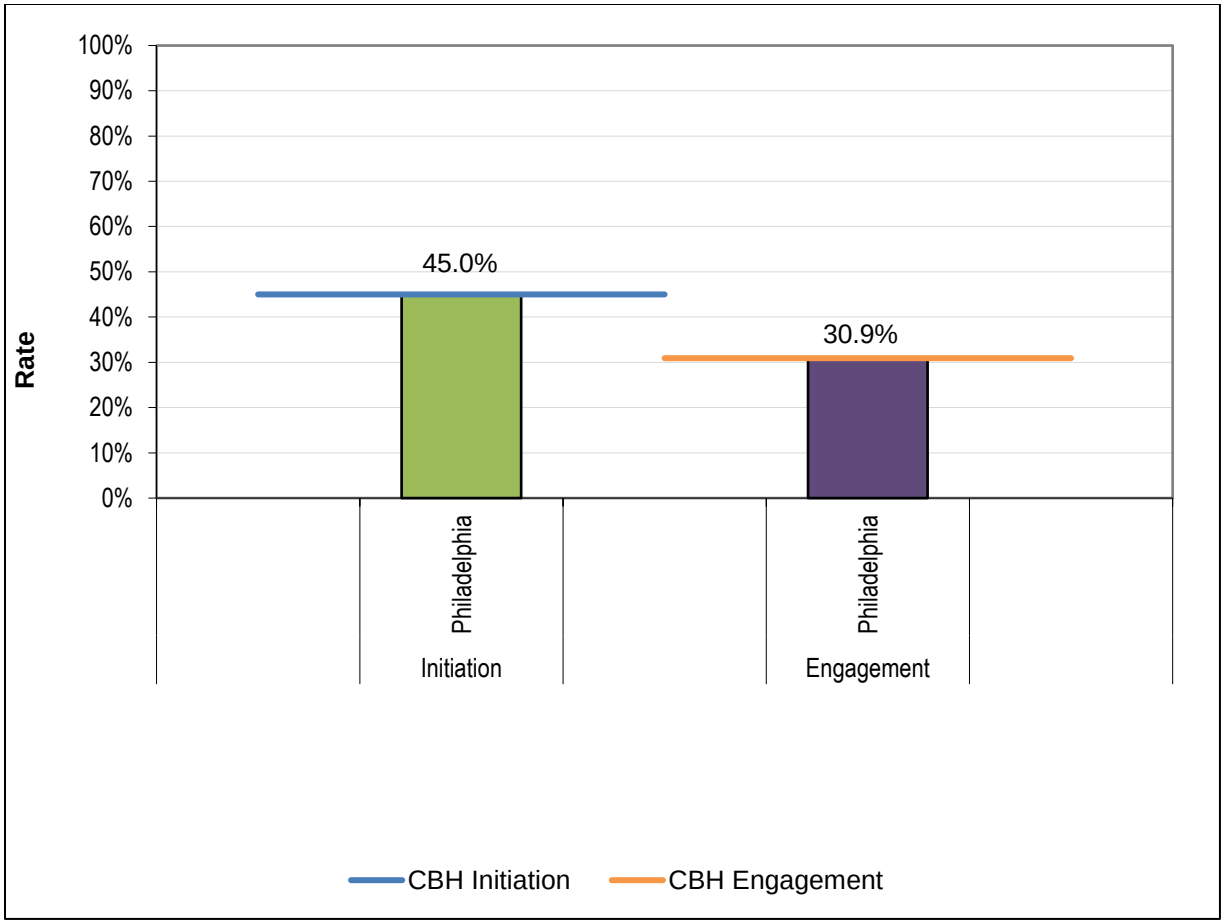

Figure 3.11: MY 2016 IET Initiation and Engagement Rates (13–17 Years)

Figure 3.12 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. For both IET rates, for Philadelphia County was statistically significantly above the HC BH (Statewide) average of 38.5% for Initiation and 26.0% for Engagement by 6.5 and 4.9 percentage points, respectively.

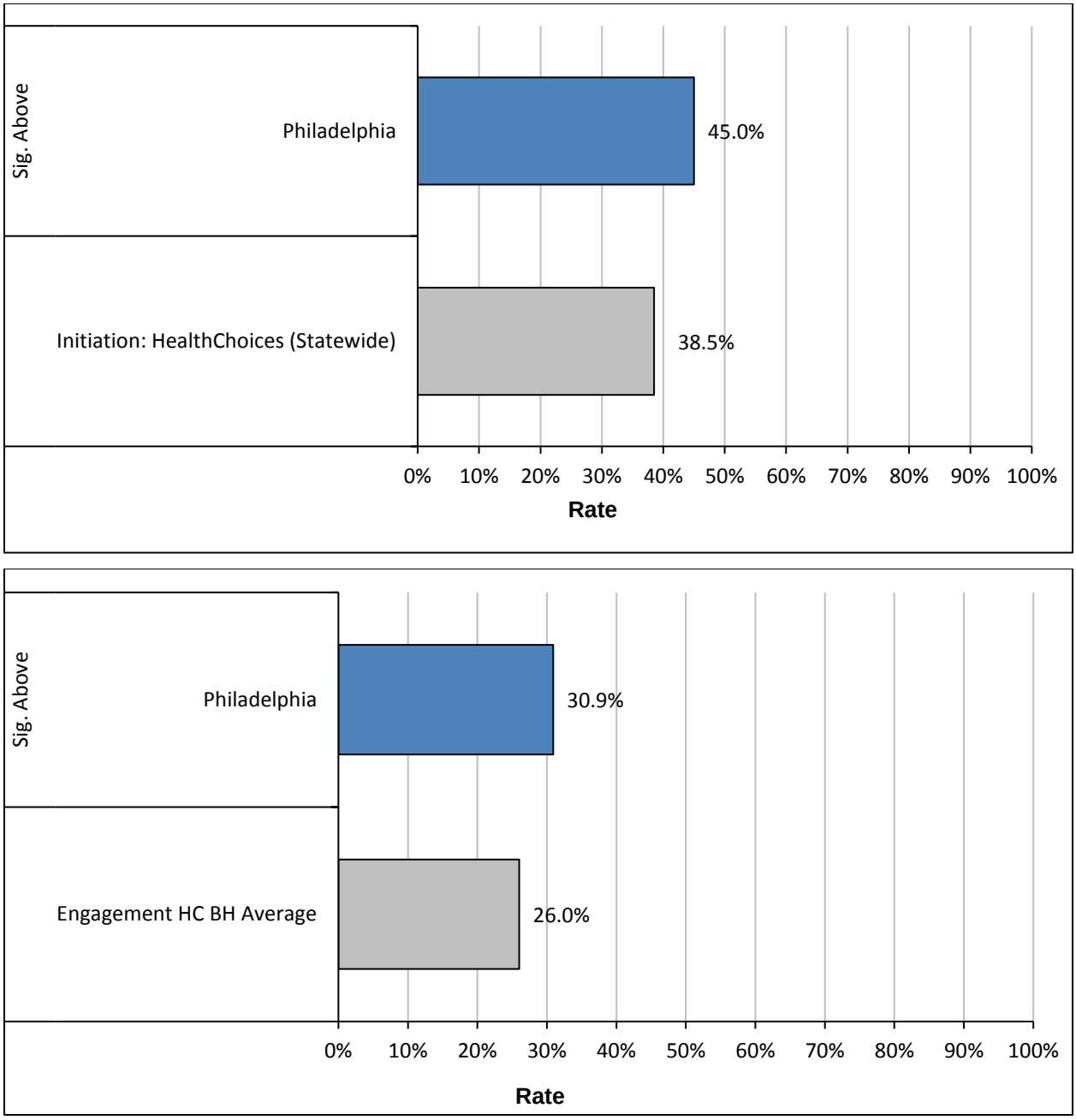

Figure 3.12: Comparison of CBH MY 2016 IET Rates (13–17 Years) versus HealthChoices (Statewide) MY 2016 IET Rates (13–17 Years)

(b) Age Group: 18+ Years Old

The MY 2016 HealthChoices Aggregate rates in the 18 and older age group were 25.6% for Initiation and 16.8% for Engagement (**Table 3.7**). Both rates were statistically significantly lower than the corresponding MY 2015 rates: the HealthChoices Aggregate Initiation rate decreased by 1.1 percentage points and the Engagement rate decreased by 1.8 percentage points from the prior year. The MY 2016 HealthChoices Aggregate Initiation rate in this age cohort was below the HEDIS 2017 25th percentile, while the Engagement rate was between the 50th and 75th percentiles. The CBH MY 2016 Initiation rate for the 18+ population was 22.3%, which was below the HEDIS 2017 25th percentile. CBH's MY 2016 rate dropped significantly from MY 2015 rate by 3.5 percentage points. Compared to the MY 2016 HealthChoices (Statewide) Average of 25.6% for Initiation, the rate for CBH was 3.3 percentage points lower. The CBH MY 2016 Engagement rate for this age cohort was 13.9%, which was between the HEDIS 2017 25th and 50th percentiles. The CBH Engagement rate for this age group was statistically significantly lower than the MY 2015 rate of 18.5% by 4.6 percentage points. Compared to the MY 2016 HealthChoices (Statewide) Average of 16.8% for Engagement, the rate for CBH was 2.9 percentage points lower.

Table 3.7: MY 2016 IET Initiation and Engagement Indicators (18+Years)

Measure	MY 2016					MY 2015	MY 2016 Rate Comparison		
				95% CI			To MY 2015		To MY 2016 HEDIS
	(N)	(D)	%	Lower	Upper	%	PPD	SSD	Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (18+ Years)									
HealthChoices (Statewide)	14,310	55,820	**25.6%**	25.3%	26.0%	26.7%	-1.1	YES	Below 25th Percentile
CBH	3,235	14,507	**22.3%**	21.6%	23.0%	25.8%	-3.5	YES	Below 25th Percentile
Philadelphia	3,235	14,507	**22.3%**	21.6%	23.0%	25.8%	-3.5	YES	Below 25th Percentile
Numerator 2: Engagement of AOD Treatment (18+ Years)									
HealthChoices (Statewide)	9,382	55,820	**16.8%**	16.5%	17.1%	18.6%	-1.8	YES	Above 50th Percentile, Below 75th Percentile
CBH	2,017	14,507	**13.9%**	13.3%	14.5%	18.5%	-4.6	YES	Below 50th Percentile, Above 25th Percentile
Philadelphia	2,017	14,507	**13.9%**	13.3%	14.5%	18.5%	-4.6	YES	Below 50th Percentile, Above 25th Percentile

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

Figure 3.13 is a graphical representation of the 18 years and older MY 2016 HEDIS Initiation and Engagement rates for CBH and its associated HC BH Contractor.

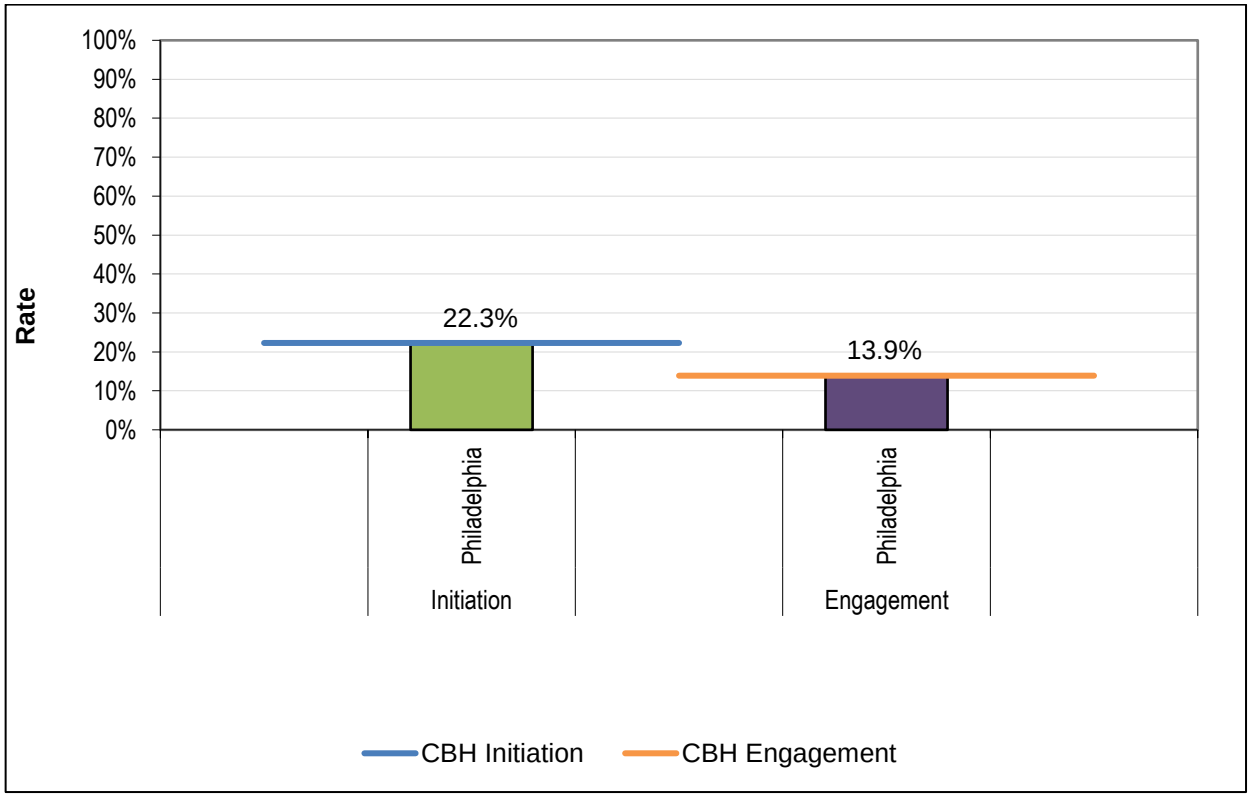

Figure 3.13: MY 2016 IET Initiation and Engagement Rates (18+ Years)

Figure 3.14, is a graphical representation of the MY 2016 HEDIS follow-up rates in the 18 years and older population for CBH and its associated HC BH Contractor. For both rates, for Philadelphia County was statistically significantly below the HC BH (Statewide) average of 25.6% for Initiation and 16.8% for Engagement by 3.3 and 2.9 percentage points, respectively.

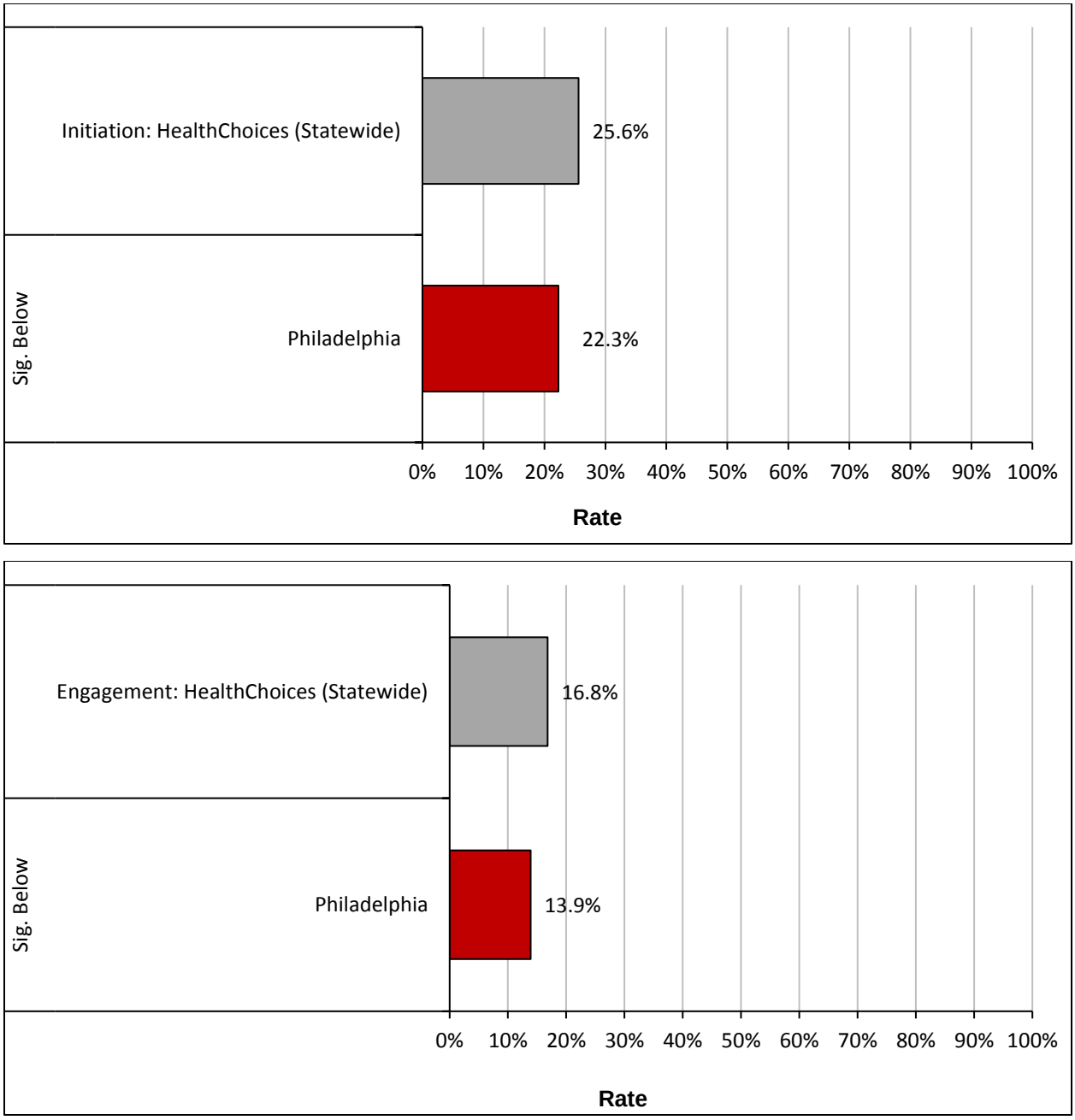

Figure 3.14: Comparison of CBH MY 2016 IET Rates (18+ Years) versus HealthChoices (Statewide) MY 2016 IET Rates (18+ Years)

(c) Age Group: 13+ Years Old (Overall)

The MY 2016 HealthChoices Aggregate rates in the 13 and older age group were 26.2% for Initiation and 17.2% for Engagement (**Table 3.8**). The Initiation rate was statistically significantly lower than the MY 2015 Initiation rate by 1.3 percentage points, and the Engagement rate was statistically significantly lower than the MY 2015 Engagement rate by 1.9 percentage points. The MY 2016 HealthChoices Aggregate Initiation rate was below the HEDIS 2017 25th percentile, while the Engagement rate was at or above the 75th percentile. The CBH MY 2016 Initiation rate for the 13+ population was 23.0%, which was below the HEDIS 2017 25th percentile. The CBH MY 2016 Engagement rate was 14.4%, and was between the HEDIS 50th and 75th percentiles. For CBH, both its Initiation and its Engagement rates were statistically significantly lower than their corresponding MY 2015 rates.

Table 3.8: MY 2016 IET Initiation and Engagement Indicators (Overall)

Measure	MY 2016 (N)	MY 2016 (D)	MY 2016 %	95% CI Lower	95% CI Upper	MY 2015 %	MY 2016 Rate Comparison To MY 2015 PPD	To MY 2015 SSD	To MY 2016 HEDIS Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (Overall)									
HealthChoices (Statewide)	15,218	58,180	**26.2%**	25.8%	26.5%	27.5%	-1.3	YES	Below 25th Percentile
CBH	3,433	14,947	**23.0%**	22.3%	23.6%	27.0%	-4.0	YES	Below 25th Percentile
Philadelphia	3,433	14,947	**23.0%**	22.3%	23.6%	27.0%	-4.0	YES	Below 25th Percentile
Numerator 2: Engagement of AOD Treatment (Overall)									
HealthChoices (Statewide)	9,996	58,180	**17.2%**	16.9%	17.5%	19.1%	-1.9	YES	At or Above 75th Percentile
CBH	2,153	14,947	**14.4%**	13.8%	15.0%	19.4%	-5.0	YES	Above 50th Percentile, Below 75th Percentile
Philadelphia	2,153	14,947	**14.4%**	13.8%	15.0%	19.4%	-5.0	YES	Above 50th Percentile, Below 75th Percentile

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

Figure 3.15 is a graphical representation of the MY 2016 HEDIS follow-up rates in the overall population for CBH and its associated HC BH Contractor.

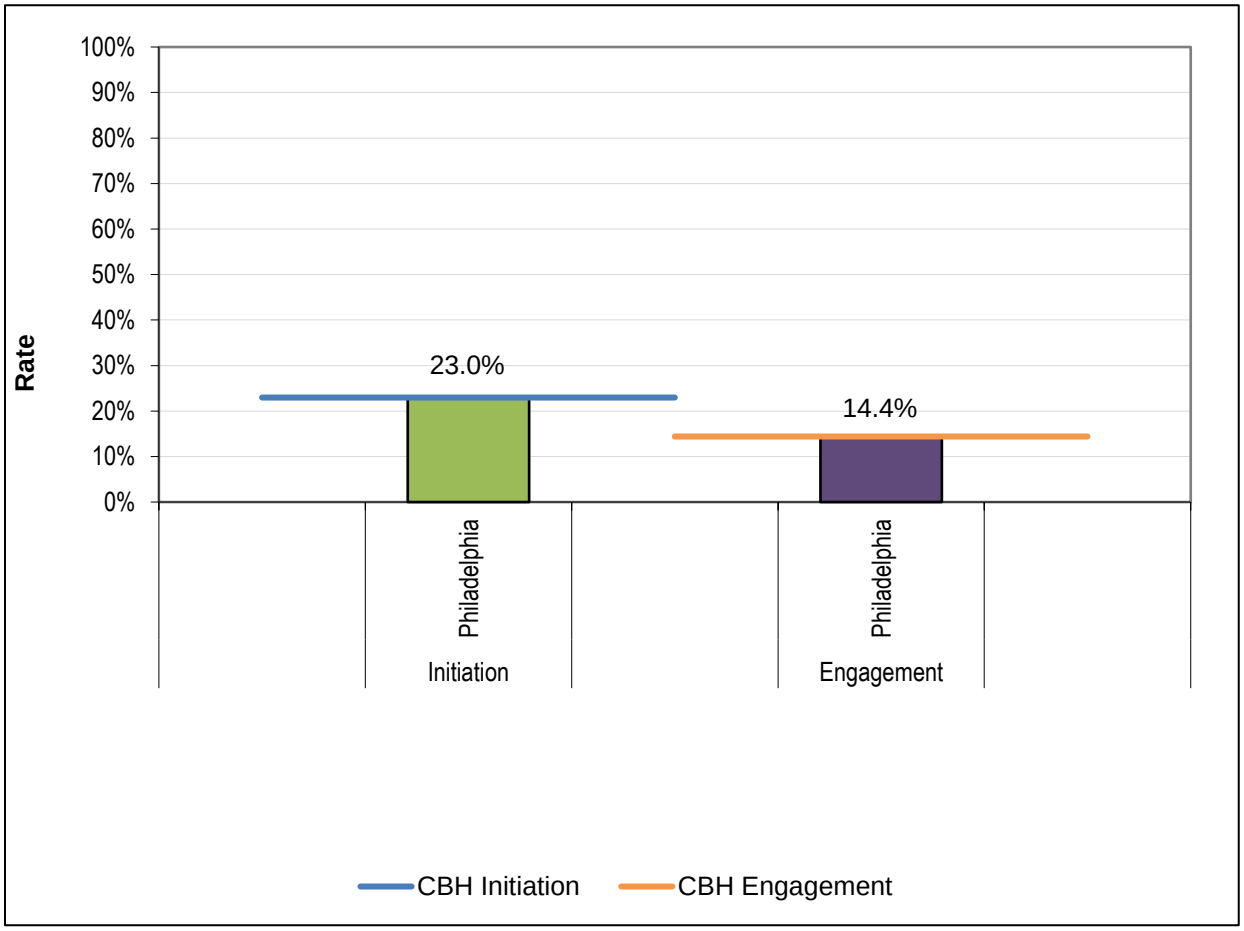

Figure 3.15: MY 2016 IET Initiation and Engagement Rates (Overall)

Figure 3.16 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. The rates for Philadelphia were statistically significantly lower than the HC Statewide rate for Initiation (by 3.2 percentage points) and Engagement (by 2.8 percentage points).

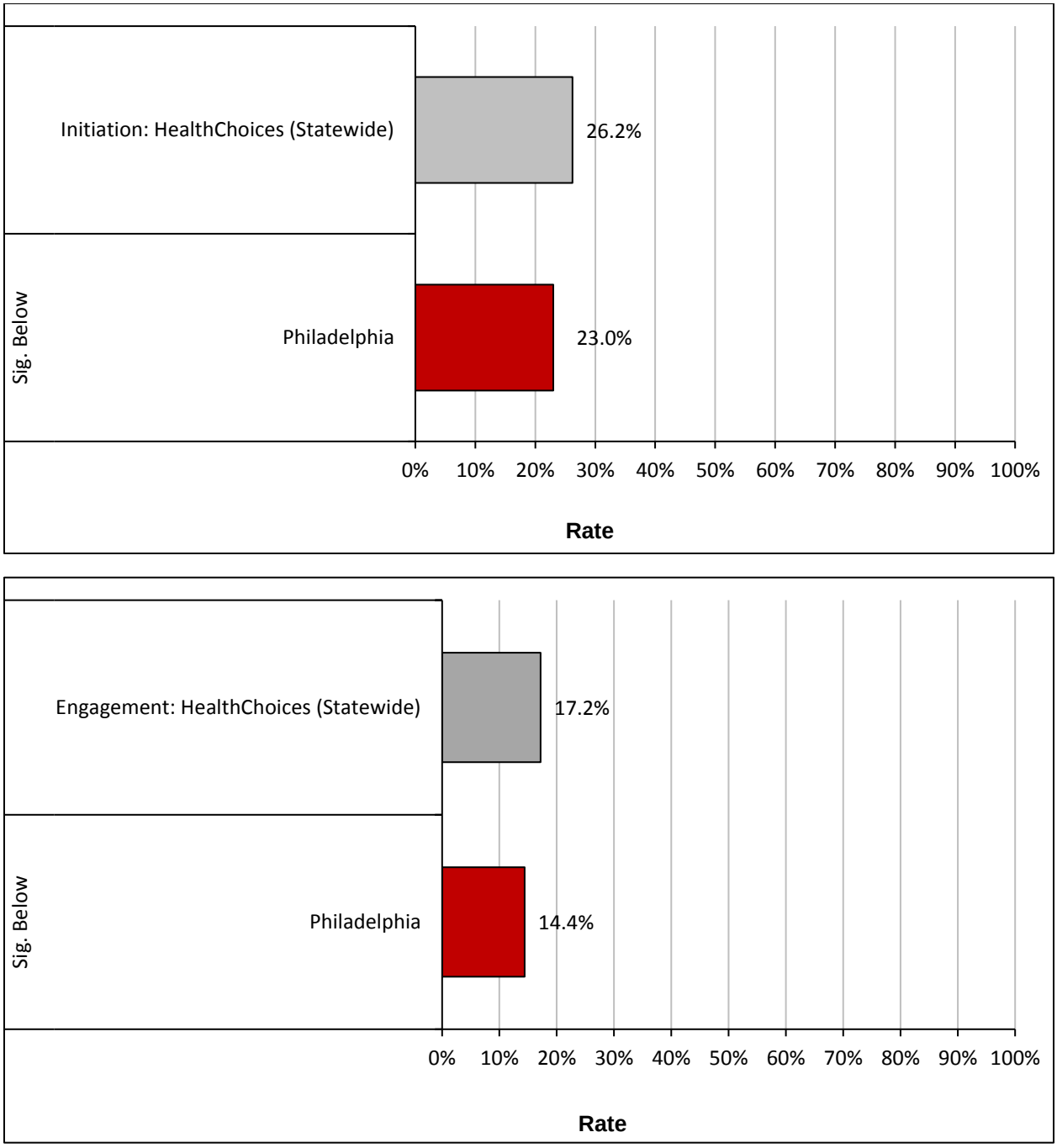

Figure 3.16: Comparison of CBH MY 2016 IET Rates (Overall) versus HealthChoices (Statewide) MY 2016 IET Rates (Overall)

Conclusion and Recommendations

For MY 2016, the aggregate HealthChoices rate in the overall population was 26.2% for the Initiation rate and 17.2% 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 2015 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 further develop 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 Studies

The purpose of this section is to describe two quality studies performed between 2016 and 2017 for the HealthChoices population. The studies are included in this report as optional EQR activities which occurred during the Review Year (42 CFR §438.358 (c)(5)).

Initiation and Engagement of Alcohol and other Drug Dependence Treatment, Opioid (IET-Opioid) Study

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 use disorder (OUD). 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

IPRO 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 OUD between January 1, 2016 and November 15, 2016 in order to measure the percentage of members who receive these services after the OUD 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 and received by IPRO. Data were pulled to account for the claims lag between dates of service and claims processing. Any claims not submitted to or not accepted by PROMISe were not included in this analysis. The analysis compared initiation and engagement rates for three age groups: 13-17, 18+, and Total. For the baseline period (MY 2014) of the study, 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

From baseline (MY2014), 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 OUD diagnosis details were unspecified for about 85% of the sample, those with a continuous OUD 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. OUD diagnosis was the primary diagnosis for 74.6% members; these members had significantly higher rates than those with a non-OUD 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.

In MY 2015, there were a total of 14,676 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 2015 was 45.52%, and the overall engagement rate was 33.89%. From MY 2014 to MY 2015, the overall initiation rate saw a statistically significant increase of 4.84% and the overall engagement rate saw a statistically significant increase of 5.59%. In MY 2016, there were a total of 22,461 members that met the denominator criteria that were included in this study. The overall initiation rate for MY 2015 was 37.46%, and the overall engagement rate was 27.07%. From MY 2014 to MY 2016, the overall initiation rate saw a statistically significant decrease of 3.22% and the overall engagement rate saw a statistically significant decrease of 1.22%. From MY 2015 to MY 2016, the overall initiation rate saw a statistically significant decrease of 8.06% and the overall engagement rate saw a statistically significant decrease of 6.82%.

Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Overview/Study Objective

As part of its continuing focus on measuring and addressing substance use disorders, DHS directed IPRO to continue to calculate the HEDIS Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) measure for MY 2016. In the fall of 2016, FUA entered into the 2017 HEDIS measure set. . As a result, IPRO conducted several comparative analyses, both for 7- and for 30-day follow-up periods, for several measurement years, using combinations of different years' HEDIS specifications, in order to assess potential impact on rates. This analysis built on comparison of FUA rates based on HEDIS versus PA-modified specifications that was conducted in 2016. A longer-term objective of this study is to collect physical health and behavioral health encounter data to identify factors impacting follow-up rates across both domains of care.

Data Collection and Analysis

IPRO analyzed behavioral and physical health encounter data for instances of an ED visit (the index event), using the ED Value Set, with a principal diagnosis of AOD, using the AOD Dependence Value Set, during the measurement year. The denominator for this measure is based on ED visits, not on members. If a member had more than one ED visit, all ED visits between January 1 and December 1 of the measurement year were identified to ensure no more than one visit was included per 31-day period. ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission, were excluded. Eligible members were continuously enrolled from the date of the ED visit through 30 days after the ED visit; no gaps in enrollment were allowed. Members with detoxification-only chemical benefits were not eligible, nor were members in hospice care. For the 2016 analysis, PA-specific FUA stratifications included cohorts of 18-64 years of age, 65+ years of age, and Totals. HEDIS stratifications included cohorts of 13-17 years of age, 18+ years of age, and Totals. Rates were calculated for MY 2014, MY 2015, and MY 2016 using the MY 2014, MY 2015, and MY 2016 specifications for PA-specific reports, as well as HEDIS MY 2015 and MY 2016 specifications. In 2017, analysis focused on comparing HEDIS specifications to one another and across measurement years.

Results/Conclusions

Using the HEDIS (MY 2016) specifications, the Total 7-Day Follow-up rate was 11.03% in MY 2014. The FUH 7-day statistically significantly decreased to 9.94% in MY 2015. For Total 30-Day Follow-up, the rate was 17.56% in MY 2014 and 16.47% in MY 2015. The Total 7-Day Follow-up rate was 11.03% in MY 2014 using HEDIS MY 2015 specifications and statistically significantly increased to 13.44% in MY 2015 using the HEDIS MY 2016 specifications. The Total 30-Day Follow-up rate was 17.56% in MY 2014 using HEDIS MY 2015 specifications, and statistically significantly increased to 20.55% in MY 2015 using the HEDIS MY 2016 specifications. Using the HEDIS MY 2015 specifications, the Total 7-Day Follow-up rate in MY 2015 was statistically significantly higher than the MY 2015 rate calculated using the HEDIS MY 2016 specifications (9.94% vs. 13.44%). Using the HEDIS (MY 2015) specifications, the Total 30-Day Follow-up rate in MY 2015 was statistically significantly higher than the MY 2015 rate calculated using the HEDIS MY 2016 specifications (16.47% vs. 20.55%).

V: 2016 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 2016 EQR Technical Reports, which were distributed in April 2017. The 2017 EQR Technical Report is the tenth report to include descriptions of current and proposed interventions from each BH-MCO that address the 2016 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, 2017 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 2017, as well as any additional relevant documentation provided by the BH-MCO. **Table 5.1** presents CBH's responses to opportunities of improvement cited by IPRO in the 2016 EQR Technical Report, detailing current and proposed interventions.

Table 5.1: BH-MCO's Responses to Opportunities for Improvement Cited in the 2016 EQR Technical Report

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) 2013, RY 2014, and RY 2015 found CBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 7/30/17/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
CBH 2016.01	Within Subpart C: Enrollee Rights and Protections Regulations, CBH was partially compliant with one out of seven categories – Enrollee Rights.	May 2015 May 2016 Ongoing	CBH revised its training curriculum and submitted it to OMHSAS for approval.  Quality Management Staff Training.ppt Based on OMHSAS feedback, the training curriculum was revised and submitted for approval.  Quality Management Training 2016.ppt The curriculum that was approved by OMHSAS and is being used currently for trainings is below.  C&G Panel Training 2016.ppt
		On-going beginning June/July 2015	CBH trained all complaints and grievances staff to handle and respond to member complaints and grievances appropriately. All current and newly hired staff also received training on member rights and procedures for filing a complaint or grievance.
		Ongoing	Newly hired complaints and grievances staff are trained upon hire. All complaints and grievances panel members are trained on an annual basis.  C&G Panel Member 2017 Training Sign-In Audits to monitor staff performance were conducted on a quarterly basis. In September 2016, a Quality Assurance Specialist was hired to conduct audits on a monthly basis.

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) 2013, RY 2014, and RY 2015 found CBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 7/30/17/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
CBH 2016.02	CBH was partially compliant with four out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, and 4) Practice Guidelines	November 2014	CBH developed a policy for conducting utilization review according to medical necessity criteria as well as requirements for documentation.  Standard 28.1 Docs UR.docx  Standard 28.1 Documentation Requir
		December 2, 2014 & January 6, 2015	The Utilization Review Policy and documentation requirements were reviewed with Medical Affairs staff.  Standard 28.1 Docs Meeting December 2 2  Standard 28.1 Docs Meeting January 6 201
		Ongoing	Newly hired Medical Affairs staff are trained on utilization review and documentation requirements upon hire. In September 2016, a Quality Assurance Specialist was hired to conduct audits of Medical Affairs staff documentation on a monthly basis.
		October 2015	The denial module in CBH's electronic clinical information system was revised to include member's Medical Assistance number on all denial notices.
		June 2016	A refresher Denial Notice Training was held for all clinical staff in June 2016.  Denial Training June 2016.pptx  Denials Notice Trainings June 2016 S

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) 2013, RY 2014, and RY 2015 found CBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 7/30/17/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		August 2016	The Denial Audit Tool was revised several times since August 2016 and reflects all of the required elements of a denial notice. The latest version of the Denial Audit Tool is below.  CBH Denial Notice Audit Template rev. D 54 denial notices are audited each month by Clinical Supervisors then the Quality Assurance Specialist re-audits the Supervisors' audits in order to monitor the quality of the denial notices and to identify and correct areas of deficiency. Sample report is attached.  CCMS Re-Audit Report- June 2017.pdf
CBH 2016.03	CBH was partially compliant with 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 & Subcontractors 8) Continuation of Benefits, and	July & August 2015	CBH revised its letter templates; developed complaint protocols, a summary sheet, and hearing scripts; revised its training curriculum; and trained its complaints and grievances staff and panel members to meet the requirements of Subpart F.  Complaints Letter Template.doc  Grievance Letter Template.doc  Quality Management Staff Training.ppt  Quality Management Staff Training Sign-In  First Level Complaint Protocol.doc  Second Level Complaint Protocol.do  Panel Training Sign-In Sheets.pdf  Complaint Summary Sheet w How To Com  Complaint Summary Sheet.doc  Panel Training 2015.pptx  Complaints Hearing Script.doc  Grievance Hearing Script.doc

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) 2013, RY 2014, and RY 2015 found CBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 7/30/17/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
	9) Effectuation of Reversed Resolutions.	May 2016 Ongoing	Based on OMHSAS feedback, the training curriculum was revised and submitted for approval.  Quality Management Training 2016.ppt The curriculum that was approved by OMHSAS and is being used currently for trainings is below.  C&G Panel Training 2016.ppt
		Ongoing	Newly hired complaints and grievances staff are trained upon hire. All complaints and grievances panel members are trained on an annual basis.  C&G Panel Member 2017 Training Sign-In Audits to monitor staff performance were conducted on a quarterly basis. In September 2016, a Quality Assurance Specialist was hired to conduct audits on a monthly basis.

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 2015, CBH began to address opportunities for improvement related to compliance categories within Subparts: C (Enrollee Rights), D (Access to Care, Coordination and Continuity of Care, Coverage and Authorization of Services, and Practice Guidelines), and F . The partially compliant categories within Subpart F (Federal and State Grievance System Standards Regulations) 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 & Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions. Proposed actions and evidence of actions taken by CBH 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 CBH into compliance with the relevant Standards.

Root Cause Analysis and Action Plan

The 2017 EQR would have been the ninth EQR for which BH-MCOs would have been 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 are noted as opportunities for improvement in the 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.

Following several years of underperformance in the key quality indicator areas; however, OMHSAS deemed in 2017 that it was necessary to change the EQR process from a retrospective to more of a prospective process. This meant, among other things, eliminating the requirement to complete RCAs and CAPs responding to MY 2015. Instead, BH-MCOs were required to submit member level files for MY 2016 in the summer of 2017, from which rates were calculated and validated by IPRO. MY 2016 Results of HEDIS Follow-up after Hospitalization for Mental Illness (7- and 30-day) were then used to determine RCA and CAP assignments. The change coincided with the coming phase-in of VBP at the HC BH Contractor level in January, 2018. Thus, for the first time, RCA and CAP assignments were made at the Contractor level as well as at the BH MCO level. Contractors receiving assignments completed their RCAs and CAPs in November of 2017, while BH-MCOs completed their RCAs and CAPs by December 31, 2017.

Since the requirement to complete MY 2015 RCAs and CAPs was dropped, the 2017 BBA report does not include this component. Instead, MY 2016 RCAs and CAPs, already completed, will be included and discussed in the 2018 BBA report.

VI: 2017 Strengths and Opportunities for Improvement

The review of CBH's 2017 (MY 2016) performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH-MCO.

Strengths

- CBH was compliant with all elements under review for Year 2 of the Performance Improvement Project.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2014, RY 2015, and RY 2016 found CBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
    - CBH was partially compliant with one out of seven categories within Subpart C: Enrollee Rights and Protections. The partially compliant category is Enrollee Rights.
    - CBH was partially compliant with three out of 10 categories and non-compliant with one out of 10 categories 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, and 3) Practice Guidelines. The non-compliant category is Coordination and Continuity of Care.
    - CBH 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.
- CBH's MY 2016 PA-Specific 7-Day Follow-up after Hospitalization for Mental Illness rate (QI A) for the overall population was statistically significantly below (worsened) compared to the MY 2016 HC BH (Statewide) rate by 3.7 percentage points.
- CBH's MY 2016 PA-Specific 30-Day Follow-up after Hospitalization for Mental Illness rate (QI B) for the overall population was statistically significantly below (worsened) compared to the MY 2016 HC BH (Statewide) rate by 5.7 percentage points.
- CBH's MY 2016 PA-Specific 30-Day Follow-up after Hospitalization for Mental Illness (QI B) rate for the overall population statistically significantly decreased (worsened) from the prior year by 2.7 percentage points.
- CBH's MY 2016 Readmission within 30 Days of Inpatient Psychiatric Discharge rate did not change statistically significantly compared to the MY 2016 HC BH (Statewide) or prior year rates.
- CBH's MY 2016 Readmission within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.
- CBH's MY 2016 HEDIS 7- and 30-Day Follow-up after Hospitalization for Mental Illness rates (QI 1 and QI2) for ages 6-64 did not meet the OMHSAS interim goals for MY 2016, nor did they achieve the goal of meeting or exceeding the HEDIS 75th percentiles.
- CBH's MY 2016 Initiation and Engagement of AOD Treatment performance rate for ages 13+ did not achieve the goal of meeting or exceeding the 75th percentile for the corresponding 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.

Table 6.1 is a three-by-three matrix depicting the horizontal same-year comparison between the BH-MCO's performance and the applicable HC BH (Statewide) rate and the vertical comparison of the BH-MCO's MY 2016 performance to its prior year performance. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly above (▲), below (▼), or no difference (═). This comparison is determined by whether or not the 95% confidence interval for the BH-MCO rate included the benchmark rate. However,

the qualitative placement of the performance in the matrix depends on the measure. For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) measure, lower rates reflect better performance.

Table 6.1: BH-MCO Performance Matrix for MY 2016 PA-Specific 7- and 30-Day Follow-up after Hospitalization and MY 2016 Readmission Within 30 Days of Inpatient Psychiatric Discharge (Overall)

BH-MCO Year to Year Statistical Significance Comparison	Trend	BH-MCO versus HealthChoices Rate Statistical Significance Comparison		
		Poorer	No difference	Better
	Improved	C	B	A
	No Change	D FUH QI A	C REA[1]	B
	Worsened	F FUH QI B	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. BH-MCOs may have internal goals to improve. B: BH-MCOs may identify continued opportunities for improvement. C-F: Recommend BH-MCOs identify continued opportunities for improvement.
FUH QI A: PA-Specific 7-Day Follow-up after Hospitalization for Mental Illness (Overall)
FUH QI B: PA-Specific 30-Day Follow-up after Hospitalization for Mental Illness (Overall)
REA: Readmission within 30 Days of Inpatient Psychiatric Discharge

Table 6.2 quantifies the performance information contained in **Table 6.1**. It compares the BH-MCO's MY 2016 7- and 30-Day Follow-up after Hospitalization and Readmission Within 30 Days of Inpatient Psychiatric Discharge rates to prior years' rates for the same indicator for measurement years 2013 through 2016. The last column compares the BH-MCO's MY 2016 rates to the corresponding MY 2016 HC BH (Statewide) rates. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly: above (▲), below (▼), or no difference (═). This comparison is determined by whether or not the 95% confidence interval for the BH-MCO rate included the benchmark rate.

Table 6.2: MY 2016 PA-Specific 7- and 30-Day Follow-up after Hospitalization and MY 2016 Readmission Within 30 Days of Inpatient Psychiatric Discharge Rates, Compared Year-over-Year and to HC BH Statewide (Overall)

Quality Performance Measure	MY 2013 Rate	MY 2014 Rate	MY 2015 Rate	MY 2016 Rate	MY 2016 HC BH (Statewide) Rate
QI A – PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness (Overall)	50.3% ▼	56.9% ▲	51.1% ▼	**50.1%** =	**53.8%** ▼
QI B – PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall)	63.9% ▼	71.7% ▲	67.4% ▼	**64.7%** ▼	**70.4%** ▼
Readmission Within 30 Days of Inpatient Psychiatric Discharge1	11.3% ▼	13.1% ▲	13.7% =	**13.5%** =	**13.9%** =

[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 6.3 is a four-by-one matrix that represents the BH-MCO's MY 2016 performance as compared to the HEDIS 90th, 75th, 50th and 25th percentiles for the MY 2016 HEDIS FUH 7-Day (QI1) and 30-Day Follow-up (QI2) After Hospitalization metrics. A root cause analysis and plan of action is required for rates that fall below the 75th percentile.

Table 6.3: BH-MCO Performance Matrix for MY 2016 HEDIS FUH 7- and 30-Day Follow-up after Hospitalization (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.
Indicators that are less than the 50th percentile. **FUH QI 1** **FUH QI 2**

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

Table 6.4 shows the BH-MCO's MY 2016 performance for HEDIS (FUH) 7- and 30-day Follow-up After Hospitalization for Mental Illness (6–64 Years) relative to the corresponding HEDIS MY 2016 Quality Compass percentiles.

Table 6.4: BH-MCO's MY 2016 FUH rates compared to the corresponding MY 2016 HEDIS 75th percentiles (6-64 Years)

Quality Performance Measure	MY 2016		HEDIS MY 2016 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-up After Hospitalization for Mental Illness (6–64 Years)	**41.2%**	Not Met	Below 50th and at or above 25th percentile
QI 2 – HEDIS 30-Day Follow-up After Hospitalization for Mental Illness (6–64 Years)	**57.1%**	Not Met	Below 50th and at or above 25th percentile

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

VII: Summary of Activities

Structure and Operations Standards

- CBH was partially compliant with Subparts C, D and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2016, RY 2015, and RY 2014 were used to make the determinations.

Performance Improvement Projects

- CBH submitted a Year 2 PIP Update in 2017. CBH participated in quarterly meetings with OMHSAS and IPRO throughout 2017 to discuss ongoing PIP activities.

Performance Measures

- CBH reported all performance measures and applicable quality indicators in 2017.

2016 Opportunities for Improvement MCO Response

- CBH provided a response to the opportunities for improvement issued in 2016.

2017 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CBH in 2017. The BH-MCO will be required to prepare a response for the noted opportunities for improvement in 2017.

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Appendices

Appendix A: Program Evaluation Performance Summary: OMHSAS-Specific Substandards for CBH Counties

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2016, 16 substandards were considered OMHSAS-specific monitoring standards. Of the 16 OMHSAS-specific PEPS Substandards, 16 were evaluated for CBH and Philadelphia. **Table A.1** provides a count of these substandards, along with the relevant categories. Because compliance categories (first column) may contain substandards that are either annually or triennially reviewed, the total number of PEPS substandards applicable to this year's (RY 2016) evaluation of HealthChoices Oversight Entity/BH-MCO compliance for any given category may not equal the sum of those substandard counts.

Table A.1: Tally of OMHSAS-Specific Substandards Reviewed for CBH

Category (PEPS Standard)	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
	Total	NR	RY 2016	RY 2015	RY 2014
Care Management					
Care Management (CM) Staffing (Standard 27)	1	0	1	0	0
Longitudinal Care Management (and Care Management Record Review) (Standard 28)	1	0	1	0	0
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	0	4	0	0
Grievances and State Fair Hearings (Standard 71)	4	0	4	0	0
Denials					
Denials (Standard 72)	1	0	1	1	1
Executive Management					
County Executive Management (Standard 78)	1	0	1	0	0
BH-MCO Executive Management (Standard 86)	1	0	1	0	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	0	0	3
Total	16	0	13	0	4

[1] The total number of OMHSAS-Specific substandards required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with OMHSAS standards. Any PEPS substandards not reviewed indicate retired substandards previously used to evaluate the BH-MCO.

[2] The number of OMHSAS-Specific substandards that came under active review during the cycle specific to the review year. Because compliance categories (first column) may contain substandards that are either annually or triennially reviewed, the total number of PEPS substandards applicable to this year's (RY 2016) evaluation of HealthChoices Oversight Entity/BH-MCO compliance with any given category may not equal the sum of those substandard counts.

RY: Review Year.

NR: Not reviewed.

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 with selected ongoing OMHSAS-specific monitoring standards.

Findings

Care Management

The OMHSAS-specific PEPS Substandards relating to Care Management are MCO-specific review standards. CBH was evaluated on two of the two applicable substandards. Of the two substandards, CBH was non-compliant with both substandards. The status for these substandards is presented in **Table A.2**.

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

Category	PEPS Item	Review Year (RY)	Status
Care Management			
Care Management (CM) Staffing	Standard 27.7	2016	Not Met
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	2016	Not Met

CBH was non-compliant with Standard 27, Substandard 7 of (RY 2016).

PEPS Standard 27: Care Management (CM) Staffing. BH-MCO Staffing Standard for care manager and physician peer reviews; FTE count of care managers and physician peer reviews; list of care manager, clinical supervisor and MD/PA positions; copies of care manager supervisor and care manager job descriptions; CM Staffing Schedules; CM staff-to-member ratios; UM/CM organization chart; copy of P&Ps for clinical supervision, physician assistant (PA) case consultation, peer review of referral, and role of medical doctor (MD) in the supervision of care managers; table of organization of the BH-MCO.

PEPS Standard 27, Substandard 7: Other: Significant onsite review findings related to Standard 27.

CBH was non-compliant with Standard 28, Substandard 3 of (RY 2016).

PEPS Standard 28: Longitudinal Care Management (and Care Management Record Review). Results of the Care Management Record (CMR) review, denial review, and clinical interviews (summary) Sample of CMR Records.

PEPS Standard 28, Substandard 3: Other: Significant onsite review findings related to Standard 28.

Second Level Complaints and Grievances

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards. CBH was evaluated on eight of the eight applicable substandards. Of the eight substandards evaluated, CBH met two substandards, partially met two substandards, and did not meet four standards, as indicated in **Table A.3**.

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

Category	PEPS Item	Review Year (RY)	Status
Second Level Complaints and Grievances			
Complaints	Standard 68.1	RY 2016	Partially Met
	Standard 68.6	RY 2016	Not Met
	Standard 68.7	RY 2016	Not Met
	Standard 68.8	RY 2016	Not Met
Grievances and State Fair Hearings	Standard 71.1	RY 2016	Partially Met
	Standard 71.5	RY 2016	Not Met
	Standard 71.6	RY 2016	Not Met
	Standard 71.7	RY 2016	Partially Met

CBH was partially compliant with Standard 68, Substandards 1 and was non-compliant with Standard 68, Substandards 6, 7, and 8 (RY 2016).

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

PEPS Standard 68, Substandard 1: Where applicable there is evidence of county oversight and involvement in the second level complaint process.

PEPS Standard 68, Substandard 6: The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.

PEPS Standard 68, Substandard 7: Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.

PEPS Standard 68, Substandard 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.

CBH was partially compliant with Standard 71, Substandards 1 and 7 and non-compliant with Standard 71, Substandards 5 and 6 (RY 2016).

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

PEPS Standard 71, Substandard 1: Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.

PEPS Standard 71, Substandard 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.

PEPS Standard 71, Substandard 6: Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.

PEPS Standard 71, Substandard 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.

Denials

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. CBH was evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table A.4**.

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

Category	PEPS Item	Review Year	Status
Denials			
Denials	Standard 72.3	RY 2016	Met

Executive Management

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. CBH was non-compliant with 2 substandards. The status for these substandards is presented in **Table A.5**.

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

Category	PEPS Item	Review Year	Status
Executive Management			
County Executive Management	Standard 78.5	2016	Not Met
BH-MCO Executive Management	Standard 86.3	2016	Not Met

CBH was non-compliant with Standard 78, Substandard 5 (RY 2016).

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).

PEPS Standard 78, Substandard 5: Other: Significant onsite review findings related to Standard 78.

CBH was non-compliant with Substandards 3 of Standard 86 (RY 2016).

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 of 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.

PEPS Standard 86, Substandard 3: Other: Significant onsite review findings related to Standard 86.

Enrollee Satisfaction

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are county-specific review standards. All three substandards crosswalked to this category were evaluated Philadelphia County. Philadelphia County met the criteria for all three substandards, as seen in **Table A.6**.

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

Category	PEPS Item	Review Year	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Standard 108.3	RY 2014	Met
	Standard 108.4	RY 2014	Met
	Standard 108.9	RY 2014	Met

Appendix B. Required PEPS Substandards Pertinent to BBA Regulations

Refer to **Table B.1** for Required PEPS Substandards pertinent to BBA Regulations.

Table B.1 Required PEPS Substandards Pertinent to 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 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.

BBA Category	PEPS Reference	PEPS Language
	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.
§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.

BBA Category	PEPS Reference	PEPS Language
	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 assessment and performance improvement program	Standard 91.1	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.
	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.

BBA Category	PEPS Reference	PEPS Language
	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, 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 • 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 b explanation and reason for the decision(s).

BBA Category	PEPS Reference	PEPS Language
	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; 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 • 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 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

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		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; 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.

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	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).
§438.406 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 • 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 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).

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§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 • 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 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).
§438.410 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

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	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 • Expedited
	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 MCO or PIHP appeal and the State fair hearing are pending	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

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		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).
§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.

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	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.
	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-

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		rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational/vocational status and Changes in living status.
§438.208 Coordination and Continuity of Care	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.210 Coverage and authorization of services	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	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	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-

BBA Category	PEPS Reference	PEPS Language
		rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational/vocational status and Changes in living status.
§438.240 Quality assessment and performance improvement program	Standard 91.1	QM program description outlines the ongoing quality assessment and performance improvement activities, Continuous Quality Improvement process and places emphasis on, but not limited to High volume/high-risk services and treatment and Behavioral Health Rehabilitation services.
	Standard 91.2	QM work plan includes goal, aspect of care/service, scope of activity, frequency, data source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines, the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services, provider network adequacy, penetration rates, appropriateness of service authorizations, inter-rater reliability, complaint, grievance and appeal process, denial rates, grievance upheld and overturn rates and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other HV/HR services).
	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.

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	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational/vocational status and Changes in living status.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH-MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for Coordination with Other Service Agencies and School.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline 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 • 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.

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

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.
§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	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 • 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

BBA Category	PEPS Reference	PEPS Language
		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	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).
§438.408 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 • 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

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

BBA Category	PEPS Reference	PEPS Language
		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	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).

Appendix C. OMHSAS-Specific PEPS Substandards

Refer to **Table C.1** for OMHSAS-Specific PEPS Substandards.

Table C.1 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 requirements.
Executive Management		
County Executive Management	Standard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Standard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/ Family Satisfaction	Standard 108.3	County/BH-MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.
	Standard 108.4	The C/FST Director is responsible for setting program direction consistent with county direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority and directing staff to perform high quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.