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

2018 External Quality Review Report
Community Behavioral Health

FINAL
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Introduction

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.

Overview

HealthChoices (HC) Behavioral Health (BH) 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 2018 EQRs for HC BH-MCOs and to prepare the technical reports. The subject of this report is one HC BH-MCO: Community Behavioral Health (CBH). Subsequent references to MCO in this report refer specifically to this HC BH-MCO.

Objectives

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.

Report Structure

This technical report includes seven core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures
IV. Quality Study
V. 2017 Opportunities for Improvement - MCO Response
VI. 2018 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the MCO, the information for compliance with the Structure and Operations Standards section of the report is derived from monitoring and reviews conducted by OMHSAS, 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 the 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, 2017 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2017 EQR Technical Report and presents the degree to which the MCO addressed each opportunity for improvement. Section VI has a summary of the MCO's strengths and opportunities for improvement for this review period (2018), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH Quality Performance of the MCO. Lastly, Section VII provides a summary of EQR activities for the 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.

Supplemental Materials

Upon request, the following supplemental materials can be made available:

- the MCO's BBA Report for RY 2017, and
- the MCO's Annual PIP Review for RY 2018.

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) 2017, 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 (43) of the 67 counties have signed agreements using the right of first opportunity and have subcontracted with a private-sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four (24) 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 2017, 2016, and 2015). 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 2017. 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 time frame 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 time frame, 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 2017. 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. Substandards are sometimes added or otherwise changed on the crosswalk which may change the category-tally of standards from year to year. As was done for 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 C**. The RY 2017 crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in **Appendix A** and **Appendix B**, 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 2017, RY 2016, and RY 2015 provided the information necessary for the 2017 assessment. Those standards not reviewed through the PEPS system in RY 2017 were evaluated on their performance based on RY 2016 and/or RY 2015 decisions, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year time frame 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 167 substandards were applicable for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2015–2017). 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 C**, **Table C.1** provides a count of supplemental OMHSAS-specific items that are not required as part of BBA regulations but are reviewed within the three-year cycle to evaluate the BH-MCO and 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 2015–2017). Because compliance categories (first column) may contain substandards that are reviewed either annually or triennially, the total number of PEPS Substandards applicable to this year's (RY 2017) 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 2017	RY 2016	RY 2015
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	14	0	11	3	0
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

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
	Total	NR	RY 2017	RY 2016	RY 2015
Availability of Services	25	0	18	3	4
Coordination and Continuity of Care	3	0	0	3	0
Coverage and Authorization of Services	5	0	2	3	0
Provider Selection	3	1	2	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	0	8
Practice Guidelines	7	0		3	4
Quality Assessment and Performance Improvement Program	25	0	18	0	7
Health Information Systems	1	0	0	0	1
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	0	2	9	0
General Requirements	14	0	2	12	0
Notice of Action	13	0	13	0	0
Handling of Grievances and Appeals	11	0	2	9	0
Resolution and Notification: Grievances and Appeals	11	0	2	9	0
Expedited Appeals Process	6	0	2	4	0
Information to Providers and Subcontractors	2	0	0	2	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	0	2	4	0
Effectuation of Reversed Resolutions	6	0	2	4	0
Total	171	1	78	68	24

[1] The total number of 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 2017, 2016, and 2015 may not equate to the total number of applicable PEPS Substandards for evaluation of the BH-MCO (167 in RY 2017).

RY: Review Year.

NR: Not reviewed.

N/A: Not applicable.

For RY 2017, 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 of 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.

In MY 2017, PEPS Standards 91 and 104 changed from County-Specific Standards to BH-MCO-Specific Standards.

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 171 PEPS Substandards that were used to evaluate CBH and Philadelphia County compliance of BBA regulations in RY 2017, 78 substandards were under active review in RY 2017.

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 CFR 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	14 substandards were crosswalked to this category. Philadelphia County was evaluated on 14 substandards, compliant with 12 substandards, and non-compliant with 2 substandards.
Provider-Enrollee Communications 438.102	Compliant	Compliant as per PS&R sections E.4 (p. 55) and A.4.a (p. 21).
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. 73) and C.2 (p. 28).
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. 30).
Solvency Standards 438.116	Compliant	Compliant as per PS&R sections A.3 (p. 68) and A.9 (p. 73), and 2016–2017 Solvency Requirements tracking report.

N/A: not applicable.

There are seven categories within Subpart C Enrollee Rights and Protections. CBH was compliant with 5 categories and partially compliant with 1 category. The remaining category was considered not applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the 5 compliant categories, 4 were compliant as per the HealthChoices PS&R and 1 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 12 PEPS Substandards and non-compliant with 2 Substandards. Overall, Philadelphia County was deemed partially compliant for the category of 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:

- 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 [Appendix H, A., 9., p. 1]. (Responsibility includes Health Insurance Portability and Accountability Act of 1996 [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 [Appendix H, A., 8., p. 1].
- All BH-MCO staff shall be educated concerning member rights and the procedure for filing complaints and grievances [C.4., p. 44].

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 CFR 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 4 categories, partially compliant with 5 categories, and non-compliant with 1 category. Philadelphia County was evaluated and deemed compliant with the categories of Elements of State Quality Strategies and Confidentiality per the HealthChoices PS&R, as these categories were not directly addressed by any PEPS Substandards.

Of the 73 PEPS items crosswalked to Quality Assessment and Performance Improvement regulations, 72 were evaluated for Philadelphia County for RY 2017. CBH and Philadelphia County were compliant with 55 PEPS items, partially compliant with 6 PEPS item, and non-compliant with 11 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. 61).
Availability of Services (Access to Care) 438.206	Partial	25 substandards were crosswalked to this category. Philadelphia County was evaluated on 25 substandards, compliant with 20 substandards, partially compliant with 1 substandard, and non-compliant with 4 substandards.
Coordination and Continuity of Care 438.208	Non-compliant	3 substandards were crosswalked to this category. Philadelphia County was evaluated on 3 substandards and non-compliant with 3 substandards.
Coverage and Authorization of Services 438.210	Partial	5 substandards were crosswalked to this category. Philadelphia County was evaluated on 5 substandards, partially compliant with 2 substandards, and non-compliant with 3 substandards.
Provider Selection 438.214	Partial	3 substandards were crosswalked to this category. Philadelphia County was evaluated on 2 substandards, compliant with 1 substandard, non-compliant with 1 substandard, and not applicable with 1 substandard.
Confidentiality 438.224	Compliant	Compliant as per PS&R sections D.2 (p. 50), G.4 (p. 62), and C.6.c (p. 48).
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	Partial	7 substandards were crosswalked to this category. Philadelphia

Subpart D: Categories	MCO Compliance Status	Comments
438.236		County was evaluated on 7 substandards, compliant with 4 substandards, and non-compliant with 3 substandards.
Quality Assessment and Performance Improvement Program 438.240	Partial	25 substandards were crosswalked to this category. Philadelphia County was evaluated on 25 substandards, compliant with 21 substandards, partially compliant with 3 substandards, and non-compliant with 1 substandard.
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 partial and non-compliance with substandards of PEPS Standard 1 and non-compliance with substandards of PEPS Standard 28 (RY 2016).

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

Philadelphia County was partially compliant with Substandard 1 and non-compliant with Substandard 6 (RY 2017).

PEPS Standard 1, Substandard 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 time frames (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 database 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.

PEPS Standard 1, Substandard 6: BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees.

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, 2 and 3 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.

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

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). Philadelphia County was non-compliant with Substandards 1, 2 and 3 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 substandards 1 and 2 of PEPS Standard 72 (RY 2016).

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care). Philadelphia County was non-compliant with Substandards 1, 2 and 3 of Standard 28 (RY 2016).

PEPS Standard 72: Denials or reduction of services are provided, in writing, to the member, parent/custodian of a child/adolescent, and/or county Children and Youth agency for children in substitute care. Philadelphia County was partially compliant with Substandards 1 and 2 of PEPS Standard 72 (RY 2017).

PEPS Standard 72, Substandard 1: Denial notices are issued to members according to required time frames and use the required template language.

PEPS Standard 72, Substandard 2: The content of the notices adheres 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; and contains date denial decision will take effect).

Provider Selection

Philadelphia County was partially compliant with Provider Selection due to non-compliance with substandard 3 of PEPS Standard 10 (RY 2017). Substandard 2 PEPS Standard 10 (RY 2017) was not applicable, therefore not reviewed.

PEPS Standard 10: BH-MCO has an ongoing process for review of provider credentialing. Credentials verified according to schedule.

PEPS Standard 10, Substandard 3: Recredentialing incorporates results of provider profiling.

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). Philadelphia County was non-compliant with Substandards 1, 2 and 3 of Standard 28 (RY 2016).

Quality Assessment and Performance Improvement

Philadelphia County was partially compliant with Quality Assessment and Performance Improvement due to non-compliance with substandard 15 of PEPS Standard 91 (RY 2017) and partial compliance with substandards 1, 4, and 14 of PEPS Standard 91 (RY 2017).

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

PEPS Standard 91, Substandard 1: QM program description outlines ongoing quality assessment, performance improvement activities, a continuous quality improvement process, and places emphasis on, but not limited to, high-volume/high-risk services and treatment and BHRS.

PEPS Standard 91, Substandard 4: QM work plan outlines the joint studies to be conducted.

PEPS Standard 91, Substandard 14: The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the Annual Evaluation and any Corrective Actions required from previous reviews.

PEPS Standard 91, Substandard 15: The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's QM program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan.

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. In the category of Recordkeeping and Recording Requirements, Philadelphia County 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 32 items, partially compliant with 38 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 3 substandards, partially compliant with 6 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 4 substandards, partially compliant with 6 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 11 substandards, and partially compliant with 2 substandards.
Handling of Grievances and Appeals	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 11 substandards, compliant with 3 substandards, partially compliant with 6 substandards, and non-compliant with 2

Subpart F: Categories	MCO Compliance Status	Comments
438.406		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 3 substandards, partially compliant with 6 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 2 substandards, and partially compliant with 4 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 2 substandards, and partially compliant with 4 substandards.
Effectuation of Reversed Resolutions 438.424	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant with 2 substandards, and partially compliant with 4 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: 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.

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: Grievance and the Department's fair hearing rights and procedures are made known to 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. Philadelphia County was partially compliant with Substandards 1 and 2 of PEPS Standard 72 (RY 2017).

General Requirements

Philadelphia County was partially compliant with General Requirements due to partial compliance 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). 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. 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. 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. Philadelphia County was partially compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2017).

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. Philadelphia County was partially compliant with Substandards 1 and 2 of PEPS Standard 72 (RY 2017).

Handling of Grievances and Appeals

Philadelphia County was partially compliant with Handling of Grievances and Appeals due to partial compliance 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. 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. 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. Philadelphia County was partially compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2017).

Resolution and Notification: Grievances and Appeals

Philadelphia County was partially compliant with Resolution and Notification of Grievances and Appeals due to partial compliance 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. 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. 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. Philadelphia County was partially compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2017).

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. 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. Philadelphia County was partially compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2017).

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. 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. Philadelphia County was partially compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2017).

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. 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. Philadelphia County was partially compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2017).

II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for the MCO. Under the existing HC BH agreement with OMHSAS, HC BH Contractors, along with the responsible subcontracted entities (i.e., MCOs), are required to conduct a minimum of two focused studies per year. The HC BH Contractors and 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, MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2018 for 2017 activities.

Background

A new EQR PIP cycle began for 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 HC BH 30-day Readmission Rate has consistently not met the OMHSAS goal of a rate of 10% or less. In addition, all MCOs continue to remain below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS®) 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 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 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 that 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 extended 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. MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. MCOs were required to submit interim reports in 2016 and 2017. MCOs will be required to submit an additional interim report in 2018, as well as a final report in 2019. MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH Contractor-level and MCO-level data, including clinical

history and pharmacy data. This PIP is designed to be a collaboration between the HC BH Contractors and MCOs. The MCOs and each of their HC BH Contractors are required to collaboratively develop a root-cause/barrier analysis that identifies potential barriers at the 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 MCO will submit the single root-cause/barrier analysis according to the PIP schedule. This PIP was formally introduced to the 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 MCOs and HC BH Contractors, as needed.

The 2018 EQR is the 15th review to include validation of PIPs. With this PIP cycle, all 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 MCOs/HC BH Contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness. The 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 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 in *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 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, MCOs were asked to submit only one PIP interim report in starting in 2016, rather than two semiannual submissions.

Validation Methodology

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (*EQR Protocol 3: Validating Performance Improvement Projects [PIPs], Version 2.0, September 2012*) and meets the requirements of the final rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 10 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 9 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 2017 was an intervention year for all MCOs (which was then extended into 2018, as well), IPRO reviewed elements 1 through 9 for each MCO and provided preliminary feedback and guidance pertaining to sustainability.

Review Element Designation/Weighting

Calendar year 2017 was the second year of the Demonstrable Improvement stage. This section describes the scoring elements and methodology for reviewing the demonstrable improvement of the PIPs.

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 MCO's overall performance score for a PIP. Review elements 1 through 9 are for demonstrable improvement and have a total weight of 80% (**Table 2.2**). The highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for full compliance). The MCO must sustain improvement relative to the baseline after achieving demonstrable improvement.

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%

*At the time of this report, this standard was not yet reportable, in accordance with the PIP implementation schedule.

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. The project 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

MCO submitted their Year 3 PIP Update document for review in August 2018. IPRO provided feedback and comments to MCO on this submission. **Table 2.3** presents the PIP scoring matrix for this August 2018 submission, which corresponds to the key findings of the review described in the following paragraphs. CBH received a total demonstrable improvement score of 55 out of 80 points (68.8%). Overall, this PIP was partially compliant for demonstrable improvement.

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	PM	50	5%	2.5
Review Element 2 – Study Question (AIM Statement)	M	100	5%	5
Review Element 3 – Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 – Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 – Data Collection Procedures	PM	50	10%	5
Review Element 7 – Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 – Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**55**
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.
*At the time of this report, this standard was not yet reportable, in accordance with the PIP implementation schedule.

As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. The MCO was partially compliant with review element 1, specifically in regard to the project identifiers. The MCO did not include the Attestation in the submission, which compounded concerns: in the prior year, the MCO also did not submit the Attestation (which omitted the printed, signed, and dated BH HC Contract Administrator Names). The MCO's Attestations were last updated in 2014, the footer of the submission incorrectly specified that the Year 3 Update was the Proposal, and the MCO incorrectly specified the date of the submission was in 2017. Senior medical and quality staff at the MCO participated in discussions pertaining to the Year 3 Update, and provided Attestation subsequently. IPRO recommended that the MCO ensure the requisite project identifiers are reported and up-to-date. There were no other issues or concerns with the requirements for the PIP topic and relevance; the PIP incorporated comprehensive data collection and analysis of aspects of enrollee needs, care and services, and addressed a broad spectrum of these appropriately).

Although the MCO had no issues or concerns with requirements for the aim statement, there were issues with the performance indicators that were being studied in the PIP. The MCO was partially compliant with the requirement for use of objective, clearly defined, measureable, time-specific indicators to track outcomes (including the capacity to assess change and strengths of association). Although the linkages are established between the aim statement, objectives, goals, and most interventions/corresponding metrics, there was an issue in reporting the text-message based

intervention(s) and the associated parameters. The MCO did not consistently and concisely address how the barriers for the text message-based Intervention, identified during implementation, were incorporated into the PIP, in regard to the time frames and status of recalibrations. Throughout the report, the narrative pertaining to the text message-based intervention mixed the following indications: the text message-based intervention (reMind) is active; the continuously active text message-based intervention was renamed (from reMind to ConnectPoint); a text message-based intervention was suspended and then resumed and renamed (from reMind until the suspension, and then ConnectPoint once resume); a text message-based intervention was terminated entirely; and/or a new text message-based intervention was started. It was insufficient to add on updated information without removing and/or incorporating outdated information from prior annual updates. The reporting had some ambiguous definitions, and it was problematic for the reviewer to ascertain when, how, and the extent to which a transition impacted the measurement capacity and delivery of the intended services. The convolution of unnecessary and outdated details resulted in a report that was longer than necessary and difficult to follow. Reference tables were also included in the middle of the report (inconsistent with other tables, located at the end of the report), and these reference tables were not clearly numbered. In addition, there were concerns in regard to the core outcome measure to ascertain PIP performance, including the Behavioral Health Readmission Rate. No limitations were explicitly discussed, and the measures were compared from year to year; however, threats to validity were emergent and were not explicitly discussed as a limitation, although the MCO described the methodological modifications to work around specified inclusion/exclusion criteria for rate calculations. It was unclear from some of the statistical analyses, results, and associated discussions if these validity threats were a result of circumstances that could be sufficiently resolved through corrective action by the MCO. Recommendations to the MCO in regard to study variables and performance indicators included the following: reference tables should be used in accordance with standard technical writing conventions, methodology should be based on validated information with precise and clear reporting techniques, and operationalized indicators should ascertain the associations with improved outcomes.

There were no issues or concerns with requirements for identification of study populations and methodology for sampling. The MCO was also compliant with the study design specifying the data collection processes in terms of automated versus manual mechanisms, and with prospective analysis plans. However, there were several issues with data collection procedures, resulting in partial compliance with associated requirements. For data source specifications, the MCO was partially compliant as a result of ambiguity in the aforementioned definitions and timeframes because impacts on core outcome measures and validated encounter data sources could not be fully ascertained without the needed detail. For specification of a study design that used a systematic method of data collection that ensured validity and reliability for appropriate representation of the target population, the MCO was partially compliant: internal and external threats to validity were emergent and the lack of clear definitions compounded the issue, specifically in regard to constraints with outcome measures' data sources. Lastly, the above issues contributed to concerns with the timeline for data collection and reporting. Recommendations to the MCO in regard to data collection procedures including the following: circumstances impacting data collection should be sufficiently detailed and discussed in terms of threats to reliability and validity of data and implications for indicating performance changes, and reporting should be consistent and concise in terms of the subject reporting period (i.e., transitions occurring within PIP components should be discussed/ represented in the narrative/graphics in a manner that ensure clear specification of data sources; furthermore, that core outcomes should be discussed in regard to apparent limitations to data sources. Lastly, reporting should be consistent and concise in terms of the subject reporting period, and transitions occurring within PIP components should be discussed/represented with a clearly specified timeline for recalibrations to the original methodology.

There were no issues or concerns with improvement strategies (i.e., interventions), nor with the presentation of the analyses as originally planned (in regard to interpretation of how improvement was demonstrated and validated for demonstrating improvement). However, there were other issues with the demonstrability (and validity) of improvement: as a result of the issues and concerns identified in the PIP methodology and as a result of problematic reporting, initial and repeat measurement capacity limited full ascertainment of true performance of interventions and outcomes. There was also problematic identification of barriers, indicators used in analyses, and convoluted reporting, hindering the explanation and interpretation of some results. Consequently, successes of individual PIP components and rationale for follow-up activities were not clearly evidence-based. Furthermore, the problematic reporting technique

hindered the review. Recommendations to the MCO in regard to compliance with interpreting demonstrability and validity of improvement include the following: capacity to explain and interpret results should be based on validated information with precise and clear reporting techniques, the aforementioned methodological and reporting issues should be addressed to validate calculations and rigor of analyses (needed for appropriate discussion of results and to make conclusions regarding performance), and capacity to explain and interpret results should be based on validated information with precise and clear reporting techniques.

III: Performance Measures

In 2018, 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 2017. 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 6 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 7 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 during which they were in service for 2006.

For MY 2007, all PA local codes previously mapped to standard Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (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 during which 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 its performance measures. Based on these reviews, minor inconsistencies were found in how each BH-MCO produces its 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 7 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 29 HC BH Contractors participating in the MY 2017 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, 2017;
- 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, 2017, 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, 2017. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2018 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 7 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 7 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 7 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 in 2008, mental illnesses and mental disorders represent 6 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 (Avery et al., 1997). On the whole, serious mental illnesses account for more than 15% of overall disease burden in the United States (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. An outpatient visit within at least 30 days (ideally, 7 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 long-standing concern of behavioral health care systems, with some researchers having estimated that 40 to 60% 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 2017. For MY 2013 through MY 2017, 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 NCQA Quality Compass® 50th percentile, then:
   a. If rate >=5 percentage points (PPs) below the Quality Compass 50th percentile, then new goal = last year's rate + 5% improvement over last year's rate
   b. If rate ≥ 2 PPs and < 5 PPs below the Quality Compass 50th percentile, then new goal = last year's rate + 5% improvement over last year's rate, or the Quality Compass 50th percentile, whichever is less.
   c. If rate < 2 PPs below the Quality Compass 50th percentile, then new goal = the Quality Compass 50th percentile.
2. If the yearly rate is rate is above or equal to the Quality Compass 50th percentile and below the 75th percentile, then:
   a. If rate ≥ 2 PPs below the Quality Compass 75th percentile, then new goal = last year's rate + 2% improvement over last year's rate
   b. If rate < 2 PPs below the Quality Compass 75th percentile, then new goal = last year's rate + 2% improvement over last year's rate, or the Quality Compass 75th percentile, whichever is less
3. If rate is above or equal to the Quality Compass 75th percentile, then new goal = last year's goal.

Interim goals were provided to the BH-MCOs after the MY 2016 rates were received. The interim goals were updated from MY 2013 to MY 2017. 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 2017, 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 2016 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:

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

Where:

*N*1 = Current year (MY 2017) numerator
*N*2 = Prior year (MY 2016) numerator
*D*1 = Current year (MY 2017) denominator
*D*2 = Prior year (MY 2016) 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:

*p*1 = Current year (MY 2017) quality indicator rate
*p*2 = Prior year (MY 2016) 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 2017. 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 2017. 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 to 20 years 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 years old age group and the 6+ years old age groups are compared to the MY 2017 HEDIS national percentiles. NCQA produces annual HEDIS Follow-up After Mental Health benchmarks for the 6+ years age band only; therefore results for the 6 to 64 years old age group are compared to percentiles for the 6+ years old age bands. The percentile comparison for the ages 6 to 64 years 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 2017. 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 years old age group are not compared to HEDIS benchmarks for the 6+ years old 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 2017. For MYs 2013 through 2017, 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 2017 results compared to their MY 2017 goals and HEDIS percentiles, as well as to MY 2016.

Table 3.1: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Indicators (6–64 Years)

MY 2017									MY 2017 Rate Comparison		
				95% CI		Goal		MY 2016 %	To MY 2016		To MY 2017 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper	%	Met?		PPD	SSD	
QI1 – HEDIS 7-Day Follow-up (6-64 Years)											
HealthChoices (Statewide)	16,420	41,778	39.3%	38.8%	39.8%	48.5%	NO	43.7%	-4.4	Yes	Below 75th percentile, above 50th percentile
CBH	2,336	7,610	30.7%	29.7%	31.7%	47.0%	NO	41.2%	-10.5	Yes	Below 50th percentile, above 25th percentile
Philadelphia	2,336	7,610	30.7%	29.7%	31.7%	47.0%	NO	41.2%	-10.5	Yes	Below 50th percentile, above 25th percentile
QI2 – HEDIS 30-Day Follow-up (6–64 Years)											
HealthChoices (Statewide)	25,425	41,778	60.9%	60.4%	61.3%	69.2%	NO	63.5%	-2.6	Yes	Below 75th percentile, above 50th percentile
CBH	3,510	7,610	46.1%	45.0%	47.3%	65.7%	NO	57.1%	-11.0	Yes	Below 25th percentile
Philadelphia	3,510	7,610	46.1%	45.0%	47.3%	67.7%	NO	57.1%	-11.0	Yes	Below 25th percentile

MY: measurement year; CI: confidence interval; N: numerator; D: denominator: PPD: percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

The HEDIS Follow-up (6–64 Years) for HealthChoices (Statewide) was 39.3% for QI 1 and 60.9% for QI 2 (**Table 3.1**). These rates were statistically significantly lower than the HealthChoices (Statewide) rates for this age group in MY 2016, which were 43.7% and 63.5%, respectively. The HealthChoices (Statewide) rates were below the MY 2017 interim goals of 48.5% for QI 1 and 69.2% for QI 2; therefore, neither of the interim goals were met in MY 2017. Both HealthChoices (Statewide) rates were between the NCQA 50th and 75th percentile; therefore, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2017 for either rate.

For MY 2017, 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 2017 CBH/Philadelphia QI 1 rate for members age 6 to 64 years was 30.7%. The QI 1 rate was statistically significantly lower than the MY 2016 CBH/Philadelphia QI 1 rate by 10.5 percentage points. The MY 2017 CBH/Philadelphia QI 2 rate for this age group was 46.1%. The QI 2 rate was statistically significantly lower than the MY 2016 CBH/Philadelphia QI 2 rate by 11.0 percentage points. Both CBH rates were below the MY 2017 goals of 47.0% for QI 1 and 65.7% for QI 2; therefore, both interim follow-up goals were not met in MY 2017. For this age group, QI1 HEDIS rates was between the HEDIS 2018 25th and 50th percentiles and QI2 HEDIS rates was below 25th percentile; therefore the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by CBH in MY 2017 for either rate.

Figure 3.1 is a graphical representation of the MY 2017 HEDIS follow-up rates in the 6 to 64 years old population for CBH and its associated HC BH Contractor.

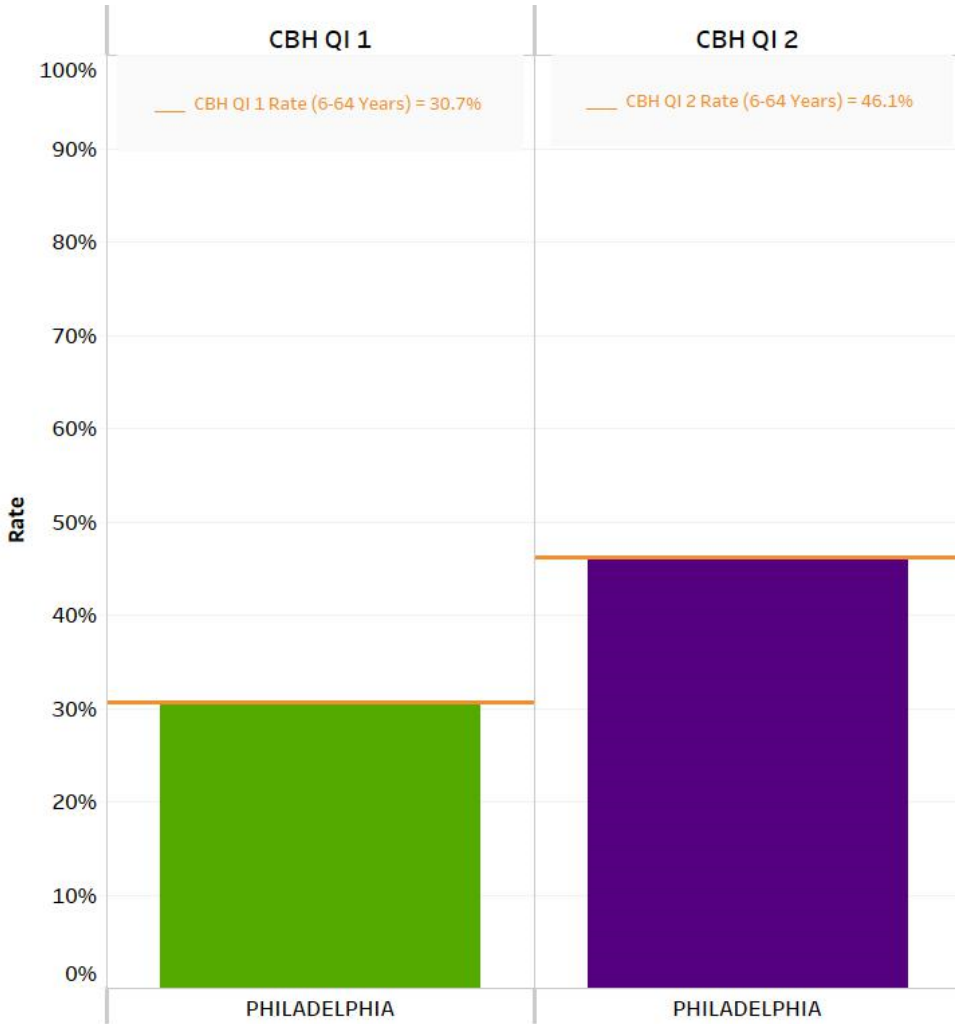

Figure 3.1: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (6–64 Years).

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 2017 QI 1 HealthChoices (Statewide) rate of 39.3% by 8.6 percentage points. The QI 2 rate for Philadelphia was statistically significantly lower than the QI 2 HealthChoices (Statewide) rate of 60.9% by 14.8 percentage points.

Figure 3.2: Comparison of CBH Contractor MY 2017 HEDIS FUH Follow-up Rates (6–64 Years) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (6-64 Years).

(b) Overall Population: 6+ Years Old

The MY 2017 HealthChoices Aggregate HEDIS follow-up rates were 39.1% for QI 1 and 60.6% for QI 2 (**Table 3.2**). These rates were statistically significantly lower than the HealthChoices Aggregate rates in MY 2016, which were 43.5% and 63.2%, respectively. For CBH/Philadelphia, the MY 2017 HEDIS rates were 30.4% for QI 1 and 45.7% for QI 2; both rates were statistically significantly lower than the corresponding MY 2016 rates by 10.7 percentage points for QI 1 and 11.1 percentage points for QI 2.

Table 3.2: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Indicators (Overall)

MY 2017						MY 2016 %	MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	
QI1 – HEDIS 7-Day Follow-up (Overall)									
Statewide	16,536	42,283	39.1%	38.6%	39.6%	43.5%	-4.4	Yes	Below 75th percentile, above 50th percentile
CBH	2,354	7,737	30.4%	29.4%	31.5%	41.1%	-10.7	Yes	Below 50th percentile, above 25th percentile
Philadelphia	2,354	7,737	30.4%	29.4%	31.5%	41.1%	-10.7	Yes	Below 50th percentile, above 25th percentile

MY 2017						MY 2016 %	MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	
QI2 – HEDIS 30-Day Follow-up (Overall)									
Statewide	25,630	42,283	60.6%	60.1%	61.1%	63.2%	-2.6	Yes	Below 75th percentile, above 50th percentile
CBH	3,533	7,737	45.7%	44.5%	46.8%	56.8%	-11.1	Yes	Below 25th percentile
Philadelphia	3,533	7,737	45.7%	44.5%	46.8%	56.8%	-11.1	Yes	Below 25th percentile

MY: measurement year; CI: confidence interval; N: numerator; D: denominator: PPD; percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

Figure 3.3 is a graphical representation of the MY 2017 HEDIS follow-up rates in the overall population for CBH and its associated HC BH Contractor.

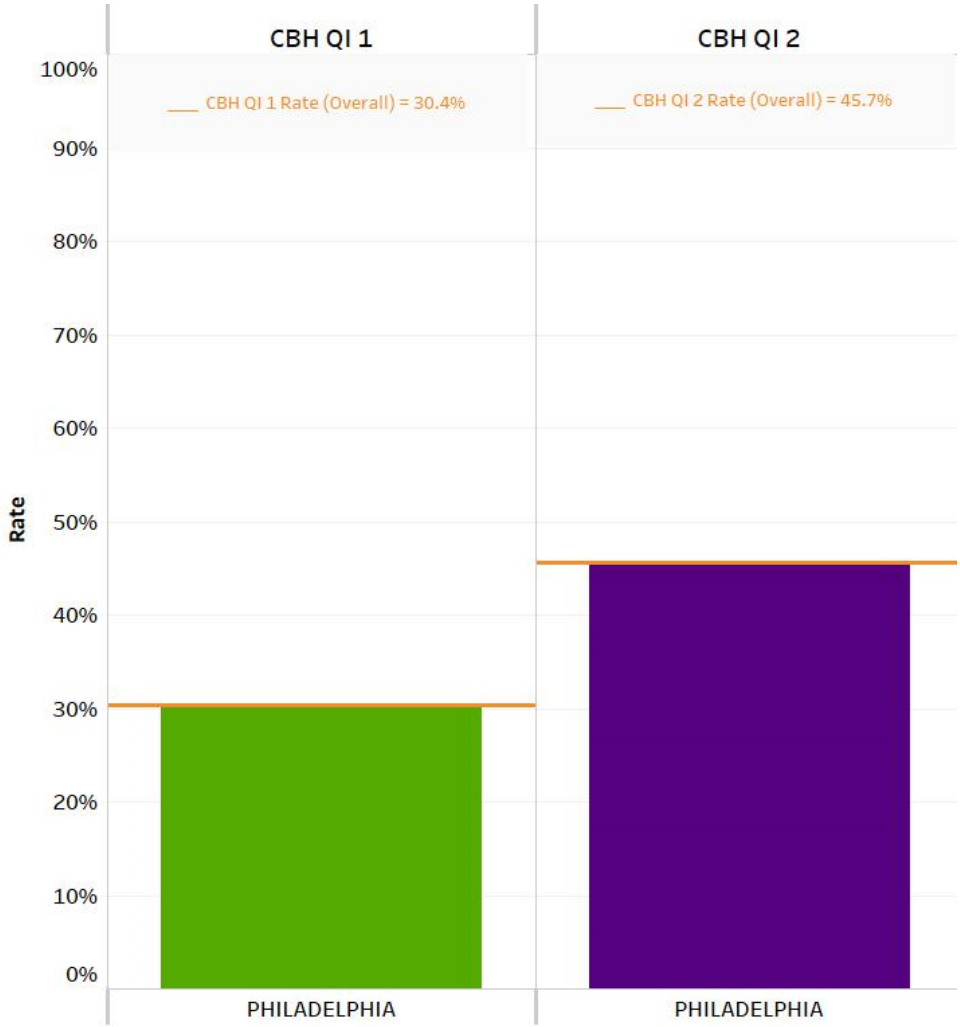

Figure 3.3: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (Overall).

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 2017 QI 1 HealthChoices (Statewide) rate of 39.1% by 8.7 percentage points. The QI 2 rate for Philadelphia was statistically significantly lower than the QI 2 HealthChoices (Statewide) rate of 60.6% by 14.9 percentage points.

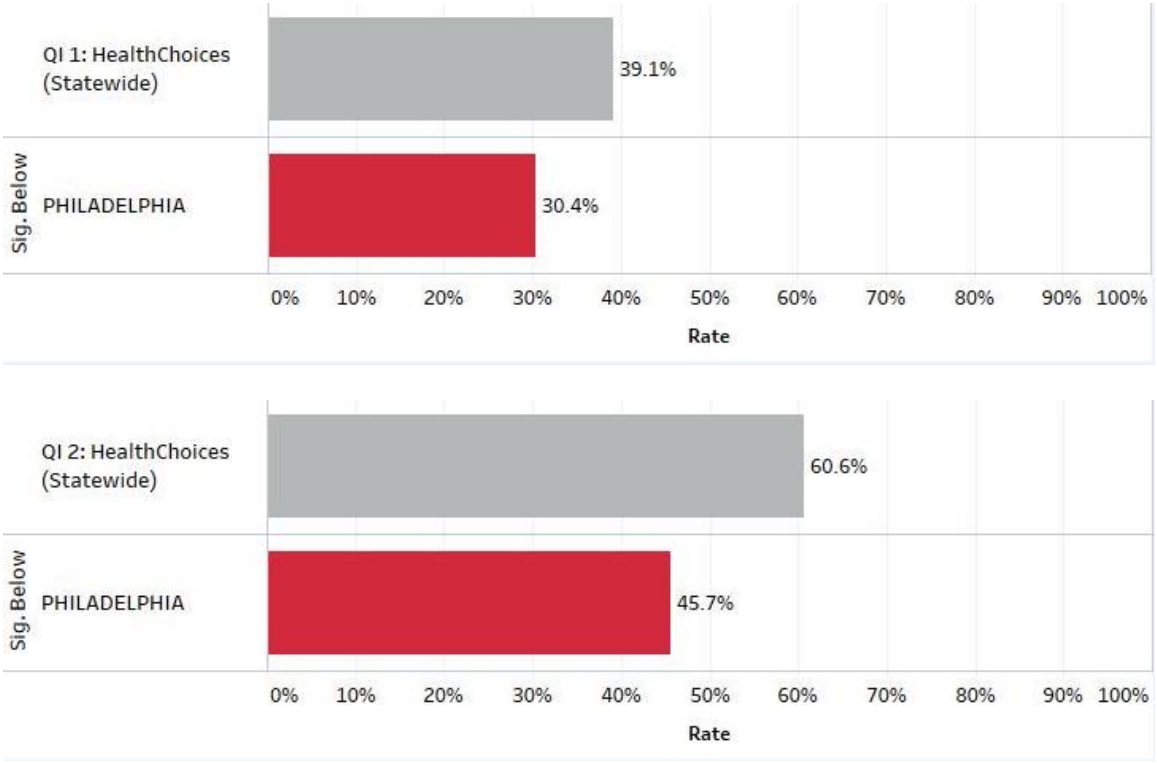

Figure 3.4: Comparison of CBH MY 2017 HEDIS FUH Follow-up Rates (Overall) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (Overall).

(c) Age Group: 6–20 Years Old

The MY 2017 HealthChoices Aggregate rates in the 6 to 20 year age group were 51.1% for QI 1 and 74.0% for QI 2 (**Table 3.3**). These rates were statistically significantly lower than the HealthChoices Aggregate rates in MY 2016, which were 56.1% and 77.4% respectively. The CBH MY 2017 HEDIS follow-up rates for members ages 6 to 20 were 49.7% for QI 1 and 66.4% for QI 2. Both QI1 and QI2 rates were statistically significantly lower than CBH's MY 2016 rates.

Table 3.3: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Indicators (6-20 Years)

MY 2017						MY 2016	MY 2017 Rate Comparison To MY 2016	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI1 – HEDIS 7-Day Follow-up (6-20 Years)								
Statewide	5,792	11,325	51.1%	50.2%	52.1%	56.1%	-5.0	Yes
CBH	824	1,659	49.7%	47.2%	52.1%	56.7%	-7.0	Yes
Philadelphia	824	1,659	49.7%	47.2%	52.1%	56.7%	-7.0	Yes
QI2 – HEDIS 30-Day Follow-up (6-20 Years)								
Statewide	8,380	11,325	74.0%	73.2%	74.8%	77.4%	-3.4	Yes
CBH	1,102	1,659	66.4%	64.1%	68.7%	75.9%	-9.5	Yes
Philadelphia	1,102	1,659	66.4%	64.1%	68.7%	75.9%	-9.5	Yes

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: Percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

Figure 3.5 is a graphical representation of the MY 2017 HEDIS follow-up rates in the 6 to 20 years old population for CBH and its associated HC BH Contractor.

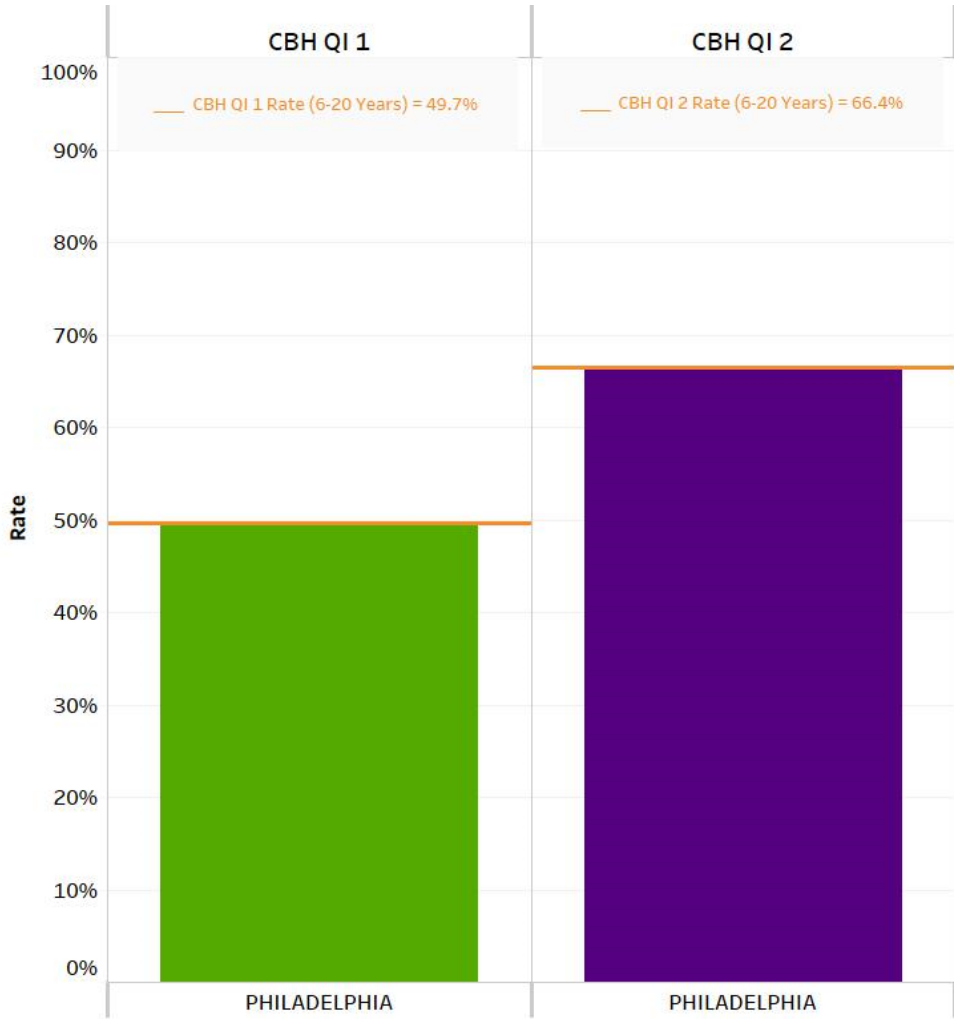

Figure 3.5: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (6-20 Years).

Figure 3.6 shows that the follow-up rates for Philadelphia were not statistically significantly different from the MY 2017 HealthChoices (Statewide) rate of 51.1% for QI 1. The QI 2 rate for Philadelphia was statistically significantly lower than the QI 2 HealthChoices (Statewide) rate of 74.0% by 7.6 percentage points.

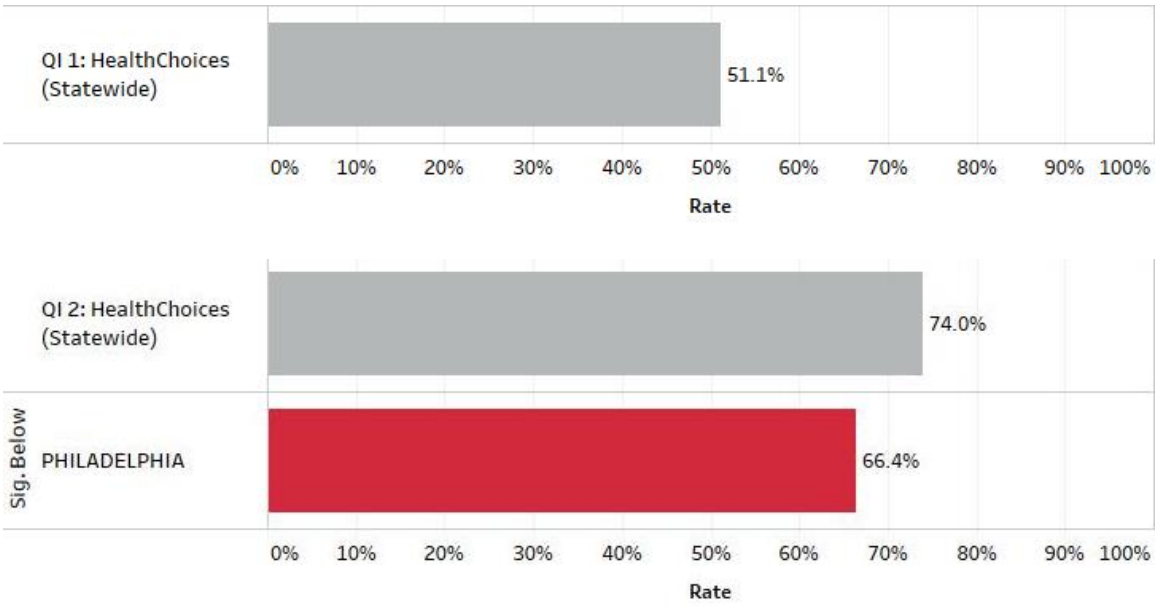

Figure 3.6: Comparison of CBH MY 2017 HEDIS FUH Follow-up Rates (6-20 Years) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (6-20 Years).

II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

The MY 2017 HealthChoices Aggregate rates were 52.2% for QI A and 69.6% for QI B (**Table 3.4**). Both rates demonstrated statistically significant decreases from the MY 2016 PA-specific follow-up rates: the QI A rate decreased from the MY 2016 rate of 53.8% by 1.6 percentage points, while the QI B rate decreased from the MY 2016 rate of 70.4% percentage points by 0.8 percentage points. The CBH MY 2017 PA-specific follow-up rates were 49.5% for QI A and 63.4% for QI B; however, the year-to-year rate differences were not statistically significant for either rate. The CBH MY 2017 PA-specific follow-up rate was lower than CBH's MY 2016 rate by 0.6 percentage points for QI A and by 1.3 percentage points for QI B.

Table 3.4: MY 2017 PA-Specific FUH 7- and 30-Day Follow-up Indicators (Overall)

MY 2017						MY 2016	MY 2017 Rate Comparison To MY 2016	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI A – PA-Specific 7-Day Follow-up (Overall)								
Statewide	22,071	42,280	52.2%	51.7%	52.7%	53.8%	-1.6	Yes
CBH	3,829	7,737	49.5%	48.4%	50.6%	50.1%	-0.6	No
Philadelphia	3,829	7,737	49.5%	48.4%	50.6%	50.1%	-0.6	No
QI B – PA-Specific 30-Day Follow-up (Overall)								
Statewide	29,440	42,280	69.6%	69.2%	70.1%	70.4%	-0.8	Yes
CBH	4,903	7,737	63.4%	62.3%	64.5%	64.7%	-1.3	No
Philadelphia	4,903	7,737	63.4%	62.3%	64.5%	64.7%	-1.3	No

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

Figure 3.7 is a graphical representation of the MY 2017 PA-Specific follow-up rates in the overall population for CBH and its associated HC BH Contractor.

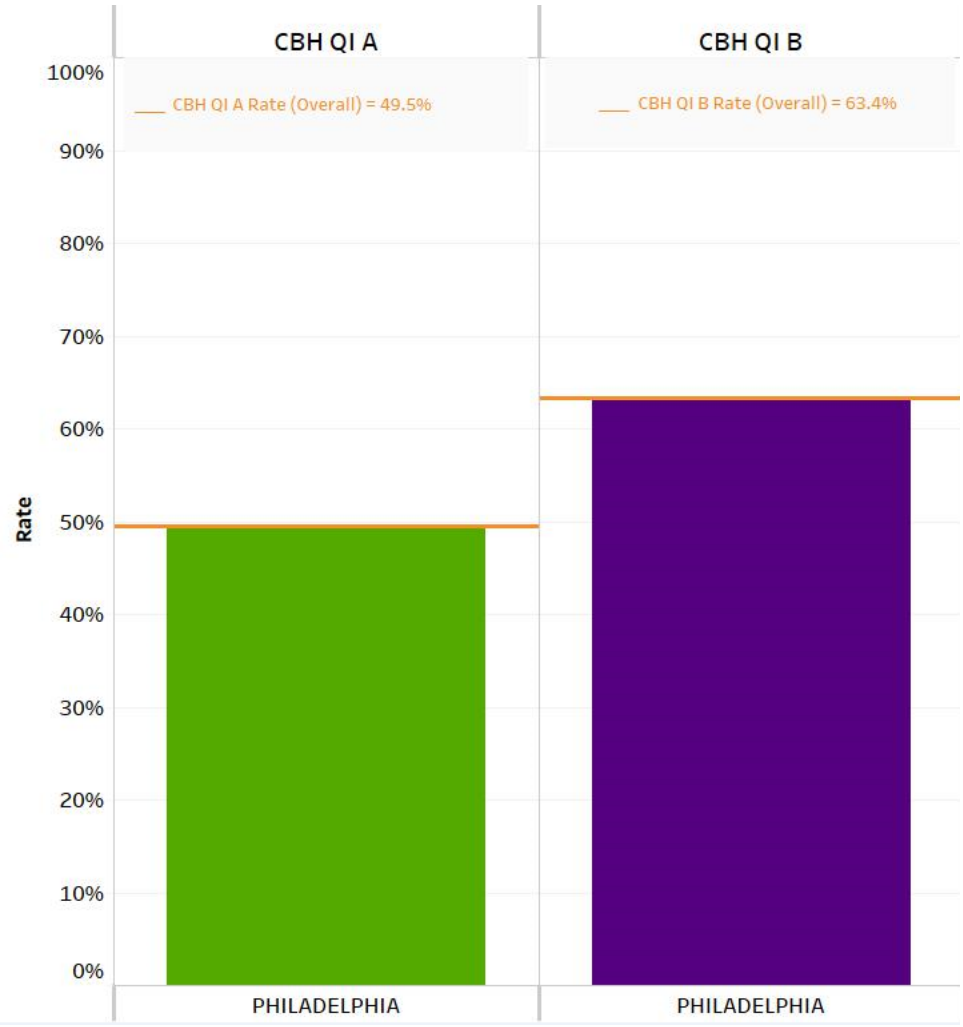

Figure 3.7: MY 2017 PA-Specific FUH 7- and 30-Day Follow-up Rates (Overall).

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 (Statewide) rate of 52.2% by 2.7 percentage points, and the QI B rate for Philadelphia was statistically significantly lower than the QI B HC BH (Statewide) rate of 69.6% by 6.2 percentage points.

Figure 3.8: Comparison of CBH MY 2017 PA-Specific FUH Follow-up Rates (Overall) versus HealthChoices (Statewide) MY 2017 PA-Specific FUH Follow-up Rates (Overall).

Conclusion and Recommendations

As with most reporting years, it is important to note that there were some changes to the HEDIS 2018 specifications, including the numerator exclusion of visits that occur on the date of discharge (although this exclusion did not extend to the PA-specific measure). That said, 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 2017 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 2017, 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 effort.
- 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 subpopulation. The potential impact on rates from the Medicaid expansion in 2017 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 2017 study conducted in 2018 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 2017. 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 29 HC BH Contractors participating in the MY 2017 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, 2017;
- 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 was 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 2017 to MY 2016 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. Statistically significant difference (SSD) at the 0.05 level between groups is 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% confidence interval (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 2017 HealthChoices Aggregate (Statewide) readmission rate was 13.4%, which represents a decrease from the MY 2016 HealthChoices Aggregate rate of 13.9% by 0.5 percentage points (**Table 3.5**); this difference was statistically significant. The CBH/Philadelphia County MY 2017 rate of 12.9% was not statistically significantly different from the MY 2016 rate of 13.5%.

Table 3.5: MY 2017 REA Readmission Indicators

MY 2017								MY 2017 Rate Comparison To MY 2016	
				95% CI					
Measure	(N)	(D)	%	Lower	Upper	Goal Met?*	MY 2016 %	PPD	SSD
Inpatient Readmission									
Statewide	7,121	52,977	**13.4%**	13.2%	13.7%	No	13.9%	-0.5	Yes
CBH	1,266	9,805	**12.9%**	12.2%	13.6%	No	13.5%	-0.6	No
Philadelphia	1,266	9,805	**12.9%**	12.2%	13.6%	No	13.5%	-0.6	No

* The OMHSAS-designated performance measure goal is a readmission rate at or below 10%.

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

Figure 3.9 is a graphical representation of the MY 2017 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 2017.

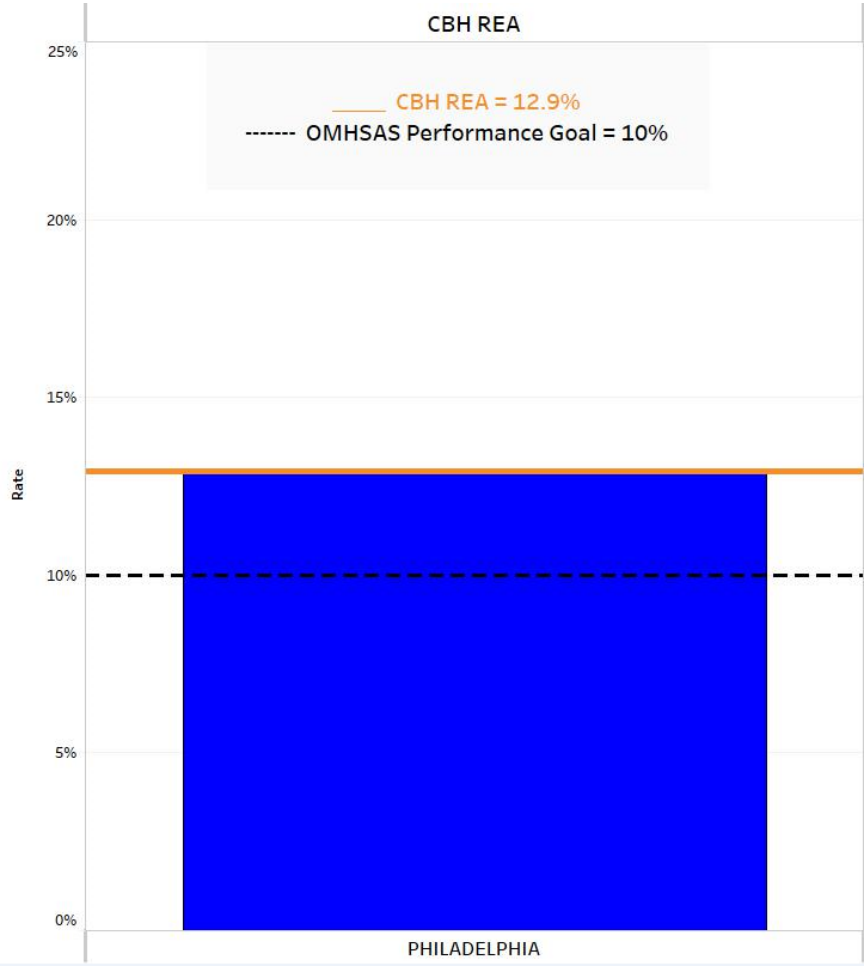

Figure 3.9: MY 2017 REA Readmission Rates for CBH.

Figure 3.10 shows that the Philadelphia County rate of 12.9% was not statistically significantly different from the HC BH (Statewide) rate of 13.4%.

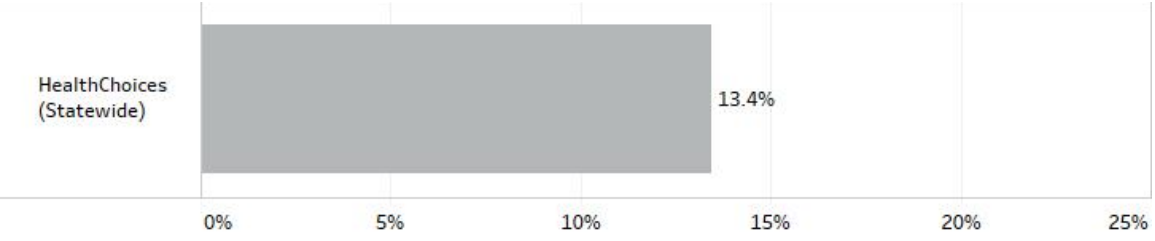

Figure 3.10: Comparison of CBH MY 2017 REA Readmission Rates (Overall) versus HealthChoices (Statewide) MY 2017 REA Readmission Rates (Overall).

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 statistically significant decrease of 0.5 percentage points in 2017. 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 2018 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 2017 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 2017, 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 CMS's Adult Quality Measure Grant Program, the 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's 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's 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 2017 and 2018. The measure was produced according to HEDIS 2018 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 2018 specifications, with one modification: members must be enrolled in the same PH-MCO and BH-MCO during the

continuous enrollment period (60 days prior to the index event, to 48 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 34 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% of adults had an alcohol use disorder problem, 2% met the criteria for a drug use disorder, and 1.1% 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 (ED), 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[1]

The entire eligible population was used for all 29 HC BH Contractors participating in the MY 2017 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, 2017;
- Continuously enrolled in both HealthChoices Behavioral Health and Physical Health from 60 days prior to the AOD diagnosis to 48 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 34 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 of both Physical Health and Behavioral Health encounters, only members who were enrolled in both Behavioral Health and Physical Health HealthChoices were included in this measure. The source for all

[1] HEDIS 2018 Volume 2 Technical Specifications for Health Plans (2018).

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 incomplete information 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-specific rates were calculated using the numerator and denominator for that particular HC BH Contractor. For each of these rates, the 95% 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+ years, and ages 13+ years) 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 2017 HealthChoices Aggregate (Statewide) rates in the 13–17 years age group were 46.3% for Initiation and 34.6% for Engagement (**Table 3.6**). These rates were statistically significantly higher compared to the MY 2016 13–17 years age group HealthChoices Aggregate rates of 38.5% and 26.0%, respectively. In MY 2017, the HealthChoices Aggregate rate for Initiation was between the HEDIS percentiles for the 50th and 75th percentiles, while the HealthChoices Aggregate rate for Engagement was at or above the 75th percentile. The CBH MY 2017 13–17 years age group Initiation rate was 55.3%, which was statistically significantly higher than the MY 2016 CBH rate of 45.0% by 10.3 percentage points. Similarly, the CBH MY 2017 13–17 years age group Engagement rate was 38.6%, which was statistically significantly higher than the MY 2016 rate of 30.9% by 7.7 percentage points. CBH's Initiation and Engagement rates for MY 2017 were at or above 75th percentiles.

Table 3.6: MY 2017 IET Initiation and Engagement Indicators (13–17 Years)

MY 2017							MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	
Numerator 1: Initiation of AOD Treatment (13–17) Years									
Statewide	1316	2843	**46.3%**	44.4%	48.1%	38.5%	7.8	YES	Below 75th Percentile, Above 50th Percentile
CBH	308	557	**55.3%**	51.1%	59.5%	45.0%	10.3	YES	At or Above 75th Percentile
Philadelphia	308	557	**55.3%**	51.1%	59.5%	45.0%	10.3	YES	At or Above 75th Percentile
Numerator 2: Engagement of AOD Treatment (13–17) Years									
Statewide	984	2843	**34.6%**	32.8%	36.4%	26.0%	8.6	YES	At or Above 75th Percentile
CBH	215	557	**38.6%**	34.5%	42.7%	30.9%	7.7	YES	At or Above 75th Percentile
Philadelphia	215	557	**38.6%**	34.5%	42.7%	30.9%	7.7	YES	At or Above 75th Percentile

MY: measurement year; CI: confidence interval N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; AOD: alcohol or other drug dependence; CBH: Community Behavioral Health.

Figure 3.11 is a graphical representation of the MY 2017 HEDIS follow-up rates in the 13–17 years age population for CBH and its associated HC BH Contractor.

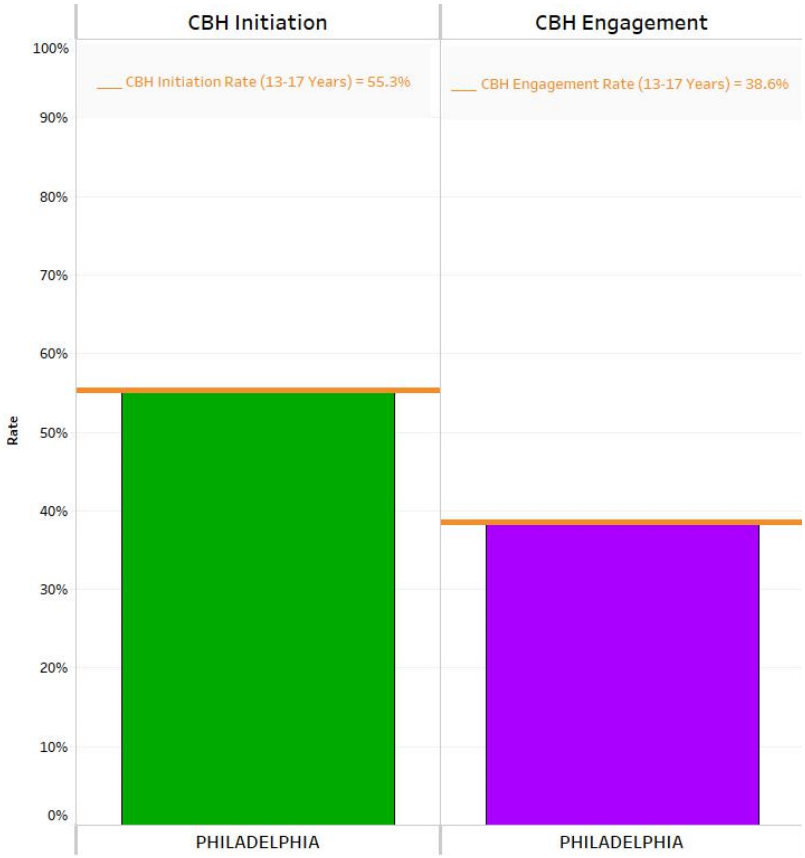

Figure 3.11: MY 2017 IET Initiation and Engagement Rates (13–17 Years).

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, Philadelphia County was statistically significantly above the HC BH (Statewide) rate of 46.3% for Initiation by 9 percentage points. Philadelphia's engagement rate was comparable with the HC BH (Statewide) rate of 34.6%.

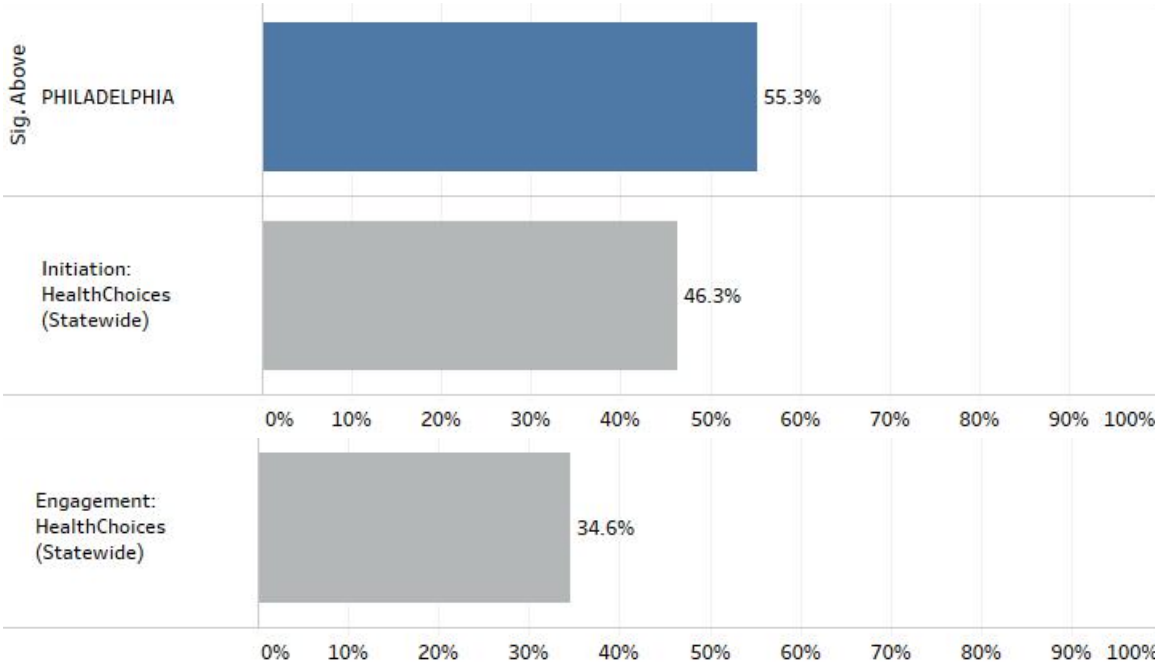

Figure 3.12: Comparison of CBH MY 2017 IET Rates (13–17 Years) versus HealthChoices (Statewide) MY 2017 IET Rates (13–17 Years).

(b) Age Group: 18+ Years Old

The MY 2017 HealthChoices Aggregate rates in the 18+ years age group were 41.1% for Initiation and 33.7% for Engagement (**Table 3.7**). Both rates were statistically significantly higher than the corresponding MY 2016 rates: the HealthChoices Aggregate Initiation rate increased by 15.5 percentage points and the Engagement rate increased by 16.9 percentage points from the prior year. The MY 2017 HealthChoices Aggregate Initiation rate in this age cohort was above the HEDIS 2018 25th percentile and below 50th percentile, while the Engagement rate was at or above 75th percentiles. The CBH MY 2017 Initiation rate for the 18+ years population was 36.0%, which was below the HEDIS 2018 25th percentile. CBH's MY 2017 rate increased significantly from MY 2016 rate by 13.7 percentage points. The CBH MY 2017 Engagement rate for this age cohort was 28.5%, which was at or above the HEDIS 2018 75th percentile. The CBH Engagement rate for this age group was statistically significantly higher than the MY 2016 rate of 13.9% by 14.6 percentage points.

Table 3.7: MY 2017 IET Initiation and Engagement Indicators (18+ Years)

MY 2017							MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	
Numerator 1: Initiation of AOD Treatment (18+ Years)									
Statewide	27307	66505	**41.1%**	40.7%	41.4%	25.6%	15.5	YES	Below 50th Percentile, Above 25th Percentile
CBH	5404	15010	**36.0%**	35.2%	36.8%	22.3%	13.7	YES	Below 25th Percentile
Philadelphia	5404	15010	**36.0%**	35.2%	36.8%	22.3%	13.7	YES	Below 25th Percentile
Numerator 2: Engagement of AOD Treatment (18+ Years)									
Statewide	22379	66505	**33.7%**	33.3%	34.0%	16.8%	16.9	YES	At or Above 75th Percentile
CBH	4272	15010	**28.5%**	27.7%	29.2%	13.9%	14.6	YES	At or Above 75th Percentile
Philadelphia	4272	15010	**28.5%**	27.7%	29.2%	13.9%	14.6	YES	At or Above 75th Percentile

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; AOD: alcohol or other drug dependence; CBH: Community Behavioral Health.

Figure 3.13 is a graphical representation of the 18+ years age group MY 2017 HEDIS Initiation and Engagement rates for CBH and its associated HC BH Contractor.

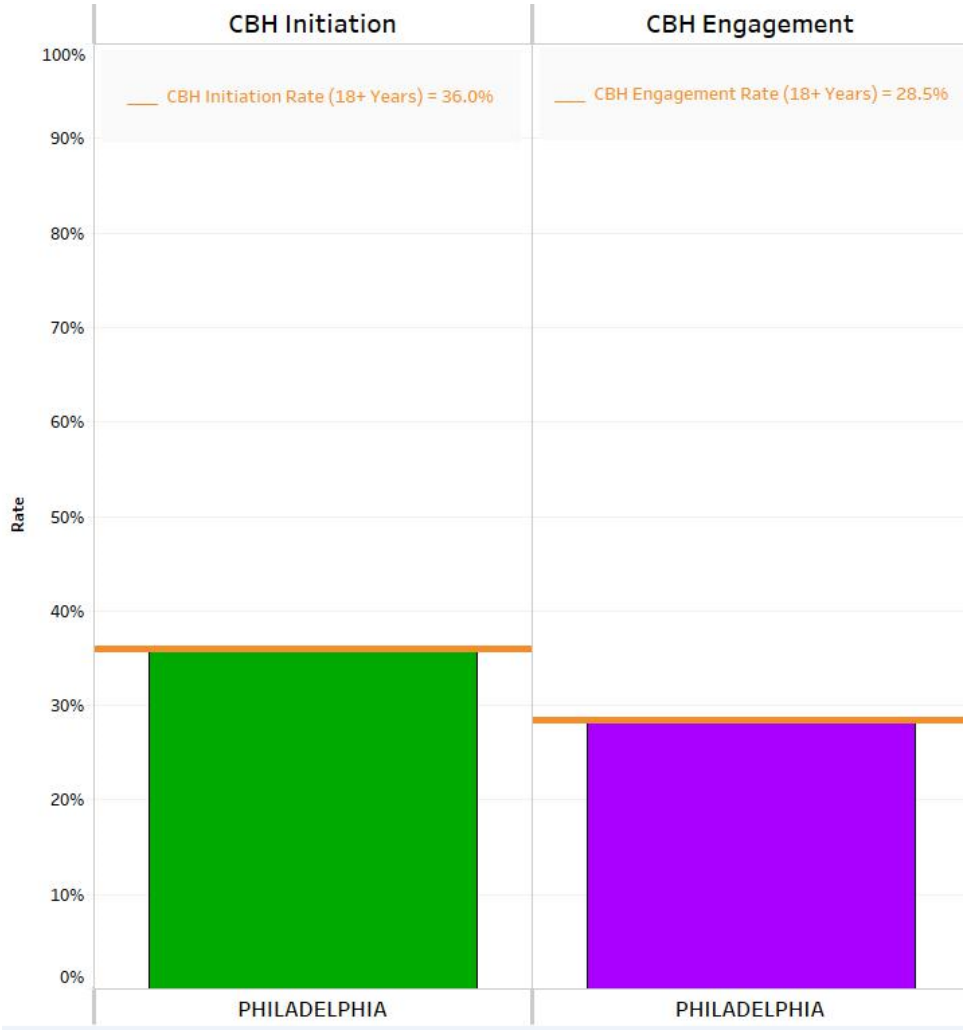

Figure 3.13: MY 2017 IET Initiation and Engagement Rates (18+ Years).

Figure 3.14 is a graphical representation of the MY 2017 HEDIS follow-up rates in the 18+ years age group population for CBH and its associated HC BH Contractor. For both rates, Philadelphia County was statistically significantly below the HC BH (Statewide) rate of 41.1% for Initiation and 33.7% for Engagement by 5.1 and 5.2 percentage points, respectively.

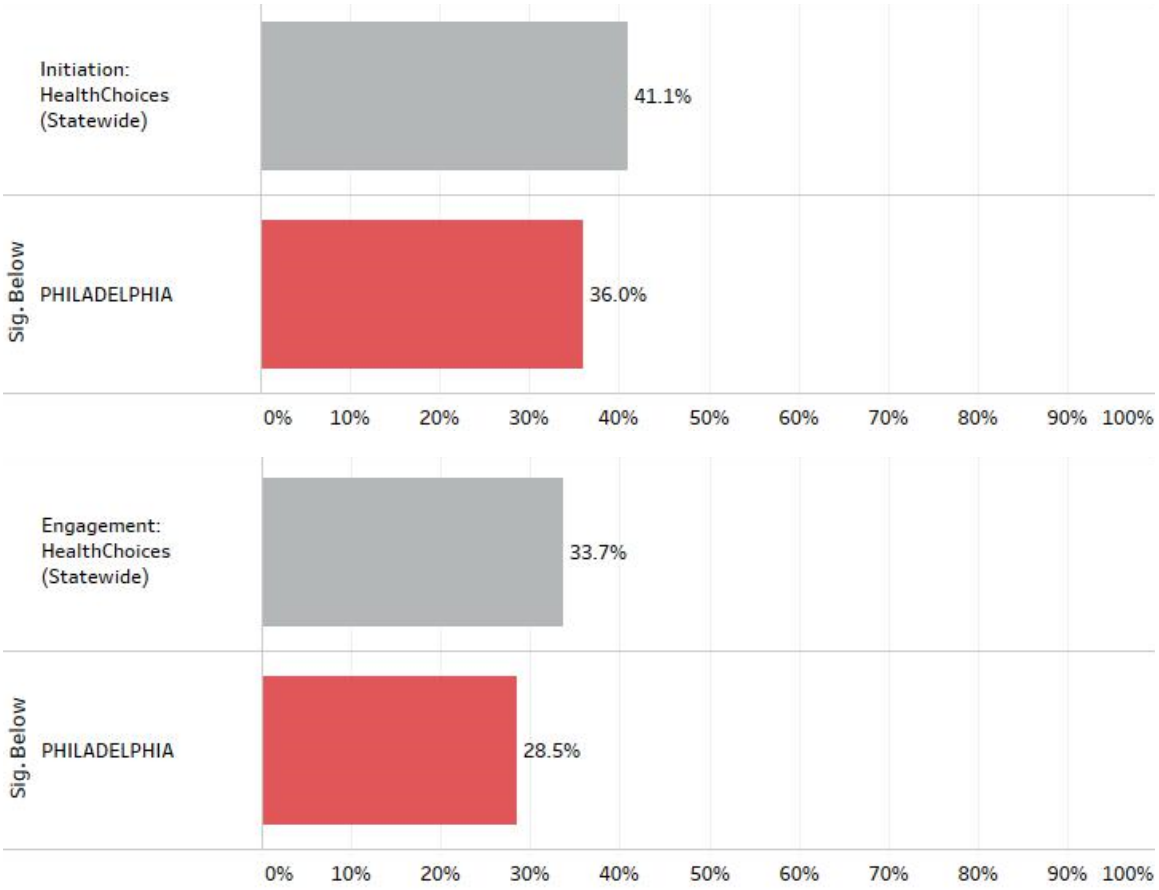

Figure 3.14: Comparison of CBH Contractor MY 2017 IET Rates (18+ Years) versus HealthChoices (Statewide) MY 2017 IET Rates (18+ Years).

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

The MY 2017 HealthChoices Aggregate rates in the 13+ years age group were 41.3% for Initiation and 33.7% for Engagement (**Table 3.8**). The Initiation rate was statistically significantly higher than the MY 2016 Initiation rate by 15.1 percentage points, and the Engagement rate was statistically significantly higher than the MY 2016 Engagement rate by 16.5 percentage points. The MY 2017 HealthChoices Aggregate Initiation rate was above the HEDIS 2018 25th percentile and below the 50th percentile, while the Engagement rate was at or above the 75th percentile. The CBH MY 2017 Initiation rate for the 13+ years age population was 36.7%, which was below the HEDIS 2018 25th percentile. The CBH MY 2017 Engagement rate was 28.8%, and was at or above the HEDIS 75th percentile. For CBH, both its Initiation and its Engagement rates were statistically significantly higher than their corresponding MY 2016 rates.

Table 3.8: MY 2017 IET Initiation and Engagement Indicators (Overall)

MY 2017							MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	
Numerator 1: Initiation of AOD Treatment (Overall)									
Statewide	28623	69348	**41.3%**	40.9%	41.6%	26.2%	15.1	YES	Below 50th Percentile, Above 25th Percentile
CBH	5712	15567	**36.7%**	35.9%	37.5%	23.0%	13.7	YES	Below 25th Percentile
Philadelphia	5712	15567	**36.7%**	35.9%	37.5%	23.0%	13.7	YES	Below 25th Percentile
Numerator 2: Engagement of AOD Treatment (Overall)									
Statewide	23363	69348	**33.7%**	33.3%	34.0%	17.2%	16.5	YES	At or Above 75th Percentile
CBH	4487	15567	**28.8%**	28.1%	29.5%	14.4%	14.4	YES	At or Above 75th Percentile
Philadelphia	4487	15567	**28.8%**	28.1%	29.5%	14.4%	14.4	YES	At or Above 75th Percentile

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; AOD: alcohol or other drug dependence; CBH: Community Behavioral Health.

Figure 3.15 is a graphical representation of the MY 2017 HEDIS follow-up rates in the overall population for CBH and its associated HC BH Contractor.

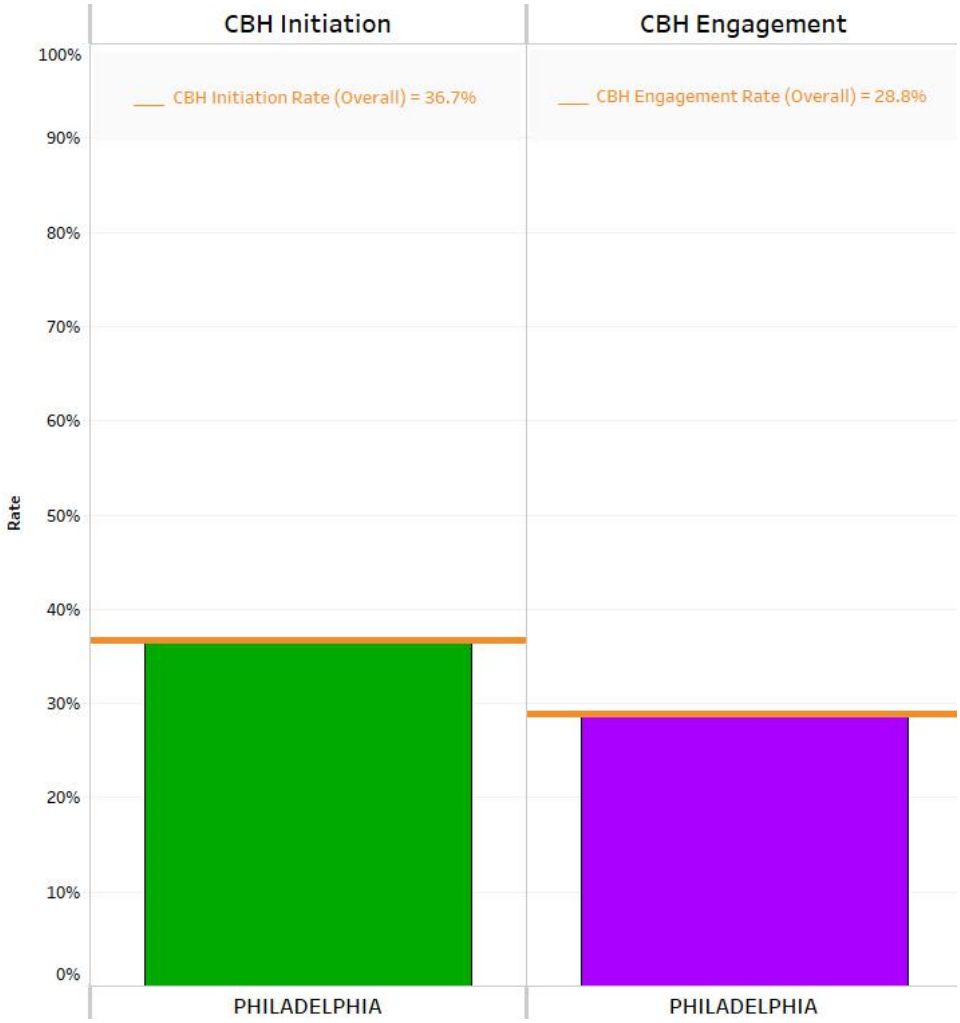

Figure 3.15: MY 2017 IET Initiation and Engagement Rates (Overall).

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 County were statistically significantly lower than the HC Statewide rate for Initiation (by 4.6 percentage points) and Engagement (by 4.9 percentage points).

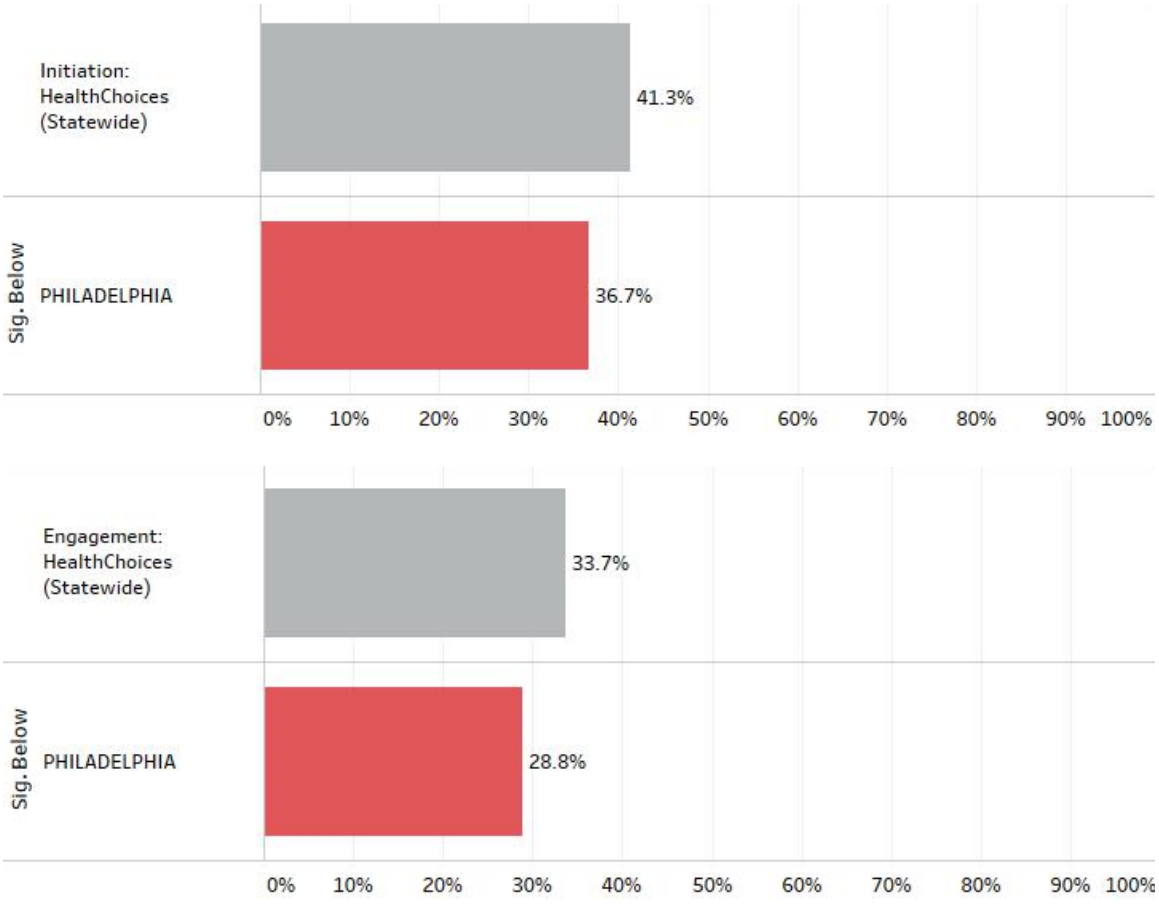

Figure 3.16: Comparison of CBH MY 2017 IET Rates (Overall) versus HealthChoices (Statewide) MY 2017 IET Rates (Overall).

Conclusion and Recommendations

For MY 2017, the aggregate HealthChoices rate in the overall population was 41.3% for the Initiation rate and 33.7% for the Engagement rate. The Initiation rate was above the HEDIS 25th percentile and below 50th percentile, while the Engagement rate was at or above the 75th percentile. Both the Initiation and the Engagement rates statistically significantly increased from MY 2016 rates. As seen with other performance measures, there is significant variation between the HC BH Contractors. Overall, BH HC Contractor CBH performed better in Engagement rates, meeting or exceeding the HEDIS goal of 75th percentile. As with most reporting years, it is important to note that there were some changes to the HEDIS 2018 specifications, including the extension of the Engagement of AOD Treatment time frame to 34 days from 30 days and the addition of Medication Assisted Treatment. 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, CBH should focus on the Initiation rate, as it was below the 75th percentile for this measure.

IV: Quality Studies

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

Certified Community Behavioral Health Clinics

On July 1, 2017, Pennsylvania launched its SAMHSA-funded Certified Community Behavioral Health Clinics (CCBHCs) Demonstration Project ("Demonstration"), to run through June 30, 2019. The purpose of the Demonstration is to develop and test an all-inclusive (and all-payer) prospective payment system model for community clinics to integrate behavioral and physical health care services in a more seamless manner. The model is centered on the provision of nine core services. Crisis services, screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services are provided directly by the CCBHCs. The other services may be provided through a contract with a Designated Collaborating Organization (DCO). To receive CCBHC certification, clinics also had to provide a minimum set of Evidence Based Practices (EBP), which was selected based on community needs assessments and centered on recovery-oriented care and support for children, youth, and adults. Seven clinics were eventually certified and participated: Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA). In several cases, CCBHC-certified clinics share agreements with one or more DCOs to supplement the core services provided at the clinic. The counties covered by these clinics span three BH-MCOs: CBH, CCBH, and MBH.

In 2017, activities focused on implementing and scaling up the CCBHC model within the seven clinic sites. Data collection and reporting is a centerpiece of this quality initiative in two important ways. First, the CCBHC Demonstration in Pennsylvania features a process measure Dashboard, hosted by the EQRO through REDCap, whereby clinics are able to monitor progress on the implementation of their CCBHC model. From July through December 2017—the Dashboard was operational in October 2017—clinics tracked and reported on clinical activities in a range of quality domains reflecting the priorities of the initiative: clinic membership, process, access and availability, engagement, evidence-based practices, and satisfaction. The Dashboard provides for each clinic a year-to-date (YTD) comparative display that shows clinic and statewide results on each process measure, as well as average scores for three domains of the satisfaction surveys (see below): convenience of provider location, satisfaction with provider services, and timeliness and availability of appointments. In support of this, and to ensure alignment with SAMHSA reporting requirements, a data dictionary (and spreadsheet template) was developed for the clinics to use in reporting their monthly, quarterly, and YTD results in the Dashboard. These Dashboard results were reported out to a CCBHC Stakeholder Committee at the end of the two quarters.

A second important feature of the Demonstration is an assessment, to be completed at its conclusion by the EQRO, to test whether the CCBHC clinics perform significantly better over the demonstration period compared to a control group of clinics located under the same HC BH contractors as the CCBHC clinics. Measurement of performance, in terms of both quality as well as overall cost, will span multiple areas and scales, involving a variety of administrative sources, medical records, and other sources. Several measures in the CCBHC measure set, including those reported directly by clinics (primarily medical record-based), are placed in a Quality Bonus Payment (QBP) program. To support this reporting, clinics in 2017 collected and reported baseline data on quality measures. The EQRO also used SurveyMonkey to support the administration and collecting of person-experience-of-care surveys for adults (PEC) as well as for children and youth (Y/FEC). Finally, in the latter half of 2017, clinics began to collect and report on a quarterly basis, consumer-level files documenting various relevant characteristics of their CCBHC consumers, including housing, veteran, and insurance statuses. Throughout the process, OMHSAS and EQRO provided technical assistance focused on data collection, management, and reporting, where much of the focus was on walking through the quality and process measures and their operationalization using the clinics' data plans. In this respect, 2017 was a period of building up the capacity of the clinics to bring the vision of the CCBHC Demonstration to its full fruition. Results from Demonstration year (DY) 1 will be reported in next year's BBA report.

V: 2017 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 2017 EQR Technical Reports, which were distributed in April 2017. The 2017 EQR Technical Report is the 11th report to include descriptions of current and proposed interventions from each BH-MCO that address the (2017) 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 June 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 for improvement cited by IPRO in the 2017 EQR Technical Report, detailing current and proposed interventions.

Table 5.1: CBH Responses to Opportunities for Improvement

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) 2014, RY 2015, and RY 2016 found CBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/18/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
CBH 2017.01	Within Subpart C: Enrollee Rights and Protections Regulations, CBH was partially compliant on 1 out of 7 categories – Enrollee Rights.	Ongoing	CBH is currently awaiting a response from OMHSAS regarding a request for exemption to PS&R Appendix H changes before instituting changes to the training curriculum.
CBH 2017.02	CBH was partially compliant with 3 out of 10 categories and non-compliant with 1 out of 10 categories within Subpart D: Quality Assessment and Performance	March 2017, ongoing	CBH conducts monthly denial notice audits. Sample Doctor's Denial Note Audit Tool and Summary is attached.  Doctor's Denial Note Audit Tool and Findin

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) 2014, RY 2015, and RY 2016 found CBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/18/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
	Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, and 3) Practice Guidelines. The non-compliant category was: Coordination and Continuity of Care.	October 2018	Denial Notice training for all clinical staff, including Physician/Psychologist Advisors, is scheduled for October 26, 2018.
CBH 2017.03	CBH was partially compliant with 8 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.	February 2018	Conduct monthly audits of complaints and grievances. Audit tools are attached.  C&G Audit Tools 2017.xlsx The following revised documents were submitted to OMHSAS on February 21, 2018, for approval.  CAP_Supporting_Documentation_.zip

CBH: Community Behavioral Health.

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 2016, 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 (Federal and State Grievance System Standards Regulations). The partially compliant categories within Subpart F 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, and 8) 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 10th year for which BH-MCOs would have been required to prepare a Root Cause Analysis and Action Plan for performance measures that were 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 change meant, among other things, eliminating the requirement to complete root cause analyses (RCAs) and corresponding action plans (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 Value-Based Payment (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 2017, while BH-MCOs completed their RCAs and CAPs by December 31, 2017. In 2018, coinciding with the carve-in of long-term care, OMHSAS directed BH-MCOs to begin focusing their RCA and CAP work on the HEDIS FUH All Ages measure and implemented a new goal-setting logic to spur performance improvement in the measure. Based on the MY2017 performance, all five BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and CAPs to achieve their MY 2019 goals. HC BH Contractors that scored below the 75th NCQA Quality Compass percentile were also asked to submit RCAs and CAPs. All five BH-MCOs submitted their RCAs and CAPs on April 1, 2019. HC BH Contractors will be submitting their RCAs and CAPs by April 30, 2019.

MY 2016 RCAs and CAPs, already completed last year, are included in this 2018 BBA report. **Table 5.2** presents CBH's submission of its RCA and CAP for the FUH 6-64 years 7- and 30-day measures.

Table 5.2: CBH RCA and CAP for the FUH 7- and 30-Day Measures (6–64 Years)

HealthChoices BH Contractor: Community Behavioral Health	**Measure:** Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	**Response Date:** 12/29/17
Goal Statement: (Please specify individual goals for each measure):		
Analysis: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.	**Findings** **CBH completed a fishbone diagram to begin the root cause analysis process. The fishbone diagram is attached.** Follow-up Fishbone FINAL.docx	
People (1) CBH is not consistently connecting with members to ensure initial aftercare appointments are scheduled within 7 days of discharge from an acute inpatient (AIP) facility. 1b. CBH was not enforcing the requirement for 24-hour submission of discharge information that is stated in its agreement with the providers. 1c. CBH was not prioritizing receiving discharge information from providers and, even when received, entry of the information into the CBH electronic health record was not prioritized. 1d. Time and resource constraints at CBH resulted in CBH prioritizing the completion of initial and concurrent reviews.	**Initial Response:** Baseline data show that it was taking CBH Member Services an average of 8.02 days to follow-up with members after an AIP discharge.	
	Follow-up Status Response: **Root Cause:** Time and resource constraints at CBH resulted in CBH prioritizing the completion of initial and concurrent reviews. **Determination:** Attainable and impactful. Time and resource constraints prevented CBH Clinical Management from obtaining and entering discharge information from AIPs in a timely manner to allow CBH Member Services to follow up with members within 7 days of a member's discharge from an AIP. By prioritizing the obtaining of discharge information from AIPs and the entering of discharge information into CBH's clinical information system, CBH will be able to reduce the time it takes for CBH to obtain discharge information from AIPs and enter it into the CBH electronic health record, and to provide a follow-up call to members within 7 days of discharge from an AIP. The summary report for the telephonic project is attached. telephonicpilotphase 3.pdf	
People (2.1) Member does not follow up with aftercare recommendations. 2.1.b. Members do not understand the discharge plan. 2.1.c. AIPs do not spend sufficient time to explain the Discharge Management Plan (DMP) to members. 2.1.d. Staff resources at AIP are limited and they do not have the time. 2.1.e. AIP staff have high case/work loads. 2.1.f. Discharge planning is a low priority for AIPs.	**Initial Response:** Eight months of data collection (1/1–8/31/2017) showed that only 62.3% of members stated they understood their DMP and only 43.7% said they followed through with their DMP. Additionally, if a member reported that they did not understand their DMP, 91.8% did not follow through with the DMP recommendations. The results of the readmission survey are attached. ReadmissionSurveys 2ndEval 11_8_17.pdf	
	Follow-up Status Response: **Root Cause:** Discharge planning is not prioritized at AIPs. **Determination:** Attainable and impactful. Discharge planning is not prioritized at AIPs and the purpose of AIP treatment is not explained to members. In addition, the AIPs are not given sufficient time to engage in the psycho-educational component of the discharge management plan (i.e., explaining the different components of	

	the discharge plan). CBH will address this through a retraining of the Clinical Care Management staff, enhancing the concurrent review process, and through the 7-day 30-day action plan intervention.
People (2.2) Member does not follow up with aftercare recommendations. 2.2.b. Member felt they were discharged too soon. 2.2.c. Member felt they had unmet needs (e.g., housing, income). 2.2.d. Member does not understand purpose of AIP stay. 2.2.e. AIP staff does not explain the purpose of an AIP stay to member. 2.2.f. Discharge planners are not aware that the explanation of the purpose of an AIP stay is their responsibility.	**Initial Response:** Same as 2.1. **Follow-up Status Response:** **Root Cause:** Discharge planners are not aware that the explanation of the purpose of an AIP stay is their responsibility. **Determination:** Attainable and impactful. Same as 2.1.
People (2.3) Member does not follow up with aftercare recommendations. 2.3.b. Member does not perceive a need for aftercare. 2.3.c. Member feels better. 2.3.d. AIP treatment provided relief of symptoms that may be temporary. 2.3.e. Member does not understand the chronic nature of mental illness. 2.3.f. AIP does not spend sufficient time to explain DMP to member (psycho-education component of DMP).	**Initial Response: Member sees no perceived need for aftercare** **Follow-up Status Response:** Same as 2.1.
People (3.1) Members do not follow through with the aftercare provider identified in DMP, but rather a provider of their choice. 3.1.b. Members are not involved in discharge planning decisions. 3.1.c. AIPs are not engaging members regarding their aftercare planning. 3.1.d. AIP discharge planners do not have sufficient time to engage members. 3.1.e. Other operational/ administrative concerns take priority. 3.1.f. AIPs place emphasis on members' stabilization during their AIP stay only.	**Initial Response:** Follow-up rates may improve if discharge planning considered the members' preference of provider for aftercare. **Follow-up Status Response:** **Root Cause:** AIPs place emphasis on members' stabilization during their AIP stay only. **Determination:** Not impactful. Although members go to a different provider, they are still considered to be completing follow-up and would meet the 7-day/30-day follow-up measure. Any intervention to address this root cause would not impact the overall 7-day/30-day follow-up measures.
People (3.2) Members do not follow through with the aftercare provider identified in DMP, but rather a provider of their choice. 3.2.b. Member is not involved in discharge	**Initial Response:** Same at 3.1 **Follow-up Status Response:** **Root Cause:** AIPs have prior positive experience with providers they refer to frequently (ease of referral and known slot availability).

HealthChoices BH Contractor: Community Behavioral Health	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date: 12/29/17
planning decision. 3.2.c. AIPs are not engaging members regarding their aftercare planning. 3.2.d. AIPs are referring to provider(s) that they prefer (have an established relationship with certain outpatient providers). 3.2.e. AIPs have prior positive experience with providers they refer to frequently (ease of referral and known slot availability).	**Determination:** Not impactful. Same as 3.1.	
People (4.1) Following discharge, AIPs are not following up with members. 4.1.b. AIPs are not prioritizing follow-up after discharge. 4.1.c. Insufficient financial incentives for AIPS to follow up. 4.1.d. Financial cost versus benefits obtained from completing follow-ups is not favorable for AIPs. 4.1.e. Investment in completing follow-up is not seen as fiscally responsible by AIPs.	**Initial Response:** Follow-up rates could be improved if AIPs made follow-up calls to members to make sure they made it to their follow-up appointment. **Follow-up Status Response:** **Root Cause:** Investment in completing follow-up is not seen as fiscally responsible by AIPs. **Determination:** Neither attainable nor impactful. CBH does not have data to support the assumption that providers are not following up with members post-inpatient discharge.	
People (4.2) Following discharge, AIP providers are not following up with members. 4.2.b. AIPS do not believe follow-up is effective. 4.2.c. AIPS believe they do not have control of members' behaviors. 4.2.d. Follow-up is seen as the responsibility of outpatient providers and members.	**Initial Response:** Same as 4.1. **Follow-up Status Response:** **Root Cause:** Follow-up is seen as the responsibility of outpatient providers and members. **Determination:** Neither attainable nor impactful. Same as 4.1.	
People (4.3) Following discharge, AIP providers are not following up with members. 4.3.b. AIPs believes they are no longer responsible for member. 4.3.c. AIPs do not define follow-up as part of inpatient treatment episode. 4.3.d. Follow-up is seen as the responsibility of outpatient providers and members.	**Initial Response:** Same as 4.1. **Follow-up Status Response:** **Root Cause:** Follow-up is seen as the responsibility of outpatient providers and members. **Determination:** Neither attainable nor impactful. Same as 4.1.	
Providers (1.1) No warm handoff from AIPs to an outpatient provider. 1.1.b. Lack of relationships between AIP and outpatient providers. 1.1.c. Difficulty connecting (e.g., scheduling	**Initial Response:** Baseline data, which were presented at the Inpatient/Outpatient Provider Forum (attached), show that members who use outpatient services after discharge experience a 53% reduction in risk of readmission compared to those members that do not use outpatient services. Of those members that readmit within 30 days, more than two-thirds readmit within the first two	

HealthChoices BH Contractor: Community Behavioral Health	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date: 12/29/17
conflicts, no clear contact person at outpatient/inpatient). 1.1.d. No clear process to facilitate communication. 1.1.e. Complexity due to volume and staff turnover at inpatient and outpatient providers. 1.1.f. No clear owner of this process at inpatient, outpatient, or CBH to establish regular communication and relay information from inpatient to outpatient providers.	weeks. In addition, 65% of members that attended outpatient services prior to an inpatient hospitalization continued outpatient treatment after discharge, but only 25% of members who had not attended outpatient services prior to an inpatient hospitalization started outpatient treatment after discharge.  draft Adult AIP Forum 2017.pptx **Follow-up Status Response:** **Root Cause:** No clear owner of this process at inpatient, outpatient, or CBH to establish regular communication and relay information from inpatient to outpatient providers. **Determination:** Attainable and impactful. In order to facilitate follow-up connections, CBH will create a standardized report for outpatient providers advising them of members who were previously enrolled in treatment with them but have been hospitalized.	
Providers (1.2) No warm handoff from AIP provider to outpatient provider. 1.2.b. Lack of relationships between AIP and outpatient providers. 1.2.c. No mechanism to reimburse outpatient providers to do discharge planning work while member is still inpatient. 1.2.d. CBH is currently unable to process a claim for outpatient services while a member is inpatient. 1.2.e. Current billing rules view this as a duplication of services.	**Initial Response:** Same as 1.1. **Follow-up Status Response:** **Root Cause:** Current billing rules view this as a duplication of services. **Determination:** Not attainable. Currently, an outpatient provider can only bill for an inpatient visit if they are approved to provide mobile mental health treatment. Most providers have chosen not to pursue mobile mental health treatment, and billing rules would have to be changed at the state level for CBH to be permitted to pay for a warm handoff visit.	
Providers (2) Discharge planning happening on last day of an AIP stay. 2.b. Administrative burdens on AIP discharge planners with many competing tasks/duties to be completed. 2.c. AIPs do not see discharge planning as a priority. 2.d. Discharge planning is not viewed as component of active treatment. 2.e. AIPs see the main goal of AIP treatment as stabilization.	**Initial Response:** All four of the participating AIPs participating in the DMP audits were tasked with creating a swim lane process flow of their Discharge Management Planning Process. All four facilities identified that discharge management planning began on the day of discharge. The swim lane process flow activity can be found in the attached PowerPoint slide deck.  DMP Audit Presentations MASTE **Follow-up Status Response:** **Root Cause:** AIPs see the main goal of AIP treatment as stabilization. **Determination:** Attainable and impactful. AIPs view the main goal of treatment to be stabilization, and discharge planning is less of a priority in the overall treatment process. CBH will address this root cause through a retraining of the Clinical Care Management staff and enhancing the concurrent review process. This will	

HealthChoices BH Contractor: Community Behavioral Health	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date: 12/29/17
	ensure that AIPs begin the DMP process through initial and concurrent reviews with CBH Clinical Management staff.	
Policies/Procedures (1) Lack of mobile services for adults (mobile therapy, ACT).1.b. CBH and AIPs have not identified mobile services as an area of need for adults. 1.c. Assumption made that adults are self-sufficient enough to get to appointments. 1.d. CBH and AIPs underestimate the barriers/challenges that adult members face. 1.e. CBH has not asked members or providers sufficiently about barriers/challenges.	**Initial Response:** Results from eight months of data collection (1/1–8/31/2017) showed that when members were asked "Why do you believe you were readmitted?", 80.2% of all respondents reported symptoms returning as a contributing factor, 46.5% reported a life event as a contributing factor, 42.2% stated med non-adherence was a contributing factor, 28.3% stated they were not fully invested in treatment, and 28.3% identified substance abuse barriers as a contributing factor in their readmission. Survey results attached.  ReadmissionSurveys 2ndEval 11_8_17.pdf	
	Follow-up Status Response: **Root Cause:** CBH has not asked members or providers sufficiently about barriers/challenges. **Determination**: Attainable and impactful. CBH and AIPs have not sufficiently assessed members' barriers/ challenges that could prevent a member from following up with aftercare recommendations. By retraining Clinical Management staff and enhancing the concurrent review process, CBH will help the AIPs to identify and address the barriers/challenges that impact members' ability to follow up with aftercare appointment(s).	
Policies/Procedures (2) There is a lack of clinical management and communication with outpatient providers. 2.b. Outpatient services are currently a non-managed level of care for CBH. 2.c. CBH has a fixed amount of resources for clinical care management and currently allocates more resources to the authorization, management, and review of higher levels of care than outpatient treatment. 2.d. CBH made a decision to maintain an open access policy for outpatient services (no pre-authorization required). 2.e. The management and communication with every outpatient provider for each member enrolled in outpatient services would create an unmanageable workload volume for CBH clinical care management staff.	**Initial Response:** Outpatient services are currently a non-managed level of care for CBH. CBH Pay-for-Performance (P4P) data show that 30,745 members received mental health outpatient services in 2016. Authorization of services and review of cases have been the primary mechanisms by which CBH gathers and shares clinical information with providers.Therefore, clinical management of outpatient services may result in better follow-up connections from AIPs.	
	Follow-up Status Response: **Root Cause:** The management and communication with every outpatient provider for each member enrolled in outpatient services would create an unmanageable workload volume for CBH clinical care management staff. **Determination:** Attainable and impactful. CBH will create a standardized report for outpatient providers advising them of members who were previously enrolled in treatment with them but have been hospitalized. This will provide a regular means of communication to notify outpatient providers of inpatient hospitalizations and prompt them to connect with inpatient providers to coordinate discharge planning.	
Policies/Procedures (3) CBH Billing Codes: Targeted Case Management (TCM) is not recognized as a follow-up service.	**Initial Response:** Working with TCM providers and providing incentives for TCM providers to connect members to outpatient services will increase 7-day/30-day follow-up rates.	

HealthChoices BH Contractor: Community Behavioral Health	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date: 12/29/17
3.b. A high percentage of members are being referred to TCM services. 3.c. Members with TCM services do not consistently have a HEDIS-approved follow-up claim. 3.d. TCM is not making connections to HEDIS-approved follow-up services. 3.e. TCM does not have any incentive to connect members to follow-up services.	**Follow-up Status Response:** **Root Cause:** TCM does not have any incentive to connect members to follow-up services. **Determination:** Not impactful. The root cause identified was incorrect. Currently, there is a P4P incentive in place for TCM providers to connect members to outpatient services.	
Policies/Procedures (4) CBH P4P incentives are not an effective means of encouraging follow-up services. 4.b. It is not worth it to the adult AIP facilities. 4.c. Perception of AIPs is that the cost of improving follow-up is not offset by the P4P award. 4.d. AIPS may not be aware that follow-up is worth approximately half of the total P4P score. 4.e. CBH is not clearly communicating this level of detail to the adult AIPs. 4.f. CBH communication with AIP providers has focused on the definition of measures rather than the weighting of measures.	**Initial Response:** The root cause identified is based on a series of assumptions about the providers' perception of P4P. Also, CBH does not have data available on the amount and type of follow-up currently being completed by the AIPs. CBH has formed a Provider Advisory Committee to begin to obtain the providers' perspective to determine if the assumptions made in this root cause analysis activity are accurate. Interventions will be developed based on feedback from the Provider Advisory Committee.	
	Follow-up Status Response: **Root Cause:** CBH communication with AIP providers has focused on the definition of measures rather than the weighting of measures. **Determination:** Unable to determine attainability or impact due to lack of data.	
Provision(1) Transportation to aftercare appointments for members. 1.b. Members have difficulty traveling to their aftercare appointments. 1.c.Members have transportation needs that are unmet. 1.d. Transportation needs were not adequately addressed prior to discharge from the AIP facility. 1.e. AIPs and CBH do not routinely include an assessment of transportation needs in a member's concurrent review or discharge planning process.	**Initial Response:** CBH currently does not have data showing the impact of transportation difficulties on 7-day/30-day follow-up.	
	Follow-up Status Response: **Root Cause:** AIPs and CBH do not routinely include an assessment of members' transportation needs during concurrent reviews or the discharge planning process. **Determinations:** Unable to determine attainability or impact due to lack of data.	

Corresponding Action Plan		
Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2016. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	**Implementation Date** Indicate start date	**Monitoring Plan** How will you know if this action is actually being carried out?

HealthChoices BH Contractor: Community Behavioral Health	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date: 12/29/17
	(month, year) duration, and frequency (e.g., Ongoing, Quarterly)	How will you measure the action's impacts on the root cause? How will you measure the action's impact on the FUH rates?
Action (1) **Root Causes:** **A**. Discharge planning is not prioritized at AIPs and the explanation of the purpose of AIP is not given to members. **B.** AIP does not spend sufficient time to explain DMP to member (psycho-education component of DMP). **Action:** 7-Day and 30-Day Follow-up Action Plans from AIPs.	7/1/17: Adult AIP submitted individual Action Plans to address 7-day and 30-day follow-up. 7/27/17: CBH Team met to begin Action Plan review. 8/10/17: Follow-up letter sent to acute inpatient facilities that had not submitted action plans. 9/19/19: CBH Team met to begin Action Plan review. 11/8/17: Follow-up meeting with acute inpatient facilities to review action plan interventions and request AIPs to use standard format for Action Plan submissions. 12/15/17: All adult AIPs submitted amended action plans. 4/15/2018: First quarter data due from AIPs. Duration and Frequency: Ongoing.	**Initial Response:** CBH gave each adult AIP facility specific and aggregate rates for 7-day and 30-day follow-up for 2014 and 2015 (most recent data available*). Each facility was asked to submit an Action Plan to CBH with specific interventions to improve their 7-day and 30-day follow-up rates. Facilities were asked to identify process owners for each intervention, process measure, frequency of measurement, and implementation plans. An example of the letter that was sent to the AIPs is attached, along with the feedback form that was used by the CBH Clinical Team to assess each Action Plan. Each facility is required to implement interventions that identify and begin to address social determinants that may prevent a member from following through with their discharge plan and ensuring that members are given a copy of their Discharge Management Plan. Facilities will be required to submit data on Action Plan interventions via a SurveyMonkey survey on a quarterly basis, which will include: number of discharges per quarter, total number of discharges eligible for any intervention related to the 7-day and 30-day follow-up intervention plan, total number of discharges for which the provider carried out the intervention (even if the outcome of the intervention was unsuccessful but the steps of the intervention were carried out as intended). Providers will begin reporting on interventions for the first quarter of 2018. CBH will meet with providers every six months to review Action Plan implementation and intervention data. Individual AIP progress will be monitored via quarterly reports for 7-day and 30-day follow-up data.   7 day 30 day Action Plan Letter Form.doc 7 Day-30 Day Action Plan Criteria Form.do ***CBH will review 2016 data when data become available. **Follow-up Status Response:** <insert follow-up response here>

HealthChoices BH Contractor: Community Behavioral Health	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date: 12/29/17
Root Cause: Time and resources constraints at CBH resulted in CBH prioritizing the completion of initial and concurrent reviews. **Action (2):** Telephonic Discharge Project.	Pilot that took place in the second quarter of 2017, which involved 4 AIP facilities, led to the creation of the Telephonic Discharge Project. 7/10/17: The first phase of the project included the initial 4 facilities involved in the pilot and an additional 5 AIP facilities. This phase ran for four weeks. 10/3/17: The remaining 7 AIP facilities in the CBH network were included in this phase of the project. The telephonic discharge process will continue on an ongoing basis for all 16 AIP facilities. 1/18/18: The CBH Clinical Leadership is planning to expand the scope of the Telephonic Discharge Project to include inpatient substance use treatment facilities.	**Initial Response:** In order to increase 7-day and 30-day follow-up, CBH has focused on providing a follow-up call to members within 7 days of discharge from an AIP. The focus of this intervention is to gather discharge information from AIPs within 24 hours of a member's discharge from an AIP. The intervention is being monitored via a standardized report that was created to track: number of eligible discharges from each AIP, time from AIP discharge to discharge information receipt by CBH, time from CBH receipt of information to entering the information into the CBH clinical information system, and time from date of discharge to member services follow-up call attempt. This information is tracked on a monthly basis and reviewed by Quality Management, Clinical Management, and Member Services. **Follow-up Status Response:**
Root Causes: **A.** The management and communication with every outpatient provider for each member enrolled in outpatient services would create an unmanageable workload volume for CBH clinical care management staff. **B.** There is no clear owner of the process to establish and maintain regular communication between inpatient and	In the summer of 2017, CBH began discussion about creating report. 11/1/17: Request was made to CBH Legal Department and CBH Information Security	**Initial Response:** To address the lack of communication that exists between inpatient and outpatient providers as well as CBH's lack of communication with outpatient providers, CBH will create a standardized report for outpatient providers advising them of members who were previously enrolled in treatment with them but have been hospitalized. This would initially be a manual process that would be based on claims from outpatient providers and authorization for service

outpatient providers in order to relay member information. **Action (3)** CBH will create a standardized report for outpatient providers advising them of members who were previously enrolled in treatment with them but have been hospitalized.	Manager to ensure HIPAA compliance. 12/13/17: CBH Legal is reviewing this request with the Divisional Deputy City Solicitor in the HIPAA Privacy Unit in the City of Philadelphia Law Department. Once this response is received from the Divisional Deputy City Solicitor, the CBH Information Security Manager will draft a Data Steward Agreement for each outpatient provider.	from AIPs. On a daily basis, CBH will review all of the admissions for AIP providers (average of approximately 30 per day) and compare them to outpatient claims information for the last four months. When a member is identified as having recently participated in outpatient treatment, CBH will send a daily e-mail to the outpatient provider notifying them of the member's AIP admission. This will allow the outpatient provider to make a connection with the AIP, as well as the member, to begin discharge planning while the member is still engaged in treatment at the AIP. In order to participate, each outpatient provider will be required to identify a data steward. The data steward will be required to sign the Data Steward Agreement and will be responsible for privacy and security of the HIPAA information included in the daily report. A control plan has not been established at this time, as this intervention is still in the planning phase. **Follow-up Status Response:**
Root Causes: **A.** Discharge planning is not prioritized at AIPs and the purpose of AIP treatment is not explained to members. **B**. AIPS view the main goal of treatment to be stabilization, and discharge planning becomes less of a priority in the overall treatment process. **C**. CBH and AIPs have not sufficiently assessed members' barriers/challenges that could prevent a member from following up with aftercare recommendations while a member is still engaged in inpatient treatment. **D.** AIPs and CBH do not routinely include an assessment of transportation needs in a member's concurrent review or discharge planning process. **Action (4)** Clinical Review Process trainings.	Second quarter 2017: Initial training. December 2017: Second training focused on the overall care management process. Subsequent trainings are scheduled for January 2018 (Data Management), February 2018 (Population Management), and March 2018 (Provider Management).	**Initial Response:** The Clinical Care Management Department created a new Clinical Foundations Training in 2017, which focuses on Recovery Principles and Pathways to Resiliency. All CBH Clinical Care Managers participated in the initial trainings in the second quarter of 2017. The trainings emphasize the overall clinical review process (initial, concurrent, and discharge) to focus on assessing barriers/challenges that could prevent a member from following up with aftercare recommendations while a member is still engaged in inpatient treatment. Once the initial trainings have been completed, the modules will be incorporated into the new hire training curriculum for CBH Clinical Care Managers. Clinical Care Management supervisors will do monthly random audits using the CBH Quality Management Audit Tool, which will be revised to reflect changes in the Clinical Foundations Training. **Follow-up Status Response:**
Root Causes: **A.** Discharge planning is not prioritized at AIPs and the explanation of the purpose of AIP is not given to members. B. AIPs view the main goal of treatment to be stabilization, and discharge planning	This intervention was approved by the RCA team, but still needs to be reviewed with Clinical leadership	**Initial Response:** To address the identified root causes, CBH will change the concurrent review process by ensuring that the concurrent review takes place on day five or day seven of a member's hospitalization. In addition, the following questions will be added to the

HealthChoices BH Contractor: Community Behavioral Health	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)		Response Date: 12/29/17
becomes less of a priority in the overall treatment process. C. CBH and AIPs have not sufficiently assessed members' barriers/challenges to that could prevent a member from following up with aftercare recommendations. **Action (5)** Enhancing Concurrent Review Process.	before implementation. It will be presented to Clinical leadership in January 2018.	concurrent review template: • Has the social worker or discharge planner met with the member to discuss treatment team's discharge recommendations? • Has the social worker or discharge planner asked member about member's preferences in next provider? • Has the social worker or discharge planner discussed transportation with member for services upon discharge? • If member identified transportation barriers, what will be put into place to remedy identified barriers? • Has the social worker or discharge planner discussed all barriers to following through with aftercare recommendations with member and developed a plan to remedy any identified barriers? • Has the social worker or discharge planner communicated treatment team aftercare recommendations with all of member's identified supports? A Control and Monitoring Plan has not yet been established for this intervention since it is still in the planning phase.	
		Follow-up Status Response:	

VI: 2018 Strengths and Opportunities for Improvement

The section provides an overview of CBH's 2018 (MY 2017) performance in the following areas: structure and operations standards, performance improvement projects, and performance measures, with identified strengths and opportunities for improvement.

Strengths

- CBH's MY 2017 Engagement of AOD Treatment performance rate for ages 13+ years did achieve the goal of meeting or exceeding the HEDIS 75th percentile.
- CBH's MY 2017 Initiation and Engagement of AOD Treatment rates for ages 13+ were statistically significantly higher (better) than the prior year, by 13.7 and 14.4 percentage points, respectively.

Opportunities for Improvement

- CBH was partially compliant with the following four elements under review for Year 3 of the Performance Improvement Project:
  - Review Element 1 – Project Topic and Relevance
  - Review Element 3 – Study Variables (Performance Indicators)
  - Review Element 6 – Data Collection Procedures
  - Review Elements 8/9 – Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement.
- Review of compliance with standards conducted by the Commonwealth in RY 2015, RY 2016, and RY 2017 found CBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
  - CBH was partially compliant with 1 out of 7 categories within Subpart C: Enrollee Rights and Protections Regulations. The partially compliant category is Enrollee Rights.
  - CBH was partially compliant with 5 out of 10 categories and non-compliant with 1 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, 3) Provider Selection, 4) Practice Guidelines, and 5) Quality Assessment and Performance Improvement Program. The non-compliant category is Coordination and Continuity of Care.
  - CBH was partially compliant with 8 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 2017 PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness rate (QI A) for the overall population was statistically significantly lower (worse) compared to the MY 2017 HC BH (Statewide) rate by 2.7 percentage points.
- CBH's MY 2017 PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness rate (QI B) for the overall population was statistically significantly lower (worse) compared to the MY 2017 HC BH (Statewide) rate by 6.2 percentage points.
- CBH's MY 2017 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not significantly improve compared to the MY 2017 HC BH (Statewide) or prior year rates.
- CBH's MY 2017 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.
- CBH's MY 2017 HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for ages 6–64 years did not meet the OMHSAS interim goals for MY 2017, nor did they achieve the goal of meeting or exceeding the HEDIS 75th percentiles.
- CBH's MY 2017 Initiation of AOD Treatment performance rate for ages 13+ years did not achieve the goal of meeting or exceeding the HEDIS 75th percentile and was statistically significantly lower (worse) compared to the MY 2017 HC BH (Statewide) rate by 4.6 percentage points.

- CBH's overall MY 2017 Engagement rate was statistically significantly lower (worse) compared to the MY 2017 HC BH (Statewide) rate by 4.9 percentage points.

Performance Measure Matrices

The Performance Measure (PM) Matrices provide a comparative look at quality indicators (QIs) included in the 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 2017 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% CI 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 2017 PA-Specific 7- and 30-Day Follow-up After Hospitalization and MY 2017 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 FUH QI B	C REA[1]	B
	Worsened	F	D	C

[1] For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.
Letter Key: A: Performance is notable. 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 2017 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 2017. The last column compares the BH-MCO's MY 2017 rates to the corresponding MY 2017 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% CI for the BH-MCO rate included the benchmark rate.

Table 6.2: MY 2017 PA-Specific 7- and 30-Day Follow-up After Hospitalization and MY 2017 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 2017 Rate	MY 2017 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%**=	**49.5%**=	**52.2%**▼
QI B – PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall)	63.9% ▼	71.7% ▲	67.4%▼	**64.7%**▼	**63.4**%=	**69.6%**▼
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	11.3% ▼	13.1% ▲	13.7% =	**13.5%**=	**12.9%**=	**13.4%**=

[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 2017 performance as compared to the HEDIS 90th, 75th, 50th, and 25th percentiles for the MY 2017 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 2017 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.
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 2017 performance for HEDIS (FUH) 7- and 30-day Follow-up After Hospitalization for Mental Illness (6–64 Years) relative to the corresponding HEDIS MY 2017 NCQA Quality Compass percentiles.

Table 6.4: BH-MCO's MY 2017 FUH Rates Compared to the Corresponding MY 2017 HEDIS 75th Percentiles (6–64 Years)

Quality Performance Measure	MY 2017		HEDIS MY 2017 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-up After Hospitalization for Mental Illness (6–64 Years)	**30.7%**	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)	**46.1%**	Not met	Below 25th percentile

[1] Rates shown are for ages 6–64 years.

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 2017, RY 2016, and RY 2015 were used to make the determinations.

Performance Improvement Projects

- CBH submitted a Year 3 PIP Update in 2018. CBH participated in quarterly meetings with OMHSAS and IPRO throughout 2018 to discuss ongoing PIP activities.

Performance Measures

- CBH reported all performance measures and applicable quality indicators in 2018.

2017 Opportunities for Improvement MCO Response

- CBH provided a response to the opportunities for improvement issued in 2017.

2018 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CBH in 2018. The BH-MCO will be required to prepare a response in 2019 for the noted opportunities for improvement.

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Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

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

Table A.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 enable 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.
	Standard 104.4	The BH-MCO submitted the following within established time frames: Annual Evaluation, QM Program Description, QM Work Plan, and Quarterly PEPS Reports.
	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, and travel and attend ongoing 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, 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 and 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 time frames (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 database 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 (e.g., adult, child and adolescent); Priority Population; Special Population.
	Standard 1.2	100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.
	Standard 1.3	Provider Exception report submitted and approved when choice of two providers is not given.
	Standard 1.4	BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).

BBA Category	PEPS Reference	PEPS Language
	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 accepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of oral interpreters is available for non-English speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Standard 24.2	Provider network database contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (e.g., routine, urgent, and 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.
	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
§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.

BBA Category	PEPS Reference	PEPS Language
	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
	Standard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Standard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.210 Provider Selection	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds, and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken, as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent, andemergent), 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 BHRS.
	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

BBA Category	PEPS Reference	PEPS Language
		effectiveness of the services received by members (e.g., 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 (e.g., 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 (e.g., quality of individualized service plans and treatment planning; adverse incidents; collaboration and cooperation with member complaints, grievance, and appeal procedures; as well as other medical and human services programs and administrative compliance).
	Standard 91.9	The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	The QM Work Plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance-based contracting selected indicator: Mental Health and Substance Abuse External Quality Review: Follow-up After Mental Health Hospitalization QM Annual Summary Report.
	Standard 91.11	The identified Performance Improvement Projects must include the following: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality. 3. Evaluation of the effectiveness of the interventions. 4. Planning and initiation of activities for increasing or sustaining improvement. 5. Timeline for reporting status and results of each project to DHS. 6. Completion of each Performance Improvement Project in a reasonable time period to allow information on the success of Performance Improvement Projects to produce new information on quality of care each year.
	Standard 91.12	The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.
	Standard 91.13	The BH-MCO has a process for its own evaluation of the impact and effectiveness of its QM program annually. A report of this evaluation will be submitted to DHS by April 15th.
	Standard 91.14	The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the Annual Evaluation and any Corrective Actions required from previous reviews.
	Standard 91.15	The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (e.g., routine, urgent, and 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.

BBA Category	PEPS Reference	PEPS Language
	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 enable 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.
	Standard 104.4	The BH-MCO submitted the following within established time frames: Annual Evaluation QM Program Description, QM Work Plan, and Quarterly PEPS Reports.
§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 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 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 time frames and use the required template language.

BBA Category	PEPS Reference	PEPS Language
	Standard 72.2	The content of the notices adheres 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; and 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 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 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.

BBA Category	PEPS Reference	PEPS Language
	Standard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Standard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of oral interpreters is available for non-English speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Standard 24.2	Provider network database contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Standard 72.2	The content of the notices adheres 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; and 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 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 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

BBA Category	PEPS Reference	PEPS Language
		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 time frames and use the required template language.
	Standard 72.2	The content of the notices adheres 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; and 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 decision letters must be written in clear, simple language that includes each issue identified in the member 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 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

BBA Category	PEPS Reference	PEPS Language
		● 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 time frames and use the required template language.
	Standard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.410 Expedited resolution of appeals	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff, and the provider network: ● BBA fair hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision, including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff, either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Standard 72.2	The content of the notices adheres 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; and 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

BBA Category	PEPS Reference	PEPS Language
		• 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 time frames and use the required template language.
	Standard 72.2	The content of the notices adheres 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; and 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

BBA Category	PEPS Reference	PEPS Language
		template language.
	Standard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).

Appendix B. OMHSAS-Specific PEPS Substandards

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

Table B.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 second-level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all second-level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the second-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 second-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 second-level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all second-level panel members have been trained. Include a copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the second-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 second-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 and provides supportive function, as defined in C/FST Contract, as opposed to directing the program.
	Standard 108.4	The C/FST Director is responsible for setting program direction consistent with County direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority, and directing staff to perform high-quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2017, 16 substandards were considered OMHSAS-specific monitoring standards. Of the 16 OMHSAS-specific PEPS Substandards, 16 were evaluated for CBH and Philadelphia. **Table C.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 2017) evaluation of HealthChoices Oversight Entity/BH-MCO compliance for any given category may not equal the sum of those substandard counts.

Table C.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 2017	RY 2016	RY 2015
Care Management					
Care Management (CM) Staffing (Standard 27)	1	0	0	1	0
Longitudinal Care Management (and Care Management Record Review) (Standard 28)	1	0	0	1	0
Second-Level Complaints and Grievances					
Complaints (Standard 68)	4	0	0	4	0
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	0
Denials					
Denials (Standard 72)	1	0	1	0	0
Executive Management					
County Executive Management (Standard 78)	1	0	0	1	0
BH-MCO Executive Management (Standard 86)	1	0	0	1	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	3	0	0
Total	16	0	4	12	0

[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 2017) 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 2 of the 2 applicable substandards. Of the 2 substandards, CBH was non-compliant with both substandards. The status for these substandards is presented in **Table C.2**.

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

Category	PEPS Item	Review Year (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 medical doctor/physician assistant (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, PA case consultation, peer review of referral, and role of 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 8 of the 8 applicable substandards. Of the 8 substandards evaluated, CBH met 2 substandards, partially met 2 substandards, and did not meet 4 standards, as indicated in **Table A.3**.

Table C.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 second-level complaint meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
PEPS Standard 68, Substandard 7: Training rosters identify that all second-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 second-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 second-level grievance process.
PEPS Standard 71, Substandard 5: The second-level grievance case file includes documentation that the member was contacted about the second-level grievance meeting and offered a convenient time and place for the meeting, and asked about their ability to get to the meeting and if they need any assistive devices.
PEPS Standard 71, Substandard 6: Training rosters identify that all second-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 second-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 C.4: OMHSAS-Specific Requirements Relating to Denials

Category	PEPS Item	Review Year	Status
Denials			
Denials	Standard 72.3	RY 2017	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 C.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); and 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 3 substandards crosswalked to this category were evaluated for Philadelphia County. Philadelphia County met the criteria for all 3 substandards, as seen in **Table A.6**.

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

Category	PEPS Item	Review Year	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Standard 108.3	RY 2017	Met
	Standard 108.4	RY 2017	Met
	Standard 108.9	RY 2017	Met