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

2018 External Quality Review Report
Community Care Behavioral Health

FINAL
4/30/19

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

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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 Care Behavioral Health (CCBH). 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 sub-contracted 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.

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

Adams, Allegheny, Berks, Chester, Erie, and York Counties hold contracts with CCBH. The North/Central County Option (NC/CO) Counties – Carbon, Monroe, and Pike – also hold a contract with CCBH. Lackawanna, Luzerne, Susquehanna, and Wyoming hold a contract with Northeast Behavioral Health Care Consortium (NBHCC), which in turn holds a contract with CCBH. The Department contracts directly with CCBH to manage the HC BH program for the North/Central State Option (NCSO) Counties – Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne. As of July 1, 2013, three counties – Blair, Clinton, and Lycoming – contracted with CCBH. For Blair County, the HC BH Contractor is Blair HealthChoices and the Oversight Entity is Central Pennsylvania Behavioral Health Collaborative. For Clinton and Lycoming Counties, the HC BH Contractor and Oversight Entity is Lycoming-Clinton Joinder Board. **Table 1.1** shows the name of the HealthChoices Oversight Entity, the associated HealthChoices HC BH Contractor(s), and the county or counties encompassed by each HC BH Contractor.

Table 1.1: HealthChoices Oversight Entities, HC BH Contractors and Counties

HealthChoices Oversight Entity	HC BH Contractor	County
Allegheny HealthChoices, Inc. (AHCI)	Allegheny County	Allegheny County
Berks County	Berks County	Berks County
Central Pennsylvania Behavioral Health Collaborative (d/b/a Blair HealthChoices)	Blair HealthChoices	Blair County
Carbon/Monroe/Pike Joinder Board (NC/CO)	Carbon/Monroe/ Pike Joinder Board (CMP)	Carbon County
		Monroe County
		Pike County
Chester County	Chester County	Chester County
Erie County	Erie County	Erie County
Lycoming-Clinton Joinder Board	Lycoming-Clinton Joinder Board	Clinton County
		Lycoming County
Northeast Behavioral Health Care Consortium (NBHCC)	Northeast Behavioral Health Care Consortium (NBHCC)	Lackawanna County
		Luzerne County
		Susquehanna County
		Wyoming County

HealthChoices Oversight Entity	HC BH Contractor	County
PA Department of Human Services – OMHSAS	Community Care Behavioral Health Organization Otherwise known as North/Central State Option (NCSO) for this review	Bradford County
		Cameron County
		Centre County
		Clarion County
		Clearfield County
		Columbia County
		Elk County
		Forest County
		Huntingdon County
		Jefferson County
		Juniata County
		McKean County
		Mifflin County
		Montour County
		Northumberland County
		Potter County
		Schuylkill County
		Snyder County
		Sullivan County
		Tioga County
		Union County
		Warren County
		Wayne County
York/Adams HealthChoices Management Unit	York/Adams HealthChoices Joinder Governing Board	Adams County
		York County

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CCBH by OMHSAS monitoring staff within the past three review years (RYs 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 2018 and entered into the PEPS Application as of October 2018 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 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 RY 2017 findings for selected OMHSAS-specific Substandards are reported in **Appendix C**. The 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 2018 assessment. Those standards not reviewed through the PEPS system in RY 2017 were evaluated on their performance based on RY 2016 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 CCBH, 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 substandards that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH-MCO and associated HealthChoices Oversight Entities against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for CCBH

Table 1.2 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 1.2: Tally of Substandards Pertinent to BBA Regulations Reviewed for CCBH

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	4	7	3
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	N/A	N/A	N/A	N/A	N/A
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	25	0	9	13	3
Coordination and Continuity of Care	3	0	0	0	3
Coverage and Authorization of Services	5	0	2	0	5
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	7	0	4	0	3
Quality Assessment and Performance Improvement Program	25	0	25	0	0
Health Information Systems	1	0	1	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	0	2	0	9
General Requirements	14	0	2	0	12
Notice of Action	13	0	7	6	0
Handling of Grievances and Appeals	11	0	2	0	9
Resolution and Notification: Grievances and Appeals	11	0	2	0	9
Expedited Appeals Process	6	0	2	0	4
Information to Providers and Subcontractors	2	0	0	0	2
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	0	2	0	4
Effectuation of Reversed Resolutions	6	0	2	0	4
Total	**171**	**0**	**74**	**29**	**70**

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

[2] The number of substandards that came under active review during the cycle specific to the review year. Due to substandards coming under active review both annually and triennially for each review year, the sum of the substandards that came under review in RY 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 HealthChoices Oversight Entities and BH-MCOs based on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. In 2008, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories. In this 2018 report, the Solvency tracking reports and the quarterly reporting of Complaint and Grievances data were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

Determination of Compliance

To evaluate HealthChoices Oversight Entity/BH-MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring substandards by provision, and evaluated the HealthChoices Oversight Entity's and BH-MCO's compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of met, partially met, or not met in the PEPS Application submitted by the Commonwealth. If a substandard was not evaluated for a particular HealthChoices Oversight Entity/BH-MCO, it was assigned a value of not determined. Compliance with the BBA provisions was then determined based on the aggregate results across the three-year period of the PEPS substandards linked to each provision. If all substandards 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 substandards were not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as non-compliant. If no crosswalked substandards 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 167 PEPS substandards that were used to evaluate CCBH and the 10 HealthChoices Oversight Entities' compliance of BBA regulations in RY 2017, 74 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 1.3** presents the findings by categories consistent with the regulations.

Table 1.3: Compliance with Enrollee Rights and Protections Regulations

Subpart C: Categories	MCO Compliance Status	By HC BH Contractor			Comments
		Fully Compliant	Partially Compliant	Not Compliant	
Enrollee Rights 438.100	Partial	Allegheny, Berks, Blair, Carbon/Monroe/Pike, Chester, Lycoming/Clinton, NBHCC, NCSO, York/Adams	Erie		14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards. Allegheny, Berks, Blair, Carbon/Monroe/Pike, Chester, Lycoming/Clinton, NBHCC, NCSO, and York/Adams were compliant with 14 substandards. Erie was partially compliant with 1 substandard and compliant with 13 substandards.
Provider-Enrollee Communications 438.102	Compliant	Compliant as per PS&R sections E.4 (p.55) and A.4.a (p.21).	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.	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).	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.	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	Compliant	Compliant as per PS&R section 4 (p. 30).	Emergency and Post-Stabilization Services	Compliant	Compliant as per PS&R section 4 (p. 30).

Subpart C: Categories	MCO Compliance Status	By HC BH Contractor			Comments
		Fully Compliant	Partially Compliant	Not Compliant	
438.114			438.114		
Solvency Standards 438.116	Compliant	Compliant as per PS&R sections A.3 (p. 68) and A.9 (p. 73), and 2017-2017 Solvency Requirements tracking report.	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. CCBH was compliant with five categories and partially compliant with one category. The remaining category was considered not applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50–447.60. The remaining category, Solvency Standards, was compliant based on the 2016–2017 Solvency Requirement tracking report.

Of the 14 PEPS substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 14 were evaluated for all HC BH Contractors associated with CCBH. Each HC BH Contractor was evaluated on 14 substandards, partially compliant on one substandard, and compliant with the remaining 13 substandards. The one partially compliant substandard was a result of Erie being partially compliant on one substandard; all other substandards were compliant for all HC BH Contractors. 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

One HC BH Contractor associated with CCBH was partially compliant with Enrollee Rights due to partial compliance with one substandard within PEPS Standard 108.

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

Erie was partially compliant on Substandard 6 of Standard 108 (RY 2016).

> **Substandard 6:** The problem resolution process specifies the role of the County, BH-MCO, and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.

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. **Table 1.4** presents the findings by categories consistent with the regulations.

Table 1.4: Compliance with Quality Assessment and Performance Improvement Regulations

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor			Comments
		Fully Compliant	Partially Compliant	Not Compliant	
Elements of State Quality Strategies 438.204	Compliant	All CCBH HC BH Contractors			Compliant as per PS&R section G.3 (p. 61).
Availability of Services (Access to Care) 438.206	Partial		All CCBH HC BH Contractors		25 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 25 substandards, compliant with 21 substandards, partially compliant with 2 substandard, and non-compliant with 2 substandards.
Coordination and Continuity of Care 438.208	Non-compliant			All CCBH HC BH Contractors	3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards, partially compliant with 1 substandard, and non-compliant with 2 substandards.
Coverage and Authorization of Services 438.210	Partial		All CCBH HC BH Contractors		5 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5 substandards, compliant with 2 substandards, partially compliant with 1 substandard, and non-compliant with 2 substandards.
Provider Selection 438.214	Compliant	All CCBH HC BH Contractors			3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards and compliant with 3 substandards.
Confidentiality 438.224	Compliant	All CCBH HC BH Contractors			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	All CCBH HC BH Contractors			8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards and compliant with 8 substandards.
Practice Guidelines 438.236	Partial		All CCBH HC BH Contractors		7 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on evaluated on 7 substandards, compliant with 3 substandards, partially compliant with 2 substandard,

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor			Comments
		Fully Compliant	Partially Compliant	Not Compliant	
					and non-compliant with 2 substandards.
Quality Assessment and Performance Improvement Program 438.240	Partial		All CCBH HC BH Contractors		25 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 25 substandards, compliant with 23 substandards, and partially compliant with 2 substandard.
Health Information Systems 438.242	Compliant	All CCBH HC BH Contractors			1 substandard was crosswalked to this category. Each HC BH Contractor was evaluated on 1 substandard and compliant with this substandard.

There are 10 categories in the Quality Assessment and Performance Improvement Regulations Standards. CCBH was compliant with 5 of the 10 categories, partially compliant with 4 categories, and non-compliant with 1 category. Two (2) of the 6 categories that CCBH was compliant with – Elements of State Quality Strategies and Confidentiality – were not directly addressed by any PEPS substandards, but were evaluated and determined to be compliant as per the HealthChoices PS&R.

For this review, 77 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations for all HC BH Contractors associated with CCBH. HC BH Contractors were compliant with 61 substandards, partially compliant with 8 substandards, and non-compliant with 8 substandards. As previously stated, some PEPS substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

All of the HC BH Contractors associated with CCBH were partially compliant with Availability of Services due to non-compliance with substandards of PEPS Standards 28 and partial compliance with Standard 93.

PEPS Standard 28: The BH-MCO has a comprehensive, defined program of care that incorporates longitudinal disease management.

All of the HC BH Contractors associated with CCBH were partially compliant with one substandard of Standard 28: Substandard 3 (RY 2017) non-compliant with two substandards of PEPS Standard 28: Substandards 1 and 2 (RY 2015):

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

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

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

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

All of the CCBH HC BH Contractors were partially compliant on one substandard of Standard 93: Substandard 3 (RY 2017).

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

Coordination and Continuity of Care

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

PEPS Standard 28: See Standard and partially compliant Substandard descriptions under **Availability of Services (Access to Care**). All of the HC BH Contractors associated with CCBH were partially compliant with one substandard of PEPS Standard 28: Substandard 3 (RY 2015), and non-compliant with two substandards of PEPS Standard 28: Substandards 1 and 2 (RY 2015).

Coverage and Authorization of Services

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

PEPS Standard 28: See Standard and partially compliant Substandard descriptions under **Availability of Services (Access to Care)**. All of the HC BH Contractors associated with CCBH were partially compliant with PEPS Standard 28: Substandard 3 (RY 2015), and non-compliant with two substandards of PEPS Standard 28: Substandards 1 and 2 (RY 2015).

Practice Guidelines

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

PEPS Standard 28: See Standard and partially compliant Substandard descriptions under **Availability of Services (Access to Care)**. All of the HC BH Contractors associated with CCBH were partially compliant with one substandard of PEPS Standard 28: Substandard 3, and non-compliant with two substandards of PEPS Standard 28: Substandards 1 and 2 (RY 2015).

PEPS Standard 93: See Standard description and partially compliant standard determination under Availability of Services. All of the CCBH HC BH Contractors were partially compliant on one substandard of Standard 93: Substandard 3 (RY 2017).

Quality Assessment and Performance Improvement

All of the HC BH Contractors associated with CCBH were partially compliant with Quality Assessment and Performance Improvement due to partial compliance with substandards of PEPS Standards 91 and 93.

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

All of the CCBH HC BH Contractors were partially compliant with one substandards of Standard 91: Substandard 4 (RY 2017).

> **Substandard 4:** QM work plan outlines the joint studies to be conducted.

PEPS Standard 93: See Standard description and partially compliant standard determination under **Availability of Services**. All of the CCBH HC BH Contractors were partially compliant with one substandard of Standard 93: Substandard 3 (RY 2017).

Subpart F: Federal and State Grievance System Standards

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances.

The PEPS documents include an assessment of the HC BH Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 1.5** presents the findings by categories consistent with the regulations.

Table 1.5: Compliance with Federal and State Grievance System Standards

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All CCBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 7 substandards, and partially compliant with 4 substandards.
General Requirements 438.402	Partial		All CCBH HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards, compliant with 10 substandards, and partially compliant with 4 substandards.
Notice of Action 438.404	Compliant	All CCBH HC BH Contractors		13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards and compliant with 13 substandards.
Handling of Grievances and Appeals 438.406	Partial		All CCBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 7 substandards, and partially compliant with 4 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All CCBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 7 substandards, and partially compliant with 4 substandards.
Expedited Appeals Process 438.410	Partial		All CCBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 5 substandards, and partially compliant with 1 substandard.
Information to Providers & Subcontractors 438.414	Compliant	All CCBH HC BH Contractors		2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards and compliant with 2 substandards.
Recordkeeping and Recording Requirements 438.416	Compliant	All CCBH HC BH Contractors		Compliant, as per the required quarterly reporting of complaint and grievances data.
Continuation of	Partial		All CCBH HC	6 substandards were crosswalked to this

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Benefits 438.420			BH Contractors	category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 5 substandards, and partially compliant with 1 substandard.
Effectuation of Reversed Resolutions 438.424	Partial		All CCBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 5 substandards, and partially compliant with 1 substandard.

There are 10 categories in the Federal and State Grievance System Standards. CCBH was compliant with 3 categories and partially compliant with 7 categories. CCBH was compliant with the Recordkeeping and Recording Requirements category, as per the quarterly reporting of Complaint and Grievances data.

For this review, 80 substandards were crosswalked to Federal and State Grievance System Standards for all HC BH Contractors associated with CCBH and included in the review. Each HC BH Contractor was evaluated on 80 substandards, compliant with 61 substandards, and partially compliant with 19 substandards. As previously stated, some PEPS substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

All HC BH Contractors associated with CCBH were partially compliant with 7 of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with substandards within PEPS Standards 68 and 71.

Statutory Basis and Definitions

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

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

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

Substandard 3: Complaint decision letters must be written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).

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

Substandard 5: Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the Complaint/Grievance (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.

All CCBH HC BH Contractors were partially compliant with one substandard of Standards 71: Substandard 4 (RY 2015).

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

General Requirements

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

PEPS Standard 68: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions. All CCBH HC BH Contractors were partially compliant with three substandards of Standards 68: Substandards 3, 4, and 5 (RY 2015).

PEPS Standard 71: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions mentioned above. All CCBH HC BH Contractors were partially compliant with one substandard of Standards 71: Substandard 4 (RY 2015).

Handling of Grievances and Appeals

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

PEPS Standard 68: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions. All CCBH HC BH Contractors were partially compliant with three substandards of Standards 68: Substandards 3, 4 and 5 (RY 2015).

PEPS Standard 71: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions mentioned above. All CCBH HC BH Contractors were partially compliant with one substandard of Standards 71: Substandard 4 (RY 2015).

Resolution and Notification: Grievances and Appeals

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

PEPS Standard 68: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions. All CCBH HC BH Contractors were partially compliant with three substandards of Standards 68: Substandards 3, 4, and 5 (RY 2015).

PEPS Standard 71: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions mentioned above. All CCBH HC BH Contractors were partially compliant with one substandard of Standards 71: Substandard 4 (RY 2015).

Expedited Appeals Process

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

PEPS Standard 71: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions. All CCBH HC BH Contractors were partially compliant with one substandard of Standards 71: Substandard 4 (RY 2015).

Continuation of Benefits

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

PEPS Standard 71: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions. All CCBH HC BH Contractors were partially compliant with one substandard of Standards 71: Substandard 4 (RY 2015).

Effectuation of Reversed Resolutions

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

PEPS Standard 71: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions. All CCBH HC BH Contractors were partially compliant with one substandard of Standards 71: Substandard 4 (RY 2015).

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 had 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 for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

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

In 2016, OMHSAS elected to begin conducting quarterly PIP review calls with each 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. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule. At the time each PIP element is reviewed, a finding is given of "met," "partially met," or "not met." Elements receiving a "met" will receive 100% of the points assigned to the element, "partially met" elements will receive 50% of the assigned points, and "not met" elements will receive 0%.

Findings

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. CCBH received a total demonstrable improvement score of 67.5 out of 80 points (84.4%). Overall, this PIP was 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)	M	100	15%	15
Review Elements 4/5 – Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 – Data Collection Procedures	M	100	10%	10
Review Element 7 – Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 – Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**67.5**
Review Element 10 – Sustainability of Documented Improvement*	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			**20%**	**N/A**
OVERALL PROJECT PERFORMANCE SCORE			**100%**	**N/A**

M: met (100 points); PM: partially met (50 points); NM: not met (0 points); N/A: not applicable
*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 satisfactorily update the attestations. IPRO recommended that the MCO submits updated attestations, reflecting sufficient approval and assurance of involvement of requisite MCO staff whenever any changes were proposed and/or reported, in correspondence to Section 1, part 6 of the of the reporting form. 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.

The MCO had no issues or concerns with requirements for the aim statement; the study questions were clearly reported and linked to the methodology. The methodology used study variables (performance indicators) that met requirements; indicators were objective, clearly defined, measureable, time-specific, and designed to track outcomes (including the capacity to assess change and strengths of association). Furthermore, 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 appropriately specifying: the data sources, systematic collection of valid and reliable data (representative of the applicable population), data collection processes (in terms of automated versus manual mechanisms), the prospective analysis plan, and the timeline of data collection, analysis, and reporting.

There were no issues or concerns with improvement strategies (i.e., interventions); causes and barriers to improvement were integrated into the analyses and quality improvement processes, and reasonable interventions were undertaken to address any causes and barriers appropriately. The MCO appropriately conducted the data analysis insofar as the analysis identified initial and repeat measurements, realistic and unambiguous targets for measures, changes in performance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity. The discussion section included: interpretations from the analyses' results of the extent to which the PIP was successful (and the follow-up activities planned as a result); narrative demonstrated meaningful change in performance (relative to the performance observed during baseline); and, validation of reported improvement in terms of attributing successful performance improvement to the interventions. However, the MCO had an issue with one

requirement pertaining to interpretation of demonstrability and validity of reported improvement, which was the MCO's adherence to the statistical analysis, as identified in the data analysis plan. The MCO provided results of all process measures included under the analysis plan, and results for process measures were reported on available data (measured through the second quarter of 2018). The MCO also provided outcome measure results, clearly tracked over the course of implementation, linked to the objectives, and with clear interpretations. The MCO performed logistic regression to identify statistically significant factors for the group using both MH and substance use disorder (SUD) services compared to the group using MH services only, and IPRO suggested that the MCO calculate the *F* statistic and *chi*-square to assess goodness of fit. The MCO did not report 2015 data, resulting in a gap. The MCO also did not adequately describe the specifications for the project-to-date (PTD) calculation in terms of the statistical analysis plan. IPRO recommended that the MCO clarify the PTD specification in terms of defining criteria for numerator and denominator eligibility. IPRO also recommended that the MCO report complete data needed for valid interpretation (i.e., with 2015 data included, for alignment of all project years for PTD for accurate interpretation of PTD figures for all measures. Lastly, although the MCO adequately compared subpopulations, the MCO could include a year-over-year comparison of rates for key subpopulations to improve reporting of sustainability (in terms of project planning).

Findings for sustainability of documented improvement were not yet applicable; IPRO will review sustainability in the final report submission in terms of documentation of ongoing, additional, or modified interventions, and repeated measurements over comparable time periods.

III: Performance Measures

In 2018, OMHSAS and IPRO conducted three EQR studies.[1] 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 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. 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.

[1] Slight discrepancies in percentage point differences (PPDs) in tables are due to rounding.

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 7 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 (WHO) 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 (Averyt 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 seven days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance and to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments (van Walraven et al., 2004). With the expansion of evidence-based practice in the recent decade, continuity has become a core principle in care delivery and in performance measurement for mental health services (Hermann, 2000). One way to improve continuity of care is to provide greater readiness of aftercare by shortening the time between discharge from the hospital and the first day of outpatient contact (Hermann, 2000).

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a 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 (RCA) 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 an RCA.

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.

Finally, it should be noted that, in anticipation of the formation of its joinder on January 1, 2017, York-Adams was treated as one Contractor in this analysis, and none of the related comparisons were made.

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 when multiple HC BH Contractors are represented by a single BH-MCO. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (i.e., across HC BH Contractors with the same contracted BH-MCO). The HC BH Contractor-specific rates were calculated using the numerators and denominators for that particular HC BH Contractor. For each of these rates, the 95% confidence interval (CI) is reported. The HealthChoices BH 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+ year 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+ year age bands. The percentile comparison for the ages 6 to 64 year old age group is presented to show BH-MCO and HC BH Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile by MY 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 ages 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 2016	MY 2017 Rate Comparison		
				95% CI		Goal			To MY 2016		To MY 2017 HEDIS
Measure	(N)	(D)	%	Lower	Upper	%	Met?	%	PPD	SSD	Medicaid Percentiles
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
CCBH	7,183	15,940	**45.1%**	44.3%	45.8%	48.7%	No	45.6%	-0.5	No	Below 75th percentile, above 50th percentile
Allegheny	1,495	3,716	**40.2%**	38.6%	41.8%	46.1%	No	41.6%	-1.3	No	Below 75th percentile, above 50th percentile
Blair	312	575	**54.3%**	50.1%	58.4%	56.8%	No	48.4%	5.8	No	At or above 75th percentile
Berks	613	1,351	**45.4%**	42.7%	48.1%	51.5%	No	44.8%	0.6	No	Below 75th percentile, above 50th percentile
Chester	352	845	**41.7%**	38.3%	45.0%	49.8%	No	43.4%	-1.8	No	Below 75th percentile, above 50th percentile
CMP	377	785	**48.0%**	44.5%	51.6%	46.6%	Yes	41.5%	6.5	Yes	At or above 75th percentile
Erie	515	1,063	**48.4%**	45.4%	51.5%	51.4%	No	45.7%	2.8	No	At or above 75th percentile
Lycoming-Clinton	205	493	**41.6%**	37.1%	46.0%	47.4%	No	45.2%	-3.6	No	Below 75th percentile, above 50th percentile
NBHCC	988	1,856	**53.2%**	50.9%	55.5%	56.0%	No	55.1%	-1.9	No	At or above 75th percentile
NCSO	1,854	4,016	**46.2%**	44.6%	47.7%	54.9%	No	50.1%	-4.0	Yes	At or above 75th percentile
York-Adams	472	1,240	**38.1%**	35.3%	40.8%	33.9%	Yes	32.8%	5.3	Yes	Below 75th percentile, above 50th 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%	-2.7	Yes	Below 75th percentile, above 50th percentile
CCBH	10,680	15,940	**67.0%**	66.3%	67.7%	69.9%	No	66.8%	0.2	No	Below 75th percentile, above 50th percentile
Allegheny	2,248	3,716	**60.5%**	58.9%	62.1%	65.3%	No	61.7%	-1.2	No	Below 75th percentile, above 50th percentile
Blair	451	575	**78.4%**	75.0%	81.9%	75.3%	Yes	75.2%	3.3	No	At or above 75th percentile
Berks	894	1,351	**66.2%**	63.6%	68.7%	70.0%	No	65.0%	1.2	No	Below 75th percentile, above 50th percentile
Chester	536	845	**63.4%**	60.1%	66.7%	68.4%	No	62.6%	0.9	No	Below 75th percentile, above 50th percentile
CMP	544	785	**69.3%**	66.0%	72.6%	73.5%	No	68.6%	0.7	No	At or above 75th percentile
Erie	717	1,063	**67.5%**	64.6%	70.3%	70.6%	No	65.7%	1.8	No	Below 75th percentile, above 50th percentile
Lycoming-Clinton	322	493	**65.3%**	61.0%	69.6%	69.0%	No	67.1%	-1.8	No	Below 75th percentile, above 50th percentile
NBHCC	1,343	1,856	**72.4%**	70.3%	74.4%	75.3%	No	73.0%	-0.7	No	At or above 75th percentile

MY 2017								MY 2016	MY 2017 Rate Comparison		
				95% CI		Goal			To MY 2016		To MY 2017 HEDIS
Measure	(N)	(D)	%	Lower	Upper	%	Met?	%	PPD	SSD	Medicaid Percentiles
NCSO	2,840	4,016	**70.7%**	69.3%	72.1%	75.0%	No	72.1%	-1.4	No	At or above 75th percentile
York-Adams	785	1,240	**63.3%**	60.6%	66.0%	58.4%	Yes	57.6%	5.7	Yes	Below 75th percentile, above 50th percentile

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

The MY 2017 HealthChoices Aggregate (Statewide) HEDIS follow-up rates in the 6 to 64 years age group were 39.3% for QI 1 and 60.9% for QI 2 (**Table 3.1**). These rates were statistically significantly lower than the HealthChoices Aggregate rates for this age group in MY 2016, which were 43.7% and 63.5%, respectively. The HealthChoices Aggregate 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 Aggregate rates were between the NCQA 50th and 75th percentile; therefore, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2017 for either rate.

The MY 2017 CCBH QI 1 rate for members ages 6 to 64 years was 45.1%, a 0.5 percentage point decrease from the MY 2016 rate of 45.6% (**Table 3.1**). The corresponding QI 2 rate was 67.0%, a 0.2 percentage point increase from the MY 2016 rate of 66.8%. CCBH's rates were below its target goals of 48.7% for QI 1 and 69.9% for QI 2; therefore, neither of the interim follow-up goals were met in MY 2017. HEDIS rates for this age group were between the HEDIS 2018 50th and 75th percentiles for QI 1 and 50th and 75th percentiles for QI 2; therefore, the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by CCBH in MY 2017 for either rate.

From MY 2016 to MY 2017, all but three of the individual HC BH Contractors showed no statistically significant changes in QI 1 rates (**Table 3.1**). CMP and York-Adams saw statistically significant increases in the QI 1 rates, while NCSO saw a significant decrease in the QI 1 rate. Of the individual HC BH Contractors, CMP and York-Adams met their MY 2017 interim QI 1 goal.

MY 2017 rates for QI 2 was not statistically significantly different compared to MY 2016 for all HC BH contractors except for York-Adams. Of all the contractors, Blair and York-Adams met their interim QI2 goal for MY 2017.

Figure 3.1 is a graphical representation of MY 2017 HEDIS FUH 7- and 30-Day follow-up rates in the 6 to 64 years old population for CCBH and its associated HC BH Contractors.

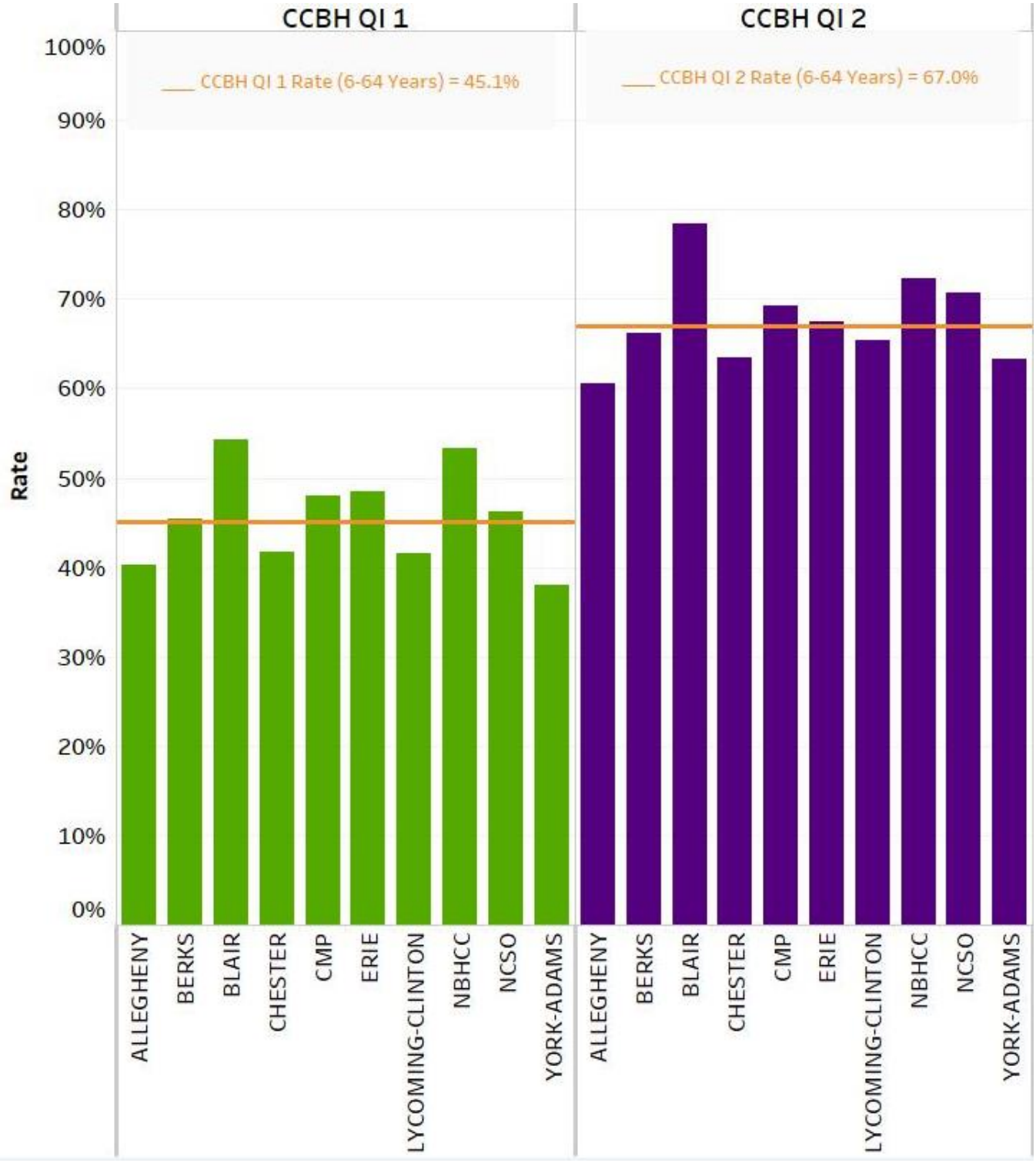
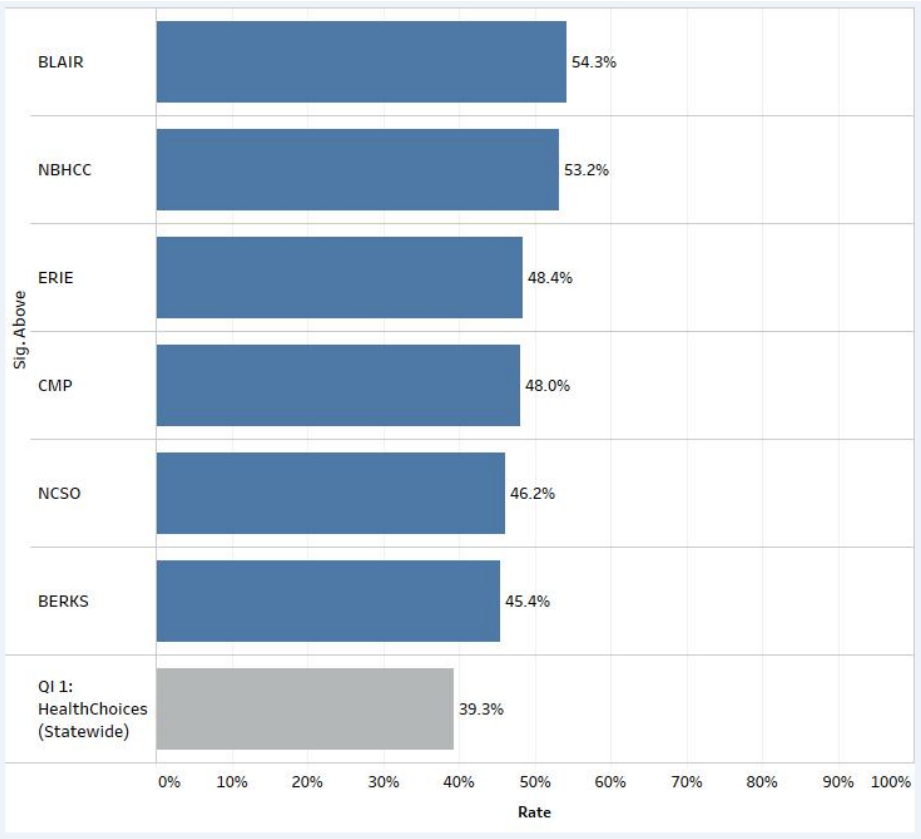


Figure 3.1: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (6–64 Years).

Figure 3.2 shows the HC BH (Statewide) rates for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the HC BH (Statewide) rate. The QI 1 rates for Berks, NCSO, CMP, Erie, NBHCC, and Blair were statistically significantly above the MY 2017 QI 1 HC BH rate of 39.3%. The QI 2 rates for Lycoming-Clinton, Berks, Erie, CMP, NCSO, NBHCC, and Blair were statistically significantly higher than the QI 2 HC BH rate of 60.9% by a range of 4.4 to 17.5 percentage points.



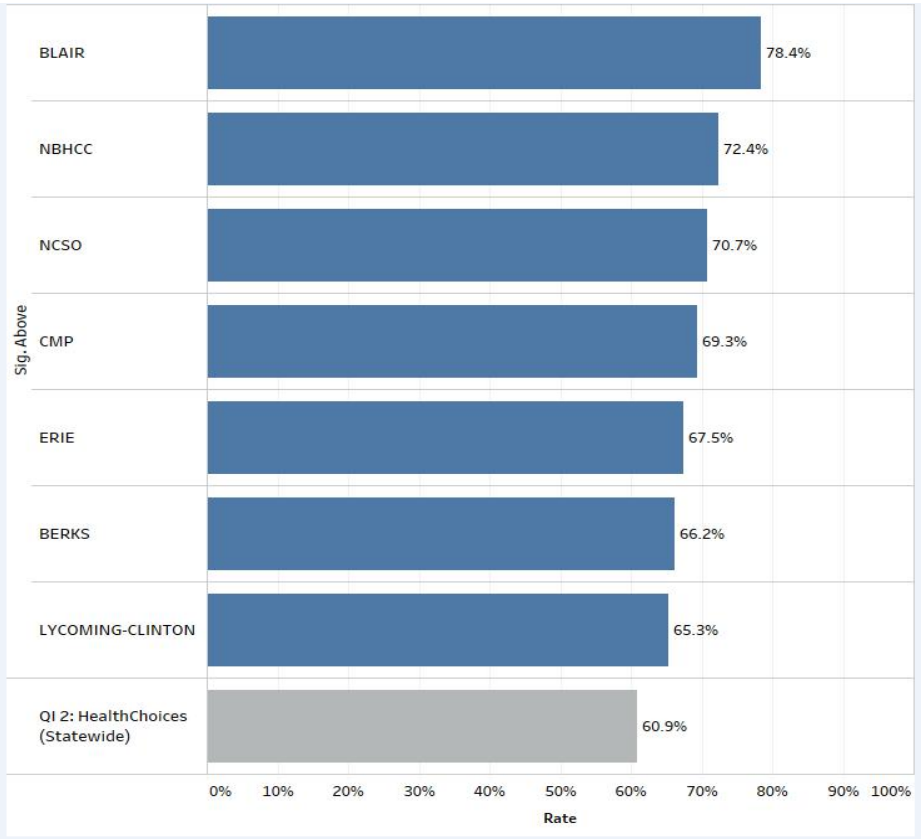


Figure 3.2: Comparison of CCBH Contractor MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (6–64 Years) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (6–64 Years).

(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 CCBH, the MY 2017 rate was 44.9% for QI1 and 66.9% for QI2. NCSO's rate for FUH QI1 fell significantly, while CMP's rate for FUH QI 1 increased (improved) significantly. Rates for York-Adams increased for both QI1 and QI2 from MY 2016 to MY 2017.

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%	-4.3	Yes	Below 75th percentile, above 50th percentile
CCBH	7,239	16,136	**44.9%**	44.1%	45.6%	45.4%	-0.5	No	Below 75th percentile, above 50th percentile
Allegheny	1,508	3,761	**40.1%**	38.5%	41.7%	41.5%	-1.4	No	Below 75th percentile, above 50th percentile
Blair	314	581	**54.0%**	49.9%	58.2%	48.5%	5.5	No	At or above 75th percentile
Berks	616	1,367	**45.1%**	42.4%	47.7%	44.4%	0.6	No	Below 75th percentile, above 50th percentile
Chester	353	858	**41.1%**	37.8%	44.5%	43.3%	-2.1	No	Below 75th percentile, above 50th percentile
CMP	379	793	**47.8%**	44.3%	51.3%	41.2%	6.6	Yes	At or above 75th percentile
Erie	520	1,078	**48.2%**	45.2%	51.3%	45.0%	3.3	No	At or above 75th percentile
Lycoming-Clinton	207	499	**41.5%**	37.1%	45.9%	45.7%	-4.3	No	Below 75th percentile, above 50th percentile
NBHCC	995	1,876	**53.0%**	50.8%	55.3%	55.0%	-2.0	No	At or above 75th percentile
NCSO	1,874	4,068	**46.1%**	44.5%	47.6%	49.8%	-3.8	Yes	At or above 75th percentile
York-Adams	473	1,255	**37.7%**	35.0%	40.4%	32.3%	5.4	Yes	Below 75th percentile, above 50th percentile
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
CCBH	10,790	16,136	**66.9%**	66.1%	67.6%	66.5%	0.4	No	Below 75th percentile, above 50th percentile
Allegheny	2,267	3,761	**60.3%**	58.7%	61.9%	61.5%	-1.3	No	Below 75th percentile, above 50th percentile
Blair	457	581	**78.7%**	75.2%	82.1%	75.1%	3.5	No	At or above 75th percentile
Berks	903	1,367	**66.1%**	63.5%	68.6%	64.4%	1.6	No	Below 75th percentile, above 50th percentile
Chester	538	858	**62.7%**	59.4%	66.0%	62.3%	0.4	No	Below 75th percentile, above 50th percentile
CMP	548	793	**69.1%**	65.8%	72.4%	68.0%	1.1	No	At or above 75th percentile
Erie	725	1,078	**67.3%**	64.4%	70.1%	65.1%	2.1	No	Below 75th percentile, above 50th percentile
Lycoming-Clinton	326	499	**65.3%**	61.1%	69.6%	67.6%	-2.2	No	Below 75th percentile, above 50th percentile
NBHCC	1,359	1,876	**72.4%**	70.4%	74.5%	72.8%	-0.4	No	At or above 75th 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	
NCSO	2,876	4,068	**70.7%**	69.3%	72.1%	71.7%	-1.0	No	At or above 75th percentile
York-Adams	791	1,255	**63.0%**	60.3%	65.7%	57.2%	5.8	Yes	Below 75th percentile, above 50th percentile

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

Figure 3.3 is a graphical representation of the MY 2017 HEDIS follow-up rates for CCBH and its associated HC BH Contractors.

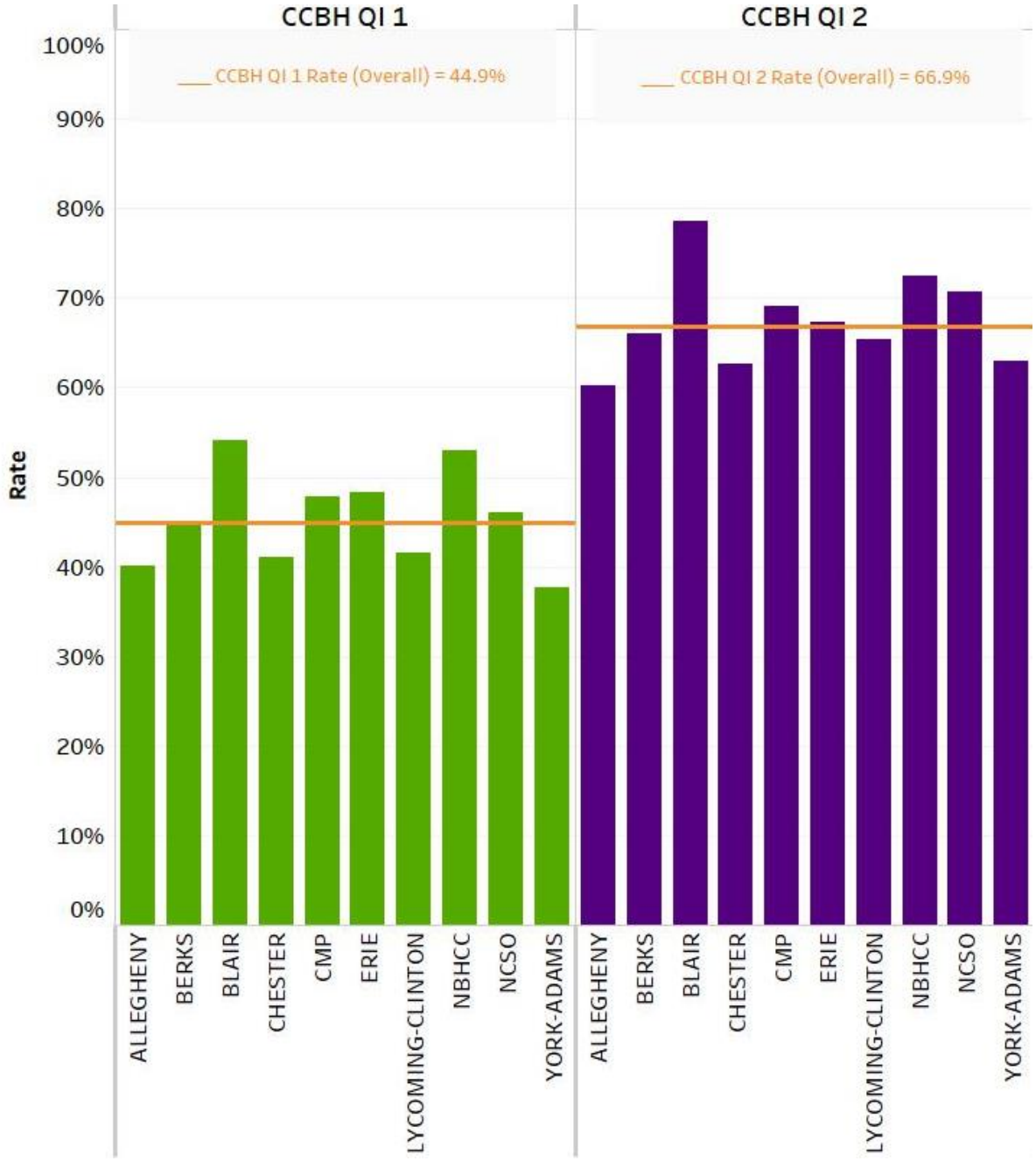


Figure 3.3: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (Overall).

Figure 3.4 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than its statewide benchmark. The QI 1 rates for Berks, NCSO, CMP, Erie, NBHCC, and Blair were statistically significantly above the MY 2017 QI 1 HC BH rate of 39.1%, with differences ranging from 6.0 percentage points above the statewide rate for Berks to 14.9 percentage points above the statewide rate for Blair. The QI 2 rates for Lycoming-Clinton, Berks, Erie, CMP, NCSO, NBHCC, and Blair were statistically significantly higher than the QI 2 HC BH rate of 60.6% by between 4.7 and 18.1 percentage points.

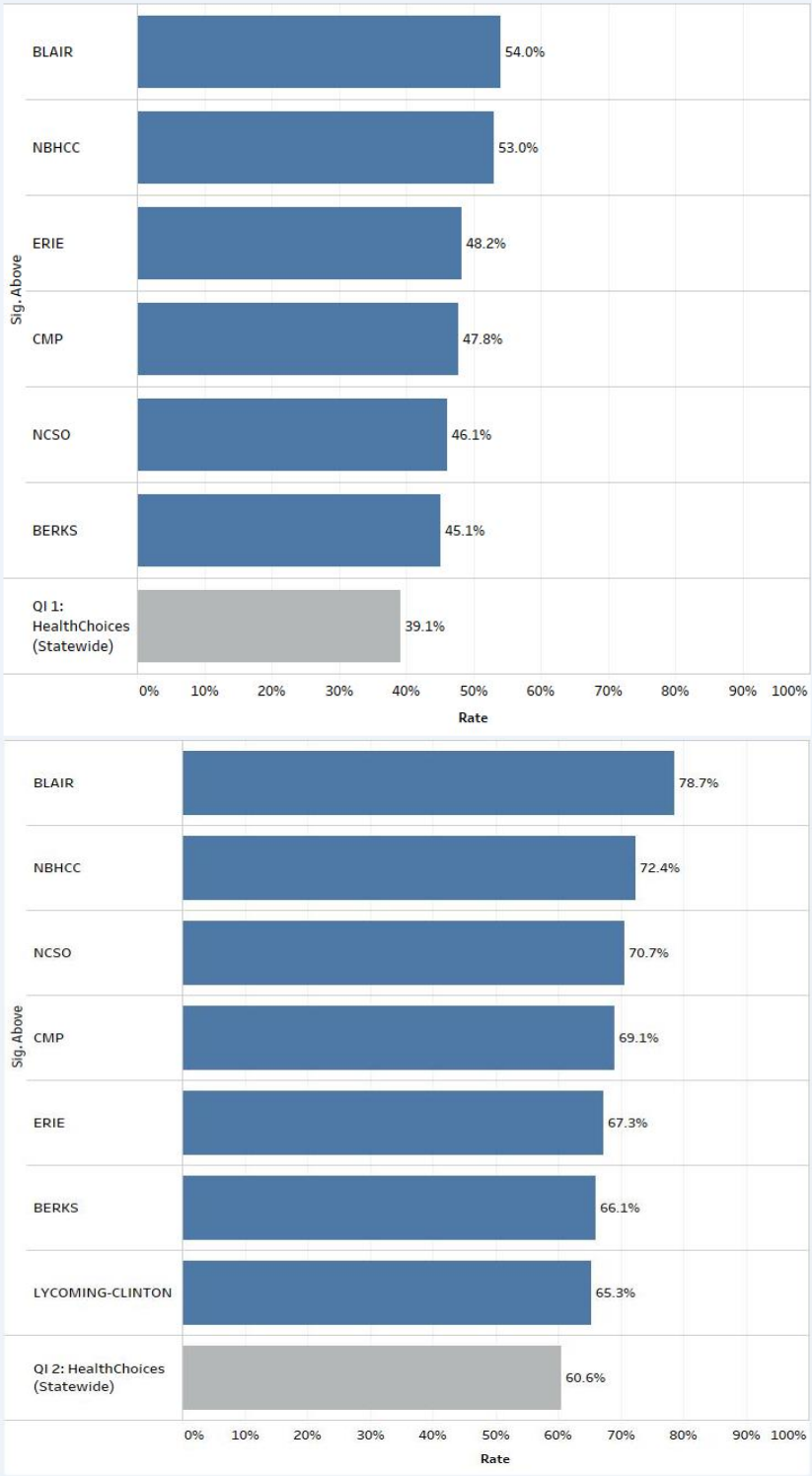


Figure 3.4: Comparison of CCBH Contractor MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (Overall) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (Overall).

(c) Age Group: 6–20 Years Old

The MY 2017 HealthChoices Aggregate rates in the 6 to 20 years age group were 51.1% for QI 1 and 74.0% for QI 2 (**Table 3.3**). These rates were statistically significantly lower compared to the MY 2016 HealthChoices Aggregate rates for the 6 to 20 years age cohort, which were 56.1% and 77.4%, respectively. The CCBH MY 2017 HEDIS rates for members ages 6 to 20 years were 54.8% for QI 1 and 77.5% for QI 2, which are statistically significantly lower compared to last year's rates (**Table 3.3**). As presented in **Table 3.3**, both rates for Allegheny statistically significantly decreased by 5.3 percentage points for QI1 and 4.2 percentage points for QI2. QI 1 rates for Chester and NCSO decreased significantly, while CMP rate increased from MY 2016 to MY 2017. The NBHCC MY 2017 HEDIS QI 2 rates for the members age group of 6 to 20 years decreased significantly compared to MY 2016.

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%	-4.9	Yes
CCBH	2,451	4,471	**54.8%**	53.3%	56.3%	58.0%	-3.2	Yes
Allegheny	459	889	**51.6%**	48.3%	55.0%	56.9%	-5.3	Yes
Blair	100	167	**59.9%**	52.1%	67.6%	63.2%	-3.3	No
Berks	190	342	**55.6%**	50.1%	61.0%	55.9%	-0.3	No
Chester	131	279	**47.0%**	40.9%	53.0%	56.7%	-9.7	Yes
CMP	139	231	**60.2%**	53.6%	66.7%	46.1%	14.1	Yes
Erie	157	268	**58.6%**	52.5%	64.7%	55.6%	3.0	No
Lycoming-Clinton	79	156	**50.6%**	42.5%	58.8%	57.4%	-6.7	No
NBHCC	282	434	**65.0%**	60.4%	69.6%	68.3%	-3.3	No
NCSO	703	1,285	**54.7%**	51.9%	57.5%	59.7%	-5.0	Yes
York-Adams	211	420	**50.2%**	45.3%	55.1%	48.5%	1.7	No
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
CCBH	3,463	4,471	**77.5%**	76.2%	78.7%	79.5%	-2.0	Yes
Allegheny	668	889	**75.1%**	72.2%	78.0%	79.3%	-4.2	Yes
Blair	144	167	**86.2%**	80.7%	91.8%	83.6%	2.7	No
Berks	257	342	**75.1%**	70.4%	79.9%	71.9%	3.2	No
Chester	196	279	**70.3%**	64.7%	75.8%	76.8%	-6.5	No
CMP	178	231	**77.1%**	71.4%	82.7%	79.6%	-2.5	No
Erie	214	268	**79.9%**	74.9%	84.8%	75.8%	4.0	No
Lycoming-Clinton	107	156	**68.6%**	61.0%	76.2%	75.4%	-6.8	No
NBHCC	351	434	**80.9%**	77.1%	84.7%	86.2%	-5.3	Yes
NCSO	1,031	1,285	**80.2%**	78.0%	82.4%	81.4%	-1.2	No
York-Adams	317	420	**75.5%**	71.2%	79.7%	74.5%	0.9	No

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

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

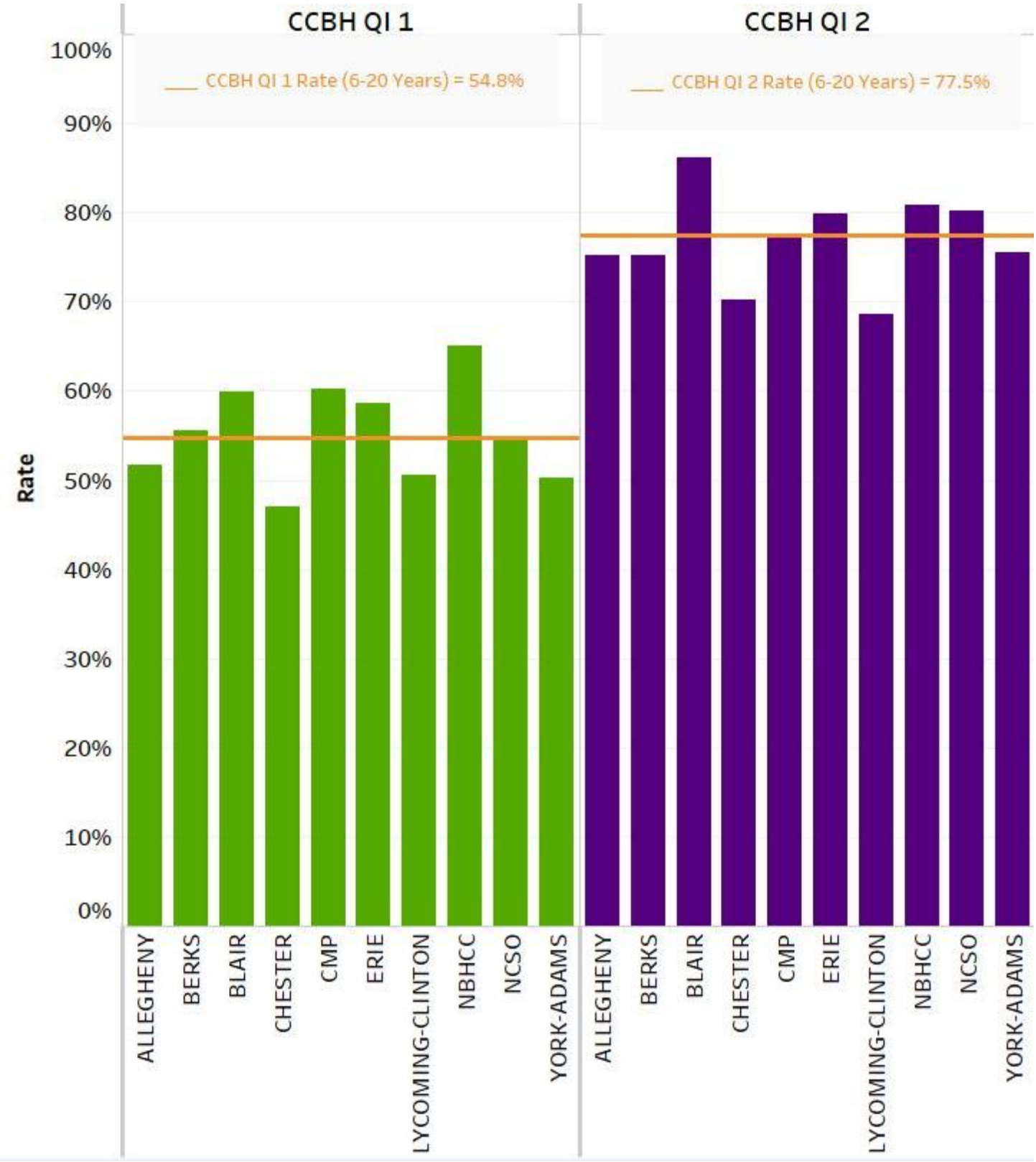


Figure 3.5: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (6–20 Years).

Figure 3.6 shows the HC BH (Statewide) rates for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide rates. The QI 1 rates for NCSO, Erie, Blair, CMP, and NBHCC were statistically significantly above the MY 2017 QI 1 HC BH rate of 51.1%, with differences ranging from 3.6 percentage points above the statewide benchmark for NCSO to 13.9 percentage points above the statewide benchmark for NBHCC. QI 2 rates for Erie, NCSO, NBHCC, and Blair were statistically significantly above the MY 2017 QI 2 HC BH rate of 74.0%, with differences ranging from 5.9 to 12.2 percentage points over the statewide rate.

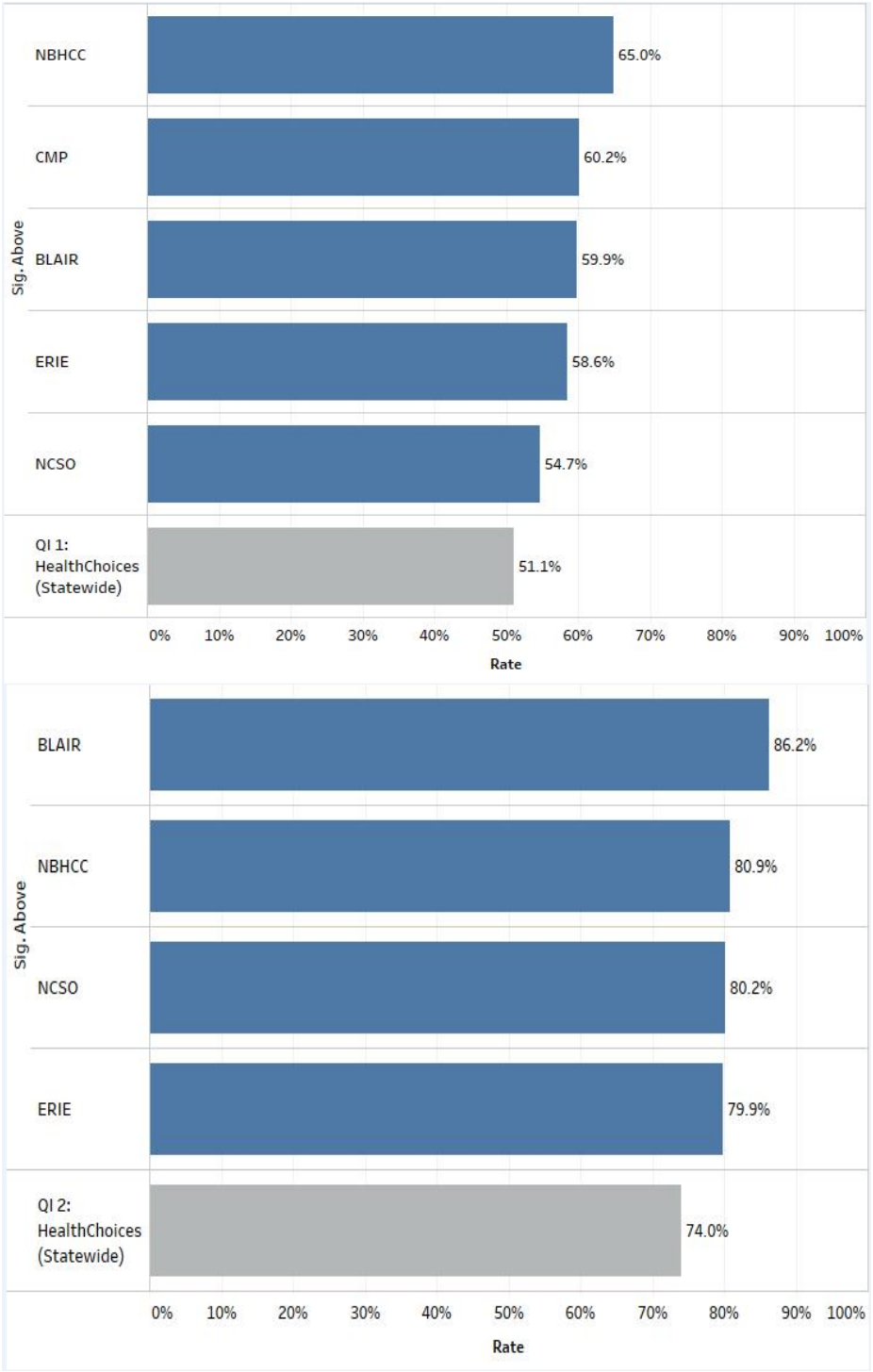


Figure 3.6: Comparison of CCBH Contractor MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (6–20 Years) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (6–20 Years).

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% by 0.8 percentage points. The MY 2017 CCBH QI A rate was 56.9%, which represents a 0.2 percentage point increase from the prior year, and the CCBH QI B rate was 74.0%, which represents a 0.8 percentage point increase from the prior year. These year-to-year changes were not statistically significant.

From MY 2016 to MY 2017, NCSO decreased and CMP increased their QI A rate by a statistically significant amount (**Table 3.4**). York-Adams experienced statistically significantly higher rates from MY 2016 to MY 2017 for both QI A and 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
CCBH	9,179	16,136	**56.9%**	56.1%	57.7%	56.7%	0.2	No
Allegheny	2,115	3,761	**56.2%**	54.6%	57.8%	58.0%	-1.8	No
Blair	373	581	**64.2%**	60.2%	68.2%	60.3%	3.9	No
Berks	794	1,367	**58.1%**	55.4%	60.7%	56.6%	1.5	No
Chester	443	858	**51.6%**	48.2%	55.0%	52.5%	-0.8	No
CMP	433	793	**54.6%**	51.1%	58.1%	47.6%	7.0	Yes
Erie	671	1,078	**62.2%**	59.3%	65.2%	58.9%	3.4	No
Lycoming-Clinton	292	499	**58.5%**	54.1%	62.9%	54.9%	3.6	No
NBHCC	1,095	1,876	**58.4%**	56.1%	60.6%	59.0%	-0.6	No
NCSO	2,363	4,068	**58.1%**	56.6%	59.6%	61.1%	-3.0	Yes
York-Adams	600	1,255	**47.8%**	45.0%	50.6%	41.4%	6.4	Yes
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
CCBH	11,945	16,136	**74.0%**	73.3%	74.7%	73.2%	0.8	No
Allegheny	2,671	3,761	**71.0%**	69.6%	72.5%	72.4%	-1.4	No
Blair	485	581	**83.5%**	80.4%	86.6%	80.8%	2.6	No
Berks	1,008	1,367	**73.7%**	71.4%	76.1%	72.5%	1.2	No
Chester	597	858	**69.6%**	66.4%	72.7%	67.0%	2.5	No
CMP	582	793	**73.4%**	70.3%	76.5%	71.1%	2.3	No
Erie	814	1,078	**75.5%**	72.9%	78.1%	73.4%	2.1	No
Lycoming-Clinton	381	499	**76.4%**	72.5%	80.2%	72.8%	3.6	No
NBHCC	1,412	1,876	**75.3%**	73.3%	77.2%	74.7%	0.6	No
NCSO	3,126	4,068	**76.8%**	75.5%	78.2%	77.5%	-0.7	No
York-Adams	869	1,255	**69.2%**	66.6%	71.8%	62.7%	6.6	Yes

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

Figure 3.7 is a graphical representation of the MY 2017 PA-specific follow-up rates for CCBH and its associated HC BH Contractors.

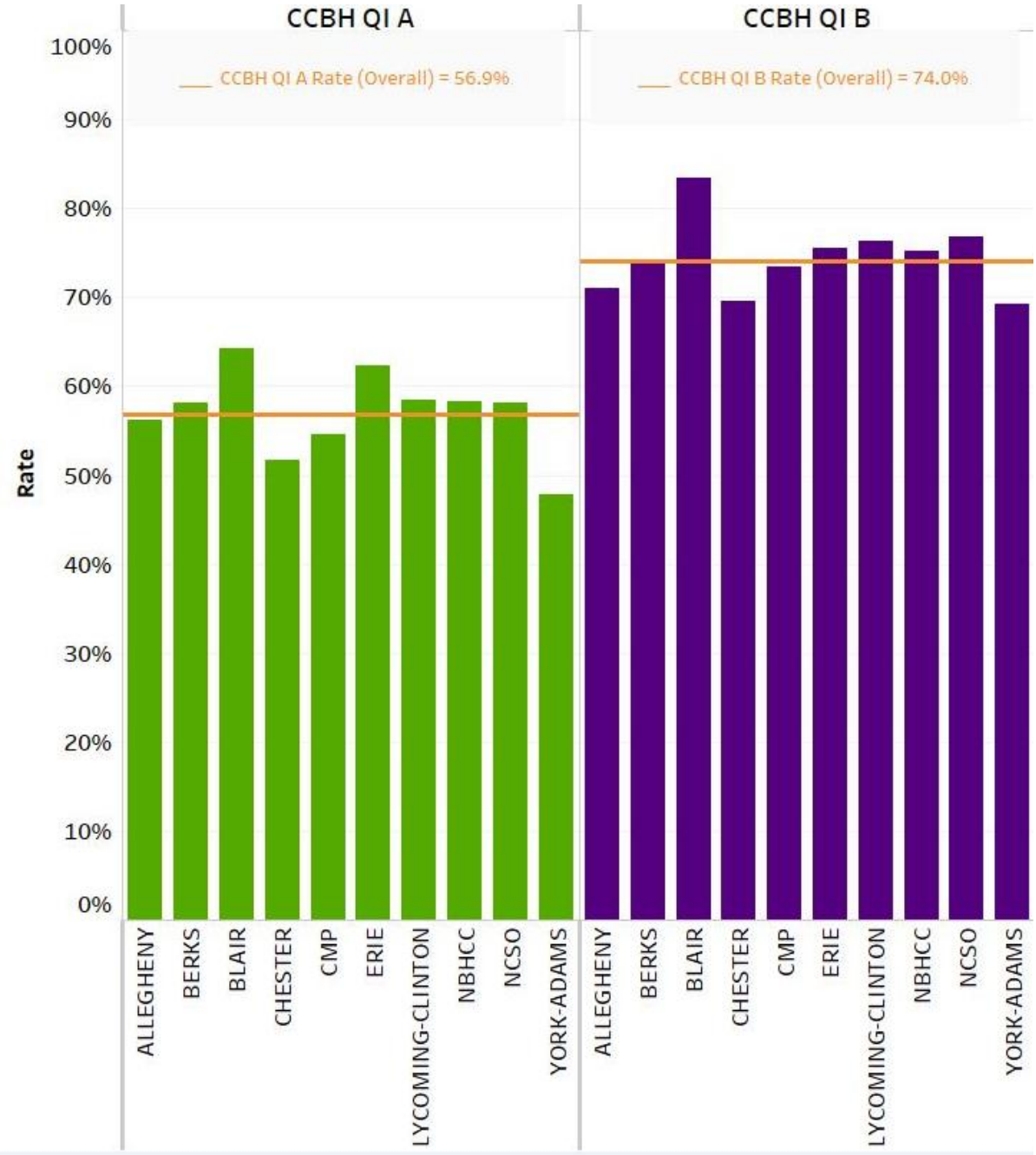


Figure 3.7: MY 2017 PA-Specific FUH 7- and 30-Day Follow-up Rates (Overall).

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. QI A rates for Allegheny, Berks, NCSO, NBHCC, Lycoming-Clinton, Erie, and Blair were statistically significantly above the MY 2017 QI A HC BH rate of 52.2%, with differences ranging from 4.0 percentage points above the statewide rate for Allegheny to 12.0 percentage points above the statewide rate for Blair. The QI A rate for York-Adams was statistically significantly lower than the statewide rate by 4.4 percentage points. QI B rates for CMP, Berks, NBHCC, Erie, Lycoming-Clinton, NCSO, and Blair were statistically significantly higher than the QI B HC rate of 69.6%, with differences ranging from 3.8 (for CMP) to 13.9 percentage points (for Blair).

Figure 3.8: Comparison of CCBH Contractor MY 2017 PA-Specific FUH 7- and 30-Day 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 rates 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 that 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 $p = 0.05$ level between groups are noted, as well as the PPD between the rates.

Individual rates were also compared to the categorical average. Rates statistically significantly above and/or below the average are indicated. Whether or not an individual rate performed statistically significantly above or below average was determined by whether or not that rate's 95% 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 CCBH MY 2017 readmission rate was 13.3%. The MY 2016 rate was 13.6%; this change was not statistically significant. CCBH did not meet the performance goal of a readmission rate at or below 10.0% in MY 2017.

From MY 2016 to MY 2017, only one of CCBH's HC BH Contractors – Chester County – demonstrated statistically significant improvement. The readmission rate for Chester decreased (improved) by 5.1 percentage points from 18.0% to 12.9%. None of the HC BH Contractors with CCBH met or beat the OMHSAS performance goal of 10%.

Table 3.5: MY 2017 REA Readmission Indicators

MY 2017							MY 2016 %	MY 2017 Rate Comparison To MY 2016	
				95% CI		Goal Met?[1]			
Measure	(N)	(D)	%	Lower	Upper			PPD	SSD
Inpatient Readmission									
Statewide	7,121	52,977	**13.4%**	13.2%	13.7%	No	13.9%	-0.5	Yes
CCBH	2,793	21,007	**13.3%**	12.8%	13.8%	No	13.6%	-0.3	No
Allegheny	626	4,767	**13.1%**	12.2%	14.1%	No	13.4%	-0.2	No
Blair	78	701	**11.1%**	8.7%	13.5%	No	13.9%	-2.8	No
Berks	334	1,857	**18.0%**	16.2%	19.8%	No	17.5%	0.5	No
Chester	141	1,093	**12.9%**	10.9%	14.9%	No	18.0%	-5.1	Yes
CMP	143	1,019	**14.0%**	11.9%	16.2%	No	13.7%	0.3	No
Erie	190	1,335	**14.2%**	12.3%	16.1%	No	14.4%	-0.1	No
Lycoming-Clinton	61	600	**10.2%**	7.7%	12.7%	No	11.7%	-1.5	No
NBHCC	400	2,875	**13.9%**	12.6%	15.2%	No	13.7%	0.2	No
NCSO	622	5,113	**12.2%**	11.3%	13.1%	No	11.9%	0.3	No
York-Adams	198	1,647	**12.0%**	10.4%	13.6%	No	11.3%	0.8	No

[1] 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; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option.

Figure 3.9 is a graphical representation of the MY 2017 readmission rates for CCBH HC BH Contractors compared to the OMHSAS performance goal of 10.0%.

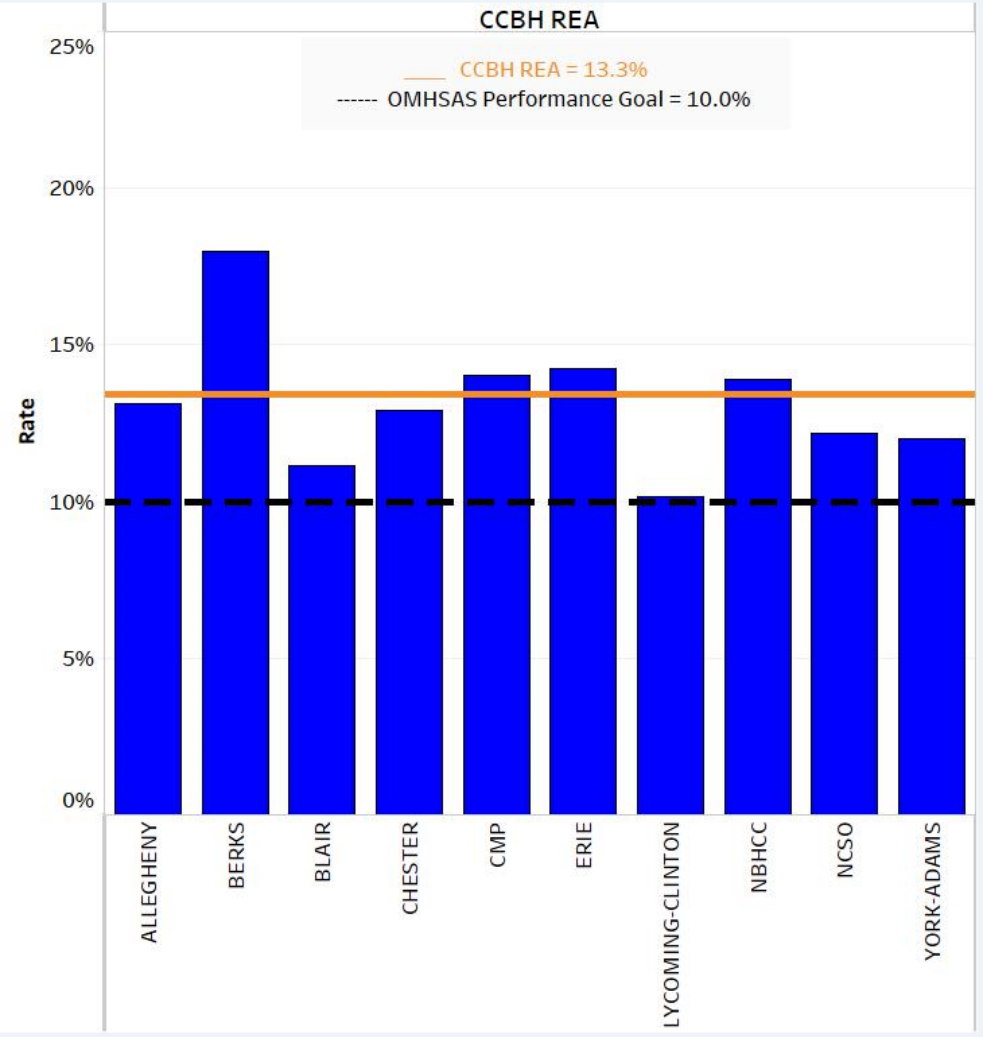


Figure 3.9: MY 2017 REA Readmission Rates.

Figure 3.10 shows the Health Choices BH (Statewide) readmission rate and the individual CCBH HC BH Contractors that performed statistically significantly higher (red) or lower (blue) than the statewide rate. NCSO and Lycoming-Clinton had readmission rates that were statistically significantly lower (better) than the HC BH Statewide rate of 13.4% by 1.2 and 3.2 percentage points, respectively. Berks demonstrated readmission rates that were statistically significantly higher than the statewide rate by 4.6 percentage points.

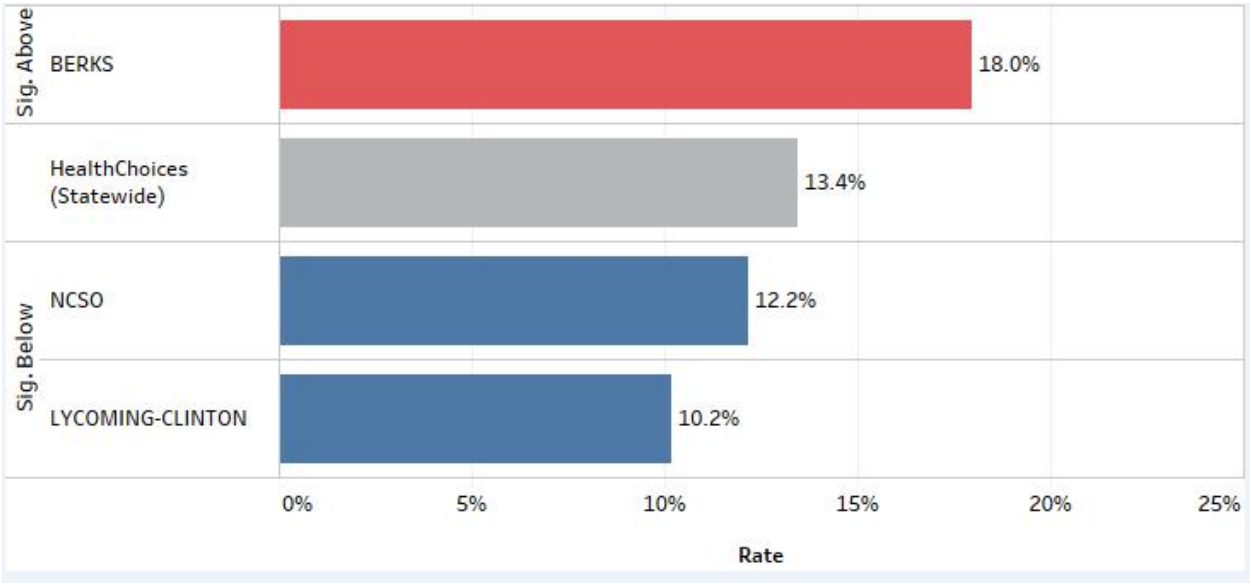


Figure 3.10: Comparison of CCBH Contractor MY 2017 REA Readmission Rates (Overall) versus HealthChoices (Statewide) MY 2017 REA Readmission Rates (Overall).

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 decrease of 0.5 percentage points in 2017, which was statistically significant. Readmission for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the current performance improvement project cycle, the recommendations may assist in future discussions.

In response to the 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[2]

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;

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

- 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 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's-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 year age group were 46.3% for Initiation and 34.6% for Engagement (**Table 3.6**). These rates were statistically significantly higher than the MY 2016 13–17 years old 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 CCBH MY 2017 13–17 years age group Initiation rate was 45.4%, which was statistically significantly higher than the MY 2016 CCBH rate of 40.2% (**Table 3.6**). CCBH MY 2017 13-17 years age group Engagement rate was 34.1%, which was statistically significantly higher than the MY 2016 rate of 27.4%. The CCBH Initiation rate was between the HEDIS 50th and 75th percentiles, and the CCBH Engagement rate came in at or above the HEDIS 75th percentile.

Of those HC BH Contractors with sufficiently large denominators to test change, Allegheny registered statistically significant changes in both initiation and engagement rates. Both Allegheny's Initiation rate and its Engagement rate increased (improved) significantly between MYs 2016 and 2017 by 8.0 and 14.0 percentage points, respectively. NCSO's initiation rate was also increased statistically significantly compared to prior year's rate by 13.4 percentage points. There was remarkable variation in performance on the Initiation submeasure among the CCBH Contractors. Four of the Contractors (Blair, Chester, Erie, and Lycoming-Clinton) had Initiation rates that were at or above the HEDIS 75th percentile, while four of the Contractors (Allegheny, CMP, NBHCC, and NCSO) had rates between the 50th and 75th percentiles; one of the Contractors (Berks) performed between the 25th and 50th percentile, and another one (York-Adams) was below the 25th percentile. Contractors demonstrated almost uniformly better performance with the Engagement rate than the initiation rate: York-Adams performed between the 50th and 75th percentiles, while the remaining nine Contractors produced rates at or above the 75th percentile.

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

	MY 2017						MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
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
CCBH	482	1062	**45.4%**	42.3%	48.4%	40.2%	5.2	YES	Below 75th Percentile, Above 50th Percentile
Allegheny	187	409	**45.7%**	40.8%	50.7%	37.7%	8.0	YES	Below 75th Percentile, Above 50th Percentile
Berks	35	98	**35.7%**	N/A	N/A	38.1%	-2.4	N/A	Below 50th

	MY 2017						MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
									Percentile, Above 25th Percentile
Blair	42	78	**53.8%**	N/A	N/A	64.7%	-10.9	N/A	At or Above 75th Percentile
Chester	26	51	**51.0%**	N/A	N/A	36.1%	14.9	N/A	At or Above 75th Percentile
CMP	16	34	**47.1%**	N/A	N/A	36.0%	11.1	N/A	Below 75th Percentile, Above 50th Percentile
Erie	37	69	**53.6%**	N/A	N/A	58.1%	-4.5	N/A	At or Above 75th Percentile
Lycoming-Clinton	16	29	**55.2%**	N/A	N/A	41.3%	13.9	N/A	At or Above 75th Percentile
NBHCC	47	101	**46.5%**	36.3%	56.8%	42.6%	4.0	NO	Below 75th Percentile, Above 50th Percentile
NCSO	47	100	**47.0%**	36.7%	57.3%	33.6%	13.4	YES	Below 75th Percentile, Above 50th Percentile
York-Adams	29	93	**31.2%**	N/A	N/A	28.0%	3.1	N/A	Below 25th 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
CCBH	362	1062	**34.1%**	31.2%	37.0%	27.4%	6.7	YES	At or Above 75th Percentile
Allegheny	151	409	**36.9%**	32.1%	41.7%	22.9%	14.0	YES	At or Above 75th Percentile
Berks	23	98	**23.5%**	N/A	N/A	29.8%	-6.3	N/A	At or Above 75th Percentile
Blair	37	78	**47.4%**	N/A	N/A	43.1%	4.3	N/A	At or Above 75th

	MY 2017						MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
									Percentile
Chester	19	51	**37.3%**	N/A	N/A	27.8%	9.5	N/A	At or Above 75th Percentile
CMP	15	34	**44.1%**	N/A	N/A	20.0%	24.1	N/A	At or Above 75th Percentile
ERIE	33	69	**47.8%**	N/A	N/A	48.8%	-1.0	N/A	At or Above 75th Percentile
Lycoming-Clinton	13	29	**44.8%**	N/A	N/A	30.4%	14.4	N/A	At or Above 75th Percentile
NBHCC	29	101	**28.7%**	19.4%	38.0%	29.8%	-1.1	NO	At or Above 75th Percentile
NCSO	28	100	**28.0%**	18.7%	37.3%	21.2%	6.8	NO	At or Above 75th Percentile
York-Adams	14	93	**15.1%**	N/A	N/A	18.3%	-3.2	N/A	Below 75th Percentile, Above 50th Percentile

MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option.
N/A: Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

Figure 3.11 is a graphical representation of the 13–17 years age group MY 2017 HEDIS Initiation and Engagement rates for CCBH and its associated HC BH Contractors.

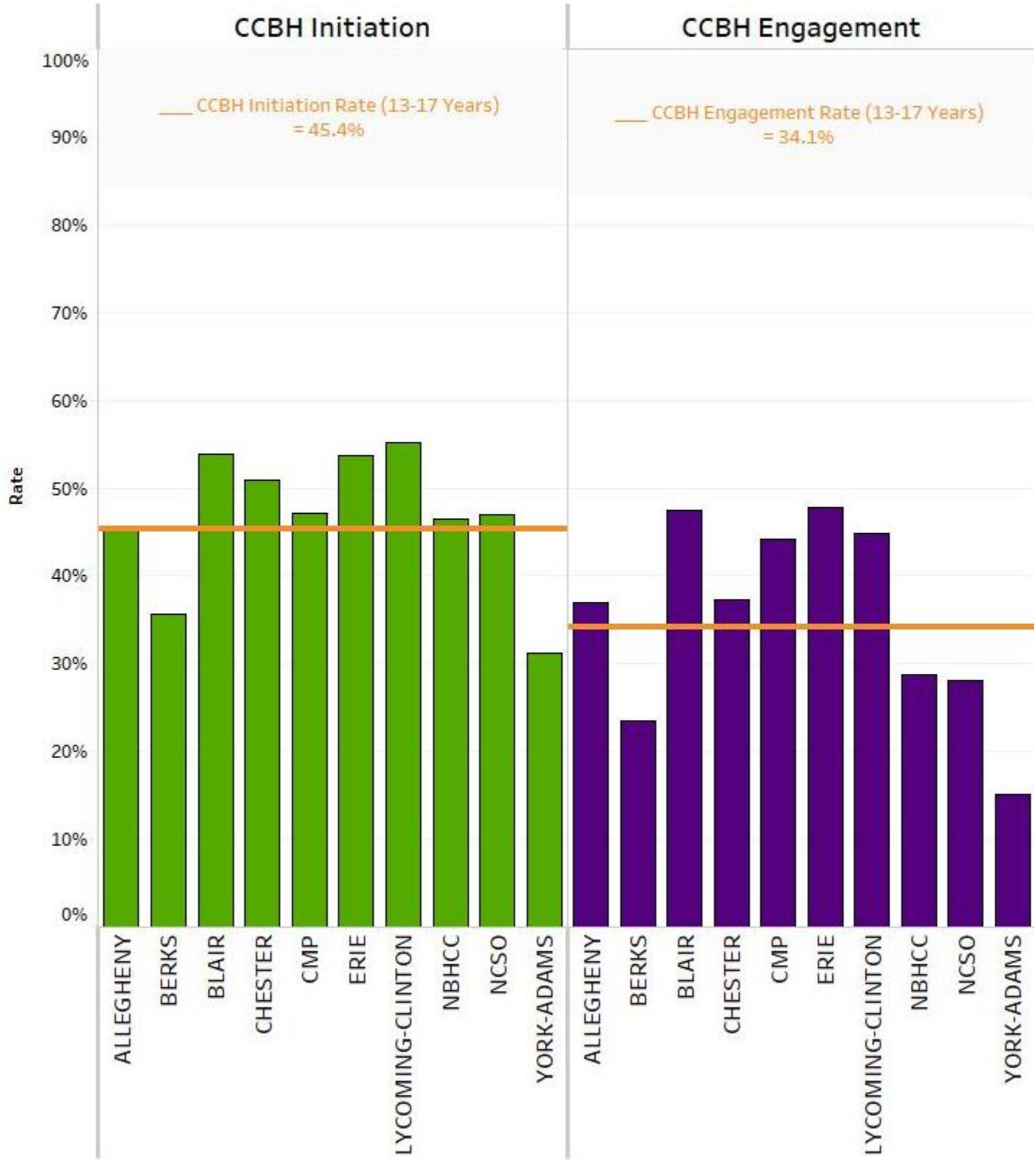


Figure 3.11: MY 2017 IET Initiation and Engagement Rates (13–17 Years).

Figure 3.12 shows the HealthChoices HC BH Contractor Average rates for this age cohort and the individual CCBH HC BH Contractor rates that would have been statistically significantly higher or lower than the HealthChoices HC BH Statewide rate. Out of contractors with large enough denominators (higher than 100), none of the rates were statistically significantly different compared to the Statewide rate of 46.3% for initiation and 34.6% for engagement rates.

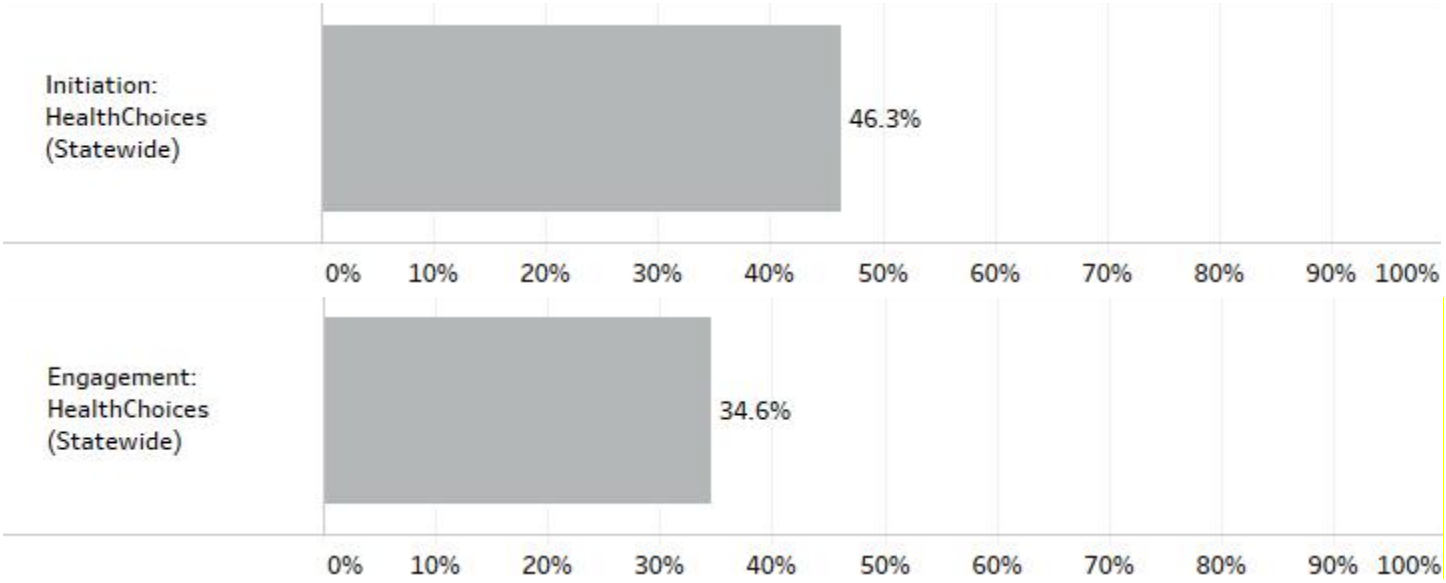


Figure 3.12: Comparison of CCBH Contractor MY 2017 IET Rates (13–17 Years) versus HealthChoices (Statewide) MY 2017 IET Rates (13–17 Years).

(b) Age Group: 18+ Years Old

The MY 2017 HealthChoices Aggregate rates in the 18 years and older 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 the 50th percentile, while the Engagement rate was at or above the 75th percentile.

The CCBH MY 2017 Initiation rate for the 18+ years population was 42.9% (**Table 3.7**). This rate was above the HEDIS 2018 50th percentile and below the 75th percentile, and was significantly higher than the MY 2016 rate. The CCBH MY 2017 Engagement rate for this age cohort was 35.6% and was at or above the HEDIS 2018 75th percentile. The CCBH Engagement rate for this age group was also statistically significantly higher than the MY 2016 rate.

As presented in **Table 3.7**, all contractors except one (Blair) experienced statistically significant increases both in their Initiation and Engagement rates over the prior year. Overall, the CCBH Contractors performed better on the Engagement, consistently scoring at or above the 75th percentile. In contrast, the Contractors fared worse on the Initiation submeasure. Only three contractors met the goal of performing at or above 75th percentile (Blair, Lycoming-Clinton, and York-Adams). Out of the remaining contractors, two (Berks and Chester) fell between the 50th and 75th percentiles, four (Allegheny, Erie, NBHCC, and NCSO) performed between the 25th and 50th percentiles, and one (CMP) performed below the 25th percentile.

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

	MY 2017						MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
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
CCBH	9776	22769	**42.9%**	42.3%	43.6%	27.6%	15.4	YES	Below 75th Percentile, Above 50th Percentile
ALLEGHENY	3587	8506	**42.2%**	41.1%	43.2%	26.5%	15.7	YES	Below 50th Percentile, Above 25th Percentile
Berks	891	1951	**45.7%**	43.4%	47.9%	27.8%	17.8	YES	Below 75th Percentile, Above 50th Percentile
Blair	322	682	**47.2%**	43.4%	51.0%	42.0%	5.2	NO	At or Above 75th Percentile
Chester	482	1128	**42.7%**	39.8%	45.7%	29.7%	13.0	YES	Below 75th Percentile, Above 50th Percentile
CMP	394	1021	**38.6%**	35.6%	41.6%	22.9%	15.6	YES	Below 25th Percentile
Erie	503	1208	**41.6%**	38.8%	44.5%	29.3%	12.4	YES	Below 50th Percentile, Above 25th Percentile
Lycoming-Clinton	288	596	**48.3%**	44.2%	52.4%	35.9%	12.4	YES	At or Above 75th Percentile
NBHCC	1101	2721	**40.5%**	38.6%	42.3%	24.5%	16.0	YES	Below 50th Percentile, Above 25th Percentile
NCSO	1308	3137	**41.7%**	40.0%	43.4%	27.7%	14.0	YES	Below 50th

	MY 2017						MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
									Percentile, Above 25th Percentile
York-Adams	900	1819	**49.5%**	47.2%	51.8%	26.2%	23.3	YES	At or Above 75th 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
CCBH	8099	22769	**35.6%**	34.9%	36.2%	18.1%	17.5	YES	At or Above 75th Percentile
Allegheny	3001	8506	**35.3%**	34.3%	36.3%	17.2%	18.1	YES	At or Above 75th Percentile
Berks	703	1951	**36.0%**	33.9%	38.2%	18.9%	17.1	YES	At or Above 75th Percentile
Blair	276	682	**40.5%**	36.7%	44.2%	31.0%	9.4	YES	At or Above 75th Percentile
Chester	400	1128	**35.5%**	32.6%	38.3%	21.1%	14.4	YES	At or Above 75th Percentile
CMP	303	1021	**29.7%**	26.8%	32.5%	13.6%	16.1	YES	At or Above 75th Percentile
Erie	441	1208	**36.5%**	33.8%	39.3%	19.7%	16.8	YES	At or Above 75th Percentile
Lycoming-Clinton	249	596	**41.8%**	37.7%	45.8%	24.1%	17.7	YES	At or Above 75th Percentile
NBHCC	887	2721	**32.6%**	30.8%	34.4%	15.4%	17.2	YES	At or Above 75th Percentile
NCSO	1058	3137	**33.7%**	32.1%	35.4%	17.3%	16.5	YES	At or Above 75th Percentile
York-Adams	781	1819	**42.9%**	40.6%	45.2%	18.2%	24.8	YES	At or Above 75th Percentile

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

Figure 3.13 is a graphical representation MY 2017 IET rates for CCBH and its associated HC BH Contractors for the 18+ years age group.

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

Figure 3.14 shows the HealthChoices HC BH Statewide rates and individual CCBH HC BH Contractors that performed statistically significantly higher or lower than the Statewide rate. The Initiation rates for Berks, Blair, Lycoming-Clinton, and York-Adams were statistically significantly higher than the HC BH Statewide rate of 41.1%, with differences from the Statewide rate ranging from 4.6 percentage points for Berks to 8.4 percentage points for York-Adams. The Engagement rates for Allegheny, Berks, Blair, Erie, Lycoming-Clinton, and York-Adams were statistically significantly higher than the HC BH Statewide rate of 33.7%, with differences ranging from 1.6 percentage points for Allegheny to 9.2 percentage points for York-Adams. Engagement rate for CMP was statistically significantly lower than the Statewide rate by 4.0 percentage points.

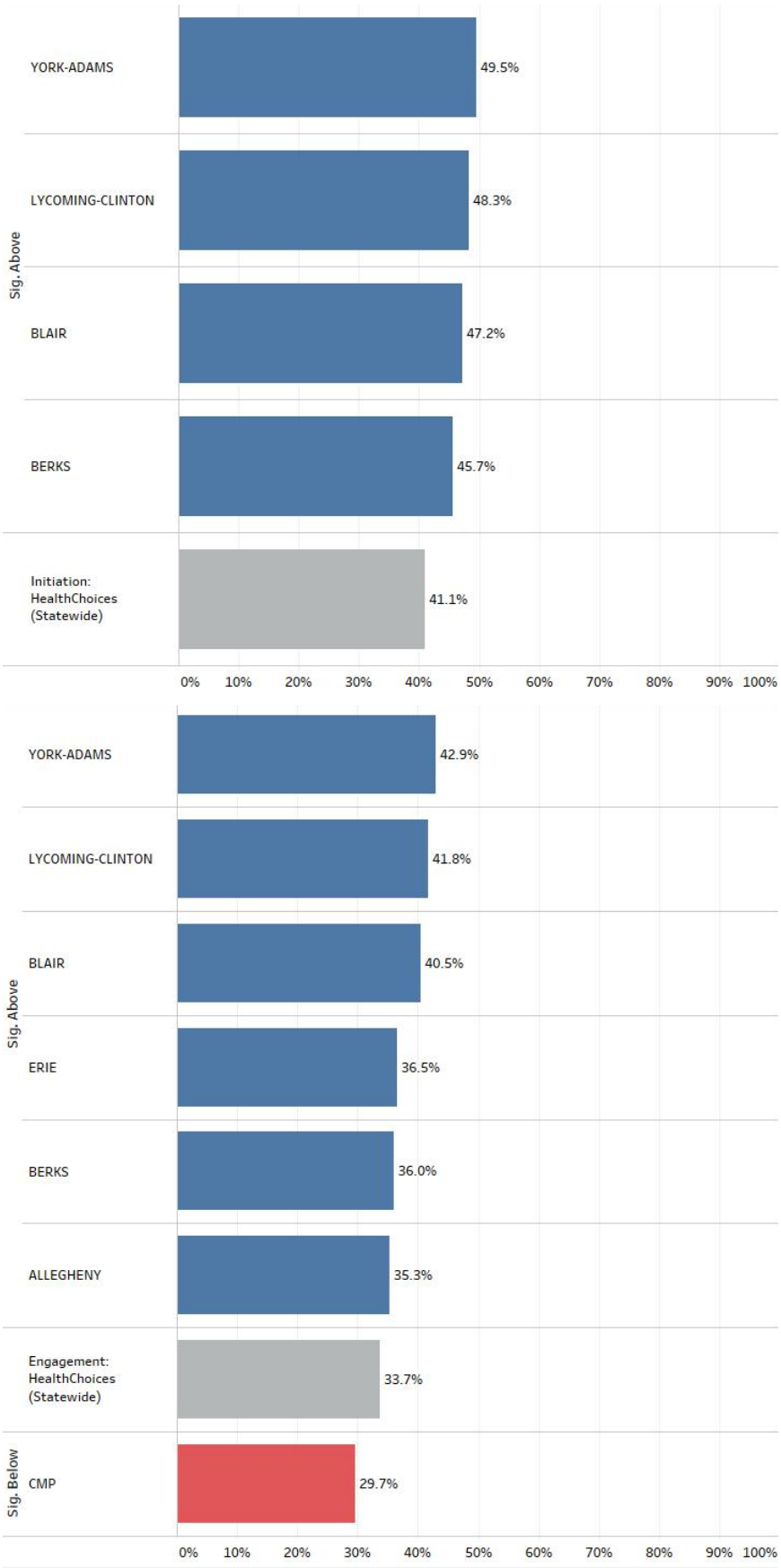


Figure 3.14: Comparison of CCBH Contractor MY 2017 IET Rates (18+ Years) versus HealthChoices (Statewide) MY 2017 IET Rates (18+ Years).

(c) Age Group: 13+ Years Old

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 CCBH MY 2017 Initiation rate for the 13+ years age population was 43.0% (**Table 3.8**). This rate was above the HEDIS 2018 50th percentile and below the 75th percentile and was significantly higher than the MY 2016 rate. The CCBH MY 2017 Engagement rate was 35.5%, which was at or above the HEDIS 2018 75th percentile. The CCBH Engagement rate was statistically significantly higher than the MY 2016 rate by 17.0 percentage points.

As presented in **Table 3.8**, Initiation and Engagement rates increased statistically significantly for all contractors except for Blair. Initiation rates in the 13+ years age population scored between the 25th and 50th percentiles for CMP, NBHCC, and NCSO. Out of the remaining contractors, four performed between the 50th and 75th percentiles (Allegheny, Berks, Chester, and Erie) and three scored at or above 75th percentile (Blair, Lycoming-Clinton, and York-Adams). For the Engagement rate, all Contractors saw significant increases from MY 2016 to MY 2017. As with other age groups and previous years, the Contractors continue to outperform the national averages on the Engagement rate submeasure, with all Contractors performing at or above the 75th percentile.

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

	MY 2017						MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
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
CCBH	10258	23831	**43.0%**	42.4%	43.7%	28.2%	14.8	YES	Below 75th Percentile, Above 50th Percentile
Allegheny	3774	8915	**42.3%**	41.3%	43.4%	27.0%	15.3	YES	Below 75th Percentile, Above 50th Percentile
Berks	926	2049	**45.2%**	43.0%	47.4%	28.4%	16.7	YES	Below 75th Percentile, Above 50th Percentile
Blair	364	760	**47.9%**	44.3%	51.5%	43.4%	4.5	NO	At or Above 75th Percentile
Chester	508	1179	**43.1%**	40.2%	46.0%	29.9%	13.1	YES	Below 75th

	MY 2017						MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
									Percentile, Above 50th Percentile
CMP	410	1055	**38.9%**	35.9%	41.9%	23.5%	15.4	YES	Below 50th Percentile, Above 25th Percentile
Erie	540	1277	**42.3%**	39.5%	45.0%	31.4%	10.9	YES	Below 75th Percentile, Above 50th Percentile
Lycoming-Clinton	304	625	**48.6%**	44.6%	52.6%	36.2%	12.4	YES	At or Above 75th Percentile
NBHCC	1148	2822	**40.7%**	38.9%	42.5%	25.3%	15.4	YES	Below 50th Percentile, Above 25th Percentile
NCSO	1355	3237	**41.9%**	40.1%	43.6%	28.0%	13.9	YES	Below 50th Percentile, Above 25th Percentile
York-Adams	929	1912	**48.6%**	46.3%	50.9%	26.3%	22.3	YES	At or Above 75th 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
CCBH	8461	23831	**35.5%**	34.9%	36.1%	18.5%	17.0	YES	At or Above 75th Percentile
Allegheny	3152	8915	**35.4%**	34.4%	36.4%	17.4%	17.9	YES	At or Above 75th Percentile
Berks	726	2049	**35.4%**	33.3%	37.5%	19.6%	15.8	YES	At or Above 75th Percentile
Blair	313	760	**41.2%**	37.6%	44.7%	31.8%	9.4	YES	At or Above 75th Percentile
Chester	419	1179	**35.5%**	32.8%	38.3%	21.3%	14.2	YES	At or Above 75th

	MY 2017						MY 2017 Rate Comparison		
				95% CI			To MY 2016		
Measure	(N)	(D)	%	Lower	Upper	MY 2016 %	PPD	SSD	To MY 2017 HEDIS Medicaid Percentiles
									Percentile
CMP	318	1055	**30.1%**	27.3%	33.0%	13.9%	16.3	YES	At or Above 75th Percentile
Erie	474	1277	**37.1%**	34.4%	39.8%	21.8%	15.3	YES	At or Above 75th Percentile
Lycoming-Clinton	262	625	**41.9%**	38.0%	45.9%	24.4%	17.5	YES	At or Above 75th Percentile
NBHCC	916	2822	**32.5%**	30.7%	34.2%	16.1%	16.4	YES	At or Above 75th Percentile
NCSO	1086	3237	**33.5%**	31.9%	35.2%	17.4%	16.1	YES	At or Above 75th Percentile
York-Adams	795	1912	**41.6%**	39.3%	43.8%	18.2%	23.4	YES	At or Above 75th Percentile

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

Figure 3.15 is a graphical representation MY 2017 IET rates for CCBH and its associated HC BH Contractors for the 18+ years age group.

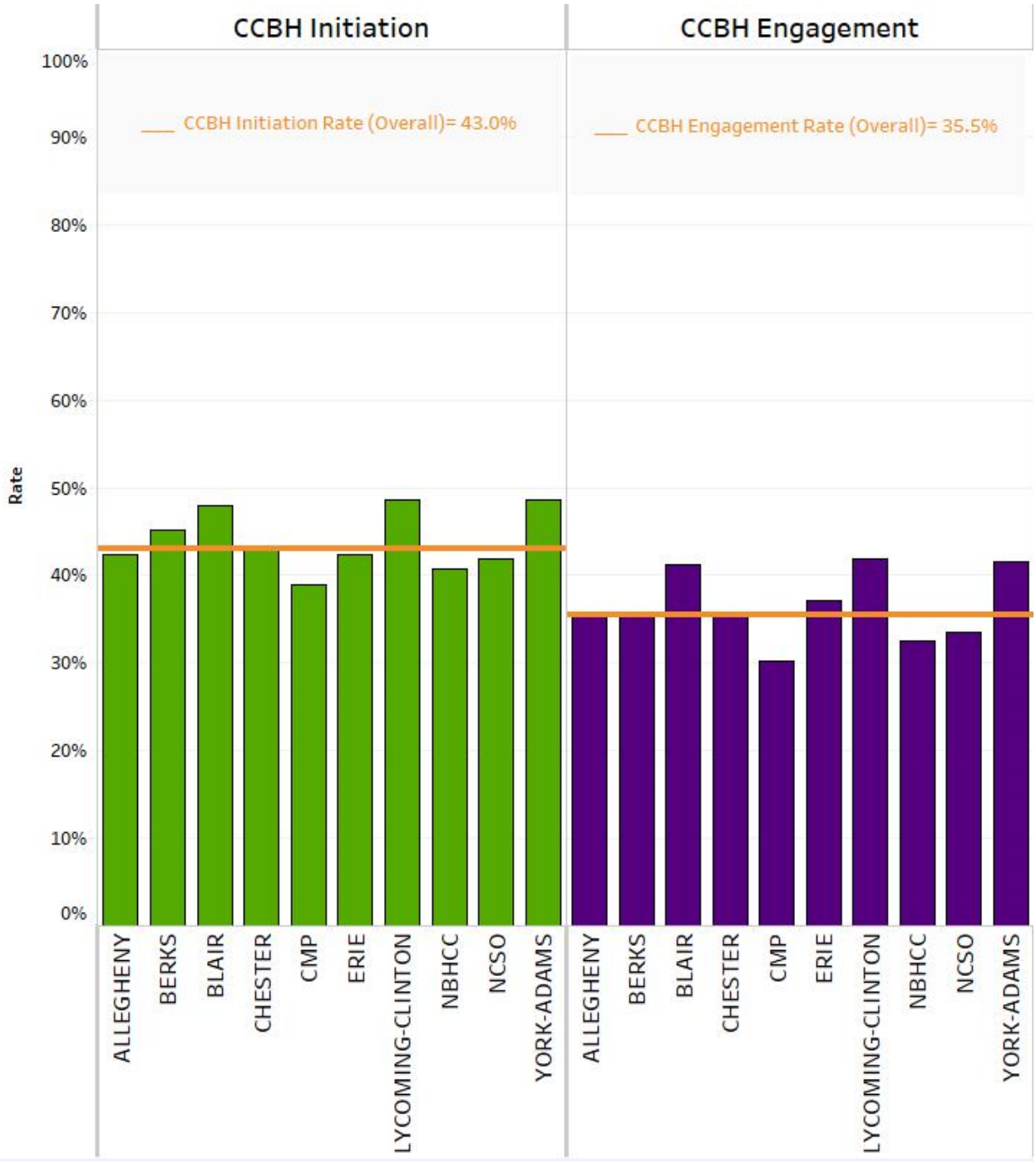


Figure 3.15: MY 2017 IET Initiation and Engagement Rates (Overall).

Figure 3.16 shows the HealthChoices (Statewide) rates and individual CCBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. The Initiation rates for Berks, Blair, York-Adams, and Lycoming-Clinton were statistically significantly higher than the HealthChoices (Statewide) rate of 41.3%, with differences ranging from 3.9 percentage points for Berks to 7.3 percentage points for Lycoming-Clinton and York-Adams. The Engagement rates for Allegheny, Erie, Blair, York-Adams, and Lycoming-Clinton were statistically significantly higher than the HC BH rate of 33.7%, with differences ranging from 1.7 percentage points for Allegheny to 8.2 percentage points for Lycoming-Clinton. The Engagement rate for CMP was statistically significantly lower than the HC BH (Statewide) rate by 3.6 percentage points.

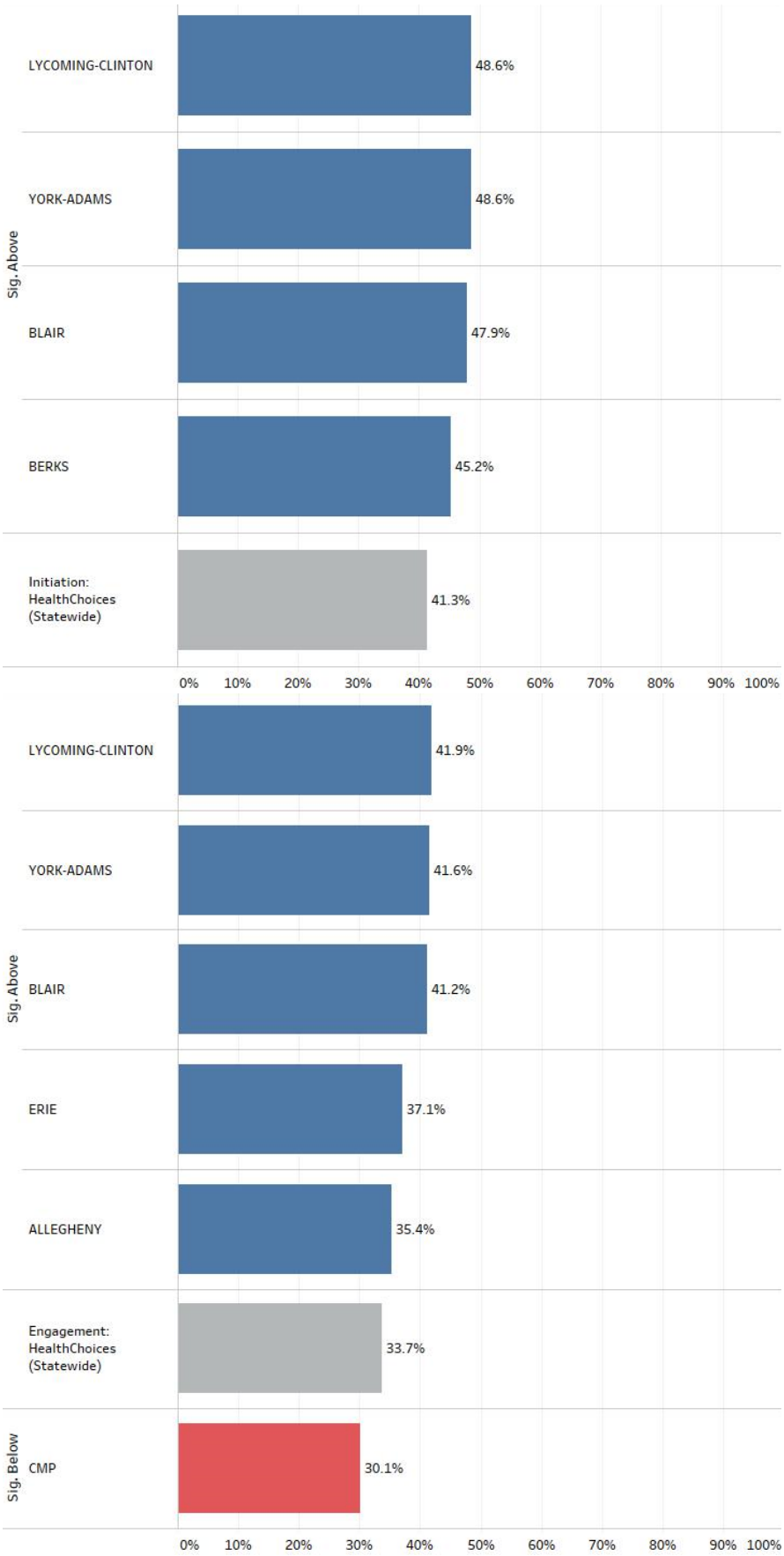


Figure 3.16: Comparison of CCBH Contractor MY 2017 IET Rates (Overall) versus HealthChoices (Statewide) MY 2017 IET Rates (Overall).

Conclusion and Recommendations

For MY 2017, the aggregate HealthChoices rate in the 13+ years age population (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 the 50th percentile, while the Engagement rate was at or above the 75th percentile. The Initiation and the Engagement rates both statistically significantly increased from MY 2016 rates. As seen with other performance measures, there is significant variation between the HC BH Contractors. 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, CCBH 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, PA 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), and 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 PA 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 Survey Monkey 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.

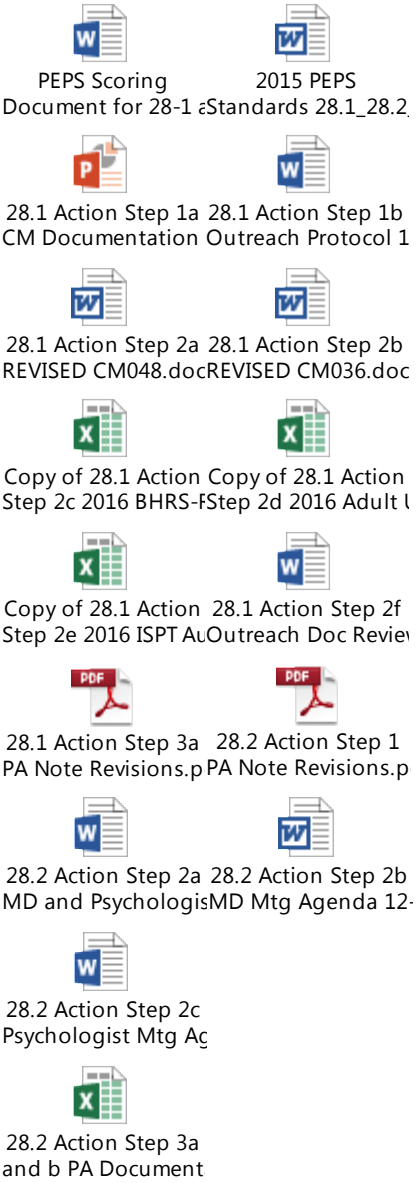
The BH-MCOs are required by OMHSAS to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the Pennsylvania Medicaid BH-MCOs. These activities follow a longitudinal format, and 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 CCBH's responses to opportunities for improvement cited by IPRO in the 2017 EQR Technical Report, detailing current and proposed interventions.

Table 5.1: BH-MCO's Responses to Opportunities for Improvement Cited in the 2017 EQR Technical Report

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2014, RY 2015, and RY 2016 found CCBH 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.
CCBH 2017.01	Within Subpart C: Enrollee Rights and Protections Regulations, CCBH was partially compliant on one out of seven categories – Enrollee Rights.	Date(s) of follow-up action taken through 6/30/18 and Ongoing	**PEPS Standard – 108.6 (RY2016) (Erie County only)** **Partially Compliant - Enrollee Rights**  Standard 108.6_Erie.doc
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
BH 2017.02	Within Subpart D: Quality Assessment and Performance Improvement Regulations, CCBH was partially compliant with five out of 10 categories, and non-compliant with	Date(s) of follow-up actions taken through 6/30/18 and Ongoing	**PEPS Standard 28.1 and 28.2 (RY 2015)** **Partially Compliant – 1) Availability of Services (Access to Care); 2) Coverage and Authorization of Services 4) Practice Guidelines** **Non-Compliant – 1) Coordination and Continuity**

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 CCBH 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.
	one category. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, 3) Subcontractual Relationships and Delegation, 4) Practice Guidelines, and 5) Quality Assessment and Performance Improvement Program. The non-compliant category was: 1) Coordination and Continuity of Care.		**of Care**  PEPS Scoring Document for 28-1 a 2015 PEPS Standards 28.1_28.2 28.1 Action Step 1a CM Documentation 28.1 Action Step 1b Outreach Protocol 1 28.1 Action Step 2a REVISED CM048.doc 28.1 Action Step 2b REVISED CM036.doc Copy of 28.1 Action Step 2c 2016 BHRS-F Copy of 28.1 Action Step 2d 2016 Adult I Copy of 28.1 Action Step 2e 2016 ISPT Au 28.1 Action Step 2f Outreach Doc Revie 28.1 Action Step 3a PA Note Revisions.p 28.2 Action Step 1 PA Note Revisions.p 28.2 Action Step 2a MD and Psychologis 28.2 Action Step 2b MD Mtg Agenda 12- 28.2 Action Step 2c Psychologist Mtg Ac 28.2 Action Step 3a and b PA Document
		Date(s) of future action planned / None	Describe one future action. Leave blank, if none.
		Date(s) of follow-up action taken through 6/30/18 and Ongoing	**PEPS Standard 93.1 (RY 2014)** **Partially Compliant – 1) Availability of Services (Access to Care) 4) Practice Guidelines 5) Quality Assessment and Performance Improvement Program**

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 CCBH 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.
			Community Care implemented the following to address the PEPs recommendations: (a) A new critical performance measure was added to all 2016 work plans to measure routine access. The data source is the member satisfaction survey. Questions #5, 6, and 7 (included in the attachment Response to 93.1a) are questions that relate to routine access. Question #5 is considered the routine access measure for Board Quality Improvement Committee (BQIC). Each contract will set their own goal or use the BQIC goal.  Response_93.1a.docx (b) Some of the typical levels of care requiring exceptions have been removed from reporting. Per an OMHSAS notification in January 2016 five specific service measures are no longer required as waiver performance standards. These included: • Drug and Alcohol Non-Hospital Detox – Adult • Drug and Alcohol Non-Hospital Detox – Child • Drug and Alcohol Non-Hospital Rehab – Adult • Drug and Alcohol Non-Hospital Rehab – Child • Drug and Alcohol Halfway House If there are any exceptions required, QMs address this in annual evaluations.
		Date(s) of future action planned/None	Describe one future-up action. Leave blank, if none.
		Date(s) of follow-up action taken through 6/30/18 and Ongoing	**PEPS Standard 99.1 (RY 2014) & 99.2 (RY2014) Partially Compliant – 3) Sub contractual relationships and Delegations** **PEPS Standard 99.1**

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 CCBH 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.
			Recommendation for PEPs 99.1 was to improve measurements in Residential Treatment Facility (RTF) Quality Reviews that can accurately demonstrate the improvement or decline in clinical delivery and reduction or increase in negative outcomes. Community Care made changes to the RTF quality review goal for the 2016 work plan. The goal was revised as follows: 100% Quality Improvement Plans (QIP) received, 80% on record review indicators, 100% of all safety concerns addressed immediately. **PEPS Standard 99.2 (RY 2014)** Recommendation for PEPs standard 99.2 was to report out on all follow-up activities associated with Significant Member Incidents (SMI) to include, but not limited to: documentation reviews, on-site reviews, QIP and Red Flag meetings, for all contracts. Community Care responded by indicating: documentation reviews, on-site reviews, and QIPs are reflected in the annual evaluation report on SMIs. The number of Red Flag meetings is contained in the annual evaluation introduction section.
		December 2018	The SMI data collection process will be streamlined; instead of asking each contract to submit SMI data, the data will be pulled directly from COGNOS (an internal database), which should lead to more reliable/valid data.
		Date(s) of follow-up action taken through 6/30/18	**PEPS Standards 91.4 & 91.7 (RY2016)** **Partially Compliant – 5) Quality Assessment and Performance Improvement Program**  Standards 91.4_91.7.doc
		February 2019 and March 1, 2019	**PEPS 91.7** 1. New QCMC reports including denial and upheld/ overturned grievance rates are planned for February 2019.

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 CCBH 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.
			2. Denial and upheld/ overturned grievance rates to be included in 2018 annual evaluation and submitted to OMHSAS 3/1/19.
CCBH 2017.03	CCBH was partially compliant with seven out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Handling of Grievances and Appeals, 4) Resolution and Notification: Grievances and Appeals, 5) Expedited Appeals Process, 6) Continuation of Benefits, and 7) Effectuation of Reversed Resolutions.	Follow Up Actions Taken Through 6/30/18 and Ongoing	**PEPS Standard 68.3, 68.4, 68.5 (RY2015) Partially Compliant – 1) Statutory Basis and Definitions 2) General Requirements 3) Handling of Grievances and Appeals** PEPS Scoring Document for 68-3 a Response to Cells_68.3-68.5.docx 68.3_L1_Complaint_ Decision_Template_I 68.4_L1_Complaint_ Provider_Acknowled 68.5_L1_Complaint_ Provider_Decision_T 68.5_Sample QIP Tracking Form.pdf
		7/1/18-8/31/18	From 7/1/18 – 8/31/18, Community Care has made significant changes to policies, procedures and documents in order to comply with changes to Appendix H that were implemented 9/1/18. Community Care will monitor these processes and revise as needed to maintain compliance.
		Follow Up Actions Taken Through 6/30/18 and Ongoing	**PEPS Standard 71.4 (RY2015) Partially Compliant – 1) Statutory Basis and Definitions 4) Resolution and Notification: Grievances and Appeals 5) Expedited Appeals Process 6) Continuation of Benefits 7) Effectuation of Reversed Resolutions** PEPS Scoring Document for 71-4.c Response_71.4.docx

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 CCBH 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.
			71.4_PPI Process.doc
		7/1/18-8/31/18	From 7/1/18 – 8/31/18, Community Care has made significant changes to policies, procedures and documents in order to comply with changes to Appendix H that were implemented 9/1/18. Community Care will monitor these processes and revise as needed to maintain compliance.

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, CCBH began to address opportunities for improvement related to compliance categories within Subparts: C (Enrollee Rights), D (partially compliant: Access to Care, Coverage and Authorization of Services, Subcontractual Relationships and Delegation, Practice Guidelines, and Quality Assessment and Performance Improvement Program; non-compliant: Coordination and Continuity of Care), 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) Handling of Grievances and Appeals, 4) Resolution and Notification: Grievances and Appeals, 5) Expedited Appeals Process, 6) Continuation of Benefits, and 7) Effectuation of Reversed Resolutions. Proposed actions and evidence of actions taken by CCBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring CCBH into compliance with the relevant Standards.

Root Cause Analysis and Action Plan

The 2017 EQR would have been the 10th year for which BH-MCOs would have been required to prepare an RCA 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;
- RCA 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 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 VBP at the HC BH Contractor level in January 2018. Thus, for the first time, RCA and CAP assignments were made at the Contractor level as well as at the BH MCO level. Contractors receiving assignments completed their RCAs and CAPs in November of 2017, while BH-MCOs completed their RCAs and CAPs by December 31, 2017. 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 corresponding action plans 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 CCBH's submission of its RCA and CAP for the FUH Ages 6-64 Years 7- and 30-Day measures.

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

HealthChoices BH MCO: Community Care Behavioral Health Organization	**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): Improve Community Care's CY2016 HEDIS 7 Day rate of 46.26% to the short term goal of 48.67% and improve Community Care's CY2016 HEDIS 30 Day rate of 67.21% to the short term goal of 69.91%; Long term goal: Meet or exceed the 75th percentile for both HEDIS 7 & 30 Day Follow Up Rates		
Analysis: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply. **Community Care used the following information/analysis to identify the factors that contributed to poor performance: aggregate process report from high risk interviews, an analysis of members without follow up, an analysis of members with follow up, an analysis of our expansion vs legacy members, information from our member satisfaction survey, information from the DMP chart abstraction, and information from the HealthChoices Behavioral Health Contractors.** 20170713-process-r eport-agg-ALL (002) HEDIS No_Follow Up Analysis Nov 201 HEDIS Follow Up Analysis Nov 2017.d Expansion_Legacy_ Analysis_Dec 2017.d 2017 Member Satisfaction Survey.(CY2016_ALL_Hospit als_DMP.xlsx	**Findings (only impactful and attainable root causes are listed here).** **People Root Causes:** ● **Culturally we are less accepting of behavioral health challenges and these are viewed negatively, members prefer to not address them or deal with them on their own.** ● **There is no system in place to update and store every follow up option that can be accessed by members and inpatient staff.** ● **Individuals with co-occurring disorders may have more demands and higher needs competing for attention such as avoiding jail, poor health, and death.** ● **Shared decision making (SDM) could alter the individual's perspective on follow up but SDM does not often occur.** ● **Members lack knowledge about how the system works.** ● **Member expectations about OP lead to members not keeping their follow up appointment.** **Provider Root Causes:** ● **Inpatient staff do not have the time to conduct this type of discharge plan and do not have access to all of the resources that would be needed.** ● **Inpatient treatment and care to date has not resulted in outcomes that would lead to monetary incentives for providers.** ● **Providers work primarily traditional M-F, 8-5 hours; if they do work evenings or weekends these timeframes fill up quickly and are generally not available on a routine basis.** ● **Providers are in different stages/phases in terms of their awareness of recovery.** ● **Providers do not include family members or other supports in**	

HealthChoices BH MCO: Community Care Behavioral Health Organization	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
Summary RCA_Community CaiFishbone Diagram_HEDIS_7_3 References_RCA_Fo llowUp.docx	**discharge planning around medication to provide additional support for the member.** **Policy/Procedure Root Causes** ● **Inpatient staff may duplicate work if preferences and type of follow up changes during the individual's inpatient stay and therefore, may not change the way they schedule follow up.** ● **Members with shorter lengths of stay are not getting their needs addressed.** ● **Social determinants are complex and difficult to impact.** ● **Training in medication management is costly in both time and money; furthermore, inpatient staff would not desire another task as they are already busy.** **Provisions Root Causes:** ● **There is not a process in place for families to be routinely included for feedback and treatment preferences, which may make the discharge planning process more efficient and/or effective.** ● **Inpatient staff do not have the time to conduct this type of discharge plan and do not have access to all of the resources that would be needed.** ● **Providers focus on internal documentation for accreditation or reimbursement purposes.** ● **Training in motivational techniques are costly in both time and money and may result in staff feeling too pressured to fit in these discussions during an already busy work schedule.** ● **It is easier and faster to tell the individual what to do after discharge rather than elicit aftercare preferences, educate on medications, and role play.**	
People (1) (All Causes) (e.g., personnel, patients) 1) **Members do not have a perceived need for treatment (Friedman, 2014).** **1b. Stigma associated with mental illness (shame/blame).** **1c. Physical illness is accepted in our culture but behavioral challenges are viewed as a personality flaws.** **1d. Our healthcare is set up to address physical health issues rather than behavioral health issues.** **1e. Physical testing can confirm physical illness; behavioral challenges cannot be confirmed with a specific test.** **1f. Culturally we are less accepting of behavioral health challenges and these are viewed negatively, members prefer to not address with them or deal with them on their own.**	**Initial Response: Culturally we are less accepting of behavioral health challenges and these are viewed negatively, members prefer to not address them or deal with them on their own.** **Follow-up Status Response:** At the individual level (individual members on the inpatient unit), the root cause is impactful and attainable.	
People (2) (e.g., personnel, patients)	**Initial Response: Inpatient units are designed for acute stabilization and are able to address some issues related to dual diagnosis but are not**	

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2) **Members (10%) with co-occurring disorders end up on an inpatient units and report they relapsed before their follow up appointment. (High Risk Interview, HRI)** **2b. Members are returned to their same environment, same triggers without adequate discharge plan (meaning rehab, member readiness, timely OP) or relapse prevention plans.** **2c. Inpatient units are designed for acute stabilization and are able to address some issues related to dual diagnosis but are not designed to provide an adequate period of abstinence or comprehensive D&A treatment.**	**designed to provide an adequate period of abstinence or comprehensive D&A treatment.** **Follow-up Status Response:** Root Cause is not impactful and not attainable.	
People (3) (All Causes) (e.g., personnel, patients) 3) **Members are not incentivized to keep follow up appointments.** **1b. MA rules prohibit cash or monetary incentives to encourage members to keep follow up appointments.**	**Initial Response: MA rules prohibit cash or monetary incentives to encourage members to keep follow up appointments.** **Follow-up Status Response:** Root cause is not attainable and therefore not impactful.	
People (4) (All Causes) (e.g., personnel, patients) 4) **Our analysis of members found that members in the MA expansion group had lower rates of follow up. (Refer to Analysis on no follow up; will be referenced as "Analysis" going forward).** **1b. Members in the expansion group are likely to be new to the BH system and may not understand the importance of follow up or know follow up options.** **1c. Inpatient facilities may not do adequate education around treatment options post discharge.** **1d. Inpatient staff may assume that members already know the BH system, may not have the time to educate members on follow up, or do not know all of the current follow up options themselves.** **1e. There is no system in place to update and store every follow up option that can be accessed by members and inpatient staff; furthermore, not all follow up options are available or appropriate for all members.**	**Initial Response: There is no system in place to update and store every follow up option that can be accessed by members and inpatient staff.** **Follow-up Status Response:** There is no system in place to update and store every follow up option that can be accessed by members and inpatient staff; however, this information can be obtained from a Community Care staff member. The root cause is attainable; the impact would be minimal as this is not a large change from current practice.	

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People (5) (All Causes) (e.g., personnel, patients) 5) **Our analysis found the socio-demographic factors of age, non-white (black/other race), and male had lower rates of follow up. (Analysis)** **1b. Certain demographic factors are associated with lower rates of follow up.**	**Initial Response: Certain demographic factors are associated with lower rates of follow up.** **Follow-up Status Response:** Interventions should be sensitive to the fact that certain demographic factors are associated with lower rates of follow up and should adjust accordingly. This root cause permeates other causes and interventions. Association does not infer causality. By itself, this root cause is not attainable and therefore, not impactful.	
People (6) (All Causes) (e.g., personnel, patients) 6) **Our analysis found Members with co-occurring drug and alcohol issues had lower rates of follow up. (Analysis)** **1b. Individuals with co-occurring drug and alcohol issues may be less motivated to attend follow up.** **1c. Individuals with co-occurring disorders may have more demands and higher needs competing for attention such as avoiding jail, poor health, and death.**	**Initial Response: Individuals with co-occurring disorders may have more demands and higher needs competing for attention such as avoiding jail, poor health, and death.** **Follow-up Status Response:** Interventions could focus on motivational change in this population; however, the root cause suggest timing of the intervention does not allow for immediate BH follow up. This root cause is attainable and impactful but focused on longer term outcomes.	
People (7) (All Causes) (e.g., personnel, patients) 7) **Our analysis found that Members on involuntary commitments had lower follow up rates. (Analysis)** **1b. Individuals with involuntary commitments may not want to use the BH system at all.** **1c. These individuals may have had a prior negative experience, they may not feel that they have an issue or need to change anything;** **1d. Personal beliefs may dictate attendance at follow up care.** **1e. Attendance at service and type of service is left to the individual which is consistent with a recovery model.** **1f. Shared decision making (SDM) in partnership with member could alter the individual's perspective on follow up but SDM does not often occur.**	**Initial Response: Shared decision making (SDM) in partnership with member could alter the individual's perspective on follow up but SDM does not often occur.** **Follow-up Status Response:** In a recovery-based system, ongoing service and treatment should be determined by the clinician and individual working together; this shared decision making process does not always occur. This root cause is attainable and is impactful.	
People (8) (All Causes) (e.g., personnel, patients) 8) **Members (7%) reported during high risk interviews that they choose not to attend follow up appointment. (HRI)** **1b. Personal beliefs may dictate attendance at follow up care.**	**Initial Response: Shared decision making could alter the individual's perspective on follow up but SDM does not often occur.** **Follow-up Status Response:** The root cause is attainable and is impactful.	

1c. Attendance at service and type of service is left to the individual. **1d. the recovery model of BH services does not force someone to enter treatment long term.** **1d. Shared decision making could alter the individual's perspective on follow up but SDM does not often occur.**	
People (9) (All Causes) (e.g., personnel, patients) **9) Providers reported during a Focus Group that members who missed follow up appointments (either due to childcare, transportation, or that they forgot) did not realize how long it would take to get another appointment.** **1b. When they rescheduled their appointment, it took longer than they expected to get another appointment and they were often outside of the 7 or 30 day follow up appointment timeframe.** **1d. Members lack knowledge about how the system works.**	**Initial response: Members lack knowledge about how the system works.** **Follow-up Status Response:** The root cause is attainable and is impactful.
People (10) (All Causes) (e.g., personnel, patients) **10) Outpatient treatment may not fit into members personal goals for recovery. (Reported during Focus Group)** **1b. Regular OP treatment does not address all of their goals.** **1c. Members have heard about a service like ACT/CTT (or another more intensive service than OP) while in the IP unit and upon discharge believe they need a more intensive service than OP.** **1d. Member expectations about OP lead to members not keeping their appointment.**	**Initial Response: Member expectations about OP lead to members not keeping their appointment.** **Follow-up Status Response:** The root cause is attainable and is impactful.
Providers (1) (e.g. provider facilities, provider network) 1) **Members reported they do not have a follow up appointment scheduled at the time of discharge. (15.5% of members from Member Satisfaction Survey, 32% from HRI)** **1b. Providers did not schedule a follow up**	**Initial Response: Inpatient staff do not have the time to conduct individualized discharge plans and do not have access to all of the resources that would be needed.** **Follow-up Status Response:** The root cause could be improved upon. The use of discharge planning staff could address this issue; however, it is not known how these types of adjunct staff could be supported. This root cause is attainable and

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appointment at discharge. **1c. Individual discharge planning takes longer time and more resources to conduct versus a standardized process.** **1c. There are many aspects that could be covered in an individualized discharge plan; each aspect requires education and discussion of options that would make the process lengthy and cumbersome.** **1d. Inpatient staff do not have the time to conduct individualized discharge plans and do not have access to all of the resources that would be needed.**	impactful.	
Providers (2) (e.g. provider facilities, provider network) 2) **Lack of provider incentives for 7/30 day follow up (P4P/VBP).** **1b. The willingness to incent providers was lacking because there was a belief providers had adequate resources to schedule follow up appointments in exiting payment models.** **1c. Providing incentives to providers for quality improvement was in its infancy for behavioral health.** **1c. There was not typically money left over to reward providers for focusing on better follow up.** **1d. Inpatient treatment and care to date has not resulted in outcomes that would lead to monetary incentives for providers.**	**Initial Response: Inpatient treatment and care to date has not resulted in outcomes that would lead to monetary incentives for providers.**	
	Follow-up Status Response: P4P and VBP programs have started in Community Care. This Root Cause is impactful and attainable.	
Providers (3) (e.g. provider facilities, provider network) 3) **Availability of HEDIS compliant appointments.** **1b. Providers may not refer a member to a follow up appointment included in the HEDIS methodology.** **1c. Providers/members may prefer other appointment options commonly used in PA but not included in the HEDIS methodology so follow up appointments get missed.** **1d. The HEDIS measure is a national measure that doesn't take into account state specific follow up services.**	**Initial Response: The HEDIS measure is a national measure that doesn't take into account state specific follow up services.**	
	Follow-up Status Response: This root cause cannot be changed; however, different methodologies can be conducted and learned from. This root cause is not attainable and not impactful.	
Providers (4) (e.g. provider facilities, provider network) 4) **Shortage of psychiatric appointments.** **1b. There is national shortage of**	**Initial Response: Other medical specialties provide greater compensation.**	
	Follow-up Status Response: The Root Cause is not impactful and not attainable.	

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psychiatrists. **1c. Fewer students choose psychiatry as a medical specialty.** **1d. Other medical specialties provide greater compensation.**		
Providers (5) (e.g. provider facilities, provider network) 5) **Follow up appointment does not meet individual member preference (day, time, location, type of appointment).** **1b. Providers work primarily traditional M-F, 8-5 hours; if they do work evenings or weekends these timeframes fill up quickly and are generally not available on a routine basis.**	**Initial Response: Providers work primarily traditional M-F, 8-5 hours; if they do work evenings or weekends these timeframes fill up quickly and are generally not available on a routine basis.**	
	Follow-up Status Response: Community Care can focus on adding more providers with varied hours. This Root Cause is impactful and attainable.	
Providers (6) (e.g. provider facilities, provider network) 6) **Provider communication style conflicts with member needs (i.e. paternalistic vs shared decision making, unsympathetic provider, negative experience) (Friedman, 2014; Louks, Mason, & Backus, 1989).** **1c. Member may have had a prior negative.** **1d. Provider interactions with members have historically been paternalistic.** **1d. Members viewed providers as "being unsympathetic or not feel listened too" (O'Brien, Fahmy & Singh, as cited by Friedman, 2014, pg. 9; Priebe, Watts, Chase, & Matanov, 2005; Tehrani, Krussel, Borg, Munk-Jorgensen, 1996).** **1e. Providers were not aware of the concept of shared decision making in treatment or did not have adequate tools.** **1e. Providers are in different stages/phases in terms of their awareness of recovery.**	**Initial Response: Providers are in different stages/phases in terms of their awareness of recovery.**	
	Follow-up Status Response: This root cause Is impactful and attainable.	
Providers (7) (e.g. provider facilities, provider network) 7) **Aftercare providers are not linked to members prior to discharge (Friedman, 2014; Boyer, McAlpine, Pottick, & Olfson, 2000).** **1b. Providers do not have the staff to go on the unit.** **1c. Too costly for providers to have staff leave the office due to production needs.** **1d. In more rural settings, reimbursement rates for going on the unit are not high**	**Initial Response: In more rural settings, reimbursement rates for going on the unit are not high enough for providers to send staff the unit.**	
	Follow-up Status Response: This root cause could be altered if reimbursement rates were higher, however at this point, the rates are not being increased from the already enhanced rate, so this root cause is not attainable and not impactful.	

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enough for providers to send staff the unit.		
Provider (8) (e.g., provider facilities, provider network) 8) **Members (41%) reported during high risk interviews that they chose not to take medication.** **1b. Members experience side effects from medications and stop taking medications.** **1c. Member education in terms of what to expect when taking medications (i.e., reason for taking medications, what side effects to expected and for how long) is lacking or members did not understanding information they were given.** **1d. Providers do not include family members or other supports in discharge planning around medication to provider additional support for the member.**	**Initial Response: Providers do not include family members or other supports in discharge planning around medication to provide additional support for the member.** **Follow-up Status Response:** The root cause is attainable and is impactful.	
Policies / Procedures(1) (e.g., data systems, delivery systems, payment/reimbursement) 1) **Members that leave AMA do not have a follow up appointment scheduled. (11% of members reporting leaving AMA on our member satisfaction survey).** **1b. inpatient staff wait to make a follow up appointment and miss those who leave earlier than expected.** **1c. the preferences, and type, and timing of the follow up appointment might not be known too early during the inpatient stay so staff must wait to schedule.** **1d. There is no routine process to collect preference for follow up immediately upon inpatient admission with individuals.** **1e. Inpatient staff may duplicate work if preferences and type of follow up changes during the individual's inpatient stay and therefore, may not change the way they schedule follow up.**	**Initial Response:** **Inpatient staff may duplicate work if preferences and type of follow up changes during the individual's inpatient stay and therefore, may not change the way they schedule follow up.** **Follow-up Status Response:** The root cause could be altered to be lower burden and therefore attainable and impactful.	
Policies / Procedures (2) (e.g., data systems, delivery systems, payment/reimbursement) 2) **HEDIS methodology does not capture some PA Specific aftercare services that are used.** **1b. some services are unique or may not be consistent with other HEDIS methodology.**	**Initial Response:** **Some services are unique or may not be consistent with other HEDIS methodology.** **Follow-up Status Response:** This root cause cannot be changed; however, different methodologies can be conducted and learned from. This root cause is not attainable and not impactful.	

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Policies / Procedures(3) (e.g., data systems, delivery systems, payment/reimbursement) 3) **Good data is lacking on members who do not follow up on post-discharge because of their inherent lack of engagement.** **1b. Data cannot be collected from the individual on factors contributing to non-engagement.** **1c. There is no contact with the member in order to collect the information.**	**Initial Response:** **There is no contact with the member in order to collect the information.** **Follow-up Status Response:** This root cause is not attainable and therefore not impactful.	
Policies / Procedures(4) (e.g., data systems, delivery systems, payment/reimbursement) 4) **Our analysis found that members that had shorter lengths of stay had lower rates of follow up. (Analysis)** **1b. There may not be enough time for adequate discharge planning and assessment of all of the individual's needs.** **1c. Member may have left AMA or may have left due to policy dictating length of stay that was too short for this particular member.** **1d. Members with shorter lengths of stay are not getting their needs addressed.**	**Initial Response:** **Members with shorter lengths of stay are not getting their needs addressed.** **Follow-up Status Response:** The process to determine the appropriate length of stay could be improved upon. The needs assessment process could be improved upon. This root cause is attainable and impactful.	
Policies / Procedures(5) (e.g., data systems, delivery systems, payment/reimbursement) 5) **Providers are not able to address some of the member's social determinants (i.e. homelessness, housing issues) prior to a member's discharge.** **1b. Inpatient providers may not get this information, and when they do, the time required to impact social determinants is longer than the inpatient stay.** **1c. Inpatient service is considered an acute service to stabilize the individual and not to address social determinants.** **1d. Social determinants are complex and difficult to impact.**	**Initial Response:** **Social determinants are complex and difficult to impact.** **Follow-up Status Response:** The root cause is attainable (long term) and impactful. Intervention efforts could focus on routine collection of the social determinant data, process to facilitate solving issues around social determinants, and evidence based practices, such as Critical Time Intervention that work with members around social determinants and ongoing BH care.	
Policies / Procedures(6) (e.g., data systems, delivery systems, payment/reimbursement) 6) **Members are not given information about their medications at the time**	**Initial Response:** **Training in medication management is costly in both time and money; furthermore, inpatient staff would not desire another task as they are already busy.** **Follow-up Status Response:**	

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of discharge. (HRI – 21%) or do not have meds reconciled prior to discharge. (DMP chart abstraction found 38% of charts had medication reconciliation documented) **1b. Inpatient staff do not devote enough time to medication reconciliation and education.** **1c. Only some inpatient staff feel qualified to discuss and monitor medications with members.** **1d. Not all staff are trained in medication management and thus, this aspect is typically left to the nurse or psychiatrist.** **1e. Training in medication management is costly in both time and money; furthermore, inpatient staff would not desire another task as they are already busy.**	Increased efficiency around medication management during the inpatient stay could be achieved. This root cause is attainable and impactful.	
Provisions (1) (e.g., screening tools, medical record forms, transportation) 1) **Family/friends are not included in discharge planning as resources. (HRI 53% not included with 33% wanting family and friend involvement, DMP – 33% not included in d/c planning)** **1b. Inpatient staff do not include family in discharge planning or accept perhaps too easily if a member says they do not want family involvement.** **1c. Including the family's wishes in discharge planning may prolong the process, lead to conflict, and take time away from inpatient staff doing direct care.** **1d. There is not a process in place for families to be routinely included for feedback and treatment preferences which may make the discharge planning process more efficient and/or effective.**	**Initial Response:** **There is not a process in place for families to be routinely included for feedback and treatment preferences which may make the discharge planning process more efficient and/or effective.** **Follow-up Status Response:** This root cause is attainable and impactful.	
Provisions (2) (e.g., screening tools, medical record forms, transportation) 2) **Discharge planning is not always comprehensive or as individualized as required by the member's needs (Raven, 2000).** **1b. Individual discharge planning takes longer time and more resources to conduct versus a standardized process.** **1c. There are many aspects that could be**	**Initial Response:** **Inpatient staff do not have the time to conduct individualized discharge plans and do not have access to all of the resources that would be needed.** **Follow-up Status Response:** The root cause could be improved upon. The use of discharge planning staff could address this issue; however, it is not known how these types of adjunct staff could be supported. This root cause is attainable and impactful.	

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covered in an individualized discharge plan; each aspect requires education and discussion of options that would make the process lengthy and cumbersome. **1d. Inpatient staff do not have the time to conduct individualized discharge plans and do not have access to all of the resources that would be needed.**		
Provisions (3) (e.g., screening tools, medical record forms, transportation) 3) **Medication reconciliation was not completed at discharge in 62% of DMP charts.** **1b. The "reason for medication" was not documented, which made medication reconciliation incomplete.** **1c. Reason for medication was not a field on the EMR or paper chart.** **1d. Changes to the documentation process for both EMR and paper charting can take extensive time when adding a field to the EMR document or changing a paper chart.** **1e. Hospitals have extensive checks and balances when changing charts/records.** **1f. Providers focus on internal documentation for accreditation or reimbursement purposes.**	**Initial Response: Providers focus on internal documentation for accreditation or reimbursement purposes.** **Follow-up Status Response:** This root cause is attainable and impactful.	
Provisions (4) (e.g., screening tools, medical record forms, transportation) 4) **Member's personal recovery goals are not included on the discharge plan. (Reported from focus groups)** **1b. Inpatient staff do not conduct motivational –based discussions routinely to elicit individualized recovery goals and how ongoing treatment may help achieve goals.** **1c. These types of discussions would require training.** **1d. Training in motivational techniques are costly in both time and money and may result in staff feeling too pressured to fit in these discussions during an already busy work schedule.**	**Initial Response:** **Training in motivational techniques are costly in both time and money and may result in staff feeling too pressured to fit in these discussions during an already busy work schedule.** **Follow-up Status Response:** This root cause is attainable and impactful. Interventions should focus on efficient training methods (online, computerized) and building motivational discussions into the work already conducted by inpatient staff.	
Provisions (5) (e.g., screening tools, medical record forms, transportation) 5) **Member reports they were not provided with a discharge plan at**	**Initial Response:** **It is easier and faster to tell the individual what to do after discharge rather than elicit aftercare preferences, educate on medications, and role play.** **Follow-up Status Response:**	

discharge. (Mbr Sat – 8% reported they were not given a d/c plan, HRI – 26% reported they were not given a d/c plan) **1b. Members receive too much information during a stressful time and may not remember receiving a discharge plan or remember the details of the discharge plan.** **1c. Inpatient staff may dictate follow up care and not engage the individual in the discharge plan in a way to help the individual remember the steps of the plan.** **1d. It is easier and faster to tell the individual what to do after discharge rather than elicit aftercare preferences, educate on medications, and role play.**	This root cause if attainable and impactful. Interventions should focus on novel practices to engage the individual in discharge planning.

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. (identify the Root cause and the Action(s) that are judged as impactful & attainable)	**Implementation Date** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is actually being carried out? 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 cause: Culturally we are less accepting of behavioral health challenges and these are viewed negatively, members prefer to not address them or deal with them on their own.** **Root Cause: There is not a process in place for families to be routinely included for feedback and treatment preferences, which may make the discharge planning process more efficient.** **Action: EDP –** focuses on members with readmissions and involves daily targeting of individuals for intervention, on-site interviewing during psychiatric hospitalization, addresses motivation, active problem solving, and focuses on discharge planning, recovery planning, medication utilization and access to aftercare.	EDP and HRCM are ongoing interventions.	**Initial Response:** **EDP –** HR CM's collect secondary process measures around family/friend involvement in discharge planning; this measure is collected and reviewed quarterly. **HRCM Intervention –** HRCM's help to educate members/families when members are on inpatient units; Clinical managers monitor HRCM's during regular supervision. **CM wallet information -** This card is given to any family a Care Manager is working with. Community Care monitors follow rates on a quarterly basis. **Follow-up Status Response:**

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HRCM intervention– Members can be deemed high risk for reasons such as clinical presentation, treatment history and response or as an identified at-risk population. High Risk members require an intensive level of intervention. Comprehensive care management strategies are initiated to ensure service linkage, coordination, and timely delivery of quality health care occurs for those at-risk for significant symptoms and members who have difficulty connecting to aftercare treatment services. Community Care strives to ensure that recovery principles and tenure in the community are at the core of high risk care management. HRCM meets with members face to face on the unit to identify these barriers, address concerns, coordinate with IP staff around member needs, and help with discharge planning. **CM wallet information** intervention in collaboration with Family Advisory Board (FAB) - The Families of Child and Youth Members Advisory Board (FAB) worked with Care Management to adapt the High Risk Card used by Care Managers for Adults in hospital for families of children in hospital. This card can also be given to any family a Care Manager is working with. As a wallet card, it is a handy connection to Community Care for family members.	Wallet information – Jan 2017	
Action (2) **Root Cause: Individuals with co-occurring disorders may have more demands and higher needs competing for attention such as avoiding jail, poor health, and death.** **Action: Centers of Excellence (COE) and Care Management Medication Assistance Treatment (CM MAT) protocol.** **COE-**The PA Department of Human Services launched the Centers of Excellence (COE) in 2016 to expand access to MAT and other effective treatments. COEs are licensed drug & alcohol providers that provide counselling, methadone, buprenorphine, or naltrexone assisted treatment. Forty-five agencies received a $500,000 grant to implement.	COE - COEs provide buprenorphine and naltrexone treatment through the HealthChoices physical health network of providers and	**Initial Response:** **COE:** COE's report specific measures directly back to the state on a monthly basis. Our goal is to enroll 300 members in each COE. **CM MAT Protocol:** Baseline data was run in 2017 based on 2015/16 information and the goal is to increase the use of MAT across Community care contracts for members with AUD/OUD diagnoses; MAT use is monitored quarterly. **MAT Webinar:** Community Care tracks the number of attendees for external trainings. The Northeast MAT Summit had 171 attendees. The NorthCentral Psych Rehab Provider Meeting had 8 attendees.

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Community Care is supporting 21 of the COEs through a learning collaborative. Our care management team helps individuals with OUD navigate the health care system by: facilitating initiation into OUD treatment from emergency departments & primary care physicians; helping individuals transition from inpatient levels of care to ongoing engagement in community-based treatment; and facilitating transition of individuals with OUD leaving state & county corrections systems to ongoing treatment within the community. **CM MAT Protocol –** Community Care built indicators into our Psych Consult system that are used to identify if MAT has been used in the past or has been reviewed as an option for the member. There is a prompt for education of MAT for members. Screening for whether Narcan/ Nalaxone has ever been used to revive the member. Was the member discharged with a script for Narcan/Nalaxone (OUD dx); was the member discharged on a shot of Vivitrol? All of these prompts were added to not only identify members with an AUD/OUD, but to identify members at risk for an overdose. The goal with the MAT prompt for our Care Managers is to increase the overall use of MAT for members with Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD). **MAT Webinars -** Training and education on MAT, the new prompts within Psych Consult and the MAT initiatives as they pertain to the Opioid epidemic were done with our care management staff. Additional trainings were conducted for stakeholders and providers of MAT and the initiatives as they pertain to the Opioid epidemic.	started in January 2017. CM MAT Protocol – June 2017 MAT Webinar – June 2017 (internal staff) MAT Summit – Oct.3, 2017 held in the Northeast; NorthCentral Psych Rehab Provider meeting – Oct. 10, 2017	Community Care monitors follow-up rates on a quarterly basis. **Follow-up Status Response:**
Action (3) **Root Cause: There is no system in place to update and store every follow up option that can be accessed by members and inpatient staff.** **Root Cause: Shared decision making (SDM) could alter the individual's perspective on follow up but SDM does not often occur.**	Common Ground and DSC, HRCM and EDP are all ongoing interventions.	**Initial Response:** **Common Ground and DSC**: Data on performance of the Decision Support Centers include monthly statistics (process measure on use of CG) from the CommonGround application on health reports completed, percent with personal medicine, power statements, shared decisions, and medicines entered. Outcome data in the form of a Satisfaction Survey completed by members using the DSC are compiled

Root Cause: Members lack knowledge about how the system works. **Root Cause: Member expectations about OP lead to members not keeping their follow up appointment.** **Root Cause: Inpatient staff do not have the time to conduct this type of discharge plan and do not have access to all of the resources that would be needed.** **Root Cause: Inpatient staff may duplicate work if preferences and type of follow up changes during the individual's inpatient stay and therefore, may not change the way they schedule follow up.** **Root Cause: Members with shorter lengths of stay are not getting their needs addressed.** **Root Cause: It is easier and faster to tell the individual what to do after discharge rather than elicit aftercare preferences, educate on medications, and role play.** **Action: Common Ground and Decision Centers, High Risk Care Management (HRCM), High Risk EDP Intervention (EDP) and CCBHC's.** **Common Ground and Decision Support Centers –** Common Ground is an approach and a web application program designed by Patricia Deegan, PhD and Associates (PDA) to support shared decision making (SDM) in the context of a psychiatric medication clinic. Its use is based on the establishment of a peer-run Decision Support Center (DSC) in the waiting area of the medication clinic. This initiative supports member's self-determination, increases access to resources and peer support to make decisions regarding care, empowers individuals in their use of medication as a tool in the recovery process, and develops truly collaborative relationships between practitioners and members.		at 6 months, 18 months, and 36 months after starting the DSC (known as the Go-Live date). This data is shared with CommonGround Specialists and the Leadership Teams at each agency operating a DSC and used in improving the performance of each program. **HRCM** - Clinical managers monitor HRCM functions through ongoing supervision with HRCMs. **EDP intervention**: Community Care monitors the Engagement Rate for high risk interviews, with a goal of 75% engagement. Process measures, which are monitored quarterly include: Primary reason reported for readmission; Secondary reason reported for readmission; Primary basic necessity addressed; Secondary basic necessity addressed; Primary information requested; Secondary information requested. **CCBHC-** The following measures are monitored with CCBHC's: ● Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients ● Preventive care and screening: adult body mass index (BMI) screening and follow-up ● Weight assessment and counseling for nutrition and physical activity for children/adolescents ● Preventive care & screening: tobacco use: screening & cessation intervention ● Preventive care and screening: unhealthy alcohol use: screening and brief counseling ● Child and adolescent major depressive disorder (MDD): suicide risk assessment ● Adult major depressive disorder (MDD): suicide risk assessment ● Screening for clinical depression and follow-up plan ● Depression remission at 12 months Community Care monitors follow rates on a quarterly basis.
		Follow-up Status Response:

HealthChoices BH MCO: Community Care Behavioral Health Organization	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
HRCM intervention– Members can be deemed high risk for reasons such as clinical presentation, treatment history and response or as an identified at-risk population. High Risk members require an intensive level of intervention. Comprehensive care management strategies are initiated to ensure service linkage, coordination, and timely delivery of quality health care occurs for those at-risk for significant symptoms and members who have difficulty connecting to aftercare treatment services. Community Care strives to ensure that recovery principles and tenure in the community are at the core of high risk care management. HRCM meets with members face to face on the unit to identify these barriers, address concerns, coordinate with IP staff around member needs, and help with discharge planning. **EDP –** focuses on members with readmissions and involves daily targeting of individuals for intervention, on-site interviewing during psychiatric hospitalization, addresses motivation, active problem solving, and focuses on discharge planning, recovery planning, medication utilization and access to aftercare. **CCBHC-**The federal Excellence in Mental Health Act established Certified Community Behavioral Health Clinics (CCBHCs) as a way to improve quality and use evidence-based practices in behavioral health. CCBHC's are designed to provide a comprehensive range of mental health and substance use disorder services, particularly to vulnerable individuals with the most complex needs during a federal demonstration program with participating states, Pennsylvania being one of them. CCBHCs have a distinct integrated service delivery model – trauma-informed recovery outside the traditional four walls of a historical community behavioral health center. CCBHCs must offer the following services: Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention, and crisis	Community Care has four CCBHC providers with sites in five different areas. These programs started in July 2017.		

HealthChoices BH MCO: Community Care Behavioral Health Organization	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
stabilization; screening, assessment, and diagnosis including risk assessment; patient-centered treatment planning or similar processes, including risk assessment and crisis planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas. There are a core set of quality measures that CCBHCs must accomplish before they are eligible for the bonus payment measures (a combination of process and outcome measures, such as follow-up after hospitalization, medication adherence for people with schizophrenia, and depression remission) Community Care care management staff quickly notify CCBHCs when any of their CCBHC-enrolled members is pre-authorized for inpatient care. This facilitates timely coordination of care and discharge planning.		
Action (4) **Root Cause: Inpatient treatment and care to date has not resulted in outcomes that would lead to monetary incentives for providers.** **Action: Pay For Performance (P4PIMH) -** Value based payment model in collaboration with providers and primary contracts; provider earns up to 5% rate enhancement for meeting follow up goals.	The first P4Ps started in January 2017. In 2018, this value-based initiative will include 31 hospitals across 9 of our 10 contracts.	**Initial Response:** **P4P:** Process measures assessed include the number of discharges each quarter; individualized provider goals established as 10% improvement to their follow-up rates. Community Care monitors follow rates on a quarterly basis. **Follow-up Status Response:**
Action (5) **Root Cause: Providers work primarily traditional M-F, 8-5 hours; if they do work evenings or weekends these timeframes fill up quickly and are generally not available on a routine basis.** **Action: Community Care's Provider Relations Department adds providers to the network that offer non-traditional hours, when they**		**Initial Response:** Each individual contract provider relations representative brings potential providers to clinical operations for review and vetting. Clinical operations meeting occur bi-monthly. Annually, a summary of all providers added to the network are noted in the annual evaluation geoaccess section. Community Care monitors follow rates on a quarterly basis.

HealthChoices BH MCO: Community Care Behavioral Health Organization	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
are available.		**Follow-up Status Response:**
Action (6) **Root Cause: Providers are in different stages/phases in terms of their awareness of recovery.** **Action: Trainings or resources by Community Care that are short in duration and are free.** Community Care_Recovery_Train **Hearing Voices Training -** The Hearing Distressing Voices training program includes a *Hearing Distressing Voices* training *and* a *Train the Trainers* session. Training personnel consist of Community Care Master Trainers (who are certified by Pat Deegan and Associates to train other Trainers), Community Care Trainers (who conduct Hearing Voices training), and Stakeholder Trainers (community members who conduct Hearing Voices training). The *Hearing Distressing Voices Training* is a three-hour training developed by Pat Deegan & Associates with the purpose of developing empathy for the lived experience of a psychiatric disability. The *Train the Trainers session* prepares individuals to conduct the Hearing Distressing Voices training, including how to recruit training participants, select training volunteers, use the Training Kit and equipment (PDA), and conduct debriefing sessions. Booster sessions are available to refine and improve training skills. These trainings are free.	Trainings occur quarterly. Hearing Voices – Ongoing trainings (refer to the attached document) – Community Care Recovery Trainings for specific Hearing Voices Training information).	**Initial Response: See Trainings or resources by Community Care attachment.** **Hearing Voices Training** – Community Care tracks the number of trainings that are provided quarterly. (Refer to attached document, Recovery Trainings by Community Care). Community Care monitors follow rates on a quarterly basis. **Follow-up Status Response:**
Action (7) **Root Cause: Providers do not include family members or other supports in discharge planning around medication to provide additional support for the member.** **Root Cause: Providers focus on internal documentation for accreditation or reimbursement purposes.**	DMP: Four meetings occurred in August, September, and October 2016. Results meetings are planned with all 8 hospitals again beginning in	**Initial Response:** **DMP:** Community Care met with all eight hospitals identified in the DMP chart abstraction project; these eight hospitals represented either our highest volume hospitals or were the primary hospital in a specific contract. In 2016, Community Care shared results from the DMP chart abstraction with of these hospitals, which included information related to family and friend

HealthChoices BH MCO: Community Care Behavioral Health Organization	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
Action: DMP Results meetings – Community Care shared results of the DMP chart abstraction project, which included information about family and friends. During those meetings, providers also indicated changes to their internal documentation process, either through an Electronic Medical Record or through a paper chart took a long time to implement due to various internal barriers. Providers anticipated seeing results from changes they made to their own systems from reviews on CY2017 charts. **HRCM intervention–** Members can be deemed high risk for reasons such as clinical presentation, treatment history and response or as an identified at-risk population. High Risk members require an intensive level of intervention. Comprehensive care management strategies are initiated to ensure service linkage, coordination, and timely delivery of quality health care occurs for those at-risk for significant symptoms and members who have difficulty connecting to aftercare treatment services. Community Care strives to ensure that recovery principles and tenure in the community are at the core of high risk care management. HRCM meets with members face to face on the unit to identify these barriers, address concerns, coordinate with IP staff around member needs, and help with discharge planning. High risk CM's encourage coordination with family or friends as part of their interaction with members. **EDP –** focuses on members with readmissions and involves daily targeting of individuals for intervention, on-site interviewing during psychiatric hospitalization, addresses motivation, active problem solving, and focuses on discharge planning, recovery planning, medication utilization and access to aftercare. CM's encourage coordination with family or friends as part of their interaction with members.	January/February 2018. HRCM and EDP are ongoing interventions.	involvement. Community Care is planning results meetings with all 8 hospitals in early 2018 and will review results and request a quality improvement plan during those meetings from the hospitals. **HRCM** - Clinical managers monitor HRCM functions through ongoing supervision with HRCMs. **EDP intervention**: Community Care monitors the Engagement Rate for high risk interviews, with a goal of 75% engagement. Process measures, which are monitored quarterly include: Primary reason reported for readmission; Secondary reason reported for readmission; Primary basic necessity addressed; Secondary basic necessity addressed; Primary information requested; Secondary information requested. Community Care monitors follow rates on a quarterly basis. **Follow-up Status Response:**
Action (8) **Root cause: Social determinants are complex and difficult to impact.**		**Initial Response: ICP:** Community Care's goal for each contract is 0.25% of the 2014 Calendar Year averaged Medicaid eligible will have an Integrated

HealthChoices BH MCO: Community Care Behavioral Health Organization	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
Action: Integrated Care Plan (ICP) - In alignment with Pennsylvania Department of Human Services goal for greater integration and coordination of behavioral and physical health services, Community Care completes the care management activity of an ICP. This ICP, or member profile, is used for the collection, integration and documentation of key physical and behavioral health information that is easily accessible. **HRCM intervention–** Members can be deemed high risk for reasons such as clinical presentation, treatment history and response or as an identified at-risk population. High Risk members require an intensive level of intervention. Comprehensive care management strategies are initiated to ensure service linkage, coordination, and timely delivery of quality health care occurs for those at-risk for significant symptoms and members who have difficulty connecting to aftercare treatment services. Community Care strives to ensure that recovery principles and tenure in the community are at the core of high risk care management. HRCM meets with members face to face on the unit to identify these barriers, address concerns, coordinate with IP staff around member needs, and help with discharge planning. High risk CM's address social determinants with the member and the IP staff and coordinate with relevant agencies during the inpatient stay. **EDP –** focuses on members with readmissions and involves daily targeting of individuals for intervention, on-site interviewing during psychiatric hospitalization, addresses motivation, active problem solving, and focuses on discharge planning, recovery planning, medication utilization and access to aftercare. CM's address social determinants with the member and the IP staff and coordinate with relevant agencies during the inpatient stay.	ICP, HRCM, and EDP are ongoing interventions.	Care Plan, including PH and BH data from their MCOs; this goal has been met every year. Community Care tracks the number of completed ICPs, as well as the number of referrals for physical health coordination. **HRCM** - Clinical managers monitor HRCM functions through ongoing supervision with HRCMs. **EDP intervention**: Community Care monitors the Engagement Rate for high risk interviews, with a goal of 75% engagement. Process measures, which are monitored quarterly include: Primary reason reported for readmission; Secondary reason reported for readmission; Primary basic necessity addressed; Secondary basic necessity addressed; Primary information requested; Secondary information requested. Community Care monitors follow rates on a quarterly basis. **Follow-up Status Response:**
Action (9) **Root Cause: Training in medication management is costly in both time and money; furthermore, inpatient staff would**		**Initial Response: DMP:** Four of the hospitals in the DMP were provided with MRT training. The other four hospitals had this training prior to July 2016. All eight hospitals will be offered a refresher training in

HealthChoices BH MCO: Community Care Behavioral Health Organization	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
not desire another task as they are already busy. **Action: DMP Medication Reconciliation Training; Clozaril initiative, MAT prompt; webinars on MAT; Hearing Voices trainings** **DMP Medication Reconciliation Trainings (MRT)** – Community Care provided MRT trainings to all hospitals in the DMP. Upcoming meetings in early 2018 will offer a refresher on medication reconciliation. **Clozaril Trial Initiative-** Care managers have prompts built into our database to ask if members are appropriate for a Clozaril trial. **CM MAT Protocol –** Community Care built indicators into our Psych Consult system that are used to identify if MAT has been used in the past or has been reviewed as an option for the member. There is a prompt for education of MAT for members. Screening for Whether Narcan/Naloxone has ever been used to revive the member. Was the member discharged with a script for Narcan/Naloxone (OUD dx); was the member discharged on a shot of Vivitrol? All of these prompts were added to not only identify member with an AUD/OUD, but to identify members at risk for an overdose. The goal with the MAT prompt for our Care Managers is to increase the overall use of MAT for members with Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD). **MAT Webinars -** Training and education on MAT, the new prompts within Psych Consult and the MAT initiatives as they pertain to the Opioid epidemic were done with our Care Management staff. Additional trainings were conducted for stakeholders and providers of MAT and the initiatives as they pertain to the Opioid epidemic.	DMP MRT Training: August, September, October 2016; all 8 hospitals in the DMP will be offered a refresher training in 2018. Clozipine trial initiative started in July 2017. CM MAT Protocol – June 2017 MAT Webinar – June 2017 (internal staff) MAT Summit – Oct.3, 2017 held in the Northeast; NorthCentral Psych Rehab Provider meeting – Oct. 10, 2017	2018; monitoring occurs through record reviews with the next one planned in February and March of 2018. **Clozaril Trial:** goal is to increase clozapine utilization from 2-4%; utilization is monitored quarterly. **CM MAT Protocol** – The goal with the MAT prompt for our Care Managers is to increase the overall use of MAT for members with Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD); MAT use is monitored quarterly. **MAT Webinar:** Community Care tracks the number of attendees for external trainings. The Northeast MAT Summit had 171 attendees. The NorthCentral Psych Rehab Provider Meeting had 8 attendees. Community Care monitors follow rates on a quarterly basis. **Follow-up Status Response:**
Action (10) **Root Cause: Members lack knowledge about how the system works.** **Root Cause: Member expectations about OP lead to members not keeping their follow up**	Enhanced Outreach, HRCM, and EDP is an ongoing intervention.	**Initial Response: Enhanced Outreach:** collects information on barriers to follow up. The Outreach Supervisor monitors these barriers quarterly. **HRCM** - Clinical managers monitor HRCM functions through ongoing supervision with HRCMs.

appointment.

Action: Enhanced Outreach Protocol – Outreach calls are built by our Care Managers to our Enhanced Outreach team for all IMH discharges. A team of Care Managers, who work with acute, high risk, and non-acute consumers, formed an Intensive Outreach Team, designed to allow care management efforts to be centered on more intensive care coordination to help engage consumers in non-acute levels of care and reduce the need for readmission to often less effective restrictive levels of care. Our Enhanced outreach team attempts to contact the member within 24 hours of discharge. Care managers engage in active problem solving with members to encourage follow up.

High Risk Care Managers also have the ability to do the follow up calls using Enhanced Outreach for high risk members that they deem appropriate. In the past a member could have gotten a call from a HR CM AND someone from the outreach team. In an attempt to not duplicate efforts the HR protocol was adjusted to incorporate Care Manager ability to do the outreach calls post d/c. The Care Manager uses the Enhanced outreach template during that follow up call. Three calls are attempted for outreach. Barriers to follow up are reviewed. Behavioral health medication access is verified (did member fill scripts). MAT education opportunities are reviewed as well as any CM interventions.

HRCM intervention–Members can be deemed high risk for reasons such as clinical presentation, treatment history and response or as an identified at-risk population. High Risk members require an intensive level of intervention. Comprehensive care management strategies are initiated to ensure service linkage, coordination, and timely delivery of quality health care occurs for those at-risk for significant symptoms and members who have difficulty connecting to aftercare treatment services. Community Care strives to ensure that recovery principles and

EDP intervention: Community Care monitors the Engagement Rate for high risk interviews, with a goal of 75% engagement.
Process measures, which are monitored quarterly include: Primary reason reported for readmission; Secondary reason reported for readmission; Primary basic necessity addressed; Secondary basic necessity addressed; Primary information requested; Secondary information requested.
Community Care monitors follow up rates on a quarterly basis.

Follow-up Status Response:

HealthChoices BH MCO: Community Care Behavioral Health Organization	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
tenure in the community are at the core of high risk care management. HRCM meets with members face to face on the unit to identify these barriers, address concerns, coordinate with IP staff around member needs, and help with discharge planning. **EDP** – focuses on members with readmissions and involves daily targeting of individuals for intervention, on-site interviewing during psychiatric hospitalization, addresses motivation, active problem solving, and focuses on discharge planning, recovery planning, medication utilization and access to aftercare.		
Action (11) **Root Cause: Training in motivational techniques are costly in both time and money and may result in staff feeling too pressured to fit in these discussions during an already busy work schedule.** **Action: Community Care's High Risk Care Management (HRCM) and High Risk EDP Intervention focus on motivational techniques as part of their regular process when meeting with members.** **HRCM intervention**–Members can be deemed high risk for reasons such as clinical presentation, treatment history and response or as an identified at-risk population. High Risk members require an intensive level of intervention. Comprehensive care management strategies are initiated to ensure service linkage, coordination, and timely delivery of quality health care occurs for those at-risk for significant symptoms and members who have difficulty connecting to aftercare treatment services. Community Care strives to ensure that recovery principles and tenure in the community are at the core of high risk care management. HRCM meets with members face to face on the unit to identify these barriers, address concerns, coordinate with IP staff around member needs, and help with discharge planning. **EDP** – focuses on members with readmissions and involves daily targeting of individuals for	HRCM and EDP are ongoing interventions.	**Initial Response: HRCM:** Clinical managers monitor HRCM functions through ongoing supervision with HRCMs. **EDP: C**ommunity Care monitors the Engagement Rate for high risk interviews, with a goal of 75% engagement. Process measures, which are monitored quarterly include: Primary reason reported for readmission; Secondary reason reported for readmission; Primary basic necessity addressed; Secondary basic necessity addressed; Primary information requested; Secondary information requested. Community Care monitors follow rates on a quarterly basis.

intervention, on-site interviewing during psychiatric hospitalization, addresses motivation, active problem solving, and focuses on discharge planning, recovery planning, medication utilization and access to aftercare.		
		Follow-up Status Response:

VI: 2018 Strengths and Opportunities for Improvement

The review of CCBH's 2018 (MY 2017) performance against structure and operations standards, performance improvement projects, and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH-MCO.

Strengths

- CCBH's MY 2017 PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness rate (QI A) for the overall population was statistically significantly above the MY 2017 HC BH (Statewide) rate by 4.7 percentage points.
- CCBH's MY 2017 PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness rate (QI B) for the overall population was statistically significantly above the MY 2017 HC BH (Statewide) rate by 4.4 percentage points.
- CCBH's MY 2017 HEDIS 7-Day Follow-up After Hospitalization for Mental Illness rate (QI 1) for the overall population was statistically significantly above the MY 2017 HC BH (Statewide) rate by 5.8 percentage points.
- CCBH's MY 2017 HEDIS 30-Day Follow-up After Hospitalization for Mental Illness rate (QI 2) for the overall population was statistically significantly above the MY 2017 HC BH (Statewide) rate by 6.1 percentage points.
- CCBH's MY 2017 Initiation and Engagement of AOD Treatment rates for ages 13+ years were statistically significantly higher (better) that the 2017 MY BH (Statewide) rates by 1.7 (Initiation) and 1.8 (Engagement) percentage points, respectively.
- CCBH's MY 2017 Initiation and Engagement of AOD Treatment rates for ages 13+ years were both statistically significantly higher (improved) over the prior year, by 14.8 (Initiation) and 17.0 (Engagement) percentage points, respectively.
- CCBH's MY 2017 Engagement of AOD Treatment rate achieved the goal of meeting or exceeding the 75th percentile.

Opportunities for Improvement

- CCBH was partially compliant with the following two elements under review for Year 3 of the Performance Improvement Project:
  - Review Element 1 – Project Topic and Relevance
  - 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 CCBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
  - CCBH was partially compliant with 1 out of 7 categories within Subpart C: Enrollee Rights and Protections Regulations. The partially compliant category is Enrollee Rights.
  - CCBH was partially compliant with 4 out of 10 categories and non-compliant with 1 category within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, 3) Practice Guidelines, and 4) Quality Assessment and Performance Improvement Project. The non-compliant category is: Coordination and Continuity of Care.
  - CCBH was partially compliant with 7 out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Handling of Grievances and Appeals, 4) Resolution and Notification: Grievances and Appeals, 5) Expedited Appeals Process, 6) Continuation of Benefits, and 7) Effectuation of Reversed Resolutions.
- CCBH's MY 2017 HEDIS 7-Day and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for the 6–64 years population did not meet the OMHSAS interim goals for MY 2017, nor did they achieve the goal of meeting or exceeding the HEDIS 75th percentiles.
- CCBH's MY 2017 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%. Even though the REA rate decreased (improved) by 0.3 percentage points from MY 2016 to MY 2017, this change was not statistically significant.
- CCBH's MY 2017 PA-Specific 7-Day and 30-Day Follow-up After Hospitalization for Mental Illness (QI A and QI B) rates for the overall population were both not significantly improved from the prior year.
- CCBH's MY 2017 HEDIS 7-Day and 30-Day Follow-up After Hospitalization for Mental Illness (QI 1 and QI 2) rates for the 6–64 years population were both not significantly improved from the prior year.

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	C REA[1]	B FUH QI A FUH QI 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)	60.3%═	59.6%═	59.7%═	**56.7%▼**	**56.9%═**	**52.2%▲**
QI B – PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall)	77.0%═	75.8%▼	75.3%═	**73.2%▼**	**74.0%═**	**69.6%▲**
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	14.4%▲	14.8% ═	14.0% ▼	**13.6%═**	**13.3%═**	**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 (QI 1) and 30-Day Follow-up (QI 2) After Hospitalization metrics. An RCA 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. **FUH QI 1** **FUH QI 2**
Indicators that are less than the 50th percentile.

[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)	45.1%	Not met	Below 75th and at or above 50th percentile
QI 2 – HEDIS 30-Day Follow-up After Hospitalization for Mental Illness (6–64 Years)	67.0%	Not met	Below 75th and at or above 50th percentile

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

VII: Summary of Activities

Structure and Operations Standards

- CCBH was compliant with Subpart C and partially compliant with Subparts D and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2017, RY 2016, and RY 2015 were used to make the determinations.

Performance Improvement Projects

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

Performance Measures

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

2017 Opportunities for Improvement MCO Response

- CCBH 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 CCBH 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 enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
	Standard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan 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, travel and attend on-going training.
	Standard 108.5	The C/FST has access to providers and HC members to conduct surveys and employs of a variety of survey mechanisms to determine member satisfaction e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Standard 108.6	The problem resolution process specifies the role of the county, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
	Standard 108.7	The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
	Standard 108.8	The Annual Mailed/Telephonic survey results are representative of HC membership, identify systemic trends. Actions have been taken to address areas found deficient, as applicable.
	Standard 108.10	The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.
§438.206 Availability of Service	Standard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages. • Excel or Access data base with the following information: Name of Agency (include satellite sites). Address of Agency (and satellite sites) with zip codes. Level of Care (e.g. Partial Hospitalization, D&A Outpatient, etc). Population served (adult, child & adolescent). Priority Population. Special Population.
	Standard 1.2	100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met.
	Standard 1.3	Provider Exception report submitted & approved when choice of two providers is not given.
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).

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 excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of oral interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Standard 24.2	Provider network database contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 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 & 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.
	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free

BBA Category	PEPS Reference	PEPS Language
		from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.2104 Provider Selection	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as, other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 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 & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, and Consumer satisfaction.
§438.240 Quality assessment and performance improvement program	Standard 91.1	QM program description outlines ongoing quality assessment, performance improvement activities, a continuous quality improvement process, and places emphasis on, but not limited to, high volume/high-risk services and treatment and Behavioral Health Rehabilitation Services.
	Standard 91.2	QM work plan includes goal, aspect of care/service, scope of activity, frequency, data source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines the specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services; provider network adequacy; penetration rates; appropriateness of service authorizations; inter-rater reliability; complaint, grievance and appeal processes; denial rates; upheld and overturned grievance rates; and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall

BBA Category	PEPS Reference	PEPS Language
		utilization patterns and trends including BHRS and other high volume/high risk services).
	Standard 91.8	The QM work plan includes monitoring activities conducted to evaluate the quality and performance of the provider network (quality of individualized service plans and treatment planning, adverse incidents, collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance).
	Standard 91.9	The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	The QM work plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator: Mental Health; and, Substance Abuse External Quality Review: Follow up After Mental Health Hospitalization QM Annual Summary Report.
	Standard 91.11	The identified Performance Improvement Projects must include the following: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality. 3. Evaluation of the effectiveness of the interventions. 4. Planning and initiation of activities for increasing or sustaining improvement. 5. Timeline for reporting status and results of each project to DHS. 6. Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year.
	Standard 91.12	The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.
	Standard 91.13	The BH-MCO has a process for its own evaluation of the impact and effectiveness of its quality management program annually. A report of this evaluation will be submitted to DHS by April 15th.
	Standard 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 outline in the program description and the work plan.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, and Consumer satisfaction.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH-MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for coordination with other service agencies and schools.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DHS.
	Standard 104.2	The BH-MCO must submit to the DHS data specified by the DHS that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.

BBA Category	PEPS Reference	PEPS Language
	Standard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan 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 decision letters must b explanation and reason for the decision(s).
	Standard 68.4	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.

BBA Category	PEPS Reference	PEPS Language
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must explanation and reason for the decision(s).
	Standard 68.4	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.404 Notice of	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%

BBA Category	PEPS Reference	PEPS Language
action		requirement is met.
	Standard 23.3	List of oral interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Standard 24.2	Provider network database contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must explanation and reason for the decision(s).
	Standard 68.4	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established

BBA Category	PEPS Reference	PEPS Language
		time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.408 Resolution and notification: Grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must explanation and reason for the decision(s).
	Standard 68.4	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the

BBA Category	PEPS Reference	PEPS Language
		documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.410 Expedited resolution of appeals	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.414 Information about the grievance system to providers and subcontractors	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: ● BBA Fair Hearing ● 1st level ● 2nd level ● External ● Expedited
§438.420 Continuation of benefits while the MCO or PIHP appeal	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
and the State fair hearing are pending		• 2nd level • External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.424 Effectuation of reversed appeal resolutions	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: • BBA Fair Hearing • 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

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 2nd level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 68.9	Where applicable there is evidence of county oversight and involvement in the 2nd level complaint process.
Grievances and State Fair Hearings	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 71.8	Where applicable there is evidence of county oversight and involvement in the 2nd level grievance process.
Denials		
Denials	Standard 72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to **Appendix AA** requirements.
Executive Management		
County Executive Management	Standard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Standard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/ Satisfaction	Standard 108.3	County/BH-MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the

Category	PEPS Reference	PEPS Language
		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 CCBH 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, all were evaluated for CCBH and the counties subcontracting with CCBH. **Table C.1** provides a count of these items, along with the relevant categories. 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 CCBH

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	0	1
Longitudinal Care Management (and Care Management Record Review) (Standard 28)	1	0	0	0	1
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	0	1	1	2
Grievances and State Fair Hearings (Standard 71)	4	0	0	0	4
Denials					
Denials (Standard 72)	1	0	1	0	0
Executive Management					
County Executive Management (Standard 78)	1	0	0	0	1
BH-MCO Executive Management (Standard 86)	1	0	0	0	1
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0
Total	16	0	2	4	10

[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 on selected ongoing OMHSAS-specific monitoring standards.

Findings

The OMHSAS-specific PEPS Substandards relating to Care Management are MCO-specific review standards. These two substandards were added to the PEPS Application for RY 2015. There are two substandards crosswalked to this category, and CCBH and its HC BH Contractors were partially compliant with two substandards. The status for these substandards is presented in **Table C.2**.

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

Category	PEPS Item	Review Year	Status by HC BH Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Standard 27.7	RY 2015		All HC BH Contractors	
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	RY 2015		All HC BH Contractors	

All HC BH Contractors were partially compliant with Standard 27 (RY 2015) due to partial compliance with one substandard.

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

All HC BH Contractors were partially compliant with Substandard 7 of Standard 27 (RY 2015).

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

All HC BH Contractors were partially compliant with Standard 28 (RY 2015) due to partial compliance with one substandard.

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

All HC BH Contractors were partially compliant with Substandard 28 of Standard 28.3 (RY 2015)

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

The OMHSAS-specific PEPS Substandards relating to second-level complaints and grievances are MCO and HC BH Contractor-specific review standards. Eight substandards were evaluated for all HC BH Contractors during RY 2017. CCBH was compliant with each of the substandards crosswalked to this category. Findings are presented **Table C.3**.

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

Category	PEPS Item	Review Year	Status by HC BH Contractor		
			Met	Partially Met	Not Met
Second Level Complaints and Grievances					
Complaints	Standard 68.1	RY 2015	All HC BH Contractors		
	Standard 68.6	RY 2015	All HC BH Contractors		
	Standard 68.7	RY 2016	All HC BH Contractors		
	Standard 68.8	RY 2017	All HC BH Contractors		
Grievances and State Fair Hearings	Standard 71.1	RY 2016	All HC BH Contractors		
	Standard 71.5	RY 2015	All HC BH Contractors		
	Standard 71.6	RY 2015	All HC BH Contractors		

Category	PEPS Item	Review Year	Status by HC BH Contractor		
			Met	Partially Met	Not Met
	Standard 71.7	RY 2015	All HC BH Contractors		

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2015. CCBH was evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

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

Category	PEPS Item	Review Year	Status
Denials			
Denials	Standard 72.3	RY 2017	Met

There are two OMHSAS-specific PEPS substandards relating to Executive Management; the County Executive Management substandard is a county-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. These substandards were added to the PEPS Application during RY 2015. CCBH was evaluated for both substandards in RY 2015. The status for these substandards is presented in **Table C.5.**

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

Category	PEPS Item	Review Year	Status by HC BH Contractor			
			Met	Partially Met	Not Met	Not Evaluated
Executive Management						
County Executive Management	Standard 78.5	RY 2015	Blair	Allegheny, Erie, Lycoming/Clinton, York/Adams	Berks, Carbon/ Monroe/Pike	Chester, NBHCC, NCSO
BH-MCO Executive Management	Standard 86.3	RY 2015			All HC BH Contractors	

PEPS Standard 78: County Executive Management. Evidence exists of the County's oversight of functions and activities delegated to the BH-MCO, including: a. County Table of Organization showing a clear organization structure for oversight of BH-MCO functions; b. In the case of a multi-county contract, the Table of Organization shows a clear relationship among and between Counties' management structures, as it relates to the BH-MCO oversight; c. The role of the Single County Authority (SCA) in oversight is clear in the oversight structure; d. Meeting schedules and attendee minutes reflect County oversight of the BH-MCO (e.g., adequate staff with appropriate skills and knowledge that regularly attend meetings and focus on monitoring the contract and taking appropriate action, such as CAPs; and e. 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).

Four HC BH Contractors associated with CCBH (Allegheny, Erie, Lycoming-Clinton, and York/Adams) were partially compliant with Substandard 5 of Standard 78 (RY 2015), and two HC BH Contractors associated with CCBH (Berks and Carbon/Monroe/Pike) were non-compliant with Substandard 5 of Standard 78 (RY 2015).

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

PEPS Standard 86: BH-MCO Executive Management. Required duties and functions are in place. The BH-MCO's table of organization depicts organization relationships of the following functions/ positions: Chief Executive Officer; the appointed Medical Director is a board-certified psychiatrist licensed in Pennsylvania with at least five years experience in

mental health and substance abuse; Chief Financial Officer; Director of Quality Management; Director of Utilization Management; Management Information Systems; Director of Prior/service authorization; Director of Member Services; Director of Provider Services

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

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

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are county-specific review standards. All three substandards crosswalked to this category were evaluated for the CCBH HC BH Contractors, and all Contractors were compliant on the three substandards. The status for these substandards is presented in **Table A.6**.

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

Category	PEPS Item	Review Year	Status by HC BH Contractor		
			Met	Partially Met	Not Met
Enrollee Satisfaction					
Consumer/Family Satisfaction	Standard 108.3	RY 2016	All HC BH Contractors		
	Standard 108.4	RY 2016	Allegheny, Berks, Blair, Carbon/Monroe/Pike, Chester, Lycoming/Clinton, NBHCC, NCSO, York/Adams	Erie	
	Standard 108.9	RY 2016	All HC BH Contractors		

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

Erie was partially compliant on Substandard 4 of Standard 108 (RY 2016).

Substandard 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.