Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services
2022 External Quality Review Report
Beacon Health Options of Pennsylvania

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IPRO
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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).[1] This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients.

The Commonwealth of Pennsylvania (PA) Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2022 EQRs for HealthChoices (HC) behavioral health MCOs (BH-MCOs) and to prepare the annual technical reports. The subject of this report is one HC BH-MCO: Beacon Health Options of Pennsylvania (BHO). Subsequent references to MCO in this report refer specifically to this HC BH-MCO.

Overview

HC BH is the mandatory managed care program which provides Medical Assistance recipients with BH services in PA. The PA DHS OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with PA for the administration of the HC BH Program. In such cases, DHS holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH contractors, referred to in this report as "Primary Contractors." Primary Contractors, in turn, subcontract with a private-sector BH-MCO to manage the HC BH Program. Effective July 1, 2021, 66 of the 67 counties exercised their right of first opportunity to contract directly with a Primary Contractor. In 2021, DHS held one contract on behalf of an opt-out county, Greene.

In the interest of operational efficiency, numerous counties have come together to create HC oversight entities (HC-OEs) that coordinate the Primary Contractors while providing an oversight function of the BH-MCOs. In some cases, the HC-OE is the HC BH contractor and, in other cases, multiple Primary Contractors contract with an HC-OE to manage their HC BH Program. In the BHO managed care network, Beaver, Fayette, and the Southwest Six counties (comprising Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland Counties) hold contracts with BHO. The OE for the Southwest Six counties is Southwest Behavioral Health Management, Inc. Northwest Behavioral Health Partnership, Inc. (NWBHP; comprising Crawford, Mercer, and Venango Counties), also holds a contract with BHO. In 2021, DHS contracted directly with BHO to manage the HC BH Program for Greene County. Effective January 1, 2022, Greene County joined BHARP, effectively changing its contracted MCO from BHO to CCBH.

Objectives

The EQR-related activities that must be included in the detailed technical reports are as follows:

- validation of performance improvement projects,
- validation of MCO performance measures,
- review to determine plan compliance with structure and operations standards established by the state (*Title 42 Code of Federal Regulations [CFR] Section [§] 438.358*), and
- validation of MCO network adequacy.

Scope of EQR Activities

In accordance with the updates to the Centers for Medicare and Medicaid Services (CMS) EQRO Protocols released in late 2019,[2] this technical report includes eight core sections:

I. Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Review of Compliance with Medicaid Managed Care Regulations
IV. Validation of Network Adequacy
V. Quality Studies
VI. 2021 Opportunities for Improvement – MCO Response
VII. 2022 Strengths and Opportunities for Improvement
VIII. Summary of Activities

For the MCO, information for **Sections I** and **II** of this report is derived from IPRO's validation of the MCO's performance improvement projects (PIPs) and performance measure (PM) submissions. The PM validation, as conducted by IPRO, included a repeated measurement of three PMs: HEDIS Follow-Up After Hospitalization for Mental Illness, PA-specific

Follow-Up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. The information for compliance with Medicaid Managed Care Regulations in **Section III** 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 PA's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable. **Section IV** discusses the validation of MCO network adequacy in relation to existing federal and state standards that are covered in the Review of Compliance with Medicaid Managed Care Regulations, **Section III**. **Section V** discusses the Quality Study for the Certified Community Behavioral Health Clinic (CCBHC) federal demonstration and the Integrated Community Wellness Centers (ICWC) program. **Section VI**, 2021 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2021 (measurement year [MY] 2020) EQR annual technical report and presents the degree to which the MCO addressed each opportunity for improvement. **Section VII** includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2021), 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 VIII** provides a summary of EQR activities for the MCO for this review period. Also included are: **References** with a list of publications cited, as well as **Appendices** that include crosswalks of PEPS standards to pertinent BBA regulations and to OMHSAS-specific PEPS substandards, and results of the PEPS review for OMHSAS-specific standards.

I: Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

In accordance with current BBA regulations, IPRO validates at least one PIP for the MCO. The Primary Contractors and MCOs are required to implement improvement actions and to conduct follow-up, including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action.

Calendar year (CY) 2021 saw the initial implementation stage of the new PIP project. During this stage, the PIP project was renamed "Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders" (SUD) in accordance with feedback received by the BH-MCOs and Primary Contractors during the first year of the PIP. The MCOs submitted their recalculated baselines which allowed for any recalibration of their measures and subsequent interventions as needed.

The Aim Statement for this PIP remained: "Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach."

OMHSAS kept three common (for all MCOs) clinical objectives and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an opioid use disorder (OUD) and/or other SUD;
2. Improve retention in treatment for members with an OUD and/or other SUD diagnosis;
3. Increase concurrent use of drug and alcohol counseling in conjunction with pharmacotherapy (medication-assisted treatment [MAT]); and
4. Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH contracting networks. The two "activities" may fall under a single intervention or may compose two distinct interventions. Note that while the emphasis here is on population-based strategies, this non-clinical objective should be interpreted within the PIP lens to potentially include interventions that target or collaborate with providers and health care systems in support of a specific population (SUD) health objective.

Additionally, OMHSAS identified the following core performance indicators for the PEDTAR PIP:

1. **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) –** This Healthcare Effectiveness Data and Information Set (HEDIS®) measure measures "the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder."[3] It contains two submeasures: continuity of care within 7 days, and continuity of care within 30 days of the index discharge or visit.
2. **Substance Use Disorder-Related Avoidable Readmissions (SAR) –** This is a PA-specific measure that measures avoidable readmissions for HC members 13 years of age and older discharged from detox, inpatient rehab, or residential services with an alcohol and other drug dependence (AOD) primary diagnosis. The measure requires 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. The measure measures discharges, not individuals (starting from Day 1 of the MY, if multiple qualifying discharges within any 30-day period, only the earliest discharge is counted in the denominator). The SUD avoidable readmissions submeasure is intended here to complement FUI and recognizes that appropriate levels of care for individuals with SUD will depend on the particular circumstances and conditions of the individual. Therefore, for this submeasure, "avoidable readmission" will include detox episodes only.
3. **Mental Health-Related Avoidable Readmissions (MHR) –** This PA-specific measure will use the same denominator as SAR. The measure recognizes the high comorbidity rates of MH conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for MH conditions before they reach a critical

stage. For this measure, "readmission" will be defined as any acute inpatient admission with a primary MH diagnosis occurring within 30 days of a qualifying discharge from AOD detox, inpatient rehab, or residential services.

4. **Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of opioid use disorder (OUD) in the measurement period who received both BH counseling services and pharmacotherapy for their OUD during the measurement period. This PA-specific measure is based on a CMS measure of "the percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year."[4] This measure will be adapted to include members age 16 years and older. BH counseling is not necessarily limited to addiction counseling.
5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe alcohol use disorder (AUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD, except for members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

MCOs are expected to submit results to IPRO on an annual basis. In addition to running as annual measures, quarterly rates will be used to enable measurement on a frequency that will support continuous monitoring and adjustment by the MCOs and their Primary Contractors.

This PIP project will extend from January 2021 through December 2023, with initial PIP proposals submitted in 2020 and a final report due in September 2024. The report marks the 19th EQR review to include validation of PIPs. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline.

Technical Methods of Data Collection and Analysis

The MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with CMS protocols. These protocols follow a longitudinal format and capture information relating to:

- Project Topic
- Methodology
- Barrier Analysis, Interventions, and Monitoring
- Results
- Discussion

For the PEDTAR PIP, OMHSAS has designated the Primary Contractors to conduct quarterly PIP review calls with each MCO. The purpose of these calls will be 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 will be 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, rather than two semiannual submissions, MCOs will submit only one PIP interim report each September starting in 2021.

IPRO's validation of PIP activities is consistent with the protocol issued by CMS[5] and meets the requirements of the Final Rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 8 review elements listed below:

1. Topic Rationale
2. Aim
3. Methodology
4. Identified Study Population Barrier Analysis
5. Robust Interventions
6. Results
7. Discussion and Validity of Reported Improvement
8. Sustainability

The first seven 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 Met, Partially Met, and Not Met. Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. The overall score expresses the level of compliance.

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. MY 2020 is the baseline year, and for MY 2021, elements were reviewed and scored using the Year 1 annual reports submitted in 2022. All MCOs received some level of guidance towards improving their submissions in these findings.

Table 1.1 presents the terminologies used in the scoring process, their respective definitions, and their weight.

Table 1.1: Element Designation

Element Designation	Definition	Designation 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%

When the PIPs are reviewed, all projects are evaluated on the same elements. The scoring matrix is completed for those review elements where activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. Untimely reporting by the MCO, i.e., if not in accordance with the submission schedule, may be factored into the overall determination. At the time each 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%. Effective MY 2022, overall ratings below 85% (i.e., below "Met") will require action plans to remediate deficiencies in the PIP and/or its reporting.

The total points earned for each review element are weighted to determine the MCO's overall performance scores for a PIP. For the EQR PIPs, the highest achievable score for all demonstrable improvement elements—in this case, for MYs 2021 and 2022—is 80 points (80% x 100 points for full compliance; refer to **Table 1.2**).

Table 1.2: Review Element Scoring Weights (Scoring Matrix)

Review Element	Standard	Scoring Weight
1	Topic/rationale	5%
2	Aim	5%
3	Methodology	15%
4	Barrier analysis	15%
5	Robust interventions	15%
6	Results table	5%
7	Discussion and validity of reported improvement	20%
Total demonstrable improvement score		**80%**
8	Sustainability[1]	20%
Total sustained improvement score		**20%**
Overall project performance score		**100%**

[1]At the time of this report, these standards were not yet applicable in the current phase of PIP implementation.

As also noted in **Table 1.2** (Scoring Matrix), PIPs are reviewed for the achievement of sustained improvement. Sustained improvement is assessed for the final year of a PIP, in this case, for MY 2023. The evaluation of the sustained improvement area has two review elements. These review elements have a total weight of 20%, for a possible maximum total of 20 points. To receive these points, the MCO must sustain improvement relative to baseline after achieving

demonstrable improvement. The results for demonstrable and sustainable improvement will be reported by the MCO and evaluated by the EQRO at the end of the current PIP cycle and reported in a subsequent EQR annual technical report.

Findings

BHO successfully submitted a PEDTAR PIP proposal in the fall of 2020 based on an initial baseline period of July 1, 2019, through June 30, 2020. Implementation began in early 2021. The MCO subsequently resubmitted a revised proposal based on the full CY 2020 data with goals, objectives, and interventions recalibrated as needed. IPRO reviewed all baseline PIP submissions for adherence to PIP design principles and standards, including alignment with the statewide PIP aims and objectives as well as internal consistency and completeness. Clinical intervention highlights include education and readiness reviews for the American Society of Addiction Medicine (ASAM) criteria implementation, incentivization for concurrent pharmacotherapy and counseling in SUD treatment, and improved treatment option education for members. For its population-based prevention strategy component, BHO proposed a community forum, educational anti-stigma campaign, and Mental Health First Aid community trainings.

Prevention, Early Detection, Treatment and Recovery (PEDTAR) for Substance Use Disorders

For the Year 1 implementation review, the MCO scored 75% (60 points out of a maximum possible weighted score of 80 points; data not shown). Several of the subintervention activities were discontinued on the grounds that these activities now represent standard operating procedures (SOPs) at BHO, although IPRO found that historical data on the corresponding intervention tracking measures (ITMs) did not clearly demonstrate this. BHO reported that their PIP Workgroup had decided in the fall of 2022 to focus instead on a narrower range of intervention activities. IPRO advised that any and all PIP intervention activities would need to be monitored using ITMs. In addition, the population health strategy intervention was discontinued entirely, effective 2022. IPRO advised that BHO would need to find a suitable population health strategy going forward to satisfy this required component of the PIP.

Table 1.3: BHO PIP Compliance Assessments – Interim Year 1 Report

Review Element	PEDTAR
Element 1. Project Topic/Rationale	Met
Element 2. Aim	Met
Element 3. Methodology	Met
Element 4. Barrier Analysis	Met
Element 5. Robust Interventions	Partially Met
Element 6. Results Table	Partially Met
Element 7. Discussion and Validity of Reported Improvement	Partially Met

II: Validation of Performance Measures

Objectives

In MY 2021, OMHSAS's HC Quality Program required MCOs to run three PMs as part of their quality assessment and performance improvement (QAPI) program: the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH), a PA-specific Follow-Up After Hospitalization for Mental Illness, and a PA-specific Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were remeasured in 2021. IPRO validated all three PMs reported by each MCO for MY 2021 to ensure that the PMs were implemented to specifications and state reporting requirements (*Title 42 CFR § 438.330[b][2]*).

Follow-Up After Hospitalization for Mental Illness

This PM assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge. The measure continues to be of interest to OMHSAS for the purpose of comparing county, Primary Contractor, and BH-MCO rates to available national benchmarks and to prior years' rates.

MY 2002 was the first year that 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 HC 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.

Typically, HEDIS FUH undergoes annual updates to its specifications. Among the updates in 2020 (MY 2019), the National Committee for Quality Assurance (NCQA) added the following reporting strata for FUH, ages: 6–17, 18–64, and 65 and over. These changes resulted in a change in the reporting of FUH results in this report, which are broken out by ages: 6–17, 18–64, and 6 and over (All Ages).

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 PM assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge.

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

Eligible Population for HEDIS Follow-Up

The entire eligible population was used for all 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH 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, 2021;
- A principal International Classification of Diseases, Ninth Revision (ICD-9) or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code indicating one of the specified mental health disorders;
- Six (6) 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, 2021, 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, 2021. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS MY 2021 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 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 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.

Eligible Population for PA-Specific Follow-Up

The entire eligible population was used for all 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a principal diagnosis of mental illness occurring between January 1 and December 2, 2021;
- Six (6) 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 2, 2021, 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 2, 2021. The PA-specific measure has been adjusted to allow discharges up through December 2, 2021, which allows for the full 30-day follow-up period where same-day follow-up visits may be counted in the numerator.

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

Mental health disorders contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. In 2019, an estimated 47.6 million adults aged 18 or older (19.1%) had any mental illness in the past year while an estimated 11.4 million adults in the nation had a serious persistent mental illness (SPMI) in the past year, which corresponds to 4.6% of all U.S. adults.[6] Additionally, individuals diagnosed with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities such as obesity, cardiovascular diseases, and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns, reduced use of preventive services, and substandard medical care that they receive.[7] Roughly one-third of adults with SPMI in any given year did not receive any mental health services.[8] Further research suggests that more than half of those with SPMI did not receive services because they could not afford the cost of care.[9] Cost of care broke down as follows: 60.8% of related expenses were attributed to loss of earnings, 31.5% were attributed to healthcare expenses, while 7.7% were attributed to payments for disability benefits.[10] 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 outcomes and to prevent long-term deterioration in people with SPMI.[11] As noted in *The State of Health Care Quality Report,*[12] appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses and the likelihood of recurrence. An outpatient visit within at least 30 days (ideally, 7 days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance and to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments.[13] 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.[14] 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.[15]

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long-standing concern of BH care systems, with some researchers having estimated that 40–60% of patients fail to connect with an outpatient clinician.[16] 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.[17]

There are various measures of treatment efficacy, such as service satisfaction, functional status, and health outcomes. Among them, rehospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment.[18] Avoidable inpatient readmission is 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. Additionally, mental illness continues to impact the PA population, including those with substance abuse concerns or SUD.[19] Measuring appropriate care transitions for members with mental illness, therefore, carries wider implications for the OMHSAS quality area related to SUD prevalence and outcomes.

As noted, timely follow-up after hospitalization for mental illness has been and remains a focus for OMHSAS and results are reviewed for potential trends each year. MY 2020 results will be examined in the context of the COVID-19 pandemic, which has been implicated in rising prevalence of mental illness.[20] 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.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-Up After Hospitalization for Mental Illness, OMHSAS elected to retain and remeasure the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) indicator for this year's EQR. As directed by OMHSAS, IPRO developed the PM 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 remeasurement of the PM for validation soon thereafter for MY 2007, and then for MY 2008. Remeasurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2021 study conducted in 2022 was the 15th remeasurement of this indicator. Four clarifications were made to the specifications for MY 2013. If

a member was known to have multiple member IDs in the MY, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and 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 2021. This measure continued to be of interest to OMHSAS for the purposes of comparing Primary Contractor and BH-MCO rates to the OMHSAS performance goal and to prior rates.

This study examined BH services provided to members participating in the HC BH 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, the date-of-service, and diagnosis/procedure code criteria were outlined, as were other specifications as needed. This measure's calculation was based on administrative data only.

This PM 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 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH 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 2, 2021;
- 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; and
- The claim was clearly identified as a discharge.

The numerator comprised members who were readmitted to inpatient acute psychiatric care within 30 days of the previous inpatient psychiatric discharge. One significant change to this specification is the extension of the end date for discharges from December 1st to December 2nd to accommodate the full 30 days before the end of the MY.

Technical Methods of Data Collection and Analysis

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 Primary 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. In 2018 (MY 2017), in part to better account for the growing population of members 65 years old and older, OMHSAS changed its benchmarking to the FUH All Ages (6+ years old) measure. OMHSAS established a 3-year goal for the state to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass® published percentiles for 7-day and 30-day FUH. This change in 2018 also coincided with a more prospective and proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2017 results. These MY 2017 results were reported in the 2018 EQR annual technical report.

HEDIS percentiles for the 7-day and 30-day FUH All-Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each underperforming indicator. 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 to the BH-MCO for an RCA and QIP. This process is further discussed in **Section VI**.

For REA, OMHSAS designated the PM goal as better than (i.e., less than) or equal to 11.75% for the participating BH-MCOs and counties. For this measure, lower rates indicate better performance.

Although not part of this report, OMHSAS sponsored in 2019 the rollout of an IPRO-hosted Tableau® server reporting platform, which allows users, including BH-MCOs and Primary Contractors, to interactively query data and produce reports on PMs. These reports include statistical and non-statistical summaries and comparisons of rates by various stratifications, including by demographics, such as race and ethnicity, as well as by participation status in the Medicaid Expansion program (PA continued its Medicaid Expansion under the Affordable Care Act in 2021). This interactive reporting provides an important tool for BH-MCOs and their Primary Contractors to set performance goals as well as monitor progress toward those goals.

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 HC 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 2020 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *Z*-test statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

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

Where:

*N*1 = Current year (MY 2021) numerator,
*N*2 = Prior year (MY 2020) numerator,
*D*1 = Current year (MY 2021) denominator, and
*D*2 = Prior year (MY 2020) 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 2021) quality indicator rate, and
*p*2 = Prior year (MY 2020) quality indicator rate.

Two-tailed statistical significance tests were conducted at $p = 0.05$ 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.

Limitations

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for Primary Contractors. Caution should be exercised when interpreting results for small denominators. A denominator of 100 or greater is preferred for drawing conclusions from *Z*-tests of the PM 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.

Conclusions and Comparative Findings

The HEDIS follow-up indicators are presented for three age groups: ages 18–64 years, ages 6 years and older, and ages 6–17 years. The 6+ years old ("All Ages") results are presented to show the follow-up rates for the overall HEDIS population, and the 6–17 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 Primary Contractor level. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (and Primary Contractor with the same contracted BH-MCO). The Primary Contractor-specific rates were calculated using the numerators and denominators for that particular Primary Contractor. For each of these rates, the 95% confidence interval (CI) is reported. The HC BH aggregate (statewide) rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HC BH statewide rates to determine if they were statistically significantly above or below that value. Statistically significant BH-MCO differences are noted. Primary Contractor-specific rates were also compared to the HC BH statewide rates to determine if they were statistically significantly above or below that value. Statistically significant Primary Contractor-specific differences are noted.

The HEDIS follow-up results for the All-Ages and 18–64 years old age groups are compared to the HEDIS 2021 national percentiles to show BH-MCO and Primary Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile. The HEDIS follow-up results for the 6–17 years old age group are not compared to HEDIS benchmarks.

I: HEDIS Follow-Up Indicators

(a) Age Group: 18–64 Years Old

Table 2.1 shows the MY 2021 results for both the HEDIS 7-day and 30-day follow-up measures for members 18–64 years old compared to MY 2020.

Table 2.1: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Indicators (18–64 Years)

	MY 2021						MY 2021 Rate Comparison to:		
				95% CI			MY 2020		
Measure[1]	(N)	(D)	%	Lower	Upper	MY 2020 %	PPD	SSD	MY 2021 HEDIS Medicaid Percentiles
QI1 - HEDIS 7-Day Follow-Up (18–64 Years)									
Statewide	9984	29137	**34.3%**	33.7%	34.8%	36.4%	-2.2	YES	Below 75th Percentile, Above 50th Percentile
BHO	1611	4067	**39.6%**	38.1%	41.1%	41.0%	-1.4	NO	Below 75th Percentile, Above 50th Percentile
Beaver	185	522	**35.4%**	31.2%	39.6%	39.5%	-4.1	NO	Below 75th Percentile, Above 50th Percentile
NWBHP	278	734	**37.9%**	34.3%	41.5%	40.7%	-2.8	NO	Below 75th Percentile, Above 50th Percentile
Fayette	145	393	**36.9%**	32.0%	41.8%	36.9%	0.0	NO	Below 75th Percentile, Above 50th Percentile
Greene	52	134	**38.8%**	30.2%	47.4%	37.1%	1.7	NO	Below 75th Percentile, Above 50th Percentile
SWBHM	951	2284	**41.6%**	39.6%	43.7%	42.3%	-0.7	NO	Below 75th Percentile, Above 50th Percentile
QI2 - HEDIS 30-Day Follow-Up (18–64 Years)									
Statewide	15653	29137	**53.7%**	53.1%	54.3%	55.7%	-2.0	YES	Below 75th Percentile, Above 50th Percentile
BHO	2501	4067	**61.5%**	60.0%	63.0%	62.4%	-0.9	NO	Below 75th Percentile, Above 50th Percentile
Beaver	317	522	**60.7%**	56.4%	65.0%	66.9%	-6.1	YES	Below 75th Percentile, Above 50th Percentile
NWBHP	435	734	**59.3%**	55.6%	62.9%	59.3%	-0.1	NO	Below 75th Percentile, Above 50th Percentile
Fayette	226	393	**57.5%**	52.5%	62.5%	59.3%	-1.8	NO	Below 75th Percentile, Above 50th Percentile
Greene	76	134	**56.7%**	48.0%	65.5%	65.7%	-9.0	NO	Below 75th Percentile, Above 50th Percentile
SWBHM	1447	2284	**63.4%**	61.4%	65.4%	62.7%	0.7	NO	At or Above 75th Percentile

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; QI: quality indicator; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Figure 2.1 is a graphical representation of MY 2021 HEDIS FUH 7- and 30-day follow-up rates in the 18–64 years old population for BHO and its associated Primary Contractors. The orange line represents the MCO average.

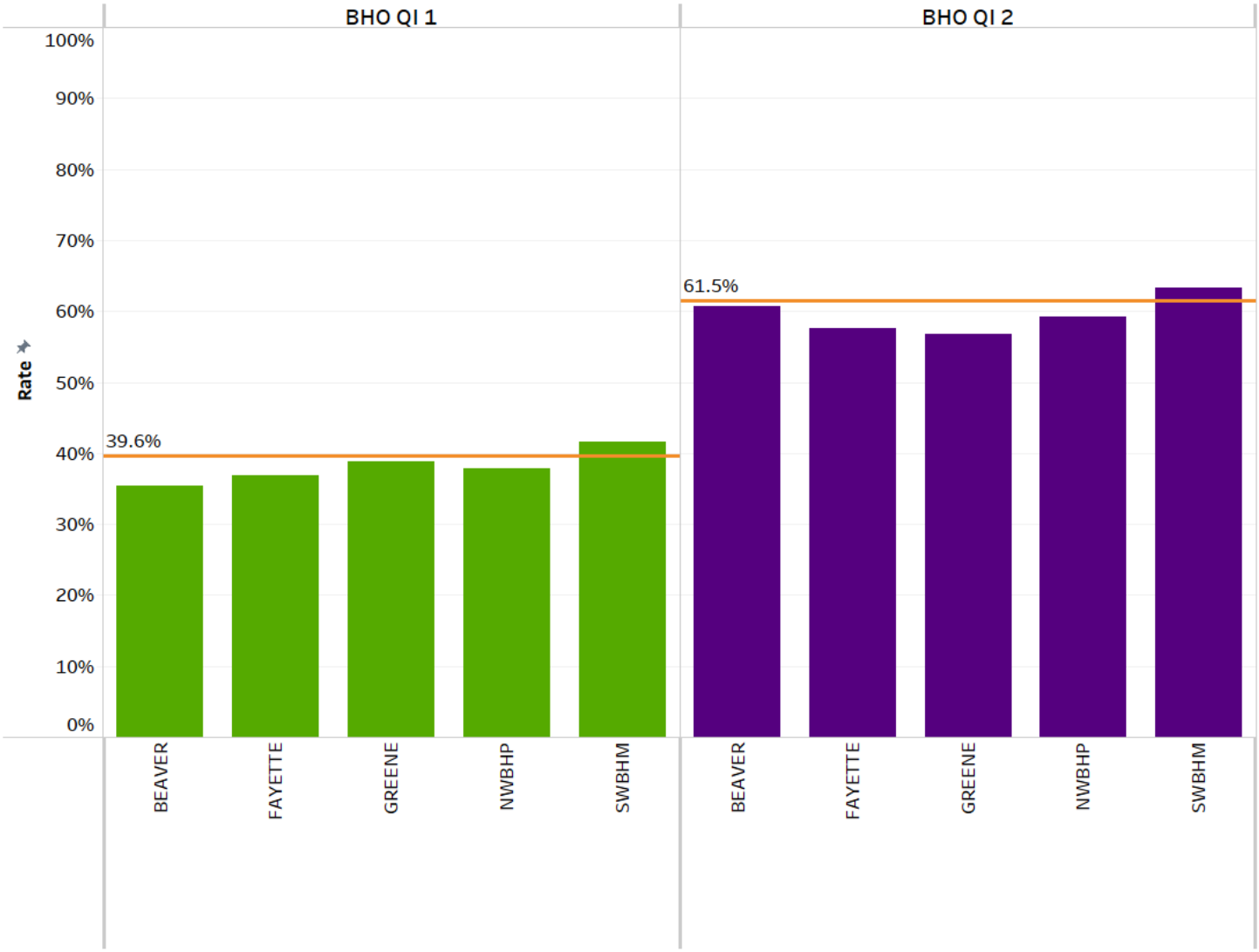

Figure 2.1: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years).

Figure 2.2 shows the HC BH (statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the HC BH (statewide) rate.

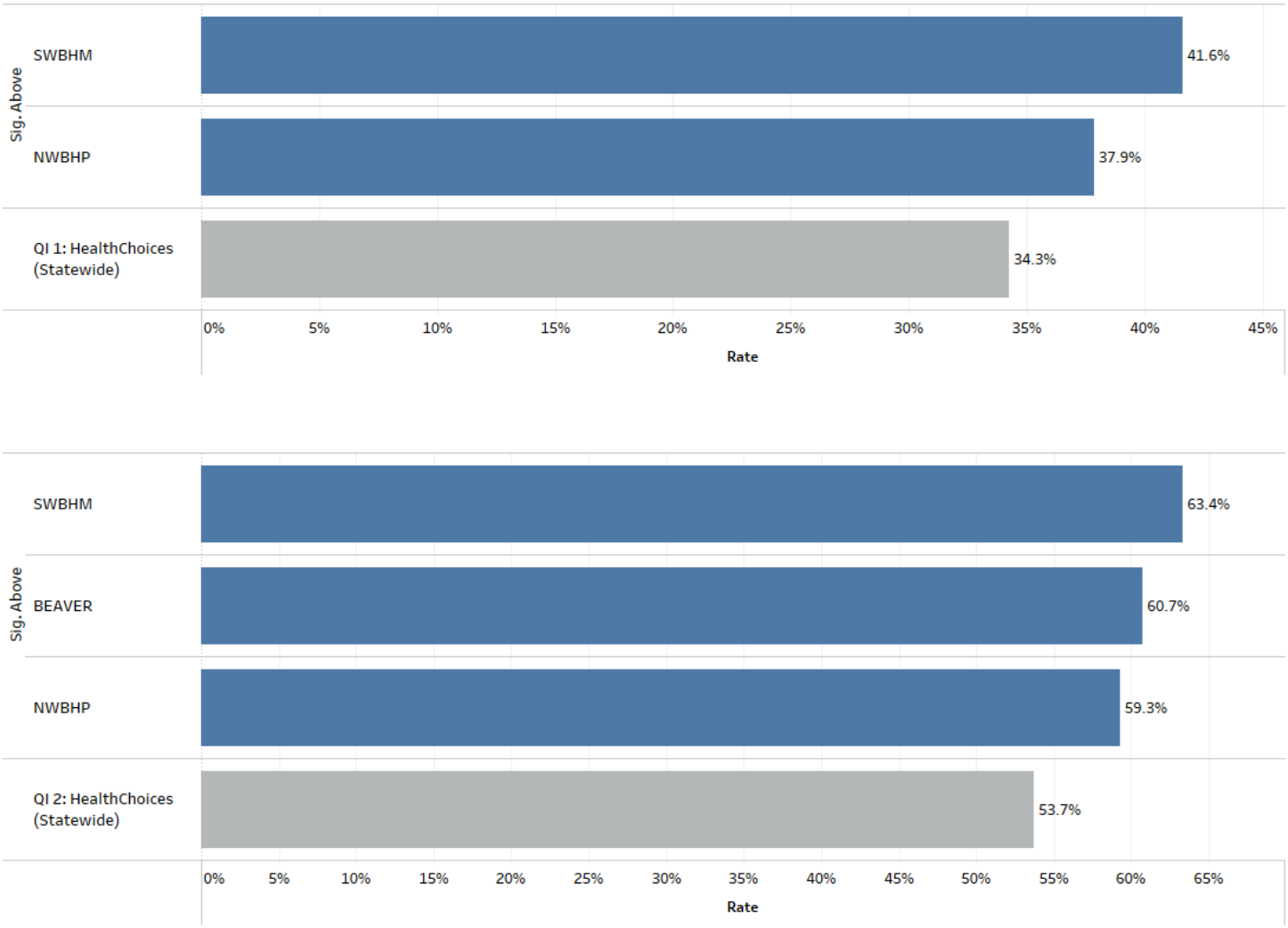

Figure 2.2: Statistically Significant Differences in BHO Contractor MY 2021 HEDIS FUH Rates (18–64 Years). BHO Primary Contractor MY 2021 HEDIS FUH rates for 18–64 years of age that are statistically significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (18–64 years).

(b) Overall Population: 6+ Years Old

The MY 2021 HC aggregate HEDIS and BHO are shown in **Table 2.2**.

Table 2.2: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Indicators (All Ages)

Measure[1]	MY 2021 (N)	MY 2021 (D)	MY 2021 %	95% CI Lower	95% CI Upper	MY 2020 %	MY 2021 Rate Comparison to: MY 2020 PPD	MY 2020 SSD	MY 2021 HEDIS Medicaid Percentiles
QI1 - HEDIS 7-Day Follow-Up (Overall)									
Statewide	14140	37506	**37.7%**	37.2%	38.2%	39.8%	-2.1	YES	Below 50th Percentile, Above 25th Percentile
BHO	2405	5492	**43.8%**	42.5%	45.1%	45.0%	-1.3	NO	Below 75th Percentile, Above 50th Percentile
Beaver	256	662	**38.7%**	34.9%	42.5%	42.7%	-4.0	NO	Below 75th Percentile, Above 50th Percentile
NWBHP	466	1087	**42.9%**	39.9%	45.9%	44.6%	-1.7	NO	Below 75th Percentile, Above 50th Percentile
Fayette	229	514	**44.6%**	40.2%	48.9%	40.3%	4.2	NO	Below 75th Percentile, Above 50th Percentile
Greene	72	170	**42.4%**	34.6%	50.1%	43.4%	-1.0	NO	Below 75th Percentile, Above 50th Percentile
SWBHM	1382	3059	**45.2%**	43.4%	47.0%	46.5%	-1.3	NO	Below 75th Percentile, Above 50th Percentile
QI2 - HEDIS 30-Day Follow-Up (Overall)									
Statewide	21707	37506	**57.9%**	57.4%	58.4%	59.4%	-1.6	YES	Below 50th Percentile, Above 25th Percentile
BHO	3640	5492	**66.3%**	65.0%	67.5%	67.0%	-0.7	NO	Below 75th Percentile, Above 50th Percentile
Beaver	423	662	**63.9%**	60.2%	67.6%	69.4%	-5.5	YES	Below 75th Percentile, Above 50th Percentile
NWBHP	704	1087	**64.8%**	61.9%	67.7%	64.8%	-0.0	NO	Below 75th Percentile, Above 50th Percentile
Fayette	332	514	**64.6%**	60.4%	68.8%	63.5%	1.1	NO	Below 75th Percentile, Above 50th Percentile
Greene	99	170	**58.2%**	50.5%	65.9%	70.6%	-12.4	YES	Below 50th Percentile, Above 25th Percentile
SWBHM	2082	3059	**68.1%**	66.4%	69.7%	67.6%	0.5	NO	At or Above 75th Percentile

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; N: numerator; D: denominator; CI: confidence interval; PPD: percentage point difference; SSD: statistically significant difference; QI: quality indicator; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Figure 2.3 is a graphical representation of the MY 2021 HEDIS FUH follow-up rates for BHO and its associated Primary Contractors. The orange line represents the MCO average.

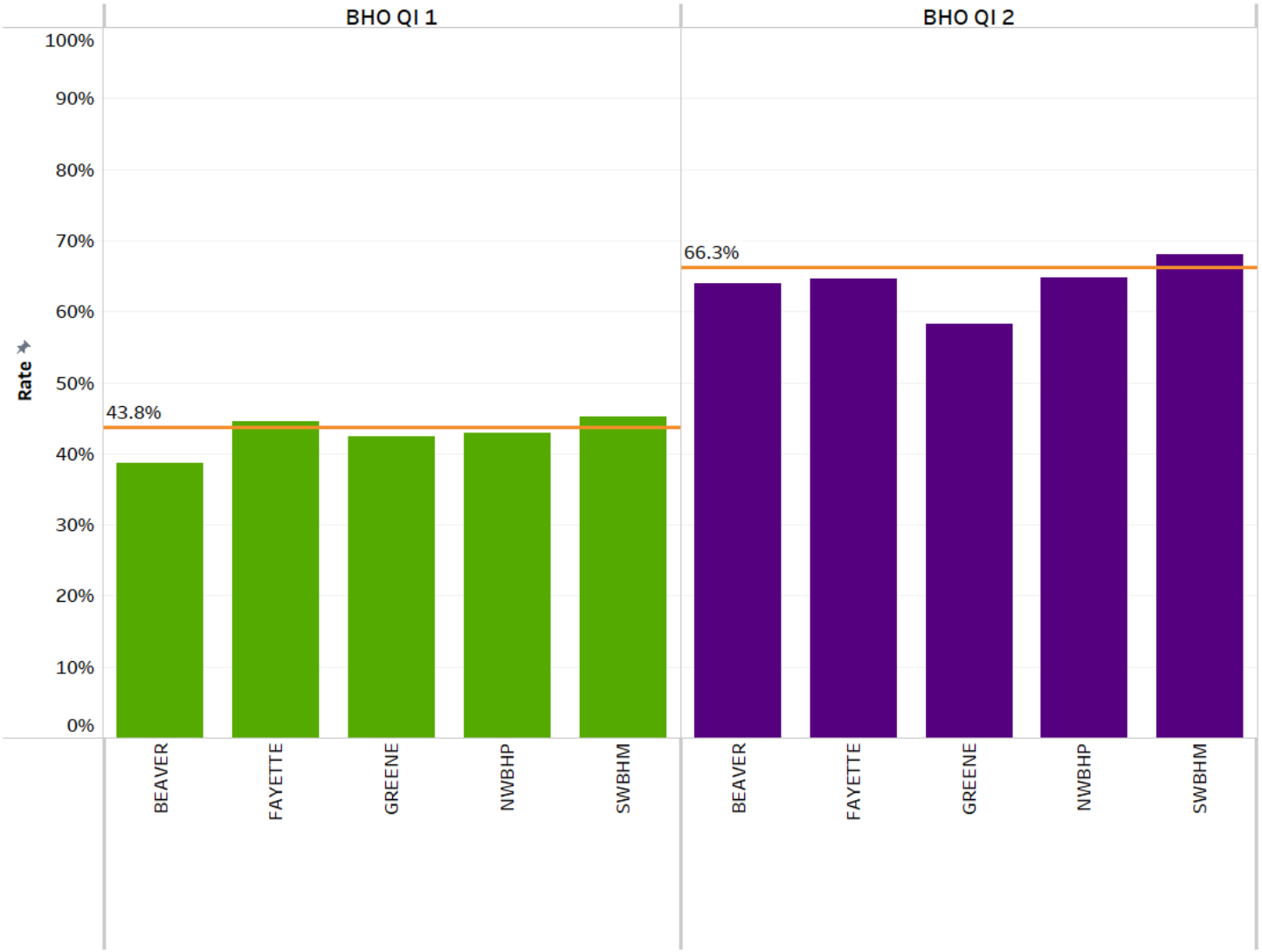

Figure 2.3: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages).

Figure 2.4 shows the HC BH (statewide) rates and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than its statewide benchmark.

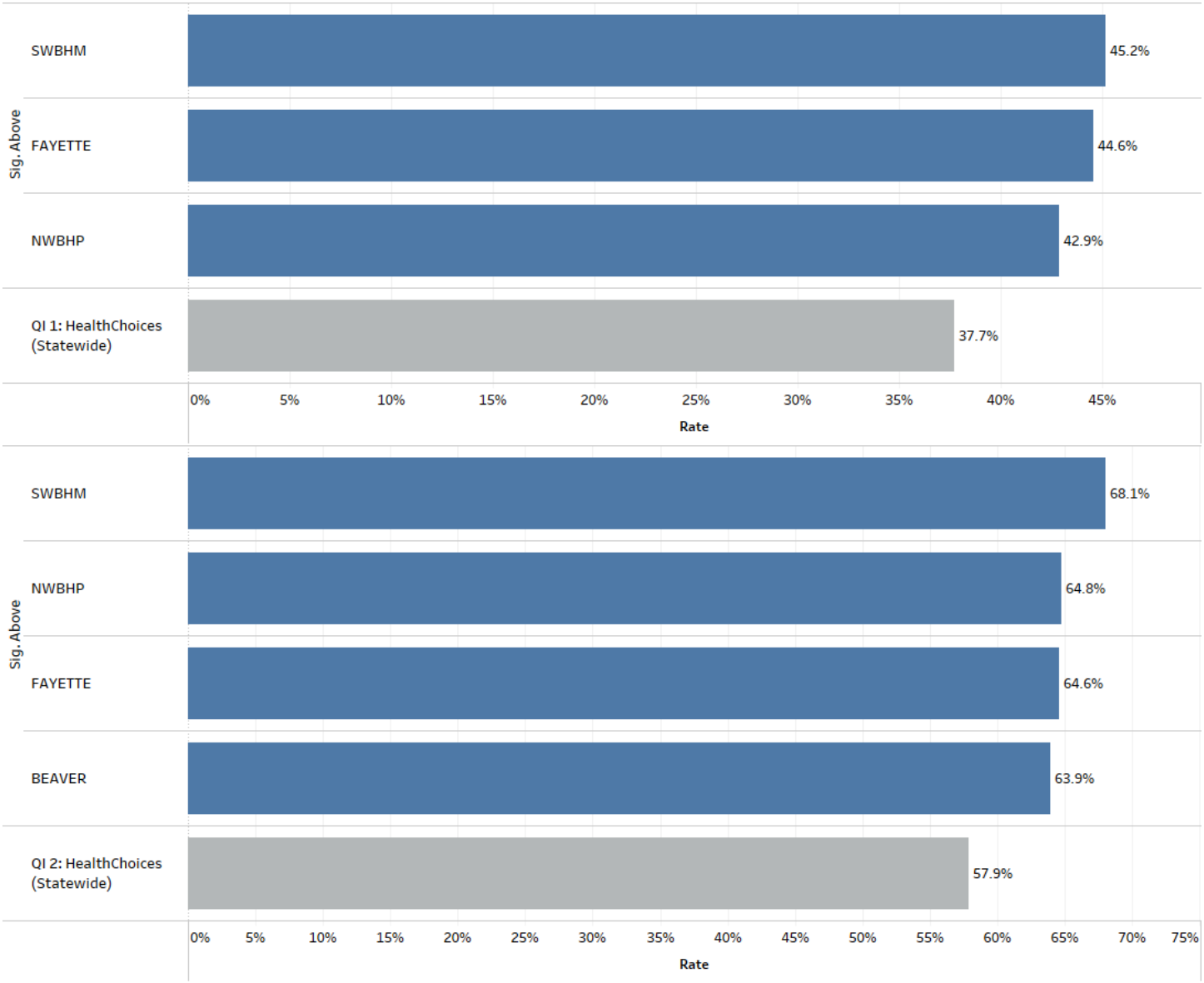

Figure 2.4: Statistically Significant Differences in BHO Contractor MY 2021 HEDIS FUH Rates (All Ages). BHO Primary Contractor MY 2021 HEDIS FUH rates for all ages that are statistically significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (all ages).

(c) Age Group: 6–17 Years Old

Table 2.3 shows the MY 2021 results for both the HEDIS FUH 7-day and 30-day follow-up measures for members 6–17 years old compared to MY 2020.

Table 2.3: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Indicators (6–17 Years)

Measure[1]	MY 2021					MY 2020 %	MY 2021 Rate Comparison to MY 2020	
				95% CI				
	(N)	(D)	%	Lower	Upper		PPD	SSD
QI1 - HEDIS 7-Day Follow-Up (6–17 Years)								
Statewide	3988	7625	**52.3%**	51.2%	53.4%	55.2%	-2.9	YES
BHO	763	1324	**57.6%**	54.9%	60.3%	60.7%	-3.1	NO
Beaver	69	131	**52.7%**	43.7%	61.6%	61.0%	-8.3	NO
NWBHP	183	336	**54.5%**	49.0%	59.9%	55.5%	-1.1	NO
Fayette	81	113	**71.7%**	62.9%	80.4%	56.2%	15.5	YES
Greene	20	32	**62.5%**	N/A	N/A	64.7%	-2.2	N/A
SWBHM	410	712	**57.6%**	53.9%	61.3%	63.3%	-5.7	YES
QI2 - HEDIS 30-Day Follow-Up (6–17 Years)								
Statewide	5787	7625	**75.9%**	74.9%	76.9%	77.1%	-1.2	NO
BHO	1097	1324	**82.9%**	80.8%	84.9%	84.7%	-1.9	NO
Beaver	103	131	**78.6%**	71.2%	86.0%	85.4%	-6.7	NO
NWBHP	262	336	**78.0%**	73.4%	82.6%	79.7%	-1.7	NO
Fayette	101	113	**89.4%**	83.3%	95.5%	82.9%	6.5	NO
Greene	23	32	**71.9%**	N/A	N/A	88.2%	-16.4	N/A
SWBHM	608	712	**85.4%**	82.7%	88.1%	86.8%	-1.5	NO

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.; N/A: Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

Figure 2.5 is a graphical representation of the MY 2021 HEDIS FUH 7- and 30-Day follow-up rates in the 6–17 years old population for BHO and its associated Primary Contractors. The orange line represents the MCO average.

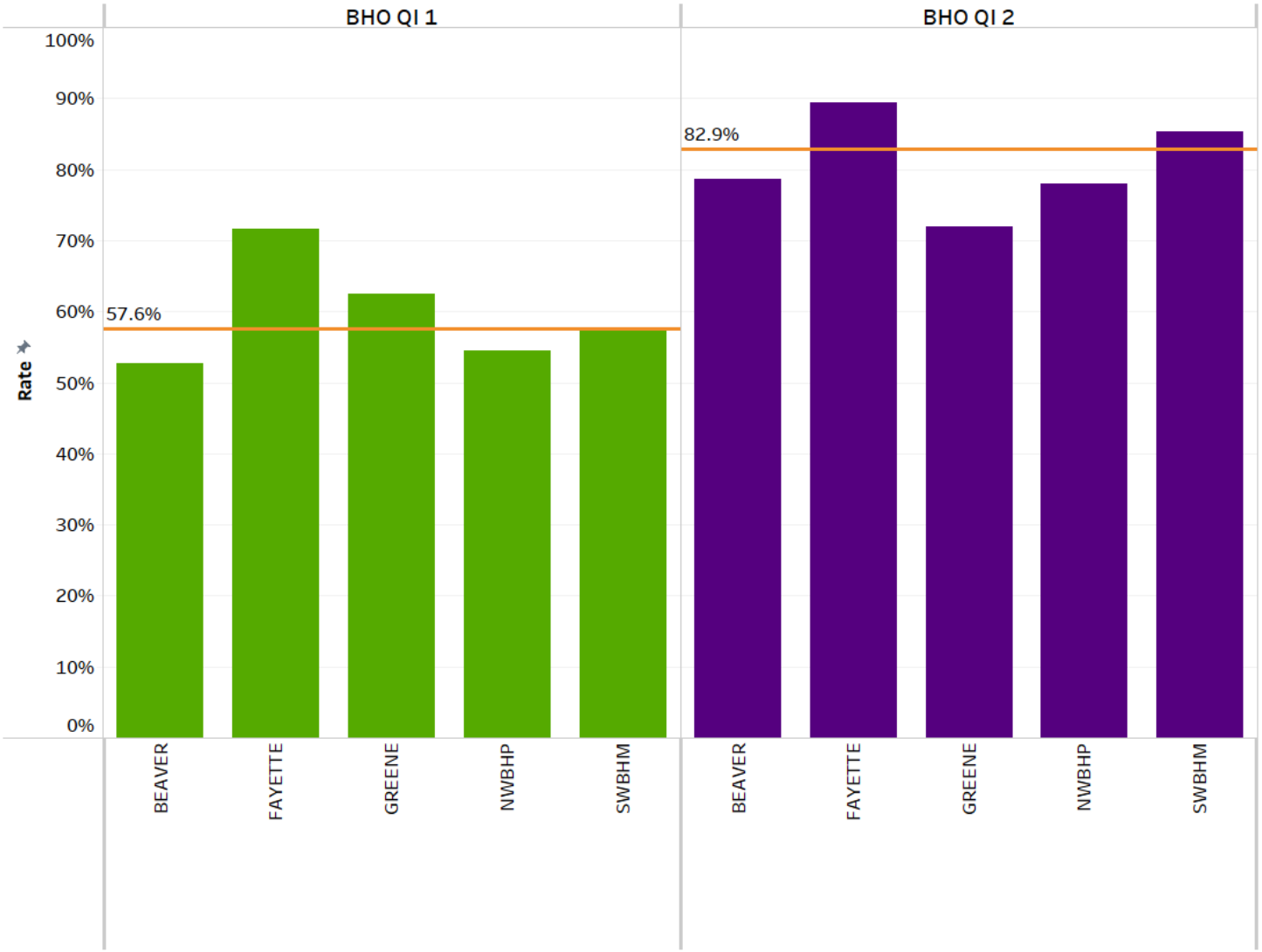

Figure 2.5: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years).

Figure 2.6 shows the HC BH (statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide rates.

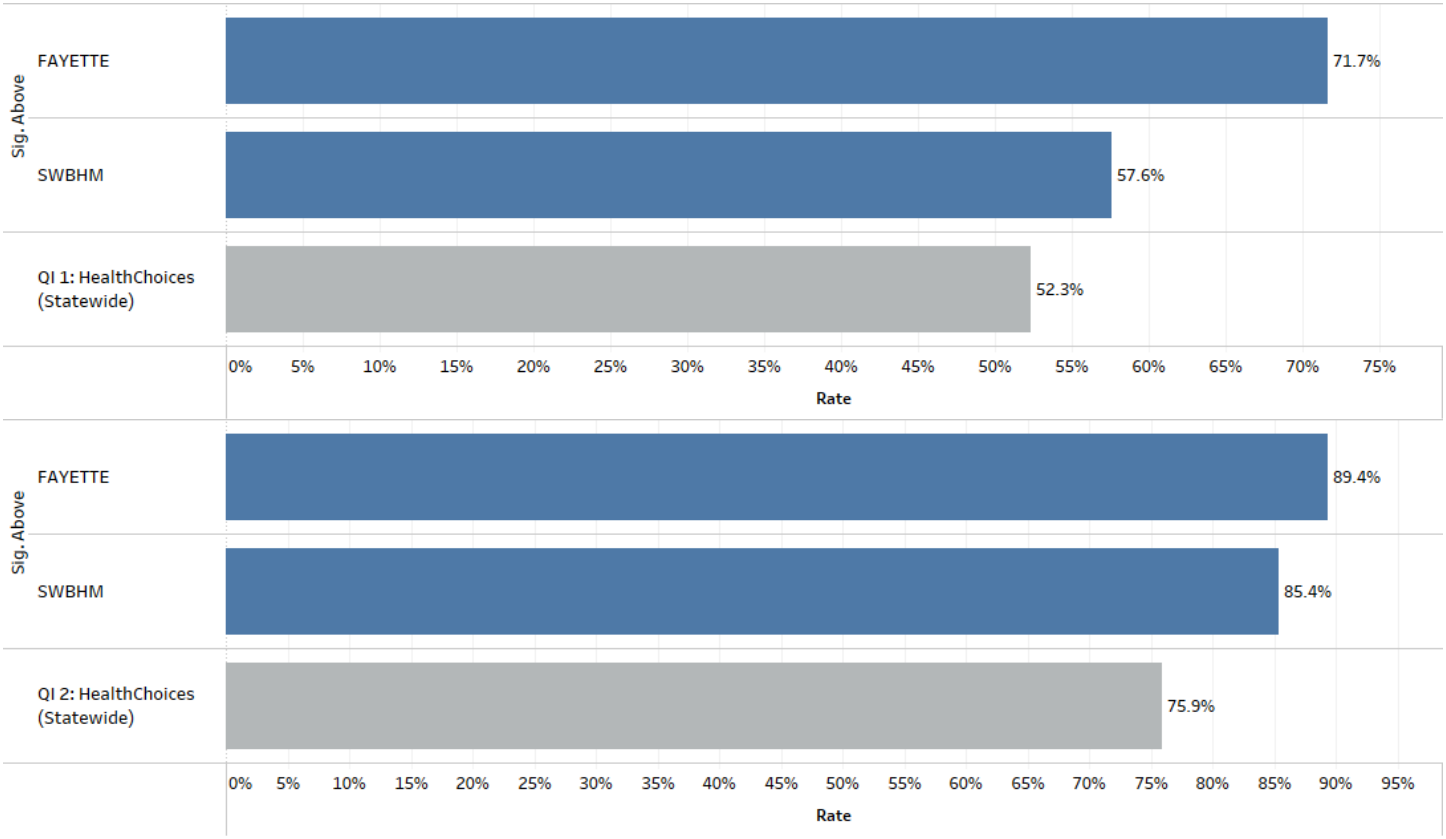

Figure 2.6: Statistically Significant Differences in BHO Contractor MY 2021 HEDIS FUH Rates (6–17 Years) BHO Primary Contractor MY 2021 HEDIS FUH rates for 6–17 years of age that are statistically significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (6–17 Years).

II: PA-Specific Follow-Up Indicators

(a) Overall Population: 6+ Years Old

Table 2.4 shows the MY 2021 PA-specific FUH 7- and 30-day follow-up indicators for all ages compared to MY 2020.

Table 2.4: MY 2021 PA-Specific FUH 7- and 30-Day Follow-Up Indicators (All Ages)

	MY 2021							
				95% CI			MY 2021 Rate Comparison to MY 2020	
Measure[1]	(N)	(D)	%	Lower	Upper	MY 2020 %	PPD	SSD
QI A - PA-Specific 7-Day Follow-Up (Overall)								
Statewide	18376	37634	**48.8%**	48.3%	49.3%	52.3%	-3.5	YES
BHO	2850	5505	**51.8%**	50.4%	53.1%	54.7%	-2.9	YES
Beaver	323	665	**48.6%**	44.7%	52.4%	55.0%	-6.4	YES
NWBHP	555	1090	**50.9%**	47.9%	53.9%	52.7%	-1.8	NO
Fayette	248	515	**48.2%**	43.7%	52.6%	47.2%	0.9	NO
Greene	90	173	**52.0%**	44.3%	59.8%	54.5%	-2.5	NO
SWBHM	1634	3062	**53.4%**	51.6%	55.1%	56.5%	-3.1	YES
QI B - PA-Specific 30-Day Follow-Up (Overall)								
Statewide	24798	37634	**65.9%**	65.4%	66.4%	68.3%	-2.4	YES
BHO	3946	5505	**71.7%**	70.5%	72.9%	72.8%	-1.2	NO
Beaver	460	665	**69.2%**	65.6%	72.8%	73.5%	-4.3	NO
NWBHP	763	1090	**70.0%**	67.2%	72.8%	70.5%	-0.5	NO
Fayette	346	515	**67.2%**	63.0%	71.3%	68.1%	-0.9	NO
Greene	117	173	**67.6%**	60.4%	74.9%	77.6%	-10.0	NO
SWBHM	2260	3062	**73.8%**	72.2%	75.4%	74.1%	-0.2	NO

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.

MY: measurement year; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Figure 2.7 is a graphical representation of the MY 2021 PA-specific follow-up rates for BHO and its associated Primary Contractors. The orange line represents the MCO average.

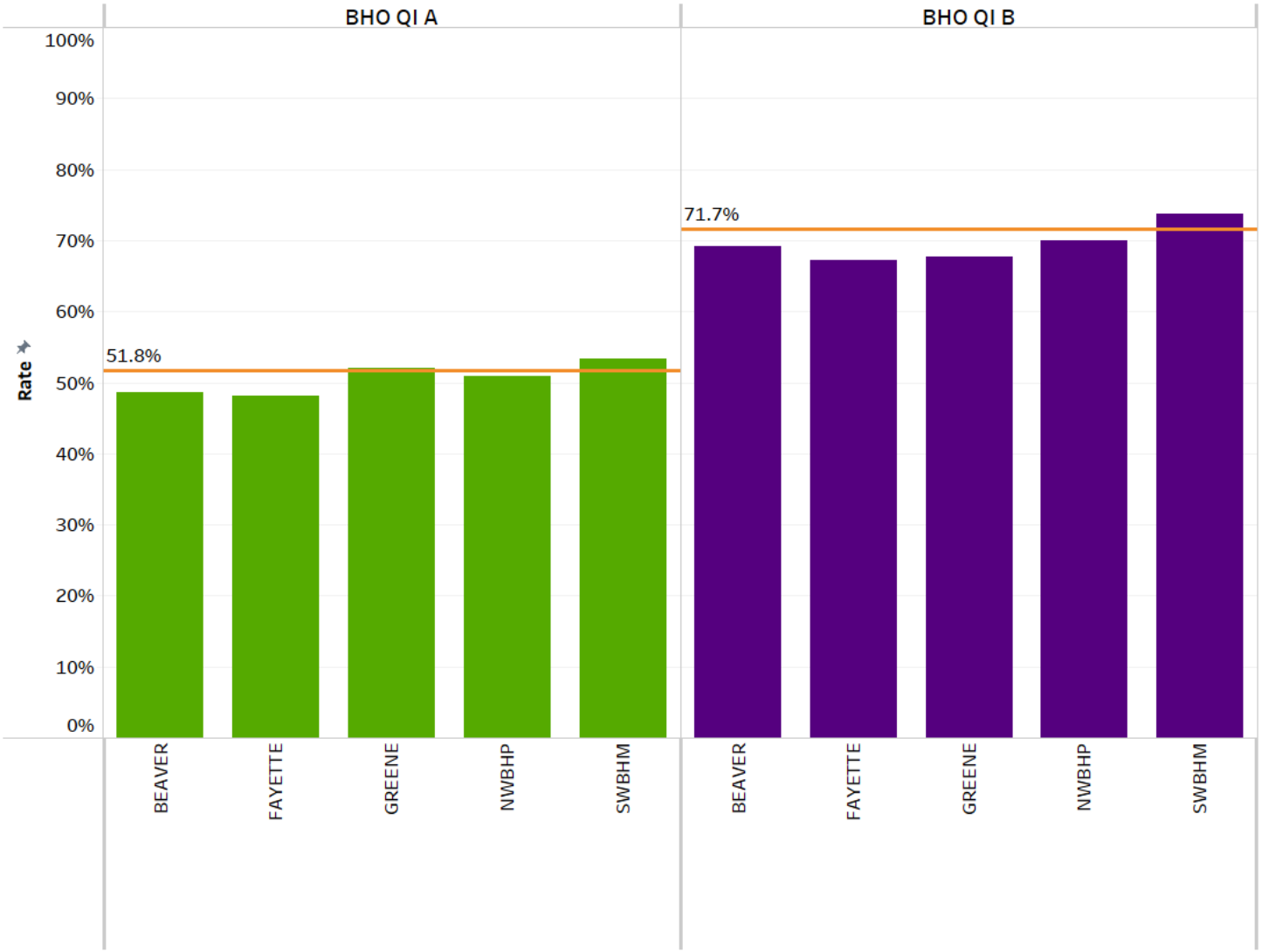

Figure 2.7: MY 2021 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages).

Figure 2.8 shows the HC BH (statewide) rates and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide benchmark.

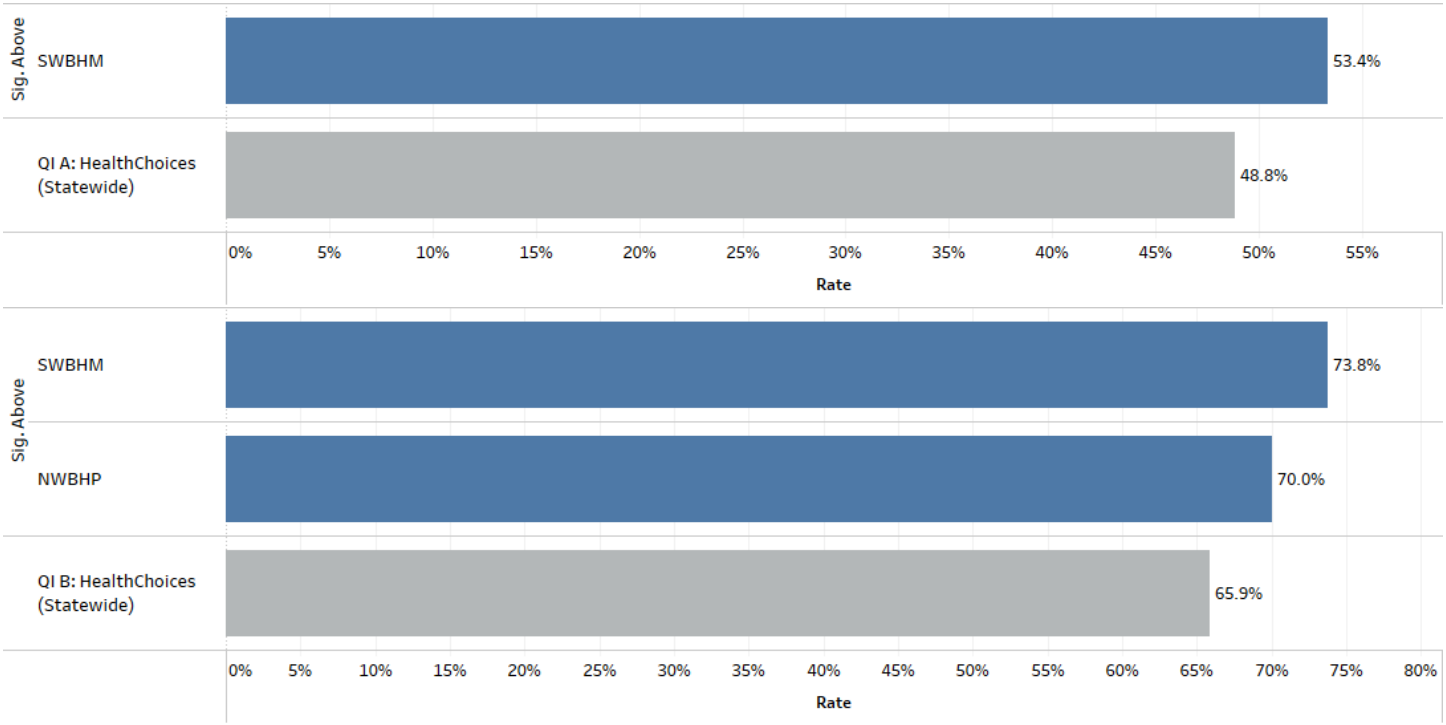

Figure 2.8: Statistically Significant Differences in BHO Contractor MY 2021 PA-Specific FUH Rates (All Ages). BHO Primary Contractor MY 2021 PA-specific FUH rates for all ages that are statistically significantly different than HC BH (statewide) MY 2021 PA-specific FUH rates (all ages).

III. Readmission Indicators

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2021 to MY 2020 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the *Z* score. Statistically significant difference (SSD) at the 0.05 level between groups is noted, as well as the percentage point difference (PPD) between the rates.

Individual rates were also compared to the categorical average. Rates statistically significantly above or below the average are indicated.

Lastly, aggregate rates were compared to the OMHSAS-designated PM goal of 11.75%. Individual BH-MCO and Primary Contractor rates are *not* required to be statistically significantly below 11.75% in order to meet the PM goal (**Table 2.5**).

Table 2.5: MY 2021 REA Readmission Indicators

	MY 2021						MY 2021 Rate Comparison to MY 2020	
				95% CI				
Measure[1,2]	(N)	(D)	%	Lower	Upper	MY 2020 %	PPD	SSD
Inpatient Readmission								
Statewide	6151	46438	**13.2%**	12.9%	13.6%	13.6%	-0.3	NO
BHO	810	6206	**13.1%**	12.2%	13.9%	12.8%	0.2	NO
Beaver	76	678	**11.2%**	8.8%	13.7%	8.9%	2.3	NO
NWBHP	157	1245	**12.6%**	10.7%	14.5%	14.3%	-1.7	NO

Measure[1,2]	MY 2021					MY 2020	MY 2021 Rate Comparison to MY 2020	
				95% CI				
	(N)	(D)	%	Lower	Upper	%	PPD	SSD
Fayette	56	557	**10.1%**	7.5%	12.6%	11.0%	-1.0	NO
Greene	22	201	**10.9%**	6.4%	15.5%	13.3%	-2.4	NO
SWBHM	499	3525	**14.2%**	13.0%	15.3%	13.3%	0.9	NO

[1] The OMHSAS-designated PM goal is a readmission rate at or below 11.75%.

[2] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.

MY: measurement year; REA: Readmission within 30 Days of Inpatient Psychiatric Discharge; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Figure 2.9 is a graphical representation of the MY 2021 readmission rates for BHO and its associated Primary Contractors. The orange line represents the MCO average.

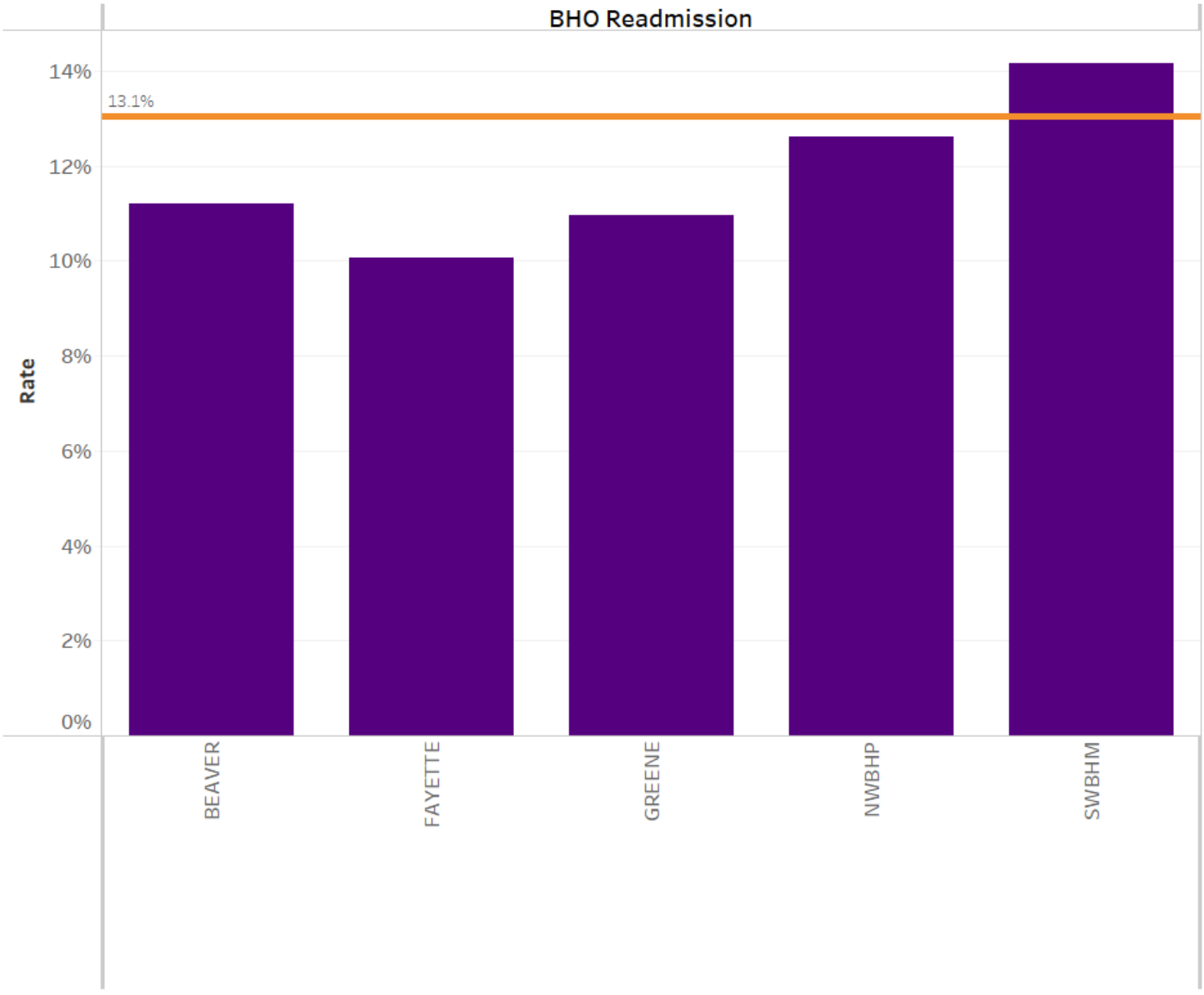

Figure 2.9: MY 2021 REA Rates for BHO Primary Contractors.

Figure 2.10 shows the HC BH (statewide) readmission rate and the individual BHO Primary Contractors that performed statistically significantly higher (red) or lower (blue) than the HC BH statewide rate.

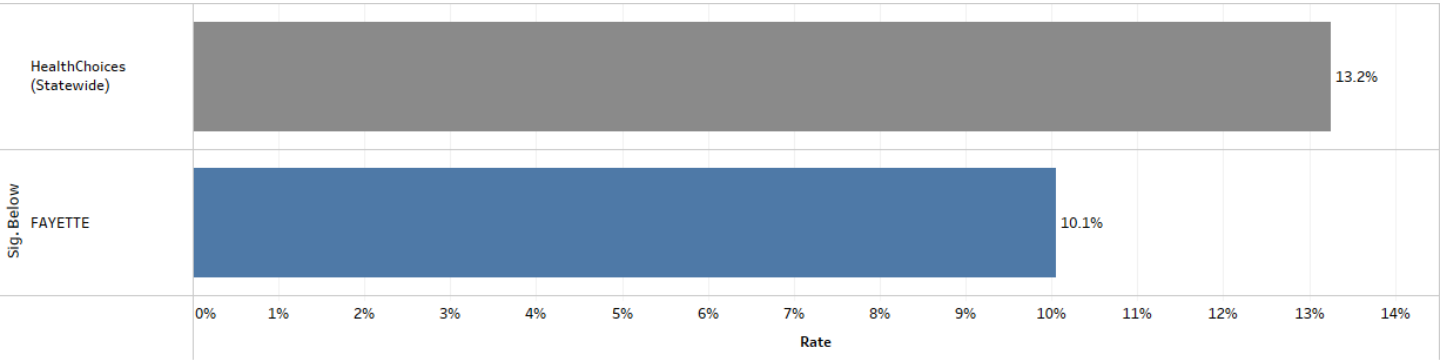

Figure 2.10: Statistically Significant Differences in BHO Primary Contractor MY 2021 REA Rates (All Ages). BHO Primary Contractor MY 2021 REA rates for all ages that are statistically significantly different than HC BH (statewide) MY 2021 REA rates (all ages).

Recommendations

There were no changes to the measures from MY 2020 to MY 2021 that impact reporting integrity. That said, efforts should continue to be made to improve FUH performance, particularly for those BH-MCOs that performed below the HC BH statewide rate. The following are recommendations that are informed by the MY 2021 review:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2021, which included actions taken as part of the previous PIP cycle, to promote continuous quality improvement with regard to timely follow-up care after psychiatric hospitalization. The information contained in 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 BH follow-up rates in the next few years as a result of their interventions. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving BH follow-up. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across MYs, and applicable to all groups. As previously noted, although not enumerated in this report, further stratified comparisons such as Medicaid Expansion versus non-Medicaid Expansion were carried out in a separate 2022 (MY 2021) FUH Rates Report produced by the EQRO and made available to BH-MCOs in an interactive Tableau workbook. BH-MCOs and Primary Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For example, it is important for BH-MCOs and Primary Contractors to analyze performance rates by racial and ethnic categories and to target the populations where these racial and ethnic disparities may exist. The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit lower follow-up rates. Further, it is important to examine regional trends in disparities. 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. The aforementioned 2022 (MY 2021) FUH Rates Report is one source BH-MCOs can use to investigate potential health disparities in FUH.
- BH-MCOs and Primary Contractors are encouraged to review the 2022 (MY 2021) FUH Rates Report in conjunction with the corresponding 2022 (MY 2021) Inpatient Psychiatric Readmission (REA) Rates Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission in less than 30 days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.
- One contractor, SWBHM, turned in follow-up within 30-day rates that met or exceeded the HEDIS 2022 75th percentile. Other BH-MCOs could benefit from drawing lessons or at least general insights from their successes.

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 Primary Contractors that did not meet the performance goal and/or performed below the HC BH statewide rate.

MY 2021 saw a general increase (worsening) for the MCO in readmission rates after psychiatric discharge. The Primary Contractor, Fayette, performed significantly below (better) than the HC statewide with a readmission rate after psychiatric discharge of 10.1% (Beaver and Greene were also below 11.75%). Nevertheless, BHO's readmission rate after psychiatric discharge for the Medicaid managed care (MMC) population remains above 11.75%, the statewide maximum goal. As a result, many recommendations previously made remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary PIP work conducted and the past PIP cycle, the recommendations may assist in future discussions.

In response to the 2021 study, the following are recommendations for improving (reducing) readmission rates after psychiatric discharge:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2021 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. In 2020, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. A new PIP starting in 2021 builds on the previous PIP by, among other things, including a performance indicator that measures MH-related readmissions within 30 days of a discharge for SUD. BH-MCOs are expected to bring about meaningful improvement in BH readmission rates for this subpopulation with comorbid BH conditions and for their HC BH members more generally. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing BH readmissions. The Primary 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.
- The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit higher readmission rates (e.g., urban populations). Comparisons among demographic groups were carried out in a separate 2022 (MY 2021) REA Rates Report produced by the EQRO which is being made available to BH MCOs in an interactive Tableau workbook.
- BH-MCOs and Primary Contractors are encouraged to review the 2022 (MY 2021) REA Rates Report in conjunction with the aforementioned 2022 (MY 2021) FUH Rates Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission within 30 days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

III: Compliance with Medicaid Managed Care Regulations

Objectives

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the MMC structure and operations standards. In review year (RY) 2021, 67 PA counties participated in this compliance evaluation.

Operational reviews are completed for each HC-OE. The Primary Contractor, whether contracting with an OE arrangement or not, 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 Primary Contractor's responsibility for the oversight of the BH-MCO's compliance.

Beaver, Fayette, and the Southwest Six counties (comprising Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland Counties) hold contracts with BHO. The OE for the Southwest Six counties is Southwest Behavioral Health Management, Inc. Northwest Behavioral Health Partnership, Inc. ([NWBHP] comprising Crawford, Mercer, and Venango Counties) also holds a contract with BHO. DHS contracts directly with BHO to manage the HC BH program for Greene County. On January 1, 2022, Greene County joined the Behavioral Health Alliance of Rural Pennsylvania (BHARP) and thereby transitioned its BH-MCO contracting to Community Care Behavioral Health (CCBH). **Table 3.1** shows the name of the HC-OE, the associated HC Primary Contractor(s), and the county(ies) encompassed by each Primary Contractor.

Table 3.1: BHO HealthChoices Oversight Entities, Primary Contractors and Counties

HealthChoices Oversight Entity	Primary Contractor	County
Beaver County Behavioral Health	Beaver County Behavioral Health	Beaver County
Northwest Behavioral Health Partnership, Inc. (NWBHP)	Northwest Behavioral Health Partnership, Inc. (NWBHP)	Crawford County
		Mercer County
		Venango County
Fayette County Behavioral Health Administration (FMBHA)	Fayette County Behavioral Health Administration	Fayette County
PA Department of Human Services	Beacon Health Options of Pennsylvania, otherwise known as Greene County for this review	Greene County
Southwest Behavioral Health Management, Inc. (Southwest Six)	Southwest Behavioral Health Management, Inc. (Southwest Six)	Armstrong County
		Indiana County
		Butler County
		Lawrence County
		Westmoreland County
		Washington County

BHO: Beacon Health Options

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of BHO by OMHSAS monitoring staff within the past 3 review years (RYs 2021, 2020, and 2019). These evaluations are performed at the BH-MCO and Primary Contractor levels, and the findings are reported in OMHSAS's PEPS Review Application for 2021. 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 HC BH Program contract are documented in the RAI. If the Readiness Review occurred within the 3-year time frame under consideration, the RAI was provided to IPRO. For those Primary Contractors and BH-MCOs that completed their Readiness Reviews outside of the current 3-year time frame, the Readiness Review substandards were deemed as complete. As necessary, the HC BH PS&R are also used.

Description of Data Obtained

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2021 and entered into the PEPS Application as of March 2022 for RY 2021. 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 BH-MCO. Within each standard, the PEPS Application specifies the substandards or items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area in which to collect or capture additional reviewer comments. Based on the PEPS Application, an BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations ("categories"), as well as against 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 PEPS 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 and state grievance systems standards. All of the PEPS substandards concerning second-level complaints and previously second-level grievances are considered OMHSAS-specific substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category.

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[21] IPRO updated the substandards crosswalk to reflect the changes to the organization and content of the relevant BBA provisions. The CMS updates included modifications to the BBA provisions, which are now required for reporting. The standards that are subject to EQR review are contained in Title 42 CFR 438, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E. In addition, findings for RY 2021 are presented here under the new rubric of the three "CMS sections": Standards, Including enrollee rights and protections, Quality assessment and performance improvement (QAPI) program, and Grievance system. Substandard tallies for each category and section roll-up were correspondingly updated.

From time to time, standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions or changes to State standards. Standards or substandards that are introduced or retired are done so following the rotating 3-year schedule for all five BH-MCOs. This may, in turn, change the category tally of standards from one reporting year to the next. In 2019 (RY 2018), two contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

As was done for prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The review findings for selected OMHSAS-specific substandards are reported in **Appendix C**. The RY 2021 crosswalks of PEPS substandards to pertinent BBA regulations and to pertinent OMHSAS-specific PEPS substandards can be found in **Appendix A** and **Appendix B**, respectively.

Because OMHSAS's review of the Primary Contractors and their subcontracted BH-MCOs occurs over a 3-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 3-year period is alternatively referred to as the Active Review period. The PEPS substandards from RY 2021, RY 2020, and RY 2019 provided the information necessary for the 2021 assessment. Those triennial standards not reviewed through the PEPS system in RY 2021 were evaluated on their performance based on RY 2020 and/or RY 2019 determinations, or other supporting documentation, if necessary. For those HC-OEs that completed their Readiness Reviews within the 3-year time frame under consideration, RAI

substandards were evaluated when none of the PEPS substandards crosswalked to a particular BBA category were reviewed.

For BHO, a total of 72 unique substandards were applicable for the evaluation of BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2021, 2020, 2019). In addition, 18 OMHSAS-specific substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. Some PEPS substandards crosswalk to more than one BBA category, while each BBA category crosswalks to multiple substandards. 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 3-year cycle to evaluate the BH-MCO and the associated Primary Contractors against other state-specific Structure and Operations Standards.

Table 3.2 tallies the PEPs substandard reviews used to evaluate the 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 2019–2021). Substandard counts under RY 2021 comprised annual and triennial substandards. Substandard counts under RYs 2020 and 2019 comprised only triennial substandards. By definition, only the last review of annual substandards is counted in the 3-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 3.2**, 94, differs from the unique count of substandards that came under active review (72).

Table 3.2: Tally of Substandards Pertinent to BBA Regulations Reviewed for BHO

BBA Regulations	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	2021	2020	2019
CMS EQR Protocol 3 "sections": Standards, Including enrollee rights and protections					
Assurances of adequate capacity and services (Title 42 CFR § 438.207)	5	-	5	-	-
Availability of services (Title 42 CFR § 438.206, Title 42 CFR § 10(h))	24	-	18	2	4
Confidentiality (Title 42 CFR § 438.224)	1	-	-	-	1
Coordination and continuity of care (Title 42 CFR § 438.208)	2	-	-	2	-
Coverage and authorization of services (Title 42 CFR Parts § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114)	4	-	2	2	-
Health information systems (Title 42 CFR § 438.242)	1	-	-	-	1
Practice guidelines (Title 42 CFR § 438.236)	6	-	-	2	4
Provider selection (Title 42 CFR § 438.214)	3	-	3	-	-
Subcontractual relationships and delegation (Title 42 CFR § 438.230)	8	-	-	-	8
CMS EQR Protocol 3 "sections": Quality assessment and performance improvement (QAPI) program					
Quality assessment and performance improvement program (Title 42 CFR § 438.330)	26	-	19	-	7
CMS EQR Protocol 3 "sections": Grievance system					
Grievance and appeal systems (Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424)	14	-	2	12	-
Total	**94**	-	**49**	**20**	**25**

[1] The total number of substandards required for the evaluation of Primary Contractor/BH-MCO compliance with the BBA regulations. Any PEPS substandards not reviewed indicate substandards that were deemed not applicable to the Primary Contractor/BH-MCO.
[2] The number of substandards that came under active review during the cycle specific to the review year. Because substandards may crosswalk to more than one category, the total tally of substandard reviews, 94, differs from the unique count of substandards that came under active review (72).
BBA: Balanced Budget Act; PEPS: Program Evaluation Performance Summary; BHO: Beacon Health Options; NR: substandards not reviewed; CMS: Centers for Medicare and Medicaid Services; EQR: external quality review; CFR: Code of Federal Regulations.

Determination of Compliance

To evaluate Primary Contractor/BH-MCO compliance with individual provisions, IPRO grouped the required and relevant monitoring substandards by provision (category) and evaluated the Primary Contractors' and BH-MCO's compliance status with regard to the PEPS substandards. Each substandard was assigned a value of "met," "partially met," or "not met" in the PEPS Application submitted by PA. If a substandard was not evaluated for a particular Primary Contractor/BH-MCO, it was assigned a value of "not reviewed." Compliance with the BBA provisions was then determined based on the aggregate results across the 3-year period of the PEPS items linked to each provision. If all items were met, the Primary Contractor/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the Primary Contractor/BH-MCO was evaluated as partially compliant. If all items were not met, the Primary Contractor/BH-MCO was evaluated as non-compliant. A value of not applicable (N/A) was assigned to provisions for which a compliance review was not required. 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 within a given category were aggregated to arrive at a summary compliance status for the category. For example, compliance findings relating to provider network mix and capacity are summarized under Assurances of adequate capacity and services, *Title 42 CFR § 438.207*.

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 sections set out in the BBA regulations and described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[22] Under each general section heading are the individual regulatory categories appropriate to those headings. IPRO's findings are therefore organized under standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement (QAPI) Program, and Grievance System.

This format reflects the goal of the review, which is to gather sufficient foundation for IPRO's required assessment of the Primary Contractor/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

Seventy-two (72) unique PEPS substandards were used to evaluate BHO and its Primary Contractors' compliance with BBA regulations in RY 2021.

Standards, Including Enrollee Rights and Protections

The general purpose of the regulations included in this section is to ensure that each Primary Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable federal and state laws that pertain to enrollee rights, and that the Primary Contractor/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees. **Table 3.3** presents the MCO and Primary Contractor substandard findings by categories.

Table 3.3: Compliance with Standards, Including Enrollee Rights and Protections

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Assurances of adequate capacity and services Title 42 CFR § 438.207	5	Partial	All BHO Primary Contractors	1.1, 1.4, 1.5, 1.6	1.2	-
Availability of Services Title 42 CFR § 438.206, Title 42 CFR § 10(h)	24	Partial	All BHO Primary Contractors	1.1, 1.3, 1.4, 1.5, 1.6, 1.7, 23.1, 23.2, 23.3, 23.4, 23.5, 24.1, 24.2, 24.3, 24.4, 24.5,	1.2, 28.1, 28.2	-

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
				24.6, 93.1, 93.2, 93.3, 93.4		
Confidentiality Title 42 CFR § 438.224	1	Compliant	All BHO Primary Contractors	120.1	-	-
Coordination and continuity of care Title 42 CFR § 438.208	2	Partial	All BHO Primary Contractors	-	28.1, 28.2	-
Coverage and authorization of services Title 42 CFR Parts § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114	4	Partial	All BHO Primary Contractors	72.2	28.1, 28.2, 72.1	-
Health information systems Title 42 CFR § 438.242	1	Compliant	All BHO Primary Contractors	120.1	-	-
Practice guidelines Title 42 CFR § 438.236	6	Partial	All BHO Primary Contractors	93.1, 93.2, 93.3, 93.4	28.1, 28.2	-
Provider selection Title 42 CFR § 438.214	3	Compliant	All BHO Primary Contractors	10.1, 10.2, 10.3	-	-
Subcontractual relationships and delegation Title 42 CFR § 438.230	8	Compliant	All BHO Primary Contractors	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8	-	-

MCO: managed care organization; CFR: Code of Federal Regulations; BHO: Beacon Health Options.

There are nine (9) categories within standards, including Enrollee Rights and Protections. BHO was compliant with 4 categories and partially compliant with 5 categories.

For this review, 54 PEPS substandards were crosswalked to categories within Compliance with Standards, Including Enrollee Rights and Protections. BHO and its Primary Contractors were reviewed on all 54 substandards. BHO and its Primary Contractors were compliant in 43 instances and partially compliant in 11 instances. 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.

Assurances of Adequate Capacities and Services

BHO was partially compliant with Assurances of adequate capacity and services due to partial compliance with Substandard 2 of PEPS Standard 1 (RY 2021).

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

Provider contracts are in place.

Substandard 2: 100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.

Availability of Services

BHO was partially compliant with Availability of Services due to partial compliance with Substandard 2 of PEPS Standard 1 (RY 2021) and partial compliance with Substandard 1 and Substandard 2 of PEPS Standard 28 (RY 2020).

Standard 1: See Standard description and determination of compliance under Assurances of adequate capacity and services.

Substandard 2: See substandard description and determination of compliance under Assurances of adequate capacity and services.

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

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.

Coordination and Continuity of Care

BHO was partially compliant with Coordination and Continuity of Care due to partial compliance with Substandard 1 and Substandard 2 of PEPS Standard 28 (RY 2020).

Standard 28: See Standard description and determination of compliance under Availability of Services.

Substandard 1: See substandard description and determination of compliance under Availability of Services.

Substandard 2: See substandard description and determination of compliance under Availability of Services.

Coverage and Authorization of Services

BHO was partially compliant with Coverage and Authorization of Services due to partial compliance with Substandard 1 and Substandard 2 of PEPS Standard 28 (RY 2020) and partial compliance with Substandard 1 of PEPS Standard 72 (RY 2021).

Standard 28: See Standard description and determination of compliance under Availability of Services.

Substandard 1: See substandard description and determination of compliance under Availability of Services.

Substandard 2: See substandard description and determination of compliance under Availability of Services.

Standard 72: Denials or reduction of services are provided, in writing, to the member, parent/custodian of a child/adolescent, and/or county Children and Youth agency for children in substitute care. [E.3), p.39 and Appendix AA, Attachments 2a, 2b, 2c, and 2d].

Substandard 1: Denial notices are issued to members according to required timeframes and use the required template language.

Practice Guidelines

BHO was partially compliant with Practice Guidelines due to non-compliance with Substandard 1 and Substandard 2 of PEPS Standard 28 (RY 2020).

Standard 28: See Standard description and determination of compliance under Availability of Services.

Substandard 1: See substandard description and determination of compliance under Availability of Services.

Substandard 2: See substandard description and determination of compliance under Availability of Services.

Quality Assessment and Performance Improvement Program

The general purpose of the regulations included under this subpart is to ensure that all services available under PA's MMC program, the HC Program, are available and accessible to MCO enrollees. The PEPS documents include an

assessment of the Primary Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 3.4** presents the findings by categories consistent with the regulations.

Table 3.4: Compliance with Quality Assessment and Performance Improvement Program

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Quality assessment and performance improvement program Title 42 CFR § 438.330	26	Partial	All BHO Primary Contractors	91.1, 91.2, 91.5, 91.6, 91.7, 91.8, 91.9, 91.10, 91.11, 91.12, 91.13, 91.14, 91.15, 93.1, 93.2, 93.3, 93.4, 98.1, 98.2, 98.3, 104.1, 104.2, 104.3, 104.4	91.3, 91.4,	-

MCO: managed care organization; CFR: Code of Federal Regulations; BHO: Beacon Health Options.

For this review, 26 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 26 substandards were reviewed for BHO and its Primary Contractors. BHO and its Primary Contractors were compliant with 24 substandards and partially compliant with 2 substandards.

Quality Assessment and Performance Improvement Program

BHO was partially compliant with Quality assessment and performance improvement program due to partial compliance with Substandard 3 and 4 of PEPS Standard 91 (RY 2021).

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 BHRS.

Substandard 3: The QM Program Description includes the following basic elements:

- Performance improvement projects
- Collection and submission of performance measurement data
- Mechanisms to detect underutilization and overutilization of services
- Emphasis on, but not limited to, high volume/high-risk services and treatment, such as Behavioral Health Rehabilitation Services
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs.

Substandard 4: The QM Work Plan includes:

- Objective
- Aspect of care/service
- Scope of activity
- Frequency
- Data source
- Sample size
- Responsible person
- Specific, measurable, attainable, realistic and timely performance goals, as applicable.

Grievance System

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 Primary Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 3.5** presents the findings by categories consistent with the regulations.

Table 3.5: Compliance with Grievance System

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Grievance and appeal systems Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	14	Partial	All BHO Primary Contractors	68.1, 68.2, 68.3, 68.4, 68.7, 71.1, 71.2, 71.3, 71.4, 71.7, 71.9, 72.2	72.1	68.9

MCO: managed care organization; CFR: Code of Federal Regulations; BHO: Beacon Health Options.

For this review, 14 substandards were crosswalked to Grievance System. All 14 substandards were reviewed for BHO and its Primary Contractors. BHO and its Primary Contractors were compliant with 12 substandards, partially compliant with 1 substandard, and non-compliant with 1 substandard.

Grievance and Appeal Systems

BHO was partially compliant with Grievance and Appeal System due to non-compliance with Substandard 9 of PEPS Standard 68 (RY 2021) and partial compliance with Substandard 1 of PEPS Standard 72 (RY 2021).

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.

Substandard 9: Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint 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 72: See Standard description and determination of compliance under Coverage and Authorization of Services.

Substandard 1: See substandard description and determination of compliance under Coverage and Authorization of Services.

IV: Validation of Network Adequacy

Objectives

As set forth in *Title 42 CFR §438.358*, validation of network adequacy is a mandatory EQR activity. The purpose of this section is to assess the BH-MCO's network adequacy in accordance with standards established under *Title 42 CFR § 438.68(b) (1)(iii)* and *457.1218*.

Description of Data Obtained

For the 2021 review year, the BH-MCO's network adequacy was assessed based on compliance with certain federal and OMHSAS-specific standards that were crosswalked to standards falling directly or indirectly under *Title 42 CFR § 438.68(b) (1)(iii)* and *457.1218*. Compliance status was determined as part of the larger assessment of compliance with MMC regulations. As of MY 2021, EQR validation protocols for assessing network adequacy had not been published by CMS. Since the publication of the *2020 Medicaid and CHIP Managed Care Final Rule*, OMHSAS is actively reviewing its network adequacy monitoring program to ensure all relevant requirements are covered in the annual validation activity going forward. For BH, those requirements include: quantitative network adequacy standards, ensuring timely access to services, ensuring provider accessibility, allowing access to out-of-network providers, documenting an MCO's capacity to serve all enrollees, and adhering to the 2008 Mental Health Parity and Addictions Equity Act (MHPAEA) regulations on treatment limitations.[23]

Findings

Table 4.1 describes the RY 2021 compliance status of BHO with respect to network adequacy standards that were in effect in 2021. Definitions for most standards may be found in **Section III**, Compliance with Medicaid Managed Care Regulations. The following standards are specific to validation of network adequacy (any substandards for which the MCO is not fully compliant are defined further below):

Standard 11: BH-MCO has conducted orientation for new providers and ongoing training for network.

Standard 59: BM-MCO has implemented public education and prevention programs, including BH educational materials.

Standard 78: 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. 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, and Abuse (FWA).

Standard 100: Utilization Management and Quality Management: Provider Satisfaction: The Primary Contractor, either directly or via a BH-MCO or other subcontractor, must have systems and procedures to assess provider satisfaction with network management. The systems and procedures must include, but not be limited to, an annual provider satisfaction survey. Areas of the survey must include claims processing, provider relations, credentialing, prior authorization, service management and quality management.

Table 4.1: Compliance with Standards Related to Network Adequacy

Standard Description	Substandard Count	MCO Compliance Status	Primary Contractors	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Standard 1	7	Partial	All BHO Primary Contractors	1.1, 1.3, 1.4, 1.5, 1.6, 1.7	1.2	-
Standard 10	3	Compliant	All BHO Primary Contractors	10.1, 10.2, 10.3	-	-
Standard 11	3	Compliant	All BHO Primary Contractors	11.1, 11.2, 11.3	-	-
Standard 23	5	Compliant	All BHO Primary Contractors	23.1, 23.2, 23.3, 23.4, 23.5	-	-
Standard 24	6	Compliant	All BHO Primary Contractors	24.1, 24.2, 24.3, 24.4, 24.5, 24.6	-	-
Standard 59	1	Compliant	All BHO Primary Contractors	59.1	-	-
Standard 78	5	Compliant	Beaver, Crawford/Mercer/Venango, Fayette, and Southwest Six	78.1, 78.2, 78.3, 78.4, 78.5	-	-
			Greene (N/A)	-	-	-
Standard 91	15	Partial	All BHO Primary Contractors	91.1, 91.2, 91.5, 91.6, 91.7, 91.8, 91.9, 91.10, 91.11, 91.12, 91.13, 91.14, 91.15	91.3, 91.4	-
Standard 93	4	Compliant	All BHO Primary Contractors	93.1, 93.2, 93.3, 93.4	-	-
Standard 99	8	Compliant	All BHO Primary Contractors	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8	-	-
Standard 100	1	Compliant	All BHO Primary Contractors	100.1	-	-

MCO: managed care organization; CFR: Code of Federal Regulations; BHO: Beacon Health Options.

For this review, 58 substandards were crosswalked to Network Adequacy. All 58 substandards were reviewed for BHO and its Primary Contractors, except for Greene County, which was exempt from review on Standard 78. BHO and these Primary Contractors were compliant with 55 substandards and partially compliant with 3 substandards. Greene County opted out of the county's first right of opportunity to oversee the MCO-delegated functions and activities falling under Standard 78; instead OMHSAS contracted directly with BHO and provided oversight of select functions and activities. Greene County was found compliant with the remaining 53 substandard requirements related to network adequacy.

BHO was partially compliant with Network Adequacy due to partial compliance with Substandard 2 of PEPS Standard 1 (RY 2021) and partial compliance with Substandard 3 and 4 of PEPS Standard 91 (RY 2021).

BHO was partially compliant with Substandard 2 of PEPS Standard 1 (RY 2021).

Standard 1: See Standard description and determination of compliance under Assurances of adequate capacity and services.

Substandard 2: See substandard description and determination of compliance under Assurances of adequate capacity and services.

BHO was partially compliant with Substandards 3 and 4 of PEPS Standard 91 (RY 2021).

Standard 91: See Standard description and determination of compliance under Quality assessment and performance improvement program.

Substandard 3: See substandard description and determination of compliance under Quality assessment and performance improvement program.

Substandard 4: See substandard description and determination of compliance under Quality assessment and performance improvement program.

V: Quality Studies

Objectives

The purpose of this section is to describe quality studies performed in 2021 for the HC population. The studies are included in this report as optional EQR activities that occurred during the Review Year.[24]

Integrated Community Wellness Centers

In 2019, PA DHS made the decision to discontinue participation in the CCBHC Demonstration but to continue and build on the CCBHC model in a PA DHS-administered Integrated Community Wellness Centers (ICWC) program under an MMC agreement with CMS. The purpose of the CCBHC Demonstration was 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, BH screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services, along with outpatient clinic primary care screening and monitoring, are provided or managed directly by the ICWC clinics. The other services, including targeted case management, peer support, psychiatric rehabilitation services, and intensive community-based mental health care to members of the armed forces and veterans 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. Under ICWC, the same nine core services of the CCBHC model are provided under PA's HC MMC program using a similar bundled payment arrangement with clinics certified to participate as ICWC clinics. For the first year of ICWC, 2020, the original seven clinics—Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA)—were invited to participate in the new program. Although none of the participating clinics are in BHO's network, discussion of ICWC is included in this report to account for any possible utilization of ICWC services among BHO's members.

Description of Data Obtained

Like CCBHC, ICWC features a process measure dashboard, hosted by the EQRO. Clinics enter monthly, quarterly, and year-to-date (YTD) data into a REDCap® project which feeds, on a weekly basis, a server-based Tableau workbook where clinics are able to monitor progress on the implementation of their ICWC model. Using the Dashboard, clinics in 2021 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 client satisfaction. The Tableau workbook also featured a comparative display that showed clinic and statewide results on each process measure.

Findings

In 2021, the number of individuals receiving at least one core service jumped to 22,690 from just over 17,700 in 2020. The unweighted average (across all the clinics) number of days until initial evaluation increased to 10.8 days from 8 days in 2020. In the area of depression screening and follow-up, just over 90% of positive screenings resulted in the documentation of a follow-up plan the same day. More than 5,400 individuals within the ICWC program received drug and alcohol outpatient or intensive outpatient treatment during the period.

Process measures reflect important progress in increasing both the access and quality of community-based care for individuals with BH conditions, but the ICWC quality measures are designed to more meaningfully measure the impact of these efforts. Under the CMS-approved ICWC preprint, a subset of the CCBHC measures is reported to CMS on an annual CY basis, along with HEDIS Follow-Up After High Intensity Care for Substance Use Disorder (FUI). **Table 5.1** summarizes how well the ICWC clinics performed on quality measures compared to applicable performance targets and national benchmarks.

Table 5.1: ICWC Quality Performance Compared to Targets and National Benchmarks

Measure	ICWC Weighted Average	Comparison		
		ICWC CY 2021 Performance Target	National Benchmark	Benchmark Description
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 7 day	10.0%	N/A (Improvement over baseline)	N/A	Between the 5th and 10th percentile of the HEDIS 2022 Quality Compass
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 30 day	19.3%	N/A (Improvement over baseline)	N/A	Below the 5th percentile of the HEDIS 2022 Quality Compass
Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Initiation	61.1%	80.2%	N/A	Above the 95th percentile of the HEDIS 2022 Quality Compass
Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Continuation and Maintenance	60.9%	89.6%	N/A	Between the 75th and 90th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 7 day	22.3%	26.7%	N/A	Between the 90th and 95th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 30 day	34.8%	38.8%	N/A	Between the 90th and 95th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 day	100%	53.4%	N/A	Above the 95th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 day	100%	64.2%	N/A	Above the 95th percentile of the HEDIS 2022 Quality Compass
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18–64 - Initiation	3.0%	19.3%	N/A	Below the 5th percentile of the HEDIS 2022 Quality Compass
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18–64 - Engagement	17.0%	28.2%	N/A	Between the 50th and 75th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 18–64 (FUH-A) - 7 day	9.0%	30.2%	N/A	Below the 5th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 18–64 (FUH-A) - 30 day	18.0%	41.6%	N/A	Below the 5th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 6–17 (FUH-C) - 7 day	27.1%	43.8%	N/A	Between the 5th and 10th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 6–17 (FUH-C) - 30 day	23.1%	55.6%	N/A	Below the 5th percentile of the HEDIS 2022 Quality Compass
Antidepressant Medication Management (AMM) - Acute	63.0%	48.8%	N/A	Between the 50th and 75th percentile of the HEDIS 2022 Quality Compass

Measure	ICWC Weighted Average	Comparison		
		ICWC CY 2021 Performance Target	National Benchmark	Benchmark Description
Antidepressant Medication Management (AMM) - Continuation	37.0%	89.5%	N/A	Between the 10th and 25th percentile of the HEDIS 2022 Quality Compass
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	55.3%	57.3%	N/A	Between the 25th and 50th percentile of the HEDIS 2022 Quality Compass
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	74.9%	85.0%	N/A	Between the 10th and 25th percentile of the HEDIS 2022 Quality Compass
Plan All-Cause Readmissions Rate (PCR)	15.0%	6.9%	N/A	HEDIS 2022 Quality Compass 50th percentile
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	56.0%	16.2%	14.3%	MIPS 2022 (eCQM)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	32.6%	26.3%	28.8%	MIPS 2022 (eCQM)
Screening for Depression and Follow-Up Plan (CDF-BH)	32.0%	37.7%	33.2%	MIPS 2022 (CQM)
Depression Remission at Twelve Months (DEP-REM-12)	13.7%	N/A	8.2%	MIPS 2022 (eCQM)
Body Mass Index (BMI) Screening and Follow-Up Plan	43.1%	51.0%	45.0%	MIPS 2022 (eCQM)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)	58.0%	64.5%	N/A	Between the 5th and 10th percentile of the HEDIS 2022 Quality Compass
Tobacco Use: Screening and Cessation Intervention (TSC)	70.6%	56.0%	60.4%	MIPS 2021 (CQM)
Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	67.0%	51.1%	68.4%	MIPS 2021 (CQM)

ICWC: integrated community wellness center; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable; ADHD: attention deficit/hyperactivity disorder; MIPS: Merit-Based Incentive Pay System; eCQM: electronic clinical quality measure; CQM: clinical quality measure.

Quality measures where the ICWC clinics surpassed targets include: FUM, AMM (Acute), PCR, SRA-BH-C, SRA-A, TSC, and ASC.

VI: 2021 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 2021 (MY 2020) EQR annual technical report and in the 2022 (MY 2021) FUH All-Ages Goal Report.

The request for MCO response to the opportunities for improvement related to PEPS deficiencies was distributed in September 2022. The 2022 EQR annual technical report is the 15th report to include descriptions of current and proposed interventions from each BH-MCO that address the prior year's deficiencies.

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 PA 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, 2022, 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 MCO responses submitted to IPRO in December 2022 to address partial and non-compliant PEPS standards findings, as well as any additional relevant documentation provided by the BH-MCO.

The request for MCO response to the opportunities for improvement related to MY 2021 underperformance in the HEDIS FUH All-Ages measures were distributed, along with the MY 2021 results, in January 2023. The Root Cause Analysis and Quality Improvement Plan form similarly provides for a standardized format for BH-MCOs to describe root causes of underperformance and propose a detailed quality improvement plan to address those factors, complete with a timeline of implementation, monitoring, and reporting activities. BH-MCOs submitted their responses by March 17, 2023, and the Primary Contractors submitted their responses by March 31, 2023.

Quality Improvement 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 2020, BHO began to address opportunities for improvement related to compliance categories within two of the three CMS sections pertaining to compliance with MMC regulations. Within Compliance with Standards, Including Enrollee Rights and Protections, BHO was partially compliant with the following BBA categories: Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, and Practice Guidelines. Within Compliance with Grievance System, BHO was partially compliant with Grievance and Appeal Systems. Proposed actions and evidence of actions taken by BHO 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 BHO into compliance with the relevant Standards.

Table 6.1 presents BHO's responses to opportunities for improvement cited by IPRO in the 2021 (MY 2020) EQR annual technical report, detailing current and proposed interventions. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 6.1: BHO Responses to Opportunities for Improvement

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2018, RY 2019, and RY 2020 found Beacon to be partially compliant with two out of three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22 /Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
BHO 2022.01	Within CMS EQR Protocol 3: Compliance with Standards, Including Enrollee Rights and Protections, BHO was partially compliant on four out of nine categories. The partially compliant categories are: 1) Availability of Services 2) Coordination and continuity of care 3) Coverage and authorization of services 4) Practice guidelines	**Date(s) of follow-up action taken through 6/30/22.** **February 2022 –** OMHSAS approved Clinical Documentation Policy and Procedure, and ACMR audit tool **February 2022** – OMHSAS approved Clinical Supervision Policy and Procedure **June 2022 –** Clinical Staff IRR Training completed **September 2021 –** RY2020 CAP for 28.1 and 28.2 implemented **CY2021 Annual QOCC Training** – course completion record **CY2020 PEPS Corrective Action Plan** – PEPS Standards 28.1 and 28.2	**Availability of Services** (Access to Care) - PEPS Standard 28, Substandard 1 – Clinical/chart reviews reflect appropriate, consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. **Beacon-PA Response:** **Clinical Documentation Audit Policy and Procedure and Clinical Documentation Templates** – The Clinical Documentation Audit Policy and Procedure was revised and approved by both the Primary Contractors and OMHSAS. In part the policy states: *"Active Care Management Record (ACMR) Reviews: Supervisors and Care Managers conduct interrater reliability audits using the ACMR review tool. For ACMR reviews (see Clinical Supervision policy), supervisors select a case reviewed during the month, notifies the care manager to audit the identified case using the ACMR review tool. Comparative results are reviewed during supervision, and areas of strengths and areas for improvement are discussed. Supervisor and Care Manager ACMR review results are documented on monthly supervision form."* A copy of the approved policy, the ACMR review tool (listed as one of the attachments), and the Clinical Supervision policy that is referenced are being provided. **Inter-Rater Reliability (IRR) Testing –** Beacon-PA Clinical Staff completed annual IRR testing with a performance target of 90%. A summary of the results is being provided. Staff that did not score 90% or better (4 of 51) will have a supervisory plan implemented. Results demonstrate consistency across the clinical team in the application of medical necessity criteria. **Annual Quality of Care / Care Concerns Reporting training** –

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2018, RY 2019, and RY 2020 found Beacon to be partially compliant with two out of three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22 /Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
			Beacon-PA requires annual care concerns reporting training for all staff. The course completion report for CY2021 is being provided. This was noted as a follow-up action item from the previous EQR summary. **RY 2020 Corrective Action Plan for Standards 28.1 and 28.2** In Review Year 2020 the following recommendations were made for Beacon-PA. The BH-MCO must revise and enhance CM training, CM templates, CM documentation oversight, and CM documentation P&Ps to ensure that the medical record includes sufficient documentation of the clinical rationale for authorization decisions. Documentation should communicate clinical support for each of the MNC for every LOC that requires authorization. A CAP was developed, submitted and approved on 1/7/2022. This CAP was closed by OMHSAS on 9/12/22.
		Date(s) of future action planned **July 2022** - completion of ASAM training	**ASAM Criteria Clinician Training –** Beacon-PA Clinical staff were assigned the updated ASAM Criteria Clinician Training that was released in April 2022. The completion due date for this training was 7/29/22. **RY 2020 Corrective Action Plan for Standards 28.1 and 28.2** Review Year 2020 CAP approved by OHMSAS on 1/7/22 provided retraining of clinical staff on the Updated ASAM criteria clinical training released in April 2022. This CAP was closed by OHMSAS on 9/12/22.
		Date(s) of follow-up action taken through 6/30/22 **July 2021** - Final Summary from Mercer Consulting and OMHSAS for the 2020 Triennial Review	**Availability of Services** (Access to Care) - PEPS Standard 28, Substandard 2 – The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. **Beacon-PA Response:**

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2018, RY 2019, and RY 2020 found Beacon to be partially compliant with two out of three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22 /Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
		2021 IRR Testing (Peer Advisors) **CY2021**– Denial audits results (Peer Advisors)	In the Mercer Consulting summary for the denial records reviewed during the most recent triennial review (2020), the following was noted: ***Clinical documentation was much more robust in the medical records associated with denials. Reviewers endorsed "the record contains sufficient relevant clinical information to evaluate and make the benefit determination", "the record contains clinical information that supports the full or partial denial of the requested LOC and the number of units", and "the peer reviewer has the appropriate qualifications to make the determination "*** in all records. In addition, in all but one of the records reviewed it was further noted ***"the peer reviewer documented a clinical rationale specific to the individual, as well as reference to the relevant MNC, in their communications with members and providers."*** There were no recommendations or corrective actions cited by Mercer Consulting in this area. **Inter-Rater Reliability (IRR) Testing (Peer Advisors) -** Annually Beacon conducts an Interrater Reliability (IRR) evaluation which includes all PA Clinicians and Peer Reviewers. The results of the 2021 IRR for Peer Advisors demonstrated that 13/13 Peer reviewers met the 90% state requirement. **CY2021 Denial Record Audits (Peer Advisors)** - To ensure appropriate clinical and MNC rationale are indicated in Beacon denial records, audits are performed on a regular basis throughout the year. In CY 2021, the peer reviewer, denial audit results demonstrated an average compliance score of 97%.
		Date(s) of future action planned **CY2021 PEPS Review** – address findings related to	**CY2021 PEPS Review** - Address findings from the CY2021 PEPS Review related to denial notices and required template language. Final PEPS report with recommended corrective action was received on 9/2/22.

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2018, RY 2019, and RY 2020 found Beacon to be partially compliant with two out of three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22 /Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
		denial notices **July 2022** - completion of ASAM training Denial Notice Monitoring Tool Revision Policy and Procedure Review and Revision	**ASAM Criteria Clinician Training –** Beacon-PA Clinical staff were assigned the updated ASAM Criteria Clinician Training that was released in April 2022. The completion due date for this training was 7/29/22. **Denial Notice Monitoring Tool:** The Beacon-PA clinical team, in collaboration with the Primary Contractors, revised the monitoring tool for denial notices. The tool is designed to monitor accuracy and interrater reliability for review of denial notices. It is also used as a means to provide feedback and supervision to the clinical denial letter writing team members. **Policy and Procedure Review / Revision:** In addition to the Documentation Policy and Clinical Supervision Policy, included above, Beacon-PA revised its' Peer Review, Consult, and Denials policy to align with recommendations from Mercer Consulting during the most recent triennial review. This primarily related to amending the triggers for requesting consultation. Additional policy and procedure reviews will occur based on the recommendations from Mercer Consulting for the Triennial Review.
		Date(s) of follow-up action taken through 6/30/22 See above for Availability of Services	**Coordination and Continuity of Care** - PEPS Standard 28, Substandard 1 – Clinical/chart reviews reflect appropriate, consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. (Non-compliant) Describe one follow-up action. Leave blank, if none. **Beacon-PA Response:** Refer to response above for Availability of Services
		Date(s) of future action planned	**Refer to response above for Availability of Services**

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2018, RY 2019, and RY 2020 found Beacon to be partially compliant with two out of three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22 /Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
		See above for Availability of Services	
		Date(s) of follow-up action taken through 6/30/22 See above for Availability of Services	**Coordination and Continuity of Care** - PEPS Standard 28, Substandard 2 – The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. **Beacon-PA Response:** Refer to response above for Availability of Services
		Date(s) of future action planned See above for Availability of Services	**Refer to response above for Availability of Services**
		Date(s) of follow-up action taken through 6/30/22 See above for Availability of Services	**Coverage and Authorization of Services** - PEPS Standard 28, Substandard 1 – Clinical/chart reviews reflect appropriate, consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. (Non-compliant) Describe one follow-up action. Leave blank, if none. **Beacon-PA Response:** Refer to response above for Availability of Services
		Date(s) of future action planned See above for Availability of Services	**Refer to response above for Availability of Services**
		Date(s) of follow-up action taken through 6/30/22	**Coverage and Authorization of Services** - PEPS Standard 28, Substandard 2 – The medical necessity decision made by the BH-

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2018, RY 2019, and RY 2020 found Beacon to be partially compliant with two out of three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22 /Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
		See above for Availability of Services	MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. **Beacon-PA Response:** Refer to response above for Availability of Services
		Date(s) of future action planned See above for Availability of Services	**Refer to response above for Availability of Services**
		Date(s) of follow-up action taken through 6/30/22 See above for Availability of Services	**Practice Guidelines** - PEPS Standard 28, Substandard 1 – Clinical/chart reviews reflect appropriate, consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. (Non-compliant) Describe one follow-up action. Leave blank, if none. **Beacon-PA Response:** Refer to response above for Availability of Services
		Date(s) of future action planned See above for Availability of Services	**Refer to response above for Availability of Services**
		Date(s) of follow-up action taken through 6/30/22 See above for Availability of Services	**Practice Guidelines** - PEPS Standard 28, Substandard 2 – The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. **Beacon-PA Response:** Refer to response above for Availability of Services

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2018, RY 2019, and RY 2020 found Beacon to be partially compliant with two out of three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22 /Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
		Date(s) of future action planned See above for Availability of Services	**Refer to response above for Availability of Services**
BHO 2022.02	Within CMS EQR Protocol 3: Compliance with Grievance System, BHO was partially compliant with Grievance and appeal systems.	**Date(s) of follow-up action taken through 6/30/22** **April 2022 –** Evidence of completion for RY2020 CAP for Std. 68.9 being provided	**Grievance and Appeal Systems** – PEPS Standard 68, Substandard 9 - Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review. **Beacon-PA Response:** **RY 2020 Corrective Action Plan for Standard 68.0** – Beacon-PA was required to ensure that follow-up and corrective plans of action were documented in the member file, and made available to OMHSAS, the Primary Contractor, or other BH-MCO staff upon request. The completed CAP with documented evidence of completion and OMHSAS approval noted is being provided. A sample of a completed checklist for each of the Primary Contractors is being provided. These include follow-up actions if indicated. An example of the Complaint Audits document is being provided. The audits of complaint files now includes a review for completed follow-up actions, if indicated. This is a cumulative audit report for all complaints, although just a sample is being submitted.
		Date(s) of future action	**Completed CAP for 2020** – CAP was approved and implemented

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2018, RY 2019, and RY 2020 found Beacon to be partially compliant with two out of three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22 /Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
		planned: Ongoing monitoring of complaint process	prior to 6/30/22 but was not completed and closed until September 2022. Complaints will continue to be monitored to ensure sustained performance.

BHO: Beacon Health Options of Pennsylvania; MCO: managed care organization; RY: reporting year=measurement year; PEPS: Program Evaluation Performance Summary; OMHSAS: Office of Mental Health & Substance Abuse Services; MA: Medical Affairs; QM: quality management; EQR: external quality review; BH: behavioral health; PSRs: Place of Service Review; EBPs: evidence-based practices; MAT: medication-assisted therapies; DHS: Department of Human Services; PA: peer advisor; PR: peer review; PEDTAR: Prevention, Early Detection, Treatment and Recovery; UM: utilization management; BBA: Balanced Budget Act; QC: quality control.

Root Cause Analysis and Quality Improvement Plan

For PMs that are noted as opportunities for improvement in the EQR annual technical report, BH-MCOs are required to submit:

- a goal statement;
- root cause analysis and analysis findings;
- action plan to address findings;
- implementation dates; and
- a monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

Following several years of underperformance in the key quality indicator areas and coinciding with the phase-in of Value-Based Payment (VBP) at the HC BH Contractor level, OMHSAS determined in 2018 that it was necessary to change the PM remediation process so that BH-MCOs would set goals for the coming year. 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, BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and CAPs to achieve their MY 2019 goals. HC BH Contractors that scored below the 75th NCQA Quality Compass percentile were also asked to submit RCAs and CAPs. BH-MCOs submitted their RCAs and CAPs on April 1, 2019. HC BH Contractors submitted their RCAs and CAPs by April 30, 2019. As a result of this shift to a proactive process, MY 2018 goals for FUH All Ages were never set. However, MY 2018 results were calculated in late 2019 to determine RCA and "Quality Improvement Plan" (QIP) assignments, along with goals, for MY2020, and this proactive goal-setting approach has been in place ever since.

As a result of this shift to a proactive process, MY 2018 goals for FUH All Ages were not set. However, MY 2018 results were calculated in late 2019 to determine RCA and "Quality Improvement Plan" (QIP) assignments, along with goals, for MY2020, and this proactive goal-setting approach has been in place ever since.

In MY 2021, BHO scored below the 75th percentile on both the 7- and 30-day measures and, as a result, was required to complete an RCA and QIP response for both measures. **Table 6.2** and **Table 6.3** present BHO's submission of its RCA and QIP for the FUH All-Ages 7-day and 30-day measures, respectively. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 6.2: BHO RCA and QIP for the FUH 7-Day Measure (All Ages)

BHO RCA and QIP for the FUH 7-Day Measure (All Ages) for MY 2021 Underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):	***Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:***
Beacon, in partnership with our 11 county partners, inpatient, outpatient, and case management providers conducted a root cause analysis to effectively determine the causal factors for Follow-Up After Hospitalization (FUH) 7- and 30-day measures that scored below the identified goals. The following information was considered to determine the causal factors: • COVID impact statements from providers across all levels of care • Provider reports on barriers to non-adherence / service delivery • Patient level detail for members who failed to attend their aftercare follow-up appointments for each Primary Contractor • FUH performance across high volume facilities, both inpatient and outpatient • Member reports on barriers to non-adherence • Inpatient, outpatient, and case management delivery systems • Race/ethnicity gaps in follow up appointments Beacon utilized several analytic methods including fish bone diagramming, causal loop diagramming, and process identification and gap analysis. These methods further define the factors (influencing and causal) that contributed to performance below standards.	A comprehensive RCA was conducted with Beacon and their Primary Contractors to ensure our understanding of the barriers across specific systems of care. Data on MY 2021 7 and 30-day follow up rates and goals were reviewed. This review included provider rates and performance (IP and OP), county by county performance, service code follow-up appointments, member race and ethnicity analysis, and age. Cause and effect probing was utilized during the RCA sessions to uncover barriers. The information from the RCA sessions was aggregated and analyzed to identify overall thematic findings. To conduct the analysis and identify opportunities for improvement, an ideal-state process flow was completed, and a high-level Fishbone diagram was constructed. In consideration of each of the analytic methods employed, the overall findings are as follows for the Beacon network: • **COVID 19 Fatigue: This barrier is considered to be the major barrier for Beacon's decline in performance from the previous year.** o Providers report in this second year of the pandemic that staff shortages are their largest barrier. This includes retaining existing staff and the inability to recruit new staff to behavioral health services. This barrier was determined to be County wide in the Beacon network. The barriers outlined below continue to exist in less critical ways yet collectively are a barrier to aftercare follow-up for Beacon members being discharged from an Inpatient level of care. • **Social determinates of health/health equity** o Member needs are not being addressed consistently during aftercare/discharge planning o Cultural considerations are being monitored consistently ▪ MY2021 findings demonstrated some disparity between black and white members in certain counties for both 7 & 30-day

<table>
<tr><th colspan="2">BHO RCA and QIP for the FUH 7-Day Measure (All Ages) for MY 2021 Underperformance</th></tr>
<tr><td></td><td>rates.
• Failed outreach following IP stay
o Invalid/inaccurate contact information for member
• Coordination of care efforts between all stakeholders
o Inconsistency in case management/Peer Support Specialist (PSS) services
o Redundant referral loops; communication of outcomes minimal
o IP/OP system of care communications is lacking
• COVID 19 Impact on the Mental Health System
o Providers – The impact to providers has been extensive, with some providers closing, many unable to staff appropriately, wait lists for children referred to IBHS, hospitals overwhelmed with COVID, BH not a priority, and discharge planning not a priority.
o Facilities - No authorizations required for INPT stay with suspensions of UM reviews, with no UM review the case shaping does not start at admission, and with less OP providers for Aftercare appointments discharge planning is difficult.
o Transportation
o Community Supports – Lack of available “safety nets” in the community, i.e., schools closed or using hybrid model, no peer support face to face, churches closes or not meeting indoors, housing insecurity due to work loss, daycare closing affecting family dynamics/support and the increased SDoH needs of members and their families.
o Minority members were disproportionately impacted by COVID

Attachments Beacon FUH RCA Fishbone 2023.</td></tr>
<tr><td>List out below the factors you identified in your RCA. <u>Insert more rows as needed</u> (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).</td><td>Discuss each factor’s role in contributing to underperformance and any disparities (as defined above) in the performance indicator in question. Assess its “causal weight” as well as your MCO’s current and expected capacity to address it (“actionability”).</td></tr>
<tr><td>COVID Impact
• Providers – Inability to provide services, lack of trained staff, no telehealth capability, Children wait list to IBHS services, and the overflow into Family based services
• Facilities – Hospital BH beds filled with COVID patients, hospitals overwhelmed with COVID need, unable to focus on adequate discharge planning due to COVID.</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):

COVID 19 Fatigue: Critical
• Providers report in this second year of the pandemic that staff shortages are their largest barrier. This includes retaining existing staff and the inability to recruit new staff to behavioral health services.</td></tr>
</table>

<table>
<tr><th colspan="2">BHO RCA and QIP for the FUH 7-Day Measure (All Ages) for MY 2021 Underperformance</th></tr>
<tr><td>Transportation
Community Supports – lack of community “safety nets” like schools, peer supports, religious meetings, day care closings and housing insecurity.
Health Equity – increased need in the area of Social Determinants of Health (SDoH), member focusing on basic needs, increased mental health needs due to isolation, and minority members disproportionately impacted by COVID</td><td>COVID 19 had a devastating impact to the Mental Health System and Medical systems in the State as a whole
The impact to providers and facilities was critical.
Transportation, Community Supports and Health Equity are important factors in supporting the overall performance
Current and expected actionability: It has been determined that this Barrier is of critical importance. The actionability has been discussed and will require a multi prong, systemic approach to help stabilize the provider community. The OP provider community will require system action to stabilize which may be very challenging, but is incrementally actionable.</td></tr>
<tr><td>People (1)
(e.g., personnel, patients)

Members/clients/patients
Member “feels better” following discharge and doesn’t attend follow up appointment
Member insists on making their own follow-up appointment/refuses aftercare plan
Contact information for member is inaccurate or member does not respond to outreach calls
Returning home to a stressful environment
Member fear or distrust of the system
Past history of member not showing for follow up appointments; OP providers not willing to schedule due to history with member/patient
Members 65+ often follow up with PCP; not willing to go to BH provider</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important

Members do not have a full understanding of the importance of follow up appointments with behavioral health care providers and therefore do not consistently make or keep scheduled follow up visits at 7 days.
Individuals with dual diagnoses and/or complex needs with chronic medical and substance use issues often require more coordination across the continuum of care and they may not feel the need to follow up with a psychiatrist or therapist.
Individuals often lack family support with treatment (such as parents not bringing
their child to follow up appointments, no family involvement in discharge planning,
parent(s)/caretaker(s) unwillingness to sign releases to coordinate care, family not accepting appropriate levels of care for the child, changing patient /family dynamics, etc.).
Members may have their first experience with the BH care system and feel their needs can be met by their PCP.
Individuals may be reluctant to seek treatment and continue with follow up care due to mental health stigma.
Current and expected actionability: It has been determined that this is of importance and attainable action.</td></tr>
<tr><td>Providers (1)
(e.g. provider facilities, provider network)</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important</td></tr>
</table>

<table>
<tr><th colspan="2">BHO RCA and QIP for the FUH 7-Day Measure (All Ages) for MY 2021 Underperformance</th></tr>
<tr><td>• IP/OP Not including natural supports in process
• Walk-in/open access not available in all counties
• OP Providers not prioritizing IP d/c appointments
• Limited appointment availability within 7 or 14days
• Discharge instructions/paperwork is cumbersome
• Communication breakdown between IP, OP, & county liaison
• OP providers indicate difficulty in timely response from hospital
• County liaison not receiving discharge summary from IP provider</td><td>There is a perceived lack of coordinated and well established processes and communication channels across the continuum of care (inpatient to outpatient) to adequately address the continuity of care needs of the members upon admission through discharge. Continuity of communication and coordination across providers is of critical weight to this performance indicator.

Current and expected actionability:
It has been determined that this causal role is actionable incrementally based on a pilot project in Fayette County to link OP providers and the Counties largest Hospital to improve communication systems. This focus on building relationships and contacts across the IP/OP providers appears to be improving the Fayette 7-day measure.</td></tr>
<tr><td>Policies / Procedures (1)
(e.g., data systems, delivery systems, payment/reimbursement)

• Coordination, notification, and aftercare planning across the continuum of care upon IP admission is burdensome on IP providers
• Data and information sharing is limited across the system of care</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important
The IP and OP providers communication at the beginning of discharge planning through the member attending a timely after care OP appointment has many touch points where lack of communication and coordination are evident in the members who do not attend their aftercare appointment.

Current and expected actionability:
Opportunities to improve in these areas are attainable, but may take up to a year to fully implement action.</td></tr>
<tr><td>Policies / Procedures (2)
(e.g., data systems, delivery systems, payment/reimbursement)

• Outreach to member following discharge:
o Member contact information is not accurate across systems/multiple points of contact</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important

There appear to be opportunities to confirm the member’s contact information prior to discharge, which would improve success with follow up outreach. There is also the opportunity to connect the OP provider with the member prior to discharge. This causal role appears to weigh heavily on the delivery system’s ability to engage with the member following an inpatient discharge.

Current and expected actionability:
Review of our largest volume IP facilities and their surrounding OP providers has not been assessed outside of the Fayette Co. pilot.
Actions will be taken to improve upon this gap, as indicated in the QIP.</td></tr>
<tr><td>Provisions (1)
(e.g., screening tools, medical record forms, transportation)

Social determinates of health and health equity</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important

Health equity, inclusive of culturally and linguistically appropriate services and social</td></tr>
</table>

• Member has basic needs that are not met (e.g., housing, food insecurity, transportation); barrier to attending follow up appointment • Cultural disparities and needs were not known and not explicitly addressed	determinates of health have not been coordinated effectively throughout the system of care. This was not consistent in there appears to be a lack of data and information sharing among all involved in a member's care, leading to unaddressed health inequities across the Beacon network. Ensuring that a member's most basic needs and cultural considerations are met is a critical component to ensuring that the individual is able to navigate their recovery journey successfully.
	Current and expected actionability: Incrementally actionable. Currently, race and ethnicity data are being stratified into performance indicator reports for dissemination and information sharing to Primary Contractors, providers, and members. Quarterly in 2022, health disparities in FUH performance, was identified intermittingly in a few counties. Ensuring the Cultural Competency and accessibility of services in the Beacon Provider Network will have an impact on this barrier.

Quality Improvement Plan for CY 2023

Rate Goal for 2023 (State the 2023 rate goal from your MY2021 FUH Goal Report here): **46.0% for 7-day; 67.1% for 30-day**

The factors above can be thought of as barriers to improvement. For each barrier identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2022 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with Primary Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.

Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
PROVIDER: **COVID Fatigue**: Providers across PA are reporting staffing shortages that impact capacity and inability to hire new staff resulting in unit closures, reduced admissions or no capacity. The second full year of the	COVID Fatigue interventions: 1. Provider Field Coordinators returning to the field to assist providers to address pressing issues / concerns 2. Rapid Provider Engagement Team: developed in Summer of 2022 to provide functional area real-time feedback for providers concerns/issues 3. VBP arrangements with high volume hospitals/systems that have an FUH	1. June 2022 2. August 2022 3. 2022 4. Q1 2023 5. Q3 2023 6. Q2 2023	Success of these interventions may be difficult to quantify. Some potential measures are included below: 1. # of provider field coordinator visits 2. # of provider issues resolved by PFCs and Rapid Provider Engagement Team 3. FUH 7 day measure rates for provider in the VBP arrangement 4. Completion of HEDIS trainings 5. Completion of Open Minds training(s) 6. Discussion with OMHSAS and DHS concerning regulations for facility staffing.

pandemic continues to decimate the provider community at every level of care.	measure as a part of the quality outcomes. Provider Quality managers meet monthly to review FUH data, identify barriers, and assist providers with solutions to these barriers. 4. HEDIS Trainings for providers 5. Open Minds training forums for providers on Staff retention and recruiting 6. State requirements for provider community staffing (look at regulations / admin relief, (i.e., LPN in addition to RN coverage in 24 hour care settings)		
People: Members do not have a full understanding of the importance of follow up appointments with behavioral health care providers and therefore do not consistently make or keep scheduled follow up visits at 7 days.	1. Beacon after care coordinators conduct outreach to members within two days following IP discharge 2. Beacon Complete Care Coordinators (C3) conduct intensive outreach to members engaged in the C3 program within two days following IP discharge 3. Blended Case Management (BCM)/Peer Support Specialist (PPS) to engage members with an inpatient admission to assist in their transition back into the community to their OP follow-up appointment.	1. Ongoing (Implemented 2001) 2. Ongoing (Implemented 2017) 3. Ongoing (Implemented April 2021)	1. Aftercare coordination process measure will be monitored by the Beacon QM department to determine the number of contacts made by the clinical aftercare coordinators within two days following an inpatient admission. Process Measure: N: # AC contacts made within two days of IP d/c D: #IP discharges Frequency of measurement: Quarterly Effectiveness will be identified via compliance with FUH appointment. Additional analysis will be conducted for attempted to contacts that were not successful and members who were non-compliant with FUH appointment. 2. Complete Care Coordination (C3) process measure will be monitored by the Beacon QM department to determine the number of contacts made by the clinical complete care coordination team to

BHO RCA and QIP for the FUH 7-Day Measure (All Ages) for MY 2021 Underperformance			
			members who are engaged in the intensive care management (C3) program. Process Measure: N: # C3 contacts made within two days of IP d/c/ D: #Engaged C3 program member IP discharges Frequency of measurement: Quarterly Analysis will be conducted to determine demonstrable effective intensive outreach by C3 team for members who are engaged in the program via compliance with FUH appointment. 3. Monitoring of BCM/PSS services for individuals with an inpatient discharge will be conducted by Beacon QM. Process Measure: # of members with BCM/PSS 1 month pre/post IP discharge and their FUH 7 and 30-day outcome compliance Frequency of measurement: Quarterly Analysis will be conducted to determine demonstrable effectiveness of BCM/PSS services as a conduit for member transitions to community via compliance with FUH appointment.
Providers There is a perceived lack of coordinated and well established processes and communication channels across the continuum of care (inpatient to outpatient) to adequately address the continuity of care needs of	Review of the Fayette Co. pilot with Highland Hospital initiated in 2020 and in full operation in 2021 appears to have bridged the gap for more members discharged from IP. This is evidenced by the Fayette Co. 7-day rates improving while most other counties decreased in performance.	Beacon facilitates a quarterly FUH QIP subcommittee (established 2020) that includes Primary Contractors and county representatives. Coordination of Care barriers and the success of the Highland pilot strategy	The FUH QIP subcommittee will document discussions and follow up action items to be addressed in the subcommittee meeting minutes. Any follow-up items identified for action will be completed and reported by the responsible party and reflected in the subcommittee minutes.

BHO RCA and QIP for the FUH 7-Day Measure (All Ages) for MY 2021 Underperformance			
the members upon admission through discharge.	1. Identify a high volume hospital to participate in a pilot, as well as, OP provider partners. 2. Design a process map for each hospital that is participating in the pilot. 3. Identify key responsible parties for the pilot implementation and the monthly reporting metrics.	will be discussed for piloting in other counties where communication channels across the continuum exist. A standing agenda item regarding expansion of the pilot project will be added to the quarterly agenda. 1. Q2-Q3 2023 2. Q2-Q3 2023 3. Q2-Q3 2023	
Policies/Procedures FUH Performance-Based Incentives for IP providers are intended support in facilitating improvement in this area. It is unknown at this time whether the high volume IP providers who are eligible for the incentives are utilizing incentives to improve coordination efforts. Additionally, performance indicator data and associated analysis sharing across the system of care is important to ensure payment/reimbursement systems are efficiently improving transitions to community for Beacon members.	Beacon will monitor IP providers who are contracted for Value Based Payment (VBP) arrangements and share information with the FUH QIP subcommittee for further action with counties/providers. 1. IP Providers with VBP arrangements will have a strategic improvement plan to improve their FUH 7 and 30 day rates. 2. Provider Quality managers will review IP providers FUH performance monthly/quarterly and participate in discussions regarding barriers and potential solutions to those barriers	VBP monitoring reports are currently shared with the FUH QIP subcommittee and the QM/UM Committees on a quarterly basis in 2023.	Beacon QM will provide VBP monitoring reports that are developed in accordance with the VBP methodology for IP providers that are eligible for the current Pay for Performance model. The FUH QIP subcommittee will document discussions and follow up action items to be addressed in the subcommittee meeting minutes. Any follow-up items identified for action will be completed and reported by the responsible party and reflected in the subcommittee minutes. Provider Quality managers will report quarterly on progress toward FUH improvement by facility at the QM/UM Committees
Provisions: Health equity, inclusive of culturally and linguistically appropriate services and social determinates of health	Health Equity Transformation: Quality Improvement Activity 1. Conduct Health Equity training for our Primary Contractors 2. Conduct NCQA Health Equity	Implementation of Beacon's Health Equity Transformation Initiative began in Q2 2021. 1. Quarterly	Success of this initiative will be determined by Beacon's ability to: • Stratify performance, process, and intervention measures by race and ethnicity to address any disparities found.

BHO RCA and QIP for the FUH 7-Day Measure (All Ages) for MY 2021 Underperformance			
have not been coordinated effectively throughout the system of care. There appears to be a lack of data and information sharing among all involved in a member's care, leading to unaddressed health inequities across the Beacon network. Ensuring that a member's most basic needs and cultural considerations are met is a critical component to ensuring that the individual is able to navigate their recovery journey successfully.	standards training for Beacon staff 3. Discuss health equity with members at member forums/committees 4. Increase provider utilization of z-codes to indicate social determinate of health needs, Send out provider alerts 5. Create and disseminate a monthly survey via Check Market platform that includes Cultural capacity of providers within the Beacon network.	2. Monthly beginning March 2023 3. Beginning January 2023 4. Beginning Q1-Q2 2023 5. Q1 2023	• Integration of provider cultural competency into the standard treatment of care; ensuring the provider network is robust in culturally and linguistically appropriate services for the population served. • Providers will increase utilization of z-codes on claims to indicate social determine needs; Beacon will have the ability to conduct z-code analysis to evaluate and target specific basic needs of the system of care geographically. • Inclusion of members of color lived experience to drive education of the provider community concerning health disparity.

Table 6.3: BHO RCA and QIP for the FUH 30-Day Measure (All Ages)

BHO RCA and QIP for the FUH 30-Day Measure (All Ages) for MY 2021 Underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?): Beacon, in partnership with our 11 county partners, inpatient, outpatient, and case management providers conducted a root cause analysis to effectively determine the causal factors for Follow-Up After Hospitalization (FUH) 7- and 30-day measures that scored below the identified goals. The following information was considered to determine the causal factors: • COVID impact statements from providers across all levels of care • Provider reports on barriers to non-adherence / service delivery • Patient level detail for members who failed to attend their aftercare follow-up appointments for each Primary Contractor	***Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*** A comprehensive RCA was conducted with Beacon and their Primary Contractors to ensure our understanding of the barriers across specific systems of care. Data on MY 2021 7 and 30-day follow up rates and goals were reviewed. This review included provider rates and performance (IP and OP), county by county performance, service code follow-up appointments, member race and ethnicity analysis, and age. Cause and effect probing was utilized during the RCA sessions to uncover barriers. The information from the RCA sessions was aggregated and analyzed to identify overall thematic findings. To conduct the analysis and identify opportunities for improvement,

<table>
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<tr><td>

- FUH performance across high volume facilities, both inpatient and outpatient
- Member reports on barriers to non-adherence
- Inpatient, outpatient, and case management delivery systems
- Race/ethnicity gaps in follow up appointments

Beacon utilized several analytic methods including fish bone diagramming, causal loop diagramming, and process identification and gap analysis. These methods further define the factors (influencing and causal) that contributed to performance below standards.

</td><td>

an ideal-state process flow was completed, and a high-level Fishbone diagram was constructed.

In consideration of each of the analytic methods employed, the overall findings are as follows for the Beacon network:

- **COVID 19 Fatigue: This barrier is considered to be the major barrier for Beacon's decline in performance from the previous year.**
  - Providers report in this second year of the pandemic that staff shortages are their largest barrier. This includes retaining existing staff and the inability to recruit new staff to behavioral health services. This barrier was determined to be County wide in the Beacon network.

The barriers outlined below continue to exist in less critical ways yet collectively are a barrier to aftercare follow-up for Beacon members being discharged from an Inpatient level of care.

- **Social determinates of health/heath equity**
  - Member needs are not being addressed consistently during aftercare/discharge planning
  - Cultural considerations are being monitored consistently
    - MY2021 findings demonstrated some disparity between black and white members in certain counties for both 7 & 30-day rates.
- **Failed outreach following IP stay**
  - Invalid/inaccurate contact information for member
- **Coordination of care efforts between all stakeholders**
  - Inconsistency in case management/Peer Support Specialist (PSS) services
  - Redundant referral loops; communication of outcomes minimal
  - IP/OP system of care communications is lacking
- **COVID 19 Impact on the Mental Health System**
  - Providers – The impact to providers has been extensive, with some providers closing, many unable to staff appropriately, wait lists for children referred to IBHS, hospitals overwhelmed with COVID, BH not a priority, and discharge planning not a priority.
  - Facilities - No authorizations required for INPT stay with suspensions of UM reviews, with no UM review the case shaping does not start at admission, and with less OP providers for Aftercare appointments discharge planning is difficult.

</td></tr>
</table>

BHO RCA and QIP for the FUH 30-Day Measure (All Ages) for MY 2021 Underperformance	
	o Transportation o Community Supports – Lack of available "safety nets" in the community, i.e., schools closed or using hybrid model, no peer support face to face, churches closes or not meeting indoors, housing insecurity due to work loss, daycare closing affecting family dynamics/support and the increased SDoH needs of members and their families. o Minority members were disproportionately impacted by COVID **Attachments** Beacon FUH RCA Fishbone 2023.
List out below the factors you identified in your RCA. <u>Insert more rows as needed</u> (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance and any disparities (as defined above) in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
COVID Impact • **Providers** – Inability to provide services, lack of trained staff, no telehealth capability, Children wait list to IBHS services, and the overflow into Family based services • **Facilities –** Hospital BH beds filled with COVID patients, hospitals overwhelmed with COVID need, unable to focus on adequate discharge planning due to COVID. • **Transportation** • **Community Supports –** lack of community "safety nets" like schools, peer supports, religious meetings, day care closings and housing insecurity. • **Health Equity –** increased need in the area of Social Determinants of Health (SDoH), member focusing on basic needs, increased mental health needs due to isolation, and minority members disproportionately impacted by COVID	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** **COVID 19 Fatigue: Critical** • Providers report in this second year of the pandemic that staff shortages are their largest barrier. This includes retaining existing staff and the inability to recruit new staff to behavioral health services. ***COVID 19 had a devastating impact to the Mental Health System and Medical systems in the State as a whole*** • The impact to providers and facilities was critical. • Transportation, Community Supports and Health Equity are important factors in supporting the overall performance ***Current and expected actionability:*** It has been determined that this Barrier is of critical importance. The actionability has been discussed and will require a multi prong, systemic approach to help stabilize the provider community. The OP provider community will require system action to stabilize which may be very challenging, but is incrementally actionable.
People (1) *(e.g., personnel, patients)* Members/clients/patients • Member "feels better" following discharge and doesn't attend	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important*** Members do not have a full understanding of the importance of follow up appointments with behavioral health care providers and therefore do not consistently

<table>
<tr><th colspan="2">BHO RCA and QIP for the FUH 30-Day Measure (All Ages) for MY 2021 Underperformance</th></tr>
<tr><td>follow up appointment
• Member insists on making their own follow-up appointment/refuses aftercare plan
• Contact information for member is inaccurate or member does not respond to outreach calls
• Returning home to a stressful environment
• Member fear or distrust of the system
• Past history of member not showing for follow up appointments; OP providers not willing to schedule due to history with member/patient
• Members 65+ often follow up with PCP; not willing to go to BH provider</td><td>make or keep scheduled follow up visits at 7 days.
• Individuals with dual diagnoses and/or complex needs with chronic medical and substance use issues often require more coordination across the continuum of care and they may not feel the need to follow up with a psychiatrist or therapist.
• Individuals often lack family support with treatment (such as parents not bringing
their child to follow up appointments, no family involvement in discharge planning,
parent(s)/caretaker(s) unwillingness to sign releases to coordinate care, family not accepting appropriate levels of care for the child, changing patient /family dynamics, etc.).
• Members may have their first experience with the BH care system and feel their needs can be met by their PCP.
• Individuals may be reluctant to seek treatment and continue with follow up care due to mental health stigma.</td></tr>
<tr><td></td><td>Current and expected actionability: It has been determined that this is of importance and attainable action.</td></tr>
<tr><td>Providers (1)
(e.g. provider facilities, provider network)
• IP/OP Not including natural supports in process
• Walk-in/open access not available in all counties
• OP Providers not prioritizing IP d/c appointments
• Limited appointment availability within 7 or 14days
• Discharge instructions/paperwork is cumbersome
• Communication breakdown between IP, OP, & county liaison
• OP providers indicate difficulty in timely response from hospital
• County liaison not receiving discharge summary from IP provider</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important
There is a perceived lack of coordinated and well established processes and communication channels across the continuum of care (inpatient to outpatient) to adequately address the continuity of care needs of the members upon admission through discharge. Continuity of communication and coordination across providers is of critical weight to this performance indicator.</td></tr>
<tr><td></td><td>Current and expected actionability:
It has been determined that this causal role is actionable incrementally based on a pilot project in Fayette County to link OP providers and the Counties largest Hospital to improve communication systems. This focus on building relationships and contacts across the IP/OP providers appears to be improving the Fayette 7-day measure.</td></tr>
<tr><td>Policies / Procedures (1)
(e.g., data systems, delivery systems, payment/reimbursement)
• Coordination, notification, and aftercare planning across the continuum of care upon IP admission is burdensome on IP providers</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important
The IP and OP providers communication at the beginning of discharge planning through the member attending a timely after care OP appointment has many touch points where lack of communication and coordination are evident in the members who do not attend their aftercare appointment.</td></tr>
</table>

BHO RCA and QIP for the FUH 30-Day Measure (All Ages) for MY 2021 Underperformance	
• Data and information sharing is limited across the system of care	***Current and expected actionability:*** Opportunities to improve in these areas are attainable, but may take up to a year to fully implement action.
Policies / Procedures (2) *(e.g., data systems, delivery systems, payment/reimbursement)* • **Outreach to member following discharge:** o Member contact information is not accurate across systems/multiple points of contact	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important*** There appear to be opportunities to confirm the member's contact information prior to discharge, which would improve success with follow up outreach. There is also the opportunity to connect the OP provider with the member prior to discharge. This causal role appears to weigh heavily on the delivery system's ability to engage with the member following an inpatient discharge.
	Current and expected actionability: Review of our largest volume IP facilities and their surrounding OP providers has not been assessed outside of the Fayette Co. pilot. Actions will be taken to improve upon this gap, as indicated in the QIP.
Provisions (1) *(e.g., screening tools, medical record forms, transportation)* **Social determinates of health and health equity** • Member has basic needs that are not met (e.g., housing, food insecurity, transportation); barrier to attending follow up appointment • Cultural disparities and needs were not known and not explicitly addressed	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important*** Health equity, inclusive of culturally and linguistically appropriate services and social determinates of health have not been coordinated effectively throughout the system of care. This was not consistent in there appears to be a lack of data and information sharing among all involved in a member's care, leading to unaddressed health inequities across the Beacon network. Ensuring that a member's most basic needs and cultural considerations are met is a critical component to ensuring that the individual is able to navigate their recovery journey successfully.
	Current and expected actionability: Incrementally actionable. Currently, race and ethnicity data are being stratified into performance indicator reports for dissemination and information sharing to Primary Contractors, providers, and members. Quarterly in 2022, health disparities in FUH performance, was identified intermittingly in a few counties. Ensuring the Cultural Competency and accessibility of services in the Beacon Provider Network will have an impact on this barrier.

BHO RCA and QIP for the FUH 30-Day Measure (All Ages) for MY 2021 Underperformance			
Quality Improvement Plan for CY 2023			
Rate Goal for 2023 (State the 2023 rate goal from your MY2021 FUH Goal Report here): **46.0% for 7-day; 67.1% for 30-day**			
The factors above can be thought of as barriers to improvement. For each barrier identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2022 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with Primary Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.			
Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
PROVIDER: **COVID Fatigue**: Providers across PA are reporting staffing shortages that impact capacity and inability to hire new staff resulting in unit closures, reduced admissions or no capacity. The second full year of the pandemic continues to decimate the provider community at every level of care.	COVID Fatigue interventions: 7. Provider Field Coordinators returning to the field to assist providers to address pressing issues / concerns 8. Rapid Provider Engagement Team: developed in Summer of 2022 to provide functional area real-time feedback for providers concerns/issues 9. VBP arrangements with high volume hospitals/systems that have an FUH measure as a part of the quality outcomes. Provider Quality managers meet monthly to review FUH data, identify barriers, and assist providers with solutions to these barriers. 10. HEDIS Trainings for providers 11. Open Minds training forums for providers on Staff retention and recruiting 12. State requirements for provider community staffing (look at	7. June 2022 8. August 2022 9. 2022 10. Q1 2023 11. Q3 2023 12. Q2 2023	Success of these interventions may be difficult to quantify. Some potential measures are included below: 7. # of provider field coordinator visits 8. # of provider issues resolved by PFCs and Rapid Provider Engagement Team 9. FUH 7 day measure rates for provider in the VBP arrangement 10. Completion of HEDIS trainings 11. Completion of Open Minds training(s) 12. Discussion with OMHSAS and DHS concerning regulations for facility staffing.

BHO RCA and QIP for the FUH 30-Day Measure (All Ages) for MY 2021 Underperformance			
	regulations / admin relief, (i.e., LPN in addition to RN coverage in 24 hour care settings)		
People: Members do not have a full understanding of the importance of follow up appointments with behavioral health care providers and therefore do not consistently make or keep scheduled follow up visits at 7 days.	4. Beacon after care coordinators conduct outreach to members within two days following IP discharge 5. Beacon Complete Care Coordinators (C3) conduct intensive outreach to members engaged in the C3 program within two days following IP discharge 6. Blended Case Management (BCM)/Peer Support Specialist (PPS) to engage members with an inpatient admission to assist in their transition back into the community to their OP follow-up appointment.	4. Ongoing (Implemented 2001) 5. Ongoing (Implemented 2017) 6. Ongoing (Implemented April 2021)	4. Aftercare coordination process measure will be monitored by the Beacon QM department to determine the number of contacts made by the clinical aftercare coordinators within two days following an inpatient admission. Process Measure: N: # AC contacts made within two days of IP d/c D: #IP discharges Frequency of measurement: Quarterly Effectiveness will be identified via compliance with FUH appointment. Additional analysis will be conducted for attempted to contacts that were not successful and members who were non-compliant with FUH appointment. 5. Complete Care Coordination (C3) process measure will be monitored by the Beacon QM department to determine the number of contacts made by the clinical complete care coordination team to members who are engaged in the intensive care management (C3) program. Process Measure: N: # C3 contacts made within two days of IP d/c/ D: #Engaged C3 program member IP discharges Frequency of measurement: Quarterly Analysis will be conducted to determine demonstrable effective intensive outreach by C3 team for members who are engaged in the program via compliance with FUH appointment. 6. Monitoring of BCM/PSS services for individuals with an inpatient discharge will be conducted by Beacon QM. Process Measure: # of members with BCM/PSS 1 month pre/post IP discharge and their FUH 7 and 30-day outcome compliance Frequency of measurement: Quarterly

BHO RCA and QIP for the FUH 30-Day Measure (All Ages) for MY 2021 Underperformance			
			Analysis will be conducted to determine demonstrable effectiveness of BCM/PSS services as a conduit for member transitions to community via compliance with FUH appointment.
Providers There is a perceived lack of coordinated and well established processes and communication channels across the continuum of care (inpatient to outpatient) to adequately address the continuity of care needs of the members upon admission through discharge.	Review of the Fayette Co. pilot with Highland Hospital initiated in 2020 and in full operation in 2021 appears to have bridged the gap for more members discharged from IP. This is evidenced by the Fayette Co. 7-day rates improving while most other counties decreased in performance. 4. Identify a high volume hospital to participate in a pilot, as well as, OP provider partners. 5. Design a process map for each hospital that is participating in the pilot. 6. Identify key responsible parties for the pilot implementation and the monthly reporting metrics.	Beacon facilitates a quarterly FUH QIP subcommittee (established 2020) that includes Primary Contractors and county representatives. Coordination of Care barriers and the success of the Highland pilot strategy will be discussed for piloting in other counties where communication channels across the continuum exist. A standing agenda item regarding expansion of the pilot project will be added to the quarterly agenda. 4. Q2-Q3 2023 5. Q2-Q3 2023 6. Q2-Q3 2023	The FUH QIP subcommittee will document discussions and follow up action items to be addressed in the subcommittee meeting minutes. Any follow-up items identified for action will be completed and reported by the responsible party and reflected in the subcommittee minutes.
Policies/Procedures FUH Performance-Based Incentives for IP providers are intended support in facilitating improvement in this area. It is unknown at this time whether the high volume IP providers who are eligible for the incentives are utilizing incentives to improve coordination efforts. Additionally, performance indicator data and associated	Beacon will monitor IP providers who are contracted for Value Based Payment (VBP) arrangements and share information with the FUH QIP subcommittee for further action with counties/providers. 3. IP Providers with VBP arrangements will have a strategic improvement plan to improve their FUH 7 and 30 day rates. 4. Provider Quality managers will review IP providers FUH	VBP monitoring reports are currently shared with the FUH QIP subcommittee and the QM/UM Committees on a quarterly basis in 2023.	Beacon QM will provide VBP monitoring reports that are developed in accordance with the VBP methodology for IP providers that are eligible for the current Pay for Performance model. The FUH QIP subcommittee will document discussions and follow up action items to be addressed in the subcommittee meeting minutes. Any follow-up items identified for action will be completed and reported by the responsible party and reflected in the subcommittee minutes.

BHO RCA and QIP for the FUH 30-Day Measure (All Ages) for MY 2021 Underperformance			
analysis sharing across the system of care is important to ensure payment/reimbursement systems are efficiently improving transitions to community for Beacon members.	performance monthly/quarterly and participate in discussions regarding barriers and potential solutions to those barriers.		Provider Quality managers will report quarterly on progress toward FUH improvement by facility at the QM/UM Committees
Provisions: Health equity, inclusive of culturally and linguistically appropriate services and social determinates of health have not been coordinated effectively throughout the system of care. There appears to be a lack of data and information sharing among all involved in a member's care, leading to unaddressed health inequities across the Beacon network. Ensuring that a member's most basic needs and cultural considerations are met is a critical component to ensuring that the individual is able to navigate their recovery journey successfully.	Health Equity Transformation: Quality Improvement Activity 6. Conduct Health Equity training for our Primary Contractors 7. Conduct NCQA Health Equity standards training for Beacon staff 8. Discuss health equity with members at member forums/committees 9. Increase provider utilization of z-codes to indicate social determinate of health needs, Send out provider alerts 10. Create and disseminate a monthly survey via Check Market platform that includes Cultural capacity of providers within the Beacon network.	Implementation of Beacon's Health Equity Transformation Initiative began in Q2 2021. 1. Quarterly 2. Monthly beginning March 2023 3. Beginning January 2023 4. Beginning Q1-Q2 2023 5. Q1 2023	Success of this initiative will be determined by Beacon's ability to: • Stratify performance, process, and intervention measures by race and ethnicity to address any disparities found. • Integration of provider cultural competency into the standard treatment of care; ensuring the provider network is robust in culturally and linguistically appropriate services for the population served. • Providers will increase utilization of z-codes on claims to indicate social determine needs; Beacon will have the ability to conduct z-code analysis to evaluate and target specific basic needs of the system of care geographically. • Inclusion of members of color lived experience to drive education of the provider community concerning health disparity.

VII: 2022 Strengths, Opportunities for Improvement and Recommendations

This section provides an overview of BHO's MY 2021 performance in the following areas: structure and operations standards, PIPs, and PMs, with identified strengths and opportunities for improvement. This section also provides an assessment of the strengths and weaknesses of BHO with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (as described in Title 42 CFR 438.310(c)(2)).

Strengths

- Under MMC regulations, BHO was fully compliant with the provisions under Confidentiality, Health Information Systems, Provider Selection, and Subcontractual Relationships and Delegations.
- BHO's MY 2021 PA-specific 7-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 A) for the All Ages age set populations significantly improved over the previous year.

Opportunities for Improvement

- Review of Compliance with Standards conducted by PA in RY 2019, RY 2020, and RY 2021 found BHO to be partially compliant with three sections associated with MMC regulations.
  - BHO was partially compliant with 5 out of 9 categories within Compliance with Standards, Including Enrollee Rights and Protections. The partially compliant categories are: 1) Assurances of Adequate Capacity, 2) Availability of Services, 3) Coordination and Continuity of Care, 4) Coverage and Authorization of Services, and 5) Practice Guidelines.
  - BHO was partially compliant with the single category of Quality Assessment and Performance Improvement Program.
  - BHO was partially compliant with the single category of Grievance and Appeal Systems within Grievance System.
- BHO's MY 2021 HEDIS 7- and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and 2) for ages 18–64 and 6+ years fell below their respective HEDIS Quality Compass 75th percentiles.
- BHO's MY 2021 HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1) for ages 6–17 years fell below their respective HEDIS Quality Compass 75th percentiles.
- BHO's MY 2021 PA-Specific 7- and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1) for ages 6+ years was below the MY 2020 rate.
- BHO's MY 2021 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 11.75%.
- Review of Compliance with Standards conducted by PA in RY 2019, RY 2020, and RY 2021 found BHO to be partially compliant with Network Adequacy.

Assessment of Quality, Timeliness, and Access

Responsibility for **quality** of, **timeliness** of, and **access** to health care services and supports is distributed among providers, payers, and Primary Contractors. Due to the BH carve-out within PA's HC program, BH-MCOs and PH-MCOs operate under separate contracts, with BH-MCOs contracting with non-overlapping Primary Contractors, making this distribution even more complex. However, when it comes to improving healthcare quality, timeliness, and access, the BH-MCO can focus on factors closer to its locus of control.

Table 7.1 details the full list of recommendations that are made for the MCO for each of the applicable EQR activities. For PIPs, the recommendations are based on the review that was conducted for MY 2021. The PIP recommendations may include issues from prior years if they remain unresolved. For PMs, the strengths and opportunities noted above in this section summarize findings from the current report, while recommendations are based on issues that were not only identified as opportunities from the current report but were also identified as outstanding opportunities from last year's EQR technical report.

Table 7.1: EQR Recommendations

EQR Task/Measure	IPRO's Recommendation	Standards
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	IPRO advised that any and all PIP intervention activities would need to be monitored using ITMs. In addition, the population health strategy intervention was discontinued entirely, effective 2022. IPRO advised that BHO would need to find a suitable population health strategy going forward to satisfy this required component of the PIP.	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	IPRO concurs with BHO's findings of its RCA and proposed remediations in its QIP, which center on addressing: COVID-19 fatigue through provider engagement and VBP interventions, increasing timely outreach post-discharge, while addressing social determinants of health, and improving communication and coordination among providers and related resources.	Timeliness, Access
PA Follow-Up After Hospitalization for Mental Illness rates	IPRO concurs with BHO's findings of its RCA and proposed remediations in its QIP, which center on addressing: COVID-19 fatigue through provider engagement and VBP interventions, increasing timely outreach post-discharge, while addressing social determinants of health, and improving communication and coordination among providers and related resources.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	BHO should continue to conduct RCA into the drivers of readmissions among members discharged from an inpatient psychiatric stay. It should leverage the barrier analyses already conducted for its PEDTAR PIP, but also conduct additional RCA for members without AOD diagnoses.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Assurances of adequate capacity and services	BHO was partially compliant with a substandard that 100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met. The Primary Contractors with BHO were not fully compliant for all applicable levels of care. BHO should work with these contractors to expand its network, if needed, to come into compliance at all applicable levels of care.	Quality, Timeliness, Access
Availability of Services	In addition to the above-mentioned partial compliance on provider choice, BHO was partially compliant with two substandards centered on a defined program of care that incorporates longitudinal disease management. BHO should focus on rationalizing allocation of case management resources which will furthermore strengthen documentation related to the application of medical necessity criteria.	Quality, Timeliness, Access
Coordination and continuity of care	BHO was partially compliant with two substandards centered on a defined program of care that incorporates longitudinal disease management. BHO should focus on rationalizing allocation of case management resources which will furthermore strengthen documentation related to the application of medical necessity criteria.	Quality, Timeliness, Access
Coverage and authorization of services	In addition to the partial compliance centered on defining a program of care, BHO was found partially compliant on the substandard that denial notices be issued to members according to required timeframes and use the required template language. IPRO notes here the Corrective Action Plan Required, namely: BHO must ensure that when requested services are denied, approved services are clearly stated to members in the denial letter. This can be accomplished by using the appropriate OMHSAS-approved templates.	Quality, Timeliness, Access
Practice Guidelines	BHO was partially compliant with two substandards centered on a defined program of care that incorporates longitudinal disease management. BHO should focus on rationalizing allocation of case management resources	Quality, Timeliness, Access

EQR Task/Measure	IPRO's Recommendation	Standards
	which will furthermore strengthen documentation related to the application of medical necessity criteria.	
Quality assessment and performance improvement program	BHO was found partially compliant with substandards concerned with the QM Program Description and Work Plan. IPRO concurs with OMHSAS' recommendations and corrective action plan: The Program Description states that Quality Improvement Activities / Projects will be identified for improvement in clinical care and services areas, but specific Performance Improvement Projects are not identified. The Work Plan lists data to be collected under each activity and mentions members with special health needs. It is recommended that this information be stated and more clearly described in the Program Description. For the OMHSAS CAP, BHO needs to clarify goals and activities in the 2022 Work Plan to identify specific and measurable goals.	
Grievance and appeal systems	BHO was found partially compliant on the substandard that denial notices be issued to members according to required timeframes and use the required template language. IPRO notes here the Corrective Action Plan Required, namely: BHO must ensure that when requested services are denied, approved services are clearly stated to members in the denial letter. This can be accomplished by using the appropriate OMHSAS-approved templates. BHO was found not compliant with the substandard that Complaint case files include documentation of any referrals and subsequent corrective action and follow-up related to complaint issues. BHO should ensure that any follow-up and corrective actions are documented in a member's file or appropriately referenced for ready access.	Quality, Timeliness, Access

EQR: external quality review; MCO: managed care organization; N/A: not applicable.

VIII: Summary of Activities

Performance Improvement Projects

- BHO successfully implemented their PEDTAR PIP for 2021.

Performance Measures

- BHO reported all PMs and applicable quality indicators for 2021.

Medicaid Managed Care Regulations

- BHO was partially compliant with standards, including Quality assessment and performance improvement program, and Grievance System. As applicable, compliance review findings from RY 2021, RY 2020, and RY 2019 were used to make the determinations.

Network Adequacy

- Review of Compliance with Standards conducted by PA in RY 2019, RY 2020, and RY 2021 found BHO to be partially compliant with Network Adequacy.

Quality Studies

- DHS and OMHSAS launched ICWC in 2020. For any of its members receiving ICWC services, BHO covered those services under a Prospective Payment System rate.

2021 Opportunities for Improvement MCO Response

- BHO provided a response to the opportunities for improvement issued in 2021.

2022 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for BHO in 2022 (MY 2021). The BH-MCO will be required to prepare a response in 2023 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. Note that, in 2019, five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

Table A.1: Required PEPS Substandards Pertinent to BBA Regulations

BBA Category	PEPS Reference	PEPS Language
Assurances of adequate capacity and services Title 42 CFR § 438.207	Substandard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access time frames (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service (e.g., all outpatient providers should be listed on the same page or consecutive pages). • Excel or Access database with the following information: Name of Agency (include satellite sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (e.g., adult, child and adolescent); Priority Population; Special Population.
	Substandard 1.2	100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.
	Substandard 1.4	BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).
	Substandard 1.5	BH-MCO has notified the Department of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Substandard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees.
Availability of Services Title 42 CFR § 438.206, Title 42 CFR § 10(h)	Substandard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access time frames (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service (e.g., all outpatient providers should be listed on the same page or consecutive pages). • Excel or Access database with the following information: Name of Agency (include satellite sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (e.g., adult, child and adolescent); Priority Population; Special Population.
	Substandard 1.2	100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.
	Substandard 1.3	Provider Exception report submitted and approved when choice of two providers is not given.
	Substandard 1.4	BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).
	Substandard 1.5	BH-MCO has notified the Department of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Substandard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or

BBA Category	PEPS Reference	PEPS Language
		not accepting any new enrollees.
	Substandard 1.7	Confirm FQHC providers.
	Substandard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Substandard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Substandard 23.3	List of oral interpreters is available for non-English speakers.
	Substandard 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.)
	Substandard 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.)
	Substandard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Substandard 24.2	Provider network database contains required information for ADA compliance.
	Substandard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Substandard 24.4	BH-MCO is able to access interpreter services.
	Substandard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Substandard 24.6	BH-MCO can make alternate formats available upon request.
	Substandard 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.
	Substandard 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.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
Confidentiality Title 42 CFR § 438.224	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Coordination and continuity of care Title 42 CFR § 438.208	Substandard 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.
	Substandard 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.
Coverage and	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical

BBA Category	PEPS Reference	PEPS Language
authorization of services Title 42 CFR Parts § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114		necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 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.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Substandard 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 DHS 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).
Health information systems Title 42 CFR § 438.242	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Practice guidelines Title 42 CFR § 438.236	Substandard 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.
	Substandard 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.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
Provider selection Title 42 CFR § 438.214	Substandard 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.
	Substandard 10.2	100% of decisions made within 180 days of receipt of application.
	Substandard 10.3	Recredentialing incorporates results of provider profiling.
Subcontractual relationships and delegation Title 42 CFR § 438.230	Substandard 99.1	The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning.
	Substandard 99.2	The BH-MCO reports monitoring results for adverse incidents.
	Substandard 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.
	Substandard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Substandard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.

BBA Category	PEPS Reference	PEPS Language
	Substandard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Substandard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Substandard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
Quality assessment and performance improvement program Title 42 CFR § 438.330	Substandard 91.1	The QM Program Description clearly outlines the BH-MCO QM structure.
	Substandard 91.2	The QM Program Description clearly outlines the BH-MCO QM content.
	Substandard 91.3	The QM Program Description includes the following basic elements: Performance improvement projects Collection and submission of performance measurement data Mechanisms to detect underutilization and overutilization of services Emphasis on, but not limited to, high volume/high-risk services and treatment, such as Behavioral Health Rehabilitation Services Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs.
	Substandard 91.4	The QM Work Plan includes: Objective Aspect of care/service Scope of activity Frequency Data source Sample size Responsible person Specific, measurable, attainable, realistic and timely performance goals, as applicable.
	Substandard 91.5	The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).
	Substandard 91.6	The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.
	Substandard 91.7	The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members: Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates Appropriateness of service authorizations and inter-rater reliability Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction.
	Substandard 91.8	The QM Work Plan includes a provider profiling process.
	Substandard 91.9	The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services: Telephone access and responsiveness rates Overall utilization patterns and trends including BHRS and other high volume/high risk services.
	Substandard 91.10	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.
	Substandard 91.11	The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.
	Substandard 91.12	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 Evaluation
	Substandard 91.13	The identified performance improvement projects must include the following: Measurement of performance using objective quality indicators Implementation of system interventions to achieve improvement in quality

BBA Category	PEPS Reference	PEPS Language
		Evaluation of the effectiveness of the interventions Planning and initiation of activities for increasing or sustaining improvement Timeline for reporting status and results of each project to the Department of Human Services (DHS) 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
	Substandard 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.
	Substandard 91.15	The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
	Substandard 98.1	The BH-MCO reports monitoring results for telephone access standard and responsiveness rates. Standard: Abandonment rate
	Substandard 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. BH-MCO takes action to correct utilization problems, including patterns of over- and under-utilization.
	Substandard 98.3	The BH-MCO reports monitoring results for coordination with other service agencies and schools.
	Substandard 104.1	The BH-MCO must measure and report its performance using standard measures required by DHS.
	Substandard 104.2	The BH MCO must submit data to DHS, as specified by 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.
	Substandard 104.3	Performance Improvement Plans status reported within the established time frames.
	Substandard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly PEPS Reports
Grievance and appeal systems Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	Substandard 68.1	Interview with Complaint Coordinator(s) demonstrate a clear understanding of the Complaint process including how Member rights and Complaint procedures are made known to Members, BH-MCO staff and the provider network. • 1st level • 2nd level • External • Expedited • Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.

BBA Category	PEPS Reference	PEPS Language
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and 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 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 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: • Internal • External • Expedited • Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Substandard 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 DHS 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. Note that, in 2019, two contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

Table B.1: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Care Management		
Care Management (CM) Staffing	Substandard 27.7	Other: Significant onsite review findings related to Standard 27.
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	Other: Significant onsite review findings related to Standard 28.
Complaints and Grievances		
Complaints	Substandard 68.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including, but not limited to: the Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
	Substandard 68.1.2	Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints.
	Substandard 68.5	A verbatim transcript and/or recording of the second level Complaint review meeting is maintained to demonstrate appropriate representation, adherence to the Complaint review meeting process, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Substandard 68.6	Sign-in sheets are included for each Complaint review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
	Substandard 68.8	Complaint case files include Member and provider contacts related to the Complaint case, investigation notes and evidence, Complaint review summary and identification of all review committee participants, including name, affiliation, job title and role.
Grievances	Substandard 71.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
	Substandard 71.1.2	Training rosters and training curriculums identify that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.
	Substandard 71.5	A verbatim transcript and/or recording of the Grievance review meeting is maintained to demonstrate appropriate representation, adherence to the Grievance review meeting process, familiarity with

Category	PEPS Reference	PEPS Language
		the issues being discussed and that input was provided from all panel members.
	Substandard 71.6	Sign-in sheets are included for each Grievance review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
	Substandard 71.8	Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role.
Denials		
Denials	Substandard 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	Substandard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Substandard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/Family Satisfaction	Substandard 108.3	County's/BH-MCO's role of fiduciary (if applicable) is clearly defined, and provides supportive function as defined in the C/FST Contract, as opposed to directing the program.
	Substandard 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.
	Substandard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling, and have resulted in provider action to address issues identified.

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In 2019 (RY 2018), two contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In RY 2021, 18 OMHSAS-specific substandards were evaluated for BHO and most of its contractors, with the exception of Greene County, which was evaluated on 17 substandards. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in 2021, along with the relevant categories.

Table C.1: Tally of OMHSAS-Specific Substandards Reviewed for BHO

	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
Category (PEPS Standard)	**Total**	**NR**	**RY 2021**	**RY 2020**	**RY 2019**
Care Management					
Care Management (CM) Staffing	1	0	0	1	0
Longitudinal Care Management (and Care Management Record Review)	1	0	0	1	0
Complaints and Grievances					
Complaints	5	0	0	5	0
Grievances	5	0	0	5	0
Denials					
Denials	1	0	1	0	0
Executive Management					
County Executive Management	1	0	0	1	0
BH-MCO Executive Management	1	0	0	1	0
Enrollee Satisfaction					
Consumer/Family Satisfaction	3	0	3	0	0
Total	**18**	**0**	**4**	**14**	**0**

[1] The total number of OMHSAS-specific substandards required for the evaluation of Primary Contractor/BH-MCO compliance with OMHSAS standards. Any PEPS substandards not reviewed indicate substandards that were deemed not applicable to the Primary Contractor/BH-MCO.

[2] The number of OMHSAS-specific substandards that came under active review during the cycle specific to the review year.

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; BHO: Beacon Health Options of Pennsylvania; RY: review year; NR: substandards not reviewed.

Format

This document groups the monitoring standards under the subject headings Care Management, 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 Primary Contractor/BH-MCO's compliance with selected ongoing OMHSAS-specific monitoring standards.

Findings

Care Management

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

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Substandard 27.7	2020	-	All BHO Primary Contractors	-
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	2020	All BHO Primary Contractors	-	-

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; BHO: Beacon Health Options of Pennsylvania.

All Primary Contractors associated with BHO were partially compliant with Substandard 7 of PEPS Standard 27 (RY 2020).

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

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

Complaints and Grievances

The OMHSAS-specific PEPS substandards relating to second-level complaints and grievances include MCO-specific and county-specific review standards. BHO and its Primary Contractors were evaluated on 10 of the 10 applicable substandards. Of the 10 substandards evaluated, BHO partially met 3 substandards as indicated in **Table C.3.**

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Complaints and Grievances					
Complaints	Substandard 68.1.1	2020	Crawford/Mercer/Venango, Fayette, Greene, Southwest Six	Beaver	
	Substandard 68.1.2	2020	All BHO Primary Contractors		
	Substandard 68.5	2020	All BHO Primary Contractors		
	Substandard 68.6	2020		All BHO Primary Contractors	
	Substandard 68.8	2020	All BHO Primary Contractors		
Grievances	Substandard 71.1.1	2020	Crawford/Mercer/Venango, Fayette, Greene, Southwest Six	Beaver	
	Substandard 71.1.2	2020	All BHO Primary Contractors		
	Substandard 71.5	2020	All BHO Primary Contractors		
	Substandard 71.6	2020	All BHO Primary Contractors		
	Substandard 71.8	2020	All BHO Primary Contractors		

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; BHO: Beacon Health Options of Pennsylvania.

One Primary Contractor associated with BHO (Beaver) were partially compliant with Substandard 1 of PEPS Standard 68.1 (RY 2020).

Standard 68.1: 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.

Substandard 1: Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including but not limited to: The Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns

All Primary Contractors associated with BHO were partially compliant with Substandard 6 of PEPS Standard 68 (RY 2020).

Standard 68: The Complaint and Fair Hearing processes, procedures and Member rights related to the processes are made known to Members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

Substandard 6: Sign-in sheets are included for each Complaint review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.

One Primary Contractor associated with BHO (Beaver) was partially compliant with Substandard 1 of PEPS Standard 71.1 (RY 2020).

Standard 71.1: The Primary Contractor is responsible for monitoring the Grievance process for compliance with Appendix H and the Program Evaluation Performance Summary (PEPS).

Substandard 1: Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, including but not limited to: The Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.

Denials

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. BHO and its Primary Contractors were 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	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Denials					
Denials	Substandard 72.3	2021	All BHO Primary Contractors	-	-

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; BHO: Beacon Health Options of Pennsylvania.

Executive Management

There are two OMHSAS-specific PEPS substandards relating to Executive Management; the County Executive Management substandard is a county-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. BHO and its Primary Contractors Beaver, Crawford/Mercer/Venango, Fayette, and Southwest Six were evaluated for the County Executive Management. Greene was exempted from review for this substandard. BHO was compliant with County Executive Management. BHO and all its Primary Contractors were evaluated on the BH-MCO Executive Management substandard and were partially compliant. The status for these substandards is presented in **Table C.5**.

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Executive Management					
County Executive Management	Substandard 78.5	2020	Beaver, Crawford/Mercer/Venango, Fayette, Southwest Six	-	-
BH-MCO Executive Management	Substandard 86.3	2020	-	All BHO Primary Contractors	-

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; BHO: Beacon Health Options of Pennsylvania.

All Primary Contractors associated with BHO were partially compliant with Substandard 3 of PEPS Standard 86 (RY 2021).

Standard 86: The appointed Medical Director is a board certified psychiatrist licensed in PA with at least five years experience in mental health and substance abuse. 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
- 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

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

Enrollee Satisfaction

The OMHSAS-specific PEPS substandards relating to Enrollee Satisfaction are county-specific review standards. All three substandards crosswalked to this category were evaluated for the BHO Primary Contractors which were compliant on all three substandards. The status by county for these is presented in **Table C.6**.

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Enrollee Satisfaction					
Consumer/Family Satisfaction	Substandard 108.3	2021	All BHO Primary Contractors	-	-
	Substandard 108.4	2021	All BHO Primary Contractors	-	-
	Substandard 108.9	2021	All BHO Primary Contractors	-	-

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; BHO: Beacon Health Options of Pennsylvania.