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

2020 External Quality Review Report
Community Behavioral Health

FINAL

April 2021

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

ISO
9001:2015
CERTIFIED

Table of Contents

Introduction 4
I: Validation of Performance Improvement Projects 6
Background 6
Validation Methodology 8
II: Validation of Performance Measures 9
Follow-Up After Hospitalization for Mental Illness 9
Readmission Within 30 Days of Inpatient Psychiatric Discharge 23
III: Compliance with Medicaid Managed Care Regulations 27
Methodology 27
Data Sources 27
Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for CBH 28
Determination of Compliance 29
Format 29
Findings 30
IV: Quality Studies 35
Certified Community Behavioral Health Clinics 35
Integrated Community Wellness Centers 39
V: 2019 Opportunities for Improvement – MCO Response 41
Current and Proposed Interventions 41
Quality Improvement Plan for Partial and Non-compliant PEPS Standards 41
Root Cause Analysis and Quality Improvement Plan 44
VI: 2020 Strengths and Opportunities for Improvement 58
Strengths 58
Opportunities for Improvement 58
Performance Measure Matrices 58
VII: Summary of Activities 61
Performance Improvement Projects 61
Performance Measures 61
Medicaid Managed Care Regulations 61
Quality Studies 61
2019 Opportunities for Improvement MCO Response 61
2020 Strengths and Opportunities for Improvement 61
References 62
Appendices 64
Appendix A. Required PEPS Substandards Pertinent to BBA Regulations 64
Appendix B. OMHSAS-Specific PEPS Substandards 71
Appendix C: Program Evaluation Performance Summary: OMHSAS-Specific Substandards for CBH Counties 73

List of Tables and Figures

Table 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (18–64 Years) ... 13
Figure 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years). ... 14
Figure 2.2: CBH Contractor MY 2019 HEDIS FUH Follow-Up Rates (18–64 Years) that are Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (18–64 Years). ... 15
Table 2.2: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (All Ages) ... 16
Figure 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages). ... 17
Figure 2.4: CBH MY 2018 HEDIS FUH Follow-Up Rates (All Ages) that are Significantly Different than HC BH (Statewide) MY 2018 HEDIS FUH Follow-Up Rates (All Ages). ... 18
Table 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (6-17 Years) ... 18
Figure 2.5: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years). ... 19
Figure 2.6: CBH MY 2019 HEDIS FUH Follow-Up Rates (6–17 Years) that are Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (6–17 Years). ... 20
Table 2.4: MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Indicators (All Ages) ... 20
Figure 2.7: MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages). ... 21
Figure 2.8: CBH MY 2019 PA-Specific FUH Follow-Up Rates (All Ages) that are Significantly Different than HC BH (Statewide) MY 2019 PA-Specific FUH Follow-Up Rates (All Ages). ... 22
Table 2.5: MY 2019 REA Readmission Indicators ... 24
Figure 2.9: MY 2019 REA Readmission Rates for CBH. ... 25
Figure 2.10: CBH/Philadelphia County MY 2019 REA Readmission Rates (All Ages) were not Significantly Different than HC BH (Statewide) MY 2019 REA Readmission Rates (All Ages). ... 25
Table 3.1: Tally of Substandards Pertinent to BBA Regulations Reviewed for CBH ... 29
Table 3.2: Compliance with Standards, including Enrollee Rights and Protections ... 30
Table 3.3: Compliance with Quality Assessment and Performance Improvement Program ... 32
Table 3.4: Compliance with Grievance System ... 33
Table 4.1: CCBHC Quality Performance Compared to Statewide and National Benchmarks ... 36
Figure 4.1: Comparison of CCBHC to Control Clinics on Adult Patient Experience of Care ... 38
Figure 4.2: Comparison of CCBHC to Control Clinics on Child Patient Experience of Care ... 38
Table 4.2: ICWC Annual and Quarterly Quality Measures ... 39
Table 5.1: CBH Responses to Opportunities for Improvement ... 42
Table 5.2: CBH RCA and CAP for the FUH 7–Day Measure (All Ages) ... 45
Table 5.3: CBH RCA and CAP for the FUH 30–Day Measure (All Ages) ... 52
Table 6.1: BH-MCO Performance Matrix for MY 2019 PA-Specific 7- and 30-Day Follow-Up After Hospitalization and MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge (All Ages) ... 59
Table 6.2: MY 2019 PA-Specific 7- and 30-Day Follow-Up After Hospitalization and MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge Rates, Compared Year-over-Year and to HC BH Statewide (All Ages) ... 59
Table 6.3: BH-MCO Performance Matrix for MY 2019 HEDIS FUH 7- and 30-Day Follow-Up After Hospitalization (All Ages) ... 60
Table 6.4: BH-MCO's MY 2019 FUH Rates Compared to the Corresponding MY 2019 HEDIS 75th Percentiles (All Ages) .. 60
Table A.1: Required PEPS Substandards Pertinent to BBA Regulations ... 64
Table B.1: OMHSAS-Specific PEPS Substandards ... 71
Table C.1: Tally of OMHSAS-Specific Substandards Reviewed for CBH ... 73
Table C.2: OMHSAS-Specific Requirements Relating to Care Management ... 74
Table C.3: OMHSAS-Specific Requirements Relating to Complaints and Grievances ... 74
Table C.4: OMHSAS-Specific Requirements Relating to Denials ... 76
Table C.5: OMHSAS-Specific Requirements Relating to Executive Management ... 76
Table C.6: OMHSAS-Specific Requirements Relating to Enrollee Satisfaction ... 76

Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA). The HEDIS Compliance Audit™ is a trademark of the NCQA. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). Tableau® is a registered trademark of Tableau Software.

Introduction

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients.

OMHSAS contracted with Island Peer Review Organization (IPRO) as its EQRO to conduct the 2020 EQRs for HC BH-MCOs and to prepare the technical reports. The subject of this report is one HC BH-MCO: Community Behavioral Health (CBH). Subsequent references to MCO in this report refer specifically to this HC BH-MCO.

Overview

HealthChoices (HC) Behavioral Health (BH) is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program. In such cases, the Department 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 behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Forty-three (43) of the 67 counties have signed agreements using the right of first opportunity and have subcontracted with a BH-MCO. Twenty-four (24) counties have elected not to enter into a capitated agreement and, as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties.

In the interest of operational efficiency, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the Primary Contractors while providing an oversight function of the BH-MCOs. In some cases the HealthChoices Oversight Entity is the Primary Contractor and, in other cases, multiple Primary Contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. In the CBH managed care network, the City of Philadelphia and Philadelphia County share a common border. As such, the City of Philadelphia is the HealthChoices Oversight Entity and the Primary Contractor that holds an agreement with CBH. CBH is a county-operated BH-MCO. Members enrolled in the HC BH Program in Philadelphia County are assigned CBH as their BH-MCO.

Objectives

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

- review to determine plan compliance with structure and operations standards established by the State (42 CFR 438.358),
- validation of performance improvement projects, and
- validation of MCO performance measures.

Report Structure

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[1] this technical report includes seven core sections:

I. Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Review of Compliance with Medicaid Managed Care Regulations
IV. Quality Studies
V. 2019 Opportunities for Improvement – MCO Response
VI. 2020 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the MCO, Information for Sections II and III of this report is derived from IPRO's validation of the MCO's performance improvement projects (PIPs) and performance measure (PM) submissions. The PM validation, as conducted by IPRO, included a repeated measurement of two PMs: 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 the Commonwealth's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable. Section IV discusses the Quality Study for the Certified Community Behavioral Health Clinic federal demonstration and the Integrated Community Wellness Centers (ICWC) program. Section V, 2019 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2019 (MY 2018) EQR Technical Report and presents the degree to which the MCO addressed each opportunity for improvement. Section VI includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2019), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH Quality Performance of the MCO. Lastly, Section VII provides a summary of EQR activities for the MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

Supplemental Materials

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

- the MCO's BBA Report for MY 2019, and
- All attachments or embedded objects within MCO Responses to Opportunities for Improvement (as identified in the MCO's 2019 BBA Report).

I: Validation of Performance Improvement Projects

In accordance with current BBA regulations, IPRO validates at least one performance improvement project (PIP) for the MCO. Under the existing HC BH agreement with OMHSAS, Primary Contractors, along with the responsible subcontracted entities (i.e., MCOs), are required to conduct a minimum of two focused studies per year. The Primary Contractors and MCOs are required to implement improvement actions and to conduct follow-up, including, but not limited to, subsequent studies or re-measurement of previous studies in order to demonstrate improvement or the need for further action.

Background

CY 2019 saw the winding down of one PIP project and the formation of a new project. MCOs submitted their final reports for the EQR PIP topic "Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis." The results of IPRO's validation of the complete project were reported in the 2019 BBA reports.

In 2019, OMHSAS directed IPRO to complete a preliminary study of substance use disorders (SUD) in the Commonwealth preliminary to selection of a new PIP topic. As a result, OMHSAS selected the topic, "Successful Prevention, Early Detection, Treatment, and Recovery (SPEDTAR) for Substance Use Disorders" as a PIP for all BH-MCOs in the State. The PIP will extend from 2021 through 2023, including a final report due in 2024. While the topic will be common to Primary Contractors and BH-MCOs, each project will be developed as a collaboration and discussion between Primary Contractors and their contracted BH-MCOs. Primary Contractors and BH-MCOs were directed to begin conducting independent analyses of their data and partnering to develop relevant PMs and interventions. BH-MCOs will be responsible for coordinating, implementing, and reporting the project.

The Aim Statement for this PIP, reflecting an emphasis on reducing racial and ethnic health disparities, is: "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 selected 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 and/or other SUD;
2. Improve retention in treatment for members with an opioid and/or other SUD diagnosis;
3. Increase concurrent use of drug and alcohol counseling in conjunction with Pharmacotherapy (Medication-Assisted Treatment); 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 PMs for the SPEDTAR 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."[2] 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 proposes to require 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. The measure will measure 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, as defined by the PA-specific FUH measure, 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 as well as 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."[3] 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 to IPRO results 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. Final baseline results will be run for the performance indicators in Summer 2021 and PIP interventions recalibrated as needed.

The report marks the 17th EQR review to include validation of PIPs. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline.

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 SPEDTAR 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.

Validation Methodology

IPRO's validation of PIP activities is consistent with the protocol issued by CMS[4] 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 full, partial, and non-compliance.

II: Validation of Performance Measures

In 2019, OMHSAS and IPRO conducted two EQR studies. Both the Follow-up After Hospitalization for Mental Illness (FUH) and Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were remeasured.

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.

Measurement year (MY) 2002 was the first year follow-up rates were reported. Quality Indicator (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 2019 (MY 2018), 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

The entire eligible population was used for all 25 Primary Contractors participating in the MY 2019 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, 2019;
- A principal ICD-9- or 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, 2019, 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, 2019. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2020 methodology for the Follow-Up After Hospitalization for Mental Illness measure.

HEDIS Follow-Up Indicators

Quality Indicator 1 (QI 1): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge (calculation based on industry standard codes used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner on the date of discharge up to 7 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator 2 (QI 2): Follow-Up After Hospitalization for Mental Illness Within 30 Days After Discharge (calculation based on industry standard codes used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

PA-Specific Follow-Up Indicators

Quality Indicator A (QI A): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge (calculation based on numerator 1 codes and additional PA-specific codes not used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 7 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator B (QI B): Follow-Up After Hospitalization for Mental Illness Within 30 Days after Discharge (calculation based on numerator 1 codes and additional PA-specific codes not used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator Significance

Mental disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. In 2018, 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 serious mental illness in the past year, which corresponds to 4.6% of all U.S. adults.[5] Additionally, patients with schizophrenia or bipolar disorder have elevated rates of preventable medical comorbidities 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.[6] Roughly one-third of adults with serious mental illness (SMI) in any given year did not receive any mental health services, showing a disparity among those with SMI.[7] Further research suggests that more than half of those with SMI did not receive services because they could not afford the cost of care.[8] Cost of care broke down as follows: 60.8% of patients' 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.[9] For these reasons, timely and appropriate treatment for mental illnesses is essential.

It has long been recognized that continuity of care is critical to positive outcome and to prevent long-term deterioration in people with severe and persistent mental illness.[10] As noted in *The State of Health Care Quality Report,*[11] 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.[12] 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.[13] 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.[14]

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long-standing concern of behavioral health care systems, with some researchers having estimated that 40–60% of patients fail to connect with an outpatient clinician.[15] Research has demonstrated that patients who do not have an outpatient appointment after discharge were more likely to be re-hospitalized in the same year than patients who kept at least one outpatient appointment.[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] Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care and is an effective means to control the cost and maximize the quality of mental health services. Additionally, mental illness continues to impact the PA population, including those with substance abuse concerns or substance use disorder (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. While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs for each 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 2019 (MY 2018), 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 2019 also coincided with a more 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 2018 results. These MY 2018 results were reported in the 2019 BBA 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 V**.

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 or 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 (Pennsylvania continued its Medicaid expansion under the Affordable Care Act in 2019). This

interactive reporting provides an important tool for BH-MCOs and their HC Oversight Entities to set performance goals as well 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 2018 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *Z* statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

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

Where:

- $N1$ = Current year (MY 2019) numerator,
- $N2$ = Prior year (MY 2018) numerator,
- $D1$ = Current year (MY 2019) denominator, and
- $D2$ = Prior year (MY 2018) denominator.

The single proportion estimate was then used for estimating the standard error (SE). *Z*-test statistic was obtained by dividing the difference between the proportions by the standard error of the difference. Analysis that uses the *Z* test assumes that the data and their test statistics approximate a normal distribution. To correct for approximation error, the Yates correction for continuity was applied:

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

Where:

- $p1$ = Current year (MY 2019) quality indicator rate, and
- $p2$ = Prior year (MY 2018) 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*-score 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.

Findings

BH-MCO and Primary Contractor Results

The HEDIS follow-up indicators are presented for three age groups: ages 18 to 64, ages 6 and older, and ages 6 to 17. The 6+ years old ("All Ages") results are presented to show the follow-up rates for the overall HEDIS population, and the 6 to 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 6+ years old age groups are compared to the HEDIS 2019 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 to 17 years old age group and 18 to 64 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 2019 results for both the HEDIS 7-day and 30-day follow-up measures for members aged 18 to 64 years old compared to MY 2018.

Table 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (18–64 Years)

MY 2019							MY 2019 Rate Comparison to MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	MY 2018 %	PPD	SSD
QI 1 – HEDIS 7-Day Follow-Up (18–64 Years)								
HC BH (Statewide)	10,935	30,472	**35.9%**	35.3%	36.4%	35.5%	0.4	NO
CBH	1,290	5,613	**23.0%**	21.9%	24.1%	22.0%	1.0	NO
Philadelphia	1,290	5,613	**23.0%**	21.9%	24.1%	22.0%	1.0	NO
QI 2 – HEDIS 30-Day Follow-Up (18–64 Years)								
HC BH (Statewide)	16,997	30,472	**55.8%**	55.2%	56.3%	56.0%	-0.3	NO
CBH	2,109	5,613	**37.6%**	36.3%	38.8%	36.2%	1.4	NO
Philadelphia	2,109	5,613	**37.6%**	36.3%	38.8%	36.2%	1.4	NO

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 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; HC: HealthChoices; BH: behavioral health; CBH: Community Behavioral Health.

For MY 2019, CBH was subcontracted to provide BH services to only one county located in the Southeast region of the Commonwealth – Philadelphia County; therefore, the CBH performance alone provides the BH-MCO performance for Philadelphia County.

Figure 2.1 is a graphical representation of the MY 2019 HEDIS follow-up rates in the 18 to 64 years old population for CBH and its associated Primary Contractor. The orange line represents the MCO average.

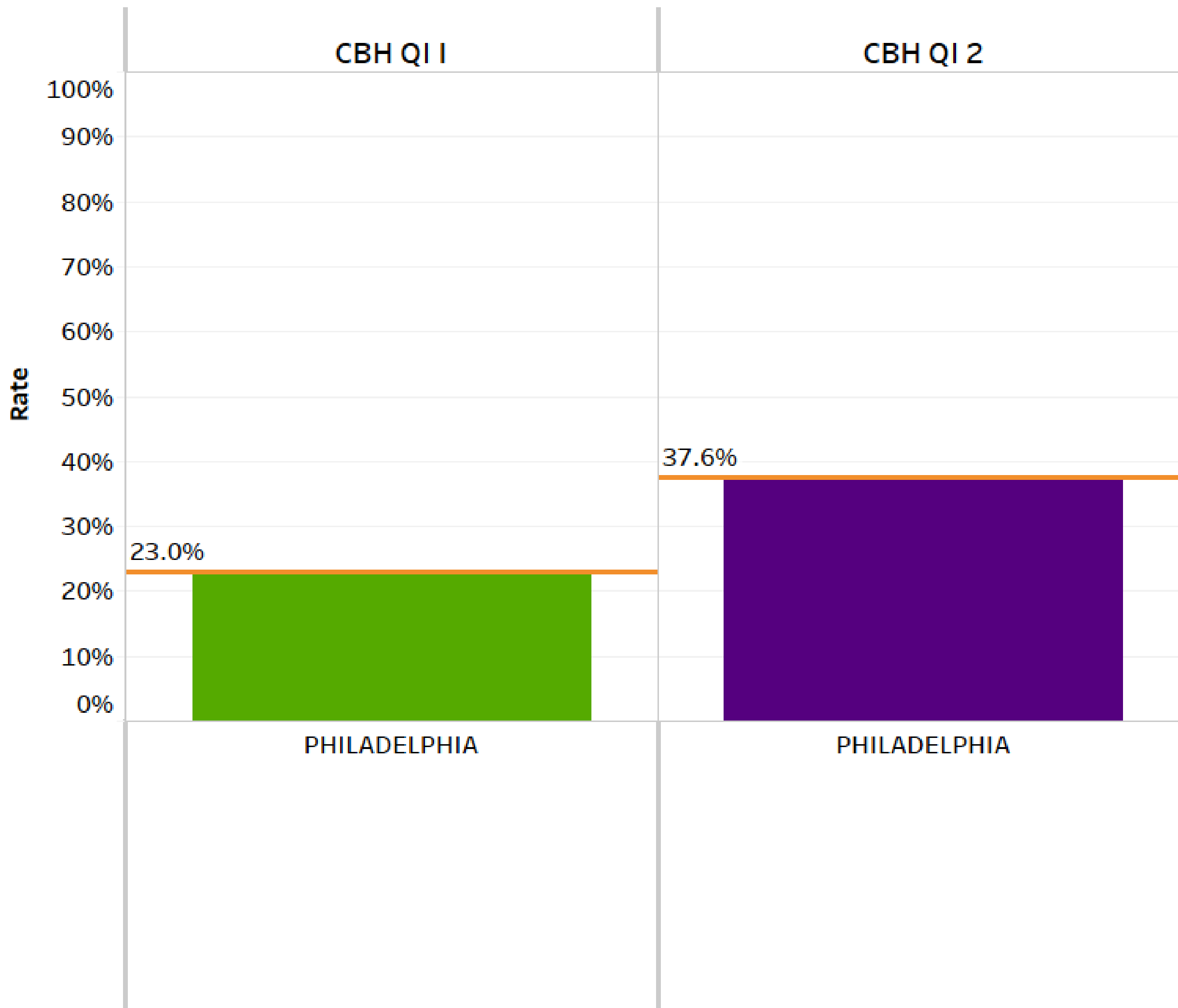

Figure 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years).

Figure 2.2 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.

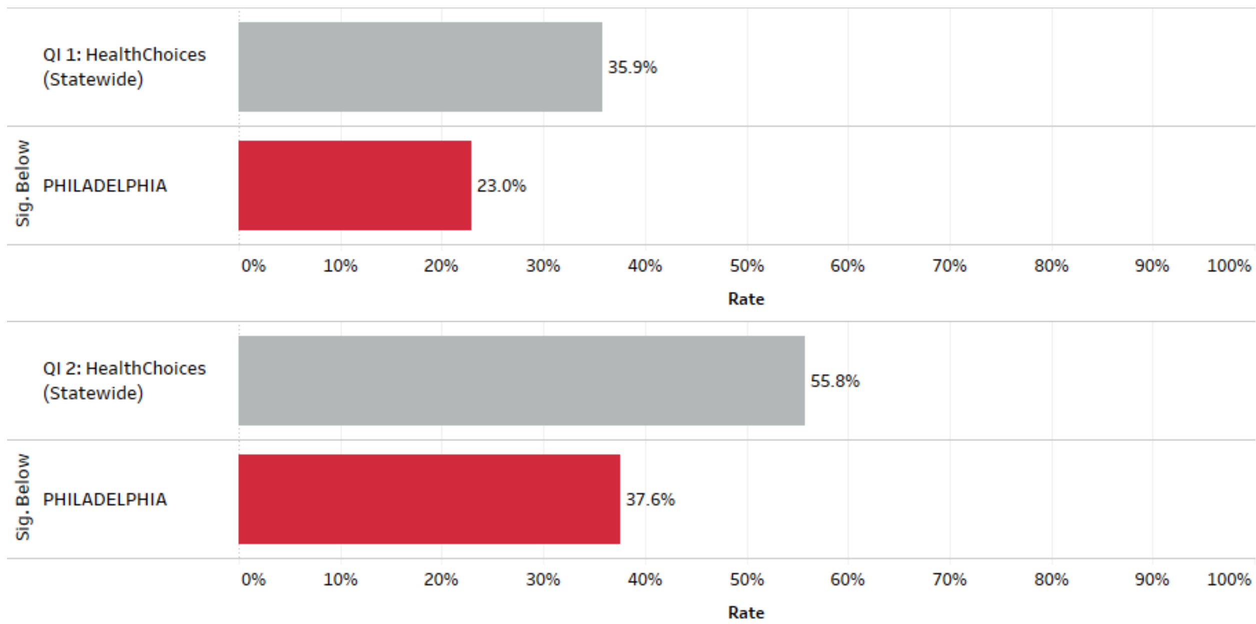

Figure 2.2: CBH Contractor MY 2019 HEDIS FUH Follow-Up Rates (18–64 Years) that are Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (18–64 Years).

(b) Overall Population: 6+ Years Old

The MY 2019 HC Aggregate HEDIS and CBH are shown in **Table 2.2**.

Table 2.2: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (All Ages)

MY 2019						MY 2018 %	MY 2019 Rate Comparison		
				95% CI			To MY 2018		To HEDIS 2019 Percentiles
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	
QI 1 – HEDIS 7-Day Follow-Up (All Ages)									
HC BH (Statewide)	15,843	39,823	**39.8%**	39.3%	40.3%	39.4%	0.4	NO	Below 75th percentile, above 50th percentile
CBH	1,849	6,842	**27.0%**	26.0%	28.1%	26.1%	0.9	NO	Below 25th Percentile
Philadelphia	1,849	6,842	**27.0%**	26.0%	28.1%	26.1%	0.9	NO	Below 25th Percentile
QI 2 – HEDIS 30-Day Follow-Up (All Ages)									
HC BH (Statewide)	24,029	39,823	**60.3%**	59.9%	60.8%	60.2%	0.2	NO	Below 75th percentile, above 50th percentile
CBH	2,867	6,842	**41.9%**	40.7%	43.1%	40.5%	1.4	NO	Below 25th percentile
Philadelphia	2,867	6,842	**41.9%**	40.7%	43.1%	40.5%	1.4	NO	Below 25th percentile

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 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; HC: HealthChoices; BH: behavioral health; CBH: Community Behavioral Health.

Figure 2.3 is a graphical representation of the MY 2019 HEDIS follow-up rates in the overall population for CBH and its associated Primary Contractor. The orange line represents the MCO average.

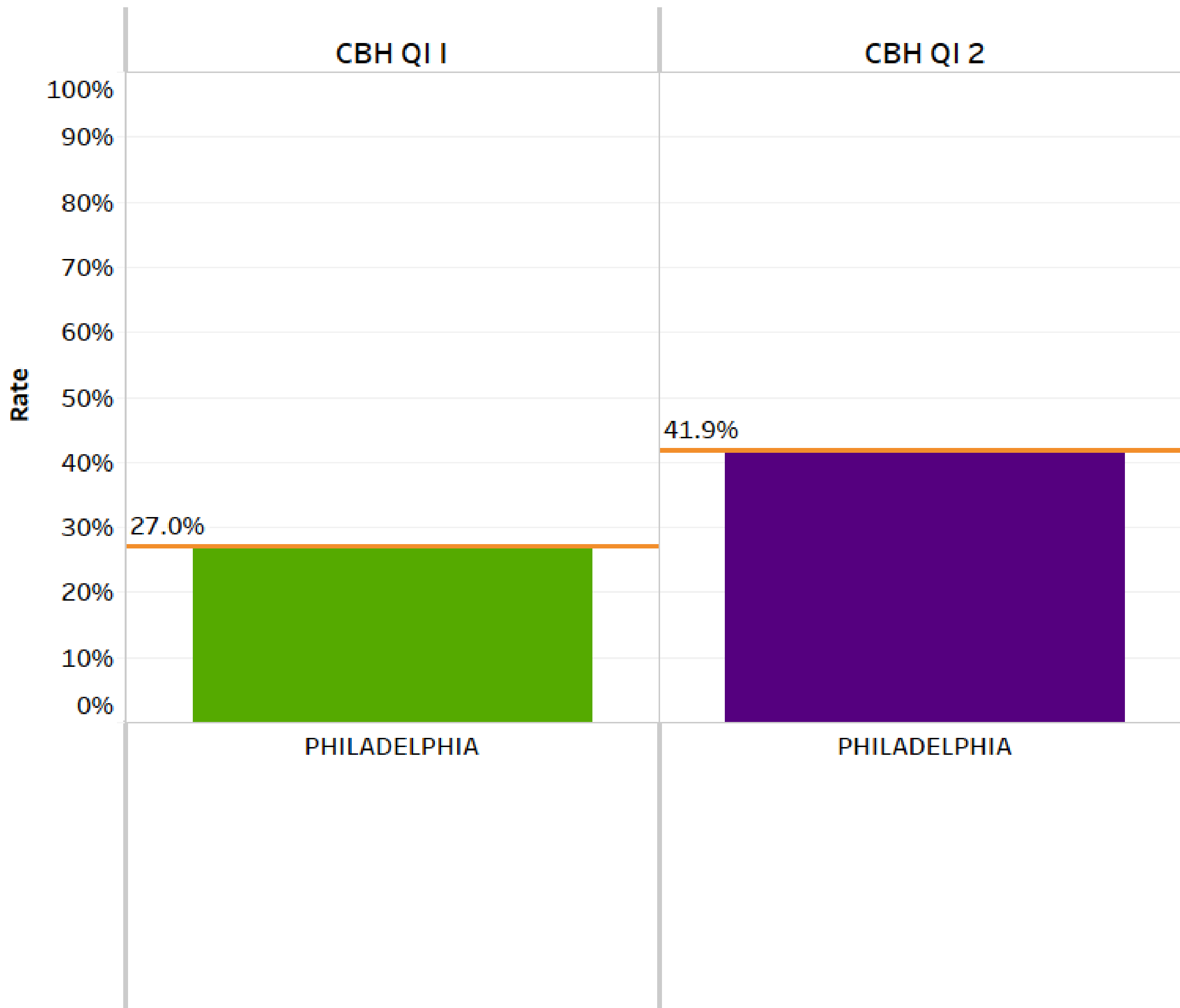

Figure 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages).

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 the statewide benchmark.

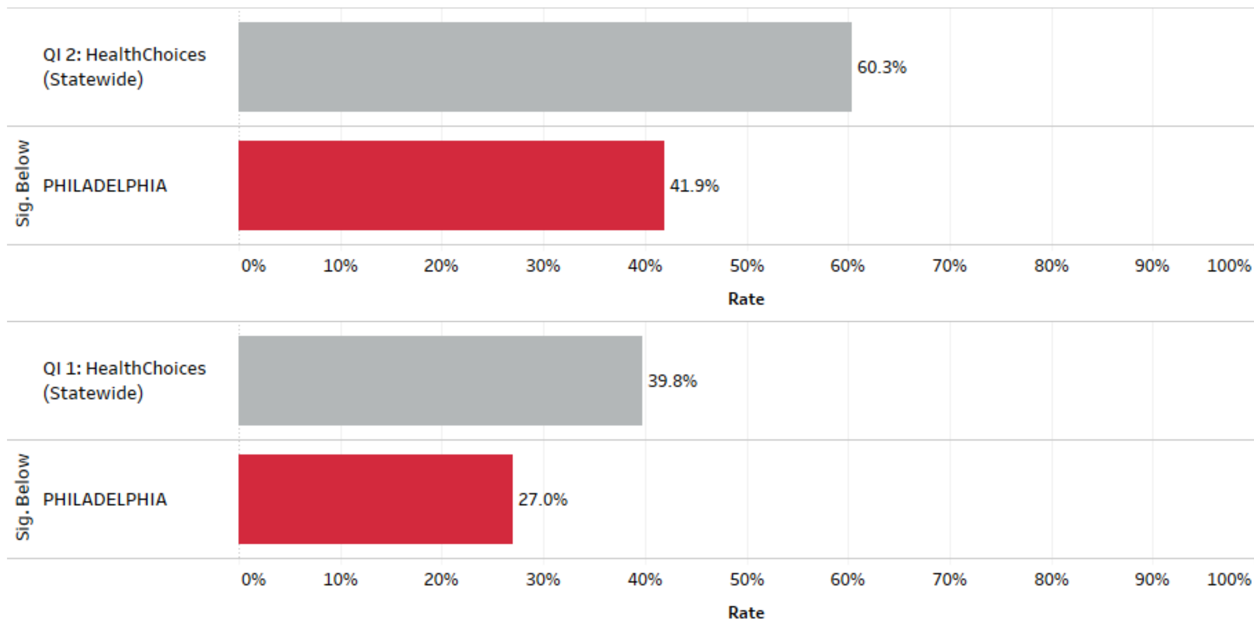

Figure 2.4: CBH MY 2018 HEDIS FUH Follow-Up Rates (All Ages) that are Significantly Different than HC BH (Statewide) MY 2018 HEDIS FUH Follow-Up Rates (All Ages).

(c) Age Group: 6–17 Years Old

Table 2.3 shows the MY 2019 results for both the HEDIS 7-day and 30-day follow-up measures for members aged 6–17 years compared to MY 2018.

Table 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (6-17 Years)

MY 2019						MY 2018	MY 2019 Rate Comparison to MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI 1 – HEDIS 7-Day Follow-Up (6-17 Years)								
HC BH (Statewide)	4,750	8,573	**55.4%**	54.3%	56.5%	55.7%	-0.3	NO
CBH	537	1,049	**51.2%**	48.1%	54.3%	51.5%	-0.3	NO
Philadelphia	537	1,049	**51.2%**	48.1%	54.3%	51.5%	-0.3	NO
QI 2 – HEDIS 30-Day Follow-Up (6-17 Years)								
HealthChoices (Statewide)	6,756	8,573	**78.8%**	77.9%	79.7%	77.7%	1.1	NO
CBH	724	1,049	**69.0%**	66.2%	71.9%	67.4%	1.7	NO
Philadelphia	724	1,049	**69.0%**	66.2%	71.9%	67.4%	1.7	NO

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 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; HC: HealthChoices; BH: behavioral health; CBH: Community Behavioral Health.

Figure 2.5 is a graphical representation of the MY 2019 HEDIS follow-up rates in the 6 to 17 years old population for CBH and its associated Primary Contractor. The orange line represents the MCO average.

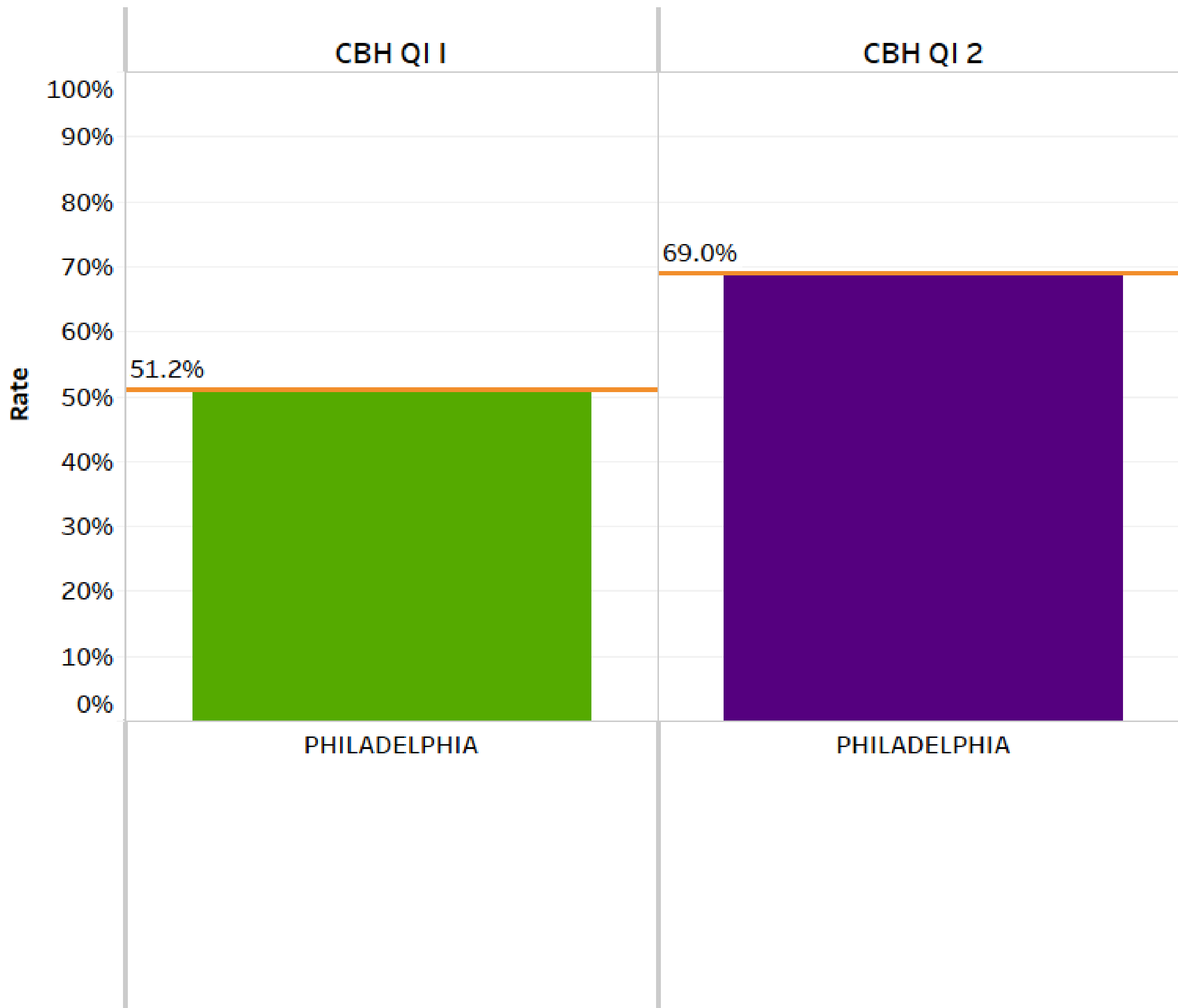

Figure 2.5: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years).

Figure 2.6 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.

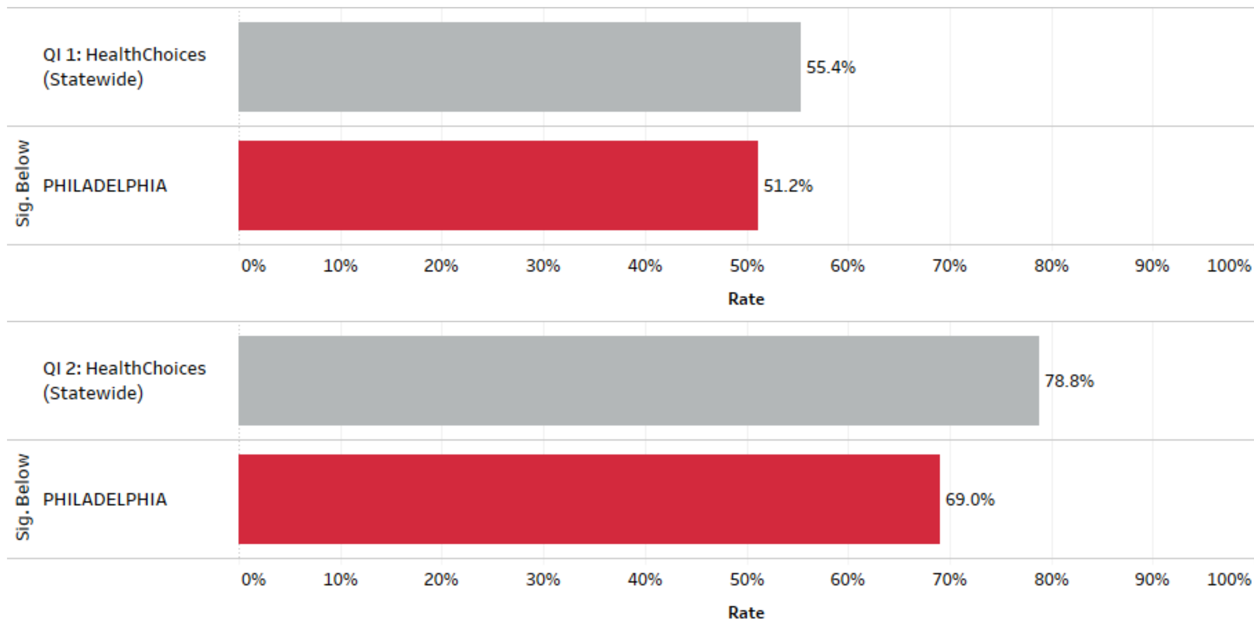

Figure 2.6: CBH MY 2019 HEDIS FUH Follow-Up Rates (6–17 Years) that are Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (6–17 Years).

II: PA-Specific Follow-Up Indicators

(a) Overall Population: 6+ Years Old

Table 2.4 shows the MY 2019 PA-specific FUH 7- and 30-day follow-up indicators compared to MY 2018.

Table 2.4: MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Indicators (All Ages)

MY 2019						MY 2018	MY 2019 Rate Comparison to MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI A – PA-Specific 7-Day Follow-Up (All Ages)								
HC BH (Statewide)	21,098	39,900	**52.9%**	52.4%	53.4%	53.1%	-0.2	NO
CBH	3,248	6,872	**47.3%**	46.1%	48.5%	47.7%	-0.5	NO
Philadelphia	3,248	6,872	**47.3%**	46.1%	48.5%	47.7%	-0.5	NO
QI B – PA-Specific 30-Day Follow-Up (All Ages)								
HC BH (Statewide)	27,741	39,900	**69.5%**	69.1%	70.0%	69.6%	-0.0	NO
CBH	4,215	6,872	**61.3%**	60.2%	62.5%	61.4%	-0.0	NO
Philadelphia	4,215	6,872	**61.3%**	60.2%	62.5%	61.4%	-0.0	NO

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 rates.

MY: measurement year; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; HC: HealthChoices; BH: behavioral health; CBH: Community Behavioral Health.

Figure 2.7 is a graphical representation of the MY 2019 PA-Specific follow-up rates in the overall population for CBH and its associated Primary Contractor. The orange line represents the MCO average.

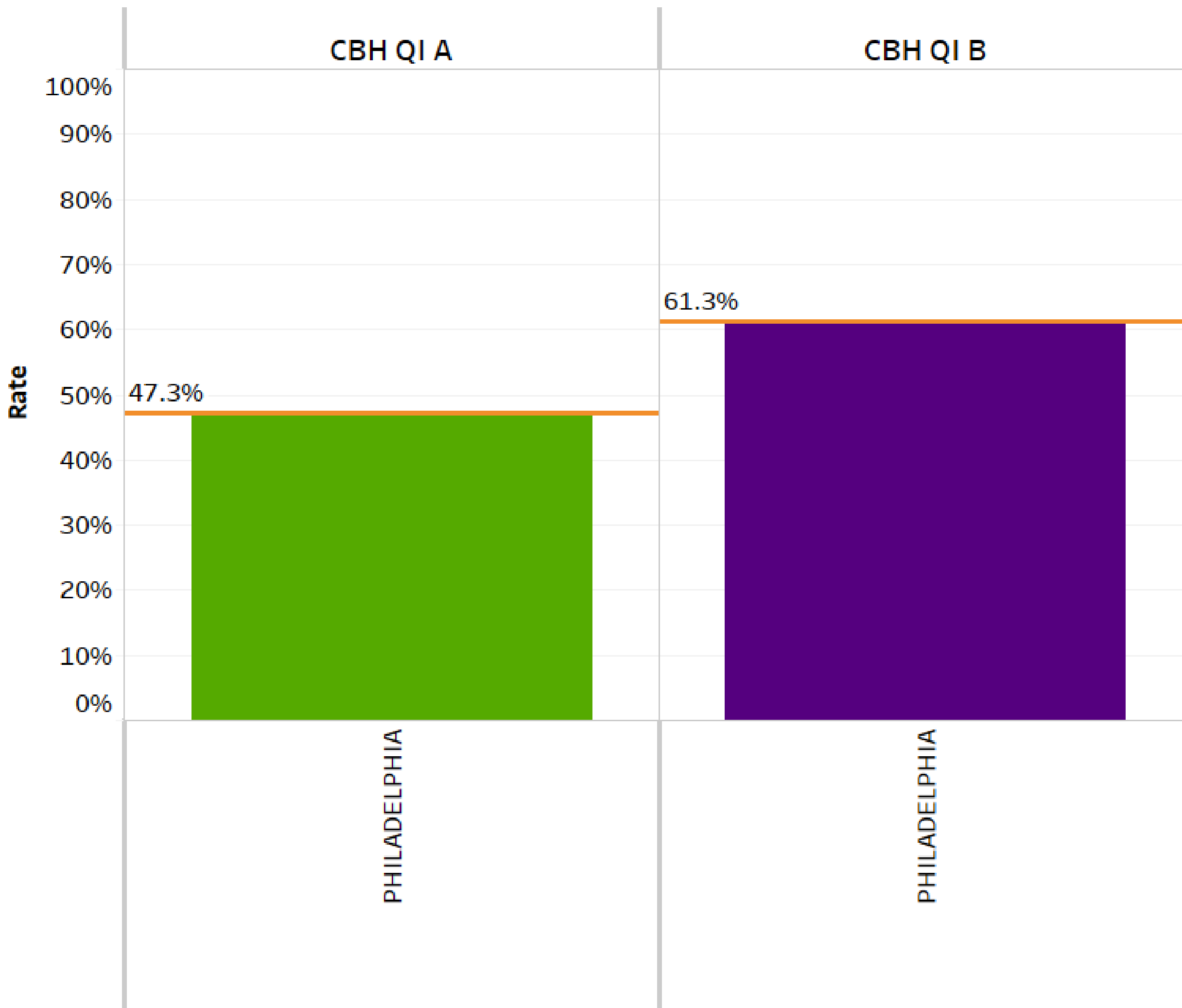

Figure 2.7: MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages).

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.

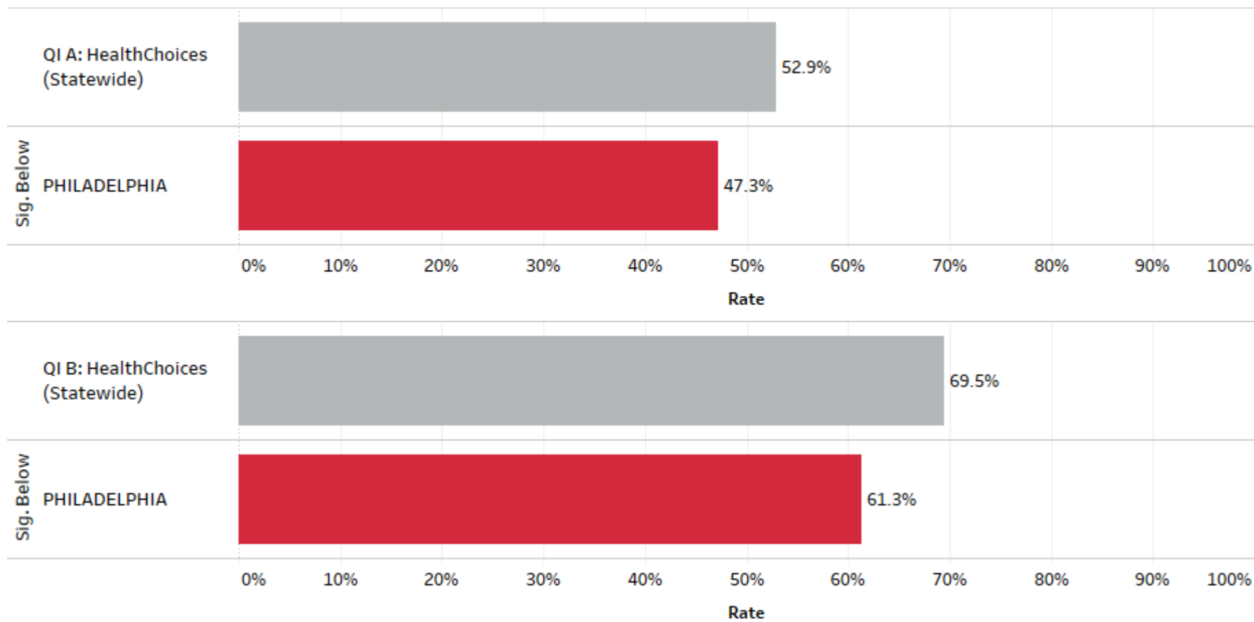

Figure 2.8: CBH MY 2019 PA-Specific FUH Follow-Up Rates (All Ages) that are Significantly Different than HC BH (Statewide) MY 2019 PA-Specific FUH Follow-Up Rates (All Ages).

Conclusion and Recommendations

As with most reporting years, it is important to note that there were some changes to the HEDIS MY 2019 specifications, including revision of the denominator to include members with a principal diagnosis of intentional self-harm. That said, efforts should continue to be made to improve Follow-Up After Hospitalization for Mental Illness performance, particularly for those BH-MCOs that performed below the HC BH Statewide rate. Following are recommendations that are informed by the MY 2019 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 2019, 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 behavioral health 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 behavioral health care follow-up. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. This year's findings indicate that, with some notable Primary Contractor exceptions, FUH rates have, for the most part increased (improved) for the BH-MCO, although overall 7- and 30-day follow-up rates for the MCO remain below the HEDIS Quality Compass 75th percentile. As previously noted, although not enumerated in this report, further stratified comparisons such Medicaid Expansion versus non-Medicaid Expansion were carried out in a separate 2019 (MY 2019) 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. It is recommended that BH-MCOs and Primary Contractors continue to focus interventions on populations that exhibit lower follow-up rates. Further, it is important to examine regional trends in disparities. For instance, previous studies indicate that African Americans in rural areas have disproportionately low follow-up rates, which stands in contrast to the finding that overall follow-up rates are

generally higher in rural areas than in urban areas. Possible reasons for racial-ethnic disparities include access, cultural competency, and community factors; these and other drivers should be evaluated to determine their potential impact on performance. The aforementioned RY 2020 (MY 2019) 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 RY 2020 (MY 2019) FUH Rates Report in conjunction with the corresponding RY 2020 (MY 2019) inpatient psychiatric readmission Rates (REA) Report. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.
- CCBH turned in 7-day follow-up rates that met or exceeded the HEDIS MY 2019 75th percentile. Other BH-MCOs could benefit from drawing lessons or at least general insights from their successes.

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 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 2019 study conducted in 2019 was the 11th 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 measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and a transfer to another acute facility. As with the Follow-Up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH (Statewide) level for MY 2019. 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 behavioral health 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 well 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 25 Primary Contractors participating in the MY 2019 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 1, 2019;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim was clearly identified as a discharge.

The numerator comprised members who were readmitted to inpatient acute psychiatric care within 30 days of the previous inpatient psychiatric discharge.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs. The source for all administrative data was the BH-MCOs' transactional claims systems. The BH-MCOs were given the opportunity for resubmission, as necessary.

Performance Goals

OMHSAS designated the PM goal as better than (i.e., less than) or equal to 10.0% for the participating BH-MCOs and counties. For this measure, lower rates indicate better performance.

Findings

BH-MCO and Primary Contractor Results

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2019 to MY 2018 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 10.0%. Individual BH-MCO and Primary Contractor rates are *not* required to be statistically significantly below 10.0% in order to meet the PM goal (**Table 2.5**).

Table 2.5: MY 2019 REA Readmission Indicators

MY 2019								MY 2019 Rate Comparison To MY 2018	
				95% CI					
Measure	(N)	(D)	%	Lower	Upper	Goal Met?[1]	MY 2018 %	PPD	SSD
Inpatient Readmission									
HC BH (Statewide)	6,803	50,310	**13.5%**	13.2%	13.8%	NO	13.7%	-0.2	NO
CBH	1,207	8,773	**13.8%**	13.0%	14.5%	NO	13.3%	0.4	NO
Philadelphia	1,207	8,773	**13.8%**	13.0%	14.5%	NO	13.3%	0.4	NO

[1]The OMHSAS-designated PM goal is a readmission rate at or below 10%.

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 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; HC: HealthChoices; BH: behavioral health; CBH: Community Behavioral Health.

Figure 2.9 is a graphical representation of the MY 2019 readmission rates for CBH and its associated Primary Contractor. The orange line represents the MCO average.

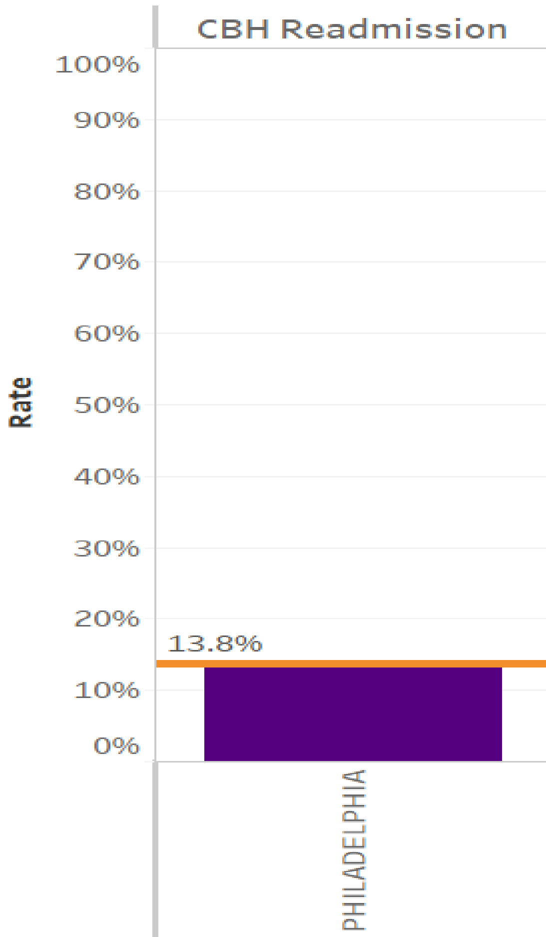

Figure 2.9: MY 2019 REA Readmission Rates for CBH.

Figure 2.10 shows that the Philadelphia County rate of 13.8% was not statistically significantly different from the HC BH (Statewide) rate of 13.5%.

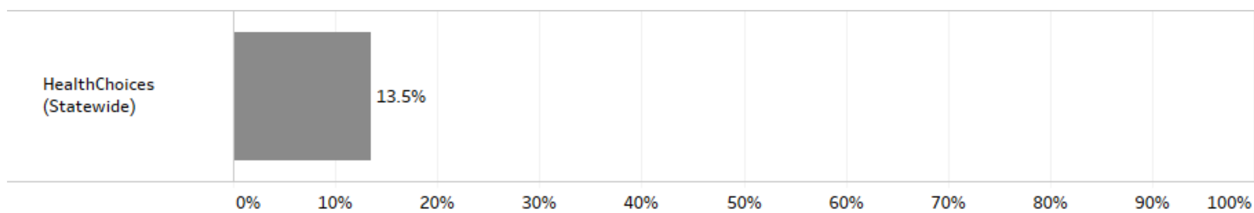

Figure 2.10: CBH/Philadelphia County MY 2019 REA Readmission Rates (All Ages) were not Significantly Different than HC BH (Statewide) MY 2019 REA Readmission Rates (All Ages).

Conclusion and Recommendations

Continued efforts should be made to improve performance with regard to Readmission Within 30 Days of Inpatient Psychiatric Discharge, particularly for those BH-MCOs and Primary Contractors that did not meet the performance goal and/or performed below the HC BH Statewide rate.

MY 2019 saw a continued increase (worsening) for the MCO in readmission rates after psychiatric discharge, which remains above 10%. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the past PIP cycle, the recommendations may assist in future discussions.

In response to the 2019 study, the following general recommendations are applicable to all five participating BH-MCOs:

- 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 2019 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 2019, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. BH-MCOs are expected to sustain meaningful improvement in BH readmission rates going forward as a result of the PIP. 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 RY 2020 (MY 2019) 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 RY 2020 (MY 2019) REA Rates Report in conjunction with the aforementioned RY 2020 (MY 2019) FUH 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.

III: Compliance with Medicaid Managed Care Regulations

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the Medicaid Managed Care (MMC) structure and operations standards. In review year (RY) 2019, 67 Pennsylvania counties participated in this compliance evaluation.

Operational reviews are completed for each HC Oversight Entity. The Primary Contractor, whether contracting with an Oversight Entity 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 BH-MCO's compliance.

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

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CBH by OMHSAS monitoring staff within the past 3 review years (RYs 2019, 2018, and 2017). These evaluations are performed at the BH-MCO and HC Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for 2020. 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 HC Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current 4-year time frame, the Readiness Review substandards were deemed as complete. As necessary, the HC BH Program's PS&Rs are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2019 and entered into the PEPS Application as of March 2020 for RY 2019. 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 HC Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the substandards or items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area in which to collect or capture additional reviewer comments. Based on the PEPS Application, an HC Oversight Entity/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 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,[20] IPRO updated the substandards crosswalk to reflect the changes to the organization and content of the relevant BBA provisions. The CMS updates included updates to the BBA provisions, which are now required for reporting. The standards that are subject to EQR review are contained in 42 C.F.R. 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 2019 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 was correspondingly updated.

From time to time, standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions. 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. In some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). ID numbers for some existing substandard also changed. For this report, in order to distinguish substandards, a parenthetical notation "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its 3-year review (in RY 2020).

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 2019 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 HealthChoices Oversight Entities 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 2019, RY 2018, and RY 2017 provided the information necessary for the 2019 assessment. Those triennial standards not reviewed through the PEPS system in RY 2019 were evaluated on their performance based on RY 2018 and/or RY 2017 determinations, or other supporting documentation, if necessary. For those HC Oversight Entities 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 CBH, a total of 69 unique substandards were applicable for the evaluation of HC Oversight Entity/BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2019, 2018, 2017). 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 HC Oversight Entity against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for CBH

Table 3.1 tallies the PEPs Substandard reviews used to evaluate the HC Oversight Entity/BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2017–2019). Substandard counts under RY 2019 comprised annual and triennial substandards. Substandard counts under RYs 2018 and 2017 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 3.1**, 90, differs from the unique count of substandards that came under active review (69).

Table 3.1: Tally of Substandards Pertinent to BBA Regulations Reviewed for CBH

	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
BBA Regulation	**Total**	**NR**	**2019**	**2018**	**2017**
CMS EQR Protocol 3 "sections": Standards, including enrollee rights and protections					
Assurances of adequate capacity and services	4	2	4		
Availability of Services	22		12	4	6
Confidentiality	1			1	
Coordination and continuity of care	2		2		
Coverage and authorization of services	4		4		
Health information systems	1			1	
Practice guidelines	6		2	4	
Provider selection	2	1			2
Subcontractual relationships and delegation	8			8	
CMS EQR Protocol 3 "sections": Quality assessment and performance improvement (QAPI) program					
Quality assessment and performance improvement program	26		19	7	
CMS EQR Protocol 3 "sections": Grievance system					
Grievance and appeal systems	14		14		
Total	**90**	**2**	**57**	**25**	**8**

[1]The total number of substandards required for the evaluation of HC Oversight Entity/BH-MCO compliance with the BBA regulations. Any PEPS Substandards not reviewed indicate substandards that were deemed not applicable to the HC Oversight Entity/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, 90, differs from the unique count of substandards that came under active review (69).
BBA: Balanced Budget Act; PEPS: Program Evaluation Performance Summary; CBH: Community Behavioral Health.

Determination of Compliance

To evaluate HC Oversight Entity/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 the Commonwealth. If a substandard was not evaluated for a particular HC Oversight Entity/BH-MCO, it was assigned a value of "not determined." Compliance with the BBA provisions was then determined based on the aggregate results across the 3-year period of the PEPS items linked to each provision. If all items were met, the HC Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HC Oversight Entity/BH-MCO was evaluated as partially compliant. If all items were not met, the HC Oversight Entity/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, 42 C.F.R. § 438.207.

Format

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three sections set out in the BBA regulations and described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[21] 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 HC Oversight Entity/BH-MCO's compliance with BBA regulations as an element of the analysis of their strengths and weaknesses. In addition, this level of analysis avoids any redundancy with the detailed level of review found in the PEPS documents.

Findings

Sixty-nine (69) unique PEPS Substandards were used to evaluate CBH and Philadelphia County compliance with BBA regulations in RY 2019.

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 3.2** presents the MCO and Primary Contractor substandard findings by categories.

Table 3.2: 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 42 C.F.R. § 438.207	4	Compliant	Philadelphia	1.1, 1.2, 1.4, 1.5		
Availability of Services 42 C.F.R. § 438.206, 42 C.F.R. § 10(h)	22	Partial	Philadelphia	1.1, 1.2, 1.4, 1.5, 1.7, 23.1, 23.2, 23.3, 23.4, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 28.1, 93.1, 93.2	23.5, 28.2	93.3, 93.4
Confidentiality 42 C.F.R. § 438.224	1	Compliant	Philadelphia	120.1		
Coordination and continuity of care 42 C.F.R. § 438.208	2	Partial	Philadelphia	28.1	28.2	
Coverage and authorization of services 42 C.F.R. Parts § 438.210(a–e), 42 C.F.R. § 441, Subpart B, and § 438.114	4	Partial	Philadelphia	28.1	28.2	72.1, 72.2
Health information systems 42 C.F.R. § 438.242	1	Compliant	Philadelphia	120.1		
Practice guidelines 42 C.F.R. § 438.236	6	Partial	Philadelphia	28.1, 93.1, 93.2	28.2	93.3, 93.4
Provider selection 42 C.F.R. § 438.214	2	Compliant	Philadelphia	10.1, 10.3		
Subcontractual relationships and delegation 42 C.F.R. § 438.230	8	Compliant	Philadelphia	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.

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

For this review, 53 PEPS substandards were crosswalked to categories within Compliance with Standards, including Enrollee Rights and Protections. Fifty (50) substandards were evaluated for Philadelphia County, while 3 substandards (Substandards 1.3, 1.6, and 10.2) were not reviewed for Philadelphia County. Philadelphia County was compliant in 39 instances, partially compliant in five instances, and non-compliant in six 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.

Availability of Services

CBH was partially compliant with Availability of Services due to partial compliance with 1 substandard within Standard 23 (RY 2019), 1 substandard within Standard 28 (RY 2019), and non-compliance with 2 substandards within Standard 93 (RY 2018).

CBH was partially compliant with Substandard 5 of Standard 23.

Standard 23: "BH-MCO shall make services available that ensure effective communication with non-English speaking populations that include: (a) Oral Interpretation services [Interpreters or telephone interpreter services]; (b) Written Translation services, including member handbooks, consumer satisfaction forms, and other vital documents in the member's primary language (for language groups with 5% or more of the total eligible membership]; (c) Telephone answering procedures that provide access for non-English speaking members.

Limited English Proficiency (LEP) Requirements (Section 601 of Title V of the Civil Rights Act of 1964 - 42 U.S.C. Section 200d et seq.) must be met by the BH-MCO. An LEP individual is a person who does not speak English as their primary language, and who has a limited ability to read, write, speak or understand English."

> **Substandard 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.)

CBH was partially compliant with Substandard 2 of Standard 28.

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

> **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.

CBH was non-compliant with Substandards 3 and 4 of Standard 93.

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

> **Substandard 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 4:** The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.

Coordination and Continuity of Care

CBH was partially compliant with Coverage and Authorization of Services due to partial compliance with 1 substandard within Standard 28 (RY 2019).

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

Coverage and Authorization of Services

CBH was partially compliant with Coverage and Authorization of Services due to partial compliance with 1 substandard within Standard 28 (RY 2019), and non-compliance with 2 substandards within Standard 72 (RY 2019).

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

CBH was non-compliant with Substandards 1 and 2 of Standard 72.

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.

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

Practice Guidelines

CBH was partially compliant with Availability of Services due to partial compliance with 1 substandard within Standard 28 (RY 2019) and non-compliance with 2 substandards within Standard 93 (RY 2018).

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

Standard 93: See Standard description and determination of compliance under Availability of Services.

Quality Assessment and Performance Improvement (QAPI) Program

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's MMC Program, the HealthChoices Program, are available and accessible to MCO enrollees. The PEPS documents for each Primary Contractor include an assessment of the Primary Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 3.3** presents the findings by categories consistent with the regulations.

Table 3.3: 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 42 C.F.R. § 438.330	26	Partial	Philadelphia	91.1, 91.2, 91.3, 91.4, 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, 98.1, 98.2, 98.3, 104.1, 104.2, 104.3, 104.4		93.3, 93.4

For this review, 26 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 26 substandards were reviewed for Philadelphia County. Philadelphia County was compliant with 24 substandards and non-compliant with 2 substandards.

Quality Assessment and Performance Improvement Program

CBH was partially compliant with Quality Assessment and Performance Improvement Program due to non-compliance with 2 substandards within Standard 93 (RY 2018).

Standard 93: See Standard description and determination of compliance under Availability of Services.

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 3.4** presents the findings by categories consistent with the regulations.

Table 3.4: 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 42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	14	Partial	Philadelphia	68.1, 68.3, 68.4, 68.7, 71.1, 71.2, 71.3, 71.4, 71.7, 71.9	68.2	68.9, 72.1, 72.2

CFR: Code of Federal Regulations; MCO: managed care organization.

For this review, 14 substandards were crosswalked to Grievance System. All 14 substandards were reviewed for Philadelphia County. Philadelphia County was compliant with 10 substandards, partially compliant with 1 substandard, and non-compliant with 3 substandards.

Grievance and Appeal Systems

CBH was partially compliant with Grievance and Appeal Systems due to partial compliance with 1 substandard within PEPS Standard 68 (RY 2019), non-compliance with 1 substandard within PEPS Standard 68 (RY 2019), and non-compliance with 2 substandards within Standard 72 (RY 2019).

CBH was partially compliant with Substandard 2 of Standard 68.

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 2:** Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.

CBH was non-compliant with Substandard 9 of Standard 68.

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 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.

CBH was non-compliant with Substandards 1 and 2 of Standard 72.

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.

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

IV: Quality Studies

The purpose of this section is to describe quality studies performed in 2019 for the HealthChoices population. The studies are included in this report as optional EQR activities that occurred during the review year.[22]

Certified Community Behavioral Health Clinics

On July 1, 2017, Pennsylvania launched its SAMHSA-funded Certified Community Behavioral Health Clinics (CCBHCs) Demonstration Project ("Demonstration") to run through June 30, 2019. The purpose of the Demonstration is to develop and test an all-inclusive (and all-payer) prospective payment system model for community clinics to integrate behavioral and physical health care services in a more seamless manner. The model is centered on the provision of nine core services. Crisis services, behavioral health 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 CCBHCs. 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. Seven clinics were eventually certified and participated: Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA). In several cases, CCBHC-certified clinics shared agreements with one or more DCOs to supplement the core services provided at the clinic. The counties covered by these clinics span three BH-MCOs: CBH, CCBH, and MBH.

During Demonstration Year (DY) 1, activities focused on continuing to implement and scale up the CCBHC model within the seven clinic sites. Data collection and reporting was a centerpiece of this quality initiative in two important ways. First, the CCBHC Demonstration in Pennsylvania featured a process measure dashboard, hosted by the EQRO through REDCap, whereby clinics were able to monitor progress on the implementation of their CCBHC model. Using the dashboard, clinics tracked and reported on clinical activities in a range of quality domains reflecting the priorities of the initiative: clinic membership, process, access and availability, engagement, evidence-based practices, and client satisfaction. The dashboard provided for each clinic a year-to-date (YTD) comparative display that showed clinic and statewide results on each process measure, as well as average scores for three domains of the satisfaction surveys (see below): convenience of provider location, satisfaction with provider services, and timeliness and availability of appointments. These dashboard results were reported out to a CCBHC Stakeholder Committee at the end of each quarter.

A second important feature of the Demonstration is an assessment, to be completed at its conclusion by the EQRO, to test whether the CCBHC clinics perform significantly better over the demonstration period compared to a control group of clinics located under the same Primary Contractors as the CCBHC clinics. Measurement of performance, in terms of both quality and overall cost, will span multiple areas and scales, involving a variety of administrative sources, medical records, and other sources. Several measures in the CCBHC measure set, including the SRA-A and SRA-BH-C reported directly by clinics (primarily medical record-based), are placed in a quality bonus payment (QBP) program. Throughout the two-year Demonstration, clinics performed a variety of activities to support these reporting objectives. Clinics collected and reported baseline data on quality measures. The EQRO also used SurveyMonkey to support the administration and collection of patient experience of care (PEC) surveys for adults as well as for children and youth (Y/FEC). Finally, clinics collected and reported, on a quarterly basis, consumer-level files documenting various relevant characteristics of their CCBHC consumers, including housing, veteran, and insurance statuses. Throughout the process, OMHSAS and EQRO provided technical assistance focused on data collection, management, and reporting, where much of the focus was on operationalizing the quality and process measures using the clinics' data plans.

Demonstration Year 2 Results

By the end of DY 2 (June 30, 2019), the number of individuals receiving at least one core service surpassed 19,900. Many of those individuals also received some form of EBP: cognitive behavioral therapy (6,907 or 34.7%), trauma-focused interventions (1,081 or 5.4%), medication-assisted treatment (1,049 or 5.3%), parent-child interaction therapy (91 or

0.5%), and wellness recovery action plan (WRAP) (355 or 1.8%). The average number of days until initial evaluation was 5.8 days. In the area of depression screening and follow-up, more than 91% of positive screenings resulted in the documentation of a follow-up plan the same day. More than 3,300 individuals within the CCBHC 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 behavioral health conditions, but the CCBHC Demonstration quality measures are designed to more meaningfully measure the impact of these efforts. **Table 4.1** summarizes how well the CCBHC clinics did on quality measures compared to statewide and national benchmarks. No statistical tests were carried out for these comparisons.

Table 4.1: CCBHC Quality Performance Compared to Statewide and National Benchmarks

Measure	CCBHC Weighted Average	Comparison		
		State Weighted Average	National Average	Description (if National)
Follow-Up Care for Children Prescribed ADHD Medication - Initiation	64.2%		43.4%	HEDIS 2019 Quality Compass 50th percentile
Follow-Up Care for Children Prescribed ADHD Medication - Continuation	74.6%		55.5%	HEDIS 2019 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 day	13.1%		11.4%	HEDIS 2019 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 day	14.8%		17.8%	HEDIS 2019 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Mental Illness - 7 day	100%		37.9%	HEDIS 2019 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Mental Illness - 30 day	100%		54.3%	HEDIS 2019 Quality Compass 50th percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Initiation	15.0%	41.9%		
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Engagement	4.8%	28.4%		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 7 day	127%	35.3%		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 30 day	22.3%	55.7%		
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 7 day	16.7%	55.2%		
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 30 day	29.0%	77.7%		
Antidepressant Medication Management - Acute	52.4%	52.4%		
Antidepressant Medication Management - Continuation	32.7%	35.4%		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	51.0%	78.0%		

Measure	CCBHC Weighted Average	Comparison		
		State Weighted Average	National Average	Description (if National)
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.6%	88.3%		
Plan All-Cause Readmissions Rate (lower is better)	15.5%	12.6%		
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	82%		35.0%	MIPS 2020 (eCQMs)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	82.2%		39.3%	MIPS 2020 (eCQMs)
Screening for Depression and Follow-Up Plan	44.8%		37.0%	MIPS 2020 (eCQMs)
Depression Remission at Twelve Months	7.2%		12.8%	MIPS 2020 (eCQMs)
Body Mass Index (BMI) Screening and Follow-Up Plan	52.1%		47.6%	MIPS 2020 (claims)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	69.8%		79.1%	HEDIS 2019 Quality Compass 50th percentile
Tobacco Use: Screening and Cessation Intervention	63.4%		60.4%	MIPS 2019 (CMS web interface measures)
Unhealthy Alcohol Use: Screening and Brief Counseling	91.6%		68.4%	MIPS 2019 (registry)

CCBHC: Certified Community Behavioral Health Clinics; ADHD: attention deficit/hyperactivity disorder; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; FUH: Follow-Up After Hospitalization for Mental Illness; SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia; MIPS: Merit-Based Incentive Pay System; eCQM: electronic Clinical Quality Measure; SRA: suicide risk assessment; MDD: major depressive disorder; BMI: body mass index; CMS: Centers for Medicare & Medicaid Services; gray-shaded cells: not applicable.

With respect to adult PEC, CCBHC clinics appeared to do about as well as their peer clinics, although no statistical tests were run to compare across all clinics. **Figure 4.1** compares CCBHC clinics to a control group of comparable clinics located under the same Primary Contractor by comparing percentages of adults reporting satisfaction along a variety of domains, as captured by the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey.

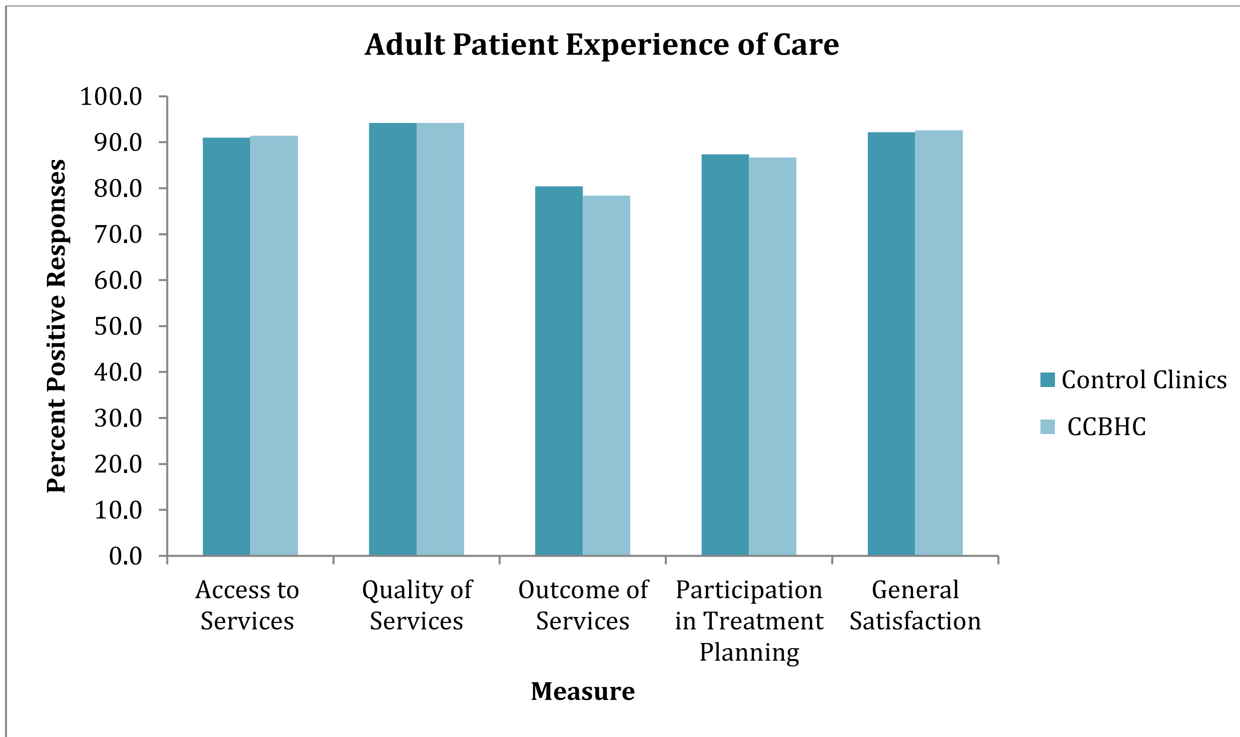

Figure 4.1: Comparison of CCBHC to Control Clinics on Adult Patient Experience of Care

In contrast, as **Figure 4.2** shows, the percentages of children and youth reporting satisfaction with CCBHC services on the Y/FEC survey were, for the most part, higher than the percentages reported for the same domains in control clinics, although a higher percentage of control clinic clients in this age group reported satisfaction with access to services (it was also slightly higher for participation in treatment planning). Once again, these comparisons were not statistically evaluated for this study.

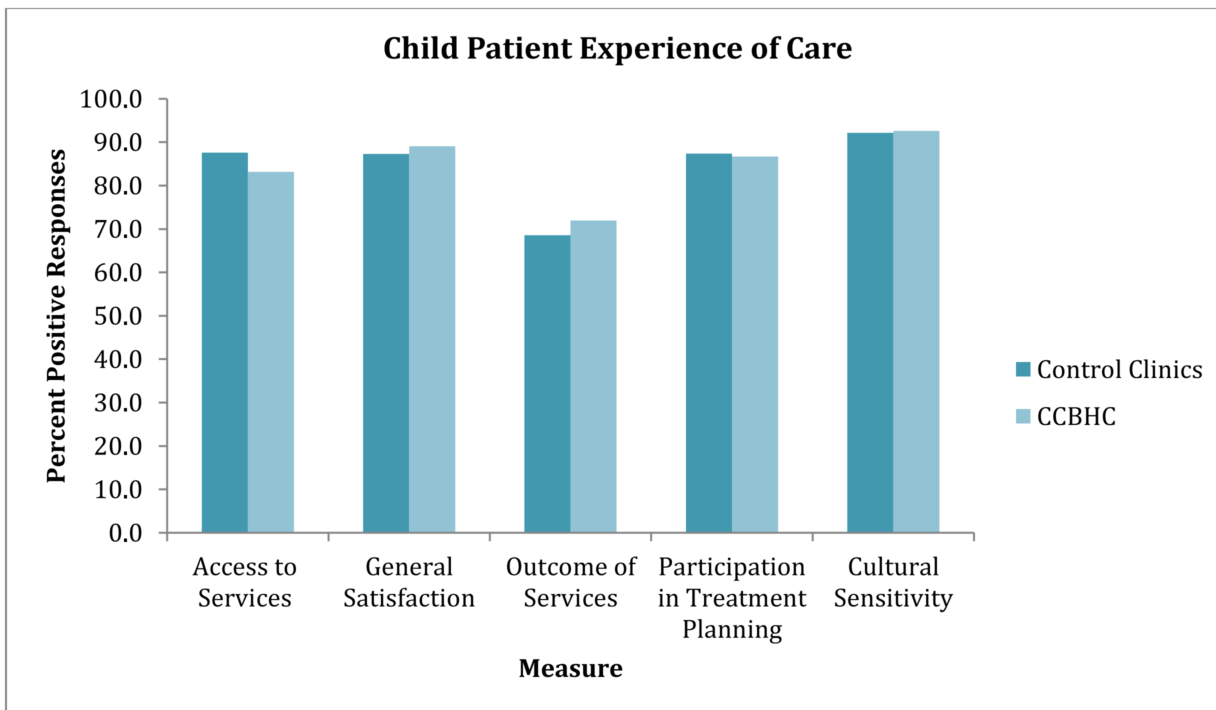

Figure 4.2: Comparison of CCBHC to Control Clinics on Child Patient Experience of Care.

Pennsylvania's CCBHC goal for patient experiences of care is to average a score of 80% or higher (normalized on a Likert scale) for each of three major domains: convenience of provider location, timeliness and availability of appointments, and satisfaction with provider services. When grouping survey items across the three major domains, the DY 2 weighted average results for the three domains meet or surpass the yearly goal for both the PEC (n = 1,705) and Y/FEC surveys (n = 802).

Quality bonus payments (QBP) were also available for six of the quality measures: FUH-A (Adult), FUH-C (Child), IET, SAA, and SRA-A (Adult), and SRA-BH-C (Child). Payments were made based on percentage-point improvement over DY 1. All clinics earned QBP payments in DY 2 for at least some of the measures, with the SRA measures seeing the most sizable improvements and payouts.

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. Under this agreement, the same nine core services of the CCBHC model would be provided under PA's HealthChoices 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 certified to participate in the new program.

In addition, a subset of the CCBHC measures would be reported on to CMS on an annual calendar year basis, along with HEDIS Follow-Up After High Intensity Care for Substance Use Disorder (FUI). The year 2020 was set as the first measurement year for ICWC. **Table 4.2** lists these measures, some of which are to be reported directly by the ICWC clinics, and some by the State, are listed here, along with a set of dashboard ("process") measures, which will be reported to OMHSAS on a quarterly basis.

Table 4.2: ICWC Annual and Quarterly Quality Measures

Statewide Measures
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)
Follow-Up Care for Children Prescribed ADHD Medication (ADD-BH)
Antidepressant Medication Management (AMM-BH)
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET-BH)
Plan All-Cause Readmission Rate (PCR)
Follow-Up After Discharge from the Emergency Department for Mental Health Treatment (FUM)
Follow-Up After Discharge from the Emergency Department (FUA)
Follow-Up After High Intensity Care for Substance Use Disorder (FUI)
Follow-Up After Hospitalization for Mental Illness (Adult) (FUH-BH-A)
Follow-Up After Hospitalization for Mental Illness (Child) FUH-BH-C)
ICWC Measures
Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)
Screening for Clinical Depression and Follow-Up Plan (CDF-BH)
Weight Assessment for Children/Adolescent: Body Mass Index Assessment for Children/Adolescents (WCC-BH)
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)
Depression Remission at 12 Months (DEP-REM-12)

Dashboard Measures
Number of referrals the ICWC make to specialty providers
Number of referrals made for veterans
Number of children (0-17) who receive at least one ICWC service in 12 months.
Number of adults (18+) who receive at least one ICWC service in 12 months
Number of first contacts by ICWC members
Average number of days from contact to initial evaluation
Number of initial screenings of members age 12 to 17 and ≥ 18 years using a validated child depression screening tool with a (+) finding with a follow-up plan documented the same day
Targeted Service delivery services by: Peer support services D & A peer services done by certified recovery specialists Telehealth
Number of unique individuals in D & A outpatient treatment or intensive outpatient treatment

V: 2019 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 2019 EQR Technical Report and in the 2020 (MY 2019) FUH All-Ages Goal Report.

The request for MCO response to the opportunities for improvement related to PEPS deficiencies was distributed in June 2020. The 2020 EQR Technical Report is the 13th 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 Pennsylvania Medicaid BH-MCOs. These activities follow a longitudinal format and are designed to capture information relating to:

- follow-up actions that the BH-MCO has taken through June 30, 2020, to address each recommendation;
- future actions that are planned to address each recommendation;
- when and how future actions will be accomplished;
- the expected outcome or goals of the actions that were taken or will be taken; and
- the BH-MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of the end of 2020, 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 2019 underperformance in the HEDIS FUH All-Ages measures were distributed, along with the MY 2019 results, in January 2021. 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 15, 2021.

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 2018, CBH began to address opportunities for improvement related to compliance categories within the following Subparts: C (Enrollee Rights and Protections Regulations), D (Quality Assessment and Performance Improvement), and F (Federal and State Grievance System Standards Regulations). Within Subpart C, CBH was partially compliant with Enrollee Rights. Within Subpart D, CBH was partially compliant with: 1) Availability of Services (Access to Care), 2) Practice Guidelines, 3) Provider Selection, and 4) Quality Assessment and Performance Improvement Program. CBH was non-compliant with Coordination and Continuity of Care and Coverage and Authorization of Services. Within Subpart F, CBH was partially compliant with: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions. Proposed actions and evidence of actions taken by CBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring CBH into compliance with the relevant Standards.

Table 5.1 presents CBH's responses to opportunities for improvement cited by IPRO in the 2019 EQR Technical Report, detailing current and proposed interventions. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 5.1: CBH Responses to Opportunities for Improvement

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found CBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
CBH 2019.01	Within Subpart C: Enrollee Rights and Protections Regulations, CBH was partially compliant on one out of seven categories – Enrollee Rights.	Ongoing. New hires are trained at time of hire. Existing employees are trained annually.	The most recent training curricula for complaints and grievances are attached.
CBH 2019.02	Within Subpart D: Quality Assessment and Performance Improvement Regulations, CBH was partially compliant with four out of 10 categories and non-compliant with two out of 10 categories. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Provider Selection, 3) Practice Guidelines, 4) Quality Assessment and Performance Improvement Program. The non-compliant categories were: 1) Coordination and Continuity of Care, 2) Coverage and Authorization of Services	July 28, 2020	Most recent bulletin requiring providers to inform CBH when they are not accepting new enrollees was issued on July 28, 2020.
		Ongoing/Annually	Recredentialing status is included in annual provider profiles which are shared with providers.
		November 2019	Denial Notice training for all clinical staff, including Physician Advisors and Psychologists was conducted in November 2019.
		Monthly since March 2017	CBH conducts monthly denial notice audits. The denial audit tool was updated to ensure that the denials are capturing denial rationales and effective dates.
		Quarterly – Ongoing	CBH monitors timeliness of denial notices through a quarterly denials report that is submitted to OMHSAS in the Annual and Quarterly report. The last quarterly report was submitted on August 14, 2020.
		January 1, 2019	The OMHSAS required denial Notice Templates were deployed on January 1, 2019 and are currently in use.
		April 2020	Denial notices that were sent to OMHSAS in April 2020 included attachment (3b) of Appendix AA in the submission.
		June 3, 2019	A simplified word list was shared with Clinical Care Management (CCM) and Medical Affairs (MA) staff to use instead of using medical jargon.
		Ongoing	Denial note templates are reviewed in individual and group supervision.
		Ongoing	Physicians are utilizing the denial note template.
		Annual and Ongoing	CBH aligned its workplan with the PEPS Standards. The workplan was submitted to OMHSAS on March 1, 2020 and resubmitted

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			with the Annual PEPS report on April 30, 2020.
		Annual and Ongoing	CBH completed an annual evaluation of the QM Program to evaluate effectiveness. The annual evaluation was submitted to OMHSAS on April 30, 2020. A summary of the annual evaluation can be found on our website and is attached here.
		March 1, 2020 April 30, 2020	CBH removed reference to the 2nd level grievance from the Quality Management Program Description and work plan. This was not reported on in the RY 2019 annual evaluation that was submitted to OMHSAS on April 30, 2020 and was removed from the QM Program Description and Workplan that was submitted on March 1, 2020.
		Annual and Ongoing	CBH completed a comprehensive member experience survey in December of 2019. The results of the survey were reported in the Annual PEPS Evaluation submitted to OMHSAS on April 30, 2020. The workplan was revised to include the member experience survey as a measurable and specific goal. The workplan was submitted March 1, 2020.
CBH 2019.03	Within Subpart F: Federal and State Grievance System Standards Regulations, CBH was partially compliant with eight out of 10 categories The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.	February, 2018	CBH submitted documents to OMHSAS on February 21, 2018 to meet these standards and were submitted in the previous EQR Opportunity response report. The documents in this folder are the versions currently in use.

CBH: Community Behavioral Health; MCO: managed care organization; RY: reporting year; OMHSAS: Office of Mental Health & Substance Abuse Services; CCM: Clinical Care Management; MA: Medical Affairs; PEPS: Program Evaluation Performance Summary; QM: Quality Management; EQR: external quality review.

Root Cause Analysis and Quality Improvement Plan

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

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

Following several years of underperformance in the key quality indicator areas, OMHSAS determined in 2017 that it was necessary to change the PM remediation process so that BH-MCOs would set goals for the coming year. In 2017, this change meant, among other things, eliminating the requirement to complete root cause analyses (RCAs) and quality improvement plans (QIPs) responding to MY 2015. Instead, BH-MCOs were required to submit member-level files for MY 2016 in the summer of 2017, from which rates were calculated and validated by IPRO. MY 2016 Results of HEDIS Follow-Up After Hospitalization for Mental Illness (7- and 30-day) were then used to determine RCA and QIP assignments.

The change coincided with the coming phase-in of value-based payment (VBP) at the Primary Contractor level in January 2018. Thus, for the first time, RCA and QIP assignments were made at the Contractor level as well as at the BH-MCO level. Contractors receiving assignments completed their RCAs and QIPs in November 2017, while BH-MCOs completed their RCAs and QIPs by December 31, 2017. In 2018, coinciding with the carve-in of long-term care, OMHSAS directed BH-MCOs to begin focusing their RCA and QIP 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 MY 2017 performance, BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and QIPs to achieve their MY 2019 goals. Primary Contractors that scored below the 75th NCQA Quality Compass percentile were also asked to submit RCAs, with the option of submitting a QIP, either through their BH-MCO submission, or separately. BH-MCOs submitted their RCAs and QIPs on April 1, 2019. Primary Contractors submitted their RCAs and QIPs by April 30, 2019. As a result of this shift to a proactive process, MY 2018 goals for FUH All-Ages were never set.

Instead, in late 2020, MY 2019 results were calculated and compared to the MY 2019 goals to determine RCA and QIP assignments, along with goals, for MY 2021. In MY 2019, CBH 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 5.2** presents CBH's submission of its RCA and QIP for the FUH All-Ages 7-day measure, and **Table 5.3** presents CBH's submission of its RCA and QIP for the FUH All-Ages 30-day measure. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 5.2: CBH RCA and CAP for the FUH 7–Day Measure (All Ages)

RCA for MY 2019 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?):

Community Behavioral Health (CBH) analyzed its 7- and 30-day follow-up after hospitalization for mental illness (FUH) HEDIS data for measurement year (MY) 2019 and found no significant differences between racial or ethnic groups. Analyses showed no statistically significant differences in 7- or 30-day follow-up for gender, or primary language spoken, but there was a significant difference for members age 65 and older as compared with members younger than 65. We further analyzed FUH rates for a subset of members younger than 65 years and found a significant difference in follow-up rates for children younger than 18 as compared with adults age 18 and older. The detailed rates are at right.

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:

Analyses of FUH for MY2019 show no statistically significant disparities for race, ethnicity, gender, and primary language spoken, but a significant difference for age:

	7-Day Follow-up			30-Day Follow-up		
Category	**Den**	**Num**	**Rate**	**Den**	**Num**	**Rate**
Total	**3355**	**990**	**29.51%**	**3355**	**1494**	**44.53%**
Age						
65+	107	12	11.21%	107	20	18.69%
<65	3248	978	30.11%	3248	1474	45.38%
6-17			41.28%			59.4%
18+			22.09%			35.97%
Race						
American Indian/Alaska Native	4	0	0.00%	4	0	0.00%
Asian	64	30	46.88%	64	44	68.75%
Black	2108	615	29.17%	2108	929	44.07%
Other	85	30	35.29%	85	41	48.24%
White	753	203	26.96%	753	311	41.30%
Ethnicity						
Hispanic	341	112	32.84%	341	169	49.56%
Gender						
Female	1566	480	30.65%	1566	714	45.59%
Male	1789	510	28.51%	1789	780	43.60%
Primary Language						
English	3268	957	29.28%	3268	1443	44.16%
Laotian	1	0	0.00%	1	0	0.00%
Spanish	69	29	42.03%	69	39	56.52%
Unknown	9	1	11.11%	9	4	44.44%
Ukrainian	3	1	33.33%	3	3	100.00%
Vietnamese	5	2	40.00%	5	5	100.00%

Diagnosis Label	FUH Denom	7Day FUH Num	7Day FUH	30Day FUH Num	30Day FUH
Paranoid Schizophrenia	649	347	53.5%	430	66.3%
Bipolar disorder	546	210	38.5%	291	53.3%
schizoaffective disorders	475	239	50.3%	304	64.0%
Major depressive	422	147	34.8%	227	53.8%

RCA for MY 2019 Underperformance

In addition, CBH analyzed 7- and 30-day follow-up by diagnosis and found significant differences in follow-up rates for members with certain primary and secondary diagnoses. For the top 10 primary diagnoses for members discharged from acute inpatient (AIP), there were significant differences in rates of 7-day FUH for members with a diagnosis of: Bipolar Disorder, Major Depressive Disorder, Unspecified Psychosis, PTSD, and Unspecified Mood Disorder.

disorder, recurring					
unspecified psychosis not due to a substance or known physiological	390	133	34.1%	179	45.9%
Major depressive disorder, single episode	388	135	34.8%	189	48.7%
Persistent mood [affective] disorders	112	57	50.9%	80	71.4%
PTSD	83	24	28.9%	35	42.2%
Conduct disorders	60	35	58.3%	46	76.7%
Unspecified mood [affective] disorder	55	16	29.1%	21	38.2%
ADHD	45	34	75.6%	38	84.4%

For the top 10 secondary diagnoses for members discharged from acute inpatient (AIP), there were significant differences in rates of 7-Day FUH for members with a diagnosis of: opioid related disorders, cannabis related disorders, alcohol related disorders, and personal risk factors not elsewhere classified.

Diagnosis Label	FUH Denom	7Day FUH Num	7Day FUH	30Day FUH Num	30Day FUH
Symptoms and signs involving emotional state	678	289	42.6%	406	59.9%
Opioid related disorders	132	48	36.4%	65	49.2%
Cannabis related disorders	132	45	34.1%	66	50.0%
Cocaine related disorders	116	45	38.8%	58	50.0%
Alcohol related disorders	81	27	33.3%	40	49.4%
Hallucinogen related disorders	73	33	45.2%	42	57.5%
Reaction to severe stress, and adjustment disorders	65	36	55.4%	46	70.8%
Personal risk factors, not elsewhere classified	65	22	33.8%	35	53.8%
Nicotine dependence	56	27	48.2%	34	60.7%
Attention-deficit hyperactivity disorders	53	32	60.4%	42	79.2%

RCA for MY 2019 Underperformance	
CBH also conducted a root-cause analysis (RCA) to identify barriers to and root causes of members not following up within 7 days of AIP discharge. Similarly, CBH requested an RCA and performance improvement plan from AIP providers who did not meet the 7-day FUH goals for MY2019 and 2020. The fishbone diagram outlining the root causes identified by both the internal and provider RCAs can be found at right. CBH then developed an affinity diagram outlining helpers for the top 10 barriers and root causes identified by CBH and providers. The affinity diagram can be found at right. CBH identified existing interventions for each of the root causes and where there are gaps in existing interventions necessary to address root causes. CBH then used a prioritization matrix and multi-voting technique to prioritize the development of new interventions. This prioritization matrix is at right. CBH will move forward with developing any intervention that scored higher than 20 on the prioritization matrix in calendar year (CY) 2021. CBH then used this information to develop the logic model of change for 7-Day FUH for interventions that will be undertaken during CY2021, which can be found at right.	

RCA for MY 2019 Underperformance	
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").***
People (1) *(e.g., personnel, patients)* 1. Member not ready to engage in treatment for Substance Use Disorder (SUD) a. Member not understanding how co-occurring substance use impacts mental health b. Member did not seek AIP treatment for substance use issues	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Members may not be aware of how their co-occurring SUD(s) impact their mental illness. They did not seek treatment for their SUD and so may not be willing to focus on that issue while in AIP. The root cause is that members with co-occurring SUDs are not ready to engage in treatment. ***Current and expected actionability: Actionable***
People (2) *(e.g., personnel, patients)* 2. Member not being educated about their mental illness and need for follow-up/how follow-up can help them a. Lack of member insight b. Part of mental illness – member not able/unwilling to follow discharge plan c. Members sought hospital admission for non-clinical reasons d. Members admitted on a 302 e. Member treatment fatigue	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Members are not following up because they have treatment fatigue. If they were admitted involuntarily on a 302, they may not want or think they need treatment after discharge. Some members may have sought hospital admission for non-clinical reasons such as homelessness. Mental illness may also be interfering with a member's ability or willingness to follow their discharge plan. Member's may not have insight into their mental illness. The root cause of these associated causes is that members aren't sufficiently educated about their mental illness and the need for follow-up treatment and how it can help them. ***Current and expected actionability: Actionable***
People (3) *(e.g., personnel, patients)* 3. Lack of sufficient member education about medications and shared decision-making a. Don't like side effects of medication b. Lack of member insight into their mental illness and how medication will help c. Not understanding LAIs *d.* Members not adherent to medication	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Members are not adherent to their medication after discharge. They may not understand long-acting injectables (LAIs) or they may lack insight into how medication helps their mental illness. They may also not like side effects of the medications. The root cause for these associated causes is insufficient member education about medications or shared decision-making with providers about medications. ***Current and expected actionability: Actionable***
Providers (1) *(e.g. provider facilities, provider network)* 1. OP provider can't bill while person is in hospital/AIP can't bill once person is discharged a. Insufficient value-based Payment (VBP) or pay-for-performance (P4P) incentives b. No financial incentive for care coordination before/after member is discharged c. Lack of communication/coordination between providers/lack of warm hand-off	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat important*** There currently is not reimbursement mechanism for either AIP providers to bill for outreach to member after member has been discharged or OP providers to bill for services while member is still in AIP. VBP and P4P may be insufficient to offset the cost of unreimbursed services. This results in a lack of communication or coordination between providers and a lack of warm hand-off between AIP and OP providers. ***Current and expected actionability: Actionable***

RCA for MY 2019 Underperformance	
Providers (2) *(e.g. provider facilities, provider network)* 2. Culture of only being responsible for person while in the hospital a. AIP doesn't follow-up with member after discharge	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat important*** The AIP may not be following up with the member because there could be a culture that the AIP isn't responsible for the member after discharge. Although CBH can communicate follow-up expectations to AIP provider, it is up to the provider to change the culture of its program.
	Current and expected actionability: Not Actionable
Providers (3) *(e.g. provider facilities, provider network)* 3. Lack of relationships between AIP and OP providers a. Lack of communication between providers to secure appointments b. Discharge information not communicated to OP provider c. OP provider not outreaching to member after follow-up	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Discharge and follow-up appointment information may not be communicated by the AIP provider to the OP provider. The root cause of this is a lack of relationships between AIP and OP providers that would enable them to develop a process of coordinated care and would equip the OP provider with the information needed to outreach to member for follow-up.
	Current and expected actionability: Actionable
Providers (4) *(e.g. provider facilities, provider network)* 4. OP provider capacity/staffing issues – lack capacity, doctor time a. Difficulty of obtaining timely appointments at OP provider b. Member told about walk-in appointments instead of given actual appointment c. Providers double-booking appointments due to no-shows d. Lack of timely OP/doctor appointments	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Members may not be able to follow-up within 7 days because of a lack of timely OP or doctor appointments. This may be due to OP providers double booking appointments to account for no-shows. The member is told by the AIP to go to a walk-in appointment instead of being given an actual appointment, which leaves it up to the member to decide when to go to the OP provider for the follow-up appointment. This may be due to the difficulty of AIP providers to secure a timely OP appointment for the member. The root cause of this is OP provider capacity due to staffing issues and lack of sufficient doctor time.
	Current and expected actionability: Actionable
Providers (5) *(e.g. provider facilities, provider network)* 5. Poor prescribing practices a. Poor assessment leading to inappropriate pharmacotherapy b. Lack of timely pre-authorizations c. Provider not considering side effects of medication d. Member not adhering to medication	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** In addition to causes of member non-adherence to medication are provider causes. Providers may not be considering side-effects of medication when prescribing them for the member. There may be a lack of timely pre-authorization of the prescription which leads to the member being unable to fill the prescription in a timely manner. There may also be poor assessment of the member by the AIP which leads to inappropriate pharmacotherapy for the member.
	Current and expected actionability: Actionable
Providers (6) *(e.g. provider facilities, provider network)* 6. AIP providers don't treat co-occurring SUD a. SUD may not have been stabilized during admission/may not have been addressed b. AIPs may not be educating members on need for SUD treatment	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** In addition to causes of co-occurring SUDs that are member-focused, there are provider-focused causes as well. These include AIP providers not educating members on the need for SUD treatment. AIP providers also may not have addressed or stabilized the member's SUD during AIP episode. The root cause of this is that AIP providers not treating co-

RCA for MY 2019 Underperformance	
c. Members have co-occurring SUDs (SUD)	occurring SUD while the member is in the hospital.
	Current and expected actionability: Actionable
Policies/Procedures (1) *(e.g., data systems, delivery systems, payment/reimbursement)* 1. Unclear expectations of what is expected of providers regarding discharge planning and coordination of care a. No adult inpatient standards requiring follow-up appointments within 7 days b. Providers can't find standards that exist c. Lack of communication/coordination of care between AIP and OP providers	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat important*** In addition to the provider-focused causes of the lack of communication and coordination of care between AIP and OP providers are those causes that are due to CBH policies or procedures. Currently, standards for adult AIP providers are released as bulletins, are contained in contracts, or the provider manual. These individual documents may be difficult for providers to find. There are no AIP standards for adult providers that explicitly state the AIP provider's role in ensuring timely follow-up after discharge. The root cause of this is unclear expectations by AIP providers of CBH expectations around ensuring 7-day follow-up.
	Current and expected actionability: Actionable
Policies/Procedures (2) *(e.g., data systems, delivery systems, payment/reimbursement)* 2. Delayed feedback to providers about performance a. Providers unsure of impact of performance improvement efforts	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** AIP Providers may be conducting performance improvement activities but are unsure of the impact of these activities because of delayed feedback on performance from CBH. This makes it more difficult for providers to conduct rapid cycle improvement interventions.
	Current and expected actionability: Actionable
Policies/Procedures (3) *(e.g., data systems, delivery systems, payment/reimbursement)* 3. No OP Performance Standards a. Providers not aware of standards and/or expectations for OP appointments	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important*** Although CBH released a bulletin outlining HealthChoices standards and CBH expectations around OP appointment access, not all OP providers may be aware of the standards or expectations for timely access to OP appointments, especially for members being discharged from AIP.
	Current and expected actionability: Actionable
Provisions/Social Determinants of Health (1) *(e.g., screening tools, medical record forms, transportation)* 1. Member lack of phones/lack of minutes/lack of good contact info a. CBH and providers unable to make contact with member b. Member is transient and does not have consistent, reliable contact information	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** CBH and both AIP and outpatient providers are unable to make contact with the member after discharge from AIP for appointment reminders and to address any barriers to follow-up because the member lacks reliable contact information due to being transient, lacks a cell phone, or lacks minutes on their cell phone will makes them unwilling to answer calls if they are unsure of who is calling them.
	Current and expected actionability: Actionable
Provisions/Social Determinants of Health (2) *(e.g., screening tools, medical record forms, transportation)* 1. AIPs not asking about transportation needs and ensuring access after discharge a. Members not being able to afford cost of transportation b. Don't know how to access Logisticare transportation service c. Stigma – don't want to go to services in	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Members may not be able to keep their follow-up appointment because they don't have access to transportation. This may be due to AIPs not making an appointment for the member that's at a location that's convenient for the member. Alternatively, some members may not want to utilize services in their own neighborhood, but transportation issues to access appointments that are further away are not addressed by the AIP provider. Some members may not know how to access

<table>
<tr><th colspan="2">RCA for MY 2019 Underperformance</th></tr>
<tr><td rowspan="2">their neighborhood
d. OP appointment not at a location that's convenient for member/easy to get to
e. Member doesn't have transportation to follow-up appointment</td><td>Logisticare services. Members who are not aware of Logisticare transportation services may not be able to afford alternative transportation to their appointment. The root cause of this is that the AIP provider isn't assessing transportation needs for the member after discharge and making the connection to transportation resources for the member.</td></tr>
<tr><td>Current and expected actionability: Actionable</td></tr>
<tr><td rowspan="2">Provisions/Social Determinants of Health (3)
(e.g., screening tools, medical record forms, transportation)
1. AIPs not identifying and addressing housing needs in discharge planning and ensuring connection with resources after discharge
a. Members prioritizing housing needs over mental health needs
b. Homelessness leads to unstructured life
c. Not being able to remember and keep appointments
d. Members sought hospital admission for non-clinical reasons related to homelessness
e. Lack of insight (due to mental illness) about living conditions and not willing to get help because of lack of insight – leading to hospitalization</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical
Homelessness and housing instability leads to a variety of conditions that act as barriers to timely follow-up after discharge. Members may prioritize their housing needs over their mental health needs after AIP discharge. Homelessness also leads to an unstructured life, making it more difficult for the member to keep follow-up appointments. Members may also have sought hospital admission for reasons related to their homelessness. Members may also lack insight into how housing instability impacts their mental health.</td></tr>
<tr><td>Current and expected actionability: Actionable</td></tr>
</table>

Table 5.3: CBH RCA and CAP for the FUH 30–Day Measure (All Ages)

RCA for MY 2019 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?):

Community Behavioral Health (CBH) analyzed its 7- and 30-day follow-up after hospitalization for mental illness (FUH) HEDIS data for measurement year (MY) 2019 and found no significant differences between racial or ethnic groups. Analyses showed no statistically significant differences in 7- or 30-day follow-up for race, ethnicity, gender, or primary language spoken, but there was a significant difference for members age 65 and older as compared with members younger than 65. We further analyzed FUH rates for a subset of members younger than 65 years and found a significant difference in follow-up rates for children younger than 18 as compared with adults age 18 and older. The detailed rates are at right.

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:

Analyses of FUH for MY2019 show no statistically significant disparities for race, ethnicity, gender, and primary language spoken, but a significant difference for age:

	7-Day Follow-up			30-Day Follow-up		
Category	**Den**	**Num**	**Rate**	**Den**	**Num**	**Rate**
Total	**3355**	**990**	**29.51%**	**3355**	**1494**	**44.53%**
Age						
65+	107	12	11.21%	107	20	18.69%
<65	3248	978	30.11%	3248	1474	45.38%
6-17			41.28%			59.4%
18+			22.09%			35.97%
Race						
American Indian/Alaska Native	4	0	0.00%	4	0	0.00%
Asian	64	30	46.88%	64	44	68.75%
Black	2108	615	29.17%	2108	929	44.07%
Other	85	30	35.29%	85	41	48.24%
White	753	203	26.96%	753	311	41.30%
Ethnicity						
Hispanic	341	112	32.84%	341	169	49.56%
Gender						
Female	1566	480	30.65%	1566	714	45.59%
Male	1789	510	28.51%	1789	780	43.60%
Primary Language						
English	3268	957	29.28%	3268	1443	44.16%
Laotian	1	0	0.00%	1	0	0.00%
Spanish	69	29	42.03%	69	39	56.52%
Unknown	9	1	11.11%	9	4	44.44%
Ukrainian	3	1	33.33%	3	3	100.00%
Vietnamese	5	2	40.00%	5	5	100.00%

Diagnosis Label	**FUH Denom**	**7Day FUH Num**	**7Day FUH**	**30Day FUH Num**	**30Day FUH**
Paranoid Schizophrenia	649	347	53.5%	430	66.3%
Bipolar disorder	546	210	38.5%	291	53.3%
schizoaffective disorders	475	239	50.3%	304	64.0%
Major depressive	422	147	34.8%	227	53.8%

RCA for MY 2019 Underperformance

In addition, CBH analyzed 7- and 30-day follow-up by diagnosis and found significant differences in follow-up rates for members with certain primary and secondary diagnoses. For the top 10 primary diagnoses for members discharged from acute inpatient (AIP), there were significant differences in rates of 30-day FUH for members with a diagnosis of: Bipolar Disorder, Major Depressive Disorder, Unspecified Psychosis, PTSD, and Unspecified Mood Disorder.

disorder, recurring					
unspecified psychosis not due to a substance or known physiological	390	133	34.1%	179	45.9%
Major depressive disorder, single episode	388	135	34.8%	189	48.7%
Persistent mood [affective] disorders	112	57	50.9%	80	71.4%
PTSD	83	24	28.9%	35	42.2%
Conduct disorders	60	35	58.3%	46	76.7%
Unspecified mood [affective] disorder	55	16	29.1%	21	38.2%
ADHD	45	34	75.6%	38	84.4%

For the top 10 secondary diagnoses for members discharged from AIP, there were significant differences in rates of 30-Day FUH for members with a diagnosis of: opioid related disorders, cannabis related disorders, alcohol related disorders, and personal risk factors not elsewhere classified.

Diagnosis Label	FUH Denom	7Day FUH Num	7Day FUH	30Day FUH Num	30Day FUH
Symptoms and signs involving emotional state	678	289	42.6%	406	59.9%
Opioid related disorders	132	48	36.4%	65	49.2%
Cannabis related disorders	132	45	34.1%	66	50.0%
Cocaine related disorders	116	45	38.8%	58	50.0%
Alcohol related disorders	81	27	33.3%	40	49.4%
Hallucinogen related disorders	73	33	45.2%	42	57.5%
Reaction to severe stress, and adjustment disorders	65	36	55.4%	46	70.8%
Personal risk factors, not elsewhere classified	65	22	33.8%	35	53.8%
Nicotine dependence	56	27	48.2%	34	60.7%
Attention-deficit hyperactivity disorders	53	32	60.4%	42	79.2%

CBH also conducted a root-cause analysis (RCA) to identify barriers to and root causes of members not following up within 30 days of AIP discharge. Similarly, CBH requested an RCA and performance improvement plan from AIP providers who did not meet the 30-day FUH goals for MY2019 and 2020. The fishbone diagram outlining the root causes identified by both the internal and provider RCAs can be found at right.

CBH then developed an affinity diagram

RCA for MY 2019 Underperformance	
outlining helpers for the top 10 barriers and root causes identified by CBH and providers. The affinity diagram can be found at right. CBH identified existing interventions for each of the root causes and where there are gaps in existing interventions necessary to address root causes. CBH then used a prioritization matrix and multi-voting technique to prioritize the development of new interventions. This prioritization matrix is at right. CBH will move forward with developing any intervention that scored higher than 20 on the prioritization matrix in calendar year (CY) 2021. CBH then used this information to develop the logic model of change for 30-Day FUH for interventions that will be undertaken during CY2021, which can be found at right.	
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").***
People (1) *(e.g., personnel, patients)* 1. Member not ready to engage in treatment for substance use disorder a. Member not understanding how co-occurring substance use impacts mental health b. Member did not seek AIP treatment for substance use issues	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Members may not be aware of how their co-occurring substance use disorder(s) impact their mental illness. They did not seek treatment for their substance use disorder and so may not be willing to focus on that issue while in AIP. The root cause is that members with co-occurring substance use disorders are not ready to engage in treatment. ***Current and expected actionability: Actionable***
People (2) *(e.g., personnel, patients)* 2. Member not being educated about their mental illness and need for follow-up/how follow-up can help them a. Lack of member insight b. Part of mental illness – member not able/unwilling to follow discharge plan c. Members sought hospital admission for non-clinical reasons d. Members admitted on a 302 e. Member treatment fatigue	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Members are not following up because they have treatment fatigue. If they were admitted involuntarily on a 302, they may not want or think they need treatment after discharge. Some members may have sought hospital admission for non-clinical reasons such as homelessness. Mental illness may also be interfering with a member's ability or willingness to follow their discharge plan. Member's may not have insight into their mental illness. The root cause of these associated causes is that members aren't sufficiently educated about their mental illness and the need for follow-up treatment and how it can help them. ***Current and expected actionability: Actionable***
People (3) *(e.g., personnel, patients)* 3. Lack of sufficient member education about medications and shared decision-making a. Don't like side effects of medication	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Members are not adherent to their medication after discharge. They may not understand long-acting injectables (LAIs) or they may lack

RCA for MY 2019 Underperformance	
b. Lack of member insight into their mental illness and how medication will help c. Not understanding LAIs *d.* Members not adherent to medication	insight into how medication helps their mental illness. They may also not like side effects of the medications. The root cause for these associated causes is insufficient member education about medications or shared decision-making with providers about medications. ***Current and expected actionability: Actionable***
Providers (1) *(e.g. provider facilities, provider network)* 1. Outpatient provider can't bill while person is in hospital/AIP can't bill once person is discharged a. Insufficient VBP/P4P incentives b. No financial incentive for care coordination before/after member is discharged c. Lack of communication/coordination between providers/lack of warm hand-off	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat important*** There currently is not reimbursement mechanism for either AIP providers to bill for outreach to member after member has been discharged or outpatient providers to bill for services while member is still in AIP. VBP and pay-for-performance (P4P) may be insufficient to offset the cost of unreimbursed services. This results in a lack of communication or coordination between providers and a lack of warm hand-off between AIP and outpatient providers. ***Current and expected actionability: Actionable***
Providers (2) *(e.g. provider facilities, provider network)* 2. Culture of only being responsible for person while in the hospital b. AIP doesn't follow-up with member after discharge	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat important*** The AIP may not be following up with the member because there could be a culture that the AIP isn't responsible for the member after discharge. Although CBH can communicate follow-up expectations to AIP provider, it is up to the provider to change the culture of its program. ***Current and expected actionability: Not Actionable***
Providers (3) *(e.g. provider facilities, provider network)* 3. Lack of relationships between AIP and outpatient providers d. Lack of communication between providers to secure appointments e. Discharge information not communicated to outpatient provider f. Outpatient provider not outreaching to member after follow-up	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Discharge and follow-up appointment information may not be communicated by the AIP provider to the outpatient provider. The root cause of this is a lack of relationships between AIP and outpatient providers that would enable them to develop a process of coordinated care and would equip the outpatient provider with the information needed to outreach to member for follow-up. ***Current and expected actionability: Actionable***
Providers (4) *(e.g. provider facilities, provider network)* 4. Outpatient provider capacity/staffing issues – lack capacity, doctor time a. Difficulty of obtaining timely appointments at outpatient provider b. Member told about walk-in appointments instead of given actual appointment c. Providers double-booking appointments due to no-shows ***d.*** Lack of timely outpatient/doctor appointments	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** Members may not be able to follow-up within 30 days because of a lack of timely outpatient or doctor appointments. This may be due to outpatient providers double booking appointments to account for no-shows. The member is told by the AIP to go to a walk-in appointment instead of being given an actual appointment, which leaves it up to the member to decide when to go to the outpatient provider for the follow-up appointment. This may be due to the difficulty of AIP providers to secure a timely outpatient appointment for the member. The root cause of this is outpatient provider capacity due to staffing issues and lack of sufficient doctor time. ***Current and expected actionability: Actionable***

RCA for MY 2019 Underperformance	
Providers (5) *(e.g. provider facilities, provider network)* 5. Poor prescribing practices a. Poor assessment leading to inappropriate pharmacotherapy b. Lack of timely pre-authorizations **c.** Provider not considering side effects of medication **d.** Member not adhering to medication	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** In addition to causes of member non-adherence to medication are provider causes. Providers may not be considering side-effects of medication when prescribing them for the member. There may be a lack of timely pre-authorization of the prescription which leads to the member being unable to fill the prescription in a timely manner. There may also be poor assessment of the member by the AIP which leads to inappropriate pharmacotherapy for the member.
	Current and expected actionability: Actionable
Providers (6) *(e.g. provider facilities, provider network)* 6. AIP providers don't treat co-occurring SUD a. SUD may not have been stabilized during admission/may not have been addressed ***b.*** AIPs may not be educating members on need for SUD treatment ***c.*** Members have co-occurring substance use disorders (SUD)	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** In addition to causes of co-occurring substance use disorders that are member-focused, there are provider-focused causes as well. These include AIP providers not educating members on the need for SUD treatment. AIP providers also may not have addressed or stabilized the member's SUD during AIP episode. The root cause of this is that AIP providers not treating co-occurring SUD while the member is in the hospital.
	Current and expected actionability: Actionable
Policies/Procedures (1) *(e.g., data systems, delivery systems, payment/reimbursement)* 1. Unclear expectations of what is expected of providers regarding discharge planning and coordination of care a. No adult inpatient standards requiring follow-up appointments within 30 days b. Providers can't find standards that exist c. Lack of communication/coordination of care between AIP and outpatient providers	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat important*** In addition to the provider-focused causes of the lack of communication and coordination of care between AIP and outpatient providers are those causes that are due to CBH policies or procedures. Currently, standards for adult AIP providers are released as bulletins, are contained in contracts, or the provider manual. These individual documents may be difficult for providers to find. There are no AIP standards for adult providers that explicitly state the AIP provider's role in ensuring timely follow-up after discharge. The root cause of this is unclear expectations by AIP providers of CBH expectations around ensuring 30-day follow-up.
	Current and expected actionability: Actionable
Policies/Procedures (2) *(e.g., data systems, delivery systems, payment/reimbursement)* 2. Delayed feedback to providers about performance b. Providers unsure of impact of performance improvement efforts	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** AIP Providers may be conducting performance improvement activities but are unsure of the impact of these activities because of delayed feedback on performance from CBH. This makes it more difficult for providers to conduct rapid cycle improvement interventions.
	Current and expected actionability: Actionable
Policies/Procedures (3) *(e.g., data systems, delivery systems, payment/reimbursement)* 3. No outpatient Performance Standards ***a.*** Providers not aware of standards and/or expectations for outpatient appointments	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important*** Although CBH released a bulletin outlining HealthChoices standards and CBH expectations around outpatient appointment access, not all outpatient providers may be aware of the standards or expectations for timely access to outpatient appointments, especially for members being

<table>
<tr><th colspan="2">RCA for MY 2019 Underperformance</th></tr>
<tr><td rowspan="2"></td><td>discharged from AIP.</td></tr>
<tr><td>Current and expected actionability: Actionable</td></tr>
<tr><td rowspan="2">Provisions/Social Determinants of Health (1)
(e.g., screening tools, medical record forms, transportation)
1. Member lack of phones/lack of minutes/lack of good contact info
a. CBH and providers unable to make contact with member
b. Member is transient and does not have consistent, reliable contact information</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical
CBH and both AIP and outpatient providers are unable to make contact with the member after discharge from AIP for appointment reminders and to address any barriers to follow-up because the member lacks reliable contact information due to being transient, lacks a cell phone, or lacks minutes on their cell phone will makes them unwilling to answer calls if they are unsure of who is calling them.</td></tr>
<tr><td>Current and expected actionability: Actionable</td></tr>
<tr><td rowspan="2">Provisions/Social Determinants of Health (2)
(e.g., screening tools, medical record forms, transportation)
2. AIPs not asking about transportation needs and ensuring access after discharge
a. Members not being able to afford cost of transportation
b. Don’t know how to access Logisticare transportation service
c. Stigma – don’t want to go to services in their neighborhood
d. outpatient appointment not at a location that’s convenient for member/easy to get to
e. Member doesn’t have transportation to follow-up appointment</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical
Members may not be able to keep their follow-up appointment because they don’t have access to transportation. This may be due to AIPs not making an appointment for the member that’s at a location that’s convenient for the member. Alternatively, some members may not want to utilize services in their own neighborhood, but transportation issues to access appointments that are further away are not addressed by the AIP provider. Some members may not know how to access Logisticare services. Members who are not aware of Logisticare transportation services may not be able to afford alternative transportation to their appointment. The root cause of this is that the AIP provider isn’t assessing transportation needs for the member after discharge and making the connection to transportation resources for the member.</td></tr>
<tr><td>Current and expected actionability: Actionable</td></tr>
<tr><td rowspan="2">Provisions/Social Determinants of Health (3)
(e.g., screening tools, medical record forms, transportation)
3. AIPs not identifying and addressing housing needs in discharge planning and ensuring connection with resources after discharge
a. Members prioritizing housing needs over mental health needs
b. Homelessness leads to unstructured life
c. Not being able to remember and keep appointments
d. Members sought hospital admission for non-clinical reasons related to homelessness
e. Lack of insight (due to mental illness) about living conditions and not willing to get help because of lack of insight – leading to hospitalization</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical
Homelessness and housing instability leads to a variety of conditions that act as barriers to timely follow-up after discharge. Members may prioritize their housing needs over their mental health needs after AIP discharge. Homelessness also leads to an unstructured life, making it more difficult for the member to keep follow-up appointments. Members may also have sought hospital admission for reasons related to their homelessness. Members may also lack insight into how housing instability impacts their mental health.</td></tr>
<tr><td>Current and expected actionability: Actionable</td></tr>
</table>

VI: 2020 Strengths and Opportunities for Improvement

The section provides an overview of CBH's 2020 (MY 2019) performance in the following areas: structure and operations standards, performance improvement projects (no MY 2019 results to report), and PMs, with identified strengths and opportunities for improvement.

Strengths

- CBH's MY 2019 HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for ages 18–64, and 6+ years improved compared to the previous year, but not by a statistically significant margin.
- CBH's MY 2019 HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for all age cuts examined (6–17, 18–64, and 6+ years) improved compared to the previous year, but not by a statistically significant margin.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2017, RY 2018, and RY 2019 found CBH to be partially compliant with three sections associated with Medicaid Managed Care regulations.
  - CBH was partially compliant with 4 out of 9 categories within Compliance with Standards, including Enrollee Rights and Protections. The partially compliant categories are: 1) Assurances of Adequate Capacity and Services, 2) Availability of Services, 3) Coverage and Authorization of Services, and 4) Practice Guidelines.
  - CBH was partially compliant with the eponymous category in Quality Assessment and Performance Improvement Program.
  - CBH was partially compliant with the single category Grievance and Appeal Systems within Grievance System.

- CBH's MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.
- CBH's MY 2019 HEDIS 7- and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for all age cuts examined (6–17, 18–64, and 6+ years) were statistically significantly lower (worse) compared to the MY 2019 HC BH (Statewide) rates.
- CBH's MY 2019 HEDIS 7- and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for ages 6+ years did not achieve the goal of meeting or exceeding the HEDIS 75th percentile.
- CBH's MY 2019 PA-Specific 7-Day (QI A) age cuts 18-64 and 30-day (QI B) across all age cuts Follow-Up After Hospitalization for Mental Illness rates for the overall population were statistically significantly lower (worse) compared to the MY 2019 HC BH (Statewide) rates.
- CBH's MY 2019 PA-Specific 7-Day (QI A) Follow-Up After Hospitalization for Mental Illness rates for the overall population was lower (worse) compared to the previous year, but not by a statistically significant margin.
- CBH's MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge overall rate did not meet the OMHSAS designated performance goal of 10.0%.

Performance Measure Matrices

The PM Matrices provide a comparative look at quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HC BH-MCO. The comparisons are presented in matrices that are color-coded to indicate when the findings for these measures are notable and whether there is cause for action.

Table 6.1 is a three-by-three matrix depicting the horizontal same-year comparison between the BH-MCO's performance and the applicable HC BH (Statewide) rate and the vertical comparison of the BH-MCO's MY 2019 performance to its prior year performance. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly above (▲), below (▼), or no difference (═). However, the qualitative placement of the performance in the matrix depends on the measure. For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) measure, lower rates reflect better performance.

Table 6.1: BH-MCO Performance Matrix for MY 2019 PA-Specific 7- and 30-Day Follow-Up After Hospitalization and MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge (All Ages)

	Trend	BH-MCO Versus HealthChoices Rate Statistical Significance Comparison		
		Poorer	**No difference**	**Better**
BH-MCO Year-to-Year Statistical Significance Comparison	**Improved**	C	B	A
	No Change	D **FUH QI A** **FUH QI B**	C **REA[1]**	B
	Worsened	F	D	C

[1]For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.
Letter Key: A: Performance is notable. BH-MCOs may have internal goals to improve. B: BH-MCOs may identify continued opportunities for improvement. C-F: Recommend BH-MCOs identify continued opportunities for improvement.
FUH QI A: PA-Specific 7-Day Follow-Up After Hospitalization for Mental Illness (All Ages); FUH QI B: PA-Specific 30-Day Follow-Up After Hospitalization for Mental Illness (All Ages); REA: Readmission Within 30 Days of Inpatient Psychiatric Discharge.

Table 6.2 quantifies the performance information presented in **Table 6.1**. It compares the BH-MCO's MY 2019 7- and 30-Day Follow-Up After Hospitalization and Readmission Within 30 Days of Inpatient Psychiatric Discharge rates to prior years' rates for the same indicator for measurement years 2015 through 2019. The last column compares the BH-MCO's MY 2019 rates to the corresponding MY 2018 HC BH (Statewide) rates. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly above (▲), below (▼), or no difference (═).

Table 6.2: MY 2019 PA-Specific 7- and 30-Day Follow-Up After Hospitalization and MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge Rates, Compared Year-over-Year and to HC BH Statewide (All Ages)

Quality PM	MY 2015 Rate	MY 2016 Rate	MY 2017 Rate	MY 2018 Rate	MY 2019 Rate	MY 2019 HC BH (Statewide) Rate
QI A – PA-Specific 7-Day Follow-Up After Hospitalization for Mental Illness (Overall)	51.1% ▼	**50.1%** ═	**49.5%** ═	**47.7%** ▼	**47.3%** ═	**52.9%** ▼
QI B – PA-Specific 30-Day Follow-Up After Hospitalization for Mental Illness (Overall)	67.4% ▼	**64.7%** ▼	**63.4%** ═	**61.4%** ▼	**61.3%** ═	**69.5%** ▼
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	13.7% ═	**13.5%** ═	**12.9%** ═	**13.3%** ═	**13.8%** ═	**13.5%** ═

[1]For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.
PM: performance measure; MY: measurement year; HC: HealthChoices; BH: behavioral health.

Table 6.3 is a four-by-one matrix that represents the BH-MCO's MY 2019 performance as compared to the HEDIS 90th, 75th, 50th, and 25th percentiles for the MY 2019 HEDIS Overall (ages 6+ years) FUH 7-Day (QI 1) and 30-Day Follow-Up (QI 2) After Hospitalization metrics. An RCA and QIP is required for rates that fall below the 75th percentile.

Table 6.3: BH-MCO Performance Matrix for MY 2019 HEDIS FUH 7- and 30-Day Follow-Up After Hospitalization (All Ages)

HealthChoices BH-MCO HEDIS FUH Comparison[1]
Indicators that are greater than or equal to the 90th percentile.
Indicators that are greater than or equal to the 75th percentile, but less than the 90th percentile. *(Root cause analysis and plan of action required for items that fall below the 75th percentile.)*
Indicators that are greater than or equal to the 50th percentile, but less than the 75th percentile.
Indicators that are less than the 50th percentile. **FUH QI 1** **FUH QI 2**

[1]Rates shown are for ages 6 and over.
FUH QI 1: HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness (All Ages); FUH QI 2: HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness (All Ages).

Table 6.4 shows the BH-MCO's MY 2019 performance for HEDIS (FUH) 7- and 30-day Follow-Up After Hospitalization for Mental Illness (Overall) relative to the corresponding HEDIS MY 2019 NCQA Quality Compass percentiles.

Table 6.4: BH-MCO's MY 2019 FUH Rates Compared to the Corresponding MY 2019 HEDIS 75th Percentiles (All Ages)

Quality PM	MY 2019		HEDIS MY 2019 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness (Overall)	27.0%	Not met	Below 25th percentile
QI 2 – HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness (Overall)	41.9%	Not met	Below 25th percentile

[1] Rates shown are for ages 6 years and older.
PM: performance measure; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

VII: Summary of Activities

Performance Improvement Projects

- CBH submitted a Final PIP Report in 2019.

Performance Measures

- CBH reported all PMs and applicable quality indicators in 2019.

Medicaid Managed Care Regulations

- CBH was partially compliant on Compliance with Standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement Program, and Grievance System. As applicable, compliance review findings from RY 2019, RY 2018, and RY 2017 were used to make the determinations.

Quality Studies

- SAMHSA's CCBHC Demonstration continued in 2019. For any of its member receiving CCBHC services, CBH covered those services under a Prospective Payment System rate.

2019 Opportunities for Improvement MCO Response

- CBH provided a response to the opportunities for improvement issued in 2019.

2020 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CBH in 2020 (MY 2019). The BH-MCO will be required to prepare a response in 2021 for the noted opportunities for improvement.

References

[1] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[2] National Committee for Quality Assurance (NCQA). (2020). *HEDIS® volume 2: Technical specifications for health plans.* NCQA. https://store.ncqa.org/hedis-2020-volume-2-epub.html.

[3] National Quality Forum (NQF). (2020, August 12). 3400: Use of pharmacotherapy for opioid use disorder (OUD). *Quality positioning system (QPS) measure description display information. http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=3400&print=0&entityTypeID=1.*

[4] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[5] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[6] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[7] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[8] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[9] Pal, S. (2015). The economic burden of mental health care. *US Pharmacist, 40*(11), 20–21. http://bt.e-ditionsbyfry.com/publication/?m=22400&i=280644&p=54.

[10] Carson, N. J., Vesper, A., Chen, C.-N., & Le Cook, B. (2014). Quality of follow-up after hospitalization for mental illness among patients from racial-ethnic minority groups. *Psychiatric Services, 65*(7), 888–896. https://doi.org/10.1176/appi.ps.201300139.

[11] National Committee for Quality Assurance (NCQA). (2007). *The state of health care quality report.* https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/thank-you/.

[12] Carson, N. J., Vesper, A., Chen, C.-N., & Le Cook, B. (2014). Quality of follow-up after hospitalization for mental illness among patients from racial-ethnic minority groups. *Psychiatric Services, 65*(7), 888–896. https://doi.org/10.1176/appi.ps.201300139.

[13] Ride, J., Kasteridis, P., Gutacker, N., Doran, T., Rice, N., Gravelle, H., Kendrick, T., Mason, A., Goddard, M., Siddiqi, N., Gilbody, S., Williams, R., Aylott, L., Dare, C., & Jacobs, R. (2019). Impact of family practice continuity of care on

unplanned hospital use for people with serious mental illness. *Health Services Research,* 54(6), 1316–1325. https://doi.org/10.1111/1475-6773-13211.

[14] Ride, J., Kasteridis, P., Gutacker, N., Doran, T., Rice, N., Gravelle, H., Kendrick, T., Mason, A., Goddard, M., Siddiqi, N., Gilbody, S., Williams, R., Aylott, L., Dare, C., & Jacobs, R. (2019). Impact of family practice continuity of care on unplanned hospital use for people with serious mental illness. *Health Services Research,* 54(6), 1316–1325. https://doi.org/10.1111/1475-6773-13211.

[15] Smith, M. W., Stocks, C., & Santora, P. B. (2015). Hospital readmission rates and emergency department visits for mental health and substance abuse conditions. *Community Mental Health Journal*, *51*(2), 190–197. https://doi.org/10.1007/s10597-014-9784-x.

[16] Mark, T., Tomic, K. S., Kowlessar, N., Chu, B. C., Vandivort-Warren, R., & Smith, S. (2013). Hospital readmission among Medicaid patients with an index hospitalization for mental and/or substance use disorder. *Journal of Behavioral Health Services & Research, 40*(2), 207–221. https://doi.org/10.1007/s11414-013-9323-5.

[17] Mark, T., Tomic, K. S., Kowlessar, N., Chu, B. C., Vandivort-Warren, R., & Smith, S. (2013). Hospital readmission among Medicaid patients with an index hospitalization for mental and/or substance use disorder. *Journal of Behavioral Health Services & Research, 40*(2), 207–221. https://doi.org/10.1007/s11414-013-9323-5.

[18] Smith, M. W., Stocks, C., & Santora, P. B. (2015). Hospital readmission rates and emergency department visits for mental health and substance abuse conditions. *Community Mental Health Journal*, *51*(2), 190–197. https://doi.org/10.1007/s10597-014-9784-x.

[19] U.S. Department of Health & Human Services. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf.

[20] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols October 2019* (OMB Control No. 0938-0786)*.* Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[21] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols October 2019* (OMB Control No. 0938-0786)*.* Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[22] Code of Federal Regulations, Title 42: Public Health. (2021, March 17). 42 CFR § 438.358 – Activities related to external quality review. https://www.ecfr.gov/cgi-bin/ECFR?page=browse.

Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for Required PEPS Substandards pertinent to BBA Regulations.[23]

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

BBA Category	PEPS Reference	PEPS Language
Assurances of adequate capacity and services 42 C.F.R. § 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 42 C.F.R § 438.206, 42 C.F.R. § 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 not accepting any new enrollees.
	Substandard 1.7	Confirm FQHC providers.

BBA Category	PEPS Reference	PEPS Language
	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 42 C.F.R. § 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 42 C.F.R. § 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

BBA Category	PEPS Reference	PEPS Language
		Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
Coverage and authorization of services 42 C.F.R. Parts § 438.210(a–e), 42 C.F.R. § 441, Subpart B, and § 438.114	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 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 DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
Health information systems 42 C.F.R. § 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 42 C.F.R. § 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 42 C.F.R. § 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	Substandard 99.1	The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning.

BBA Category	PEPS Reference	PEPS Language
delegation 42 C.F.R. § 438.230	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.
	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 42 C.F.R. § 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 91.1	The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: Quality

BBA Category	PEPS Reference	PEPS Language
		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 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

BBA Category	PEPS Reference	PEPS Language
		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 42 C.F.R. § 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.
	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 68.4 (RY 2016, 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 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

BBA Category	PEPS Reference	PEPS Language
		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 DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

[23]In 2018, 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 some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, a "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020).

Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-Specific PEPS Substandards.[24]

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 68.6 (RY 2016, 2017)	The second level complaint case file includes documentation that the member was contacted about the second level complaint meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
	Substandard 68.7 (RY 2016, 2017)	Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.
	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

Category	PEPS Reference	PEPS Language
		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 the issues being discussed and that input was provided from all panel members.
	Substandard 71.5 (RY 2016, 2017)	The second level grievance case file includes documentation that the member was contacted about the second level grievance meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
	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 71.6 (RY 2016, 2017)	Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.
	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.

[24]In 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 some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, a "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its 3-year review (either in 2019 or 2020).

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In 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 some cases, triennial substandards entering and exiting the compliance process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, an "(RY 2017, RY 2018)" will be appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020). In RY 2019, 18 OMHSAS-specific substandards were evaluated for CBH and its Contractors. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in RY 2019, along with the relevant categories.

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

Category (PEPS Standard)	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	RY 2019	RY 2018	RY 2017
Care Management					
Care Management (CM) Staffing	1	0	1	0	0
Longitudinal Care Management (and Care Management Record Review)	1	0	1	0	0
Complaints and Grievances					
Complaints	5	0	5	0	0
Grievances	5	0	5	0	0
Denials					
Denials	1	0	1	0	0
Executive Management					
County Executive Management	1	0	0	0	0
BH-MCO Executive Management	1	0	1	0	0
Enrollee Satisfaction					
Consumer/Family Satisfaction	3	0	0	0	3
Total	18	1	14	0	3

[1]The total number of OMHSAS-Specific substandards required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with OMHSAS standards. Any PEPS Substandards not reviewed indicate substandards that were deemed not applicable to the HealthChoices Oversight Entity/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; CBH: Community Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: sub-standards not reviewed; RY: review year; CM: Care Management; BH: Behavioral Health; MCO: managed care organization.

NR: substandards not reviewed; N/A: category not applicable.

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 County/BH-MCO's compliance with selected ongoing OMHSAS-specific monitoring standards.

Findings

Care Management

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

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

Category	PEPS Item	RY	Status
Care Management			
Care Management (CM) Staffing	Substandard 27.7	2019	Not met
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	2019	Not met

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; CM: Care Management.

CBH was non-compliant with Standard 27, Substandard 7 of (RY 2019).

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

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

CBH was non-compliant with Standard 28, Substandard 3 of (RY 2019).

Standard 28: Longitudinal Care Management (and Care Management Record Review).

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

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

Complaints and Grievances

The OMHSAS-specific PEPS Substandards relating to second-level complaints and grievances include MCO-specific and County-specific review standards. CBH was evaluated on 10 of the 10 applicable substandards. Of the 10 substandards evaluated, CBH partially met 3 substandards, and did not meet 4 substandards, as indicated in **Table C.3**.

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

Category	PEPS Item	RY	Status
Complaints and Grievances			
Complaints	Substandard 68.1.1	2019	Not met
	Substandard 68.1.2	2019	Met
	Substandard 68.5	2019	Met
	Substandard 68.6	2019	Partially met
	Substandard 68.8	2019	Not met
Grievances	Substandard 71.1.1	2019	Not met
	Substandard 71.1.2	2019	Met
	Substandard 71.5	2019	Not met
	Substandard 71.6	2019	Partially met
	Substandard 71.8	2019	Partially met

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; CM: Care Management.

CBH was partially compliant with Standard 68.6 (RY 2019), Standard 71.6 (RY 2019), and Standard 71.8 (RY 2019). CBH was non-compliant with Standard 68.1.1 (RY 2019), Standard 68.8 (RY 2019), Standard 71.1.1, and Standard 71.5 (RY 2019).

Standard 68.1: The Primary Contractor is responsible for monitoring the Complaint 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 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

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 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.

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 (RY 2019):** 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.

Standard 71: The Grievance 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 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 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.

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.

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

> **Substandard 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 the issues being discussed and that input was provided from all panel members.

Denials

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

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

Category	PEPS Item	RY	Status
Denials			
Denials	Substandard 72.3	2019	Met

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; CM: Care Management.

Executive Management

There are two OMHSAS-specific PEPS substandards relating to Executive Management; the County Executive Management substandard is a county-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. CBH was non-compliant with 1 substandard. The second substandard, 78.5 was not deemed not applicable to CBH's review. The status for these substandards is presented in **Table A.5**.

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

Category	PEPS Item	RY	Status
Executive Management			
County Executive Management	Substandard 78.5	2019	Not reviewed
BH-MCO Executive Management	Substandard 86.3	2019	Partially met

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; CM: Care Management.

CBH was partially compliant with Standard 86, Substandard 3 (RY 2019).

Standard 86: BH-MCO Executive Management. Required duties and functions are in place. The BH-MCO's table of organization depicts organization relationships of the following functions/ positions: Chief Executive Officer; The appointed Medical Director is a board-certified psychiatrist licensed in Pennsylvania with at least five years of experience in mental health and substance abuse; Chief Financial Officer; Director of Quality Management; Director of Utilization Management; Management Information Systems; Director of Prior/Service Authorization; Director of Member Services; Director of Provider Services.

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

Enrollee Satisfaction

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are County-specific review standards. All 3 substandards crosswalked to this category were evaluated for Philadelphia County. Philadelphia County met the criteria for all 3 substandards, as seen in **Table C.6**.

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

Category	PEPS Item	RY	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Substandard 108.3	2017	Met
	Substandard 108.4	2017	Met
	Substandard 108.9	2017	Met

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; CM: Care Management.