Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services
2022 External Quality Review Report
Community Care Behavioral Health

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Introduction

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an external quality review organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs).[1] This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients.

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

Overview

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

In the interest of operational efficiency, numerous counties have come together to create HC oversight entities (HC-OEs) that coordinate the Primary Contractors while providing an oversight function of the BH-MCOs. In some cases, the HC-OE is the HC BH contractor and, in other cases, multiple Primary Contractors contract with an HC-OE to manage their HC BH Program. In the CCBH managed care network, Allegheny, Berks, Chester, and Erie Counties hold contracts with CCBH. Carbon, Monroe, and Pike Counties (CMP) hold a contract with CCBH as the Carbon-Monroe-Pike Joinder Board. Lackawanna, Luzerne, Susquehanna, and Wyoming Counties hold a contract with Northeast Behavioral Health Care Consortium (NBHCC), which, in turn, holds a contract with CCBH. Effective July 1, 2021, 23 Northcentral Counties (Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne) entered into a capitated agreement through a new Primary Contractor, Behavioral Health Alliance of Rural Pennsylvania, Inc. (BHARP). Through BHARP, these 23 counties maintained their contract with CCBH. Effective January 1, 2022, Greene County joined BHARP, effectively changing its contracted MCO from BHO to CCBH. For Blair County, the Primary Contractor is Blair HC. For Clinton and Lycoming Counties, the Primary Contractor is the Lycoming-Clinton Joinder Board. For York and Adams Counties, the Primary Contractor is the York-Adams HC Joinder Governing Board. On July 1, 2019, the Bedford-Somerset HC-OE changed contracts from PerformCare to CCBH. MMC compliance findings for any HC-OE changing MCO contracts are not included in BBA reporting for a period of 3 years after the change.

Objectives

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

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

Scope of EQR Activities

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

I.   Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Review of Compliance with Medicaid Managed Care Regulations
IV. Validation of Network Adequacy
V.   Quality Studies

For the MCO, information for **Sections I** and **II** of this report is derived from IPRO's validation of the MCO's performance improvement projects (PIPs) and performance measure (PM) submissions. The PM validation, as conducted by IPRO, included a repeated measurement of three PMs: HEDIS Follow-Up After Hospitalization for Mental Illness, PA-specific Follow-Up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. The information for compliance with Medicaid Managed Care Regulations in **Section III** of the report is derived from monitoring and reviews conducted by OMHSAS, as well as the oversight functions of the county or contracted entity, when applicable, against PA's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable. **Section IV** discusses the validation of MCO network adequacy in relation to existing federal and state standards that are covered in the Review of Compliance with Medicaid Managed Care Regulations, **Section III**. **Section V** discusses the Quality Study for the Certified Community Behavioral Health Clinic (CCBHC) federal demonstration and the Integrated Community Wellness Centers (ICWC) program. **Section VI**, 2021 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2021 (measurement year [MY] 2020) EQR annual technical report and presents the degree to which the MCO addressed each opportunity for improvement. **Section VII** includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2021), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH quality performance of the MCO. Lastly, **Section VIII** provides a summary of EQR activities for the MCO for this review period. Also included are: **References** with a list of publications cited, as well as **Appendices** that include crosswalks of PEPS standards to pertinent BBA regulations and to OMHSAS-specific PEPS substandards, and results of the PEPS review for OMHSAS-specific standards.

I: Validation of Performance Improvement Projects

Objectives

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

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

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

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

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

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

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

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

5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe alcohol use disorder (AUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD, except for members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

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

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

Technical Methods of Data Collection and Analysis

The MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with CMS protocols. These protocols follow a longitudinal format and capture information relating to:
- Project Topic
- Methodology
- Barrier Analysis, Interventions, and Monitoring
- Results
- Discussion

For the PEDTAR PIP, OMHSAS has designated the Primary Contractors to conduct quarterly PIP review calls with each MCO. The purpose of these calls will be to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance, as necessary. Plans will be asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, rather than two semiannual submissions, MCOs will submit only one PIP interim report each September starting in 2021.

IPRO's validation of PIP activities is consistent with the protocol issued by CMS[5] and meets the requirements of the Final Rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 8 review elements listed below:
1. Topic Rationale
2. Aim
3. Methodology
4. Identified Study Population Barrier Analysis
5. Robust Interventions
6. Results
7. Discussion and Validity of Reported Improvement
8. Sustainability

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for each element is based on Met, Partially Met, and Not Met Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. The overall score expresses the level of compliance.

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

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

Table 1.1: Element Designation

Element Designation	Definition	Designation Weight
Met	Met or exceeded the element requirements	100%
Partially Met	Met essential requirements, but is deficient in some areas	50%
Not Met	Has not met the essential requirements of the element	0%

When the PIPs are reviewed, all projects are evaluated on the same elements. The scoring matrix is completed for those review elements where activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. Untimely reporting by the MCO, i.e., if not in accordance with the submission schedule, may be factored into the overall determination. At the time each element is reviewed, a finding is given of "Met," "Partially Met," or "Not Met." Elements receiving a "Met" will receive 100% of the points assigned to the element, "Partially Met" elements will receive 50% of the assigned points, and "Not Met" elements will receive 0%. Effective MY 2022, overall ratings below 85% (i.e., below "Met") will require action plans to remediate deficiencies in the PIP and/or its reporting.

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

Table 1.2: Review Element Scoring Weights (Scoring Matrix)

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

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

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

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

Findings

CCBH successfully submitted a PEDTAR PIP proposal in the fall of 2020 based on an initial baseline period of July 1, 2019, through June 30, 2020. Implementation began in early 2021. The MCO subsequently resubmitted a revised proposal based on the full CY 2020 data with goals, objectives, and interventions recalibrated as needed. IPRO reviewed all baseline PIP submissions for adherence to PIP design principles and standards, including alignment with the Statewide PIP aims and objectives as well as internal consistency and completeness. Clinical intervention highlights include application of the Cascade of Care model with emphasis on warm handoffs and continuity of care, telehealth to support MAT, and increasing SUD screening and referrals in the primary care setting. For its population-based prevention strategy component, CCBH is developing educational MAT toolkits and an anti-stigma campaign focused on reducing SUD stigma in the racial and social justice context highlighting cultural awareness.

Prevention, Early Detection, Treatment and Recovery (PEDTAR) for Substance Use Disorders
For the Year 1 implementation review, the MCO scored 100% (80 points out of a maximum possible weighted score of 80points; data not shown). Overall, the annual report featured thoughtful and clear discussion. It was noted that overall Year 1 performance indicator goals had not been achieved, but some counties did see improvements. IPRO suggested CCBH drill deeper into the differences in these counties in order to possibly extract lessons. In addition, comparison to national rate changes in relevant measures like FUI may also provide a way to check for counterfactuals. CCBH's thorough monitoring also puts it in a position to begin to test its logic model of change linking interventions to the performance indicators, which IPRO encouraged CCBH to do going forward.

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

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

II: Validation of Performance Measures

Objectives

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

Follow-Up After Hospitalization for Mental Illness

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

MY 2002 was the first year that follow-up rates were reported. QI 1 and QI 2 utilize the HEDIS methodology for this measure. The PA-specific indicators were added to include services with high utilization in the HC BH Program that could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits. Each year, the QI 1 and QI 2 specifications are aligned with the HEDIS Follow-Up After Mental Health Hospitalization measure. The PA-specific codes that are not included in the HEDIS measure are also reviewed for accuracy on an annual basis.

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

Measure Selection and Description

In accordance with DHS guidelines, IPRO created the indicator specifications to resemble HEDIS specifications. For each indicator, the criteria specified to identify the eligible population were: product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications as needed. Indicator rates were calculated using only the BH-MCO's data systems to identify numerator positives (i.e., administratively).

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

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

Eligible Population for HEDIS Follow-Up

The entire eligible population was used for all 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:
- Members who had one (or more) hospital discharges from any acute care facility with a discharge date occurring between January 1 and December 1, 2021;
- A principal International Classification of Diseases, Ninth Revision (ICD-9) or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code indicating one of the specified mental health disorders;
- Six (6) years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2021, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 1, 2021. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS MY 2021 methodology for the Follow-Up After Hospitalization for Mental Illness measure.

HEDIS Follow-Up Indicators

Quality Indicator 1 (QI 1): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge (calculation based on industry standard codes used in HEDIS)
Numerator: An ambulatory visit with a mental health practitioner up to 7 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator 2 (QI 2): Follow-Up After Hospitalization for Mental Illness Within 30 Days After Discharge (calculation based on industry standard codes used in HEDIS)
Numerator: An ambulatory visit with a mental health practitioner up to 30 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Eligible Population for PA-Specific Follow-Up

The entire eligible population was used for all 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:
- Members who had one (or more) hospital discharges from any acute care facility with a principal diagnosis of mental illness occurring between January 1 and December 2, 2021;
- Six (6) years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 2, 2021, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 2, 2021. The PA-specific measure has been adjusted to allow discharges up through December 2, 2021, which allows for the full 30-day follow-up period where same-day follow-up visits may be counted in the numerator.

PA-Specific Follow-Up Indicators

Quality Indicator A (QI A): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge (calculation based on numerator 1 codes and additional PA-specific codes not used in HEDIS)
Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 7 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator B (QI B): Follow-Up After Hospitalization for Mental Illness Within 30 Days after Discharge (calculation based on numerator 1 codes and additional PA-specific codes not used in HEDIS)
Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator Significance

Mental health disorders contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. In 2019, an estimated 47.6 million adults aged 18 or older (19.1%) had any mental illness in the past year while an estimated 11.4 million adults in the nation had a serious persistent mental illness (SPMI) in the past year, which corresponds to 4.6% of all U.S. adults.[6] Additionally, individuals diagnosed with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities such as obesity, cardiovascular diseases, and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns, reduced use of preventive services, and substandard medical care that they receive.[7] Roughly one-third of adults with SPMI in any given year did not receive any mental health services.[8] Further research suggests that more than half of those with SPMI did not receive services because they could not afford the cost of care.[9] Cost of care broke down as follows: 60.8% of related expenses were attributed to loss of earnings, 31.5% were attributed to healthcare expenses, while 7.7% were attributed to payments for disability benefits.[10] For these reasons, timely and appropriate treatment for mental illnesses is essential.

It has long been recognized that continuity of care is critical to positive outcomes and to prevent long-term deterioration in people with SPMI.[11] As noted in *The State of Health Care Quality Report,*[12] appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses and the likelihood of recurrence. An outpatient visit within at least 30 days (ideally, 7 days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance and to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments.[13] With the expansion of evidence-based practice in the recent decade, continuity has become a core principle in care delivery and in performance measurement for mental health services.[14] One way to improve continuity of care is to provide greater readiness of aftercare by shortening the time between discharge from the hospital and the first day of outpatient contact.[15]

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long-standing concern of BH care systems, with some researchers having estimated that 40–60% of patients fail to connect with an outpatient clinician.[16] Over the course of a year, patients who have kept appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow up with outpatient care.[17]

There are various measures of treatment efficacy, such as service satisfaction, functional status, and health outcomes. Among them, rehospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment.[18] Avoidable inpatient readmission is a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care and is an effective means to control the cost and maximize the quality of mental health services. Additionally, mental illness continues to impact the PA population, including those with substance abuse concerns or SUD.[19] Measuring appropriate care transitions for members with mental illness, therefore, carries wider implications for the OMHSAS quality area related to SUD prevalence and outcomes.

As noted, timely follow-up after hospitalization for mental illness has been and remains a focus for OMHSAS and results are reviewed for potential trends each year. MY 2021 results will be examined in the context of the COVID-19 pandemic, which has been implicated in rising prevalence of mental illness.[20] While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-Up After Hospitalization for Mental Illness, OMHSAS elected to retain and remeasure the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) indicator for this year's EQR. As directed by OMHSAS, IPRO developed the PM for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and remeasurement of the PM for validation soon thereafter for MY 2007, and then for MY 2008. Remeasurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2021 study conducted in 2022 was the 15th remeasurement of this indicator. Four clarifications were made to the specifications for MY 2013. If

a member was known to have multiple member IDs in the MY, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and a transfer to another acute facility. As with the Follow-Up After Hospitalization for Mental Illness measure, the rates provided are aggregated at the HC BH (statewide) level for MY 2021. This measure continued to be of interest to OMHSAS for the purposes of comparing Primary Contractor and BH-MCO rates to the OMHSAS performance goal and to prior rates.

This study examined BH services provided to members participating in the HC BH Program. For the indicator, the criteria specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. In order to identify the administrative numerator-positives, the date-of-service, and diagnosis/procedure code criteria were outlined, as were other specifications as needed. This measure's calculation was based on administrative data only.

This PM assessed the percentage of discharges for enrollees from inpatient acute psychiatric care that were followed by an inpatient acute psychiatric care readmission within 30 days of the previous discharge.

Eligible Population
The entire eligible population was used for all 67 counties and 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:
- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 2, 2021;
- A principal ICD-9 or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event; and
- The claim was clearly identified as a discharge.

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

Technical Methods of Data Collection and Analysis
A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs for each Primary Contractor participating in the current study. The source for all administrative data was the BH-MCOs' transactional claims systems. Each BH-MCO was also required to submit the follow-up rates calculated for the four indicators, along with their data files for validation purposes. The BH-MCOs were given the opportunity for resubmission, as necessary.

Performance Goals
At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. In 2018 (MY 2017), in part to better account for the growing population of members 65 years old and older, OMHSAS changed its benchmarking to the FUH All Ages (6+ years old) measure. OMHSAS established a 3-year goal for the state to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass® published percentiles for 7-day and 30-day FUH. This change in 2018 also coincided with a more prospective and proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2017 results. These MY 2017 results were reported in the 2018 EQR annual technical report.

HEDIS percentiles for the 7-day and 30-day FUH All-Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each underperforming indicator. Rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for

each of these respective indicators will result in a request to the BH-MCO for an RCA and QIP. This process is further discussed in **Section VI**.

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

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

Data Analysis

The quality indicators were defined as rates, based on a numerator of qualifying events or members and a denominator of qualifying events or members, defined according to the specifications of the measure. The HC aggregate (statewide) for each indicator was the total numerator divided by the total denominator, which represented the rate derived for the statewide population of denominator-qualifying events or members. Year-to-year comparisons to MY 2020 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *Z*-test statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

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

Where:
   $N1$ = Current year (MY 2021) numerator,
   $N2$ = Prior year (MY 2020) numerator,
   $D1$ = Current year (MY 2021) denominator, and
   $D2$ = Prior year (MY 2020) denominator.

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

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

Where:
   $p1$ = Current year (MY 2021) quality indicator rate, and
   $p2$ = Prior year (MY 2020) quality indicator rate.

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

$$H_0: p1 = p2$$

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

Limitations

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

Conclusions and Comparative Findings

The HEDIS follow-up indicators are presented for three age groups: ages 18–64 years, ages 6 years and older, and ages 6–17 years. The 6+ year old ("All Ages") results are presented to show the follow-up rates for the overall HEDIS population, and the 6–17 years old age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old only.

The results are presented at the BH-MCO and Primary Contractor level. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (and Primary Contractor with the same contracted BH-MCO). The Primary Contractor-specific rates were calculated using the numerators and denominators for that particular Primary Contractor. For each of these rates, the 95% confidence interval (CI) is reported. The HC BH aggregate (statewide) rates were also calculated for the indicators.

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

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

I: HEDIS Follow-Up Indicators

(a) Age Group: 18–64 Years Old

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

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

Measure[1]	MY 2021					MY 2020 %	MY 2021 Rate Comparison to:		MY 2021 HEDIS Medicaid Percentiles
				95% CI			MY 2020		
	(N)	(D)	%	Lower	Upper		PPD	SSD	
QI1 - HEDIS 7-Day Follow-Up				(18–64 Years)					
Statewide	9984	29137	**34.3%**	33.7%	34.8%	36.4%	-2.2	YES	Below 75th Percentile, Above 50th Percentile
CCBH	4653	11595	**40.1%**	39.2%	41.0%	42.7%	-2.6	YES	Below 75th Percentile, Above 50th Percentile
Allegheny	998	2443	**40.9%**	38.9%	42.8%	42.2%	-1.4	NO	Below 75th Percentile, Above 50th Percentile
BH Alliance of Rural PA	1097	2694	**40.7%**	38.8%	42.6%	42.1%	-1.4	NO	Below 75th Percentile, Above 50th Percentile
Blair	195	466	**41.8%**	37.3%	46.4%	39.8%	2.0	NO	At or Above 75th Percentile
Berks	390	943	**41.4%**	38.2%	44.6%	42.2%	-0.8	NO	Below 75th Percentile, Above 50th Percentile

| Measure[1] | MY 2021 | | | | | MY 2020 % | MY 2021 Rate Comparison to: | | |
| | | | | 95% CI | | | MY 2020 | | MY 2021 HEDIS Medicaid Percentiles |
	(N)	(D)	%	Lower	Upper		PPD	SSD	
Bedford-Somerset	80	179	**44.7%**	37.1%	52.3%	43.0%	1.7	NO	At or Above 75th Percentile
Chester	254	674	**37.7%**	34.0%	41.4%	46.1%	-8.4	YES	Below 75th Percentile, Above 50th Percentile
CMP	217	549	**39.5%**	35.3%	43.7%	39.3%	0.2	NO	Below 75th Percentile, Above 50th Percentile
Erie	273	758	**36.0%**	32.5%	39.5%	41.1%	-5.1	YES	Below 75th Percentile, Above 50th Percentile
Lycoming-Clinton	123	341	**36.1%**	30.8%	41.3%	37.4%	-1.3	NO	Below 75th Percentile, Above 50th Percentile
NBHCC	642	1519	**42.3%**	39.7%	44.8%	48.4%	-6.1	YES	At or Above 75th Percentile
York-Adams	384	1029	**37.3%**	34.3%	40.3%	42.0%	-4.7	YES	Below 75th Percentile, Above 50th Percentile
QI2 - HEDIS 30-Day Follow-Up				**(18–64 Years)**					
Statewide	15653	29137	**53.7%**	53.1%	54.3%	55.7%	-2.0	YES	Below 75th Percentile, Above 50th Percentile
CCBH	6989	11595	**60.3%**	59.4%	61.2%	62.3%	-2.0	YES	Below 75th Percentile, Above 50th Percentile
Allegheny	1474	2443	**60.3%**	58.4%	62.3%	61.0%	-0.7	NO	Below 75th Percentile, Above 50th Percentile
BH Alliance of Rural PA	1688	2694	**62.7%**	60.8%	64.5%	63.7%	-1.0	NO	At or Above 75th Percentile
Blair	305	466	**65.5%**	61.0%	69.9%	65.1%	0.3	NO	At or Above 75th Percentile
Berks	529	943	**56.1%**	52.9%	59.3%	59.9%	-3.8	NO	Below 75th Percentile, Above 50th Percentile
Bedford-Somerset	116	179	**64.8%**	57.5%	72.1%	67.1%	-2.3	NO	At or Above 75th Percentile
Chester	359	674	**53.3%**	49.4%	57.1%	59.1%	-5.8	YES	Below 50th Percentile, Above 25th Percentile
CMP	346	549	**63.0%**	58.9%	67.2%	62.4%	0.6	NO	At or Above 75th Percentile
Erie	406	758	**53.6%**	49.9%	57.2%	54.0%	-0.5	NO	Below 75th Percentile, Above 50th Percentile
Lycoming-Clinton	206	341	**60.4%**	55.1%	65.7%	58.1%	2.3	NO	Below 75th Percentile, Above 50th Percentile
NBHCC	938	1519	**61.8%**	59.3%	64.2%	67.3%	-5.6	YES	Below 75th Percentile, Above 50th Percentile
York-Adams	622	1029	**60.4%**	57.4%	63.5%	64.3%	-3.8	NO	Below 75th Percentile, Above 50th Percentile

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

MY: measurement year; FUH: Follow-Up After Hospitalization; HEDIS: Healthcare Effectiveness Data and Information Set; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium.

Figure 2.1 is a graphical representation of MY 2021 HEDIS FUH 7- and 30-day follow-up rates in the 18–64 years old population for CCBH and its associated Primary Contractors. The orange line represents the MCO average.
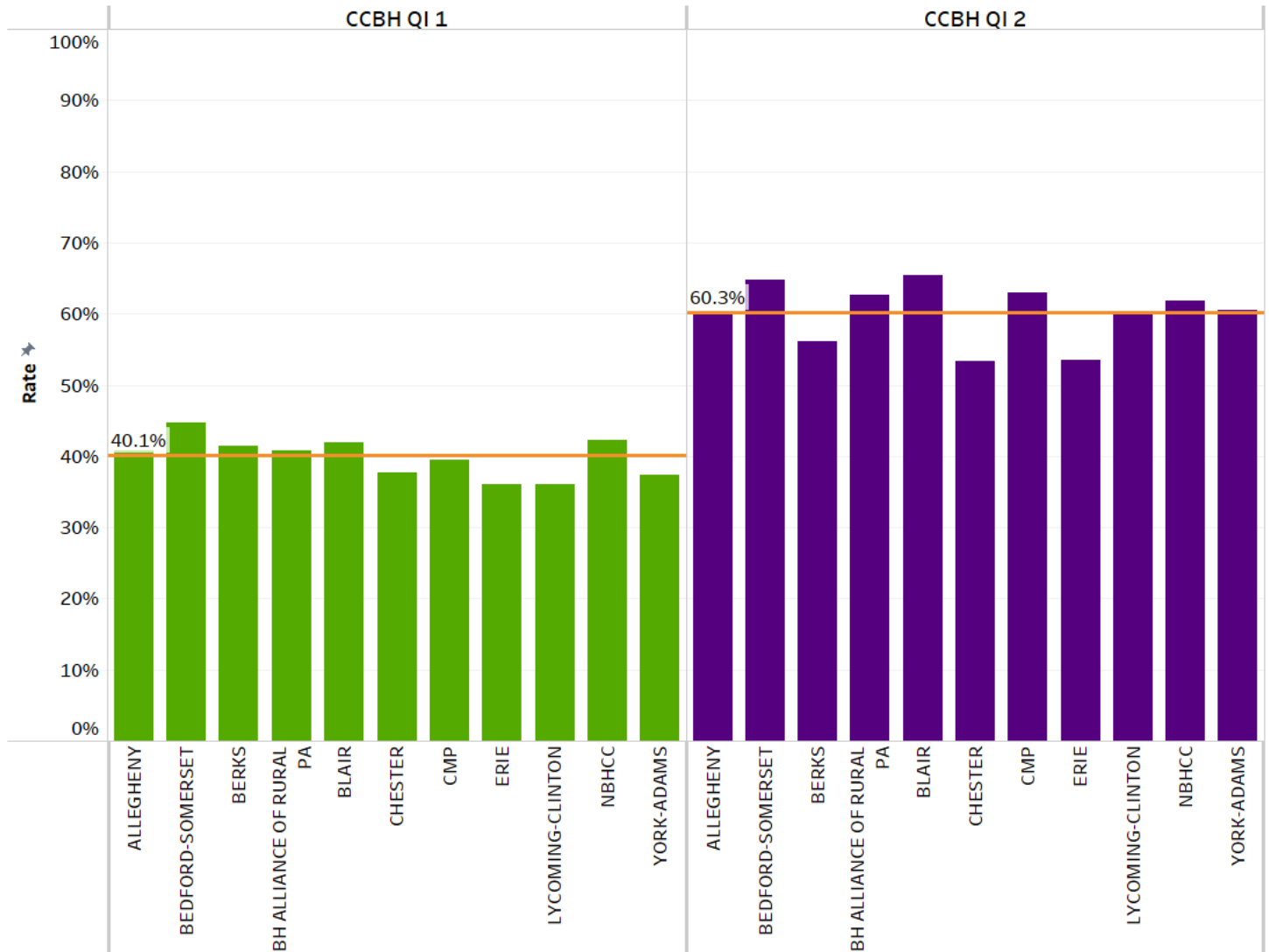
Figure 2.1: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years).

Figure 2.2 shows the HC BH (statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the HC BH (statewide) rate.
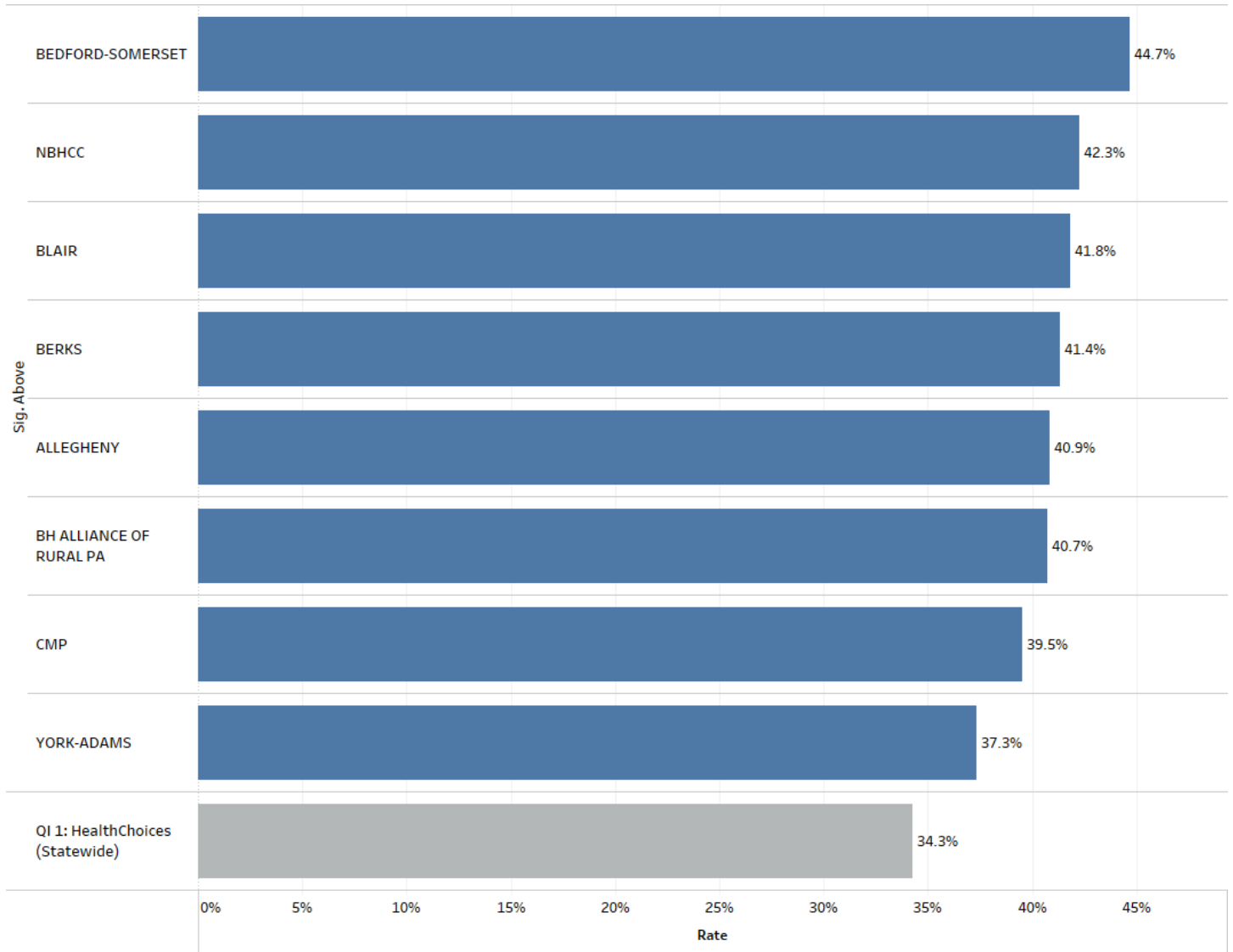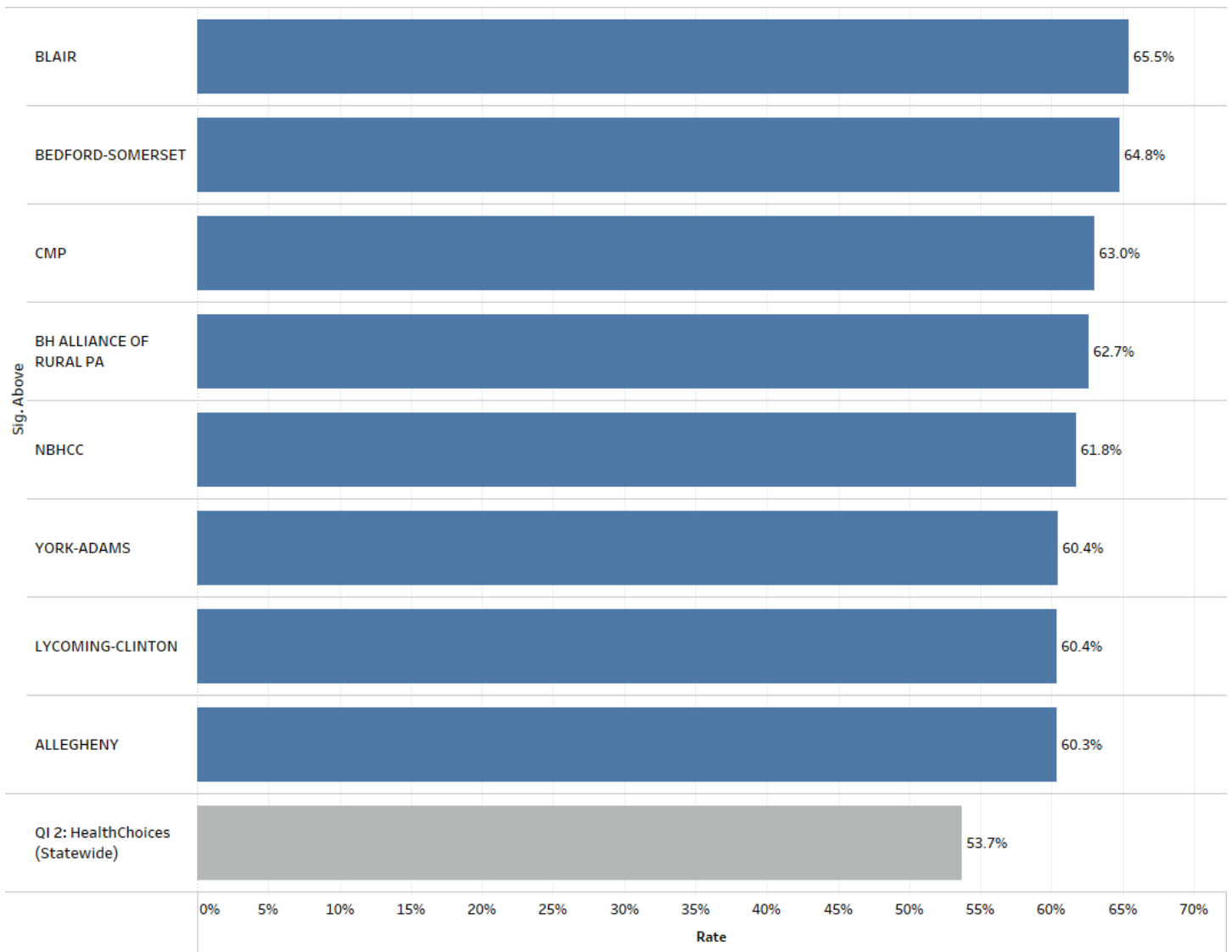
Figure 2.2: Statistically Significant Differences in CCBH Contractor MY 2021 HEDIS FUH Rates (18–64 Years). CCBH Primary Contractor MY 2021 HEDIS FUH rates for 18–64 years of age that are significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (18–64 years).

(b) Overall Population: 6+ Years Old

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

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

| Measure[1]	(N)	(D)	%	95% CI Lower	95% CI Upper	MY 2020 %	MY 2020 PPD	MY 2020 SSD	MY 2021 HEDIS Medicaid Percentiles
QI1 - HEDIS 7-Day Follow-Up					(Overall)				
Statewide	14140	37506	**37.7%**	37.2%	38.2%	39.8%	-2.1	YES	Below 50th Percentile, Above 25th Percentile
CCBH	6552	15137	**43.3%**	42.5%	44.1%	45.9%	-2.6	YES	Below 75th Percentile, Above 50th Percentile
Allegheny	1327	3136	**42.3%**	40.6%	44.1%	45.6%	-3.3	YES	Below 75th Percentile, Above 50th Percentile
BH Alliance of Rural PA	1588	3591	**44.2%**	42.6%	45.9%	45.7%	-1.5	NO	Below 75th Percentile, Above 50th Percentile
Blair	242	544	**44.5%**	40.2%	48.8%	42.5%	2.0	NO	Below 75th Percentile, Above 50th Percentile
Berks	535	1211	**44.2%**	41.3%	47.0%	44.2%	0.0	NO	Below 75th Percentile, Above 50th Percentile
Bedford-Somerset	117	245	**47.8%**	41.3%	54.2%	49.6%	-1.9	NO	At or Above 75th Percentile
Chester	370	904	**40.9%**	37.7%	44.2%	47.6%	-6.7	YES	Below 75th Percentile, Above 50th Percentile
CMP	312	735	**42.4%**	38.8%	46.1%	43.1%	-0.6	NO	Below 75th Percentile, Above 50th Percentile
Erie	433	1041	**41.6%**	38.6%	44.6%	45.5%	-3.9	NO	Below 75th Percentile, Above 50th Percentile
Lycoming-Clinton	175	457	**38.3%**	33.7%	42.9%	38.5%	-0.2	NO	Below 75th Percentile, Above 50th Percentile
NBHCC	861	1887	**45.6%**	43.4%	47.9%	51.8%	-6.2	YES	Below 75th Percentile, Above 50th Percentile
York-Adams	592	1386	**42.7%**	40.1%	45.4%	44.7%	-2.0	NO	Below 75th Percentile, Above 50th Percentile
QI2 - HEDIS 30-Day Follow-Up					(Overall)				
Statewide	21707	37506	**57.9%**	57.4%	58.4%	59.4%	-1.6	YES	Below 50th Percentile, Above 25th Percentile
CCBH	9686	15137	**64.0%**	63.2%	64.8%	65.7%	-1.7	YES	Below 75th Percentile, Above 50th Percentile
Allegheny	1982	3136	**63.2%**	61.5%	64.9%	64.4%	-1.2	NO	Below 75th Percentile, Above 50th Percentile
BH Alliance of Rural PA	2383	3591	**66.4%**	64.8%	67.9%	67.5%	-1.2	NO	Below 75th Percentile, Above 50th Percentile
Blair	372	544	**68.4%**	64.4%	72.4%	68.4%	-0.1	NO	At or Above 75th Percentile
Berks	732	1211	**60.4%**	57.7%	63.2%	62.1%	-1.6	NO	Below 75th Percentile, Above 50th Percentile
Bedford-Somerset	167	245	**68.2%**	62.1%	74.2%	72.2%	-4.1	NO	At or Above 75th Percentile
Chester	509	904	**56.3%**	53.0%	59.6%	60.9%	-4.6	NO	Below 50th Percentile, Above 25th Percentile
CMP	492	735	**66.9%**	63.5%	70.4%	65.4%	1.5	NO	Below 75th Percentile, Above 50th Percentile

Measure[1]	(N)	(D)	MY 2021 %	95% CI Lower	95% CI Upper	MY 2020 %	MY 2020 PPD	SSD	MY 2021 HEDIS Medicaid Percentiles
Erie	626	1041	**60.1%**	57.1%	63.2%	59.2%	0.9	NO	Below 75th Percentile, Above 50th Percentile
Lycoming-Clinton	291	457	**63.7%**	59.2%	68.2%	60.9%	2.8	NO	Below 75th Percentile, Above 50th Percentile
NBHCC	1226	1887	**65.0%**	62.8%	67.1%	70.1%	-5.1	YES	Below 75th Percentile, Above 50th Percentile
York-Adams	906	1386	**65.4%**	62.8%	67.9%	67.6%	-2.2	NO	Below 75th Percentile, Above 50th Percentile

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

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; QI: quality indicator; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium.

Figure 2.3 is a graphical representation of the MY 2021 HEDIS FUH follow-up rates for CCBH and its associated Primary Contractors. The orange line represents the MCO average.
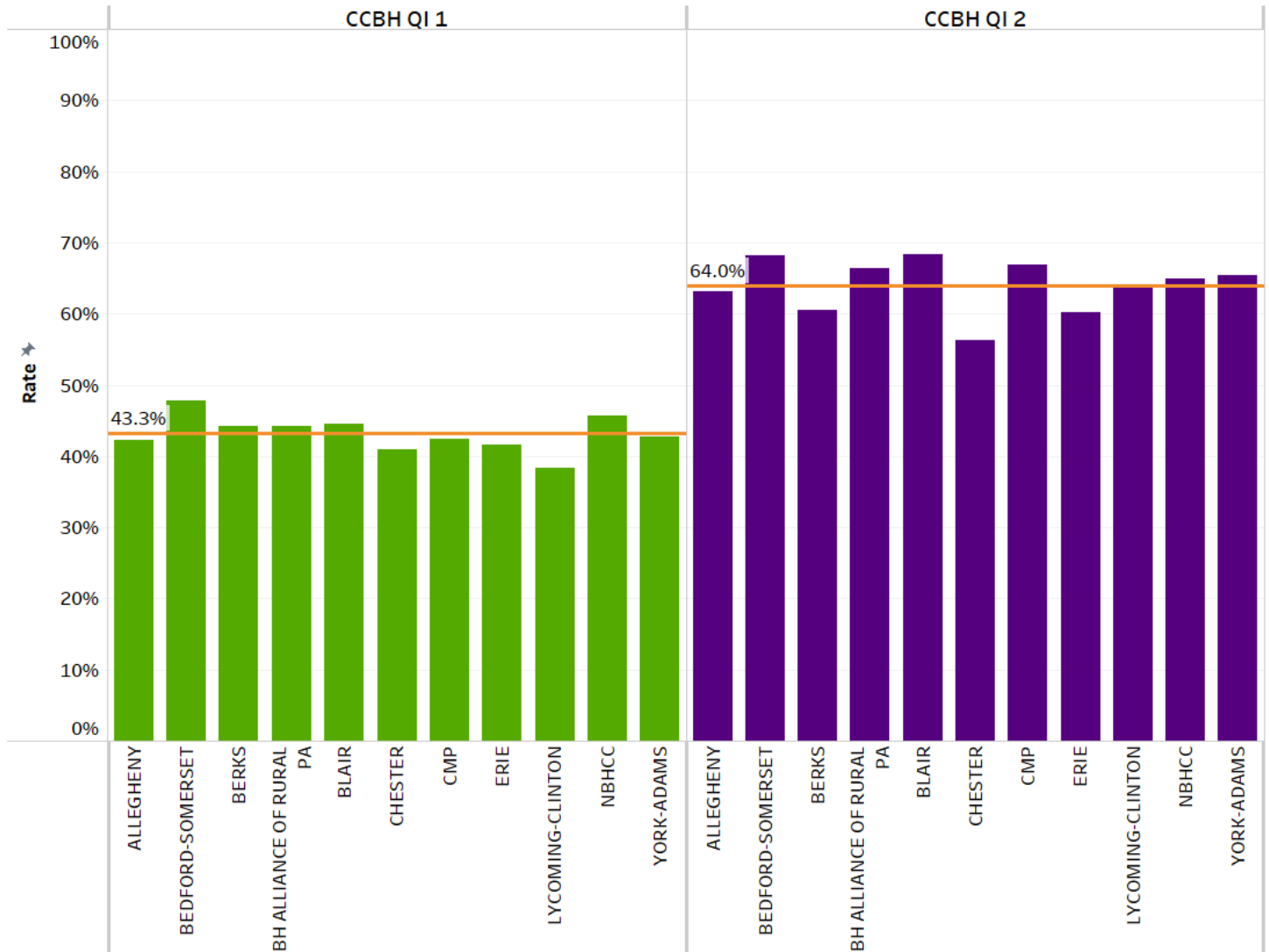
Figure 2.3: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages).

Figure 2.4 shows the HC BH (statewide) rates and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than its statewide benchmark.
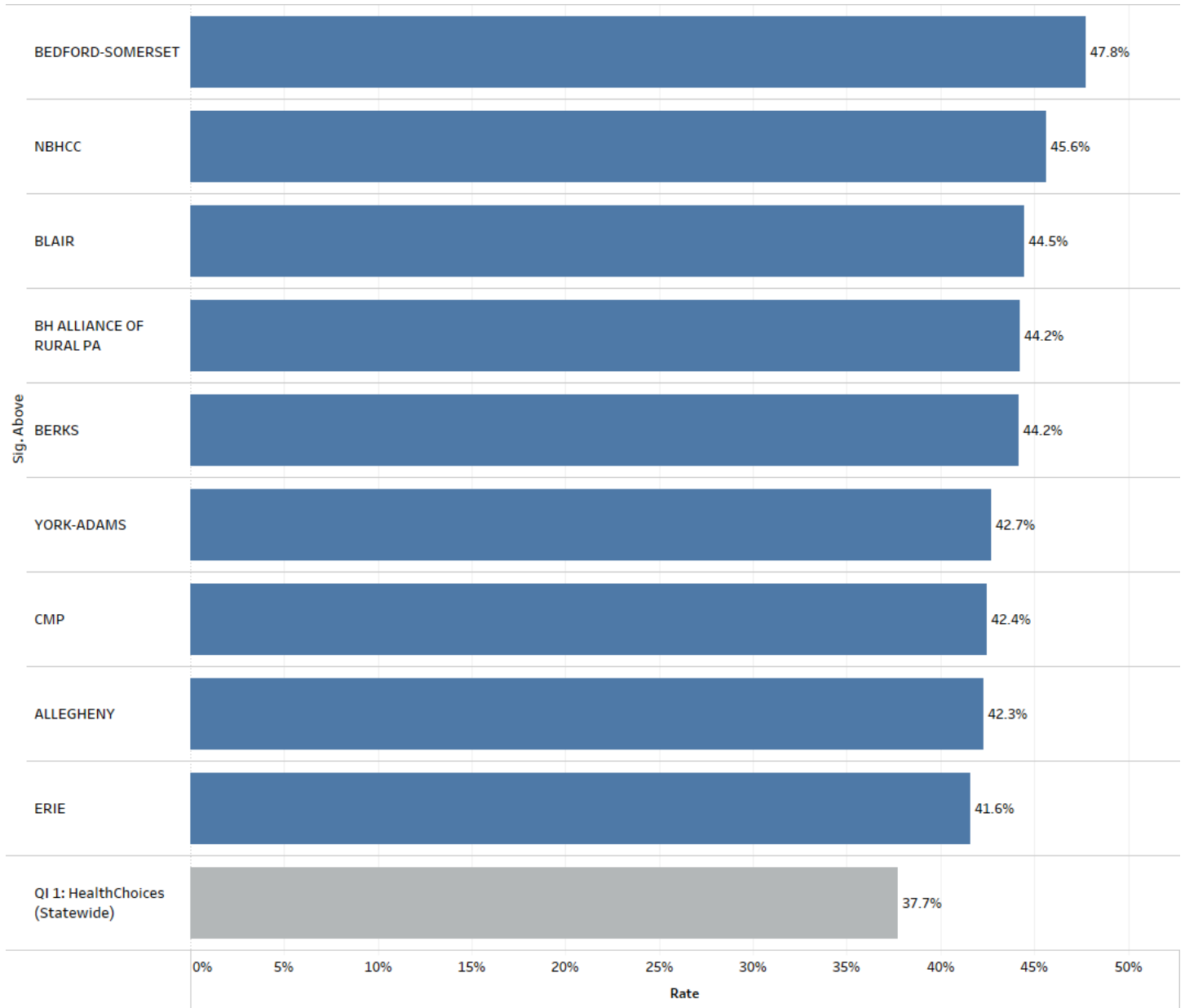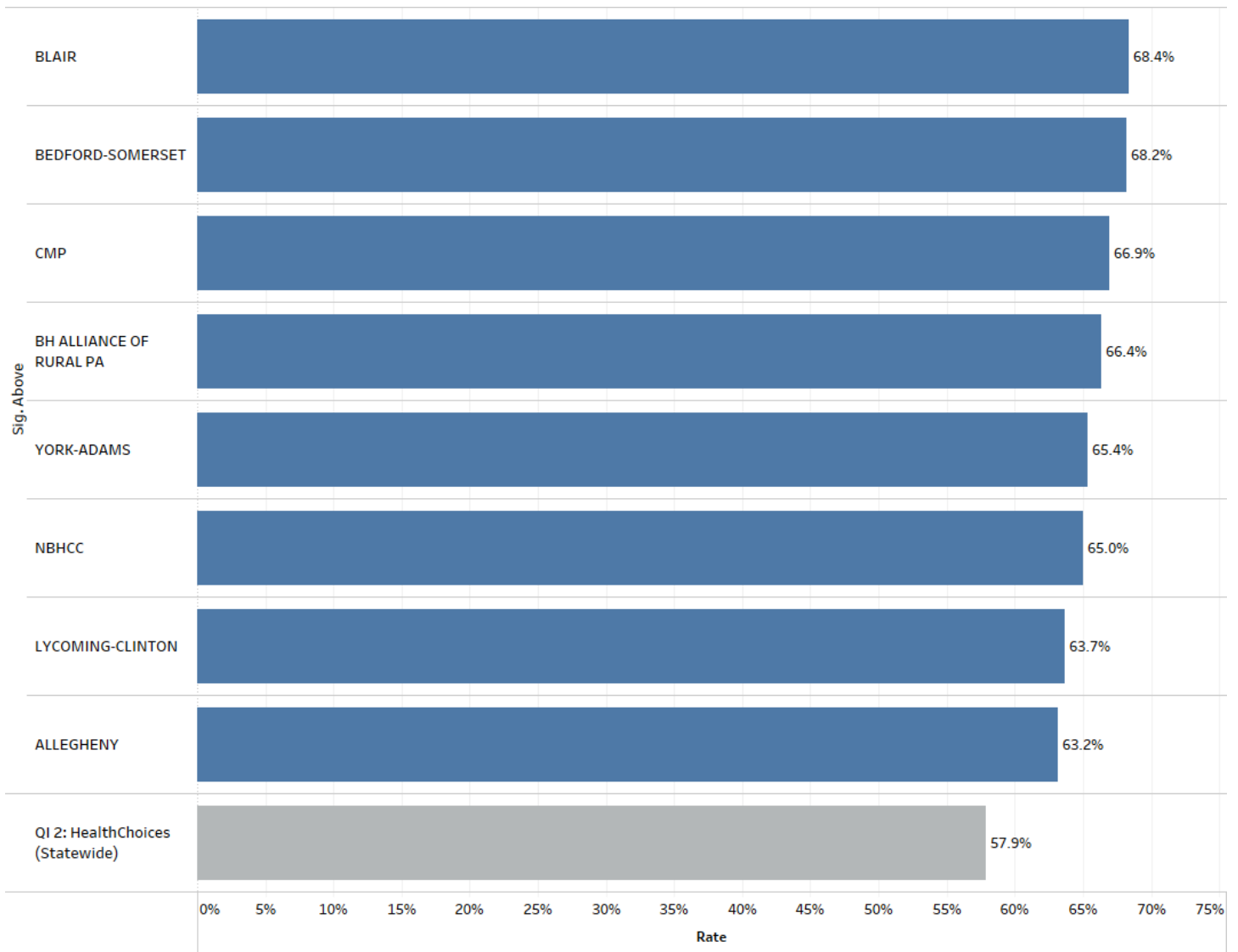
Figure 2.4: Statistically Significant Differences in CCBH Contractor MY 2021 HEDIS FUH Rates (All Ages). CCBH Primary Contractor MY 2021 HEDIS FUH rates for all ages that are significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (all ages).

(c) Age Group: 6–17 Years Old

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

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

Measure[1]	MY 2021					MY 2020 %	MY 2021 Rate Comparison to MY 2020	
	(N)	(D)	%	95% CI			PPD	SSD
				Lower	Upper			
QI1 - HEDIS 7-Day Follow-Up			**(6–17 Years)**					
Statewide	3988	7625	**52.3%**	51.2%	53.4%	55.2%	-2.9	YES
CCBH	1822	3232	**56.4%**	54.6%	58.1%	60.6%	-4.2	YES
Allegheny	301	590	**51.0%**	46.9%	55.1%	62.3%	-11.3	YES
BH Alliance of Rural PA	483	851	**56.8%**	53.4%	60.1%	59.7%	-3.0	NO
Blair	44	73	**60.3%**	N/A	N/A	55.8%	4.5	N/A
Berks	138	226	**61.1%**	54.5%	67.6%	58.9%	2.2	NO
Bedford-Somerset	34	60	**56.7%**	N/A	N/A	73.3%	-16.7	N/A
Chester	110	209	**52.6%**	45.6%	59.6%	56.6%	-3.9	NO
CMP	93	175	**53.1%**	45.5%	60.8%	59.5%	-6.4	NO
Erie	153	254	**60.2%**	54.0%	66.5%	67.0%	-6.8	NO
Lycoming-Clinton	52	114	**45.6%**	36.0%	55.2%	42.4%	3.2	NO
NBHCC	211	341	**61.9%**	56.6%	67.2%	69.4%	-7.5	NO
York-Adams	203	339	**59.9%**	54.5%	65.2%	54.5%	5.4	NO
QI2 - HEDIS 30-Day Follow-Up			**(6–17 Years)**					
Statewide	5787	7625	**75.9%**	74.9%	76.9%	77.1%	-1.2	NO
CCBH	2569	3232	**79.5%**	78.1%	80.9%	81.2%	-1.7	NO
Allegheny	461	590	**78.1%**	74.7%	81.6%	82.2%	-4.1	NO
BH Alliance of Rural PA	682	851	**80.1%**	77.4%	82.9%	81.9%	-1.8	NO
Blair	64	73	**87.7%**	N/A	N/A	84.6%	3.1	N/A
Berks	186	226	**82.3%**	77.1%	87.5%	77.9%	4.4	NO
Bedford-Somerset	48	60	**80.0%**	N/A	N/A	90.0%	-10.0	N/A
Chester	143	209	**68.4%**	61.9%	75.0%	69.7%	-1.3	NO
CMP	143	175	**81.7%**	75.7%	87.7%	79.7%	2.0	NO
Erie	208	254	**81.9%**	77.0%	86.8%	83.8%	-1.9	NO
Lycoming-Clinton	84	114	**73.7%**	65.2%	82.2%	71.7%	2.0	NO
NBHCC	275	341	**80.6%**	76.3%	85.0%	85.4%	-4.7	NO
York-Adams	275	339	**81.1%**	76.8%	85.4%	79.9%	1.3	NO

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

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; N/A: Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

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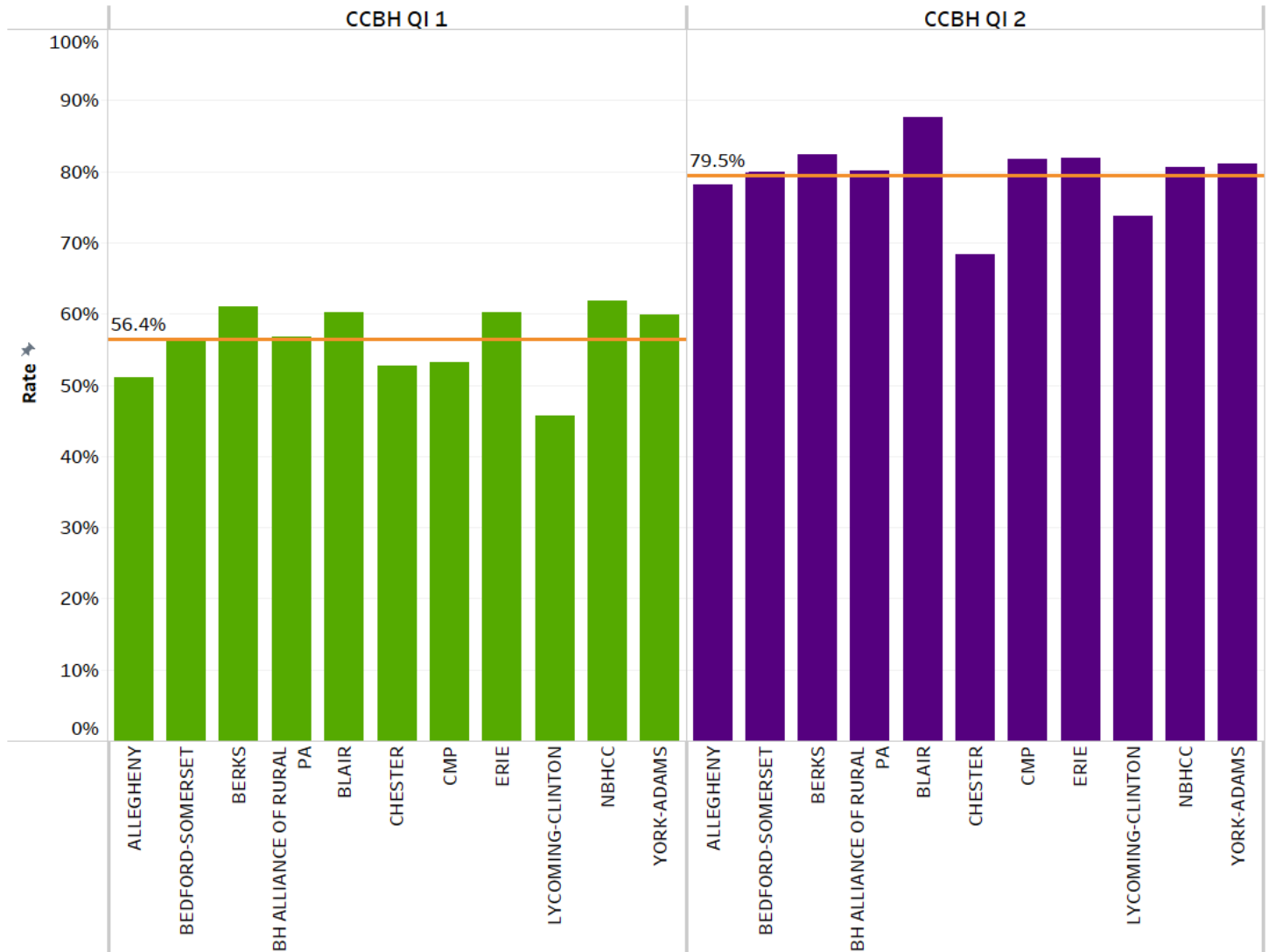

Figure 2.5: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years).

Figure 2.6 shows the HC BH (statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide rates.
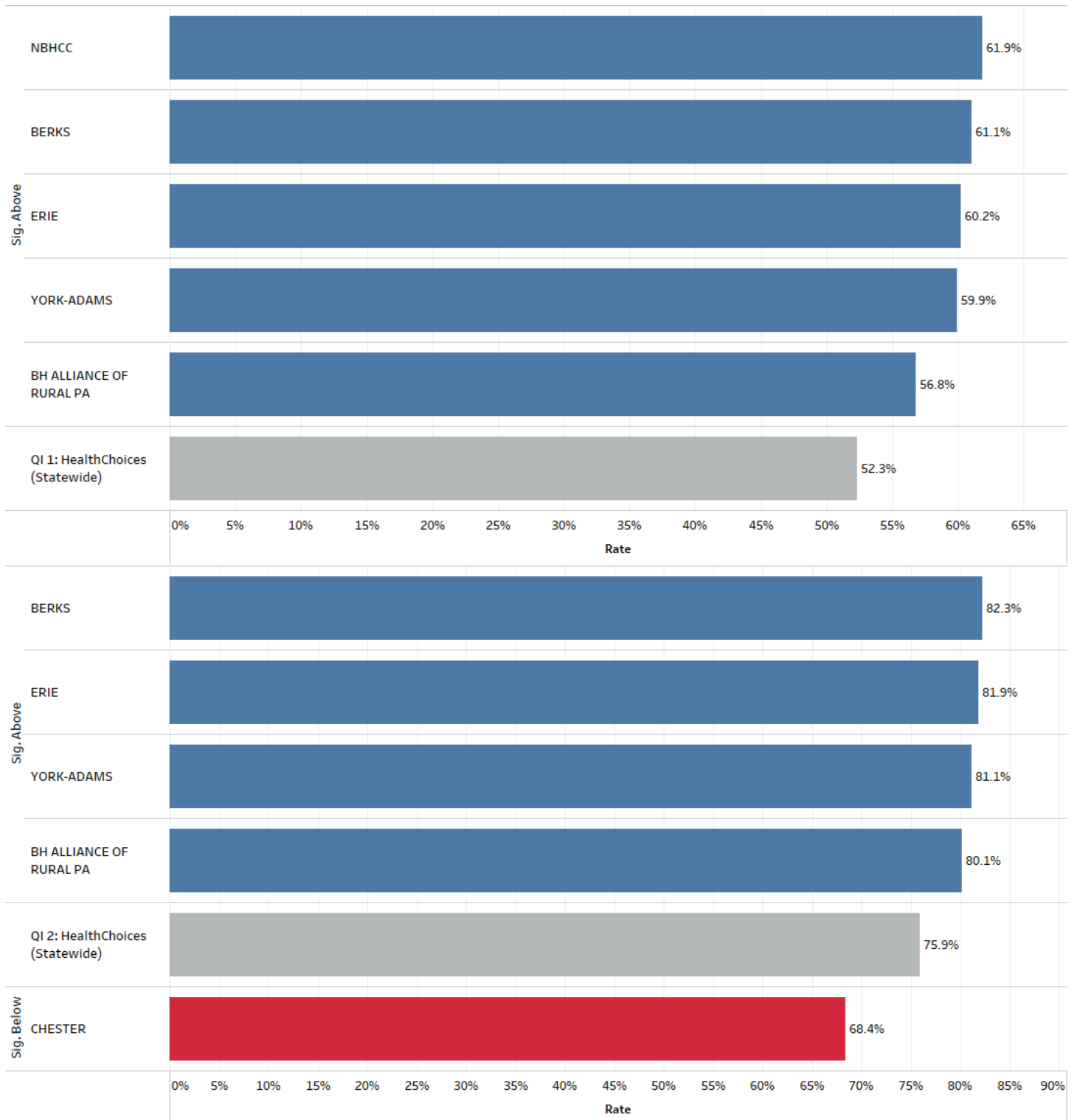
Figure 2.6: Statistically Significant Differences in CCBH Contractor MY 2021 HEDIS FUH Rates (6–17 Years). CCBH Primary Contractor MY 2021 HEDIS FUH rates for 6–17 years of age that are significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (6–17 years).

II: PA-Specific Follow-Up Indicators

(a) Overall Population: 6+ Years Old

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

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

| Measure[1] | MY 2021 | | | | | MY 2020 % | MY 2021 Rate Comparison to MY 2020 | |
| | (N) | (D) | % | 95% CI | | | PPD | SSD |
				Lower	Upper			
QI A - PA-Specific 7-Day Follow-Up			(Overall)					
Statewide	18376	37634	**48.8%**	48.3%	49.3%	52.3%	-3.5	YES
CCBH	8136	15180	**53.6%**	52.8%	54.4%	57.7%	-4.1	YES
Allegheny	1707	3146	**54.3%**	52.5%	56.0%	60.2%	-6.0	YES
BH Alliance of Rural PA	1958	3597	**54.4%**	52.8%	56.1%	56.1%	-1.7	NO
Blair	317	544	**58.3%**	54.0%	62.5%	61.1%	-2.8	NO
Berks	670	1215	**55.1%**	52.3%	58.0%	56.8%	-1.6	NO
Bedford-Somerset	146	245	**59.6%**	53.2%	65.9%	61.9%	-2.3	NO
Chester	425	910	**46.7%**	43.4%	50.0%	53.9%	-7.2	YES
CMP	351	739	**47.5%**	43.8%	51.2%	53.5%	-6.0	YES
Erie	573	1042	**55.0%**	51.9%	58.1%	59.7%	-4.7	YES
Lycoming-Clinton	237	459	**51.6%**	47.0%	56.3%	53.9%	-2.3	NO
NBHCC	1038	1893	**54.8%**	52.6%	57.1%	60.7%	-5.8	YES
York-Adams	714	1390	**51.4%**	48.7%	54.0%	54.0%	-2.6	NO
QI B - PA-Specific 30-Day Follow-Up			(Overall)					
Statewide	24798	37634	**65.9%**	65.4%	66.4%	68.3%	-2.4	YES
CCBH	10734	15180	**70.7%**	70.0%	71.4%	73.1%	-2.4	YES
Allegheny	2248	3146	**71.5%**	69.9%	73.0%	74.3%	-2.9	YES
BH Alliance of Rural PA	2600	3597	**72.3%**	70.8%	73.8%	73.1%	-0.8	NO
Blair	410	544	**75.4%**	71.7%	79.1%	77.5%	-2.1	NO
Berks	846	1215	**69.6%**	67.0%	72.3%	71.2%	-1.6	NO
Bedford-Somerset	191	245	**78.0%**	72.6%	83.4%	78.9%	-0.9	NO
Chester	546	910	**60.0%**	56.8%	63.2%	66.5%	-6.5	YES
CMP	520	739	**70.4%**	67.0%	73.7%	71.9%	-1.5	NO
Erie	715	1042	**68.6%**	65.8%	71.5%	70.1%	-1.5	NO
Lycoming-Clinton	330	459	**71.9%**	67.7%	76.1%	70.7%	1.2	NO
NBHCC	1329	1893	**70.2%**	68.1%	72.3%	75.4%	-5.2	YES
York-Adams	999	1390	**71.9%**	69.5%	74.3%	73.1%	-1.2	NO

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.
MY: measurement year; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium.

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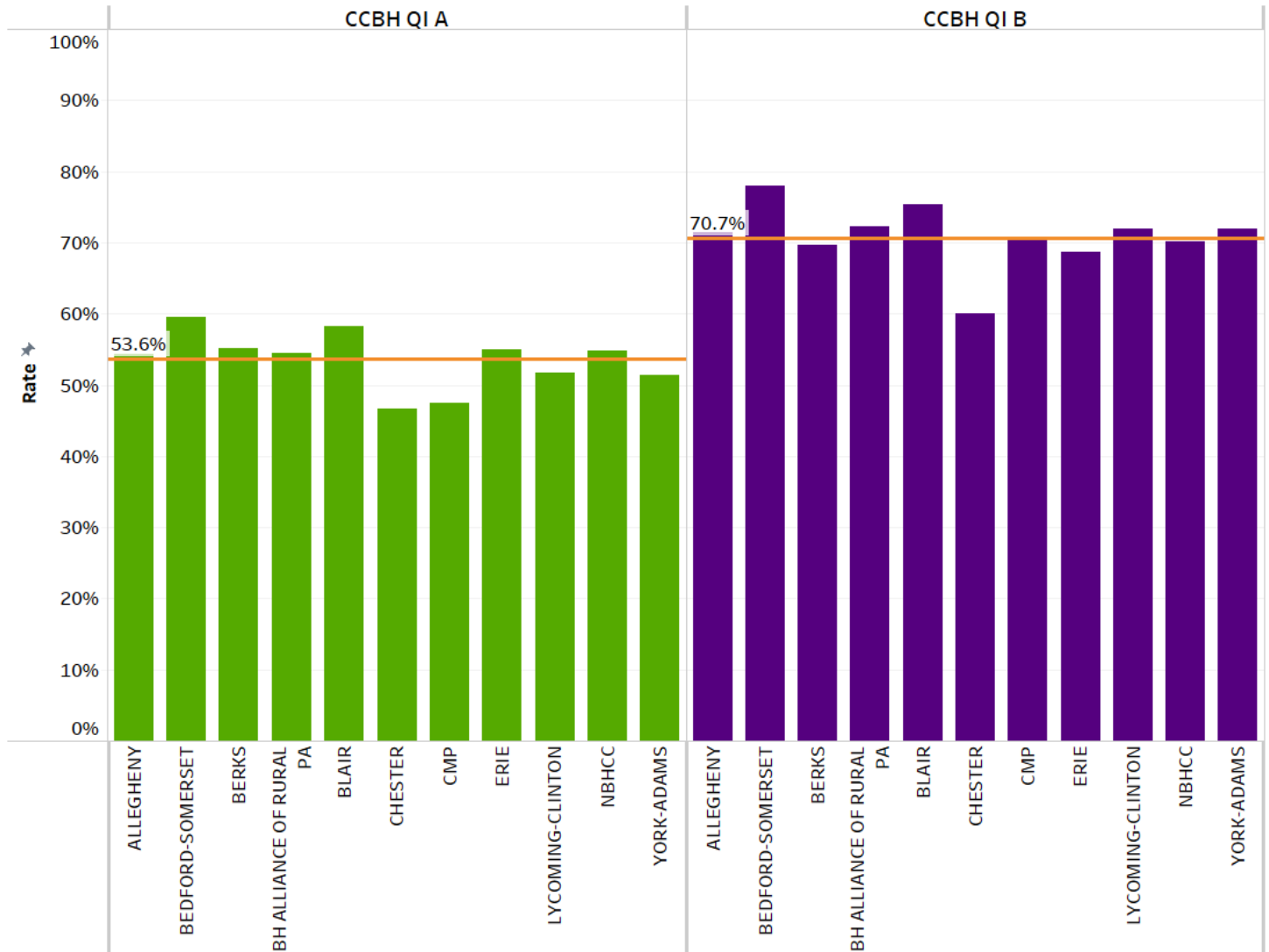

Figure 2.7: MY 2021 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages).

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

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

III. Readmission Indicators

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

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

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

Table 2.5: MY 2021 REA Readmission Indicators

Measure[1,2]	MY 2021						MY 2021 Rate Comparison to MY 2020	
	(N)	(D)	%	95% CI		MY 2020 %	PPD	SSD
				Lower	Upper			
Inpatient Readmission								
Statewide	6151	46438	**13.2%**	12.9%	13.6%	13.6%	-0.3	NO
CCBH	2336	18908	**12.4%**	11.9%	12.8%	12.4%	-0.0	NO
Allegheny	465	3882	**12.0%**	10.9%	13.0%	11.9%	0.1	NO
BH Alliance of Rural PA	479	4312	**11.1%**	10.2%	12.1%	11.5%	-0.3	NO
Blair	84	667	**12.6%**	10.0%	15.2%	15.4%	-2.8	NO
Berks	209	1524	**13.7%**	12.0%	15.5%	12.9%	0.8	NO
Bedford-Somerset	24	289	**8.3%**	4.9%	11.7%	9.6%	-1.3	NO
Chester	161	1147	**14.0%**	12.0%	16.1%	13.7%	0.3	NO
CMP	108	925	**11.7%**	9.6%	13.8%	14.2%	-2.5	NO
Erie	177	1317	**13.4%**	11.6%	15.3%	13.5%	-0.1	NO
Lycoming-Clinton	49	544	**9.0%**	6.5%	11.5%	10.2%	-1.2	NO
NBHCC	318	2483	**12.8%**	11.5%	14.1%	12.0%	0.8	NO
York-Adams	262	1818	**14.4%**	12.8%	16.1%	13.5%	1.0	NO

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

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

MY: measurement year; REA: Readmission within 30 Days of Inpatient Psychiatric Discharge; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; HC: HealthChoices; BH: behavioral health; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium.

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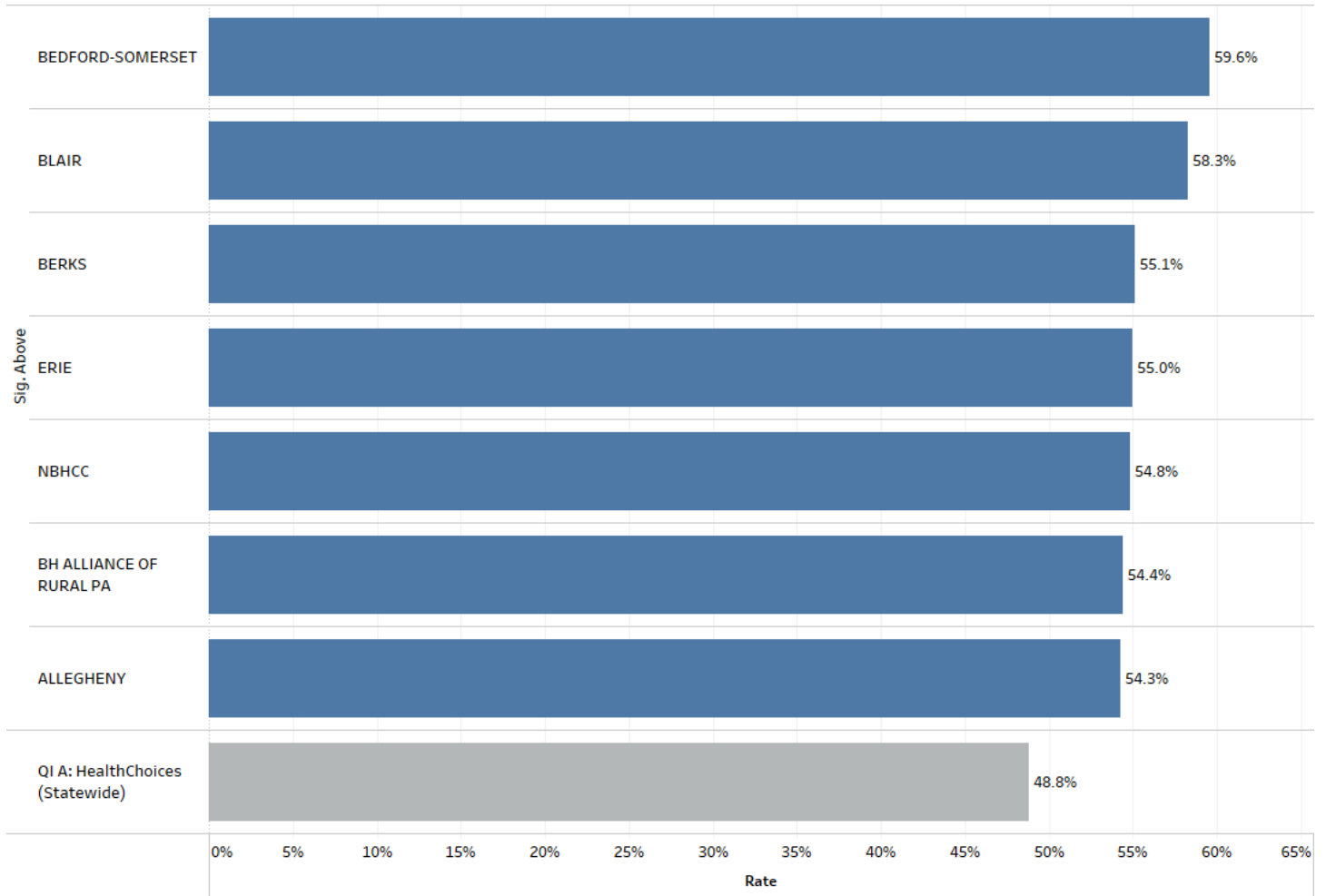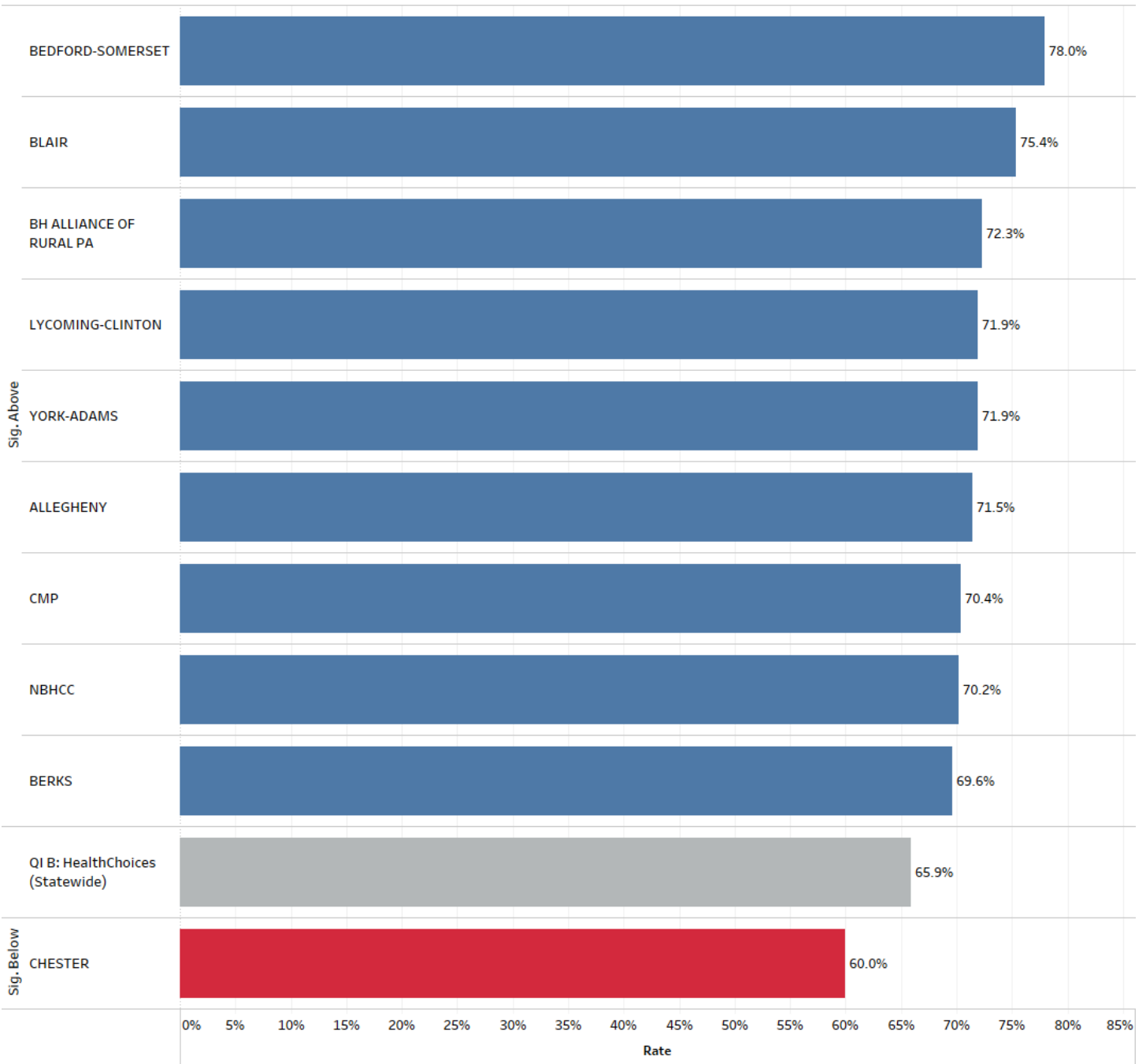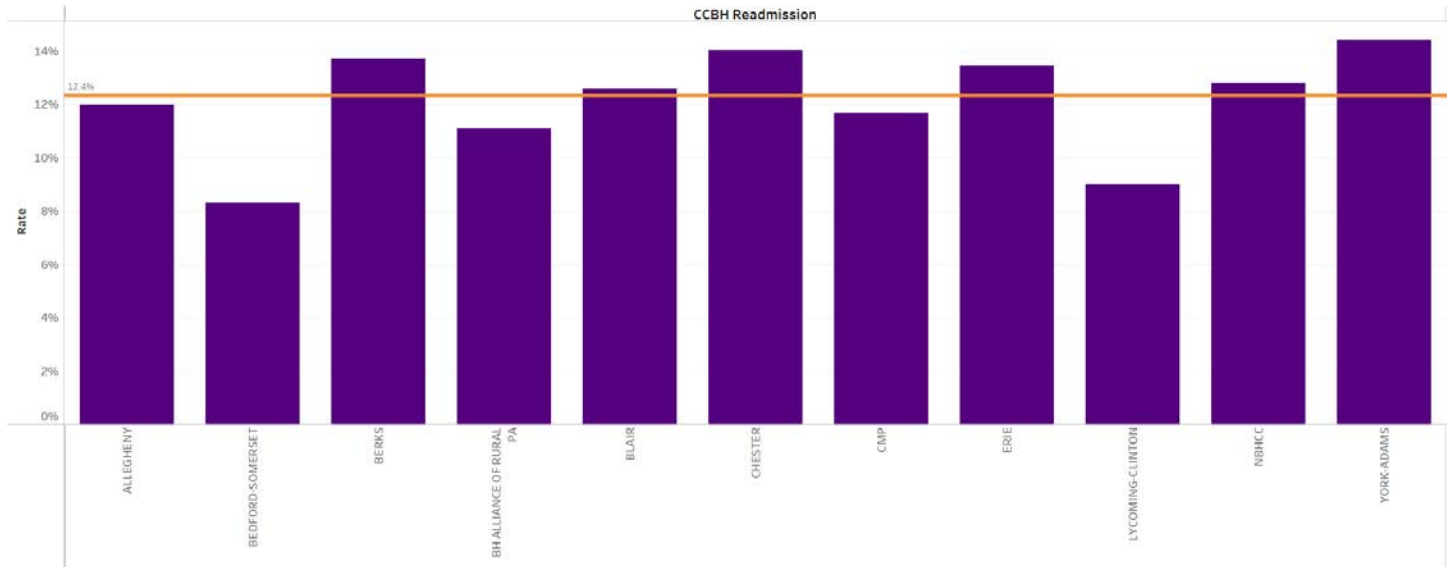

Figure 2.9: MY 2021 REA Rates for CCBH Primary Contractors.

Figure 2.10 shows the HC BH (statewide) readmission rate and the individual CCBH Primary Contractors that performed statistically significantly higher (red) or lower (blue) than the HC BH statewide rate.
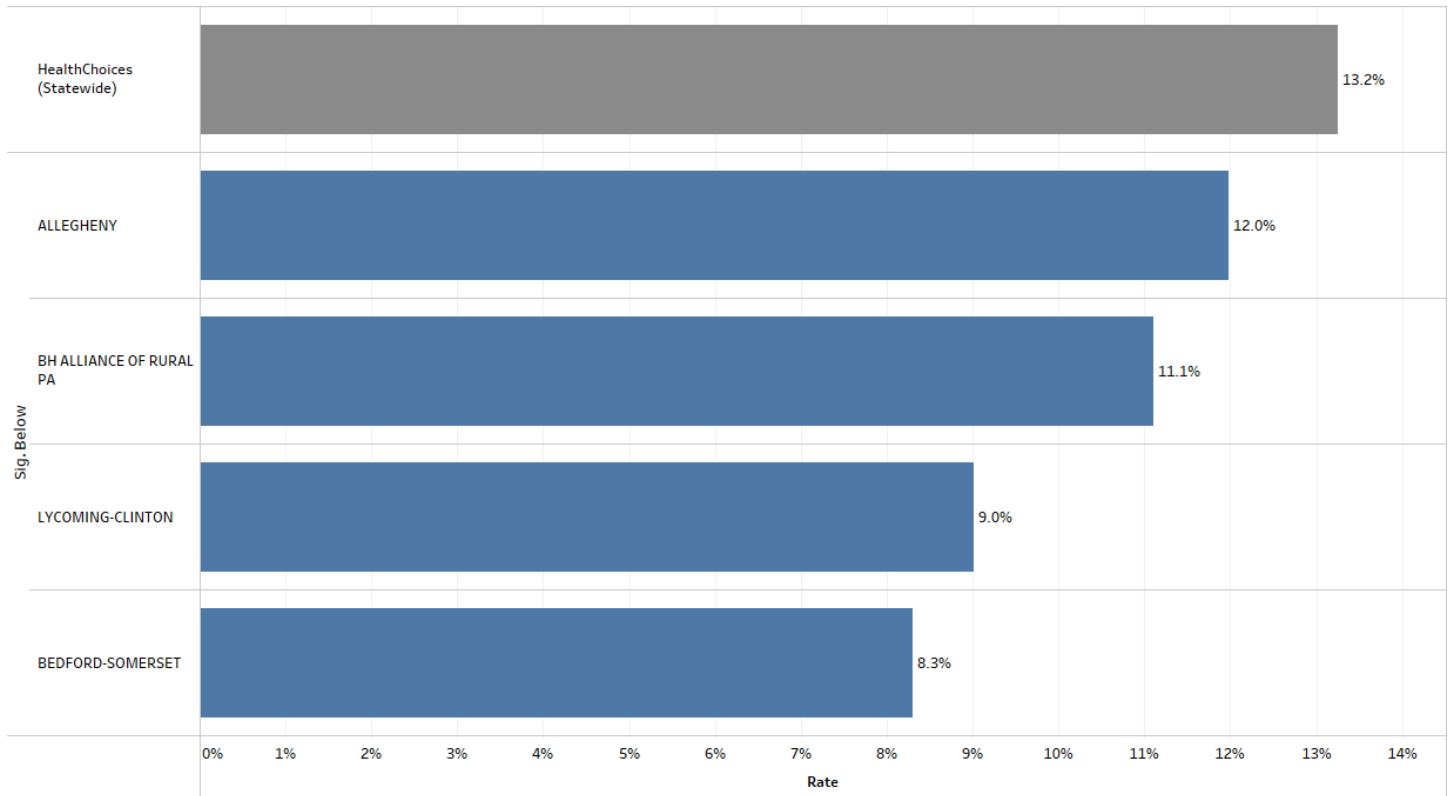
Figure 2.10: Statistically Significant Differences in CCBH Primary Contractor MY 2021 REA Rates (All Ages). CCBH Primary Contractor MY 2021 REA rates for all ages that are significantly different than HC BH (statewide) MY 2021 REA rates (all ages).

Recommendations

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

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

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

For the MCO in MY 2021, the readmission rates after psychiatric discharge were similar to MY 2020. Nevertheless, CCHB's readmission rate after psychiatric discharge for the Medicaid managed care (MMC) population generally remains above 11.75%, the statewide maximum goal. Four Primary Contractors that fell below 11.75% and met the statewide goal were Bedford-Somerset, BHARP, CMP, and Lycoming-Clinton. 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 2021 study, the following are recommendations for improving (reducing) readmission rates after psychiatric discharge:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2021 to promote continuous quality improvement with regard to mental health discharges that result in a readmission. The information contained

within this study should be used to further develop strategies for decreasing the likelihood that at-risk members will be readmitted. In 2020, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. A new PIP starting in 2021 builds on the previous PIP by, among other things, including a performance indicator that measures MH-related readmissions within 30 days of a discharge for SUD. BH-MCOs are expected to bring about meaningful improvement in BH readmission rates for this subpopulation with comorbid BH conditions and for their HC BH members more generally. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing BH readmissions. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission.

- The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit higher readmission rates (e.g., urban populations). Comparisons among demographic groups were carried out in a separate 2022 (MY 2021) REA Rates Report produced by the EQRO which is being made available to BH MCOs in an interactive Tableau workbook.

- BH-MCOs and Primary Contractors are encouraged to review the 2022 (MY 2021) REA Rates Report in conjunction with the aforementioned 2022 (MY 2021) FUH Rates Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission within 30 days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

III: Compliance with Medicaid Managed Care Regulations

Objectives

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

Operational reviews are completed for each HC-OE. The Primary Contractor, whether contracting with an OE arrangement or not, is responsible for their regulatory compliance to federal and state regulations and the HC BH PS&R Agreement compliance. The HC BH PS&R Agreement includes the Primary Contractor's responsibility for the oversight of the BH-MCO's compliance.

In the CCBH managed care network, Allegheny, Berks, Chester, and Erie Counties hold contracts with CCBH. Carbon, Monroe, and Pike Counties hold a contract with CCBH as the Carbon-Monroe-Pike Joinder Board. Lackawanna, Luzerne, Susquehanna, and Wyoming Counties hold a contract with Northeast Behavioral Health Care Consortium (NBHCC), which, in turn, holds a contract with CCBH. Effective July 1, 2021, 23 Northcentral counties (Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne) entered into a capitated agreement through a new Primary Contractor, Behavioral Health Alliance of Rural Pennsylvania, Inc. (BHARP). Through BHARP, these 23 counties maintained their contract with CCBH. Effective January 1, 2022, Greene County joined BHARP, effectively changing its contracted MCO from BHO to CCBH. For Blair County, the Primary Contractor is Blair HC. For Clinton and Lycoming Counties, the Primary Contractor is the Lycoming-Clinton Joinder Board. For York and Adams Counties, the Primary Contractor is the York-Adams HC Joinder Governing Board. On July 1, 2019, the Bedford-Somerset HC-OE changed contracts from PerformCare to CCBH. MMC compliance findings for any HC-OE changing MCO contracts are not included in BBA reporting for a period of 3 years after the change. **Table 3.1** shows the name of the HC-OE, the associated HC Primary Contractor(s), and the county or counties encompassed by each Primary Contractor.

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

HealthChoices Oversight Entity	Primary Contractor	County
Allegheny HealthChoices, Inc. (AHCI)	Allegheny County	Allegheny County
Berks County	Berks County	Berks County
Behavioral Health Services of Somerset and Bedford Counties (BHSSBC)	Behavioral Health Services of Somerset and Bedford Counties (BHSSBC) Otherwise known as Bedford-Somerset for review	Bedford County
		Somerset County
Central Pennsylvania Behavioral Health Collaborative (d/b/a Blair HealthChoices)	Blair HealthChoices	Blair County
Carbon/Monroe/Pike Joinder Board (CMP)	Carbon/Monroe/ Pike Joinder Board (CMP)	Carbon County
		Monroe County
		Pike County
Chester County	Chester County	Chester County
Erie County	Erie County	Erie County
Lycoming-Clinton Joinder Board	Lycoming-Clinton Joinder Board	Clinton County
		Lycoming County
Northeast Behavioral Health Care Consortium (NBHCC)	Northeast Behavioral Health Care Consortium (NBHCC)	Lackawanna County
		Luzerne County
		Susquehanna County
		Wyoming County
Behavioral Health Alliance of Rural Pennsylvania	Behavioral Health Alliance of Rural Pennsylvania (BHARP)	Bradford County
		Cameron County
		Centre County
		Clarion County

HealthChoices Oversight Entity	Primary Contractor	County
		Clearfield County
		Columbia County
		Elk County
		Forest County
		Huntingdon County
		Jefferson County
		Juniata County
		McKean County
		Mifflin County
		Montour County
		Northumberland County
		Potter County
		Schuylkill County
		Snyder County
		Sullivan County
		Tioga County
		Union County
		Warren County
		Wayne County
York/Adams HealthChoices Management Unit	York/Adams HealthChoices Joinder Governing Board	Adams County
		York County

CCBH: Community Care Behavioral Health.

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CCBH by OMHSAS monitoring staff within the past 3 review years (RYs 2021, 2020, and 2019). These evaluations are performed at the BH-MCO and Primary Contractor levels, and the findings are reported in OMHSAS's PEPS Review Application for 2021. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HC BH Program contract are documented in the RAI. If the Readiness Review occurred within the 3-year time frame under consideration, the RAI was provided to IPRO. For those Primary Contractors and BH-MCOs that completed their Readiness Reviews outside of the current 3-year time frame, the Readiness Review substandards were deemed as complete. As necessary, the HC BH PS&R are also used.

Description of Data Obtained

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2021 and entered into the PEPS Application as of March 2022 for RY 2021. Information captured within the PEPS Application informs this report. The PEPS Application is a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each BH-MCO. Within each standard, the PEPS Application specifies the substandards or items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area in which to collect or capture additional reviewer comments. Based on the PEPS Application, an BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations ("categories"), as well as against related supplemental OMHSAS-specific PEPS substandards that are part of OMHSAS's more rigorous monitoring criteria.

At the implementation of the PEPS Application in 2004, IPRO evaluated the standards in the PEPS Application and created a crosswalk to pertinent BBA regulations. For standards with substandards, all of the substandards within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the substandards required for fulfilling BBA

requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS's ongoing monitoring. In the amended crosswalk, the supplemental substandards no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS substandards concerning first-level complaints and grievances inform the compliance determination of the BBA categories relating to federal and state grievance systems standards. All of the PEPS substandards concerning second-level complaints and previously second-level grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category.

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

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

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

Because OMHSAS's review of the Primary Contractors and their subcontracted BH-MCOs occurs over a 3-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The 3-year period is alternatively referred to as the Active Review period. The PEPS substandards from RY 2021, RY 2020, and RY 2019 provided the information necessary for the 2021 assessment. Those triennial standards not reviewed through the PEPS system in RY 2021 were evaluated on their performance based on RY 2020 and/or RY 2019 determinations, or other supporting documentation, if necessary. For those HC-OEs that completed their Readiness Reviews within the 3-year time frame under consideration, RAI substandards were evaluated when none of the PEPS substandards crosswalked to a particular BBA category were reviewed.

For CCBH, a total of 72 unique substandards were applicable for the evaluation of BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2021, 2020, 2019). In addition, 18 OMHSAS-specific substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. Some PEPS substandards crosswalk to more than one BBA category, while each BBA category crosswalks to multiple substandards. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific substandards that are not required as part of BBA regulations but are reviewed within the 3-year cycle to evaluate the BH-MCO and the associated Primary Contractor against other state-specific Structure and Operations Standards.

Table 3.2 tallies the PEPs substandard reviews used to evaluate the BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2019–2021). Substandard counts under RY 2021 comprised annual and triennial substandards. Substandard counts under RYs 2020 and 2019 comprised only triennial substandards. By definition, only the last review of annual substandards is

counted in the 3-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 3.2**, 94, differs from the unique count of substandards that came under active review (72).

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

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	2021	2020	2019
CMS EQR Protocol 3 "sections": Standards, Including enrollee rights and protections					
Assurances of adequate capacity and services (Title 42 CFR § 438.207)	5	-	5	-	-
Availability of Services (Title 42 CFR § 438.206, Title 42 CFR § 10(h))	24	-	14	4	6
Confidentiality (Title 42 CFR § 438.224)	1	-	-	1	
Coordination and continuity of care (Title 42 CFR § 438.208)	2	-	2	-	
Coverage and authorization of services (Title 42 CFR Parts § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114)	4	-	4	-	-
Health information systems (Title 42 CFR § 438.242)	1	-	-	1	-
Practice guidelines (Title 42 CFR § 438.236)	6	-	2	4	-
Provider selection (Title 42 CFR § 438.214)	3	-	-	-	3
Subcontractual relationships and delegation (Title 42 CFR § 438.230)	8	-	-	8	-
CMS EQR Protocol 3 "sections": Quality assessment and performance improvement (QAPI) program					
Quality assessment and performance improvement program (Title 42 CFR § 438.330)	26	-	19	7	-
CMS EQR Protocol 3 "sections": Grievance system					
Grievance and appeal systems (Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424)	14	-	14	-	-
Total	**94**	**-**	**60**	**25**	**9**

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

[2] The number of substandards that came under active review during the cycle specific to the review year. Because substandards may crosswalk to more than one category, the total tally of substandard reviews, 94, differs from the unique count of substandards that came under active review (72).

RY: review year; BBA: Balanced Budget Act; CCBH: Community Care Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: substandards not reviewed; CMS: Centers for Medicare and Medicaid Services; EQR: external quality review; CFR: Code of Federal Regulations.

Determination of Compliance

To evaluate Primary Contractor BH-MCO compliance with individual provisions, IPRO grouped the required and relevant monitoring substandards by provision (category) and evaluated the Primary Contractors' and BH-MCO's compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of "met," "partially met," or "not met" in the PEPS Application submitted by PA. If a substandard was not evaluated for a particular HC-Primary Contractor/BH-MCO, it was assigned a value of "not reviewed." Compliance with the BBA provisions was then determined based on the aggregate results across the 3-year period of the PEPS items linked to each provision. If all items were met, the Primary Contractor/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the Primary Contractor/BH-MCO was evaluated as partially compliant. If all items were not met, the Primary Contractor/BH-MCO was evaluated as non-compliant. A value of not applicable (N/A) was assigned to provisions for which a compliance review was not required. A value of null was assigned to a provision when none of the existing PEPS substandards directly covered the items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results within a given category were aggregated to arrive at a summary compliance status for the category. For example, compliance findings relating to provider network mix and capacity are summarized under Assurances of adequate capacity and services, *Title 42 CFR § 438.207*.

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three sections set out in the BBA regulations and described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[22] Under each general section heading are the individual regulatory categories appropriate to those headings. IPRO's findings are therefore organized under standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement (QAPI) Program, and Grievance System.

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

Findings

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

Standards, Including Enrollee Rights and Protections

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

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

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Assurances of adequate capacity and services Title 42 CFR § 438.207	5	Compliant	All CCBH Primary Contractors	1.1, 1.2, 1.4, 1.5, 1.6	-	-
Availability of Services Title 42 CFR § 438.206, Title 42 CFR § 10(h)	24	Partial	All CCBH Primary Contractors	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 23.1, 23.2, 23.3, 23.4, 23.5, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 28.2, 93.1, 93.2, 93.3, 93.4	-	28.1
Confidentiality Title 42 CFR § 438.224	1	Compliant	All CCBH Primary Contractors	120.1	-	-
Coordination and continuity of care Title 42 CFR § 438.208	2	Partial	All CCBH Primary Contractors	28.2	-	28.1
Coverage and authorization of services Title 42 CFR Parts § 438.210(a–e), Title	4	Partial	All CCBH Primary Contractors	28.2, 72.1,	72.2	28.1

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
42 CFR § 441, Subpart B, and § 438.114						
Health information systems Title 42 CFR § 438.242	1	Compliant	All CCBH Primary Contractors	120.1	-	-
Practice guidelines Title 42 CFR § 438.236	6	Partial	All CCBH Primary Contractors	28.2, 93.1, 93.2, 93.3, 93.4	-	28.1
Provider selection Title 42 CFR § 438.214	3	Compliant	All CCBH Primary Contractors	10.1, 10.2, 10.3	-	-
Subcontractual relationships and delegation Title 42 CFR § 438.230	8	Compliant	All CCBH Primary Contractors	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8	-	-

MCO: managed care organization; CFR: Code of Federal Regulations; CCBH: Community Care Behavioral Health.

There are nine (9) categories within standards, including Enrollee Rights and Protections. CCBH was compliant with five categories and partially complaint with four categories.

For this review, 54 PEPS substandards were crosswalked to categories within Compliance with Standards, Including Enrollee Rights and Protections. All 54 substandards were evaluated for all Primary Contractors associated with CCBH. Primary Contractors with CCBH were compliant in 49 instances, partially compliant in 1 instance, and not compliant in 4 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
CCBH was partially compliant with Availability of Services due to non-compliance with 1 substandard within Standard 28 (RY 2021).

CCBH was partially compliant with Substandard 1 of Standard 28.

Standard 28: BH-MCO has a comprehensive, defined program of care that incorporates longitudinal disease management.
    Substandard 1: Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.

Coordination and continuity of care
CCBH was partially compliant with Coordination and continuity of care due to non-compliance with 1 substandard within Standard 28 (RY 2021).

Standard 28: See Standard description and determination of compliance under Availability of Services.
    Substandard 1: See Substandard description and determination of compliance under Availability of Services.

Coverage and Authorization of Services

CCBH was partially compliant with Coverage and Authorization of Services due to non-compliance with 1 substandard within Standard 28 (RY 2021) and partial compliance with 1 substandard within Standard 72 (RY 2021).

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

Practice Guidelines

CCBH was partially compliant with Availability of Services due to non-compliance with 1 substandard within Standard 28 (RY 2019).

Standard 28: See Standard description and determination of compliance under Availability of Services.
> **Substandard 1:** See Substandard description and determination of compliance under Availability of Services.

Quality Assessment and Performance Improvement Program

The general purpose of the regulations included under this subpart is to ensure that all services available under the PA's MMC program, the HC Program, are available and accessible to MCO enrollees. The PEPS documents include an assessment of the Primary Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 3.4** presents the findings by categories consistent with the regulations.

Table 3.4: Compliance with Quality Assessment and Performance Improvement Program

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Quality assessment and performance improvement program Title 42 CFR § 438.330	26	Compliant	All CCBH Primary Contractors	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, 93.4, 93.3, 98.1, 98.2, 98.3, 104.1, 104.2, 104.3, 104.4	-	-

MCO: managed care organization; CFR: Code of Federal Regulations; CCBH: Community Care Behavioral Health.

For this review, 26 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 26 substandards were reviewed for all Primary Contractors associated with CCBH. CCBH and its Primary Contractors were compliant with 26 substandards.

Grievance System

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances. The PEPS documents include an assessment of the Primary Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 3.5** presents the findings by categories consistent with the regulations.

Table 3.5: Compliance with Grievance System

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

MCO: managed care organization; CFR: Code of Federal Regulations; CCBH: Community Care Behavioral Health.

For this review, 14 substandards were crosswalked to Grievance System. All 14 substandards were reviewed for all Primary Contractors associated with CCBH. CCBH and its Primary Contractors were compliant with 12 substandards and partially compliant with 2 substandards.

Grievance and Appeal Systems

CCBH was partially compliant with Grievance and Appeal Systems due to partial compliance with substandards of PEPS Standards 71 (RY 2021) and 72 (RY 2021).

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 7: Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.

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

IV: Validation of Network Adequacy

Objectives

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

Description of Data Obtained

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

Findings

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

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

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

Standard 78: Evidence exists of the County's oversight of functions and activities delegated to the BH-MCO including: a. County Table of Organization showing a clear organization structure for oversight of BH-MCO functions. b. In the case of a multi-county contract, the Table of Organization shows a clear relationship among and between Counties' management structures, as it relates to the BH-MCO oversight. c. The role of the Single County Authority (SCA) in oversight is clear in the oversight structure. d. Meeting schedules and attendee minutes reflect County oversight of the BH-MCO (e.g., adequate staff with appropriate skills and knowledge that regularly attend meetings and focus on monitoring the contract and taking appropriate action, such as CAPs. e. Documentation of the County's reviews and/or audits of quality and accuracy of the major BH-MCO functions, including: 1) Care Management, 2) Quality Assurance (QA), 3) Financial Programs, 4) MIS, 5) Credentialing, 6) Grievance System, 7) Consumer Satisfaction, 8) Provider Satisfaction, 9) Network Development, Provider Rate Negotiation, and 10) Fraud, Waste, and Abuse (FWA).

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

Table 4.1: Compliance with Standards Related to Network Adequacy

Standard Description	Substandard Count	MCO Compliance Status	Primary Contractors	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Standard 1	7	Compliant	All CCBH Primary Contractors	1.1, 1.2, 1.4, 1.5, 1.6, 1.7	-	-
Standard 10	3	Compliant	All CCBH Primary Contractors	10.1, 10.2, 10.3	-	-
Standard 11	3	Compliant	All CCBH Primary Contractors	11.1, 11.2, 11.3	-	-
Standard 23	5	Compliant	All CCBH Primary Contractors	23.1, 23.2, 23.3, 23.4, 23.5	-	-
Standard 24	6	Compliant	All CCBH Primary Contractors	24.1, 24.2, 24.3, 24.4, 24.5, 24.6	-	-
Standard 59	1	Compliant	All CCBH Primary Contractors	59.1	-	-
Standard 78	5	Partial	Allegheny, Erie	78.1, 78.2, 78.3, 78.4,	78.5	
			Bedford-Somerset, Berks, Blair, Carbon/Monroe/Pike, Chester, Lycoming/Clinton, NBHCC, York/Adams	78.1, 78.2, 78.3, 78.4	-	78.5
			BHARP	78.2, 78.3, 78.4	78.1	78.5
Standard 91	15	Compliant	All CCBH Primary Contractors	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	-	-
Standard 93	4	Compliant	All CCBH Primary Contractors	93.1, 93.2, 93.3, 93.4	-	-
Standard 99	8	Compliant	All CCBH Primary Contractors	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8	-	-
Standard 100	1	Compliant	All CCBH Primary Contractors	100.1	-	-

MCO: managed care organization; CFR: Code of Federal Regulations; CCBH: Community Care Behavioral Health.

For this review, 58 substandards were crosswalked to Network Adequacy. All 58 substandards were reviewed for CCBH and its Primary Contractors. CCBH and these Primary Contractors were compliant with 56 substandards and partially compliant with 2 substandards.

CCBH was partially compliant with Standard 78 due to partial compliance with two substandards.

Standard 78 (see description above)

    Substandard 1: Review of County/Corporation management minutes demonstrate actions taken. BH-MCO written notification of key staff changes received within seven days-watch for high turnover, vacant positions.

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

While the specific findings and corresponding remediations related to Substandard 5 varied across CCBH's Primary Contractors, all Primary Contractors were subject to the following corrective action plan: In collaboration with the BH-MCO, the Primary Contractor must strengthen network monitoring and oversight to ensure timely access to children's services (e.g., IBHS, child psychiatrists).

V: Quality Studies

Objectives

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

Integrated Community Wellness Centers

In 2019, PA DHS made the decision to discontinue participation in the CCBHC Demonstration but to continue and build on the CCBHC model in a PA DHS-administered Integrated Community Wellness Centers (ICWC) program under an MMC agreement with CMS. The purpose of the CCBHC Demonstration was to develop and test an all-inclusive (and all-payer) prospective payment system model for community clinics to integrate behavioral and physical health care services in a more seamless manner. The model is centered on the provision of nine core services. Crisis services, BH screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services, along with outpatient clinic primary care screening and monitoring, are provided or managed directly by the ICWC clinics. The other services, including targeted case management, peer support, psychiatric rehabilitation services, and intensive community-based mental health care to members of the armed forces and veterans may be provided through a contract with a Designated Collaborating Organization (DCO). To receive CCBHC certification, clinics also had to provide a minimum set of evidence-based practices (EBP), which was selected based on community needs assessments and centered on recovery-oriented care and support for children, youth, and adults. Under ICWC, the same nine core services of the CCBHC model are provided under PA's HC MMC program using a similar bundled payment arrangement with clinics certified to participate as ICWC clinics. For the first year of ICWC, 2020, the original seven clinics—Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA)—were invited to participate in the new program.

Description of Data Obtained

Like CCBHC, ICWC features a process measure dashboard, hosted by the EQRO. Clinics enter monthly, quarterly, and year-to-date (YTD) data into a REDCap® project which feeds, on a weekly basis, a server-based Tableau workbook where clinics are able to monitor progress on the implementation of their ICWC model. Using the Dashboard, clinics in 2021 tracked and reported on clinical activities in a range of quality domains reflecting the priorities of the initiative: clinic membership, process, access and availability, engagement, evidence-based practices, and client satisfaction. The Tableau workbook also featured a comparative display that showed clinic and statewide results on each process measure.

Findings

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

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

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

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

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

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

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

VI: 2021 Opportunities for Improvement – MCO Response

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each BH-MCO has effectively addressed the opportunities for improvement cited by IPRO in the 2021 (MY 2020) EQR annual technical report and in the 2022 (MY 2021) FUH All-Ages Goal Report.

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

The BH-MCOs are required by OMHSAS to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the PA Medicaid BH-MCOs. These activities follow a longitudinal format and are designed to capture information relating to:
● follow-up actions that the BH-MCO has taken through June 30, 2022, to address each recommendation;
● future actions that are planned to address each recommendation;
● when and how future actions will be accomplished;
● the expected outcome or goals of the actions that were taken or will be taken; and
● the BH-MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

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

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

Quality Improvement Plan for Partial and Non-compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2020, CCBH began to address opportunities for improvement related to compliance categories within one of the three CMS sections pertaining to compliance with MMC regulations. Within Compliance with Grievance System, CCBH was partially compliant with Grievance and Appeal Systems. Proposed actions and evidence of actions taken by CCBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring CCBH into compliance with the relevant Standards.

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

Table 6.1: CCBH's Responses to Opportunities for Improvement

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2019, RY 2020, and RY 2021 found CCBH to be partially compliant with all three sections in CMS Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22/Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
CCBH 2022.01	Within CMS EQR Protocol 3: Compliance with Grievance System, CCBH was partially compliant with Grievance and appeal systems.	N/A	Grievance and Appeal Systems - PEPS standard 68.3, 68.4, 68.7, 68.9 (RY 2018, partially compliant); Standard 71.3 and 71.7 (RY 2018, partially compliant); Standard 72 (RY2019, partially compliant) PEPS Standard 68.3, 68.4, 68.7, and 68.9 (RY2018) **Community Care received notification that standards 68.9, 71.3, and 71.7 had no additional action needed following completion of the CAP Matrix review by OMHSAS.**
		N/A	For **PEPS standard 71.1**, Community Care submitted a CAP to OMHSAS in January 2022 that included adding a witness signature and a provider plan identification number to Community Care's Authorization for Request form for Provider to file a Grievance on behalf of the member.

CCBH: Community Care Behavioral Health; MCO: managed care organization; RY: reporting year = measurement year; PEPS: Program Evaluation Performance Summary.

Root Cause Analysis and Quality Improvement Plan

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

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

Following several years of underperformance in the key quality indicator areas and coinciding with the phase-in of Value-Based Payment (VBP) at the HC BH Contractor level, OMHSAS determined in 2018 that it was necessary to change the PM remediation process so that BH-MCOs would set goals for the coming year. OMHSAS directed BH-MCOs to begin focusing their RCA and CAP work on the HEDIS FUH All Ages measure and implemented a new goal-setting logic to spur performance improvement in the measure. Based on the MY2017 performance, BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and CAPs to achieve their MY 2019 goals. HC BH Contractors that scored below the 75th NCQA Quality Compass percentile were also asked to submit RCAs and CAPs. BH-MCOs submitted their RCAs and CAPs on April 1, 2019. HC BH Contractors submitted their RCAs and CAPs by April 30, 2019. As a result of this shift to a proactive process, MY 2018 goals for FUH All Ages were never set. However, MY 2018 results were calculated in late 2019 to determine RCA and "Quality Improvement Plan" (QIP) assignments, along with goals, for MY2020, and this proactive goal-setting approach has been in place ever since.

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

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

CCBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):	*Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*

The overall opportunity for improvement, which is the focus of this root-cause-analysis and quality improvement plan, was identified using the MY 2021 FUH Goal Report. Attachment:

IPRO's Quality Management Dashboard was used to determine disparities in HEDIS 7-day follow-up post hospitalization (FUH).

The following information/analysis was used to identify the factors that contributed to underperformance:
- 2022 HealthChoices Membership Analysis
- Analyses of Care Management Admission Interviews.
- An analysis of network availability of practitioners who identified as being Black/African American and providers who identified a specialization in treating Black/African American individuals.
- A drilldown analysis of members with and without 7-day follow-up appointments in aggregate and in contract specific groupings.
- Barrier analysis of North Central State Option completed by the Behavioral Health Alliance of Rural Pennsylvania.
- Board Quality Improvement Committee reports for network availability, and assessment of cultural needs.
- Compilation of Discharge Management Planning follow-up meetings that occurred with inpatient mental health providers in 2019.
- Information from Community Care's RCA submitted in 2022, which reflects alignment with our contractors' QIP submissions. Quality Managers from

Logic Models:

The following opportunity for improvement was identified requiring the root-cause-analysis and quality improvement plan:

Performance Measure	MY 2021 (N)	MY 2021 (D)	MY 2021 Rate
FUH HEDIS 7-Day All Ages	6,552	15,137	43.3%

The following disparities with a statistically significant difference (SSD) were identified among members with an IPMH admission:
- In the aggregate, the Black/African American cohort was less likely to have follow-up within 7-Days compared to the White cohort.
  - This also applied to the Allegheny contract (HCAL).
- In HCBK, the White cohort was less likely to have follow-up within 7-days than members who selected Other or chose not to respond.
  - The drill down analysis concluded that of the 406 members with an inpatient mental health admission in HCBK, who fall under "other/chose not to respond" for race, 63% identified as Hispanic.
  - For the remaining 37% of members who fall under the "other/chose not to respond" for race, additional discerning demographics were unable to be identified.
  - Interventions developed to address all Community Care members will apply in this situation.
- In the aggregate, the non-Hispanic cohort with an inpatient mental health admission were less likely to have follow-up within 7-days than the Hispanic cohort.
  - This also applied to HCNB.
  - The HCBK and HCCK non-Hispanic cohort with an inpatient mental health admission were less likely to have follow-up within 30-days.

Community Care conducted a literature review and data analysis of Hispanic and non-Hispanic members with an inpatient mental health admission in 2021. Results are as follows:
- Among Community Care's HealthChoices enrollees, 89.1% identified as non-Hispanic

each contract also have and will have ongoing collaboration with contractors to address and align contact-specific action plans.

- Review of current literature.

Attachments:

(Attachments removed for ATR)

(2022 HealthChoices Membership Analysis). When analyzed across contracts, the majority of members were non-Hispanic. For the contracts with a statistically significant difference in 7-day follow-up, the distribution of members identifying as non-Hispanic is as follows:

HCBK	HCCK	HCNB
58.5%	86.1%	81.4%

- Literature reviews indicate that Hispanic individuals typically have lower rates of treatment engagement than non-Hispanic individuals. Community Care's Membership Analysis supports this hypothesis with only 14% of Hispanic enrollees engaging in services in 2021, compared to 21% of non-Hispanic members. However, further data analysis of HEDIS discharges between 2018 to 2021 indicate that Hispanic members in treatment are more likely to follow-up and remain engaged in treatment.
- Interventions developed to address all Community Care members will apply in this scenario due to the majority of our members falling in the non-Hispanic category.

Performance Measure: FUH HEDIS 7-Day All Ages					
Rates with SSD					
Contract	Cohort 1	Rate 1	Cohort 2	Rate 2
HC	White	43.8%	**Black/African American**	**40.0%**
HC	**Non-Hispanic White**	**43.8%**	Hispanic	48.5%
AL	White	43.6%	**Black/African American**	**39.7%**
BK	**White**	**41.8%**	Other/Chose Not to Respond	48.5%
NB	**Non-Hispanic White**	**45.6%**	Hispanic	57.3%

List out below the factors you identified in your RCA. Insert more rows as needed (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 (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Among Community Care's HealthChoices enrollees, 15.6% identified as African American (2022 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a statistically significant disparity, the distribution of members identifying as Black/African American is as follows: AL 37.1% / ER 19.6% / NB 10.0% In 2021, 40% of the Black/African American members with an inpatient mental health admission had follow-up within 7-days. This is less than White members in 2021, who had a 7-day follow-up rate of 44%.

	While we don't have data to indicate why Black/African American members are less likely to have follow-up, a study showed that 63% of Black people perceive mental health conditions as a sign of personal weakness (National Alliance on Mental Illness, 2021). This results in feelings of shame and the fear of judgement. According to the National Institute for Mental Health (2021), Black youth are significantly less likely than White youth to receive outpatient treatment, even after a suicide attempt. Although Black and African American people have historically had relatively low rates of suicide, when compared to White people, this has been increasing for Black youths (Centers for Disease Control, 2022). For 2016-2020, suicide was the second leading cause of death in Black children aged 10-14, and third for Black individuals aged 15-34 in Pennsylvania. This factor is deemed critical.
	Current and expected actionability: Community Care has implemented interventions to specifically address disparities affecting our Black/African American population. This factor is expected to be actionable.
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues	**Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):** Community Care regularly collects information about barriers from inpatient mental health facilities through provider discussions and quality improvement plans. Specifically in 2019, Community Care conducted interviews with 8 inpatient mental health facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates. Providers reported that it is particularly hard to plan aftercare for members with legal or housing issues. Uncertainty about the future of higher needs leads to difficulty engaging individuals in follow-up scheduling and planning activities. In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Transportation was identified as a barrier affecting members in rural communities. Members interviewed by Community Care's Care Management through the Admission Interviews and Aftercare Outreach reported external barriers as factors influencing the ability to attend aftercare. These factors include things like transportation, childcare, vocational schedule, legal issues, or housing issues. - In 2021, Care Managers conducted Admission Interviews with 1,108 adult members who were readmitted to inpatient mental health within 30-days. Of those, 39.8% indicated that they did not go to their scheduled aftercare following the first inpatient mental health admission. When asked why, 26% indicated it was due to issues with transportation, schedule, housing, childcare, or other significant barrier. - A total of 2,178 adult admission interviews were completed for HEDIS discharges in 2021. During interviews members are asked "What brought you into the hospital for

	admission?" and "Is there something that you needed before you came to the hospital that might have helped you stay in your home?". Seventy-three percent of the interviews responded to one or both questions as factors related to financial health, housing, legal status, conflicts, childcare, clothing, employment, food insecurity, transportation, utilities, or other significant barriers. • In 2021, Community Care's Care Managers also spoke with 732 HEDIS discharges who did not attend aftercare to determine barriers. The most common responses for not attending were by choice, illness, transportation, and other. According to The Center for Rural Pennsylvania, of Community Care's 41 counties, all but 7 (Allegheny, Berks, Chester, Erie, Lackawanna, Luzerne, and York) are considered rural. Those living in rural counties are more likely to have further to travel to attend aftercare and are less likely to have any form of public transportation (SAMHSA, 2016). Members report that coupled with childcare and work schedules these barriers make it particularly difficult for members to commit to aftercare without sufficient planning, which is difficult to do from the inpatient setting. This factor is considered critical.
	Current and expected actionability: Community Care has developed several interventions to assist members to address external barriers to attending aftercare. We anticipate that we will continually make this a focus of Care Management and relationship building activities.
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Twenty-eight percent of the discharge summaries received in the first 2 Quarters of 2022 did not have behavioral health aftercare appointments identified during discharge reviews. For these discharges, 16.6% had a HEDIS claim within 7-days. This is compared to follow-up rates of 50.2% for members who did have an aftercare appointment identified. Community Care conducts interviews with members who have a readmission to inpatient mental health as part of the Admissions Interview activities which is described further in the interventions section. Specifically in 2021, Admission Interviews indicated that for readmitted HEDIS adult members who did not attend aftercare appointments, 27% did not have aftercare scheduled at discharge, while 18% reported difficulty with their medications as the reason for readmission, and 4% of adults indicated it was lack of timely follow-up from the first admission. Although members with readmissions are excluded from data for HEDIS follow-up, Community Care has access to barriers members are experiencing after an inpatient mental health admission by utilizing the readmission information. If barriers around discharge planning are addressed, this will likely have an impact on follow-up rates as well. During Regional Inpatient Mental Health and Ambulatory Provider Value-Based Purchasing Stakeholder Meetings in 2022, inpatient mental health providers reported difficulty getting appointments within 7-days for discharges plans, while ambulatory providers reported less

	appointment availability due to ongoing staffing issues. In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Unclear discharge instructions from inpatient mental health facilities is a barrier identified for members attending aftercare. This factor is deemed critical.
	Current and expected actionability: Community Care has developed interventions to assist members and providers with aftercare planning. We anticipate that we will continually make this a focus moving forward.
People (1.4) Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Community Care regularly collects barriers from inpatient mental health facilities through provider discussions and quality improvement plans. In 2019, Community Care conducted interviews with 8 IPMH facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates. During barrier discussions, providers reported that members often decline aftercare. In 2021, Care Managers conducted Admission Interviews with 1,108 adult members who were readmitted to an inpatient mental health within 30 days. Of the members who had an aftercare appointment scheduled but did not attend, 17% indicated because they chose not to. Furthermore, the Aftercare Outreach Care Managers spoke with 732 HEDIS discharges in 2021 who did not attend their scheduled aftercare appointment and 8.1% indicated they declined to attend. During Regional Inpatient Mental Health and Ambulatory Provider Value-Based Purchasing Stakeholder Meetings in 2022, inpatient mental health providers reported some members decline timely aftercare due to being overwhelmed by the thought of going from inpatient mental health and directly to another level of care, or anxiety related to going to a new place or navigating telehealth appointments. In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Member noncompliance is a barrier identified as impacting FUH. While we can speculate why, Friedman (2014) indicates that the perception individuals have about their own mental health heavily influences their willingness to engage in treatment. His research found that individuals who did not attend treatment indicated that the participant felt the treatment would not be effective, he or she could solve the problem on his or her own, and fear of being stigmatized. These perceptions particularly influenced individuals with first-time inpatient mental health admissions. Due to these perceptions, individuals may decline aftercare when offered by inpatient providers, feeling that acute stabilization is enough. Furthermore, if this factor

	is combined with any type of barrier to aftercare, such as transportation or childcare, attending an appointment deemed to not be beneficial, may seem insurmountable to the individual. This factor is deemed important.
	Current and expected actionability: Although this factor is important, it is complex and difficult to address on a macro level. While current and ongoing education will have an impact, stigma will continue to have profound negative effects until community-wide perceptions change.
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Community Care recognizes the importance of physical health needs when assessing and addressing behavioral health needs. In addition to being reported by providers as a barrier, Community Care collects data through Care Management activities, such as preauthorizations, continued stay reviews, and admission interviews. According to an analysis of Integrated Care Plan activities (described further in the interventions section), 31% of the HEDIS qualified discharges in 2021 had an Integrated Care Plan or a Physical Health/Behavioral Health referral, indicating a physical health need. Community Care also analyzed data captured through Admissions Interviews in 2021. There were 3,636 adult and 403 child interviews completed for members at inpatient facilities and 33.2% of adults and 10.0% of child members reported the inpatient mental health facility was actively helping them coordinate care for a medical condition. Research suggests individuals with mental illness are more likely to have chronic physical health conditions, such as high blood pressure, asthma, diabetes, heart disease and stroke than individuals without mental illness. Individuals with co-occurring physical and behavioral health conditions have health care costs that are 75% higher than the those without co-occurring conditions. The cost is 2 to 3 times higher than the average Medicaid enrollees (SAMHSA, 2021). In terms of overall wellness and recovery, this factor is deemed critical.
	Current and expected actionability: Community Care has developed several interventions to assist members to address physical health needs. We anticipate that we will continually make this a focus of company-wide activities.
Providers (2.1) Specific to Black/African American members Black and African Americans experience health inequity in behavioral health treatment	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Among Community Care's HealthChoices enrollees, 15.6% identified as African American (2022 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a statistically significant disparity, the distribution of members identifying as Black/African American is as follows: | AL	ER	NB
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37.1%	19.6%	10.0%	 In 2021, of the 2,403 Black/African American members that had an IPMH admission, 43.1% had an

appointment within 7-days. This is statistically significantly less than White members in 2020, who had a 7-day follow-up rate of 46.4%.

Starks, Nagarajan, Bailey, and Hariston (2020) indicate that Black individuals are often undertreated for depressive symptoms and furthermore, White individuals are more likely to receive antidepressants medications for symptom management. Black individuals are more likely to be over diagnosed with psychotic disorders, more likely than their White counterparts to be prescribed antipsychotic medications, and more likely to be prescribed higher doses despite similar symptom presentation. Our initial data analysis reflects findings congruent with Starks et al's study:

- According to the 2021 Membership Analysis, Schizophrenia is the eighth most prevalent diagnosis among our Black/African American members in treatment, accounting for 6% of those members. This is compared to the White members in treatment, for whom Schizoaffective Disorder ranks tenth, accounting for 2% of those members. These are the only psychotic disorders among the ten most prevalent for each cohort.
- An analysis of the 2021 member level drilldown report, 36% of Black/African American members with an inpatient mental health admission were being treated for a primary diagnosis of a psychotic disorder (Schizophrenia, Schizoaffective Disorder, or Other Psychotic Disorder). In contrast, only 21% of White members were being treated for a psychotic disorder.
- The 2021 drilldown also reveals that a total 1.17% (n.28) of Black/African American members had an inpatient stay of more than 100 days compared to .64% (n.73) of White members.
  - Of the 28 Black/African American members with an inpatient stay over 100 days, 24 (86%) were being treated for a psychotic disorder. For the White members 53 (73%) were being treated for a psychotic disorder. While conclusions cannot be made with these low numbers, there is a need to conduct more research.

This factor is deemed critical.

Current and expected actionability:
Community Care has begun implementing interventions to specifically address inequities affecting our Black/African American population. We anticipate that we will continually make this a focus of company–wide activities. This factor is expected to be actionable, but stigma will continue to have profound negative effects until community-wide perceptions change.

Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services, which impacts our members with co-occurring disorders	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* According to the 2022 HealthChoices Membership Analysis, 10% of Community Care's members in treatment have an opioid use disorder and an additional 4% have an alcohol related disorder, placing them both in the ten most prevalent diagnoses for members in treatment. For all members in treatment, 11% have a co-occurring mental health and substance use disorder diagnosis.

Specific to the 2021 HEDIS discharges, 10.6% have an opioid use disorder diagnosis and 13.5% have an alcohol use disorder diagnosis. Of the follow-up appointments in our 2021 HEDIS sample, 1.2% were for Buprenorphine Services or Methadone Maintenance. Since this was the first appointment after inpatient mental health, this is not a new service for these members and there is likely another sample initiating medication assisted treatment services. Individuals with an opioid use disorder are at the highest risk for an overdose death but only 20% access treatment (DHS, 2021).

In 2019, Community Care conducted interviews with 8 IPMH facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates. These providers indicated that the ability to obtain evidence-based treatment for opioid use disorder that includes medication assisted treatment is a contributing factor to delays in receiving treatment. Community Care feels that the ability to access medication assisted treatment and substance use disorder treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health. Members being enrolled in medication assisted treatment or other substance use disorder treatment following an inpatient mental health admission may prevent a readmission to a residential level of care before mental health aftercare can happen (Rief, Acevedo, Garnick, Fullerton, 2017).

Community Care conducts interviews with members who have a readmission to inpatient mental health as part of the Admissions Interview activities (described further in the interventions section). In 2021, Care Managers conducted Admission Interviews with 1,108 adult members who were readmitted to inpatient mental health within 30 days. When asked the reason for the readmission, 24.2% of adult members reported it was for substance use. For adult member interviews that were not a readmission (n. 3,636), 21.1% reported the reason for the inpatient mental health admission was substance use.

This factor is critical.

Current and expected actionability:
Community Care has developed several interventions to assist members to access medication assisted treatment and substance-use treatment needs. We anticipate that we will continually make this a focus of company-wide activities.

Provisions (3.1) Specific to Black/African American members	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*

Provisions (3.1) Specific to Black/African American members
There is a shortage of Black/African American treatment providers and there are limitations on identifying culturally competent care

Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Community Care has goals set for ratios of members per provider meeting availability standards:

Physician	Psychologist	Non-Doctoral Level Therapist	Ambulatory Provider Organization
5,000:1	2,000:1	2,000:1	750:1

This data is calculated by distance to providers by members' home address. Our annual Network Availability report indicates that in September of 2022, Community Care was not currently

meeting goal for Physician or Psychologist.

Community Care collects information from providers during credentialing and re-credentialing regarding voluntary disclosure of race (for private practitioners) and specialization working with minority populations (practitioners and facilities). Although not a direct comparison, we have data indicating the following:

Total Black/African American enrollees on 01/04/2023:	239,870

Total practitioners who voluntarily identified as Black/African American by category:

Psychiatrist	Psychologist	Masters Level
6	8	57

Ratio of practitioners who voluntarily identified as Black/African American by category per number of same-race enrollees, as of 02/03/2023:

Psychiatrist Goal 5,000:1	Psychologist Goal 2,000:1	Masters Level Goal 2,000:1
39,978:1	29,983:1	4,208:1

Members: per provider

Ratio of practitioners and facilities who voluntarily identified as specializing in minority populations, specifically Black/African American minorities by category per number of same-race enrollees, as of 02/03/2023:

Psychiatrist Goal 5,000:1	Psychologist Goal 2,000:1	Masters Level Goal 2,000:1	Facilities (MH OP Clinics, SUD OP Clinics, & FQHC/RHC) Goal 750:1
15,991:1	7,496:1	4,526:1	5,215:1

Members: per provider

As part of our 2021 RCA/QIP, Community Care developed a report to identify gaps in treatment availability for Black/African American members using GEOAccess to plot geographical locations of provider service address and member's home address (described further in the interventions section). Allegheny County has the most Black/African American members by both proportion and whole number, compared to other contracts. Allegheny County has more Black/African American members than all other Community Care contracts combined. For this reason, the Targeted Accessibility Analysis report was applied to Allegheny County by breaking it into 4 quadrants to identify areas of Black/African American member density and available providers who are same-

race or identify as specializing in Black/African American treatment.

Quadrant	Percent of Black/African American members under 18 meeting the access standard to culturally competent care	Percent of Black/African American members 18 & over meeting the access standard to culturally competent care
NE	39.0%	57.9%
NW	43.3%	59.4%
SE	40.0%	60.0%
SW	40.2%	59.9%
Urban Access Standard: 2 providers in 30 minute drive time		

Analyses have not been completed for the other contracts with a statistically significant disparity (HCER and HCNB) between the White and Black/African American members due to the low volume of Black/African American members and providers who have voluntarily identified.

01/31/2023		HCER	HCNB
Total Black/African American Members		16,647	19,275
Proportion of Enrollees		19.5%	10.1%
Black/African American same-race providers	Psychiatrist	1	0
	Psychologist	0	0
	Master's Level	3	0
Specializing in minority populations: Black/African American	Psychiatrist	2	0
	Psychologist	2	3
	Master's Level	4	3
	Facilities	4	0

Based on this information, Community Care can reasonably deduce that the number of providers who are Black/African American or who specialize in this minority population do not meet the needs of our Black/African American members.

This is important because Black/African American individuals are more likely to trust and engage with Black or African American providers but less likely to find one (Evans, Rosenbaum, Malina, Morrissey, and Rubin, 2020). Historically Black individuals do not have adequate access to same-race treatment providers. In the United States, only 2% of psychiatrists identify as Black (Starks, 2021) and 4% of psychologists (Healthline, 2021). This is crucial because Black and African American providers are known to provide more appropriate and effective care to Black and African American individuals (Mental Health America, 2021).

As this barrier will take time to address, The National Alliance on Mental Illness recommends that until the gap is closed it should be filled with culturally competent care. In order for a provider to be culturally competent, it goes beyond having a diverse workforce. Providers need to invest in gaining cultural knowledge of the populations they serve as it relates to help-seeking, treatment, and recovery (SAMHSA, 2014). Community Care's ability to gather information on culturally competent providers is limited by the changing workforce. Staff turnover plays a significant role on

	the ability to maintain competency. This factor is deemed critical.
	Current and expected actionability: Community Care has begun implementing interventions to specifically address inequities affecting our Black/African American population. We anticipate that we will continually make this a focus of company-wide activities. This factor is expected to be actionable, but availability will continue to affect Community Care's ability to adequately address the actual root cause.
Provisions (3.2) Medication appointments with psychiatrists are often hard to secure in a timely manner	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Availability of psychiatrists has been an ongoing barrier to services in the State of Pennsylvania. Although Community Care consistently meets accessibility standards for Psychiatry, providers report difficulty getting individuals appointments with existing psychiatry time. In 2015 the Behavioral Health Alliance of Rural Pennsylvania did a point in time survey of psychiatric providers that indicated a need of double the psychiatric time currently available. This included the capacity of telehealth services and physician extenders at that time. Of the 14 surveyed providers, they are providing a 617 hours of psychiatric clinic time. Their study indicated a need for almost double the amount of current time being provided. While other services are available, psychiatry is essential for individuals with significant mental illness or serious emotional disturbances. Psychiatrists are often splitting their time between outpatient and other services, such as inpatient mental health, partial hospitalization, dual diagnosis treatment teams, etc. A need for more psychiatric time seems to be a theme across the State. Community Care's annual Network Availability report indicates that in August of 2022, Community Care was not currently meeting goal for the enrollee to physician ratio of 5,000:1 with an actual ratio of 7,495:1. If we look at this analysis over time, we can see that although HealthChoices membership has grown, the number of Psychiatrist locations has decreased.

Community Care contracted Psychiatrist by site count and ratio									
August 2018		August 2019		August 2020		August 2021		August 2022	
Site Count	Ratio	Site Count	Ratio	Site Count	Ratio	Site Count	Ratio	Site Count	Ration
216	4,538:1	208	4,783:1	205	5,515:1	191	6,337:1	194	7,495:1

In 2019, Community Care conducted interviews with 8 inpatient mental health facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates. Specific barriers identified by these providers included "Psychiatry is hard to get" and "Medication appointments are particularly challenging."

Community Care conducts interviews with members who have a readmission to inpatient mental health as part of the Admissions Interview activities (described further in the interventions section). There were 3,636 adult and 403 child interviews completed for members at inpatient

CCBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance	
	mental health facilities in 2021; of those, 1,221 were interviews for members who had a previous inpatient admission in the past 30 days. When asked the reason for the readmission or if there was something they needed that might have helped them stay in their home, 27.5% of adults and 9.0% of children reported difficulty with their medications.
	This factor is deemed important.
	Current and expected actionability: Community Care has developed some interventions to work with current capacity but has a limited scope to address this barrier specifically.

Quality Improvement Plan for CY 2023

Rate Goal for 2023 (State the 2023 rate goal from your MY2021 FUH Goal Report here): 46.8% (7-Day) 68.0 %(30-Day)

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

Barrier	*Action* Include those planned as well as already implemented.	*Implementation Date* *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	*Monitoring Plan* *How will you know if this action is taking place? How will you know the action is having its intended effect?* *What will you measure and how often? Include what measurements will be used, as applicable.*
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues *People (1.3)* Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Admissions Interview:** The Utilization Management Children's and Adult High Risk Care Managers conduct longitudinal care management and outreach to high-risk members who encounter difficulties maintaining stabilization and community tenure. The Care Managers meet with these members at inpatient mental health facilities and substance use disorder treatment settings to provide face-to-face intervention, complete the interview tool to assess strengths/needs, and collaborate with the treatment team and inpatient staff to address aftercare planning, coordination, and reduce recidivism. In 2020, the readmission interview tool was expanded to include members with initial admissions and readmissions that do not meet the original eligibility criterion of readmission within 30-days. This expansion granted the opportunity for the intervention to serve as	Ongoing practice with process updated in 2020 Intervention occurs as part of the Care Management daily activities	Member needs reported in the Admissions Interviews, including those around physical health and medications, are regularly monitored through a Tableau Dashboard. Doing so allows Community Care to identify trends related to member needs and respond appropriately. Care Managers discuss and problem solve specific cases during supervision. Community Care developed a monitoring report that was completed in late 2021 to pull information from the Admissions

CCBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance			
People (1.4) Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending **Providers (2.1) Specific to Black/African American members** Black and African Americans experience health inequity in behavioral health treatment	prevention. In addition, the high-risk care management intervention has been expanded to include children as well as individuals readmitted to substance use disorder treatment facilities.		Interview template in the electronic record and analyze how the intervention is impacting 7-day HEDIS FUH rates. This data will be reviewed quarterly in 2023 for ongoing trend analysis and any additional opportunities for improvement.
	In 2021 there were a total of 1,984 adult and 194 child interviews specific to HEDIS inpatient mental health discharges. For members that had a completed Admissions Interview, 57.6% had 7-day HEDIS follow-up. This data suggests that members who received a complete Admissions Interview were significantly more likely to attend an aftercare appointment. Specifically, members who received an Admission Interview were 17 percentage points more likely to have follow-up within 7-days.	2021	

HEDIS 7-Day Follow-Up			
Year	FUH for members with an Admission Interview	FUH for members without an Admission Interview	% Point Variance
2019	63.6%	43.6%	20.0
2020	53.1%	43.7%	9.3
2021	57.6%	40.7%	16.9

	Community Care Care Management Department monitors barriers to aftercare reported by members through this process on an ongoing basis through a Tableau Dashboard. In February 2023, Community Care added racial and ethnic filters to the Admissions Tableau dashboard for contracts with disparities to target interventions with minority populations. Note that this intervention was to happen in 2022, however was postponed due to competing priorities. **Race and Ethnicity were added to the member level detail report for the Admission Interviews in January 2023. This allows Community Care to analyze trends related to barriers across racial and ethnic backgrounds on a quarterly basis. Also in 2023, a race and ethnicity filter will be added to the Admissions Interview Tableau Dashboard to monitor, and address barriers specifically identified by minority populations at any point in time. This is estimated to occur in the second half of 2023.**	**2023**	

Starting in February 2023, Community Care will include Black/African American members as a priority population targeted for admission interviews. When analyzing the data for Admission Interviews, Community Care has identified that our Black/African American members particularly benefit from this intervention.

2021 7-Day HEDIS Follow-Up			
Cohort	FUH for members with Admission Interview	FUH for members without Admission Interview	% Point Variance
Black/African American	56.0%	37.4%	18.6
White	57.8%	41.3%	16.5

Community Care believes that this intervention improves aftercare by assisting members to overcome barriers, providing education to members and providers, coordinating care, and assistance in aftercare planning.

People (1.2)
Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues

People (1.3)
Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members

People (1.4)
Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending

Aftercare Outreach: Community Care provides outreach to members who may be at risk. All members being discharged from acute levels of care and who are not transitioned to another non-ambulatory service or placement receive follow-up to encourage adherence to a community-based aftercare appointment. The Care Manager will assist with problem solving and engaging the member to his/her aftercare appointment. If there is an Intensive Care Manager, Resource Coordinator, or Service Coordinator assigned, the Care Manager can contact the provider to ensure appropriate linkages for follow-up care.

In 2021, Community Care made Aftercare Outreach calls to 32% of our HEDIS Qualified Discharges and 32% of that number were successful reached. An analysis of the data indicates that members who had a successful Aftercare Outreach call were 10 percentage points more likely to have timely follow-up.

HEDIS 7-Day Follow-Up			
Year	FUH for members with Successful Aftercare Outreach	FUH for members without Successful Aftercare Outreach	% Point Variance
2021	52.1%	42.1%	10.0

Ongoing practice

Intervention occurs as part of the Care Management daily activities

2021

Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases during supervision. Template entry is monitored as an activity of supervision and feedback and corrective action occurs with care managers, as necessary.

Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 7-day HEDIS FUH rates. This data will be reviewed quarterly in 2023 for ongoing trend analysis and any additional opportunities for improvement.

	2020	54.1%	44.4%	9.8	
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.				
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Allegheny Care Management Team:** (HCAL) The Integrated Care Team assists Allegheny County Health Choices members, families, health plans, and providers in facilitating coordination of physical health/behavioral health care. The team advocates for members with the five physical health managed care organizations serving Allegheny County and provides behavioral health history, referrals, and direct provider and member outreach. The physical health managed care organizations receive daily internal referrals from care managers on Community Care child and adult teams for members with physical health needs and obtain member consents for enhanced coordination of care. The team provides training regarding physical health/behavioral health integration to behavioral health providers and member/community groups and supports multiple UPMC care coordination initiatives. Their established relationships with health plans and providers promote a 'whole health' collaborative approach. In January of 2018, the team increased their coordination to also coordinate with 3 Community Health Choice Plans to coordinate care for shared members who are dual eligible or receive long term services and supports.			Ongoing practice Intervention occurs as part of the Care Management daily activities	Monitoring for the needs identified occurs on an ad hoc basis through Clinical Supervision.
	In 2021, the Integrated Care Team also added a Pre/Post Natal Care Management position as part of the Community Based Care Management initiative. This Care Manager works with members during pregnancy and after delivery to coordinate with the Physical Health Managed Care Organizations, as well as provide linkage for the members to behavioral health services and resources to address social determinant of health needs. The team also added 3 Community Health Workers to support the Community Based Organizations with identifying Community Care members, ensuring coordination with current Behavioral Health Providers, and assisting to link members to Behavioral Health services. The Community Health Workers also assist members who have social determinants of health needs.			2021	
	Community Care believes that this intervention improves aftercare				

	by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.		
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services, which impacts our members with co-occurring disorders	**Centers of Excellence:** The Pennsylvania Department of Human Services launched the Centers of Excellence in 2016 to expand access to medication assisted treatment and other effective treatments. Centers of Excellence are licensed substance use disorder treatment providers that provide counseling, methadone, buprenorphine, or naltrexone assisted treatment. Centers of Excellence offer members diagnosed with an opioid use disorder peer support throughout all stages of recovery as well as Care Management to assist members in identifying, receiving, and sustaining treatment. Community Care's Care Management team helps individuals with opioid use disorder navigate the health care system by facilitating initiation into opioid use disorder treatment from emergency departments and primary care physicians; helping individuals transition from inpatient levels of care to ongoing engagement in community-based treatment; and facilitating transition of individuals with opioid use disorder leaving state and county corrections systems to ongoing treatment within the community. Currently there are over 260 Centers of Excellence registered in Pennsylvania.	Centers of Excellence initiated in January 2017 and enrollment began July 2019. Activities around this initiative remain ongoing.	Community Care regularly reviews data to ensure that Centers of Excellence thrive over time. Community Care collaborates with University of Pittsburgh Program and Evaluation Research Unit to provide detailed summary reports to all Centers of Excellence based on the Research Electronic Data Capture (REDCap) information. Regional feedback webinars occur monthly with Community Care's 50+ Center of Excellence providers. These meetings serve as a venue for providers to learn from each other and discuss current treatment trends, barriers, and possible solutions. Community Care will continue to partner with University of Pittsburgh Program and Evaluation Research Unit and the Department of Human Services to assess and monitor the impact of the newly developed risk assessment tool.
	As of October 2022, a total of 15,766 unique Community Care members have enrolled in a Center of Excellence. Community Care developed an RCA Monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 7-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement.	2022	
	All COEs within Community Care's network will transition to a value-based purchasing payment model on January 1, 2023. Performance metrics for providers include new enrollments, new enrollments retained for 90-days, new enrollments retained for 181 days, and new member access to medication assisted treatment for opioid use disorder. Specific to the barrier of getting new members into medicated assisted treatment, activities around this initiative will have a	**2023**	

	specific focus on new enrollments and new member access to medication assisted treatment for opioid use disorder. Baseline data is currently being collected.		

Year	New members enrolled in COE	New members accessing MOUD
CY2021	2,236	1,819
Jan-Aug 2022	1,672	TBD

	*MOUD pharmacy claims lag has not resolved Community Care collaborated with the University of Pittsburgh Program and Evaluation Research Unit and the Department of Human Services to develop a risk assessment tool for Centers of Excellence. This tool is being piloted in 4 Allegheny County locations in 2023, which is anticipated to eventually be used for all 270 Centers of Excellence in Pennsylvania.		
	Community Care feels that the ability to access medication assisted treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health facilities. Members being enrolled in medication assisted treatment following an inpatient mental health admission may prevent a readmission to a residential level of care before mental health aftercare can happen.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Collaborative Care at Federally Qualified Healthcare Centers:** (HCAL, HCBK, HCBL, HCCH, HCNB, HCNS, HCYY) Community Care believes that implementing Collaborative Care to integrate primary care and behavioral health is a clear remedy for many of these problems with co-morbid conditions. Based on principles of effective chronic illness care, Collaborative Care focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained Primary Care Physicians, and embedded Behavioral Health Practitioners provide evidence-based psychosocial treatments and/or medication, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected. The model consistently results in improved patient and provider satisfaction, improved functioning, and reductions in health care costs, achieving the Triple Aim of health care reform.		Federally Qualified Health Centers are a primary focus for the Director of Integration and monitoring activities occur on a regular basis. Community Care hosts quarterly Provider Meetings with Federally Qualified Healthcare Centers, of which data metrics are a routine topic.
	Community Care currently has 33 Federally Qualified Health Center providers at 123 locations throughout the network. Community	2022	

	Care hosted 3 FQHC Collaborative Care provider meetings during 2022, with the dates and topics listed below. Community Care presented on the Collaborative Care model at all 4 of the Quarterly Physical Health/Behavioral Health meetings to promote awareness of the model. The Quarterly Physical Health/Behavioral Health meetings bring together HealthChoices partners to address coordination and collaboration of care, work on joint projects, and share information and resources. In 2021, 15,235 distinct Community Care members received services at a Federally Qualified Health Center. This has increased to 16,566* distinct members in 2022.
	The distinct member data is incomplete due to the 90-day claims lag
	
	   ➢ 03/03/2022
		Psychopharmacology: An Overview of Psychiatric Medications: Kavita Fischer, MD, DFAPA, Regional Medical Director, Community Care Behavioral Health
		   ➢ 09/01/2022
			Depression Assessment in Primary Care Presented by: Kolin Good, MD Regional Medical Director, Community Care Behavioral Health
			   ➢ 12/08/2022
				Tobacco Cessation for Individuals with Behavioral Illnesses Presented by: Jaspreet S. Brar, MBBS, MPH, PhD Senior Fellow, Department of Psychiatry, UPMC Western Psychiatric Hospital, Consultant, Community Care Behavioral Health Organization.		

	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues **People (1.3)** Inadequate discharge plans	**Community Based Care Management:** Community Based Care Management is a new Care Management program aligning with the Department of Human Service's initiatives around whole-person healthcare reform. Elements of this program include: • Enhancing care management activities in the community by working directly with members and providers; • Enhancing physical and behavioral health coordination to address whole person health and wellness; • Decreasing unplanned, emergent admissions;	2020 - Planning phase	In 2022 there was a large focus on documentation and some edits made to documentation templates to ensure that data is being consistently captured for inclusion in the reports. A monitoring document was part of the 2022 and 2023 Community Based Care Management Proposal submission. Within the monitoring plan is data and goals. To

and/or issues with prescribed medications are among the top reasons for readmission among members *People (1.4)* Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending *People (1.5)* Some members have competing physical health needs which makes setting up aftercare difficult	• Increasing access to healthcare; • Enhancing crisis and substance use disorder services; • Screening members for Post-Partum Depression; and, • Screening of social determinants of health and linking members to services and resources. **Community Health Workers** are an integral part of this program and are responsible for completing face to face or telephonic admission and readmission interviews with members to identify barriers to services and resources and to plan for aftercare, advocating for person centered treatment and aftercare planning, participating in interagency and collaboration meetings with providers and members, providing ongoing follow up and support by meeting with the member in the community at provider sites and in the member home, completing warm hand offs to community resources and providers, following up with members who identify social determinant of health challenges during Customer Service New Member Welcome Calls and Post Discharge Outreach Calls, supporting the Community Based Organizations with identifying Community Care members, ensuring coordination with current Behavioral Health Providers, and assisting to link members to Behavioral Health services. Community Based Care Management also includes the use of **Pre/Post Natal Care Managers** who outreach to, engage, assess, and link members during pregnancy and post-delivery or end of pregnancy, who have an identified behavioral health need. The Pre/Post Natal Care Manager coordinates with the physical health managed care organizations to link the members to prenatal care and resources, as well as to transfer members to the physical health managed care organizations' maternity programs if there are no identified behavioral health needs. Community Based Care Management allowed Community Care the opportunity to partner with and provide funding for staff and administrative costs to **Community Based Organizations**. The Community Based Organizations provide services and resources which address social determinants of health that greatly impact the HealthChoices members.		monitor progress through the year in 2023, quarterly meeting will be held in each contract to review and discuss trend with the data. In 2022 quarterly data was provided for OMHSAS Monitoring Meetings related to Community Based Organization engagement, Community Based Organization referral sources and a reporting of social determinates of health data captured by the Community Based Organizations. This will continue in 2023. A program analysis for 2022 will be completed in June 2023.
	In 2021, Community Care hired additional internal positions to expand and enhance the community work that is done to support	2021-Development	

	members. New positions included Community Health Workers and Pre/Post Natal Care Managers per specific contracts, and a Data Analytics position shared amongst all contracts. Blair, Bedford/Somerset, and Lycoming/Clinton contracts opted to utilize existing positions either within Community Care, county partners, or the HealthChoices teams to absorb some of the Community Based Care Management responsibilities. In 2022, Delaware County was added, and additional positions were added to the staffing complement. Community Care contracted with 30 Community Based Organizations in 2022 and 1 contracted directly with Blair HealthChoices. Community Based Organizations were chosen by determining the greatest social determinates of health that impacted the community and then contracting with an agency that addressed those barriers. Examples of Community Based Organizations ranged from emergency shelters and transitional housing to local United Way and Community Action organizations.	phase 2021 – 2022 Implementation phase	
	In 2022, Community Health Workers engaged with 2,828 unique members and completed a total of 21,829 in person or phone contacts or attempts with members, Pre/Post Natal Care Managers engaged with 4,450 distinct members, and Community Based Organizations have supported 13,511 members.	2022	
	It is anticipated that 2 additional CBOs will be contracted for 2023.	**2023**	
	Community Care believes that this intervention will improve aftercare through the activities of Community Based Care Management, which includes encouraging the use of preventative services, mitigating social determinants of health barriers, reducing health disparities, improving behavioral health outcomes, and increasing partnerships with Community-Based Organizations.		
People (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of	**Community Care's Health Equity Program:** Community Care's Health Equity Program reflects the National Committee for Quality Assurance's (NCQA's) Health Equity Accreditation standards as well as Community Care's efforts to improve the provision of Culturally and Linguistically Appropriate Services and to identify and reduce health care disparities related to race, ethnicity, gender identity, sexual orientation, and language. Community Care's mission is to improve the health and well-being of the community through the delivery of quality, cost-effective,	2022	Monitoring for this intervention occurs: 1. On an ongoing basis by our Social and Racial Justice Committee (see Social & Racial Justice Steering Committee intervention), 2. On an ongoing basis by a dedicated Project Director, and, 3. Annually approved through Community Care's Board Quality

treatment and reluctance to acknowledge symptoms ***Providers (2.1) Specific to Black/African American members*** Black and African Americans experience health inequity in behavioral health treatment	and accessible behavioral health services. In conjunction with each of the counties that Community Care serves, the goal is to offer recovery-oriented, whole person-centered, outcome-focused care that reflects contemporary best practices. Community Care views the HealthChoices Program as a means of promoting individual and community health and well-being through attending to the social determinants of health and addressing social justice and health equity. Community Care's Health Equity goals: 1. Provide leadership to support the commitment to long-term change. 2. Provide opportunities for education on, and discussion of, social and racial justice among all staff and use these discussions to refine short- and long-term strategic planning. 3. Examine service delivery for members, who are part of disenfranchised and/or oppressed groups to monitor disparities; establish goals to strive for sustained improvement in elimination of disparities. 4. Support resource development, workforce diversity, and trainings that increase cultural sensitivity, cultural awareness, and cultural humility in Community Care's provider network. 5. Establish partnerships and collaborations that elevate social and racial justice in the communities we serve. 6. Continue to solicit and incorporate diverse stakeholder perspectives. 7. Utilize a continuous quality improvement process, which incorporates long-term, incremental change as well as continuous assessment and refinement of goals. The objectives of the Health Equity Program are pursued in concert with those of Community Care, members, practitioners, facilities, county and state oversight entities, community stakeholders, and other health care partners. These objectives: • Ensure that members with primary languages other than spoken English receive the same scope and quality of health care services as primary English speakers, including quality interpreting services and written materials in members' preferred languages and formats.		Improvement Committee.

	• Improve health care access and outcomes. • Decrease identified disparities. • Continually evaluate and improve the cultural and linguistic responsiveness of programs and services. Annually, Community Care identifies measurable goals to continuously improve culturally and linguistically appropriate services, including goals to reduce health disparities. Community Care developed the following goals: • Decrease the disparity between Black/African American and White members in HEDIS rates of 7- and 30-day follow-up after mental health hospitalization (FUH) by increasing the FUH of Black/African American members by 2% per year for three years. • Achieve 100% completion by relevant staff of various trainings (including but not limited to, all staff Sexual Orientation and Gender Identify and Expression Required Training; Culturally Competent Skills and Behaviors, Culture of Inclusion and Belonging, and Unconscious Bias) focused on improving culturally and linguistically responsive care to members. • Utilize the Sexual Orientation and Gender Identity and Expression job aid to collect, document, and consistently use, member information in a culturally responsive way regarding members' sexual orientation, gender identity and gender expression. • **Establish a Social/Racial Justice and Health Equity Advisory Board to include members, family members, providers, and community-based organization representatives from diverse backgrounds and experiences including those from systematically disenfranchised groups from across all Community Care contracts. This Advisory Board will review procedures, measures, programs and/or make recommendations to Community Care with a goal of continuous improvement in the implementation of culturally and linguistically responsive care to members. This Board is anticipated to be active by the second quarter of 2023 and be meet quarterly.**	2023	
	Develop additional Health Equity content for member and provider newsletters to be distributed in 2023. ▪ The May 2022 Member Newsletter, Foundations, included an article related to Sexual Orientation and Gender Identity	2023	

	and Expression https://members.ccbh.com/uploads/files/Health-Topics/Newsletters/20220418-volume10issue1-interactive-4.19.pdf ▪ The September 2022 Provider Newsletter, The Provider Line, included an update on Community Care's Anti-Stigma Resources and Education (CCARE) Campaign, and a Racial and Social Justice update. https://providers.ccbh.com/uploads/files/Provider-Newsletters/22PV2999150-Fall-2022-Provider-Newsletter_SH-0922.pdf		
	Community Care achieved the National Committee for Quality Assurance's Health Equity Accreditation in February 2023 and notified all stakeholders. The Health Equity Accreditation seal will be placed on the Community Care website.		
	Community Care believes that this intervention will improve aftercare by identifying issues across the system and developing companywide interventions to impact inequities.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Community HealthChoices:** Community HealthChoices is Pennsylvania's mandatory managed care program for dually eligible individuals (Medicare and Medicaid) and individuals with physical disabilities. Community HealthChoices was developed to enhance access to and improve coordination of medical care as well as to create a person-driven, long-term support system in which individuals have choice, control, and access to a full array of quality services that provide independence, health, and quality of life. Community HealthChoices implementation officially completed with the last phase starting January 2020. All zones are now active with Community HealthChoices. There are regular meetings with the 3 Community HealthChoices plans across Pennsylvania to identify challenging cases, barriers, training and information/resource sharing. These continued collaboration activities are led by Community Care's Director of Integration.	Community HealthChoices implemented January 2019 - January 2020 Community HealthChoices coordination occurs as part of the Care Management daily activities	Community Care hosts and participates in quarterly statewide partner meetings with the other Community HealthChoices managed care organizations in Pennsylvania to identify challenging cases, barriers, training, data sharing, and information/resource sharing. Community Care collaboratively shares information regarding 7-day follow up and inpatient admissions with Community HealthChoices. Likewise, data is shared with us regarding physical health data.
	There are currently (as of 01/25/23) 167,425 Community HealthChoices members receiving behavioral health services. In 2021, the monthly inpatient mental health utilization of Community HealthChoices fluctuated between 170 and 200 members per month. In fact, Community HealthChoices members accounted for	2021	

	14% of Community Care's 2021 HEDIS qualified discharges. Data analysis indicates that HEDIS follow-up of our Community HealthChoices members is about 8 percentage points below the aggregate.		

2021 HEDIS 7-Day Follow-Up		
FUH for CHC Members	FUH for non-CHC Members	% Point Variance
36.8%	44.2%	-7.4

	This data was analyzed to determine barriers related to Community HealthChoices members receiving timely aftercare following an inpatient mental health admission. Community Care identified the following factors to decreased FUH rate in Community HealthChoices members: • Aftercare services are not billed through Medicare as the members' primary insurer, • Many older individuals receive behavioral health services through primary care, and, • Many Community HealthChoices members have existing home and community services. To support these findings, Community Care was able to access some Community HealthChoices Medicare data to evaluate the penetration of behavioral health services with both payers (Medicaid and Medicare) combined. In the first 2 quarters of 2022, Community HealthChoices members in Allegheny County had a penetration rate of 11% when only analyzing Medicaid claims. When Medicare claims were added, 66% of Allegheny Community HealthChoices members had a behavioral health claim.		Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases during supervision. Template entry is monitored as an activity of supervision and feedback and corrective action occurs with care managers, as necessary.
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care. Unfortunately, Community Care's ability to impact our HEDIS FUH rate for Community HealthChoices is limited due to dual eligibility factors.		
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication	**Co-Occurring Disorder Initiative**–(HCAL)Allegheny County Department of Human Services, Allegheny HealthChoices Initiative, and Community Care, in close collaboration with Case Western Reserve University's Center for Evidence-Based Practices, established the Co-Occurring Disorders Initiative in Allegheny County in 2015 to increase ambulatory providers' competencies	Ongoing	This initiative is monitored regularly and ongoing as part of the contract's business procedures.

assisted treatment programming and other substance use disorder treatment services, which impacts our members with co-occurring disorders	with co-occurring disorder treatment within the existing administrative and regulatory structures. The Dual Diagnosis Capability framework for Mental Health Treatment and Addiction Treatment guide the initiative, which includes a baseline Dual Diagnosis Capability for Addictions Treatment or Dual Diagnosis Capability for Mental Health Treatment assessment, quality improvement planning, technical assistance, training, and provider meetings to discuss progress.		
	Beginning in 2022, participating outpatient programs had the opportunity to earn an enhanced rate on relevant billing codes for two years for achieving identified thresholds of co-occurring treatment capability. The purpose of this process is to further incentivize and support quality improvement of ambulatory services in their capacity to serve individuals with co-occurring mental health and substance use disorders concurrently. Eligibility for the enhanced rate is based on scores on a new Dual Diagnosis Capability for Addictions Treatment or Dual Diagnosis Capability for Mental Health Treatment. Five programs across four providers (four outpatient substance use, one outpatient mental health) made the decision to undergo the review process in 2022. Three programs across two providers achieved the enhanced rate.	2022	
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues **People (1.3)** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members **People (1.4)** Some members decline aftercare believing they don't	**Delaware County Post-Inpatient Mental Health Outreach:** HealthChoices Delaware is Community Care's newest contract, implemented July 1, 2022. In 2023, Delaware County Department of Human Services and Community Care will be exploring the possibility of having Delaware County's consumer and family satisfaction team, Voice & Vision, Inc., attempt to survey all members discharged from the County's largest volume inpatient mental health provider. Surveys are administered by peers and would be modified to include questions about barriers to timely follow-up. Although this is not an intervention that will directly impact follow-up, it is an important step to determining specific barriers to follow-up for Delaware County's population for intervention development. The advantage of using the method of peer surveys to gather information is that members may feel more comfortable with individuals who have received services and relate to the members symptomology.	2023	NA – This intervention is still being assessed for viability

need it, will not benefit from it, or can't overcome barriers associated with attending			
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues *People (1.3)* Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members *People (1.4)* Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	**Enhanced Discharge Planning:** Daily Care Management activities focus on members with readmissions and involves review of daily admissions (Care Management reviews on Monday include weekend admissions.) Care Managers conduct a semi-structured interview, using motivational approaches, problem solving, and case management follow-up activities to ensure members received needed aftercare. During these interviews, Community Care actively gathers information if members attended follow up, reasons why follow-up may have not been attended, if discharge plan was understood, etc. Care Managers provide assistance in real time with barriers identified. A report, which reflects both contract-specific and aggregate data related to the Enhanced Discharge Planning and High-Risk Care Management interviews, is compiled annually. These reports are shared with Quality and Clinical Departments as well as presented at the Care Management Leadership meeting. Care Management interventions are targeted and adjusted, as necessary, per the data.	Ongoing Intervention occurs as part of the Care Management daily activities	During these interviews, Community Care actively gathers information if members attended follow up, reasons why follow-up may have not been attended, if discharge plan was understood, etc. Care Managers provide assistance in real time with barriers identified. A report, which reflects both contract-specific and aggregate data related to the Enhanced Discharge Planning and High-Risk Care Management interviews, is compiled annually. These reports are shared with Quality and Clinical Departments, presented at the Care Management Leadership meeting, and presented at contract Quality and Care Management Committee meetings. Care Management interventions are targeted and adjusted, as necessary, per the data.
	In October 2019, Community Care expanded the interview process. Interviews now include children as well as other priority members, for example, members who may have readmitted over the standard 30-day readmission timeframe (i.e., readmitted after 35 days) or who may have other barriers related to other social determinants. This expansion may grant opportunity for this intervention to serve as prevention. In February 2020, Community Care further expanded the interview process to include members who were admitted for the first time to an IPMH. Also, 3.5 and 3.7 levels of care were added for the interviews. All contracts used the same readmission interview template to identify reasons presenting for admission and to assist in discharge planning.	Process expanded in October 2019 and again February 2020	Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 7-day HEDIS FUH rates. This data will be reviewed quarterly in 2023 for ongoing trend analysis and any additional opportunities for improvement.
	Community Care believes that this intervention improves HEDIS FUH by assisting members to overcome barriers to aftercare.		
People (1.2) Many members have multiple	**High-Risk Care Management interventions:** Members can be deemed high risk for reasons such as clinical presentation,	Ongoing	Clinical Supervisors utilize a standardized tool to rate Care Managers related to

barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues *People (1.3)* Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members *People (1.4)* Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	treatment history and response, or as an identified at-risk population. High-Risk members require a longitudinal intensive level of intervention. Comprehensive Care Management strategies are initiated to ensure service linkage, coordination, and timely delivery of quality health care for those at-risk for significant symptoms and members who have difficulty connecting to aftercare treatment services. Community Care strives to ensure that recovery principles and tenure in the community are at the core of High-Risk care management. High-Risk Care Managers met with members face-to-face on the unit to identify these barriers, address concerns, coordinate with inpatient staff around member needs, and help with discharge planning. Starting in March 2020, due to concerns surrounding the COVID-19 pandemic, Care Managers implemented both telephonic or virtual interviews to capture the data and intervene, as necessary. High-Risk Care Managers encourage coordination with family or friends as part of their interaction with members. High-Risk Care Managers address social determinants with the member and the inpatient staff and coordinate with relevant agencies during the inpatient stay.	Intervention occurs as part of the Care Management daily activities	interventions performed with members. This template includes a question related to follow-up ("The Care Manager review shows evidence of robust discharge planning, for example awareness of factors leading to readmission and/or potential triggers for readmission"). Feedback and corrective actions are taken with care managers, as necessary.
	In 2021, Community Care developed High-Risk Care Management Best Practice Guidelines to aid in standardization of High-Risk practices. Community Care uses clinical groupings to identify members who are receiving enhanced care management activities such as High Risk or Complex Care Management. Data analysis of the 2020 HEDIS FUH data indicates that members who were in these clinical groupings were 9 percent more likely to have follow-up within 7-days. Community Care is considering 2020 data preliminary as Care Managers were not always consistently using the clinical grouping to identify members receiving these interventions. We believe that the data for 2020 does not reflect all the possible members who were receiving these enhanced interventions. In 2021, Care Managers were asked to consistently use clinical grouping selection to identify members with enhanced Care Management interventions. Examples of groupings include High-Risk, Community Based Organization Engaged, or Prenatal. A report was developed for Care Management to track the consistency of the selection and a job-aide was developed.	2021	

	Data analysis of the 2021 HEDIS FUH data indicates that members who were in these clinical groupings were 9 percentage points more likely to have follow-up within 7-days.		Community Care developed an RCA Monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 7-day HEDIS FUH rates. This data will be reviewed quarterly in 2023 for ongoing trend analysis and any additional opportunities for improvement.

HEDIS 7-Day Follow-Up

Year	FUH for Members with High-Risk Care Management	FUH for Members without High-Risk Care Management	% Point Variance
2020	54.5%	45.8%	8.8
2021	50.3%	41.6%	8.7

Community Care believes that this intervention improves HEDIS FUH by assisting members to overcome barriers to aftercare.

People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Inpatient Mental Health Provider Quality Improvement Activities:** Community Care conducted its annual review of the entire inpatient mental health provider network and based on this review; five distinct providers were selected to participate the 2022 Inpatient Mental Health Quality Improvement Activity. Community Care's Inpatient Mental Health Quality Improvement Activity process is composed of staff interviews, a facility tour, discussion with executive leadership staff, and the completion of member record reviews. During a record review, if a provider did not score within the designated benchmark for the Discharge Management Planning composite score, which includes "Follow-up appointment scheduled within 7 days, including all required elements," a Quality Improvement Plan would be requested from the provider.	This process was implemented in March of 2019 as an annual activity. Prior to 2019 inpatient mental health activities occurred on a contract specific schedule.	Each year's activities are reviewed each contract's Quality and Care Management Committee meetings.

Update to review results are as follows.
Indicator: Notice to aftercare providers within 1 business day of inpatient discharge including information about discharge and medications

2019 Rate	**2020 Rate**	**2021 Rate**	**2022 Rate**
69%	73%	70%	70%

Indicator: Evidence of a Completed Discharge Management Plan

2019 Rate	**2020 Rate**	**2021 Rate**	**2022 Rate**
96%	100%	95%	98%

Indicator: Follow Up appointment scheduled within 7 days, including all required elements

2019 Rate	**2020 Rate**	**2021 Rate**	**2022 Rate**

2021

This is an annual activity that will be completed again in 2023.

As part of this process, a provider may be asked to submit a quality improvement plan. If the submitted quality improvement plan doesn't meet all required elements, a revision is requested. In the following year, providers are asked to submit an update and monitoring of their interventions. This follow-up information, along with results of the annual Quality Improvement Activity are reported at each contract's Quality and Care Management Committee.

	69%	91%	80%	84%	
	Providers who did not meet goal for any record review indicator were asked to complete a quality improvement plan. This resulted in all five providers submitting a quality improvement plan for the 2022 Inpatient Mental Health Quality Improvement Activities.				
	Community Care's Inpatient Mental Health Quality Improvement Activities will occur in the second quarter for 2023.			2023	
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers to individualized discharge planning, addressing engagement issues, and physical health needs.				
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Integrated Care Plan:** In alignment with Pennsylvania Department of Human Services goal for greater integration and coordination of behavioral and physical health services, Community Care engages in care coordination with physical health plans and documents these activities in an Integrated Care Plan. This Integrated Care Plan, or member profile, is used for the collection, integration and documentation of key physical and behavioral health information that is easily accessible. Community Care identifies members for inclusion in the project based on diagnostic history. Members are stratified to either high or low behavioral health need using a Community Care defined algorithm. The behavioral health stratification file is shared with corresponding physician health plan. The physical health plan adds their physical health high/low stratification completing the 4-quadrant analysis. Combined behavioral health/physical health member file is returned to Community Care. Process completed monthly to capture new, changed or deleted information. Data is uploaded to our clinical platform on the Integrated Care Plan Template; the electronic template documents the member's physical health and behavioral health needs, dates of coordination with respective plan, referral reason and intervention. The template is completed primarily following telephone coordination with the physical health plan representative, either ad hoc or during planning clinical rounds. Care managers will have the ability to view the members' tiers on the Clinical Group tab.			Ongoing Intervention occurs as part of the Care Management daily activities	The number of completed Integrated Care Plans is tracked and presented annually to the Quality and Care Management Committees. Goals related to Integrated Care Plans completed have been consistently met. As part of the activity, Community Care monitors Integrated Care Plans completed for members with an inpatient admission. The measurements around this activity focus on integrating physical and behavioral health care. At an administrative level, Community Care may revise procedures and processes to increase the overall number of Integrated Care Plans if a barrier is identified. On the member level, Care Managers may assist the member by coordinating with the member's physical health managed care organization on physical health needs.
	According to an analysis of the 2021 HEDIS FUH data, 31% of HEDIS qualified discharges had an Integrated Care Plan. The follow-up rates for these members were 4 percentage points higher for 7-			2021	

day.

	HEDIS 7-Day Follow-Up		
Year	FUH for Members with an Integrated Care Plan	FUH for Members without an Integrated Care Plan	% Point Variance
2021	46.2%	41.8%	4.4
2020	47.5%	45.3%	2.2
2019	47.0%	44.2%	2.8

Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.

People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members **Provisions (3.2)** Medication appointments with psychiatrists are often hard to secure in a timely manner	**Inpatient Mental Health & Ambulatory Provider Value-Based Payment Arrangement:** Community Care and its Primary Contractors engaged inpatient mental health providers in a value-based purchasing arrangement in 2017, which has expanded to include ambulatory providers in 2021. This shared savings model focuses on the successful transition from inpatient to ambulatory services and the coordination of the two service systems to maintain members in the community. Activities include a Learning Collaborative for providers to increase collaboration and knowledge of best practices at both levels of care. Measures include 30-day readmission and 7-day follow-up, but providers will also be required to participate in regional collaborative activities. This Value Based model also includes a community-based organization in the region that will address social determinants of health that impact members being admitted or have the potential to be admitted to inpatient mental health services.	Value-based payment arrangements began for inpatient mental health providers began in 2017 In 2021 the value-based payment arrangement transitioned to a shared savings model including ambulatory services	Monitoring for this intervention is driven by value-based purchasing arrangements. Measures are 7-day follow-up rate and 30-day readmission rate. So far, the provider's success in meeting goals related to follow-up have not been consistent. Ongoing activities related to value-based purchasing arrangements are occurring as expected and will continue within Community Care, with providers given performance reports via Community Care's portal on a monthly basis. Payments to providers are made according to performance.
	The final analysis of rates for measure year 2021 occurred in July 2022. Goals for the value-based purchasing arrangement were set by contract, therefore provider performance was measured in each contract separately. Thirty-six distinct inpatient mental health providers and 94 ambulatory providers participated, across 11 Community Care contracts. Inpatient mental health performance was assessed for 7-day follow-up and 30-day readmission. For 7-day follow-up, 24 of the 54 (44%) rates assessed met the contract specific goal and for 30-	2021	

	day readmission, 39 of the 54 (72%) rates assessed met the contract specific goal. Ambulatory provider performance was assessed for 30-day readmission. One hundred and twelve (78%) of the 144 rates assessed met the contract specific goal. The success of this interventions is largely attributed to including ambulatory providers in the shared savings and implementation of the Learning Collaboration. Including ambulatory providers encourages providers to build mutually beneficial interventions and collaborative relationships. The regional Learning Collaborative meetings have provided a forum for inpatient and ambulatory providers to discuss barriers to follow-up and readmission and determine the best way to overcome obstacles.		
	Measure year 2022 rates will be analyzed in July 2023.	**2023**	
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers to individualized discharge planning, aftercare, and addressing engagement issues.		
People (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms	**Network Availability of Black/African American practitioners and culturally competent providers:** Community Care asks practitioners if they would like to disclose their race/ethnicity or religion to be used during our referral process, and all providers are asked if they have any area of specialization during the credentialing and re-credentialing process. Providers who choose to disclose this are identified within Community Care's network accordingly. When members call Community Care's Member Line requesting same-race practitioners or practitioners specializing in minority populations, Customer Service Representatives are able to see this information when searching for providers in the member's region.	Ongoing	Community Care will track the number of practitioners and facilities disclosing a specialization in minority populations and practitioner race/ethnicity/religion through multiple projects occurring around network availability. These factors are consistently assessed when considering network expansion. Updates for this intervention will be kept by Community Care's Network Department to ensure movement and reportability.
Providers (2.1) Specific to Black/African American members Black and African Americans experience health inequity in behavioral health treatment ***Provisions (3.1) Specific to Black/African American***	As of February 2023, 1,346 (48%*) contracted practitioners have self-identified their race. Five percent (71) identified as Black or African American. Race/ethnicity and religion are not tracked for facility credentialed providers, as this information is dependent on who is employed by the facility at the time of credentialing and is subject to change. For specializations, 100 practitioners (4%*) and 46 (6%*) facilities responded to having specialized knowledge and cultural competency in the Black/African American population. *Number of distinct credentialed providers on 03/07/2023	2022	

members There is a shortage of Black/African American treatment providers and there are limitations on identifying culturally competent care	Customer Service Representatives, who work Community Care's Member Line can see this information when searching for providers in the member's region and are able to provide information on same-race practitioners or practitioners specializing in minority populations. Note that a prior intervention was discussing the possibility of having race and ethnicity information added to the online Provider Directory. This is being removed due to competing priorities and current barriers that limit Community Care's ability to have this information included, accurate, and up to date. Barriers include the proportion of credentialed providers who have reported, inability to accurately report for facilities due to changes in staffing, and potentially alienating those providers who have not reported.		
	Community Care feels that it is essential for members to receive culturally competent care. Encouraging providers to disclose race, ethnicity, and/or specialization(s) assists members to make informed decisions when choosing a treatment provider. This will impact Community Care's HEDIS FUH rates by linking members to providers most likely to positively impact their recovery.		
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services, which impacts our members with co-occurring disorders *Provisions (3.2)* Medication appointments with psychiatrists are often hard to secure in a timely manner	**Network Expansion:** Community Care is continually seeking to expand the network, as appropriate, to best meet the needs of members. Each individual contract provider relations representative brings potential providers to clinical operations meetings for review and vetting to ascertain the necessity of adding this provider to the network. These meetings occur at least monthly, with most occurring bi-monthly. Community Care's Network Department adds providers to the network that offer non-traditional hours when they are available. Community Care also collaborates with providers within the existing network to ensure after-hour appointments are offered and accommodated. Emphasis for non-traditional hours have been given towards medication assisted treatment providers. Non-participating provider agreements are completed, as necessary, with consideration to bring providers in that can best accommodate a member's schedule.	Ongoing part of operations	Each individual contract provider relations representative brings potential providers to clinical operations meetings for review and vetting to ascertain the necessity of adding this provider to the network. These meetings occur at least monthly, with most occurring bi-monthly. Emphasis for non-traditional hours have been given towards medication assisted treatment providers. Non-participating provider agreements are completed, as necessary, with consideration to bring providers in that can best accommodate a member's schedule. Each year's activities are reviewed the annual Board Quality Improvement Committee each contract's Quality and
	Community Care's Network Department has streamlined the initial screening process to simplify the process for providers who want to	2021-2022	

	join the network. The Network Department utilizes a script that all providers receive along with a screening form for practitioners and a service description for facilities. In Allegheny County specifically, a new process has been established for review of new practitioners and facilities requesting admission to the HealthChoices network. This is referred to as an open network, whereas most providers requesting to be included in the network are accepted and standard geographical denial criteria for practitioners were eliminated. The exception being budgetary considerations for facilities. In 2021, recredentialing for practitioners switched over to the CAQH application process, which eliminated the use of a lengthier 36-page paper application.		Care Management Committee meetings. Community Care also monitors all complaints that may be related to a provider's unwillingness to accommodate a member's schedule. Each complaint is investigated thoroughly, with a focus on the member receiving the services, as necessary. Allegheny County has developed a Provider Credentialing and Contracting report which is presented at the Quality and Care Management Committee meeting twice a year. In the future, Community Care will be using MEMM reporting to the State as a form of monitoring.
	In 2022, Community Care added over 400 new providers or contracted with existing providers for new services and/or new locations in all contracts. Some of the types of providers and services that were added to the network include Psychiatric Residential Treatment Facilities, Psychologists, and other Ambulatory Service Organizations.		
	Community Care feels this intervention has a positive impact on HEDIS FUH rate by improving the availability of appropriate levels of care and provider options following an inpatient mental health discharge.		Community Care monitors accessibility through the annual Member Satisfaction Survey, which is administered by Performance Symphony Health by asking member perception of urgent and routine appointment accessibility. Additionally, through Consumer and Family Satisfaction Teams (Consumer Action Response Team in Allegheny County) members are asked questions related to their satisfaction with available services.
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Outpatient Mental Health Quality Record Reviews:** Community Care conducts Record Reviews for ambulatory providers when these levels of care are identified as a contract priority and planned in the annual Quality Work Plan. One of the indicators often assessed during these reviews is "If member had an inpatient mental health admission during the course treatment, post-hospital follow-up occurs within 7 calendar days." And/or "if member	Annual, as determined by each contract's Quality Work Plan.	Each year's reviews are reported at each contract's Quality and Care Management Committee meetings.

	expresses concern about their medication regime, a psychiatric reassessment for medication management occurred within 14 days." Providers with a sufficient sample who do not meet goal are asked to complete a quality improvement plan on how to improve.		
	Outpatient mental health providers (practitioner, clinical, or Integrated Community Wellness Centers) were reviewed in 8 of Community Care's 12 contracts in 2022, and 7 of the 11 contracts in 2021.	2022	

Outpatient Mental Health Record Reviews		
Indicator	2021 Rate	2022 Rate
If member had an inpatient mental health admission during the course treatment, post-hospital follow-up occurs within 7 calendar days	90%	52%
If member expresses concern about their medication regime, a psychiatric reassessment for medication management occurred within 14 days	100%	75%

	Providers who did not meet goal for any record review indicator were asked to complete a quality improvement plan.		
	Several Community Care contracts have plans to review outpatient practitioners, outpatient clinic, or Integrated Community Wellness Centers in 2023.	**2023**	
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers for providing timely follow-up.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Provider Performance Issues:** Community Care tracks aftercare appointments from all inpatient discharges as part of routine Care Management functions. The Quality Management Department collates this data to determine if members have aftercare appointments prior to discharge and that those appointments are within 7-days of the discharge date. The data is monitored monthly and providers who develop a trend of provider performance issues, a quality improvement plan is requested, and the trend is monitored for resolution. This intervention applies to both inpatient and aftercare service providers. Additional information on Provider Performance Issues can be	Suspended	Community Care's Quality Management Department reviews Provider Performance Issues on a monthly basis to track and identify trends. Quality Improvement Plan requests, update requests, or notifications are sent monthly based on multiple factors, including length of trend, past trends, or past requests.

	found on Community Care's website at https://providers.ccbh.com/clinical-and-innovative-resources/information-and-resources/provider-performance-issues		
	Community Care moved to a universal discharge form to streamline discharge expectations across levels of care and reporting requirements. Inpatient mental health providers are required to fax the completed universal discharge form to Community Care within 24 hours of discharge. This ensures that Community Care has the information in a timely manner to complete outreach calls to address barriers to aftercare. The information completed in the universal discharge form is monitored through the Provider Performance Issues process to track compliance.	2021-2022	
	This activity has been suspended since May 2020 due to COVID-19. Community Care will resume this intervention when OMHSAS lifts the temporary suspension of specific authorization regulations, (bulletin 1135). At this time, Community Care anticipates this will occur in 2023.	**2023**	
	Community Care feels that this intervention impacts our HEDIS follow-up rates by addressing deficiencies at the provider level.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Performance Standards:** Community Care issues Performance Standards which are intended to be best-practice standards that providers will use to design and assess their programs and that Community Care will use to assist with assessment of the quality of services. Performance Standards are published for providers on Community Care's website at https://providers.ccbh.com/clinical-and-innovative-resources/performance-standards Community Care has issued Performance Standards specific to inpatient and outpatient levels of care which outlines expectations around aftercare planning and aftercare appointments. Community Care directs providers to the Performance Standards, and/or distributes copies of Performance Standards as part of many company activities, as appropriate, such as provider meetings, requests for quality improvement, and during credentialing.	Ongoing and several Standards updated in 2019	Community Care's Quality Management Department conducts scheduled and ad hoc record reviews of provider records to assess adherence to Performance Standards. Indicators around discharge planning are included in tools for all levels of care and rates are compared over time in annual quality and care management committee meetings for each contract. Community Care additionally monitors the expectation of 7-day follow-up from inpatient mental health through Provider Performance Issues (outlined above).
	Community Care feels that establishing performance standards supports interventions by clearly outlining the expectation of timely follow-up in documents regularly shared with the provider.		
People (1.1) Specific to Black/African American	**Prevention, Early Detection, Treatment and Recovery for Substance Use Disorders:** In 2020 Community Care, along with	2020	Quarterly reports to the Performance Improvement Plan are submitted to County

members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms *People (1.3)* Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members *Providers (2.1) Specific to Black/African American members* Black and African Americans experience health inequity in behavioral health treatment	Primary Contractors and OMHSAS, initiated a company-wide Performance Improvement Plan. The Aim of this Performance Improvement Plan is to significantly slow and eventually stop the growth of substance use disorder prevalence among HealthChoices members, while improving outcomes for those individuals with substance use disorders. Five key performance indicators (KPIs) have been identified including: 1) Follow-up after high-intensity care for substance use disorder; 2) Substance use-related avoidable readmissions; 3) Mental health-related avoidable readmissions; 4) Psychosocial interventions and pharmacotherapy for opioid use disorder; and 5) Psychosocial interventions and pharmacotherapy for alcohol use disorder. To positively impact these measures, Community Care will be implementing the Cascade of Care Model framework, which is implemented in stages, beginning with Stage 1 (Intercept), Stage 2 (Engagement) as well as Stages 3 & 4 (Retention). In November 2020, baseline data for all five KPIs was established. Community Care feels that the ability to access ambulatory substance use disorder treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health. Members being enrolled in medication assisted treatment following an inpatient admission may prevent a readmission to a residential level of care before mental health aftercare can happen.		Oversights and OMHSAS/IPRO along with an annual submission. In addition to the KPIs, Community Care annually monitors three indicators to assess the success of the interventions: utilization of medication assisted treatment, overall substance use disorder penetration rate, and PA Death by Drug Overdose Rate.
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services, which impacts our members with co-occurring disorders	Community Care established targeted interventions for the Cascade of Care model as follows: • **Warm Hand Off**: is the linking of a member with an appropriate treatment provider following a substance use disorder related event. The Warm Hand Off intervention focuses on increasing the percent of members when presenting at Physical Health hospitalization or emergency departments who initiate substance use treatment including medication assisted treatment for either alcohol use disorder or opioid use disorder over 36 months, by bridging the gap between physical health and substance use disorder treatment systems. Warm Hand Offs are done by peers, case managers of Single County Authorities, Centers of Excellence, or other contracted providers. • **Telehealth Prescribing**: aims to increase the rate of billed	Project implementation, including interventions started at the beginning of 2021 and will continue through 2023, with the last update to the project to be reported in September 2024	Interim tracking measures (ITMs) have been developed for each intervention; ITMs are monitored on a quarterly basis.

telehealth claims for prescribing medication assisted treatment for members with opioid use disorder and alcohol use disorder during or immediately following an inpatient physical health hospitalization or emergency department visit through untapped prescribing services via telehealth designed to engage individuals into substance use disorder treatment, over 36 months. • **Federally Qualified Health Center Learning Collaborative:** (implemented on June 2021 and completed in November 2021) the focus of the Learning Community was to increase the percent of individuals seeking primary care in Federally Qualified Health Centers with screening and initiation of substance use disorders treatment including medication assisted treatment for opioid/alcohol use disorders through support, education, and consultation in a learning community. These interventions are designed to impact the Key Performance Indicators as well as the overarching Performance Improvement Plan Aims statement and objectives. **Community Care, in collaboration with County Oversights and their Single County Authorities established the following objectives to be completed by the end of 2023:** • The **Anti-Stigma Campaign**, (part of the population health activities) known as Community Care's Anti-Stigma Resources and Education Campaign (or CCARE) was implemented July 1, 2021. The campaign is designed to reduce stigma for seeking help for substance use disorders resulting in more members engaging in substance use disorder care. The campaign includes anti-stigma education, targeted media posts, webinars, and community outreach and is designed to add to existing statewide substance use disorder anti-stigma efforts rather than duplicate existing programs such as the Life Unites Us and Shatterproof campaigns. The campaign has a focus on Black/African American racial disparities. It builds upon recent substance use disorder education and collaboration efforts with community partners and others to expand educational anti-stigma programs. CCARE Campaign resources are posted to the Community Care website along with a brief survey on stigma. This campaign includes a Barber/Beauty Shop pilot Project, the Our HAIR (Health Access Initiative for Recovery) which educates Black/African American barbers and	**2023** The Our HAIR initiative was implemented in Q4 2022.	

	stylists in the Pittsburgh area on how to talk to clients about suicide, substance use disorders, and other behavioral health disorders, and how to link clients to treatment resources. The hope is as stigma decreases, help seeking behavior for initiation of substance use disorder treatment will increase. • **Medication Assisted Treatment (MAT) Toolkits** were implemented July 1, 2021, as part of the population health activities for the PEDTAR. The toolkits address lack of substance use disorder treatment engagement through education on substance use disorder treatment options for members, families, and providers through development and dissemination of a MAT Toolkits were implemented and are designed to increase rates of medication assisted treatment prescribing. Members that receive rapid access to lifesaving medication may be more likely to continue in treatment. These toolkits are available in English and Spanish. • The **Community Health Worker Outreach** intervention (implemented July 1, 2021) focuses on increasing follow up and decreasing readmission through outreach by a Community Health Worker during or immediately following a withdrawal management or inpatient substance use treatment stay to educate members (at least 13 years of age) on care options, facilitate referrals, and connection to behavioral health services or other community supports. Community Health Workers specifically focus on Social Determinants of Health that might impact a member's ability to complete follow up care. Embedded within this intervention is a mandatory cultural awareness training for all Community Health Workers. Staff training in cultural awareness will improve the work that we do and how we interact with all our members. Sensitivity to different cultures will increase our understanding of help seeking behavior, access issues, and resources available to members. • **Family/Social Support** (implemented January 1, 2022) - over 24 months, provide education, trainings, and toolkits including racial and ethnic cultural competencies, to members and their families to increase rates at which members include their families in substance use disorder outpatient treatment as evidenced by increased rates for billed family therapy sessions delivered to	Family / Social Support and RMC started on January 1, 2022.	

	fidelity to best practice standards in family therapy. (Note: translation services are available for members that are non-English speaking). Family members can encourage and support members in treatment and may assist with getting members to follow up appointments. • **Recovery Management Checklist**– (implemented January 1, 2022) - over 24 months, implement ongoing monitoring by Certified Recovery Specialist to improve retention in care, provide education in relapse prevention, racial and ethnic cultural competencies, connection to community-based resources, with payment reform to support long-term monitoring of members in substance use disorder treatment. The focus of this intervention is the later stages of the Cascade of Care model with a focus on long term member retention in treatment. The Recovery Management Checklist is available in English and Spanish. Additionally, in counties with a larger percentage of members that identify as Spanish-speaking providers have bilingual staff; translation services are available for non-English speaking members.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Provider Benchmarking:** Community Care distributes annual Provider Benchmarking reports. These reports publish the previous year's Value-Based Purchasing arrangement results. This includes 7-day follow-up and 30-day readmission rates for inpatient mental health providers and aftercare ambulatory providers. See the Inpatient Mental Health & Ambulatory Provider Value-Based Payment Arrangement intervention for more information. Published reports include unblinded provider rates for all providers in the network or involved in the value-based payment arrangement, depending on the measure. The change to publish reports unblinded is meant to increase transparency and give providers the opportunity to make direct comparisons with peers.	Ongoing activity, process updated to align with value-based purchasing in 2022	The activities of each year are developed by a workgroup that meets every other week. Feedback and updated rates are used to determine the most appropriate action to facilitate change. This activity is reported annually at the Quality and Care Management Committee meetings for each contract and at the Board Quality Improvement Committee. The Provider Benchmarking Publication is annual. Activity monitoring is captured in the Inpatient Mental Health & Ambulatory Provider Value-Based Payment Arrangement intervention listed above.
	In 2023, Community Care is piloting a new approach of intervention to assist providers who are within a standard deviation of the goal. Community Care, in collaboration with	**2023**	**The provider benchmarking workgroup will be monitoring and analyzing the rates of providers targeted for interventions for**

	Primary Contractors have identified 15 inpatient mental health and ambulatory providers who will be targeted this year. Community Care asked providers to identify at least one champion within their organization to participate. There will be two workshops, March 8, 2023, and March 22, 2023, focusing on using member level detail to identify barriers, do Root-Cause-Analyses, develop interventions, and conduct Plan-Do-Study-Act cycles. Champions will end the activity with data-driven interventions and recommendations for their organization's leadership to improve rates.		**rate increases for a minimum of 18-months.**
	Community Care feels that this activity assists in addressing barriers to aftercare experienced by members and providers by defining expectations, providing education, and asking providers to think creatively about overcoming obstacles.		
People (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms	**Social & Racial Justice Steering Committee activities:** The Social & Racial Justice Steering Committee was developed in 2021 to develop interventions to address inequities in five categories - Provider Professional Development, Internal Professional Development, Member Level Advocacy, Human Resource Interventions, Community, and Policy. Workgroups were formed, including staff company-wide to address activities in the five categories. These workgroups identify sources for education and training to be shared internally and with stakeholders around inclusion and cultural diversity.	2021 and ongoing	Reoccurring weekly meetings with Senior Management review internal reports and monitoring as standing agenda items.
Providers (2.1) Specific to Black/African American members Black and African Americans experience health inequity in behavioral health treatment	The following workgroup activities occurred in 2022: • Began developing a Social and Racial Justice Advisory Board, which includes members, providers, community organizations, and other stakeholders. • Provider trainings on topics of social and racial justice, diversity, and inclusion. Trainings included, 'Making the Unconscious Conscious Through Cultural Humility', 'All These Isms: Understanding Privilege, Power and Oppression in Professional and Personal Relationships', and 'Intersectionality Matters'. • Community Care's corporate Human Resources has developed a diversity hiring dashboard to ensure that hiring managers have a diverse pool of applicants. Community Care reviews staff demographics quarterly for opportunities.	2022	Community Care tracks interventions completed by this group and how to best measure effectiveness based on each intervention. We anticipate that the planned interventions (stakeholder education, training on inclusion & cultural diversity and human resource interventions) will have an impact on the gap in disparities seen among our Black/African American population with inpatient episodes and increase the number of providers in the Community Care network who will seek specialization in minority populations.

	• As part of Community Care's Anti-Stigma Resources and Education Campaign (CCARE) barbers and stylists were trained in October on how to talk to clients about suicide, substance use disorders, and other behavioral health disorders, and how to link clients to treatment resources. See Prevention, Early Detection, Treatment and Recovery for Substance Use Disorders for more information. There have been 12 barbers/stylists who participated across 7 shops. These shops were in Homestead, Homewood, Monroeville, Swissvale, Hill District, West Mifflin, and Oakland regions of Allegheny County. • There were 4 internal staff trainings related to social and racial justice, diversity, and inclusion. Across these 4 trainings there were 767 participants. • In total, 40+ diversity/equity/inclusion related trainings were sponsored, or co-sponsored, by Community Care in 2022. This involved approximately 4,000 staff, providers, and other stakeholders.		
	Planned activities for 2023 include: • **The Policy Workgroup used a consultant to review 10 of our Community Care HealthChoices policies for opportunities for improvement.** • **The Member Level Advocacy Workgroup will be meeting with each contract's local advisory board on a quarterly basis to discuss any social, racial, or cultural concerns and share updated information about interventions.**	2023	
	Community Care believes that this intervention will improve aftercare by identifying issues across the system and developing companywide interventions to impact inequities.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues *Providers (2.1) Specific to Black/African American*	**Social Determinants of Health Workgroup: Community Care has developed a Social Determinants of Health Workgroup as part of the Community Based Care Management initiative. This workgroup is currently adding race, ethnicity, language, age, and gender to current report related to social determinants of health and Community Based Organizations to better identify disparities related to needs.**	2023	Social determinants of health are a primary focus for the Community Based Care Management Program Director. Workgroups will occur on a regular basis throughout 2023 until interventions and metrics are established.
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers that can impact		

members Black and African Americans experience health inequity in behavioral health treatment	aftercare.		
Providers (2.1) Specific to Black/African American members Black and African Americans experience health inequity in behavioral health treatment *Provisions (3.1) Specific to Black/African American members* There is a shortage of Black/African American treatment providers and there are limitations on identifying culturally competent care	**Targeted Accessibility Analysis (formally Identifying gaps in treatment availability for Black/African American members using GEOAccess):** In 2021, Community Care developed a Targeted Accessibility Analysis to identify gaps in same-race or culturally competent treatment availability for our Black/African American members. Using GEOAccess Community Care plots geographical information regarding the drive time or the distance members in rural and urban locations must travel to get to a specific type of provider. We apply member race/ethnicity information from DHS enrollment data to their geographical location. A second layer of geographical information is applied for service locations of providers who have voluntarily identified themselves as Black/African American, and yet a third layer for providers who have voluntarily identified themselves as specializing in cultural competency. This data shows gaps in same-race or culturally competent providers reasonably accessible to our Black/African American enrollees. Once possible gaps in treatment availability have been identified, Community Care can develop specific regional interventions to address need.	2021	This report will be used in conjunction with other interventions addressing culturally competent care and when considering network expansion.
	The Targeted Accessibility Analysis has been applied to Allegheny County, which is Community Care's most diverse contract. The analysis entailed slicing the County into 4 sections and showed that less than half of Black/African American members had access to same-race or culturally competent care within the established standard of 2 providers within a 30-minute drive time.	2021	
	Originally slated to occur 2022 this intervention has been reprioritized to 2023: Community Care will complete a Targeted Accessibility Analysis for Community Care contracts with disparities and provide an update to contract leadership regarding accessibility to culturally competent care for minorities.	**2023**	
	Community Care feels that it is essential for members to receive culturally competent care. This will impact Community Care's HEDIS FUH rates by linking members to providers most likely to positively impact their recovery.		

CCBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance			
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues *People (1.4)* Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	**Telehealth:** Telehealth allows behavioral health practitioners to provide clinical services, such as medication management, assessment, diagnosis, and case management to members through two-way, interactive videoconferencing and telephone calls. Prior to the COVID-19 pandemic, Community Care supported these services on a limited basis, particularly for rural areas where drive time and transportation presented as a barrier. At the initiation of the pandemic in March 2020, OMHSAS loosened the regulations surrounding Telehealth to accommodate members utilizing behavioral health services. Members were able to attend appointments via telephone; they did not have to use video or screen sharing technology. Providers were able to expand the number of services available to members. Preliminary results of the telehealth expansion include increased show rates, high member satisfaction, convenience for practitioners and members, and access to other settings and providers in real time. Satisfaction surveys were conducted by Consumer/Family Satisfaction Teams of members from Community Care counties regarding their experiences of receiving services via telehealth. Almost all members who responded agreed or strongly agreed that their provider was able to "meet all of my behavioral health needs." In 2021, several Consumer and Family Satisfaction Teams added questions related to telehealth to their surveys with positive results. Specific to Allegheny County's Consumer Action Response Team - 80% of survey respondents (n. 1,374) indicated that telehealth made it easier for them to receive the services, 72% of survey respondents (n. 349) rated their experience with telehealth as satisfied or very satisfied. In York and Adams Counties – 74% of survey respondents (n. 76) responded that their provider offered flexibility with Telehealth appointments beyond business hours, 88% of survey respondents (n. 88) indicated they are satisfied with the Telehealth services offered. And, in Bedford and Somerset Counties – 92% of survey respondents (n. 381) rated their experience	2020-2022	The availability of telehealth services is regularly monitored as part of network expansion requests and Network Adequacy Workgroup. Community Care has developed reports to monitor the use of telehealth services and regularly reminding providers to use telehealth place of service codes which was released in the March 16, 2020, Provider Alert, titled COVID-19 Update: Telehealth Services. The use of this code will be instrumental in Community Care obtaining accurate data. Provider Alert: https://providers.ccbh.com/uploads/files/Provider-Alerts/20200316-alert4-covid19.pdf The Quality Management Department reviews telehealth information in member records during record reviews to ensure the service is occurring within specifications outlined in the Provider Alert. Additionally, Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 7-day HEDIS FUH rates. This data will be reviewed quarterly in 2023 for ongoing trend analysis and any additional opportunities for improvement.

	with telehealth as satisfied or very satisfied. This data is promising when evaluating the overall effectiveness and satisfaction of telehealth services. In 2022, Community Care published a Provider Alert to all Community Care providers providing guidelines for the delivery of behavioral health service through telehealth. These guidelines are in accordance with OMHSAS Bulletin 21-09. Provider Alert: https://providers.ccbh.com/uploads/files/Provider-Alerts/202203-alert6-guidelines-delivery-bh-services-telehealth.pdf		
	Community Care analyzed the 2021 HEDIS FUH data for inpatient mental health discharges. According to this information, 40% of all HEDIS qualified follow-up was delivered via telehealth.	2021	
	It is anticipated that this service may be retained in the future, although more trainings would need to be offered to providers on topics related to telehealth, developing billing processes, and addressing current documentation procedures (e.g., how to obtain signatures on a treatment plan).		
Provisions (3.2) Medication appointments with psychiatrists are often hard to secure in a timely manner	**Telepsych:** Telepsychiatry allows behavioral health practitioners to provide clinical services to patients at remote, usually rural, locations through two-way, interactive videoconferencing, sparing both practitioners and patients the time and expense of long-distance travel. It allows members to access psychiatrists that would not otherwise be available to them. Patients may connect to a specialist via the telehealth network from their community healthcare facility.	2005 - ongoing	Community Care will continue to take an active role in expanding telepsychiatry and monitor its utilization via the number of members served and providers involved. Telepsychiatry services and related data is reported annually at Community Care's Board Quality Improvement Committee.
	In 2022 alone, 11,987 unique members were served via telepsychiatry, receiving psychiatric evaluations and medication management appointments. As of 01/26/2023 Community Care contracts with 64 providers across 192 locations for telepsychiatry.	2022	
	Community Care feels that telepsych services permits a number of members to receive psychiatry services that wouldn't ordinarily be accessible, or much sooner than would be permitted in a traditional setting. This intervention positively impacts HEDIS FUH rates by increasing accessibility and reducing barriers.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare,	**Utilization Management Provider Notification:** Notification processes are in place to inform Blended Case Managers, Family Based Mental Health Services, or other service providers as applicable, at the time of authorization of an inpatient admission	Ongoing practice with process updated in 2020	Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases

vocational schedule, legal issues, or housing issues **People (1.3)** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	for any of their members and to coordinate aftercare for children discharged to shelter placements. In Allegheny County, notification of Assertive Community Treatment teams for members who receive this service is included in this intervention.	Intervention occurs as part of the Care Management daily activities	during supervision.
	Community Care currently does not have a reliable method of collecting the Provider Notification data on an aggregate level. At this time Community Care will continue to explore ways to aggregate this data.		
	Community Care believes this activity impacts aftercare rates by involving other service providers in supporting members during and after IPMH stays.		

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

CCBH RCA and QIP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?): The overall opportunity for improvement, which is the focus of this root-cause-analysis and quality improvement plan, was identified using the MY 2021 FUH Goal Report. Attachment: IPRO's Quality Management Dashboard was used to determine disparities in HEDIS 30-day follow-up post hospitalization (FUH). The following information/analysis was used to identify the factors that contributed to underperformance: • 2022 HealthChoices Membership Analysis • Analyses of Care Management Admission Interviews. • An analysis of network availability of	***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:*** Logic Models: The following opportunity for improvement was identified requiring the root-cause-analysis and quality improvement plan: Performance Measure | MY 2021 (N) | MY 2021 (D) | MY 2021 Rate FUH HEDIS 30-Day All Ages | 9,686 | 15,137 | 64.0% The following disparities with a statistically significant difference (SSD) were identified among members with an IPMH admission: • In the aggregate, the Black/African American cohort was less likely to have follow-up within 30-days compared to the White cohort. ○ This also applied to the Allegheny contract (HCAL), Erie contract (HCER), and the Northeast contract (HCNB). • In HCBK, the White cohort was less likely to have follow-up within 30-days than members who selected Other or chose not to respond. ○ The drill down analysis concluded that of the 406 members with an inpatient mental

practitioners who identified as being Black/African American and providers who identified a specialization in treating Black/African American individuals.

- A drilldown analysis of members with and without 30-day follow-up appointments in aggregate and in contract specific groupings.
- Barrier analysis of North Central State Option completed by the Behavioral Health Alliance of Rural Pennsylvania.
- Board Quality Improvement Committee reports for network availability, and assessment of cultural needs.
- Compilation of Discharge Management Planning follow-up meetings that occurred with inpatient mental health providers in 2019.
- Information from Community Care's RCA submitted in 2022, which reflects alignment with our contractors' QIP submissions. Quality Managers from each contract also have and will have ongoing collaboration with contractors to address and align contact-specific action plans.
- Review of current literature.

Attachments:

health admission in HCBK, who fall under "other/chose not to respond" for race, 63% identified as Hispanic.
  - o For the remaining 37% of members who fall under the "other/chose not to respond" for race, additional discerning demographics were unable to be identified.
  - o Interventions developed to address all Community Care members will apply in this situation.
- In the aggregate, the non-Hispanic cohort with an inpatient mental health admission were less likely to have follow-up within 7-days than the Hispanic cohort.
  - o This also applied to HCNB.
  - o The HCBK and HCCK non-Hispanic cohort with an inpatient mental health admission were less likely to have follow-up within 30-days.

Community Care conducted a literature review and data analysis of Hispanic and non-Hispanic members with an inpatient mental health admission in 2021. Results are as follows:

- Among Community Care's HealthChoices enrollees, 89.1% identified as non-Hispanic (2022 HealthChoices Membership Analysis). When analyzed across contracts, the majority of members were non-Hispanic. For the contracts with a statistically significant difference in 7 or 30-day follow-up, the distribution of members identifying as non-Hispanic is as follows:

HCBK	HCCK	HCNB
58.5%	86.1%	81.4%

- Literature reviews indicate that Hispanic individuals typically have lower rates of treatment engagement than non-Hispanic individuals. Community Care's Membership Analysis supports this hypothesis with only 14% of Hispanic enrollees engaging in services in 2021, compared to 21% of non-Hispanic members. However, further data analysis of HEDIS discharges between 2018 to 2021 indicate that Hispanic members in treatment are more likely to follow-up and remain engaged in treatment.
- Interventions developed to address all Community Care members will apply in this scenario due to the majority of our members falling in the non-Hispanic category.

Performance Measure: FUH HEDIS 30-Day All Ages					
Rates with SSD					
Contract	Cohort 1	Rate 1	Cohort 2	Rate 2
HC	White	65.1%	**Black/African American**	**58.2%**
AL	White	65.3%	**Black/African American**	**59.4%**
AL	**Non-Hispanic White**	**65.2%**	Hispanic	82.5%
BK	**White**	**58.5%**	Other/Chose Not to Respond	65.5%
BK	**Non-Hispanic White**	**58.3%**	Hispanic	66.5%
CK	**Non-Hispanic White**	**66.0%**	Hispanic	80.6%
ER	White	62.6%	**Black/African American**	**50.8%**
NB	White	66.0%	**Black/African American**	**55.0%**

CCBH RCA and QIP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance	
List out below the factors you identified in your RCA. Insert more rows as needed (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 (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Among Community Care's HealthChoices enrollees, 15.6% identified as African American (2022 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a statistically significant disparity, the distribution of members identifying as Black/African American is as follows: **AL | ER | NB** 37.1% | 19.6% | 10.0% In 2021, 58% of the Black/African American members with an inpatient mental health admission had follow-up within 30-days. This is less than White members in 2021, who had a 30-day follow-up rate of 65%. While we don't have data to indicate why Black/African American members are less likely to have follow-up, a study showed that 63% of Black people perceive mental health conditions as a sign of personal weakness (National Alliance on Mental Illness, 2021). This results in feelings of shame and the fear of judgement. According to the National Institute for Mental Health (2021), Black youth are significantly less likely than White youth to receive outpatient treatment, even after a suicide attempt. Although Black and African American people have historically had relatively low rates of suicide, when compared to White people, this has been increasing for Black youths (Centers for Disease Control, 2022). For 2016-2020, suicide was the second leading cause of death in Black children aged 10-14, and third for Black individuals aged 15-34 in Pennsylvania. This factor is deemed critical.
	Current and expected actionability: Community Care has implemented interventions to specifically address disparities affecting our Black/African American population. This factor is expected to be actionable.
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Community Care regularly collects information about barriers from inpatient mental health facilities through provider discussions and quality improvement plans. Specifically in 2019, Community Care conducted interviews with 8 inpatient mental health facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates. Providers reported that it is particularly hard to plan aftercare for members with legal or housing issues. Uncertainty about the future of higher needs leads to difficulty engaging individuals in follow-up scheduling and planning activities.

CCBH RCA and QIP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance	
	In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Transportation was identified as a barrier affecting members in rural communities. Members interviewed by Community Care's Care Management through the Admission Interviews and Aftercare Outreach reported external barriers as factors influencing the ability to attend aftercare. These factors include things like transportation, childcare, vocational schedule, legal issues, or housing issues. • In 2021, Care Managers conducted Admission Interviews with 1,108 adult members who were readmitted to inpatient mental health within 30-days. Of those, 39.8% indicated that they did not go to their scheduled aftercare following the first inpatient mental health admission. When asked why, 26% indicated it was due to issues with transportation, schedule, housing, childcare, or other significant barrier. • A total of 2,178 adult admission interviews were completed for HEDIS discharges in 2021. During interviews members are asked "What brought you into the hospital for admission?" and "Is there something that you needed before you came to the hospital that might have helped you stay in your home?". Seventy-three percent of the interviews responded to one or both questions as factors related to financial health, housing, legal status, conflicts, childcare, clothing, employment, food insecurity, transportation, utilities, or other significant barriers. • In 2021, Community Care's Care Managers also spoke with 732 HEDIS discharges who did not attend aftercare to determine barriers. The most common responses for not attending were by choice, illness, transportation, and other. According to The Center for Rural Pennsylvania, of Community Care's 41 counties, all but 7 (Allegheny, Berks, Chester, Erie, Lackawanna, Luzerne, and York) are considered rural. Those living in rural counties are more likely to have further to travel to attend aftercare and are less likely to have any form of public transportation (SAMHSA, 2016). Members report that coupled with childcare and work schedules these barriers make it particularly difficult for members to commit to aftercare without sufficient planning, which is difficult to do from the inpatient setting. This factor is considered critical.
	Current and expected actionability: Community Care has developed several interventions to assist members to address external barriers to attending aftercare. We anticipate that we will continually make this a focus of Care Management and relationship building activities.
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Twenty-eight percent of the discharge summaries received in the first 2 Quarters of 2022 did not have behavioral health aftercare appointments identified during discharge reviews. For these discharges, 44.7% had a HEDIS claim within 7-days. This is compared to follow-up rates of 68.8% for members who did have an aftercare appointment identified. Community Care conducts interviews with members who have a readmission to inpatient mental health

	as part of the Admissions Interview activities which is described further in the interventions section. Specifically in 2021, Admission Interviews indicated that for readmitted HEDIS adult members who did not attend aftercare appointments, 27% did not have aftercare scheduled at discharge, while 18% reported difficulty with their medications as the reason for readmission, and 4% of adults indicated it was lack of timely follow-up from the first admission. Although members with readmissions are excluded from data for HEDIS follow-up, Community Care has access to barriers members are experiencing after an inpatient mental health admission by utilizing the readmission information. If barriers around discharge planning are addressed, this will likely have an impact on follow-up rates as well.
	During Regional Inpatient Mental Health and Ambulatory Provider Value-Based Purchasing Stakeholder Meetings in 2022, inpatient mental health providers reported difficulty getting appointments within 7-days for discharges plans, while ambulatory providers reported less appointment availability due to ongoing staffing issues.
	In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Unclear discharge instructions from inpatient mental health facilities is a barrier identified for members attending aftercare.
	This factor is deemed critical.
	Current and expected actionability: Community Care has developed interventions to assist members and providers with aftercare planning. We anticipate that we will continually make this a focus moving forward.
People (1.4) Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Community Care regularly collects barriers from inpatient mental health facilities through provider discussions and quality improvement plans. In 2019, Community Care conducted interviews with 8 IPMH facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates. During barrier discussions, providers reported that members often decline aftercare.
	In 2021, Care Managers conducted Admission Interviews with 1,108 adult members who were readmitted to an inpatient mental health within 30 days. Of the members who had an aftercare appointment scheduled but did not attend, 17% indicated because they chose not to. Furthermore, the Aftercare Outreach Care Managers spoke with 732 HEDIS discharges in 2021 who did not attend their scheduled aftercare appointment and 8.1% indicated they declined to attend.
	During Regional Inpatient Mental Health and Ambulatory Provider Value-Based Purchasing Stakeholder Meetings in 2022, inpatient mental health providers reported some members decline timely aftercare due to being overwhelmed by the thought of going from inpatient mental health and directly to another level of care, or anxiety related to going to a new place or navigating telehealth appointments.
	In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24

	counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Member noncompliance is a barrier identified as impacting FUH. While we can speculate why, Friedman (2014) indicates that the perception individuals have about their own mental health heavily influences their willingness to engage in treatment. His research found that individuals who did not attend treatment indicated that the participant felt the treatment would not be effective, he or she could solve the problem on his or her own, and fear of being stigmatized. These perceptions particularly influenced individuals with first-time inpatient mental health admissions. Due to these perceptions, individuals may decline aftercare when offered by inpatient providers, feeling that acute stabilization is enough. Furthermore, if this factor is combined with any type of barrier to aftercare, such as transportation or childcare, attending an appointment deemed to not be beneficial, may seem insurmountable to the individual. This factor is deemed important.
	Current and expected actionability: Although this factor is important, it is complex and difficult to address on a macro level. While current and ongoing education will have an impact, stigma will continue to have profound negative effects until community-wide perceptions change.
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Community Care recognizes the importance of physical health needs when assessing and addressing behavioral health needs. In addition to being reported by providers as a barrier, Community Care collects data through Care Management activities, such as preauthorizations, continued stay reviews, and admission interviews. According to an analysis of Integrated Care Plan activities (described further in the interventions section), 31% of the HEDIS qualified discharges in 2021 had an Integrated Care Plan or a Physical Health/Behavioral Health referral, indicating a physical health need. Community Care also analyzed data captured through Admissions Interviews in 2021. There were 3,636 adult and 403 child interviews completed for members at inpatient facilities and 33.2% of adults and 10.0% of child members reported the inpatient mental health facility was actively helping them coordinate care for a medical condition. Research suggests individuals with mental illness are more likely to have chronic physical health conditions, such as high blood pressure, asthma, diabetes, heart disease and stroke than individuals without mental illness. Individuals with co-occurring physical and behavioral health conditions have health care costs that are 75% higher than the those without co-occurring conditions. The cost is 2 to 3 times higher than the average Medicaid enrollees (SAMHSA, 2021). In terms of overall wellness and recovery, this factor is deemed critical.
	Current and expected actionability: Community Care has developed several interventions to assist members to address physical health needs. We anticipate that we will continually make this a focus of company-wide activities.
Providers (2.1) Specific to Black/African American	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight*

members	*(Critical, Important, Somewhat Important, Not Very Important, Unknown):*
Black and African Americans experience health inequity in behavioral health treatment	Among Community Care's HealthChoices enrollees, 15.6% identified as African American (2022 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a statistically significant disparity, the distribution of members identifying as Black/African American is as follows: | AL	ER	NB | |---|---|---| | 37.1% | 19.6% | 10.0% | In 2021, of the 2,403 Black/African American members that had an IPMH admission, 63.8% had an appointment within 30-days. This is statistically significantly less than White members in 2020, who had a 30-day follow-up rate of 66.4%. Starks, Nagarajan, Bailey, and Hariston (2020) indicate that Black individuals are often undertreated for depressive symptoms and furthermore, White individuals are more likely to receive antidepressants medications for symptom management. Black individuals are more likely to be over diagnosed with psychotic disorders, more likely than their White counterparts to be prescribed antipsychotic medications, and more likely to be prescribed higher doses despite similar symptom presentation. Our initial data analysis reflects findings congruent with Starks et al's study: • According to the 2021 Membership Analysis, Schizophrenia is the eighth most prevalent diagnosis among our Black/African American members in treatment, accounting for 6% of those members. This is compared to the White members in treatment, for whom Schizoaffective Disorder ranks tenth, accounting for 2% of those members. These are the only psychotic disorders among the ten most prevalent for each cohort. • An analysis of the 2021 member level drilldown report, 36% of Black/African American members with an inpatient mental health admission were being treated for a primary diagnosis of a psychotic disorder (Schizophrenia, Schizoaffective Disorder, or Other Psychotic Disorder). In contrast, only 21% of White members were being treated for a psychotic disorder. • The 2021 drilldown also reveals that a total 1.17% (n.28) of Black/African American members had an inpatient stay of more than 100 days compared to .64% (n.73) of White members. • Of the 28 Black/African American members with an inpatient stay over 100 days, 24 (86%) were being treated for a psychotic disorder. For the White members 53 (73%) were being treated for a psychotic disorder. While conclusions cannot be made with these low numbers, there is a need to conduct more research. This factor is deemed critical.
	Current and expected actionability: Community Care has begun implementing interventions to specifically address inequities affecting our Black/African American population. We anticipate that we will continually make this a focus of company-wide activities. This factor is expected to be actionable, but stigma will continue to have profound negative effects until community-wide perceptions change.

CCBH RCA and QIP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance	
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services, which impacts our members with co-occurring disorders	**Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):** According to the 2022 HealthChoices Membership Analysis, 10% of Community Care's members in treatment have an opioid use disorder and an additional 4% have an alcohol related disorder, placing them both in the ten most prevalent diagnoses for members in treatment. For all members in treatment, 11% have a co-occurring mental health and substance use disorder diagnosis. Specific to the 2021 HEDIS discharges, 10.6% have an opioid use disorder diagnosis and 13.5% have an alcohol use disorder diagnosis. Of the follow-up appointments in our 2021 HEDIS sample, 1.2% were for Buprenorphine Services or Methadone Maintenance. Since this was the first appointment after inpatient mental health, this is not a new service for these members and there is likely another sample initiating medication assisted treatment services. Individuals with an opioid use disorder are at the highest risk for an overdose death but only 20% access treatment (DHS, 2021). In 2019, Community Care conducted interviews with 8 IPMH facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates. These providers indicated that the ability to obtain evidence-based treatment for opioid use disorder that includes medication assisted treatment is a contributing factor to delays in receiving treatment. Community Care feels that the ability to access medication assisted treatment and substance use disorder treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health. Members being enrolled in medication assisted treatment or other substance use disorder treatment following an inpatient mental health admission may prevent a readmission to a residential level of care before mental health aftercare can happen (Rief, Acevedo, Garnick, Fullerton, 2017). Community Care conducts interviews with members who have a readmission to inpatient mental health as part of the Admissions Interview activities (described further in the interventions section). In 2021, Care Managers conducted Admission Interviews with 1,108 adult members who were readmitted to inpatient mental health within 30 days. When asked the reason for the readmission, 24.2% of adult members reported it was for substance use. For adult member interviews that were not a readmission (n. 3,636), 21.1% reported the reason for the inpatient mental health admission was substance use. This factor is critical.
	Current and expected actionability: Community Care has developed several interventions to assist members to access medication assisted treatment and substance-use treatment needs. We anticipate that we will continually make this a focus of company-wide activities.
Provisions (3.1) Specific to Black/African American members There is a shortage of Black/African American treatment providers and there are limitations on	**Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):** Community Care has goals set for ratios of members per provider meeting availability standards:

identifying culturally competent care

Physician	Psychologist	Non-Doctoral Level Therapist	Ambulatory Provider Organization
5,000:1	2,000:1	2,000:1	750:1

This data is calculated by distance to providers by members' home address. Our annual Network Availability report indicates that in September of 2022, Community Care was not currently meeting goal for Physician or Psychologist.

Community Care collects information from providers during credentialing and re-credentialing regarding voluntary disclosure of race (for private practitioners) and specialization working with minority populations (practitioners and facilities). Although not a direct comparison, we have data indicating the following:

Total Black/African American enrollees on 01/04/2023:	239,870

Total practitioners who voluntarily identified as Black/African American by category:

Psychiatrist	Psychologist	Masters Level
6	8	57

Ratio of practitioners who voluntarily identified as Black/African American by category per number of same-race enrollees, as of 02/03/2023:

Psychiatrist Goal 5,000:1	Psychologist Goal 2,000:1	Masters Level Goal 2,000:1
39,978:1	29,983:1	4,208:1

Members: per provider

Ratio of practitioners and facilities who voluntarily identified as specializing in minority populations, specifically Black/African American minorities by category per number of same-race enrollees, as of 02/03/2023:

Psychiatrist Goal 5,000:1	Psychologist Goal 2,000:1	Masters Level Goal 2,000:1	Facilities (MH OP Clinics, SUD OP Clinics, & FQHC/RHC) Goal 750:1
15,991:1	7,496:1	4,526:1	5,215:1

Members: per provider

As part of our 2021 RCA/QIP, Community Care developed a report to identify gaps in treatment availability for Black/African American members using GEOAccess to plot geographical locations of provider service address and member's home address (described further in the interventions section).

Allegheny County has the most Black/African American members by both proportion and whole number, compared to other contracts. Allegheny County has more Black/African American members than all other Community Care contracts combined. For this reason, the Targeted Accessibility Analysis report was applied to Allegheny County by breaking it into 4 quadrants to identify areas of Black/African American member density and available providers who are same-race or identify as specializing in Black/African American treatment.

Quadrant	Percent of Black/African American members under 18 meeting the access standard to culturally competent care	Percent of Black/African American members 18 & over meeting the access standard to culturally competent care
NE	39.0%	57.9%
NW	43.3%	59.4%
SE	40.0%	60.0%
SW	40.2%	59.9%

Urban Access Standard: 2 providers in 30 minute drive time

Analyses have not been completed for the other contracts with a statistically significant disparity (HCER and HCNB) between the White and Black/African American members due to the low volume of Black/African American members and providers who have voluntarily identified.

01/31/2023		HCER	HCNB
Total Black/African American Members		16,647	19,275
Proportion of Enrollees		19.5%	10.1%
Black/African American same-race providers	Psychiatrist	1	0
	Psychologist	0	0
	Master's Level	3	0
Specializing in minority populations: Black/African American	Psychiatrist	2	0
	Psychologist	2	3
	Master's Level	4	3
	Facilities	4	0

Based on this information, Community Care can reasonably deduce that the number of providers who are Black/African American or who specialize in this minority population do not meet the needs of our Black/African American members.

This is important because Black/African American individuals are more likely to trust and engage with Black or African American providers but less likely to find one (Evans, Rosenbaum, Malina, Morrissey, and Rubin, 2020). Historically Black individuals do not have adequate access to same-race treatment providers. In the United States, only 2% of psychiatrists identify as Black (Starks, 2021) and 4% of psychologists (Healthline, 2021). This is crucial because Black and African American providers are known to provide more appropriate and effective care to Black and African American individuals (Mental Health America, 2021).

As this barrier will take time to address, The National Alliance on Mental Illness recommends that until

	the gap is closed it should be filled with culturally competent care. In order for a provider to be culturally competent, it goes beyond having a diverse workforce. Providers need to invest in gaining cultural knowledge of the populations they serve as it relates to help-seeking, treatment, and recovery (SAMHSA, 2014). Community Care's ability to gather information on culturally competent providers is limited by the changing workforce. Staff turnover plays a significant role on the ability to maintain competency. This factor is deemed critical.
	Current and expected actionability: Community Care has begun implementing interventions to specifically address inequities affecting our Black/African American population. We anticipate that we will continually make this a focus of company-wide activities. This factor is expected to be actionable, but availability will continue to affect Community Care's ability to adequately address the actual root cause.
Provisions (3.2) Medication appointments with psychiatrists are often hard to secure in a timely manner	*Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):* Availability of psychiatrists has been an ongoing barrier to services in the State of Pennsylvania. Although Community Care consistently meets accessibility standards for Psychiatry, providers report difficulty getting individuals appointments with existing psychiatry time. In 2015 the Behavioral Health Alliance of Rural Pennsylvania did a point in time survey of psychiatric providers that indicated a need of double the psychiatric time currently available. This included the capacity of telehealth services and physician extenders at that time. Of the 14 surveyed providers, they are providing a 617 hours of psychiatric clinic time. Their study indicated a need for almost double the amount of current time being provided. While other services are available, psychiatry is essential for individuals with significant mental illness or serious emotional disturbances. Psychiatrists are often splitting their time between outpatient and other services, such as inpatient mental health, partial hospitalization, dual diagnosis treatment teams, etc. A need for more psychiatric time seems to be a theme across the State. Community Care's annual Network Availability report indicates that in August of 2022, Community Care was not currently meeting goal for the enrollee to physician ratio of 5,000:1 with an actual ratio of 7,495:1. If we look at this analysis over time, we can see that although HealthChoices membership has grown, the number of Psychiatrist locations has decreased.

Community Care contracted Psychiatrist by site count and ratio									
August 2018		August 2019		August 2020		August 2021		August 2022	
Site Count	Ratio	Site Count	Ratio	Site Count	Ratio	Site Count	Ratio	Site Count	Ration
216	4,538:1	208	4,783:1	205	5,515:1	191	6,337:1	194	7,495:1

In 2019, Community Care conducted interviews with 8 inpatient mental health facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates. Specific barriers identified by these providers included "Psychiatry is hard to get" and "Medication appointments are particularly challenging".

	Community Care conducts interviews with members who have a readmission to inpatient mental health as part of the Admissions Interview activities (described further in the interventions section). There were 3,636 adult and 403 child interviews completed for members at inpatient mental health facilities in 2021; of those, 1,221 were interviews for members who had a previous inpatient admission in the past 30 days. When asked the reason for the readmission or if there was something they needed that might have helped them stay in their home, 27.5% of adults and 9.0% of children reported difficulty with their medications. This factor is deemed important.
	Current and expected actionability: Community Care has developed some interventions to work with current capacity but has a limited scope to address this barrier specifically.

Quality Improvement Plan for CY 2023

Rate Goal for 2023 (State the 2023 rate goal from your MY2021 FUH Goal Report here): 46.8% (7-Day) 68.0 %(30-Day)

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

Barrier	**Action** *Include those planned as well as already implemented.*	**Implementation Date** *Indicate start date (month, year)* *duration and frequency (e.g., Ongoing, Quarterly)*	**Monitoring Plan** *How will you know if this action is taking place? How will you know the action is having its intended effect?* *What will you measure and how often?* *Include what measurements will be used, as applicable.*
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues	**Admissions Interview:** The Utilization Management Children's and Adult High Risk Care Managers conduct longitudinal care management and outreach to high-risk members who encounter difficulties maintaining stabilization and community tenure. The Care Managers meet with these members at inpatient mental health facilities and substance use disorder treatment settings to provide face-to-face intervention, complete the interview tool to assess strengths/needs, and collaborate with the treatment team and inpatient staff to address aftercare planning, coordination, and reduce recidivism. In 2020, the readmission interview tool was expanded to include members with initial	Ongoing practice with process updated in 2020 Intervention occurs as part of the Care	Member needs reported in the Admissions Interviews, including those around physical health and medications, are regularly monitored through a Tableau Dashboard. Doing so allows Community Care to identify trends related to member needs and respond appropriately. Care

CCBH RCA and QIP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance				

People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members

People (1.4) Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending

Providers (2.1) Specific to Black/African American members Black and African Americans experience health inequity in behavioral health treatment

admissions and readmissions that do not meet the original eligibility criterion of readmission within 30 days. This expansion granted the opportunity for the intervention to serve as prevention. In addition, the high-risk care management intervention has been expanded to include children as well as individuals readmitted to substance use disorder treatment facilities.

In 2021 there were a total of 1,984 adult and 194 child interviews specific to HEDIS inpatient mental health discharges. For members that had a completed Admissions Interview, 74.5% had 30-day HEDIS follow-up. This data suggests that members who received a complete Admissions Interview were significantly more likely to attend an aftercare appointment. Specifically, members who received an Admission Interview were 13 percentage points more likely to have follow-up in 30-days.

HEDIS 30-Day Follow-Up			
Year	FUH for members with an Admission Interview	FUH for members without an Admission Interview	% Point Variance
2019	76.7%	65.4%	11.3
2020	66.1%	64.3%	1.9
2021	74.5%	62.0%	12.5

Community Care Care Management Department monitors barriers to aftercare reported by members through this process on an ongoing basis through a Tableau Dashboard. In February 2023, Community Care added racial and ethnic filters to the Admissions Tableau dashboard for contracts with disparities to target interventions with minority populations. Note that this intervention was to happen in 2022, however was postponed due to competing priorities.
Race and Ethnicity were added to the member level detail report for the Admission Interviews in January 2023. This allows Community Care to analyze trends related to barriers across racial and ethnic backgrounds on a quarterly basis. Also in 2023, a race and ethnicity filter will be added to the Admissions Interview Tableau Dashboard to monitor, and address barriers specifically identified by minority populations at any point in time. This is estimated to occur in the second half of 2023.
Starting in February 2023, Community Care will include Black/African American members as a priority population targeted for admission interviews. When analyzing the data for Admission Interviews, Community Care has identified that our Black/African American members particularly benefit from this intervention.

Management daily activities

2021

2023

Managers discuss and problem solve specific cases during supervision.
Community Care developed a monitoring report that was completed in late 2021 to pull information from the Admissions Interview template in the electronic record and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be reviewed quarterly in 2023 for ongoing trend analysis and any additional opportunities for improvement.

CCBH RCA and QIP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance					

2021 30-Day HEDIS Follow-Up			
Cohort	FUH for members with Admission Interview	FUH for members without Admission Interview	% Point Variance
Black/African American	69.8%	56.2%	13.6
White	75.1%	63.2%	11.9

Community Care believes that this intervention improves aftercare by assisting members to overcome barriers, providing education to members and providers, coordinating care, and assistance in aftercare planning.

People (1.2)
Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues

Aftercare Outreach: Community Care provides outreach to members who may be at risk. All members being discharged from acute levels of care and who are not transitioned to another non-ambulatory service or placement receive follow-up to encourage adherence to a community-based aftercare appointment. The Care Manager will assist with problem solving and engaging the member to his/her aftercare appointment. If there is an Intensive Care Manager, Resource Coordinator, or Service Coordinator assigned, the Care Manager can contact the provider to ensure appropriate linkages for follow-up care.

Ongoing practice

Intervention occurs as part of the Care Management daily activities

Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases during supervision. Template entry is monitored as an activity of supervision and feedback and corrective action occurs with care managers, as necessary.

People (1.3)
Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members

In 2021, Community Care made Aftercare Outreach calls to 32% of our HEDIS Qualified Discharges and 32% of that number were successful reached. An analysis of the data indicates that members who had a successful Aftercare Outreach call were 12 percentage points more likely to have timely follow-up.

2021

HEDIS 30-Day Follow-Up			
Year	FUH for members with Successful Aftercare Outreach	FUH for members without Successful Aftercare Outreach	% Point Variance
2021	74.1%	62.6%	11.5
2020	77.6%	63.4%	14.2

Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.

Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be reviewed quarterly in 2023 for ongoing trend analysis and any additional opportunities for improvement.

People (1.4)
Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending

CCBH RCA and QIP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance			
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Allegheny Care Management Team:** (HCAL) The Integrated Care Team assists Allegheny County Health Choices members, families, health plans, and providers in facilitating coordination of physical health/behavioral health care. The team advocates for members with the five physical health managed care organizations serving Allegheny County and provides behavioral health history, referrals, and direct provider and member outreach. The physical health managed care organizations receive daily internal referrals from care managers on Community Care child and adult teams for members with physical health needs and obtain member consents for enhanced coordination of care. The team provides training regarding physical health/behavioral health integration to behavioral health providers and member/community groups and supports multiple UPMC care coordination initiatives. Their established relationships with health plans and providers promote a 'whole health' collaborative approach. In January of 2018, the team increased their coordination to also coordinate with 3 Community Health Choice Plans to coordinate care for shared members who are dual eligible or receive long term services and supports.	Ongoing practice Intervention occurs as part of the Care Management daily activities	Monitoring for the needs identified occurs on an ad hoc basis through Clinical Supervision.
	In 2021, the Integrated Care Team also added a Pre/Post Natal Care Management position as part of the Community Based Care Management initiative. This Care Manager works with members during pregnancy and after delivery to coordinate with the Physical Health Managed Care Organizations, as well as provide linkage for the members to behavioral health services and resources to address social determinant of health needs. The team also added 3 Community Health Workers to support the Community Based Organizations with identifying Community Care members, ensuring coordination with current Behavioral Health Providers, and assisting to link members to Behavioral Health services. The Community Health Workers also assist members who have social determinants of health needs.	2021	
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.		
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services, which impacts our members with co-	**Centers of Excellence:** The Pennsylvania Department of Human Services launched the Centers of Excellence in 2016 to expand access to medication assisted treatment and other effective treatments. Centers of Excellence are licensed substance use disorder treatment providers that provide counseling, methadone, buprenorphine, or naltrexone assisted treatment. Centers of Excellence offer members diagnosed with an opioid use disorder peer support throughout all stages of recovery as well as Care Management to assist members in identifying, receiving, and sustaining treatment. Community Care's Care Management team helps individuals with opioid use disorder navigate the health care system by facilitating initiation into opioid use disorder treatment from emergency departments and primary care physicians; helping	Centers of Excellence initiated in January 2017 and enrollment began July 2019. Activities	Community Care regularly reviews data to ensure that Centers of Excellence thrive over time. Community Care collaborates with University of Pittsburgh Program and Evaluation Research Unit to provide detailed summary reports to all Centers of Excellence based on the Research

occurring disorders	individuals transition from inpatient levels of care to ongoing engagement in community-based treatment; and facilitating transition of individuals with opioid use disorder leaving state and county corrections systems to ongoing treatment within the community. Currently there are over 260 Centers of Excellence registered in Pennsylvania.	around this initiative remain ongoing.	Electronic Data Capture (REDCap) information.
	As of October 2022, a total of 15,766 unique Community Care members have enrolled in a Center of Excellence. Community Care developed an RCA Monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement.	2022	Regional feedback webinars occur monthly with Community Care's 50+ Center of Excellence providers. These meetings serve as a venue for providers to learn from each other and discuss current treatment trends, barriers, and possible solutions.
	All COEs within Community Care's network will transition to a value-based purchasing payment model on January 1, 2023. Performance metrics for providers include new enrollments, new enrollments retained for 90-days, new enrollments retained for 181 days, and new member access to medication assisted treatment for opioid use disorder. **Specific to the barrier of getting new members into medicated assisted treatment, activities around this initiative will have a specific focus on new enrollments and new member access to medication assisted treatment for opioid use disorder. Baseline data is currently being collected.** **Community Care collaborated with the University of Pittsburgh Program and Evaluation Research Unit and the Department of Human Services to develop a risk assessment tool for Centers of Excellence. This tool is being piloted in 4 Allegheny County locations in 2023, which is anticipated to eventually be used for all 270 Centers of Excellence in Pennsylvania.**	2023	Community Care will continue to partner with University of Pittsburgh Program and Evaluation Research Unit and the Department of Human Services to assess and monitor the impact of the newly developed risk assessment tool.
	Community Care feels that the ability to access medication assisted treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health facilities. Members being enrolled in medication assisted treatment following an inpatient mental health admission may prevent a readmission to a residential level of care before mental health aftercare can happen.		
People (1.5) Some members have competing physical	**Collaborative Care at Federally Qualified Healthcare Centers:** (HCAL, HCBK, HCBL, HCCH, HCNB, HCNS, HCYY) Community Care believes that implementing Collaborative Care to integrate primary care and behavioral health is a clear remedy for many of		Federally Qualified Health Centers are a primary focus for the Director of Integration and

Within the 2023 cell, the following table appears:

Year	New members enrolled in COE	New members accessing MOUD
CY2021	2,236	1,819
Jan-Aug 2022	1,672	TBD

*MOUD pharmacy claims lag has not resolved

health needs which makes setting up aftercare difficult	these problems with co-morbid conditions. Based on principles of effective chronic illness care, Collaborative Care focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained Primary Care Physicians, and embedded Behavioral Health Practitioners provide evidence-based psychosocial treatments and/or medication, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected. The model consistently results in improved patient and provider satisfaction, improved functioning, and reductions in health care costs, achieving the Triple Aim of health care reform.		monitoring activities occur on a regular basis. Community Care hosts quarterly Provider Meetings with Federally Qualified Healthcare Centers, of which data metrics are a routine topic.
	Community Care currently has 33 Federally Qualified Health Center providers at 123 locations throughout the network. Community Care hosted 3 FQHC Collaborative Care provider meetings during 2022, with the dates and topics listed below. Community Care presented on the Collaborative Care model at all 4 of the Quarterly Physical Health/Behavioral Health meetings to promote awareness of the model. The Quarterly Physical Health/Behavioral Health meetings bring together HealthChoices partners to address coordination and collaboration of care, work on joint projects, and share information and resources. In 2021, 15,235 distinct Community Care members received services at a Federally Qualified Health Center. This has increased to 16,566* distinct members in 2022. * The distinct member data is incomplete due to the 90-day claims lag ➢ 03/03/2022 | Psychopharmacology: An Overview of Psychiatric Medications: Kavita Fischer, MD, DFAPA, Regional Medical Director, Community Care Behavioral Health ➢ 09/01/2022 | Depression Assessment in Primary Care Presented by: Kolin Good, MD Regional Medical Director, Community Care Behavioral Health ➢ 12/08/2022 | Tobacco Cessation for Individuals with Behavioral Illnesses Presented by: Jaspreet S. Brar, MBBS, MPH, PhD Senior Fellow, Department of Psychiatry, UPMC Western Psychiatric Hospital, Consultant, Community Care Behavioral Health Organization.	2022	
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation,	**Community Based Care Management:** Community Based Care Management is a new Care Management program aligning with the Department of Human Service's initiatives around whole-person healthcare reform. Elements of this program include: • Enhancing care management activities in the community by working directly with members and providers;	2020 - Planning phase	In 2022 there was a large focus on documentation and some edits made to documentation templates to ensure that data is being consistently captured for

childcare, vocational schedule, legal issues, or housing issues ***People (1.3)*** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending ***People (1.5)*** Some members have competing physical health needs which makes setting up aftercare difficult	• Enhancing physical and behavioral health coordination to address whole person health and wellness; • Decreasing unplanned, emergent admissions; • Increasing access to healthcare; • Enhancing crisis and substance use disorder services; • Screening members for Post-Partum Depression; and, • Screening of social determinants of health and linking members to services and resources. **Community Health Workers** are an integral part of this program and are responsible for completing face to face or telephonic admission and readmission interviews with members to identify barriers to services and resources and to plan for aftercare, advocating for person centered treatment and aftercare planning, participating in interagency and collaboration meetings with providers and members, providing ongoing follow up and support by meeting with the member in the community at provider sites and in the member home, completing warm hand offs to community resources and providers, following up with members who identify social determinant of health challenges during Customer Service New Member Welcome Calls and Post Discharge Outreach Calls, supporting the Community Based Organizations with identifying Community Care members, ensuring coordination with current Behavioral Health Providers, and assisting to link members to Behavioral Health services. Community Based Care Management also includes the use of **Pre/Post Natal Care Managers** who outreach to, engage, assess, and link members during pregnancy and post-delivery or end of pregnancy, who have an identified behavioral health need. The Pre/Post Natal Care Manager coordinates with the physical health managed care organizations to link the members to prenatal care and resources, as well as to transfer members to the physical health managed care organizations' maternity programs if there are no identified behavioral health needs. Community Based Care Management allowed Community Care the opportunity to partner with and provide funding for staff and administrative costs to **Community Based Organizations**. The Community Based Organizations provide services and resources which address social determinants of health that greatly impact the HealthChoices members.		inclusion in the reports. A monitoring document was part of the 2022 and 2023 Community Based Care Management Proposal submission. Within the monitoring plan is data and goals. To monitor progress through the year in 2023, quarterly meeting will be held in each contract to review and discuss trend with the data. In 2022 quarterly data was provided for OMHSAS Monitoring Meetings related to Community Based Organization engagement, Community Based Organization referral sources and a reporting of social determinates of health data captured by the Community Based Organizations. This will continue in 2023. A program analysis for 2022 will be completed in June 2023.
	In 2021, Community Care hired additional internal positions to expand and enhance the community work that is done to support members. New positions included Community Health Workers and Pre/Post Natal Care Managers per specific contracts, and a Data Analytics position shared amongst all contracts. Blair, Bedford/Somerset, and Lycoming/Clinton contracts opted to utilize existing positions either within Community Care, county partners, or the HealthChoices teams to absorb some of the	2021-Development phase 2021 – 2022 Implementation phase	

	Community Based Care Management responsibilities. In 2022, Delaware County was added, and additional positions were added to the staffing complement. Community Care contracted with 30 Community Based Organizations in 2022 and 1 contracted directly with Blair HealthChoices. Community Based Organizations were chosen by determining the greatest social determinates of health that impacted the community and then contracting with an agency that addressed those barriers. Examples of Community Based Organizations ranged from emergency shelters and transitional housing to local United Way and Community Action organizations.		
	In 2022, Community Health Workers engaged with 2,828 unique members and completed a total of 21,829 in person or phone contacts or attempts with members, Pre/Post Natal Care Managers engaged with 4,450 distinct members, and Community Based Organizations have supported 13,511 members.	2022	
	It is anticipated that 2 additional CBOs will be contracted for 2023.	**2023**	
	Community Care believes that this intervention will improve aftercare through the activities of Community Based Care Management, which includes encouraging the use of preventative services, mitigating social determinants of health barriers, reducing health disparities, improving behavioral health outcomes, and increasing partnerships with Community-Based Organizations.		
People (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms ***Providers (2.1) Specific to Black/African American members*** Black and African Americans experience	**Community Care's Health Equity Program:** Community Care's Health Equity Program reflects the National Committee for Quality Assurance's (NCQA's) Health Equity Accreditation standards as well as Community Care's efforts to improve the provision of Culturally and Linguistically Appropriate Services and to identify and reduce health care disparities related to race, ethnicity, gender identity, sexual orientation, and language. Community Care's mission is to improve the health and well-being of the community through the delivery of quality, cost-effective, and accessible behavioral health services. In conjunction with each of the counties that Community Care serves, the goal is to offer recovery-oriented, whole person-centered, outcome-focused care that reflects contemporary best practices. Community Care views the HealthChoices Program as a means of promoting individual and community health and well-being through attending to the social determinants of health and addressing social justice and health equity. Community Care's Health Equity goals: 1. Provide leadership to support the commitment to long-term change. 2. Provide opportunities for education on, and discussion of, social and racial justice among all staff and use these discussions to refine short- and long-term strategic planning. 3. Examine service delivery for members, who are part of disenfranchised and/or	2022	Monitoring for this intervention occurs: 4. On an ongoing basis by our Social and Racial Justice Committee (see Social & Racial Justice Steering Committee intervention), 5. On an ongoing basis by a dedicated Project Director, and, 6. Annually approved through Community Care's Board Quality Improvement Committee.

| health inequity in behavioral health treatment | oppressed groups to monitor disparities; establish goals to strive for sustained improvement in elimination of disparities.
4. Support resource development, workforce diversity, and trainings that increase cultural sensitivity, cultural awareness, and cultural humility in Community Care's provider network.
5. Establish partnerships and collaborations that elevate social and racial justice in the communities we serve.
6. Continue to solicit and incorporate diverse stakeholder perspectives.
7. Utilize a continuous quality improvement process, which incorporates long-term, incremental change as well as continuous assessment and refinement of goals.

The objectives of the Health Equity Program are pursued in concert with those of Community Care, members, practitioners, facilities, county and state oversight entities, community stakeholders, and other health care partners. These objectives:
• Ensure that members with primary languages other than spoken English receive the same scope and quality of health care services as primary English speakers, including quality interpreting services and written materials in members' preferred languages and formats.
• Improve health care access and outcomes.
• Decrease identified disparities.
• Continually evaluate and improve the cultural and linguistic responsiveness of programs and services.

Annually, Community Care identifies measurable goals to continuously improve culturally and linguistically appropriate services, including goals to reduce health disparities. Community Care developed the following goals:
• Decrease the disparity between Black/African American and White members in HEDIS rates of 7- and 30-day follow-up after mental health hospitalization (FUH) by increasing the FUH of Black/African American members by 2% per year for three years.
• Achieve 100% completion by relevant staff of various trainings (including but not limited to, all staff Sexual Orientation and Gender Identify and Expression Required Training; Culturally Competent Skills and Behaviors, Culture of Inclusion and Belonging, and Unconscious Bias) focused on improving culturally and linguistically responsive care to members.
• Utilize the Sexual Orientation and Gender Identity and Expression job aid to collect, document, and consistently use, member information in a culturally responsive way regarding members' sexual orientation, gender identity and gender expression.
• Establish a Social/Racial Justice and Health Equity Advisory Board to include | | |
| | | 2023 | |

	members, family members, providers, and community-based organization representatives from diverse backgrounds and experiences including those from systematically disenfranchised groups from across all Community Care contracts. This Advisory Board will review procedures, measures, programs and/or make recommendations to Community Care with a goal of continuous improvement in the implementation of culturally and linguistically responsive care to members. This Board is anticipated to be active by the second quarter of 2023 and be meet quarterly.		
	Develop additional Health Equity content for member and provider newsletters to be distributed in 2023. ▪ The May 2022 Member Newsletter, Foundations, included an article related to Sexual Orientation and Gender Identity and Expression https://members.ccbh.com/uploads/files/Health-Topics/Newsletters/20220418-volume10issue1-interactive-4.19.pdf ▪ The September 2022 Provider Newsletter, The Provider Line, included an update on Community Care's Anti-Stigma Resources and Education (CCARE) Campaign, and a Racial and Social Justice update. https://providers.ccbh.com/uploads/files/Provider-Newsletters/22PV2999150-Fall-2022-Provider-Newsletter_SH-0922.pdf **Community Care achieved the National Committee for Quality Assurance's Health Equity Accreditation in February 2023 and notified all stakeholders. The Health Equity Accreditation seal will be placed on the Community Care website.**	2023	
	Community Care believes that this intervention will improve aftercare by identifying issues across the system and developing companywide interventions to impact inequities.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Community HealthChoices:** Community HealthChoices is Pennsylvania's mandatory managed care program for dually eligible individuals (Medicare and Medicaid) and individuals with physical disabilities. Community HealthChoices was developed to enhance access to and improve coordination of medical care as well as to create a person-driven, long-term support system in which individuals have choice, control, and access to a full array of quality services that provide independence, health, and quality of life. Community HealthChoices implementation officially completed with the last phase starting January 2020. All zones are now active with Community HealthChoices. There are regular meetings with the 3 Community HealthChoices plans across Pennsylvania to identify challenging cases, barriers, training and information/resource sharing. These continued collaboration activities are led by Community Care's Director of Integration.	Community HealthChoices implemented January 2019 - January 2020 Community HealthChoices coordination occurs as part	Community Care hosts and participates in quarterly statewide partner meetings with the other Community HealthChoices managed care organizations in Pennsylvania to identify challenging cases, barriers, training, data sharing, and information/resource sharing. Community Care collaboratively shares information regarding 30-day follow up and inpatient

		of the Care Management daily activities	admissions with Community HealthChoices. Likewise, data is shared with us regarding physical health data.
	There are currently (as of 01/25/23) 167,425 Community HealthChoices members receiving behavioral health services. In 2021, the monthly inpatient mental health utilization of Community HealthChoices fluctuated between 170 and 200 members per month. In fact, Community HealthChoices members accounted for 14% of Community Care's 2021 HEDIS qualified discharges. Data analysis indicates that HEDIS follow-up of our Community HealthChoices members is about 8 percentage points below the aggregate.	2021	

2021 HEDIS 30-Day Follow-Up		
FUH for CHC Members	FUH for non-CHC Members	% Point Variance
57.0%	64.9%	-7.9

	This data was analyzed to determine barriers related to Community HealthChoices members receiving timely aftercare following an inpatient mental health admission. Community Care identified the following factors to decreased FUH rate in Community HealthChoices members: • Aftercare services are not billed through Medicare as the members' primary insurer, • Many older individuals receive behavioral health services through primary care, and, • Many Community HealthChoices members have existing home and community services. To support these findings, Community Care was able to access some Community HealthChoices Medicare data to evaluate the penetration of behavioral health services with both payers (Medicaid and Medicare) combined. In the first 2 quarters of 2022, Community HealthChoices members in Allegheny County had a penetration rate of 11% when only analyzing Medicaid claims. When Medicare claims were added, 66% of Allegheny Community HealthChoices members had a behavioral health claim.		Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases during supervision. Template entry is monitored as an activity of supervision and feedback and corrective action occurs with care managers, as necessary.
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care. Unfortunately, Community Care's ability to impact our HEDIS FUH rate for Community HealthChoices is limited due to dual eligibility factors.		
Providers (2.2) Inpatient mental health providers	**Co-Occurring Disorder Initiative–**(HCAL)Allegheny County Department of Human Services, Allegheny HealthChoices Initiative, and Community Care, in close collaboration with Case Western Reserve University's Center for Evidence-Based	Ongoing	This initiative is monitored regularly and ongoing as part of the contract's business

have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services, which impacts our members with co-occurring disorders	Practices, established the Co-Occurring Disorders Initiative in Allegheny County in 2015 to increase ambulatory providers' competencies with co-occurring disorder treatment within the existing administrative and regulatory structures. The Dual Diagnosis Capability framework for Mental Health Treatment and Addiction Treatment guide the initiative, which includes a baseline Dual Diagnosis Capability for Addictions Treatment or Dual Diagnosis Capability for Mental Health Treatment assessment, quality improvement planning, technical assistance, training, and provider meetings to discuss progress.		procedures.
	Beginning in 2022, participating outpatient programs had the opportunity to earn an enhanced rate on relevant billing codes for two years for achieving identified thresholds of co-occurring treatment capability. The purpose of this process is to further incentivize and support quality improvement of ambulatory services in their capacity to serve individuals with co-occurring mental health and substance use disorders concurrently. Eligibility for the enhanced rate is based on scores on a new Dual Diagnosis Capability for Addictions Treatment or Dual Diagnosis Capability for Mental Health Treatment. Five programs across four providers (four outpatient substance use, one outpatient mental health) made the decision to undergo the review process in 2022. Three programs across two providers achieved the enhanced rate.	2022	
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues **People (1.3)** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members **People (1.4)** Some members decline aftercare believing they	**Delaware County Post-Inpatient Mental Health Outreach:** HealthChoices Delaware is Community Care's newest contract, implemented July 1, 2022. In 2023, Delaware County Department of Human Services and Community Care will be exploring the possibility of having Delaware County's consumer and family satisfaction team, Voice & Vision, Inc., attempt to survey all members discharged from the County's largest volume inpatient mental health provider. Surveys are administered by peers and would be modified to include questions about barriers to timely follow-up. Although this is not an intervention that will directly impact follow-up, it is an important step to determining specific barriers to follow-up for Delaware County's population for intervention development. The advantage of using the method of peer surveys to gather information is that members may feel more comfortable with individuals who have received services and relate to the members symptomology.	2023	NA – This intervention is still being assessed for viability

don't need it, will not benefit from it, or can't overcome barriers associated with attending			
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues *People (1.3)* Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members *People (1.4)* Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	**Enhanced Discharge Planning:** Daily Care Management activities focus on members with readmissions and involves review of daily admissions (Care Management reviews on Monday include weekend admissions.) Care Managers conduct a semi-structured interview, using motivational approaches, problem solving, and case management follow-up activities to ensure members received needed aftercare. During these interviews, Community Care actively gathers information if members attended follow up, reasons why follow-up may have not been attended, if discharge plan was understood, etc. Care Managers provide assistance in real time with barriers identified. A report, which reflects both contract-specific and aggregate data related to the Enhanced Discharge Planning and High-Risk Care Management interviews, is compiled annually. These reports are shared with Quality and Clinical Departments as well as presented at the Care Management Leadership meeting. Care Management interventions are targeted and adjusted, as necessary, per the data.	Ongoing Intervention occurs as part of the Care Management daily activities	During these interviews, Community Care actively gathers information if members attended follow up, reasons why follow-up may have not been attended, if discharge plan was understood, etc. Care Managers provide assistance in real time with barriers identified. A report, which reflects both contract-specific and aggregate data related to the Enhanced Discharge Planning and High-Risk Care Management interviews, is compiled annually. These reports are shared with Quality and Clinical Departments, presented at the Care Management Leadership meeting, and presented at contract Quality and Care Management Committee meetings. Care Management interventions are targeted and adjusted, as necessary, per the data. Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be
	In October 2019, Community Care expanded the interview process. Interviews now include children as well as other priority members, for example, members who may have readmitted over the standard 30-day readmission timeframe (i.e., readmitted after 35 days) or who may have other barriers related to other social determinants. This expansion may grant opportunity for this intervention to serve as prevention. In February 2020, Community Care further expanded the interview process to include members who were admitted for the first time to an IPMH. Also, 3.5 and 3.7 levels of care were added for the interviews. All contracts used the same readmission interview template to identify reasons presenting for admission and to assist in discharge planning.	Process expanded in October 2019 and again February 2020	
	Community Care believes that this intervention improves HEDIS FUH by assisting members to overcome barriers to aftercare.		

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			reviewed quarterly in 2023 for ongoing trend analysis and any additional opportunities for improvement.
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues	**High-Risk Care Management interventions:** Members can be deemed high risk for reasons such as clinical presentation, treatment history and response, or as an identified at-risk population. High-Risk members require a longitudinal intensive level of intervention. Comprehensive Care Management strategies are initiated to ensure service linkage, coordination, and timely delivery of quality health care for those at-risk for significant symptoms and members who have difficulty connecting to aftercare treatment services. Community Care strives to ensure that recovery principles and tenure in the community are at the core of High-Risk care management. High-Risk Care Managers met with members face-to-face on the unit to identify these barriers, address concerns, coordinate with inpatient staff around member needs, and help with discharge planning. Starting in March 2020, due to concerns surrounding the COVID-19 pandemic, Care Managers implemented both telephonic or virtual interviews to capture the data and intervene, as necessary. High-Risk Care Managers encourage coordination with family or friends as part of their interaction with members. High-Risk Care Managers address social determinants with the member and the inpatient staff and coordinate with relevant agencies during the inpatient stay.	Ongoing Intervention occurs as part of the Care Management daily activities	Clinical Supervisors utilize a standardized tool to rate Care Managers related to interventions performed with members. This template includes a question related to follow-up ("The Care Manager review shows evidence of robust discharge planning, for example awareness of factors leading to readmission and/or potential triggers for readmission"). Feedback and corrective actions are taken with care managers, as necessary.
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members *People (1.4)* Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	In 2021, Community Care developed High-Risk Care Management Best Practice Guidelines to aid in standardization of High-Risk practices. Community Care uses clinical groupings to identify members who are receiving enhanced care management activities such as High Risk or Complex Care Management. Data analysis of the 2020 HEDIS FUH data indicates that members who were in these clinical groupings were 10 percent more likely to have follow-up within 30 days. Community Care is considering 2020 data preliminary as Care Managers were not always consistently using the clinical grouping to identify members receiving these interventions. We believe that the data for 2020 does not reflect all the possible members who were receiving these enhanced interventions. In 2021, Care Managers were asked to consistently use clinical grouping selection to identify members with enhanced Care Management interventions. Examples of groupings include High-Risk, Community Based Organization Engaged, or Prenatal. A report was developed for Care Management to track the consistency of the selection and a job-aide was developed.	2021	
	Data analysis of the 2021 HEDIS FUH data indicates that members who were in these clinical groupings were 7 percentage points more likely to have follow-up within 30-days.		Community Care developed an RCA Monitoring report that was completed in late 2021 to assess

	HEDIS 30-Day Follow-Up					factors of HEDIS qualified discharges and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be reviewed quarterly in 2023 for ongoing trend analysis and any additional opportunities for improvement.
	Year	FUH for Members with High-Risk Care Management	FUH for Members without High-Risk Care Management	% Point Variance		
	2020	75.6%	65.4%	10.2		
	2021	69.3%	62.6%	6.6		
	Community Care believes that this intervention improves HEDIS FUH by assisting members to overcome barriers to aftercare.					

People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Inpatient Mental Health Provider Quality Improvement Activities:** Community Care conducted its annual review of the entire inpatient mental health provider network and based on this review; five distinct providers were selected to participate the 2022 Inpatient Mental Health Quality Improvement Activity. Community Care's Inpatient Mental Health Quality Improvement Activity process is composed of staff interviews, a facility tour, discussion with executive leadership staff, and the completion of member record reviews. During a record review, if a provider did not score within the designated benchmark for the Discharge Management Planning composite score, which includes "Follow-up appointment scheduled within 7 days, including all required elements," a Quality Improvement Plan would be requested from the provider.	This process was implemented in March of 2019 as an annual activity. Prior to 2019 inpatient mental health activities occurred on a contract specific schedule.	Each year's activities are reviewed each contract's Quality and Care Management Committee meetings.
	Update to review results are as follows. Indicator: Notice to aftercare providers within 1 business day of inpatient discharge including information about discharge and medications	2021	This is an annual activity that will be completed again in 2023.

2019 Rate	**2020 Rate**	**2021 Rate**	**2022 Rate**
69%	73%	70%	70%

Indicator: Evidence of a Completed Discharge Management Plan

2019 Rate	**2020 Rate**	**2021 Rate**	**2022 Rate**
96%	100%	95%	98%

Indicator: Follow Up appointment scheduled within 7 days, including all required elements

2019 Rate	**2020 Rate**	**2021 Rate**	**2022 Rate**
69%	91%	80%	84%

Providers who did not meet goal for any record review indicator were asked to

As part of this process, a provider may be asked to submit a quality improvement plan. If the submitted quality improvement plan doesn't meet all required elements, a revision is requested. In the following year, providers are asked to submit an update and monitoring of their interventions. This follow-up information, along with results of the annual Quality Improvement

	complete a quality improvement plan. This resulted in all five providers submitting a quality improvement plan for the 2022 Inpatient Mental Health Quality Improvement Activities.		Activity are reported at each contract's Quality and Care Management Committee.
	Community Care's Inpatient Mental Health Quality Improvement Activities will occur in the second quarter for 2023.	2023	
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers to individualized discharge planning, addressing engagement issues, and physical health needs.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Integrated Care Plan:** In alignment with Pennsylvania Department of Human Services goal for greater integration and coordination of behavioral and physical health services, Community Care engages in care coordination with physical health plans and documents these activities in an Integrated Care Plan. This Integrated Care Plan, or member profile, is used for the collection, integration and documentation of key physical and behavioral health information that is easily accessible. Community Care identifies members for inclusion in the project based on diagnostic history. Members are stratified to either high or low behavioral health need using a Community Care defined algorithm. The behavioral health stratification file is shared with corresponding physician health plan. The physical health plan adds their physical health high/low stratification completing the 4-quadrant analysis. Combined behavioral health/physical health member file is returned to Community Care. Process completed monthly to capture new, changed or deleted information. Data is uploaded to our clinical platform on the Integrated Care Plan Template; the electronic template documents the member's physical health and behavioral health needs, dates of coordination with respective plan, referral reason and intervention. The template is completed primarily following telephone coordination with the physical health plan representative, either ad hoc or during planning clinical rounds. Care managers will have the ability to view the members' tiers on the Clinical Group tab.	Ongoing Intervention occurs as part of the Care Management daily activities	The number of completed Integrated Care Plans is tracked and presented annually to the Quality and Care Management Committees. Goals related to Integrated Care Plans completed have been consistently met. As part of the activity, Community Care monitors Integrated Care Plans completed for members with an inpatient admission. The measurements around this activity focus on integrating physical and behavioral health care. At an administrative level, Community Care may revise procedures and processes to increase the overall number of Integrated Care Plans if a barrier is identified. On the member level, Care Managers may assist the member by coordinating with the member's physical health managed care organization on physical health needs.
	According to an analysis of the 2021 HEDIS FUH data, 31% of HEDIS qualified discharges had an Integrated Care Plan. The follow-up rates for these members were 4-5 percentage points higher for 30-day.	2021	

HEDIS 30-Day Follow-Up			
Year	FUH for Members with an Integrated Care Plan	FUH for Members without an Integrated Care Plan	% Point Variance
2021	67.0%	62.5%	4.5
2020	67.0%	65.1%	1.9
2019	67.8%	65.6%	2.2

Community Care believes that this intervention improves aftercare by assisting

	members to overcome barriers to aftercare related to physical health needs and coordinating care.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members *Provisions (3.2)* Medication appointments with psychiatrists are often hard to secure in a timely manner	**Inpatient Mental Health & Ambulatory Provider Value-Based Payment Arrangement:** Community Care and its Primary Contractors engaged inpatient mental health providers in a value-based purchasing arrangement in 2017, which has expanded to include ambulatory providers in 2021. This shared savings model focuses on the successful transition from inpatient to ambulatory services and the coordination of the two service systems to maintain members in the community. Activities include a Learning Collaborative for providers to increase collaboration and knowledge of best practices at both levels of care. Measures include 30-day readmission and 7-day follow-up, but providers will also be required to participate in regional collaborative activities. This Value Based model also includes a community-based organization in the region that will address social determinants of health that impact members being admitted or have the potential to be admitted to inpatient mental health services.	Value-based payment arrangements began for inpatient mental health providers began in 2017 In 2021 the value-based payment arrangement transitioned to a shared savings model including ambulatory services	Monitoring for this intervention is driven by value-based purchasing arrangements. Measures are 7-day follow-up rate and 30-day readmission rate. So far, the provider's success in meeting goals related to follow-up have not been consistent. Ongoing activities related to value-based purchasing arrangements are occurring as expected and will continue within Community Care, with providers given performance reports via Community Care's portal on a monthly basis. Payments to providers are made according to performance.
	The final analysis of rates for measure year 2021 occurred in July 2022. Goals for the value-based purchasing arrangement were set by contract, therefore provider performance was measured in each contract separately. Thirty-six distinct inpatient mental health providers and 94 ambulatory providers participated, across 11 Community Care contracts. Inpatient mental health performance was assessed for 7-day follow-up and 30-day readmission. For 7-day follow-up, 24 of the 54 (44%) rates assessed met the contract specific goal and for 30-day readmission, 39 of the 54 (72%) rates assessed met the contract specific goal. Ambulatory provider performance was assessed for 30-day readmission. One hundred and twelve (78%) of the 144 rates assessed met the contract specific goal. The success of this interventions is largely attributed to including ambulatory providers in the shared savings and implementation of the Learning Collaboration. Including ambulatory providers encourages providers to build mutually beneficial interventions and collaborative relationships. The regional Learning Collaborative meetings have	2021	

	provided a forum for inpatient and ambulatory providers to discuss barriers to follow-up and readmission and determine the best way to overcome obstacles.		
	Measure year 2022 rates will be analyzed in July 2023.	2023	
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers to individualized discharge planning, aftercare, and addressing engagement issues.		
People (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms *Providers (2.1) Specific to Black/African American members* Black and African Americans experience health inequity in behavioral health treatment *Provisions (3.1) Specific to Black/African American members* There is a shortage of Black/African American treatment providers and there are limitations on identifying culturally	**Network Availability of Black/African American practitioners and culturally competent providers:** Community Care asks practitioners if they would like to disclose their race/ethnicity or religion to be used during our referral process, and all providers are asked if they have any area of specialization during the credentialing and re-credentialing process. Providers who choose to disclose this are identified within Community Care's network accordingly. When members call Community Care's Member Line requesting same-race practitioners or practitioners specializing in minority populations, Customer Service Representatives are able to see this information when searching for providers in the member's region.	Ongoing	Community Care will track the number of practitioners and facilities disclosing a specialization in minority populations and practitioner race/ethnicity/religion through multiple projects occurring around network availability. These factors are consistently assessed when considering network expansion. Updates for this intervention will be kept by Community Care's Network Department to ensure movement and reportability.
	As of February 2023, 1,346 (48%*) contracted practitioners have self-identified their race. Five percent (71) identified as Black or African American. Race/ethnicity and religion are not tracked for facility credentialed providers, as this information is dependent on who is employed by the facility at the time of credentialing and is subject to change. For specializations, 100 practitioners (4%*) and 46 (6%*) facilities responded to having specialized knowledge and cultural competency in the Black/African American population. *Number of distinct credentialed providers on 03/07/2023 Customer Service Representatives, who work Community Care's Member Line can see this information when searching for providers in the member's region and are able to provide information on same-race practitioners or practitioners specializing in minority populations. Note that a prior intervention was discussing the possibility of having race and ethnicity information added to the online Provider Directory. This is being removed due to competing priorities and current barriers that limit Community Care's ability to have this information included, accurate, and up to date. Barriers include the proportion of credentialed providers who have reported, inability to accurately report for facilities due to changes in staffing, and potentially alienating those providers who have not reported.	2022	
	Community Care feels that it is essential for members to receive culturally competent care. Encouraging providers to disclose race, ethnicity, and/or specialization(s) assists		

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competent care	members to make informed decisions when choosing a treatment provider. This will impact Community Care's HEDIS FUH rates by linking members to providers most likely to positively impact their recovery.		
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services, which impacts our members with co-occurring disorders	**Network Expansion:** Community Care is continually seeking to expand the network, as appropriate, to best meet the needs of members. Each individual contract provider relations representative brings potential providers to clinical operations meetings for review and vetting to ascertain the necessity of adding this provider to the network. These meetings occur at least monthly, with most occurring bi-monthly. Community Care's Network Department adds providers to the network that offer non-traditional hours when they are available. Community Care also collaborates with providers within the existing network to ensure after-hour appointments are offered and accommodated. Emphasis for non-traditional hours have been given towards medication assisted treatment providers. Non-participating provider agreements are completed, as necessary, with consideration to bring providers in that can best accommodate a member's schedule.	Ongoing part of operations	Each individual contract provider relations representative brings potential providers to clinical operations meetings for review and vetting to ascertain the necessity of adding this provider to the network. These meetings occur at least monthly, with most occurring bi-monthly. Emphasis for non-traditional hours have been given towards medication assisted treatment providers.
Provisions (3.2) Medication appointments with psychiatrists are often hard to secure in a timely manner	Community Care's Network Department has streamlined the initial screening process to simplify the process for providers who want to join the network. The Network Department utilizes a script that all providers receive along with a screening form for practitioners and a service description for facilities. In Allegheny County specifically, a new process has been established for review of new practitioners and facilities requesting admission to the HealthChoices network. This is referred to as an open network, whereas most providers requesting to be included in the network are accepted and standard geographical denial criteria for practitioners were eliminated. The exception being budgetary considerations for facilities. In 2021, recredentialing for practitioners switched over to the CAQH application process, which eliminated the use of a lengthier 36-page paper application.	2021-2022	Non-participating provider agreements are completed, as necessary, with consideration to bring providers in that can best accommodate a member's schedule. Each year's activities are reviewed the annual Board Quality Improvement Committee each contract's Quality and Care Management Committee meetings. Community Care also monitors all complaints that may be related to a provider's unwillingness to accommodate a member's schedule. Each complaint is investigated thoroughly, with a focus on the member receiving the services, as necessary.
	In 2022, Community Care added over 400 new providers or contracted with existing providers for new services and/or new locations in all contracts. Some of the types of providers and services that were added to the network include Psychiatric Residential Treatment Facilities, Psychologists, and other Ambulatory Service Organizations.		
	Community Care feels this intervention has a positive impact on HEDIS FUH rate by improving the availability of appropriate levels of care and provider options following an inpatient mental health discharge.		Allegheny County has developed a Provider Credentialing and

			Contracting report which is presented at the Quality and Care Management Committee meeting twice a year. In the future, Community Care will be using MEMM reporting to the State as a form of monitoring. Community Care monitors accessibility through the annual Member Satisfaction Survey, which is administered by Performance Symphony Health by asking member perception of urgent and routine appointment accessibility. Additionally, through Consumer and Family Satisfaction Teams (Consumer Action Response Team in Allegheny County) members are asked questions related to their satisfaction with available services.
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Outpatient Mental Health Quality Record Reviews:** Community Care conducts Record Reviews for ambulatory providers when these levels of care are identified as a contract priority and planned in the annual Quality Work Plan. One of the indicators often assessed during these reviews is "If member had an inpatient mental health admission during the course treatment, post-hospital follow-up occurs within 7 calendar days." And/or "if member expresses concern about their medication regime, a psychiatric reassessment for medication management occurred within 14 days." Providers with a sufficient sample who do not meet goal are asked to complete a quality improvement plan on how to improve.	Annual, as determined by each contract's Quality Work Plan.	Each year's reviews are reported at each contract's Quality and Care Management Committee meetings.
	Outpatient mental health providers (practitioner, clinical, or Integrated Community Wellness Centers) were reviewed in 8 of Community Care's 12 contracts in 2022, and 7 of the 11 contracts in 2021.	2022	

Outpatient Mental Health Record Reviews		
Indicator	2021	2022

		Rate	Rate		
	If member had an inpatient mental health admission during the course treatment, post-hospital follow-up occurs within 7 calendar days	90%	52%		
	If member expresses concern about their medication regime, a psychiatric reassessment for medication management occurred within 14 days	100%	75%		
	Providers who did not meet goal for any record review indicator were asked to complete a quality improvement plan.				
	Several Community Care contracts have plans to review outpatient practitioners, outpatient clinic, or Integrated Community Wellness Centers in 2023.			2023	
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers for providing timely follow-up.				
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Provider Performance Issues:** Community Care tracks aftercare appointments from all inpatient discharges as part of routine Care Management functions. The Quality Management Department collates this data to determine if members have aftercare appointments prior to discharge and that those appointments are within 7-days of the discharge date. The data is monitored monthly and providers who develop a trend of provider performance issues, a quality improvement plan is requested, and the trend is monitored for resolution. This intervention applies to both inpatient and aftercare service providers.			Suspended	Community Care's Quality Management Department reviews Provider Performance Issues on a monthly basis to track and identify trends. Quality Improvement Plan requests, update requests, or notifications are sent monthly based on multiple factors, including length of trend, past trends, or past requests.
	Additional information on Provider Performance Issues can be found on Community Care's website at https://providers.ccbh.com/clinical-and-innovative-resources/information-and-resources/provider-performance-issues				
	Community Care moved to a universal discharge form to streamline discharge expectations across levels of care and reporting requirements. Inpatient mental health providers are required to fax the completed universal discharge form to Community Care within 24 hours of discharge. This ensures that Community Care has the information in a timely manner to complete outreach calls to address barriers to aftercare. The information completed in the universal discharge form is monitored through the Provider Performance Issues process to track compliance.			2021-2022	
	This activity has been suspended since May 2020 due to COVID-19. Community Care will resume this intervention when OMHSAS lifts the temporary suspension of specific authorization regulations, (bulletin 1135). At this time, Community Care anticipates this will occur in 2023.			2023	
	Community Care feels that this intervention impacts our HEDIS follow-up rates by				

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	addressing deficiencies at the provider level.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Performance Standards:** Community Care issues Performance Standards which are intended to be best-practice standards that providers will use to design and assess their programs and that Community Care will use to assist with assessment of the quality of services. Performance Standards are published for providers on Community Care's website at https://providers.ccbh.com/clinical-and-innovative-resources/performance-standards Community Care has issued Performance Standards specific to inpatient and outpatient levels of care which outlines expectations around aftercare planning and aftercare appointments. Community Care directs providers to the Performance Standards, and/or distributes copies of Performance Standards as part of many company activities, as appropriate, such as provider meetings, requests for quality improvement, and during credentialing. Community Care feels that establishing performance standards supports interventions by clearly outlining the expectation of timely follow-up in documents regularly shared with the provider.	Ongoing and several Standards updated in 2019	Community Care's Quality Management Department conducts scheduled and ad hoc record reviews of provider records to assess adherence to Performance Standards. Indicators around discharge planning are included in tools for all levels of care and rates are compared over time in annual quality and care management committee meetings for each contract. Community Care additionally monitors the expectation of 7-day follow-up from inpatient mental health through Provider Performance Issues (outlined above).
People (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms *People (1.3)* Inadequate discharge plans and/or issues with	**Prevention, Early Detection, Treatment and Recovery for Substance Use Disorders:** In 2020 Community Care, along with Primary Contractors and OMHSAS, initiated a company-wide Performance Improvement Plan. The Aim of this Performance Improvement Plan is to significantly slow and eventually stop the growth of substance use disorder prevalence among HealthChoices members, while improving outcomes for those individuals with substance use disorders. Five key performance indicators (KPIs) have been identified including: 1) Follow-up after high-intensity care for substance use disorder; 2) Substance use-related avoidable readmissions; 3) Mental health-related avoidable readmissions; 4) Psychosocial interventions and pharmacotherapy for opioid use disorder; and 5) Psychosocial interventions and pharmacotherapy for alcohol use disorder. To positively impact these measures, Community Care will be implementing the Cascade of Care Model framework, which is implemented in stages, beginning with Stage 1 (Intercept), Stage 2 (Engagement) as well as Stages 3 & 4 (Retention). In November 2020, baseline data for all five KPIs was established. Community Care feels that the ability to access ambulatory substance use disorder treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health. Members being enrolled in	2020	Quarterly reports to the Performance Improvement Plan are submitted to County Oversights and OMHSAS/IPRO along with an annual submission. In addition to the KPIs, Community Care annually monitors three indicators to assess the success of the interventions: utilization of medication assisted treatment, overall substance use disorder penetration rate, and PA Death by Drug Overdose Rate.

prescribed medications are among the top reasons for readmission among members	medication assisted treatment following an inpatient admission may prevent a readmission to a residential level of care before mental health aftercare can happen.		
	Community Care established targeted interventions for the Cascade of Care model as follows:	Project implementation, including interventions started at the beginning of 2021 and will continue through 2023, with the last update to the project to be reported in September 2024	Interim tracking measures (ITMs) have been developed for each intervention; ITMs are monitored on a quarterly basis.
Providers (2.1) Specific to Black/African American members Black and African Americans experience health inequity in behavioral health treatment	• **Warm Hand Off**: is the linking of a member with an appropriate treatment provider following a substance use disorder related event. The Warm Hand Off intervention focuses on increasing the percent of members when presenting at Physical Health hospitalization or emergency departments who initiate substance use treatment including medication assisted treatment for either alcohol use disorder or opioid use disorder over 36 months, by bridging the gap between physical health and substance use disorder treatment systems. Warm Hand Offs are done by peers, case managers of Single County Authorities, Centers of Excellence, or other contracted providers.		
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services, which impacts our members with co-occurring disorders	• **Telehealth Prescribing:** aims to increase the rate of billed telehealth claims for prescribing medication assisted treatment for members with opioid use disorder and alcohol use disorder during or immediately following an inpatient physical health hospitalization or emergency department visit through untapped prescribing services via telehealth designed to engage individuals into substance use disorder treatment, over 36 months.		
	• **Federally Qualified Health Center Learning Collaborative:** (implemented on June 2021 and completed in November 2021) the focus of the Learning Community was to increase the percent of individuals seeking primary care in Federally Qualified Health Centers with screening and initiation of substance use disorders treatment including medication assisted treatment for opioid/alcohol use disorders through support, education, and consultation in a learning community.		
	These interventions are designed to impact the Key Performance Indicators as well as the overarching Performance Improvement Plan Aims statement and objectives.		
	Community Care, in collaboration with County Oversights and their Single County Authorities established the following objectives to be completed by the end of 2023:		
	• The **Anti-Stigma Campaign**, (part of the population health activities) known as Community Care's Anti-Stigma Resources and Education Campaign (or CCARE) was implemented July 1, 2021. The campaign is designed to reduce stigma for seeking help for substance use disorders resulting in more members engaging in substance use disorder care. The campaign includes anti-stigma education, targeted media posts, webinars, and community outreach and is designed to add to existing statewide substance use disorder anti-stigma efforts rather than duplicate existing programs such as the Life Unites Us and Shatterproof campaigns. The campaign has a focus on Black/African American racial disparities. It builds upon recent substance use disorder education and collaboration efforts with community partners and others to expand	**2023**	

educational anti-stigma programs. CCARE Campaign resources are posted to the Community Care website along with a brief survey on stigma. This campaign includes a Barber/Beauty Shop pilot Project, the Our HAIR (Health Access Initiative for Recovery) which educates Black/African American barbers and stylists in the Pittsburgh area on how to talk to clients about suicide, substance use disorders, and other behavioral health disorders, and how to link clients to treatment resources. The hope is as stigma decreases, help seeking behavior for initiation of substance use disorder treatment will increase.

The Our HAIR initiative was implemented in Q4 2022.

• **Medication Assisted Treatment (MAT) Toolkits** were implemented July 1, 2021, as part of the population health activities for the PEDTAR. The toolkits address lack of substance use disorder treatment engagement through education on substance use disorder treatment options for members, families, and providers through development and dissemination of a MAT Toolkits were implemented and are designed to increase rates of medication assisted treatment prescribing. Members that receive rapid access to lifesaving medication may be more likely to continue in treatment. These toolkits are available in English and Spanish.

• The **Community Health Worker Outreach** intervention (implemented July 1, 2021) focuses on increasing follow up and decreasing readmission through outreach by a Community Health Worker during or immediately following a withdrawal management or inpatient substance use treatment stay to educate members (at least 13 years of age) on care options, facilitate referrals, and connection to behavioral health services or other community supports. Community Health Workers specifically focus on Social Determinants of Health that might impact a member's ability to complete follow up care. Embedded within this intervention is a mandatory cultural awareness training for all Community Health Workers. Staff training in cultural awareness will improve the work that we do and how we interact with all our members. Sensitivity to different cultures will increase our understanding of help seeking behavior, access issues, and resources available to members.

• **Family/Social Support** (implemented January 1, 2022) - over 24 months, provide education, trainings, and toolkits including racial and ethnic cultural competencies, to members and their families to increase rates at which members include their families in substance use disorder outpatient treatment as evidenced by increased rates for billed family therapy sessions delivered to fidelity to best practice standards in family therapy. (Note: translation services are available for members that are non-English speaking). Family members can encourage and support members in treatment and may assist with getting members to follow up appointments.

Family / Social Support and

• **Recovery Management Checklist**– (implemented January 1, 2022) - over 24 months, implement ongoing monitoring by Certified Recovery Specialist to improve retention in

	care, provide education in relapse prevention, racial and ethnic cultural competencies, connection to community-based resources, with payment reform to support long-term monitoring of members in substance use disorder treatment. The focus of this intervention is the later stages of the Cascade of Care model with a focus on long term member retention in treatment. The Recovery Management Checklist is available in English and Spanish. Additionally, in counties with a larger percentage of members that identify as Spanish-speaking providers have bilingual staff; translation services are available for non-English speaking members.	RMC started on January 1, 2022.	
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Provider Benchmarking:** Community Care distributes annual Provider Benchmarking reports. These reports publish the previous year's Value-Based Purchasing arrangement results. This includes 7-day follow-up and 30-day readmission rates for inpatient mental health providers and aftercare ambulatory providers. See the Inpatient Mental Health & Ambulatory Provider Value-Based Payment Arrangement intervention for more information. Published reports include unblinded provider rates for all providers in the network or involved in the value-based payment arrangement, depending on the measure. The change to publish reports unblinded is meant to increase transparency and give providers the opportunity to make direct comparisons with peers.	Ongoing activity, process updated to align with value-based purchasing in 2022	The activities of each year are developed by a workgroup that meets every other week. Feedback and updated rates are used to determine the most appropriate action to facilitate change. This activity is reported annually at the Quality and Care Management Committee meetings for each contract and at the Board Quality Improvement Committee. The Provider Benchmarking Publication is annual. Activity monitoring is captured in the Inpatient Mental Health & Ambulatory Provider Value-Based Payment Arrangement intervention listed above.
	In 2023, Community Care is piloting a new approach of intervention to assist providers who are within a standard deviation of the goal. Community Care, in collaboration with Primary Contractors have identified 15 inpatient mental health and ambulatory providers who will be targeted this year. Community Care asked providers to identify at least one champion within their organization to participate. There will be two workshops, March 8, 2023, and March 22, 2023, focusing on using member level detail to identify barriers, do Root-Cause-Analyses, develop interventions, and conduct Plan-Do-Study-Act cycles. Champions will end the activity with data-driven interventions and recommendations for their organization's leadership to improve rates.	**2023**	**The provider benchmarking workgroup will be monitoring and analyzing the rates of providers targeted for interventions for rate increases for a minimum of 18-months.**

CCBH RCA and QIP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance			
	Community Care feels that this activity assists in addressing barriers to aftercare experienced by members and providers by defining expectations, providing education, and asking providers to think creatively about overcoming obstacles.		
People (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms *Providers (2.1) Specific to Black/African American members* Black and African Americans experience health inequity in behavioral health treatment	**Social & Racial Justice Steering Committee activities:** The Social & Racial Justice Steering Committee was developed in 2021 to develop interventions to address inequities in five categories - Provider Professional Development, Internal Professional Development, Member Level Advocacy, Human Resource Interventions, Community, and Policy. Workgroups were formed, including staff company-wide to address activities in the five categories. These workgroups identify sources for education and training to be shared internally and with stakeholders around inclusion and cultural diversity.	2021 and ongoing	Reoccurring weekly meetings with Senior Management review internal reports and monitoring as standing agenda items.
	The following workgroup activities occurred in 2022: • Began developing a Social and Racial Justice Advisory Board, which includes members, providers, community organizations, and other stakeholders. • Provider trainings on topics of social and racial justice, diversity, and inclusion. Trainings included, 'Making the Unconscious Conscious Through Cultural Humility', 'All These Isms: Understanding Privilege, Power and Oppression in Professional and Personal Relationships', and 'Intersectionality Matters'. • Community Care's corporate Human Resources has developed a diversity hiring dashboard to ensure that hiring managers have a diverse pool of applicants. Community Care reviews staff demographics quarterly for opportunities. • As part of Community Care's Anti-Stigma Resources and Education Campaign (CCARE) barbers and stylists were trained in October on how to talk to clients about suicide, substance use disorders, and other behavioral health disorders, and how to link clients to treatment resources. See Prevention, Early Detection, Treatment and Recovery for Substance Use Disorders for more information. There have been 12 barbers/stylists who participated across 7 shops. These shops were in Homestead, Homewood, Monroeville, Swissvale, Hill District, West Mifflin, and Oakland regions of Allegheny County. • There were 4 internal staff trainings related to social and racial justice, diversity, and inclusion. Across these 4 trainings there were 767 participants. • In total, 40+ diversity/equity/inclusion related trainings were sponsored, or co-sponsored, by Community Care in 2022. This involved approximately 4,000 staff, providers, and other stakeholders.	2022	Community Care tracks interventions completed by this group and how to best measure effectiveness based on each intervention. We anticipate that the planned interventions (stakeholder education, training on inclusion & cultural diversity and human resource interventions) will have an impact on the gap in disparities seen among our Black/African American population with inpatient episodes and increase the number of providers in the Community Care network who will seek specialization in minority populations.
	Planned activities for 2023 include: • **The Policy Workgroup used a consultant to review 10 of our Community Care HealthChoices policies for opportunities for improvement.** • **The Member Level Advocacy Workgroup will be meeting with each contract's**	**2023**	

	local advisory board on a quarterly basis to discuss any social, racial, or cultural concerns and share updated information about interventions.		
	Community Care believes that this intervention will improve aftercare by identifying issues across the system and developing companywide interventions to impact inequities.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues *Providers (2.1) Specific to Black/African American members* Black and African Americans experience health inequity in behavioral health treatment	**Social Determinants of Health Workgroup: Community Care has developed a Social Determinants of Health Workgroup as part of the Community Based Care Management initiative. This workgroup is currently adding race, ethnicity, language, age, and gender to current report related to social determinants of health and Community Based Organizations to better identify disparities related to needs.**	**2023**	Social determinants of health are a primary focus for the Community Based Care Management Program Director. Workgroups will occur on a regular basis throughout 2023 until interventions and metrics are established.
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers that can impact aftercare.		
Providers (2.1) Specific to Black/African American members Black and African Americans experience health inequity in behavioral health treatment *Provisions (3.1) Specific to Black/African American members* There is a shortage of Black/African American treatment providers and there are limitations on	**Targeted Accessibility Analysis (formally Identifying gaps in treatment availability for Black/African American members using GEOAccess):** In 2021, Community Care developed a Targeted Accessibility Analysis to identify gaps in same-race or culturally competent treatment availability for our Black/African American members. Using GEOAccess Community Care plots geographical information regarding the drive time or the distance members in rural and urban locations must travel to get to a specific type of provider. We apply member race/ethnicity information from DHS enrollment data to their geographical location. A second layer of geographical information is applied for service locations of providers who have voluntarily identified themselves as Black/African American, and yet a third layer for providers who have voluntarily identified themselves as specializing in cultural competency. This data shows gaps in same-race or culturally competent providers reasonably accessible to our Black/African American enrollees. Once possible gaps in treatment availability have been identified, Community Care can develop specific regional interventions to address need.	2021	This report will be used in conjunction with other interventions addressing culturally competent care and when considering network expansion.
	The Targeted Accessibility Analysis has been applied to Allegheny County, which is Community Care's most diverse contract. The analysis entailed slicing the County into 4	2021	

identifying culturally competent care	sections and showed that less than half of Black/African American members had access to same-race or culturally competent care within the established standard of 2 providers within a 30-minute drive time.		
	Originally slated to occur 2022 this intervention has been reprioritized to 2023: Community Care will complete a Targeted Accessibility Analysis for Community Care contracts with disparities and provide an update to contract leadership regarding accessibility to culturally competent care for minorities.	**2023**	
	Community Care feels that it is essential for members to receive culturally competent care. This will impact Community Care's HEDIS FUH rates by linking members to providers most likely to positively impact their recovery.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues

People (1.4) Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending | **Telehealth:** Telehealth allows behavioral health practitioners to provide clinical services, such as medication management, assessment, diagnosis, and case management to members through two-way, interactive videoconferencing and telephone calls. Prior to the COVID-19 pandemic, Community Care supported these services on a limited basis, particularly for rural areas where drive time and transportation presented as a barrier. At the initiation of the pandemic in March 2020, OMHSAS loosened the regulations surrounding Telehealth to accommodate members utilizing behavioral health services. Members were able to attend appointments via telephone; they did not have to use video or screen sharing technology. Providers were able to expand the number of services available to members. Preliminary results of the telehealth expansion include increased show rates, high member satisfaction, convenience for practitioners and members, and access to other settings and providers in real time. Satisfaction surveys were conducted by Consumer/Family Satisfaction Teams of members from Community Care counties regarding their experiences of receiving services via telehealth. Almost all members who responded agreed or strongly agreed that their provider was able to "meet all of my behavioral health needs." In 2021, several Consumer and Family Satisfaction Teams added questions related to telehealth to their surveys with positive results. Specific to Allegheny County's Consumer Action Response Team -
▪ 80% of survey respondents (n. 1,374) indicated that telehealth made it easier for them to receive the services,
▪ 72% of survey respondents (n. 349) rated their experience with telehealth as satisfied or very satisfied.
In York and Adams Counties –
▪ 74% of survey respondents (n. 76) responded that their provider offered flexibility with Telehealth appointments beyond business hours,
▪ 88% of survey respondents (n. 88) indicated they are satisfied with the | 2020-2022 | The availability of telehealth services is regularly monitored as part of network expansion requests and Network Adequacy Workgroup. Community Care has developed reports to monitor the use of telehealth services and regularly reminding providers to use telehealth place of service codes which was released in the March 16, 2020 Provider Alert, titled COVID-19 Update: Telehealth Services. The use of this code will be instrumental in Community Care obtaining accurate data. Provider Alert: https://providers.ccbh.com/uploads/files/Provider-Alerts/20200316-alert4-covid19.pdf

The Quality Management Department reviews telehealth information in member records during record reviews to ensure the service is occurring within specifications outlined in the Provider Alert. |

	Telehealth services offered. And, in Bedford and Somerset Counties – ▪ 92% of survey respondents (n. 381) rated their experience with telehealth as satisfied or very satisfied. This data is promising when evaluating the overall effectiveness and satisfaction of telehealth services. In 2022, Community Care published a Provider Alert to all Community Care providers providing guidelines for the delivery of behavioral health service through telehealth. These guidelines are in accordance with OMHSAS Bulletin 21-09. Provider Alert: https://providers.ccbh.com/uploads/files/Provider-Alerts/202203-alert6-guidelines-delivery-bh-services-telehealth.pdf		Additionally, Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be reviewed quarterly in 2023 for ongoing trend analysis and any additional opportunities for improvement.
	Community Care analyzed the 2021 HEDIS FUH data for inpatient mental health discharges. According to this information, 40% of all HEDIS qualified follow-up was delivered via telehealth.	2021	
	It is anticipated that this service may be retained in the future, although more trainings would need to be offered to providers on topics related to telehealth, developing billing processes, and addressing current documentation procedures (e.g., how to obtain signatures on a treatment plan).		
Provisions (3.2) Medication appointments with psychiatrists are often hard to secure in a timely manner	**Telepsych:** Telepsychiatry allows behavioral health practitioners to provide clinical services to patients at remote, usually rural, locations through two-way, interactive videoconferencing, sparing both practitioners and patients the time and expense of long-distance travel. It allows members to access psychiatrists that would not otherwise be available to them. Patients may connect to a specialist via the telehealth network from their community healthcare facility.	2005 - ongoing	Community Care will continue to take an active role in expanding telepsychiatry and monitor its utilization via the number of members served and providers involved. Telepsychiatry services and related data is reported annually at Community Care's Board Quality Improvement Committee.
	In 2022 alone, 11,987 unique members were served via telepsychiatry, receiving psychiatric evaluations and medication management appointments. As of 01/26/2023 Community Care contracts with 64 providers across 192 locations for telepsychiatry.	2022	
	Community Care feels that telepsych services permits a number of members to receive psychiatry services that wouldn't ordinarily be accessible, or much sooner than would be permitted in a traditional setting. This intervention positively impacts HEDIS FUH rates by increasing accessibility and reducing barriers.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or	**Utilization Management Provider Notification:** Notification processes are in place to inform Blended Case Managers, Family Based Mental Health Services, or other service providers as applicable, at the time of authorization of an inpatient admission for any of their members and to coordinate aftercare for children discharged to shelter placements. In Allegheny County, notification of Assertive Community Treatment teams for members who receive this service is included in this intervention.	Ongoing practice with process updated in 2020	Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases during supervision.
	Community Care currently does not have a reliable method of collecting the Provider	Intervention	

CCBH RCA and QIP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance		
housing issues ***People (1.3)*** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	Notification data on an aggregate level. At this time Community Care will continue to explore ways to aggregate this data.	occurs as part of the Care Management daily activities
	Community Care believes this activity impacts aftercare rates by involving other service providers in supporting members during and after IPMH stays.	

CCBH: Community Care Behavioral Health.

VII: 2022 Strengths, Opportunities for Improvement and Recommendations

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

Strengths

- Review of compliance with MMC regulations conducted by PA in RY 2019, RY 2020, and RY 2021 found CCBH to be fully compliant with the following standards: Assurances of Adequate Capacity and Services, Confidentiality, Health Information Systems, Subcontractual Relationships and Delegation, and with Quality Assessment and Performance Improvement Program.

Opportunities for Improvement

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

Assessment of Quality, Timeliness, and Access

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

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

Table 7.1: EQR Recommendations

EQR Task/Measure	IPRO's Recommendation	Standards
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	It was noted that overall Year 1 performance indicator goals had not been achieved, but some counties did see improvements. IPRO suggested CCBH drill deeper into the differences in these counties in order to possibly extract lessons. In addition, comparison to national % changes in relevant measures like FUI may also provide a way to check for counterfactuals.	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	In a reversal from the previous year, 2021 saw a significant drop in CCBH's follow-up rates. In its RCA, CCBH notes many factors centering mostly on its members, for example problems addressing childcare or obtaining transportation, although CCBH also notes larger provider (e.g., lack of psychiatrists) and systemic issues such as stigma. Its RCA remains robust, as do many of its interventions. QIP interventions that show promise, like the Admissions Interview--members who received an Admission Interview were 13 percentage points more likely to have follow-up in 30-days—and High Risk Care Management, should be continued and possibly expanded. Where questions remain, CCBH should continue to leverage its in-house data to evaluate interventions like the Collaborative Care at FQHCs to determine which interventions are helping improve follow-up rates and which ones are not, and why. In its current PEDTAR PIP, CCBH is leveraging its partnership with counties, single county authorities, and Centers of Excellence (COEs) to improve warm handoffs for initiation and engagement into specialty SUD treatment as well as improve MAT penetration rates, especially for its historically underserved African-American and Hispanic members. To the extent that there is comorbidity, CCBH should expect FUH of such members to improve as their SUD conditions are better identified and managed. The PIP's anti-stigma campaign, combined with provider trainings, will also help improve performance with respect to prevention. And the expansion of VBP arrangements to COEs in CCBH's service area effective January 2023 should also be expected to improve FUH of MH-SUD comorbid members. Expansion of the network also shows promise in addressing MH treatment shortage areas. Finally, CCBH's focus on addressing health equity, as evidenced by its recent NCQA Health Equity Accreditation, should translate to reduce observed inequities in many quality areas, including follow-up.	Timeliness, Access
PA Follow-Up After Hospitalization for Mental Illness rates	See recommendations for HEDIS FUH.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	CCBH continues to make progress on reducing readmissions after hospitalizations for mental illness, although the MCO rate remain unchanged from MY 2020, suggesting CCBH should continue with, and possibly expand, existing efforts in this area. CCBH's success with securing follow-up visits post-discharge for this population—as reflected in its consistently strong performance on the HEDIS Quality Compass FUH percentiles, COVID-19 notwithstanding—is likely helping to reduce avoidable readmissions. In its current PEDTAR PIP, CCBH is planning to leverage its partnership with counties, single county authorities (SCAs), and Centers of Excellence (COE) to improve warm handoffs for initiation and engagement into specialty SUD treatment as well as improve MAT penetration rates, especially for its historically underserved African-	Timeliness, Access

EQR Task/Measure	IPRO's Recommendation	Standards
	American and Hispanic members. If CCBH is able to bring about similar outcome improvements for its members with SUD, while simultaneously addressing deficiencies in its grievance and appeal system that ultimately impact quality, timeliness, and access to care, the MCO can expect to achieve at or above par performance in this important area of treatment (services). The PIP's anti-stigma campaign, combined with provider trainings, will also help improve performance with respect to prevention.	
Compliance with Medicaid Managed Care Regulations		
Availability of Services	CCBH was found partially compliant for this category based on non-compliance with the substandard requiring that Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. IPRO concurs with OMHSAS's proposed corrective action: CCBH must revise its psychological testing request form to include a dedicated space for the specific referral question to be answered through psychological testing. Consistent with MNC for psychological testing, this dedicated space should encourage the requesting provider to explain how the psychological testing is expected to answer the referral question or how the referral question could not be answered on the absence of the requested testing.	Quality, Timeliness, Access
Coordination and continuity of care	CCBH was found partially compliant for this category based on non-compliance with the substandard requiring that Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. IPRO concurs with OMHSAS's proposed corrective action: CCBH must revise its psychological testing request form to include a dedicated space for the specific referral question to be answered through psychological testing. Consistent with MNC for psychological testing, this dedicated space should encourage the requesting provider to explain how the psychological testing is expected to answer the referral question or how the referral question could not be answered on the absence of the requested testing.	Quality, Timeliness, Access
Coverage and authorization of services	In addition to the non-compliance with the application of medical necessity criteria substandard, CCBH was partially compliant with a substandard specifying content and intelligibility of decision notices. IPRO concurs with the following OMHSAS recommendations and CAPs: Recommendation: CCBH should ensure that their PAs are careful in adding language like "less intensive," "less restrictive," and "severity level" to denial rationales. Medically necessary services may not be denied because another "less intensive" service is not tried. Corrective Action Plan (CAP): CCBH must ensure that denial rationales are clear and document a member's behaviors, symptoms, clinical needs and/or improvements to form the basis of a medical necessity determination without using unnecessary language that educates, instructs, or case manages.	Quality, Timeliness, Access
Practice guidelines	CCBH was found partially compliant for this category based on non-compliance with the substandard requiring that Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. IPRO concurs with OMHSAS's proposed corrective action: CCBH must revise its psychological testing request form to include a dedicated space for the specific referral question to be answered through	Quality, Timeliness, Access

EQR Task/Measure	IPRO's Recommendation	Standards
	psychological testing. Consistent with MNC for psychological testing, this dedicated space should encourage the requesting provider to explain how the psychological testing is expected to answer the referral question or how the referral question could not be answered on the absence of the requested testing.	
Grievance and appeal systems	In addition to being partially compliant with the substandard specifying content and intelligibility of decision notices, CCBH was partially complaint with the substandard requiring Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member. IPRO concurs with OMHSAS's CAP: A dated witness signature and provider plan identification number must be added to CCBH's "Authorization for Representation: Member Consent for Provider to File a Grievance" form and consistently completed to meet Appendix H requirements.	Quality, Timeliness, Access

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

VIII: Summary of Activities

Performance Improvement Projects
- CCBH successfully implemented their PEDTAR PIP for 2021.

Performance Measures
- CCBH reported all PMs and applicable quality indicators for 2021.

Medicaid Managed Care Regulations
- CCBH was partially compliant with Standards, including Enrollee Rights and Protections, fully compliant with Quality Assessment and Performance Improvement Program, and partially compliant with Grievance System. As applicable, compliance review findings from RY 2021, RY 2020, and RY 2019 were used to make the determinations.

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

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

2021 Opportunities for Improvement MCO Response
- CCBH provided a response to the opportunities for improvement issued in 2021.

2022 Strengths and Opportunities for Improvement
- Both strengths and opportunities for improvement were noted for CCBH in 2022 (MY 2021). The BH-MCO will be required to prepare a response in 2023 for the noted opportunities for improvement.

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Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for required PEPS substandards pertinent to BBA Regulations. Note that, in 2019, five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

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

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

BBA Category	PEPS Reference	PEPS Language
	Substandard 1.7	Confirm FQHC providers.
	Substandard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Substandard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Substandard 23.3	List of oral interpreters is available for non-English speakers.
	Substandard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Substandard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Substandard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Substandard 24.2	Provider network database contains required information for ADA compliance.
	Substandard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Substandard 24.4	BH-MCO is able to access interpreter services.
	Substandard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Substandard 24.6	BH-MCO can make alternate formats available upon request.
	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
Confidentiality Title 42 CFR § 438.224	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Coordination and continuity of care Title 42 CFR § 438.208	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
Coverage and authorization of services	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.

BBA Category	PEPS Reference	PEPS Language
Title 42 CFR Parts § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Substandard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DHS Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
Health information systems Title 42 CFR § 438.242	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Practice guidelines Title 42 CFR § 438.236	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
Provider selection Title 42 CFR § 438.214	Substandard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Substandard 10.2	100% of decisions made within 180 days of receipt of application.
	Substandard 10.3	Recredentialing incorporates results of provider profiling.
Subcontractual relationships and delegation Title 42 CFR § 438.230	Substandard 99.1	The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning.
	Substandard 99.2	The BH-MCO reports monitoring results for adverse incidents.
	Substandard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as other medical and human services programs.
	Substandard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Substandard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	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

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

BBA Category	PEPS Reference	PEPS Language
		Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year
	Substandard 91.14	The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the Annual Evaluation and any Corrective Actions required from previous reviews.
	Substandard 91.15	The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
	Substandard 98.1	The BH-MCO reports monitoring results for telephone access standard and responsiveness rates. Standard: Abandonment rate
	Substandard 98.2	The BH-MCO reports monitoring results for overall utilization patterns and trends, including BHRS service utilization and other high volume/high risk services patterns of over- or under-utilization. BH-MCO takes action to correct utilization problems, including patterns of over- and under-utilization.
	Substandard 98.3	The BH-MCO reports monitoring results for coordination with other service agencies and schools.
	Substandard 104.1	The BH-MCO must measure and report its performance using standard measures required by DHS.
	Substandard 104.2	The BH MCO must submit data to DHS, as specified by DHS, that enables the measurement of the BH-MCO's performance. QM program description must outline timeline for submission of QM program description, work plan, annual QM summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.
	Substandard 104.3	Performance Improvement Plans status reported within the established time frames.
	Substandard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly PEPS Reports
Grievance and appeal systems Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	Substandard 68.1	Interview with Complaint Coordinator(s) demonstrate a clear understanding of the Complaint process including how Member rights and Complaint procedures are made known to Members, BH-MCO staff and the provider network. • 1st level • 2nd level • External • Expedited • Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	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.

BBA Category	PEPS Reference	PEPS Language
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the Grievance process, including how Grievance rights and procedures are made known to Members, BH-MCO staff and the provider network: • Internal • External • Expedited • Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Substandard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DHS Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-specific PEPS substandards. Note that, in 2019, two contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

Table B.1: OMHSAS-Specific PEPS Substandards

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

Category	PEPS Reference	PEPS Language
		discussed and that input was provided from all panel members.
	Substandard 71.6	Sign-in sheets are included for each Grievance review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
	Substandard 71.8	Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role.
Denials		
Denials	Substandard 72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to Appendix AA requirements.
Executive Management		
County Executive Management	Substandard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Substandard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/Family Satisfaction	Substandard 108.3	County's/BH-MCO's role of fiduciary (if applicable) is clearly defined, and provides supportive function as defined in the C/FST Contract, as opposed to directing the program.
	Substandard 108.4	The C/FST Director is responsible for: setting program direction consistent with County direction; negotiating contract; prioritizing budget expenditures; recommending survey content and priority; and directing staff to perform high quality surveys.
	Substandard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling, and have resulted in provider action to address issues identified.

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

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

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

Category (PEPS Standard)	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	RY 2021	RY 2020	RY 2019
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	1	0	0
BH-MCO Executive Management	1	0	1	0	0
Enrollee Satisfaction					
Consumer/Family Satisfaction	3	0	0	0	3
Total	18	0	15	0	3

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

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

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; CCBH: Community Care Behavioral Health; RY: review year. NR: substandards not reviewed.

Format

This document groups the monitoring standards under the subject headings Care Management, Complaints and Grievances, Denials, Executive Management, and Enrollee Satisfaction. The status of each substandard is presented as it appears in the PEPS Review Application (i.e., met, partially met, not met) and/or applicable RAI tools (i.e., complete, pending) submitted by OMHSAS. This format reflects the goal of this supplemental review, which is to assess the Primary Contractor/BH-MCO's compliance with selected ongoing OMHSAS-specific monitoring standards.

Findings

Care Management

The OMHSAS-specific PEPS substandards relating to Care Management are MCO-specific review standards. These two substandards were added to the PEPS Application for RY 2015. There are two substandards crosswalked to this category, and CCBH and its Primary Contractors were partially or not compliant with two substandards. The status for these substandards is presented in **Table C.2**.

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Substandard 27.7	2021	-	-	All CCBH Primary Contractors
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	2021	All CCBH Primary Contractors	-	-

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

All Primary Contractors associated with CCBH were non-compliant with Substandard 7 of Standard 27 (RY 2021).

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.

Findings centered on concerns over care manager training and supervision. Recommendations and corrective action plans include ensuring a minimum annual trainings (including of evidence based practices), assessments, and establishing a robust monitoring program with regular opportunities for feedback.

Complaints and Grievances

The OMHSAS-specific PEPS substandards relating to second-level complaints and grievances are MCO and Primary Contractor-specific review standards. Ten substandards were evaluated for all Primary Contractors during RY 2021. CCBH was compliant with 6 and partially compliant with 4 of the substandards crosswalked to this category. Findings are presented in **Table C.3**.

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Complaints and Grievances					
Complaints	Substandard 68.1.1	2021	Allegheny, Berks, BHARP, Blair, Erie, Lycoming/Clinton, York/Adams	Carbon/Monroe/Pike, Chester, NBHCC	-
	Substandard 68.1.2	2021	All CCBH Primary Contractors	-	-
	Substandard 68.5	2021	All CCBH Primary Contractors		-
	Substandard 68.6	2021		All CCBH Primary Contractors	
	Substandard 68.8	2021	All CCBH Primary Contractors		-
Grievances	Substandard 71.1.1	2021	Allegheny, Berks, BHARP, Blair, Erie, Lycoming/Clinton,	Carbon/Monroe/Pike, Chester, NBHCC	-

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	**Partially Met**	**Not Met**
Complaints and Grievances					
			York/Adams		
	Substandard 71.1.2	2021	All CCBH Primary Contractors	-	-
	Substandard 71.5	2021	All CCBH Primary Contractors		-
	Substandard 71.6	2021		All CCBH Primary Contractors	
	Substandard 71.8	2021	All CCBH Primary Contractors		-

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

Carbon/Monroe/Pike, Chester, and NBHCC were partially compliant on Substandard 1 of Standard 68.1 (RY 2021).

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 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.

All Primary Contractors associated with CCBH were partially compliant with Substandard 6 of Standard 68 (RY 2021)

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 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.

Carbon/Monroe/Pike, Chester, and NBHCC were partially compliant on Substandard 1 of Standard 71.1 (RY 2021).

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 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.

All Primary Contractors associated with CCBH were partially compliant with Substandard 6 of Standard 71 (RY 2021)

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 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.

Denials

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

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Denials					
Denials	Substandard 72.3	2021	All CCBH Primary Contractors	-	-

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

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. The status for these substandards is presented in **Table C.5.**

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Executive Management					
County Executive Management	Substandard 78.5	2021	-	Allegheny, Erie	Bedford/Somerset, Berks, BHARP, Blair, Carbon/Monroe/Pike, Chester, Lycoming/Clinton, NBHCC, York/Adams
BH-MCO Executive Management	Substandard 86.3	2021	-	-	All CCBH Primary Contractors

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

Two Primary Contractors associated with CCBH (Allegheny and Erie) were partially compliant with Substandard 5 of Standard 78 (RY 2021), and the rest of the CCBH contractors were non-compliant.

Standard 78: Evidence exists of the County's oversight of functions and activities delegated to the BH-MCO including: a. County Table of Organization showing a clear organization structure for oversight of BH-MCO functions.   b. In the case of a multi-county contract, the Table of Organization shows a clear relationship among and between Counties' management structures, as it relates to the BH-MCO oversight. c. The role of the Single County Authority (SCA) in oversight is clear in the oversight structure. d. Meeting schedules and attendee minutes reflect County oversight of the BH-MCO (e.g., adequate staff with appropriate skills and knowledge that regularly attend meetings and focus on monitoring the contract and taking appropriate action, such as CAPs. f. Documentation of the County's reviews and/or audits of quality and accuracy of the major BH-MCO functions, including: 1) Care Management, 2) Quality Assurance (QA), 3) Financial Programs, 4) MIS, 5) Credentialing, 6) Grievance System, 7) Consumer Satisfaction, 8) Provider Satisfaction, 9) Network Development, Provider Rate Negotiation, and 10) Fraud, Waste, and Abuse (FWA).

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

All Primary Contractors associated with CCBH were non-compliant with Substandard 3 of Standard 86 (RY 2021).

Standard 86: The appointed Medical Director is a board certified psychiatrist licensed in PA with at least five years experience in mental health and substance abuse. Required duties and functions are in place. The BH-MCO's table of organization depicts organization relationships of the following functions/ positions:

- Chief Executive Officer
- Chief Financial Officer
- Director of Quality Management
- Director of Utilization Management
- Management Information Systems
- Director of Prior/service authorization
- Director of Member Services
- Director of Provider Services

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

Enrollee Satisfaction

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

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

| Category | PEPS Item | RY | Status by Primary Contractor | | |
			Met	Partially Met	Not Met
Enrollee Satisfaction					
Consumer/Family Satisfaction	Substandard 108.3	2019	All CCBH Primary Contractors	-	-
	Substandard 108.4	2019	All CCBH Primary Contractors	-	-
	Substandard 108.9	2019	All CCBH Primary Contractors	-	-

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