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

2015 External Quality Review Report
Community Behavioral Health

FINAL
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Glossary of Terms

Average (i.e., arithmetic mean or mean)	The sum of all items divided by the number of items in the list. All items have an equal contribution to the calculation; therefore, this is unweighted.
Confidence Interval	Confidence interval (CI) is a range of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% CI indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would be within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the CI 95 times, or 95% of the time.
HealthChoices Aggregate Rate	The sum of all behavioral health (BH) managed care organization (MCO) numerators divided by the sum of all BH-MCO denominators.
HealthChoices BH-MCO Average	The sum of the individual BH-MCO rates divided by the total number of BH-MCOs (five BH-MCOs). Each BH-MCO has an equal contribution to the HealthChoices BH-MCO Average value.
HC BH Contractor Average	The sum of the individual HC BH Contractor rates divided by the total number of HC BH Contractors (34). Each HC BH Contractor has an equal contribution to the HC BH Contractor Average value.
Rate	A proportion indicated as a percentage of members who received services out of the total population of identified eligible members.
Percentage Point Difference	The arithmetic difference between two rates.
Weighted Average	Similar to an arithmetic mean (the most common type of average), where instead of each of the data points contributing equally to the final average, some data points contribute more than others.
Statistical Significance	A result that is unlikely to have occurred by chance. The use of the word "significance" in statistics is different from the standard definition that suggests that something is important or meaningful.
Z-ratio	How far and in what direction the calculated rate diverged from the most probable result (i.e., the distribution's mean). Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

Introduction

Purpose and Background

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

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

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

HealthChoices Behavioral Health is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2015 EQRs for the HealthChoices Behavioral Health (BH) MCOs and to prepare the technical reports. This technical report includes seven core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures
IV. Quality Study
V. 2014 Opportunities for Improvement - MCO Response
VI. 2015 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the HealthChoices BH-MCOs, the information for the compliance with the Structure and Operations Standards section of the report is derived from monitoring and reviews conducted by OMHSAS of the BH-MCOs, as well as the oversight functions of the county or contracted entity when applicable, against the Commonwealth's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable.

Information for Sections II and III of this report is derived from Island Peer Review Organization's (IPRO's) validation of each BH-MCO's performance improvement projects (PIPs) and performance measure submissions. The Performance Measure validation as conducted by IPRO included a repeated measurement of two Performance Measures – Follow-up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. For the first year, IPRO produced a third Performance Measure, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. The results of this measure are being studied by PA DHS/OMHSAS, and the data presentation will be included in the 2015 EQR BBA Technical Report.

Section IV contains the results of a Quality Study conducted by OMHSAS and IPRO that examines the HealthChoices readmission rate, using both Physical and Behavioral health encounter data, and conducts analysis to determine what factors correlate with an increased 30-day readmission rate. Following Section IV, Section V, 2014 Opportunities for Improvement – MCO Response, includes the BH-MCO's responses to opportunities for improvement noted in the 2014 EQR Technical Report, and presents the degree to which the BH-MCO addressed each opportunity for improvement. Section VI has a summary of the BH-MCO's strengths and opportunities for improvement for this review period (2015) as determined by IPRO, and a "report card" of the BH-MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HealthChoices Behavioral Health Managed Care Organization. Lastly, Section VII provides a summary of EQR activities for the BH-MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA Regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

I: Structure and Operations Standards

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the structure and operations standards. In review year (RY) 2014, 64 Pennsylvania counties participated in this compliance evaluation.

Organization of the HealthChoices Behavioral Health Program

OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program; the mandatory managed care program that provides Medical Assistance recipients with services to treat mental health and/or substance abuse diagnoses/disorders. Forty-three of the 67 counties have signed agreements using the right of first opportunity and have sub-contracted with a private sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four counties have elected not to enter into a capitated agreement and as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties. In the interest of operational efficiency, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the HC BH Contractors while providing an oversight function of the BH-MCOs.

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

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CBH by OMHSAS monitoring staff within the past three review years (RYs 2014, 2013, 2012). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for RY 2014. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year timeframe under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review Substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's Program Standards and Requirements (PS&R) are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2015 and entered into the PEPS Application as of October 2015 for RY 2014. Information captured within the PEPS Application informs this report. The PEPS Application is a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each HealthChoices Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the substandards or Items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional reviewer comments. Based on the PEPS Application, a HealthChoices Oversight Entity/BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS's more rigorous monitoring criteria.

At the implementation of the PEPS Application in 2004, IPRO evaluated the standards in the Application and created a crosswalk to pertinent BBA regulations. For standards with substandards, all of the substandards within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the substandards required for fulfilling BBA requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS's ongoing monitoring. In the amended crosswalk,

the supplemental substandards no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Substandards concerning first level complaints and grievances inform the compliance determination of the BBA categories relating to Federal & State Grievance Systems Standards. All of the PEPS Substandards concerning second level complaints and grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category. As was done for the prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The RY 2014 crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in **Appendix A** and **B**, respectively. The review findings for selected OMHSAS-specific Substandards are reported in **Appendix C**.

Because OMHSAS's review of the HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS Substandards from RY 2014, RY 2013, and RY 2012 provided the information necessary for the 2015 assessment. Those standards not reviewed through the PEPS system in RY 2014 were evaluated on their performance based on RY 2013 and/or RY 2012 decisions, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed.

For CBH, this year a total of 163 Items were identified as being required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations. In addition, 16 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Substandards were relevant to more than one BBA regulation or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS Item may contribute more than once to the total number of Items required and/or reviewed. **Table 2** provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of CBH against the Structure and Operations Standards for this report. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH-MCO and associated HealthChoices Oversight Entities against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for CBH

Table 2: Substandards Pertinent to BBA Regulations Reviewed for CBH

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	PEPS Reviewed in RY 2012	Not Reviewed[1]
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	9	3	0	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	24	18	2	4	0
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	2	2	0	0
Provider Selection	3	3	0	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	8	0

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	PEPS Reviewed in RY 2012	Not Reviewed[1]
Practice Guidelines	6	0	2	4	0
Quality Assessment and Performance Improvement Program	23	16	0	7	0
Health Information Systems	1	0	0	1	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	2	9	0	0
General Requirements	14	2	12	0	0
Notice of Action	13	13	0	0	0
Handling of Grievances and Appeals	11	2	9	0	0
Resolution and Notification: Grievances and Appeals	11	2	9	0	0
Expedited Appeals Process	6	2	4	0	0
Information to Providers and Subcontractors	2	0	2	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	2	4	0	0
Effectuation of Reversed Resolutions	6	2	4	0	0

[1] Items "Not Reviewed" were not scheduled or not applicable for evaluation. "Not Reviewed" items, including those that were "Not Applicable," did not substantially affect the findings for any category, if other items within the category were reviewed.

For RY 2014, nine categories, 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements were not directly addressed by the PEPS Substandards reviewed. As per OMHSAS's judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health Program's PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH-MCOs. The category of Marketing Activities is Not Applicable because, as a result of the Centers for Medicare and Medicaid Services (CMS) HealthChoices waiver, DHS has been granted an allowance to offer only one BH-MCO per county. Compliance for the Cost Sharing category is not assessed by PEPS Substandards, as any cost sharing imposed on Medicaid enrollees is in accordance with CMS regulation 42 CFR 447.50-447.60.

Before 2008, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all HC BH Contractors and BH-MCOs based on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. In 2008, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories. In this 2015 report, the Solvency tracking reports and the quarterly reporting of Complaint and Grievances data were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

Determination of Compliance

To evaluate HealthChoices Oversight Entity/BH-MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring substandards by provision, and evaluated the HC BH Contractors' and BH-MCO's compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of met, partially met or not met in the PEPS Application submitted by the Commonwealth. If a substandard was not evaluated for a particular HealthChoices Oversight Entity/BH-MCO, it was assigned a value of Not Determined. Compliance with the BBA provisions was then determined based on the aggregate results across the three-year period of the PEPS Items linked to each provision. If all Items were met, the HealthChoices Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as partially compliant. If all Items were not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as non-compliant. If no crosswalked Items were evaluated for a given provision, and no other source of information was available to determine compliance, a value of Not Applicable ('N/A') was assigned for that provision. A value of Null was

assigned to a provision when none of the existing PEPS Substandards directly covered the Items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results for all provisions within a given category were aggregated to arrive at a summary compliance status for the category. For example, all provisions relating to enrollee rights are summarized under Enrollee Rights - 438.100.

Format

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in the *CMS EQR Protocol #1: Assessment of Compliance with Medicaid Managed Care Regulations* ("Quality of Care External Quality Review," 2012). Under each general subpart heading are the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a manner consistent with the three subparts in the BBA regulations explained in the Protocol i.e., Enrollee Rights and Protections, Quality Assessment and Performance Improvement (including access, structure and operation and measurement and improvement standards), and Federal and State Grievance System Standards.

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

Findings

Of the 163 PEPS Items identified as required to fulfill BBA regulations, 163 Items were evaluated for CBH and Philadelphia County.

Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this subpart is to ensure that each HC BH Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable Federal and State laws that pertain to enrollee rights, and that the HC BH Contractor/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees (42 C.F.R. § 438.100 [a], [b]). **Table 3** presents the findings by categories consistent with the regulations.

Table 3: Compliance with Enrollee Rights and Protections Regulations

Subpart C: Categories	MCO Compliance Status	Comments
Enrollee Rights 438.100	Partial	12 substandards were crosswalked to this category. Philadelphia County was evaluated on 12 substandards, compliant on 9 substandards, partially compliant on 1 substandard, and non-compliant on 2 substandards.
Provider-Enrollee Communications 438.102	Compliant	Compliant as per PS&R sections E.4 (p.52) and A.4.a (p.20).
Marketing Activities 438.104	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH-MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	Compliant as per PS&R sections A.9 (p. 70) and C.2 (p.32).
Cost Sharing 438.108	Compliant	Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	Compliant as per PS&R section 4 (p.37).
Solvency Standards 438.116	Compliant	Compliant as per PS&R sections A.3 (p.65) and A.9 (p. 70), and 2014-2015 Solvency Requirements tracking report.

N/A: not applicable

There are seven categories within Enrollee Rights and Protections Standards. CBH was compliant on five categories and partially compliant on one category. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50-447.60. The remaining category, Solvency Standards, was compliant based on the 2014-2015 Solvency Requirement tracking report. Philadelphia County was evaluated and compliant on 9 PEPS substandards, partially compliant on 1 PEPS substandard and non-compliant on 2 substandards that were crosswalked to Enrollee Rights and Protections Regulations. Overall, Philadelphia County was deemed partially compliant for the category Enrollee Rights. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Enrollee Rights

Philadelphia County was partially compliant with Enrollee Rights and Protections due to partial compliance with Substandard 1, and non-compliance with Substandards 2 and 3 of PEPS Standard 60 (RY 2014).

PEPS Standard 60: Complaint/Grievance Staffing. The BH-MCO shall identify a lead person responsible for overall coordination of the complaint and grievance process, including the provision of information and instructions to members. (Responsibility includes HIPAA Privacy duties related to complaints and mechanisms for tracking and reporting of HIPAA related complaints.) The BH-MCO shall designate and train sufficient staff responsible for receiving, processing and responding to member complaints and grievances in accordance with the requirements contained in Appendix H. All BH-MCO staff shall be educated concerning member rights and the procedure for filing complaints and grievances.

Philadelphia County was partially compliant on Substandard 1 of Standard 60 (RY 2014).

> **Substandard 1:** Table of organization identifies lead person responsible for overall coordination of complaint and grievance process and adequate staff to receive, process and respond to member complaints and grievances.

Philadelphia County was non-compliant on Substandards 2 and 3 of Standard 60 (RY 2014).

> **Substandard 2:** Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
> **Substandard 3:** Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.

Subpart D: Quality Assessment and Performance Improvement Regulations

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's Medicaid managed care program, the HealthChoices Program, are available and accessible to MCO enrollees [42 C.F.R. § 438.206 (a)].

The PEPS documents for each HC BH Contractor include an assessment of the HC BH Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 4** presents the findings by categories consistent with the regulations.

Table 4: Compliance with Quality Assessment and Performance Improvement Regulations

Subpart D: Categories	MCO Compliance Status	Comments
Elements of State Quality Strategies 438.204	Compliant	Compliant as per PS&R section G.3 (p.58).
Availability of Services	Partial	24 substandards were crosswalked to this category.

Subpart D: Categories	MCO Compliance Status	Comments
(Access to Care) 438.206		Philadelphia County was evaluated on 24 substandards, compliant on 22 substandards, and partially compliant on 2 substandards.
Coordination and Continuity of Care 438.208	Partial	2 substandards were crosswalked to this category. Philadelphia County was evaluated on 2 substandards and partially compliant on 2 substandards.
Coverage and Authorization of Services 438.210	Partial	4 substandards were crosswalked to this category. Philadelphia County was evaluated on 4 substandards, compliant on 1 substandard, and partially compliant on 3 substandards.
Provider Selection 438.214	Compliant	3 substandards were crosswalked to this category. Philadelphia County was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	Compliant as per PS&R sections D.2 (p.49), G.4 (p.59) and C.6.c (p.47).
Subcontractual Relationships and Delegation 438.230	Compliant	8 substandards were crosswalked to this category. Philadelphia County was evaluated on 8 substandards and compliant on 8 substandards.
Practice Guidelines 438.236	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant on 4 substandards, and partially compliant on 2 substandards.
Quality Assessment and Performance Improvement Program 438.240	Compliant	23 substandards were crosswalked to this category. Philadelphia County was evaluated on 23 substandards and compliant on 23 substandards.
Health Information Systems 438.242	Compliant	1 substandard was crosswalked to this category. Philadelphia County was evaluated on 1 substandard and compliant on this substandard.

Based on the Items reviewed for the 10 categories of Quality Assessment and Performance Improvement Regulations, Philadelphia County was fully compliant on six categories and partially compliant on four categories. Philadelphia County was evaluated through and deemed compliant on the categories Elements of State Quality Strategies and Confidentiality per the HealthChoices Program Standards and Requirements (PS&R), as these categories were not directly addressed by any PEPS substandards.

Of the 71 PEPS Items crosswalked to Quality Assessment and Performance Improvement regulations, 71 were evaluated for Philadelphia County for RY 2014. Sixty-two items evaluated were compliant, and nine items were partially compliant for Philadelphia County. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

Philadelphia County was partially compliant with Availability of Services (Access to Care) due to partial compliance with Substandards 1 and 2 of PEPS Standard 28 (RY 2013).

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

> **Substandard 1:** Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
> **Substandard 2:** The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.

Coordination and Continuity of Care

Philadelphia County was partially compliant with Coordination and Continuity of Care due to partial compliance with Substandards 1 and 2 of PEPS Standard 28 (RY 2013).

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 12 of this report.

Coverage and Authorization of Services

Philadelphia County was partially compliant with Coverage and Authorization of Services due to partial compliance with substandards of PEPS Standards 28 (RY 2013) and 72 (RY 2014).

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 12 of this report.

PEPS Standard 72: Denials. Denials or reduction of services are provided, in writing, to the member, parent/custodian of a child/adolescent, and/or county child and youth agency for children in substitute care. The denial note includes: a) specific reason for denial, b) service approved at a lesser rate, c) service approved for a lesser amount than requested, d) service approved for shorter duration than requested, e) service approved using a different service or Item than requested and description of the alternate service, if given, f) date decision will take effect, g) name of contact person, h) notification that member may file a grievance and/or request a DHS Fair Hearing, and i) if currently receiving services, the right to continue to receive services during the grievance and/or DHS Fair Hearing process.

Philadelphia County was partially compliant on Substandard 2 of PEPS Standard 72 (RY 2014).

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

Practice Guidelines

Philadelphia County was partially compliant with Practice Guidelines due to partial compliance with a substandard of PEPS Standard 28 (RY 2013).

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 12 of this report.

Subpart F: Federal and State Grievance System Standards

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

The PEPS documents include an assessment of the HC BH Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 5** presents the findings by categories consistent with the regulations.

Table 5: Compliance with Federal and State Grievance System Standards

Subpart F: Categories	MCO Compliance Status	Comments
Statutory Basis and Definitions 438.400	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 11 substandards, compliant on 5 substandards, partially compliant on 2 substandards, and non-compliant on 4 substandards.
General Requirements 438.402	Partial	14 substandards were crosswalked to this category. Philadelphia County was evaluated on 14 substandards, compliant on 5 substandards, partially compliant on 3 substandards, and non-compliant on 6 substandards.
Notice of Action 438.404	Partial	13 substandards were crosswalked to this category. Philadelphia County was evaluated on 13 substandards, compliant on 12 substandards, and partially compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 11 substandards, compliant on 5 substandards, partially compliant on 2 substandards, and non-compliant on 4 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 11 substandards, compliant on 5 substandards, partially compliant on 2 substandards, and non-compliant on 4 substandards.
Expedited Appeals Process 38.410	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant on 4 substandards, and partially compliant on 2 substandards.
Information to Providers & Subcontractors 438.414	Partial	2 substandards were crosswalked to this category. Philadelphia County was evaluated on 2 substandards, compliant on 1 substandard and non-compliant on 1 substandard.
Recordkeeping and Recording Requirements 438.416	Compliant	Compliant as per the required quarterly reporting of complaint and grievances data.
Continuation of Benefits 438.420	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant on 2 substandards, and partially compliant on 2 substandards.
Effectuation of Reversed Resolutions 438.424	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant on 2 substandards, and partially compliant on 2 substandards.

Based on the Substandards reviewed, Philadelphia County was fully compliant on 1 of the 10 evaluated categories of Federal and State Grievance System Standards regulations, and partially compliant on the other 9 categories. The category Recordkeeping and Recording Requirements was compliant per quarterly reporting of complaints and grievances. In all, 80 PEPS Items were crosswalked to Federal and State Grievance System Standards, and Philadelphia

County was evaluated on 80 Items. Philadelphia County was fully compliant on 45 Items, partially compliant on 16 Items, and non-compliant on 19 Items. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Statutory Basis and Definitions

Philadelphia County was partially compliant with Statutory Basis and Definitions due to non-compliance or partial compliance with substandards of PEPS Standards 68, 71 and 72.

PEPS Standard 68: Complaints. Complaint (and BBA Fair Hearing) rights and procedures are made known to Independent Enrollment Assistance Program (IEAP), members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

Philadelphia County was non-compliant on Substandards 1, 3, 4 and 5 of Standard 68 (RY 2013).

> **Substandard 1:** Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how the compliant rights and procedures are made known to members, BH-MCO staff and the provider network. 1. BBA Fair Hearing 2. 1st level 3. 2nd level 4.External 5.Expedited.
> **Substandard 3:** Complaint decision letters must be written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
> **Substandard 4:** The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
> **Substandard 5:** Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.

PEPS Standard 71: Grievances and State Fair Hearings. Grievance and DHS Fair Hearing rights and procedures are made known to Enrollment Assistance Program (EAP), members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

Philadelphia County was partially compliant on Substandard 3 of Standard 71 (RY 2013).

> **Substandard 3:** Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.

PEPS Standard 72: See Standard description and determination of substandard compliance under Coverage and Authorization of Services on page 12 of this report.

General Requirements

Philadelphia County was partially compliant with General Requirements due to partial or non-compliance with substandards of PEPS Standards 60, 68, 71 and 72.

PEPS Standard 60: See Standard description and determination of substandard compliance under Enrollee Rights and Protections (Enrollee Rights) on page 10 of this report.

PEPS Standard 68: See Standard description and determination of substandard compliance under Statutory Basis and Definitions on page 14 of this report.

PEPS Standard 71: See Standard description and determination of substandard compliance under Statutory Basis and Definitions on page 14 of this report.

PEPS Standard 72: See Standard description and determination of substandard compliance under Coverage and Authorization of Services on page 12 of this report.

Notice of Action

Philadelphia County was partially compliant with Notice of Action due to partial compliance with Substandard 2 of PEPS Standard 72.

PEPS Standard 72: See Standard description and determination of substandard compliance under Coverage and Authorization of Services on page 12 of this report.

Handling of Grievances and Appeals

Philadelphia County was partially compliant with Handling of Grievances and Appeals due to partial compliance with substandards of PEPS Standards 68, 71 and 72.

PEPS Standard 68: See Standard description and determination of substandard compliance under Statutory Basis and Definitions on page 14 of this report.

PEPS Standard 71: See Standard description and determination of substandard compliance under Statutory Basis and Definitions on page 14 of this report.

PEPS Standard 72: See Standard description and determination of substandard compliance under Coverage and Authorization of Services on page 12 of this report.

Resolution and Notification: Grievances and Appeals

Philadelphia County was partially compliant with Resolution and Notification of Grievances and Appeals due to partial compliance with substandards of PEPS Standards 68, 71 and 72.

PEPS Standard 68: See Standard description and determination of substandard compliance under Statutory Basis and Definitions on page 14 of this report.

PEPS Standard 71: See Standard description and determination of substandard compliance under Statutory Basis and Definitions on page 14 of this report.

PEPS Standard 72: See Standard description and determination of substandard compliance under Coverage and Authorization of Services on page 12 of this report.

Expedited Appeals Process

Philadelphia County was partially compliant with Expedited Appeals process due to partial compliance with substandards of PEPS Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of substandard compliance under Statutory Basis and Definitions on page 14 of this report.

PEPS Standard 72: See Standard description and determination of substandard compliance under Coverage and Authorization of Services on page 12 of this report.

Information to Providers & Subcontractors

Philadelphia County was partially compliant with Information to Providers & Subcontractors due to non-compliance with Substandard 1 of PEPS Standard 68.

PEPS Standard 68: See Standard description and determination of substandard compliance under Statutory Basis and Definitions on page 14 of this report.

Continuation of Benefits

Philadelphia County was partially compliant with Continuation of Benefits due to partial compliance with substandards of PEPS Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of substandard compliance under Statutory Basis and Definitions on page 14 of this report.

PEPS Standard 72: See Standard description and determination of substandard compliance under Coverage and Authorization of Services on page 12 of this report.

Effectuation of Reversed Resolutions

Philadelphia County was partially compliant with Effectuation of Reversed Resolutions due to partial compliance with substandards of PEPS Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of substandard compliance under Statutory Basis and Definitions on page 14 of this report.

PEPS Standard 72: See Standard description and determination of substandard compliance under Coverage and Authorization of Services on page 12 of this report.

II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH-MCO. Under the existing HealthChoices Behavioral Health agreement with OMHSAS, HC BH Contractors along with the responsible subcontracted entities (i.e., BH-MCOs), are required to conduct a minimum of two focused studies per year. The HC BH Contractors and BH-MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or re-measurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, BH-MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2015 for 2014 activities.

A new EQR PIP cycle began for BH-MCOs and HC BH Contractors in 2014. For this PIP cycle, OMHSAS selected the topic, "Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis" as the topic for this PIP. The topic was selected because the Aggregate HealthChoices 30-day Readmission Rate has consistently not met the OMHSAS goal of a rate of 10% or less. In addition, all HealthChoices BH-MCOs continue to remain below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Follow-up After Hospitalization (FUH) metrics.

The Aim Statement for this PIP is "Successful transition from inpatient care to ambulatory care for Pennsylvania HealthChoices members hospitalized with a mental health or a substance abuse diagnosis." OMHSAS selected three common objectives for all BH-MCOs:

1. Reduce behavioral health and substance abuse readmissions post-inpatient discharge.
2. Increase kept ambulatory follow-up appointments post-inpatient discharge.
3. Improve medication adherence post-inpatient discharge.

Additionally, OMHSAS is requiring all BH-MCOs to submit the following core performance measures on an annual basis:

1. **Readmission Within 30 Days of Inpatient Psychiatric Discharge (Mental Health Discharges)**
   The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days without a substance abuse diagnosis during the initial stay.
2. **Readmission Within 30 Days of Inpatient Psychiatric Discharge (Substance Abuse Discharges)**
   The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days with a substance abuse diagnosis (primary or secondary) during the initial stay.
3. **Adherence to Antipsychotic Medications for Individuals with Schizophrenia**
   The percentage of members diagnosed with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. This measure is based on the HEDIS measure of the same name.
4. **Components of Discharge Management Planning**
   This measure is based on review of facility discharge management plans, and assesses the following:
   a. The percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses and provider phone numbers.
   b. The percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses and provider phone numbers where at least one of the scheduled appointments occurred.

This PIP project will extend from January 2014 through December 2017, with initial PIP proposals submitted in 2014 and a final report due in June 2018. The non-intervention baseline period was from January 2014 to December 2014. BH-MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. BH-MCOs will be required to submit interim reports in June 2016 and June 2017, as well as a final report in June 2018. BH-MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH Contractor-level and BH-MCO-level data, including clinical history and pharmacy data. This PIP is designed to be a

[1] The Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of the National Committee of Quality Assurance (NCQA).

collaboration between the HC BH Contractors and BH-MCOs. The BH-MCOs and each of their HC BH Contractors are required to collaboratively develop a root-cause/barrier analysis that identifies potential barriers at the BH-MCO level of analysis. Each of the barriers identified should include the contributing HC BH Contract level data and illustrate how HC BH Contractor knowledge of their high risk populations contributes to the barriers within their specific service areas. Each BH-MCO will submit the single root-cause/barrier analysis according to the PIP schedule.

This PIP was formally introduced to the BH-MCOs and HC BH Contractors during a Quality Management Directors meeting on June 4, 2014. During the latter half of 2014, OMHSAS and IPRO conducted follow-up calls with the BH-MCOs and HC BH Contractors as needed.

The 2015 EQR is the 12th review to include validation of PIPs. With this PIP cycle, all BH-MCOs/HC BH Contractors share the same baseline period and timeline. To initiate the PIP cycle in 2014, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given to the BH-MCOs/HC BH Contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness. As calendar year 2015 is the first intervention year, the BH-MCOs were expected to implement the interventions that were planned in 2014, monitor the effectiveness of their interventions, and to improve their interventions based on their monitoring results.

The BH-MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with the Centers for Medicare & Medicaid Services (CMS) protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

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

Validation Methodology

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (*Validating Performance Improvement Projects, Final Protocol, Version 1.0, May 1, 2002*) and meets the requirements of the final rule on the EQR of Medicaid MCOs issued on January 24, 2003. IPRO's review evaluates each project for compliance with the ten review elements listed below:

1. Project Topic and Topic Relevance
2. Study Question (Aim Statement)
3. Study Variables (Performance Indicators)
4. Identified Study Population
5. Sampling Methods
6. Data Collection Procedures
7. Improvement Strategies (Interventions)
8. Interpretation of Study Results (Demonstrable Improvement)
9. Validity of Reported Improvement
10. Sustainability of Documented Improvement

The first nine elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. As calendar year 2015 was an intervention year for all BH-MCOs, IPRO reviewed elements 1 through 9 for each BH-MCO.

Review Element Designation/Weighting

Calendar year 2015 was an intervention year; therefore, scoring cannot be completed for all elements. This section describes the scoring elements and methodology that will occur during the sustainability period.

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance.

Points are awarded for the two phases of the project noted above, and are combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance. **Table 6** presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 6: Review Element Scoring Designations and Definitions

Element Designation	Definition	Weight
Full	Met or exceeded the element requirements	100%
Partial	Met essential requirements, but is deficient in some areas	50%
Non-compliant	Has not met the essential requirements of the element	0%

Overall Project Performance Score

The total points earned for each review element are weighted to determine the BH-MCO's overall performance score for a PIP. The seven review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all seven demonstrable improvement elements is 80 points (80% x 100 points for Full Compliance; **Table 7**).

PIPs are also reviewed for the achievement of sustained improvement. This has a weight of 20%, for a possible maximum total of 20 points (**Table 7**). The BH-MCO must sustain improvement relative to the baseline after achieving demonstrable improvement. The evaluation of the sustained improvement area has two review elements.

Scoring Matrix

At the time each PIP element is reviewed, a finding is given of "Met," "Partially Met," or "Not Met." Elements receiving a "Met" will receive 100% of the points assigned to the element, "Partially Met" elements will receive 50% of the assigned points, and "Not Met" elements will receive 0%.

Table 7: Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Topic and Topic Relevance	5%
2	Study Question (Aim Statement)	5%
3	Study Variables (Performance Indicators)	15%
4/5	Identified Study Population and Sampling Methods	10%
6	Data Collection Procedures	10%
7	Improvement Strategies (Interventions)	15%
8/9	Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	20%
Total Demonstrable Improvement Score		80%
10	Sustainability of Documented Improvement	20%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

Findings

CBH submitted their PIP Final Proposal document in April 2015, and submitted their PIP Year 1 Update document for review in October 2015. As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. The initial proposal was reviewed by OMHSAS and IPRO and recommendations were provided to CBH. CBH was given the opportunity to schedule a technical assistance meeting to review their changes based on the initial review. CBH's assistance call occurred in August 2015.

CBH's proposal included objectives that align with the PIP objectives, however not all objectives fully met the criteria for reducing readmission for the entire SA and MH population. CBH included a rationale for conducting the PIP based on analysis of readmission data from their membership. As the initial proposal was submitted prior to the availability of

complete baseline year (2014) data, baseline rates were not included in the proposal. With the exception of the DMP measure, for which there is no available data at this point, the BH-MCO provided long term goals for each outcome indicator.

The BH-MCO provided a table with general descriptions of interventions and general barriers addressed. In their feedback, IPRO recommended that CBH provide more detail about specific processes and data sources relating to interventions. IPRO also recommended that each planned program or process measure within an identified intervention should be tied to the barrier that the program is designed to address.

III: Performance Measures

In 2015, OMHSAS and IPRO conducted three EQR studies. Both the Follow-up After Hospitalization for Mental Illness (FUH) and Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were re-measured in 2015. OMHSAS also elected to implement a statewide measure that focuses on substance abuse services, the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) HEDIS measure.

Follow-up After Hospitalization for Mental Illness

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

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

The last major change to the PA-specific follow-up measures was in MY 2006. Codes added to the measures as per suggestions from OMHSAS, the counties, and BH-MCOs changed the measures substantially, and rates for these indicators were no longer comparable to those from preceding MYs. Consequently, these indicators were renamed to QI A and QI B, respectively. As these indicators represented a significant deviation from HEDIS measure specifications, comparisons to HEDIS rates were not made. In addition, for MY 2006 the follow-up measure was collected for the newly implemented HealthChoices Northeast Counties, and these counties were asked to collect data for the six-month time frame that they were in service for 2006.

For MY 2007, all PA local codes previously mapped to standard CPT and HCPCS codes as per HIPAA requirements were retired and removed. Additionally, the measure was initiated for the 23 North/Central State Option Counties implemented in January 2007. As with the Northeast Counties for MY 2006, the North/Central County Option Counties were asked to collect data for the six-month time frame that they were in service for 2007.

For MY 2008 to MY 2012, and in MY 2014 there were only minor changes made to the specifications. The specifications were modified each year to align with the HEDIS measure.

In July 2013, after the BH-MCOs submitted their MY 2012 results, IPRO and OMHSAS conducted an encounter data validation of each BH-MCO. Part of this validation was a complete review of how each MCO produced and validated their performance measures. Based on these reviews, minor inconsistencies were found in how each BH-MCO produces their PM results. It was found that not all BH-MCOs include denied claims in their submission, and there are differences in how BH-MCOs identify transfers. Based on the results of these validations, the following changes were made to the specifications for subsequent years: If a member was known to have multiple member IDs in the MY, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure and that they must use the original procedure and revenue code submitted on the claim.

On January 1, 2013 a number of CPT codes for psychiatry and psychotherapy services were retired and replaced with new codes. The HEDIS follow-up measures for MY 2013 included retired codes in the follow-up specifications, but for MY 2014 the retired CPT codes were removed from all follow-up specifications.

Measure Selection and Description

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

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

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

Eligible Population

The entire eligible population was used for all 34 HC BH Contractors participating in the MY 2014 study.

Eligible cases were defined as those members in the HealthChoices program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a discharge date occurring between January 1 and December 1, 2014;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Six years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2014, 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, 2014. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2015 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 Seven Days after Discharge (Calculation based on Industry Standard codes used in HEDIS)

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

Quality Indicator 2 (QI 2): Follow-up After Hospitalization for Mental Illness Within 30 Days after Discharge (Calculation based on Industry Standard codes used in HEDIS)

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

PA-Specific Follow-up Indicators

Quality Indicator A (QI A): Follow-up After Hospitalization for Mental Illness within Seven 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 seven days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

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

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

Quality Indicator Significance

According to the *Global Burden of Disease: 2004 Update* released by the World Health Organization (WHO) in 2008, mental illnesses and mental disorders represent six of the 20 leading causes of disability worldwide. Among developed nations, depression is the leading cause of disability for people ages 0-59 years, followed by drug and alcohol use disorders and psychoses (e.g., bipolar disorder and schizophrenia; World Health Organization, 2008). Mental disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. Additionally, patients with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities (Dombrovski & Rosenstock, 2004; Moran, 2009) such as obesity, cardiovascular diseases and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns (Gill, 2005; Leslie & Rosenheck, 2004), reduced use of preventive services (Druss et al., 2002) and substandard medical care that they receive (Desai et al., 2002; Frayne et al., 2005; Druss et al., 2000). Moreover, these patients are five times more likely to become homeless than those without these disorders (Averyt et al., 1997). On the whole, serious mental illnesses account for more than 15 percent of overall disease burden in the U.S. (National Institute of Mental Health, 2009), and they incur a growing estimate of $317 billion in economic burden through direct (e.g., medication, clinic visits or hospitalization) and indirect (e.g., reduced productivity and income) channels (Insel, 2008). For these reasons, timely and appropriate treatment for mental illnesses is essential.

It has long been recognized that continuity of care is critical to positive outcome and to prevent long-term deterioration in people with severe and persistent mental illness (D'Mello et al., 1995). As noted in its 2007 *The State of Health Care Quality* report by the NCQA, appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses, and the likelihood of recurrence (NCQA, 2007). An outpatient visit within at least 30 days (ideally seven days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance and to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments (van Walraven et al., 2004). With the expansion of evidence-based practice in the recent decade, continuity has become a core principle in care delivery and in performance measurement for mental health services (Hermann, 2000). One way to improve continuity of care is to provide greater readiness of aftercare by shortening the time between discharge from the hospital and the first day of outpatient contact (Hermann, 2000).

However, the difficulty in engaging psychiatric patients after inpatient hospitalization has been a longstanding concern of behavioral health care systems, with some researchers having estimated that 40 to 60 percent of patients fail to connect with an outpatient clinician (Cuffel et al., 2002). Research has demonstrated that patients who do not have an outpatient appointment after discharge were two times more likely to be re-hospitalized in the same year than patients who kept at least one outpatient appointment (Nelson et al., 2000). Over the course of a year, patients who have kept appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow-up with outpatient care (Nelson et al., 2000). Patients who received follow-up care were also found to have experienced

better quality of life at endpoint, better community function, lower severity of symptoms, and greater service satisfaction (Adair et al., 2005). Patients with higher functioning in turn had significantly lower community costs, and improved provider continuity was associated with lower hospital (Mitton et al., 2005) and Medicaid costs (Chien et al., 2000).

There are various measures of treatment efficacy, such as service satisfaction, functional status and health outcomes. Among them, re-hospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment (Chien et al., 2000). Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care, and is an effective means to control the cost and maximize the quality of mental health services.

As noted, this measure and the issue of follow-up have been and remain of interest to OMHSAS, and results are reviewed for potential trends each year. While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Methodology

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

Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. The three-year OMHSAS goal is to achieve the 75th percentile for ages 6 to 64, based on the annual HEDIS published percentiles for 7-day and 30-day FUH by MY 2016. For MY 2013 through MY 2015, BH-MCOs will be given interim goals for the next MY for both the 7-day and 30-day follow-up rates based on their previous years' results.

The interim goals are defined as follows:

1. If a BH-MCO achieves a rate greater than or equal to the NCQA 75th percentile, the goal for the next MY is to maintain or improve the rate above the 75th percentile.
2. If a BH-MCO's rate is within 2% of the 75th percentile and above the 50th percentile, their goal for the next MY is to meet or exceed the 75th percentile.
3. If a BH-MCO's rate is more than 2% below the 75th percentile and above the 50th percentile, their goal for the next MY is to increase their current year's rate by 2%.
4. If a BH-MCO's rate is within 2% of the 50th percentile, their goal for the next MY is to increase their rate by 2%.
5. If a BH-MCO's rate is between 2% and 5% below the 50th percentile, their goal for the next MY is to increase their current year's rate by the difference between their current year's rate and the 50th percentile.
6. If a BH-MCO's rate is greater than 5% below the 50th percentile, their goal for the next MY is to increase their current year's rate by 5%.

Interim goals were provided to the BH-MCOs after the MY 2013 rates were received. The interim goals will be updated from MY 2013 to MY 2015. The interim goals are used the BH-MCOs progress in achieving the OMHSAS goal of the 75th percentile.

HEDIS percentiles for the 7-day and 30-day FUH indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis for these indicators. As noted in Section V of this report, beginning with MY 2012 performance, and continuing through MY 2014, rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request for a root cause analysis.

Data Analysis

The quality indicators were defined as rates, based on a numerator and a denominator. The denominator equaled the number of discharges eligible for the quality indicator, while the numerator was the total number of members for which the particular event occurred. The HealthChoices Aggregate for each indicator was the total numerator divided by the total denominator, which represented the rate derived from the total population of discharges that qualified for the indicator. The aggregate rate represented the rate derived from the total population of members that qualified for the indicator (i.e., the aggregate value). Year-to-year comparisons to MY 2013 data were provided where applicable. 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-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

HC BH Contractors with Small Denominators

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for all HC BH Contractors. Caution should be exercised when interpreting results for small denominators, as they produce rates that are less stable. Rates produced from small denominators may be subject to greater variability or greater margin of error. A denominator of 100 or greater is preferred for drawing conclusions from performance measure results.

Findings

BH-MCO and HC BH Contractor Results

The HEDIS follow-up indicators are presented for three age groups: ages 6 to 64, ages 6 and older, and ages 6 to 20. The results for the 6 to 64 years old age group are presented to compare the BH-MCOs and HC BH Contractor results to the OMHSAS interim and final goals for this age group. The 6+ years old results are presented to show the follow-up rates for the overall HEDIS population, and the 6-20 year old age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old only.

The results are presented at the BH-MCO and HC BH Contractor level when multiple HC BH Contractors are represented by a single BH-MCO. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (i.e., across HC BH Contractors with the same contracted BH-MCO). The HC BH Contractor-specific rates were calculated using the numerators and denominators for that particular HC BH Contractor. For each of these rates, the 95% Confidence Interval (CI) is reported. The HealthChoices BH-MCO Average and HC BH Contractors Average rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HealthChoices BH-MCO Average to determine if they were statistically significantly above or below that value. Whether or not a BH-MCO performed statistically significantly above or below the average was determined by whether or not that BH-MCO's 95% CI included the HealthChoices BH-MCO Average for the indicator. Statistically significant BH-MCO differences are noted.

HC BH Contractor-specific rates were compared to the HC BH Contractor Average to determine if they were statistically significantly above or below that value. Whether or not a HC BH Contractor performed statistically significantly above or below the average was determined by whether or not that HC BH Contractor 95% CI included the HC BH Contractor Average for the indicator. Statistically significant HC BH Contractor-specific differences are noted.

The HEDIS follow-up results for the 6 to 64 year old age group and the 6+ year old age groups are compared to the MY 2014 HEDIS national percentiles. NCQA produces annual HEDIS Follow-up After Mental Health benchmarks for the 6+ year age band only; therefore, results for the 6 to 64 year old age group are compared to percentiles for the 6+ year age bands. The percentile comparison for the 6 to 64 year old age group is presented to show BH-MCO and HC BH Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile by MY 2016. HEDIS percentile comparisons for the 6+ years old age group are presented for illustrative purposes only. The HEDIS follow-up results for the 6 to 20 year old age group are not compared to HEDIS benchmarks for the 6+ age band.

I: HEDIS Follow-up Indicators

(a) Age Group: 6–64 Years Old

As noted in the Performance Goal section, OMHSAS has elected to set a three-year goal for both the HEDIS 7-day and 30-day follow-up measures for members ages 6 to 64 years old. The goal is for all HC BH Contractor and BH-MCO rates to meet or exceed the HEDIS 75th percentile by MY 2015. For MYs 2013 through 2015, BH-MCOs will be given interim goals for the next MY for both the 7-day and 30-day follow-up rates based on their previous years' results. **Table 8** shows the MY 2014 results compared to their MY 2014 goals and HEDIS percentiles.

Table 8: MY 2014 HEDIS Follow-up Indicator Rates: 6–64 Years Old

	MY 2014							MY 2013	Rate Comparison			
Measure	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2014 Goal	2014 Goal Met?	%	PPD: MY 13 to MY 14	% Change: MY 13 to MY 14[1]	SSD: MY 13 to MY 14	HEDIS MY 2015 Medicaid Percentiles
QI 1 – HEDIS 7-Day Follow-up for Ages 6–64 Years Old												
HealthChoices Aggregate	16,736	35,193	**47.6%**	47.0%	48.1%	48.9%	NO	47.9%	-0.4	-0.80%	NO	Above 50th Percentile, Below 75th Percentile
CBH	3,190	6,917	**46.1%**	44.9%	47.3%	48.7%	NO	47.7%	-1.6	-3.33%	NO	Below 50th Percentile, Above 25th Percentile
Philadelphia	3,190	6,917	**46.1%**	44.9%	47.3%	48.7%	NO	47.7%	-1.6	-3.33%	NO	Below 50th Percentile, Above 25th Percentile
QI 2 – HEDIS 30-Day Follow-up for Ages 6–64 Years Old												
HealthChoices Aggregate	23,882	35,193	**67.9%**	67.4%	68.3%	69.8%	NO	68.4%	-0.6	-0.85%	NO	Above 50th Percentile, Below 75th Percentile
CBH	4,331	6,917	**62.6%**	61.5%	63.8%	64.8%	NO	63.5%	-0.9	-1.40%	NO	Below 50th Percentile, Above 25th Percentile
Philadelphia	4,331	6,917	**62.6%**	61.5%	63.8%	64.8%	NO	63.5%	-0.9	-1.40%	NO	Below 50th Percentile, Above 25th Percentile

[1] Percentage change is the percentage increase or decrease of the MY 2014 rate when compared to the MY 2013 rate. The formula is: (MY 2014 rate – MY 2013 rate)/MY 2013 rate.
N: numerator; D: denominator: PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval.

The MY 2014 HealthChoices Aggregate HEDIS follow-up rates in the 6 to 64 year age group were 47.6% for QI 1 and 67.9% for QI 2 (**Table 8**). These rates were comparable to (i.e. not statistically significantly different from) the HealthChoices Aggregate rates for this age group in MY 2013, which were 47.9% and 68.4% respectively. The HealthChoices Aggregate rates were below the MY 2014 interim goals of 48.9% for QI 1 and 69.8% for QI 2; therefore, both interim goals were not met in MY 2014. Both HealthChoices Aggregate rates were between the NCQA 50th and 75th percentile; therefore, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2014 for either rate.

For MY 2014, CBH was subcontracted to provide behavioral health services to only one county located in the Southeast region of the commonwealth, Philadelphia County; therefore, the CBH performance comprises the BH-MCO performance for Philadelphia County alone.

The MY 2014 CBH HEDIS follow-up rates for members ages 6 to 64 were 46.1% for QI 1 and 62.6% for QI 2 (**Table 8**); both rates were higher than CBH's corresponding MY 2013 rates of 47.7% for QI 1 and 63.5% for QI 2; however, the year-to-year differences were not statistically significant for either rate. The CBH QI 1 rate for the 6 to 64 year old population was statistically significantly lower than the QI 1 HealthChoices BH-MCO Average of 47.4% by 1.3 percentage points, and the QI 2 rate was statistically significantly lower than the QI 2 HealthChoices BH-MCO Average of 68.0% by 5.4 percentage points. Both interim follow-up goals for CBH were not met in MY 2014, as CBH's rates were below its

target goals of 48.7% for QI 1 and 64.8% for QI 2. Both HEDIS rates were between the HEDIS 2015 25th and 50th percentiles; therefore, the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by CBH or Philadelphia County in MY 2014 for either rate.

Figure 1 is a graphical representation of MY 2014 HEDIS follow-up rates in the 6 to 64 year old population for Philadelphia County. **Figure 2** shows that the QI 1 rate for Philadelphia County was statistically significantly below the MY 2014 QI 1 HC BH Contractor Average of 47.6% by 1.5 percentage points. The QI 2 rate for Philadelphia was statistically significantly lower than the QI 2 HC BH Contractor Average of 69.8% by 7.1 percentage points.

Figure 1: MY 2014 HEDIS Follow-up Indicator Rates: 6-64 Years Old

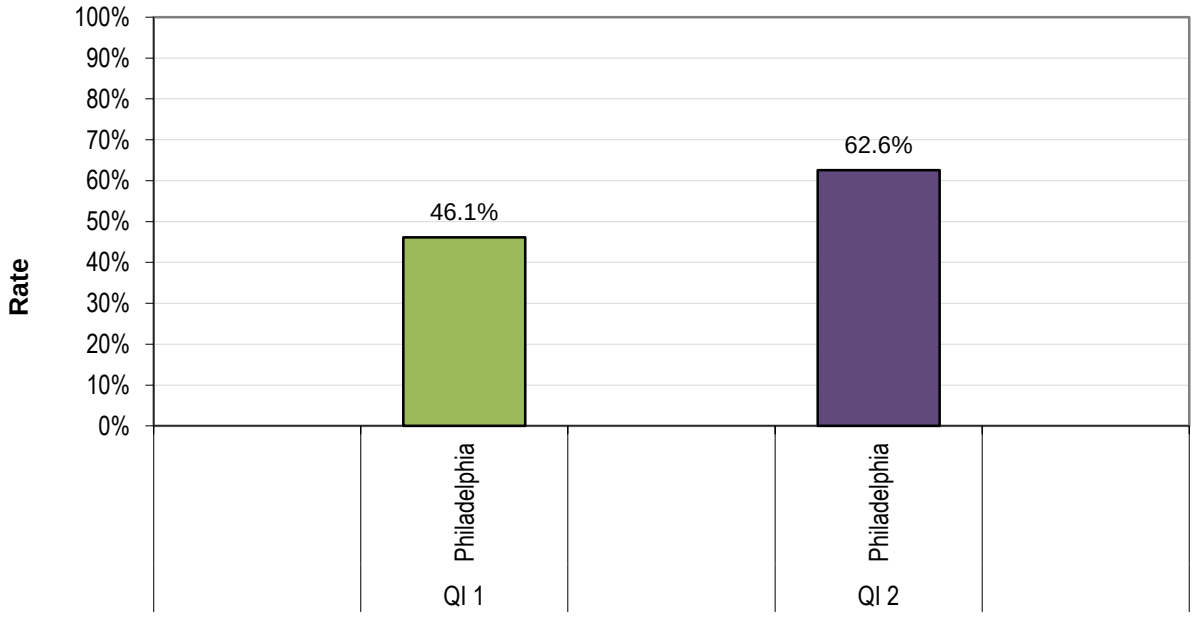
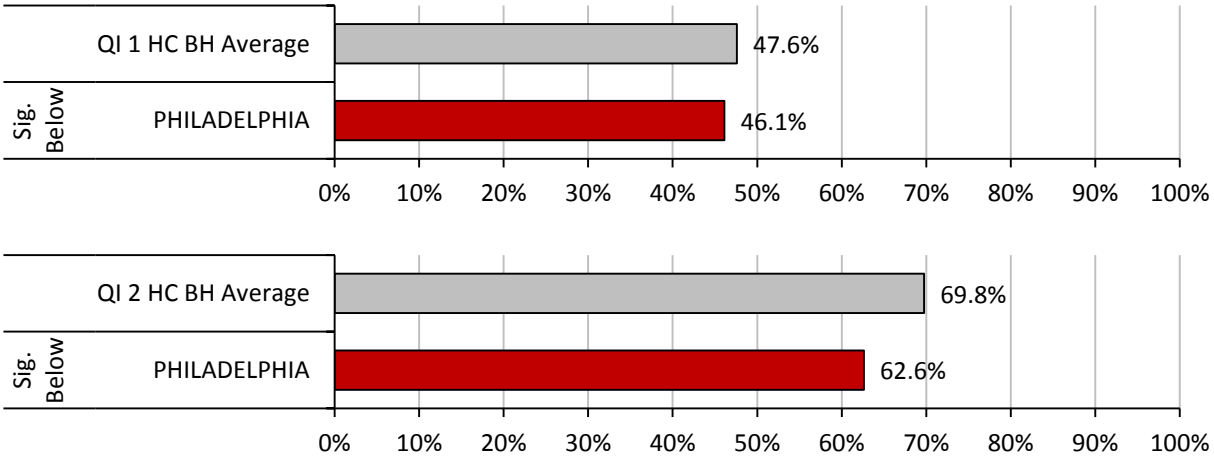


Figure 2: HEDIS Follow-up Rates Compared to MY 2014 HealthChoices HC BH Contractor Average: 6-64 Years Old



(b) Overall Population: 6+ Years Old

Table 9: MY 2014 HEDIS Follow-up Indicator Rates – Overall Population

Measure	MY 2014 (N)	MY 2014 (D)	MY 2014 %	MY 2014 Lower 95% CI	MY 2014 Upper 95% CI	MY 2014 BH-MCO Average	MY 2014 HC BH Contractor Average	MY 2013 %	Rate Comparison of MY 2014 against: MY 2013 PPD	MY 2013 SSD	HEDIS MY 2015 Percentile
QI 1 – HEDIS 7-Day Follow-up for Ages 6+ Years Old											
HealthChoices Aggregate	16,917	35,824	**47.2%**	46.7%	47.7%	47.1%	47.3%	47.7%	-0.4	NO	Above 50th Percentile, Below 75th Percentile
CBH	3,233	7,075	**45.7%**	44.5%	46.9%			47.4%	-1.7	NO	Below 50th Percentile, Above 25th Percentile
Philadelphia	3,233	7,075	**45.7%**	44.5%	46.9%			47.4%	-1.7	NO	Below 50th Percentile, Above 25th Percentile
QI 2– HEDIS 30-Day Follow-up for Ages 6+ Years Old											
HealthChoices Aggregate	24,152	35,824	**67.4%**	66.9%	67.9%	67.6%	69.3%	68.1%	-0.7	NO	Above 50th Percentile, Below 75th Percentile
CBH	4,385	7,075	**62.0%**	60.8%	63.1%			63.0%	-1.0	NO	Below 50th Percentile, Above 25th Percentile
Philadelphia	4,385	7,075	**62.0%**	60.8%	63.1%			63.0%	-1.0	NO	Below 50th Percentile, Above 25th Percentile

N: numerator; D: denominator: PPD; percentage point difference; SSD: statistically significant difference; CI: confidence interval.

The MY 2014 HealthChoices Aggregate HEDIS follow-up rates were 47.2% for QI 1 and 67.4% for QI 2 (**Table 9**). These rates were comparable to the MY 2013 HealthChoices Aggregate rates, which were 47.7% for QI 1 and 68.1% for QI 2. For CBH, the MY 2014 HEDIS rates were 45.7% for QI 1 and 62.0% for QI 2; both rates were lower than CBH's corresponding MY 2013 rates of 47.4% for QI 1 and 63.0% for QI 2. However, the year-to-year differences were not statistically significant. The CBH QI 1 rate was statistically significantly lower than the QI 1 HealthChoices BH-MCO Average of 47.1% by 1.4 percentage points, while the QI 2 rate was statistically significantly higher than the QI 2 HealthChoices BH-MCO Average of 67.6% by 5.6 percentage points. CBH had the lowest QI 2 rate of the five BH-MCOs evaluated in MY 2014.

Figure 3 is a graphical representation of the MY 2014 HEDIS follow-up rates for Philadelphia. **Figure 4** shows that the QI 1 rate for Philadelphia was statistically significantly below the MY 2014 QI 1 HC BH Contractor Average of 47.3% by 1.6 percentage points. The QI 2 rate for Philadelphia was statistically significantly lower than the QI 2 HC BH Contractor Average of 69.3% by 7.3 percentage points.

Figure 3: MY 2014 HEDIS Follow-up Indicator Rates – Overall Population

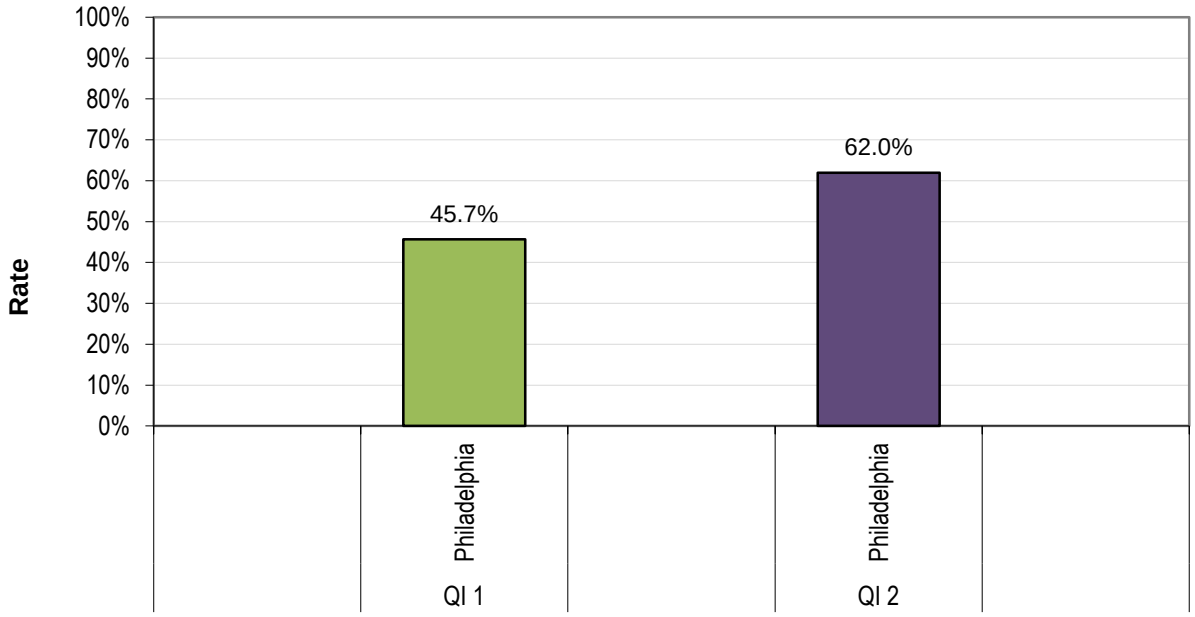
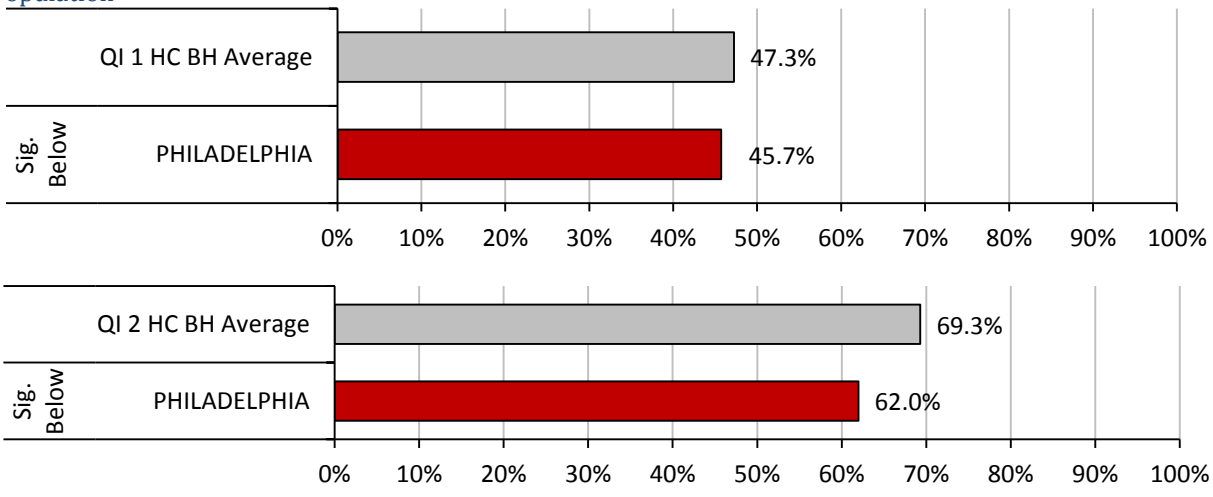


Figure 4: HEDIS Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average – Overall Population



(c) Age Group: 6–20 Years Old

Table 10: MY 2014 HEDIS Follow-up Indicator Rates: 6-20 Years Old

Measure	MY 2014 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2013 %	Rate Comparison: MY 14 vs. MY 13 PPD	SSD
QI 1 – HEDIS 7-Day Follow-up for Ages 6–20 Years Old										
HealthChoices Aggregate	5,672	10,031	**56.5%**	55.6%	57.5%	56.4%	56.5%	56.9%	-0.3	NO
CBH	898	1,568	**57.3%**	54.8%	59.8%			55.3%	2.0	NO
Philadelphia	898	1,568	**57.3%**	54.8%	59.8%			55.3%	2.0	NO
QI 2 – HEDIS 30-Day Follow-up for Ages 6-20 Years Old										
HealthChoices Aggregate	7,720	10,031	**77.0%**	76.1%	77.8%	76.6%	78.3%	77.4%	-0.4	NO
CBH	1,158	1,568	**73.9%**	71.6%	76.1%			73.1%	0.8	NO
Philadelphia	1,158	1,568	**73.9%**	71.6%	76.1%			73.1%	0.8	NO

N: numerator; D: denominator; PPD: Percentage point difference; SSD: statistically significant difference; CI: confidence interval.

The MY 2014 HealthChoices Aggregate HEDIS follow-up rates in the 6 to 20 year age group were 56.5% for QI 1 and 77.0% for QI 2 (**Table 10**). These rates were comparable to the MY 2013 HealthChoices Aggregate rates for the 6 to 20 year age cohort, which were 56.9% and 77.4% respectively. The CBH MY 2014 HEDIS follow-up rates for members ages 6 to 20 were 57.3% for QI 1 and 73.9% for QI 2; both rates were higher than CBH's corresponding MY 2013 rates of 55.3% for QI 1 and 73.1% for QI 2; however, the year-to-year rate differences were not statistically significant for either rate. The CBH MY 2014 QI 1 rate for the 6 to 20 year old population was not statistically different from the QI 1 HealthChoices BH-MCO Average of 56.4%, while the QI 2 rate was statistically significantly lower than the QI 2 HealthChoices BH-MCO Average of 76.6% by 2.8 percentage points.

Figure 5 is a graphical representation of the MY 2014 HEDIS follow-up rates in the 6 to 20 year old population for CBH Philadelphia. **Figure 6** shows that the QI 2 rate for Philadelphia was statistically significantly lower than the MY 2014 QI 2 HC BH Contractor Average of 78.3% by 4.5 percentage points.

Figure 5: MY 2014 HEDIS Follow-up Indicator Rates: 6-20 Years Old

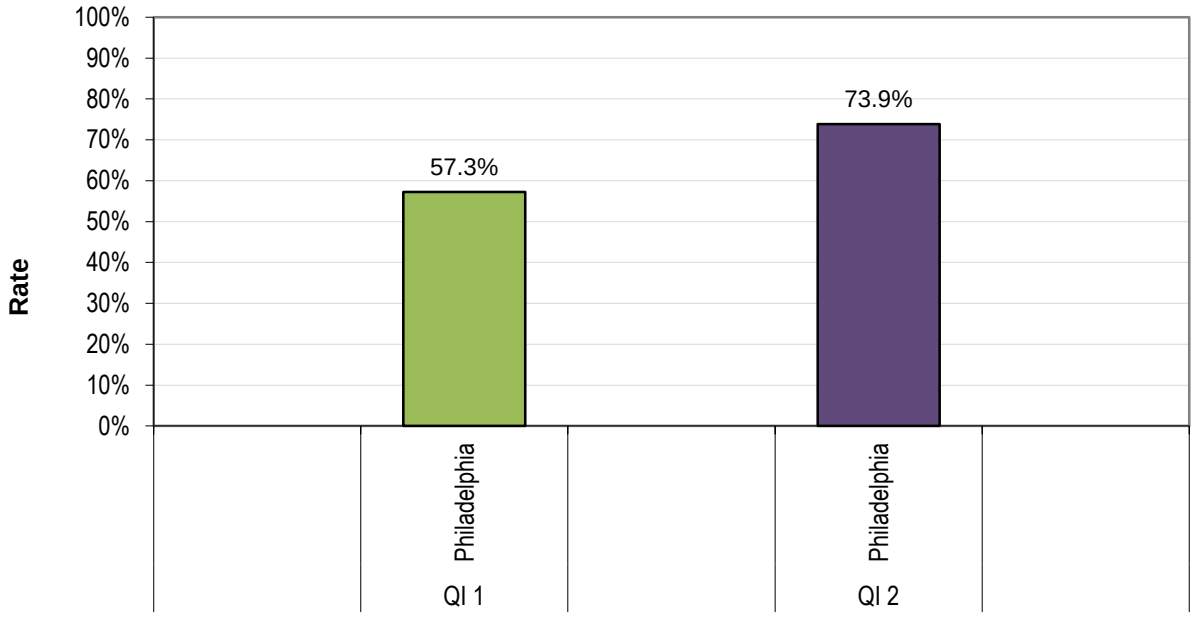
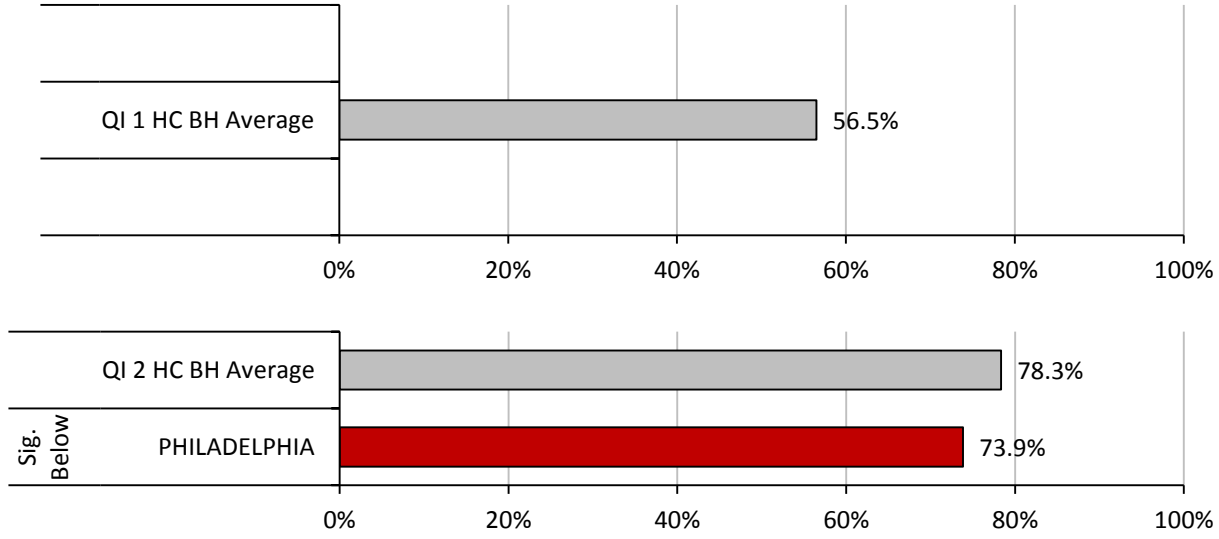


Figure 6: HEDIS Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average: 6-20 Years Old



II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

Table 11: MY 2014 PA-Specific Follow-up Indicator Rates with Year-to-Year Comparisons – Overall Population

Measure	MY 2014 (N)	MY 2014 (D)	MY 2014 %	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2013 %	Rate Comparison of MY 14 vs. MY 13 PPD	Rate Comparison of MY 14 vs. MY 13 SSD
QI A – PA-Specific 7-Day Follow-up for Ages 6+										
HealthChoices Aggregate	20,971	35,824	**58.5%**	58.0%	59.1%	58.2%	57.7%	57.6%	1.0	YES
CBH	4,028	7,075	**56.9%**	55.8%	58.1%			50.3%	6.7	YES
Philadelphia	4,028	7,075	**56.9%**	55.8%	58.1%			50.3%	6.7	YES
QI B – PA-Specific 30-Day Follow-up for Ages 6+										
HealthChoices Aggregate	26,814	35,824	**74.8%**	74.4%	75.3%	74.8%	75.5%	73.9%	1.0	YES
CBH	5,076	7,075	**71.7%**	70.7%	72.8%			63.9%	7.8	YES
Philadelphia	5,076	7,075	**71.7%**	70.7%	72.8%			63.9%	7.8	YES

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval.

The MY 2014 HealthChoices Aggregate PA-specific follow-up rates were 58.5% for QI A and 74.8% for QI B (**Table 11**). Both of the PA-specific follow-up rates were statistically significantly higher than the MY 2013 HealthChoices Aggregate rates of 57.6% and 73.9% by 1.0 percentage point. The CBH MY 2014 PA-specific follow-up rates were 56.9% for QI A and 71.7% for QI B; both rates were statistically significantly higher than CBH's corresponding MY 2013 rates of 50.3% for QI A (6.7 percentage point difference) and 63.9% for QI B (7.8 percentage point difference). The QI A rate for CBH was statistically significantly lower than the QI A HealthChoices BH-MCO Average of 58.2% by 1.2 percentage points, and the QI B rate for CBH was statistically significantly lower than the QI B HealthChoices BH-MCO Average of 74.8% by 3.1 percentage points. CBH had the lowest QI B rate of the five BH-MCOs evaluated in MY 2014.

Figure 7 is a graphical representation of the MY 2014 PA-specific follow-up rates for Philadelphia. **Figure 8** shows that the QI B rate for Philadelphia was statistically significantly below the MY 2014 QI B HC BH Contractor Average of 75.5% by 3.8 percentage points.

Figure 7: MY 2014 PA-Specific Follow-up Indicator Rates – Overall Population

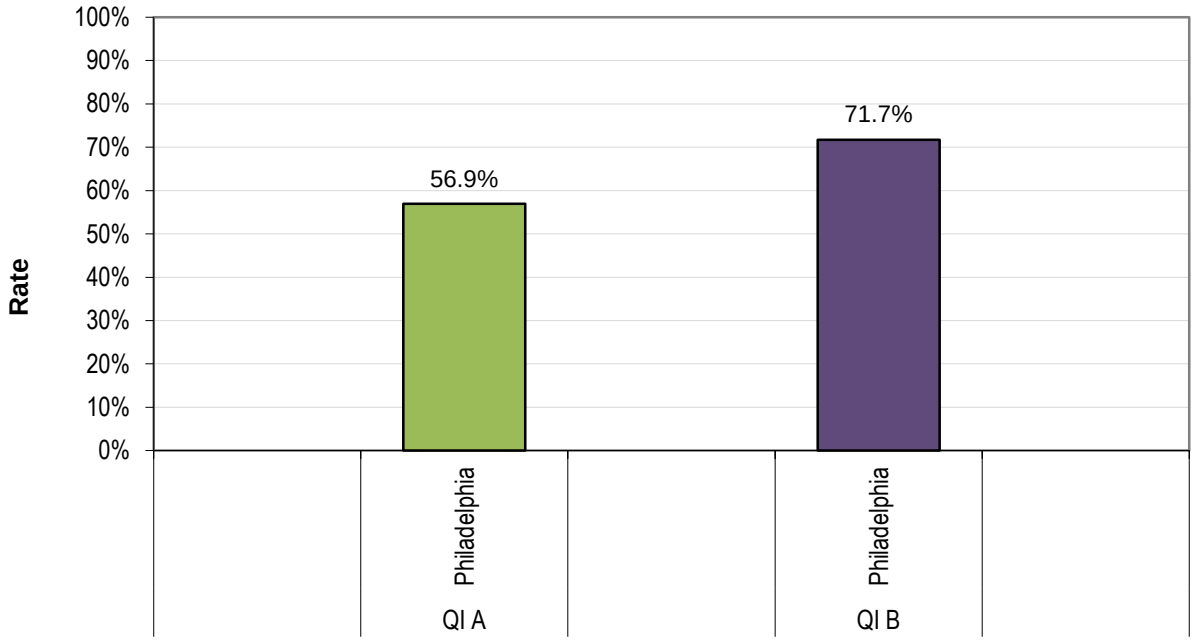
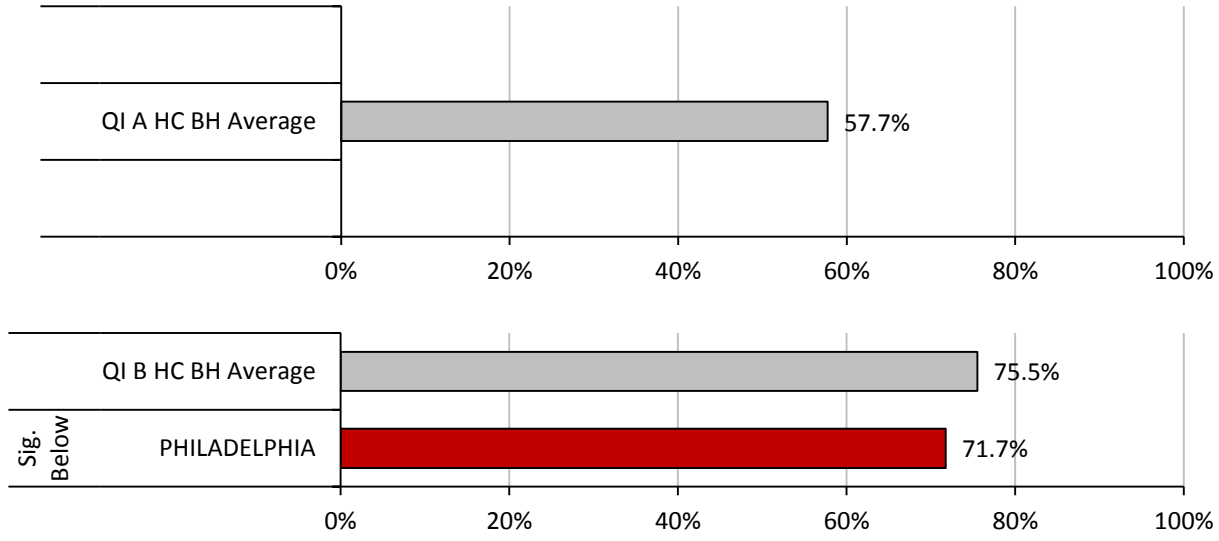


Figure 8: PA-Specific Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average – Overall Population



Conclusion and Recommendations

The study concluded that efforts should continue to be made to improve performance with regard to Follow-up After Hospitalization for Mental Illness particularly for those BH-MCOs that performed below the HealthChoices BH-MCO Average.

In response to the 2015 study, which included results for MY 2013 and MY 2014, the following general recommendations were made to all five participating BH-MCOs:

- Despite a number of years of data collection and interventions, FUH rates have not increased meaningfully, and FUH for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted, the recommendations may assist in future discussions.
- The purpose of this re-measurement study is to inform OMHSAS, the HC BH Contractors and the BH-MCOs of the effectiveness of the interventions implemented during 2012, 2013 and 2014 to promote continuous quality improvement with regard to follow-up care after psychiatric hospitalization. The information contained within this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. Although the current cycle of performance improvement projects were in their baseline period for the PIP implemented at the beginning of MY 2015, BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in next few years as a result of the newly implemented interventions. To that end, the HC BH Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving behavioral health follow-up. The HC BH Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across MYs, and applicable to all groups. The findings of this re-measurement indicate that, despite some improvement over the last five MYs, significant rate disparities persist between racial and ethnic groups. It is important for BH-MCOs and HC BH Contractors to analyze performance rates by racial and ethnic categories and to target the demographic populations that do not perform as well as their counterparts. It is recommended that BH-MCOs and HC BH Contractors continue to focus interventions on populations that exhibit lower follow-up rates (e.g., black/African American population). Further, it is important to examine regional trends in disparities. For instance, the results of this study indicate that African Americans in rural areas have disproportionately low follow-up rates, in contrast to the finding that overall follow-up rates are higher in rural areas than in urban areas. Possible reasons for racial-ethnic disparities include access, cultural competency and community factors; these and other drivers should be evaluated to determine their potential impact on performance.
- BH-MCOs and HC BH Contractors are encouraged to review the findings of the follow-up study in conjunction with inpatient psychiatric readmission rates. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either had or did not have evidence of ambulatory follow-up/aftercare visit(s) during the interim period.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-up After Hospitalization for Mental Illness, OMHSAS elected to retain and re-measure the Readmission Within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Re-measurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2014 study conducted in 2015 was the eighth re-measurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the 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 a same day readmission from a transfer to another acute facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH Contractor level for MY 2013.

This measure continued to be of interest to OMHSAS for the purposes of comparing HC BH Contractor, and BH-MCO rates to the OMHSAS performance goal and to prior rates.

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

This performance measure assessed the percentage of discharges for enrollees from inpatient acute psychiatric care that were subsequently 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 34 HC BH Contractors participating in the MY 2014 study.

Eligible cases were defined as those members in the HealthChoices Behavioral Health Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2014;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim must be clearly identified as a discharge.

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

Methodology

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

Performance Goals

OMHSAS designated the performance measure goal as better than (i.e. less than) or equal to 10.0% for the participating BH-MCOs and counties. **This measure is an inverted rate, in that lower rates are preferable.**

Findings

BH-MCO and HC BH Contractor Results

The results are presented at the BH-MCO and then HC BH Contractor level. Year-to-year comparisons of MY 2014 to MY 2013 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-ratio. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

Individual rates are also compared to the categorical average. Rates statistically significantly above and/or below the average are indicated. Whether or not an individual rate performed statistically significantly above or below average was determined by whether or not that rate's 95% CI included the average for the indicator.

Lastly, aggregate rates are compared to the OMHSAS-designated performance measure goal of 10.0%. Individual BH-MCO and HC BH Contractor rates are *not* required to be statistically significantly below 10.0% in order to meet the performance measure goal.

Table 12: MY 2014 Readmission Rates with Year-to-Year Comparisons

Measure	MY 2014 (N)	(D)	%	LOWER 95% CI	UPPER 95% CI	BH-MCO Average	BH HC Contractor Average	2014 Goal Met?	MY 2013 %
Inpatient Readmission									
HealthChoices Aggregate	6,510	45,657	**14.3%**	13.9%	14.6%	14.3%	14.0%	NO	13.6%
CBH	1,205	9,230	**13.1%**	12.4%	13.8%				11.3%
Philadelphia	1,205	9,230	**13.1%**	12.4%	13.8%				11.3%

N: numerator; D: denominator; CI: confidence interval.

The MY 2014 HealthChoices Aggregate readmission rate was 14.3%, higher than the MY 2013 HealthChoices Aggregate rate of 13.6% by 0.6 percentage points although not statistically significant. The CBH/Philadelphia County MY 2014 rate of 13.1% was statistically significantly higher than the MY 2013 rate of 11.3% by 1.8 percentage points (**Table 12**). The CBH readmission rate was statistically significantly lower than the MY 2014 HealthChoices BH-MCO Average of 14.3% by 1.2 percentage points. Note that this measure is an inverted rate, in that lower rates indicate better performance. CBH and Philadelphia County did not meet the performance goal of a readmission rate below 10.0% in MY 2014.

Figure 9 is a graphical representation of the MY 2014 readmission rates for Philadelphia County relative to the performance goal of 10%. **Figure 10** compares the Philadelphia County readmission rate to the MY 2014 HC BH Contractor Average rate of 14.0%. The Philadelphia County rate of 13.1% was statistically significantly lower (better) than the HC BH Contractor Average by 0.9 percentage points.

Figure 9: MY 2014 Readmission Rates

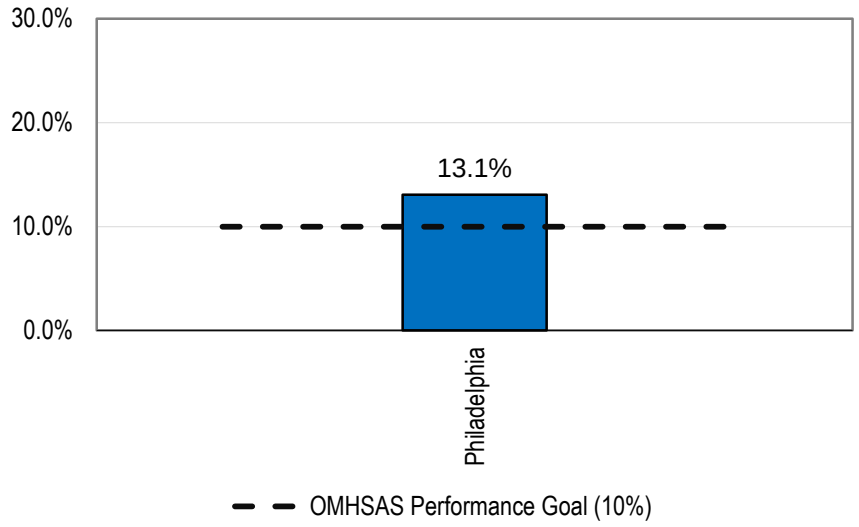
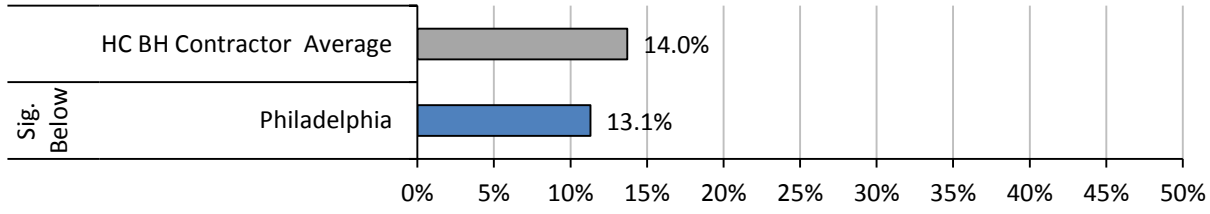


Figure 10: MY 2014 Readmission Rates Compared to HealthChoices HC BH Contractor Average



Conclusion and Recommendations

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

BH-MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the 2014 (MY 2013) Readmission Within 30 Days of Inpatient Psychiatric Discharge data tables.

Despite a number of years of data collection and interventions, readmission rates have continued to increase. Readmission for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the current performance improvement project cycle, the recommendations may assist in future discussions.

In response to the 2015 study, the following general recommendations are applicable to all five participating BH-MCOs:

Recommendation 1: The purpose of this re-measurement study is to inform OMHSAS, the HC BH Contractors and the BH-MCOs of the effectiveness of the interventions implemented during 2012, 2013 and 2014 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. Although the current cycle of performance improvement projects were in their baseline period during the MY 2014 review year, BH-MCOs are expected to demonstrate meaningful improvement in behavioral health readmission rates in the next few years as a result of the newly implemented interventions. To that end, the HC BH Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing behavioral health readmissions. The HC BH Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission.

Recommendation 2: It is essential to ensure that improvements are consistent, sustained across MYs, and applicable to all groups. The findings of this re-measurement indicate that there are significant rate disparities between rural and urban settings. It is important for BH-MCOs and HC BH Contractors to target the demographic populations that do not perform as well as their counterparties. It is recommended that the BH-MCOs and HC BH Contractors continue to focus interventions on populations that exhibit higher readmission rates (e.g. urban populations).

Recommendation 3: BH-MCOs and HC BH Contractors are encouraged to review the findings of the behavioral health readmission study in conjunction with follow-up after hospitalization rates. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either had or did not have evidence of ambulatory follow-up/aftercare visit(s) during the interim period.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

As part of the Center for Medicaid and Medicare Services' (CMS) Adult Quality Measure Grant Program, the Department of Health Services (DHS) was required to report the Initiation and Engagement of Alcohol and Other Drug Dependence (IET) measure. Although the grant ended in December 2014, DHS will continue reporting the IET measure as part of CMS' Adult Quality Core Measure set. This measure was reported initially by one county for MY 2012 and expanded to the HealthChoices population in MY 2013. Due to several implementation issues identified with BH-MCO access to all applicable data and at DHS' request, this measure was produced by IPRO. IPRO began development of this measure in 2014 for MY 2013, and continued to produce the measure in 2015 for MY 2014. The measure was produced using HEDIS specifications, using encounter data that was submitted to DHS by the BH-MCOs and the Physical Health MCOs. As directed by OMHSAS, IPRO produced rates for this measure for the HealthChoices population, by BH-MCO, and by BH HC Contractor.

This study examined substance abuse services provided to members participating in the HealthChoices Behavioral Health and Physical Health Programs. For the indicator, the criteria specified to identify the eligible population were

product line, age, enrollment, anchor date, and event/diagnosis. Date of service and diagnosis/procedure codes were used to identify the administrative numerator positives. The denominator and numerator criteria were identical to the HEDIS 2015 specifications. This performance measure assessed the percentage of members who had a qualifying encounter with a diagnosis of alcohol or other drug dependence (AOD) who had an initiation visit within 14 days of the initial encounter, and the percentage of members who also had 2 visits within 30 days after the initiation visit.

Quality Indicator Significance

Substance abuse is a major health issue in the United States. According to the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), 8.5 percent of adults had alcohol use disorder problem, 2 percent met the criteria for a drug use disorder, and 1.1 percent met the criteria for both (U.S. Department of Health & Human Services, 2008). Research shows that people who are dependent on alcohol are much more likely than the general population to use drugs, and vise versa. Patients with co-occurring alcohol and other drug use disorders are more likely to have psychiatric disorders, such as personality, mood, and anxiety disorders, and they are also more likely to attempt suicide and to suffer health problems (Arnaout & Petrakis, 2008).

With appropriate intervention for AOD dependence, the physical and behavioral health conditions of patients can be improved and the use of health care services, such as the emergency departments, will be decreased. In 2009 alone, there were nearly 4.6 million drug-related ED visits nationwide (National Institute on Drug Abuse, 2011). Improvement in the socioeconomic situation of patients and lower crime rates will follow if suitable treatments are implemented.

Eligible Population

The entire eligible population was used for all 34 BH HC Contractors participating in the MY 2014 study. Eligible cases were defined as those members in the HealthChoices Behavioral Health and Physical Health Programs who met the following criteria:

- Members who had an encounter with a primary or secondary AOD diagnosis between January 1 and November 15, 2014;
- Continuously enrolled in both HealthChoices Behavioral Health and Physical Health from 60 days prior to the AOD diagnosis to 44 days after the AOD diagnosis with no gaps in enrollment;
- No encounters with an AOD diagnosis in the 60 days prior to the initial encounter;
- If a member has multiple encounters that meet the criteria, only the first encounter is used in the measure.

This measure is reported for three age cohorts: ages 13 to 17 years old, ages 18+ years old, and ages 13+ years old.

Numerators

This measure has two numerators:

Numerator 1 – Initiation of AOD Treatment: Members who initiate treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization with an AOD diagnosis within 14 days of the diagnosis.

Numerator 2 – Engagement of AOD Treatment: Members who initiated treatment and who had two or more additional inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with a diagnosis of AOD within 30 days of the initiation visit. The engagement numerator was only evaluated for members who passed the initiation numerator.

Methodology

As this measure requires the use both Physical Health and Behavioral Health encounters, only members who were enrolled in both Behavioral Health and Physical Health HealthChoices where included in this measure. The source for all information was administrative data provided to IPRO by the BH-MCOs and PH MCOs. The source for all administrative data was the MCOs' transactional claims systems. As administrative data from multiple sources was needed to produce this measure, the measure was programmed and reported by IPRO. The results of the measure were presented to representatives of each BH-MCO, and the BH-MCOs were given an opportunity to respond to the results of the measure.

Limitations

As physical health encounters with an AOD diagnosis are used in this measure, a BH-MCO does not have complete information of all encounters used in this measure. This will limit the BH-MCOs ability to independently calculate their performance of this measure, and determine the effectiveness of interventions.

Performance Goals

As this is the first year this measure was reported for HealthChoices, no goals were set for MY 2014.

Findings

BH-MCO and HC BH Contractor Results

The results are presented at the BH-MCO and HC BH Contractor level when multiple HC BH Contractors are represented by a single BH-MCO. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (i.e., across HC BH Contractors with the same contracted BH-MCO). The HC BH Contractor's-specific rates were calculated using the numerator and denominator for that particular HC BH Contractors. For each of these rates, the 95% Confidence Interval (CI) was reported. Both the HealthChoices BH-MCO Average and HealthChoices HC BH Contractors Average rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HealthChoices BH-MCO Average to determine if they were statistically significantly above or below that value. Whether or not a BH-MCO performed statistically significantly above or below the average was determined by whether or not that BH-MCO's 95% CI included the HealthChoices BH-MCO Average for the indicator. Statistically significant BH-MCO differences are noted.

HC BH Contractor-specific rates were compared to the HealthChoices HC BH Contractor Average to determine if they were statistically significantly above or below that value. Whether or not a HC BH Contractor performed statistically significantly above or below the average was determined by whether or not that HC BH Contractor 95% CI included the HealthChoices HC BH Contractor Average for the indicator. Statistically significant HC BH Contractor-specific differences are noted.

The performance measure results for the three age cohorts (13 to 17 years old, ages 18+, and ages 13+) are compared to HEDIS national percentiles. NCQA produces annual HEDIS IET benchmarks for these three age bands; therefore, results for each age group are compared to national percentiles for the corresponding age bands.

(a) Age Group: 13–17 Years Old

Table 13: MY 2014 IET rates with Year-to-Year Comparisons

Measure	MY 2014							MY 2013			Rate Comparison MY 2013 to HEDIS Benchmarks
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH MCO Average	BH HC Contractor Average	%	PPD	SSD	
Age Cohort: 13–17 Years – Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	1,134	3,063	**37.0%**	35.3%	38.7%	34.7%	33.3%	35.4%	1.6	NO	Below 50th, at or above 25th percentile
CBH	283	579	**48.9%**	44.7%	53.1%			50.4%	-1.5	NO	At or above 75th Percentile
Philadelphia	283	579	**48.9%**	44.7%	53.1%			50.4%	-1.5	NO	At or above 75th Percentile
Age Cohort: 13–17 Years – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	791	3,063	**25.8%**	24.2%	27.4%	23.5%	19.7%	24.9%	0.9	NO	At or above 75th Percentile
CBH	222	579	**38.3%**	34.3%	42.3%			39.0%	-0.7	NO	At or above 75th Percentile
Philadelphia	222	579	**38.3%**	34.3%	42.3%			39.0%	-0.7	NO	At or above 75th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval.

The MY 2014 HealthChoices Aggregate rates in the 13-17 year age group were 37.0% for initiation and 25.8% for engagement. These rates were comparable to the MY 2013 13-17 year old HealthChoices Aggregate rates of 35.4% and 24.9%, respectively (**Table 13**). The HealthChoices Aggregate rate for initiation was between the HEDIS percentiles for the 25th and 50h percentile, while the HealthChoices Aggregate rate for engagement was at or above the 75th percentile.

The CBH MY 2014 13-17 year old initiation rate of 48.9% did not change statistically significantly from the MY 2013 rate of 50.4%, a decrease of 1.5 percentage points (**Table 13**). The CBH MY 2014 13-17 year old engagement rate of 38.3% decreased slightly from the MY 2013 rate of 39.0% by 0.7 percentage points; however, this change was not statistically significant. The CBH MY 2014 13-17 year old initiation rate of 48.9% was statistically significantly higher than the initiation HealthChoices BH-MCO average of 34.7% by 14.2 percentage points. The engagement rate of 38.3% was statistically significantly higher than the engagement HealthChoices BH-MCO Average of 23.5% by 14.8 percentage points. The CBH initiation and engagement rates for this age group were at or above the HEDIS 2015 75th percentile.

Figure 11 shows the MY 2013 IET rates in the 13-17 year age cohort for CBH and Philadelphia. As depicted in **Figure 12**, both IET rates for Philadelphia were statistically significantly greater than the HC BH Contractor Average of 33.3% for Initiation and 19.7% for Engagement by 15.6 and 18.6 percentage points, respectively.

Figure 11: MY 2014 IET Rates: 13–17 Years Old

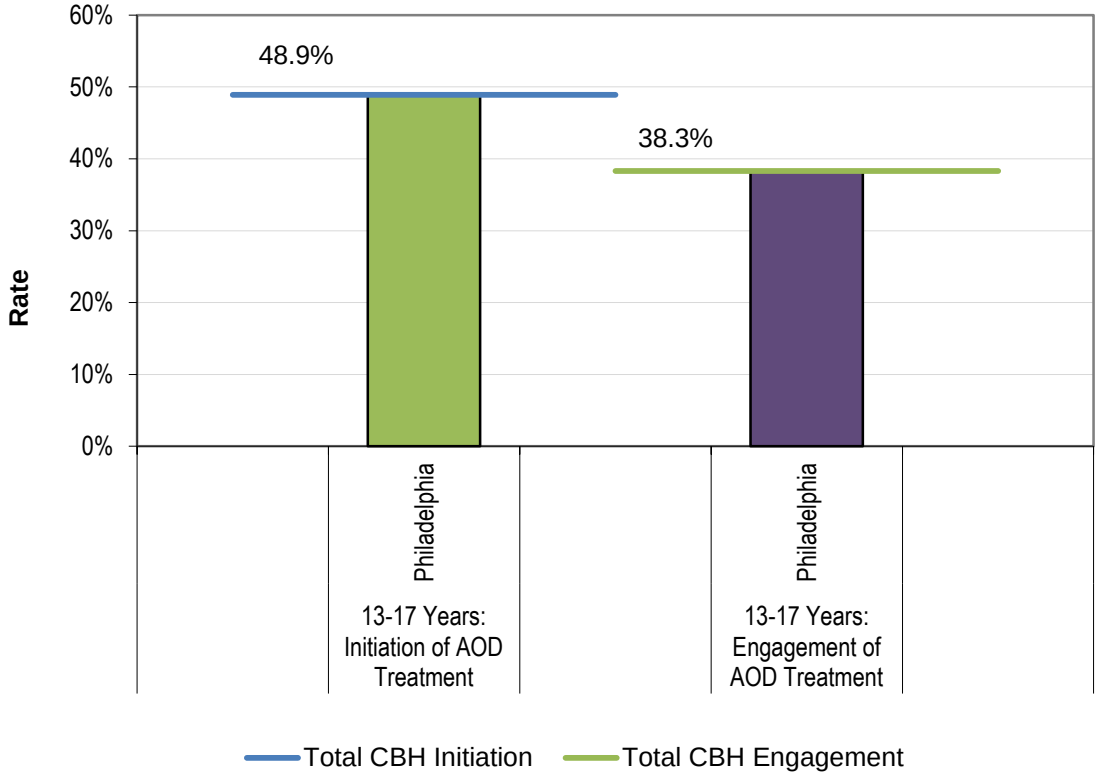
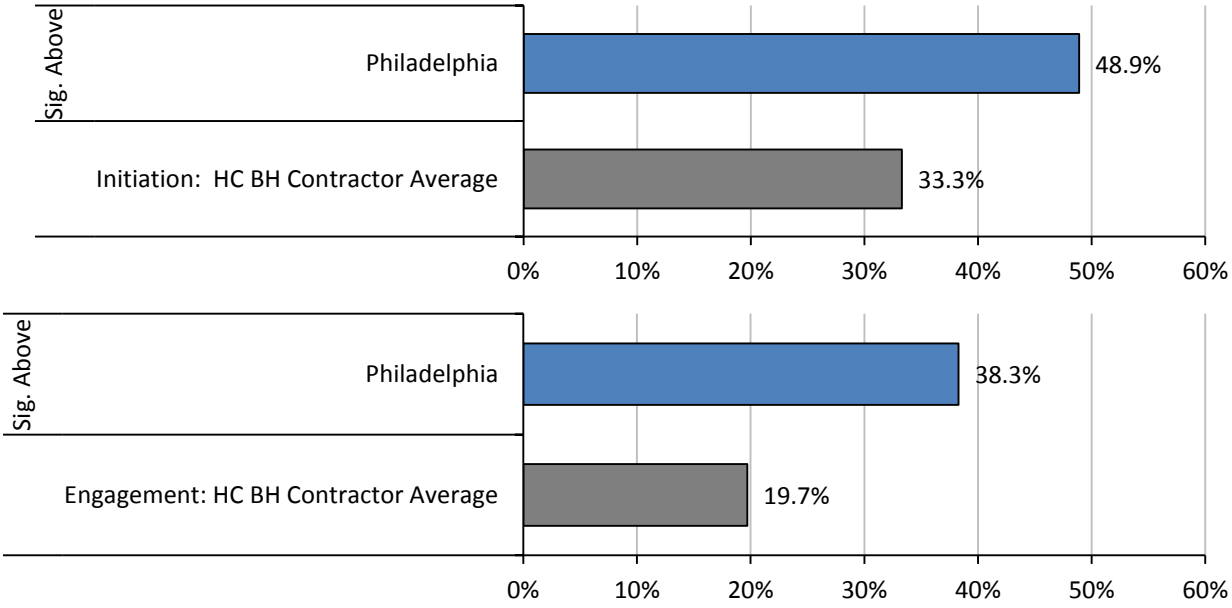


Figure 12: MY 2014 IET Rates Compared to HealthChoices County Average: 13–17 Years Old



(b) Age Group: 18+ Years Old

Table 14: MY 2014 IET Rates: 18+YearsWith Year-to-Year Comparisons

Measure	MY 2014 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	MY 2013 %	PPD	SSD	Rate Comparison MY 2013 to HEDIS Benchmarks
Age Cohort: 18+ Years –Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	11,616	39,023	**29.8%**	29.3%	30.3%	28.7%	28.3%	29.4%	0.4	NO	Below 25th Percentile
CBH	3,638	10,742	**33.9%**	33.0%	34.8%			32.8%	1.1	NO	Below 25th Percentile
Philadelphia	3,638	10,742	**33.9%**	33.0%	34.8%			32.8%	1.1	NO	Below 25th Percentile
Age Cohort: 18+ Years – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	7,842	39,023	**20.1%**	19.7%	20.5%	18.8%	18.0%	20.3%	-0.2	NO	At or above 75th Percentile
CBH	2,719	10,742	**25.3%**	24.5%	26.1%			25.0%	0.3	NO	At or above 75th Percentile
Philadelphia	2,719	10,742	**25.3%**	24.5%	26.1%			25.0%	0.3	NO	At or above 75th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval.

The MY 2013 HealthChoices aggregate initiation rate for the 18 and older age group was 29.8%, falling below the HEDIS 2015 Medicaid 25th percentile benchmark (**Table 14**). The MY 2014 HealthChoices aggregate engagement rate in this age cohort was at or above the HEDIS 75th percentile with a rate of 20.1%.

The CBH MY 2014 18+ year old initiation rate of 33.9% did not change statistically significantly from the MY 2013 rate of 32.8%, an increase of 1.1 percentage points (**Table 14**). The CBH MY 2014 18+ year old engagement rate of 25.3% increased slightly from the MY 2013 rate of 25.0% by 0.3 percentage points; however, this change was not statistically significant. The CBH MY 2014 18+ year old initiation rate of 33.9% was statistically significantly higher than the initiation HealthChoices BH-MCO average of 28.7% by 5.2 percentage points. The engagement rate of 25.3% was statistically significantly higher than the engagement HealthChoices BH-MCO Average of 18.8% by 6.5 percentage points. The CBH initiation rate for this age group was below the HEDIS 2015 25th percentile, while the engagement rate was at or above the 75th percentile.

Figure 13 shows the MY 2013 IET rates in the 18+ year age cohort for CBH and Philadelphia. As depicted in **Figure 14**, both IET rates for Philadelphia were statistically significantly greater than the HC BH Contractor Average of 28.3% for Initiation and 18.0% for Engagement by 5.6 and 7.3 percentage points, respectively.

Figure 13: MY 2014 IET Rates – 18+Years

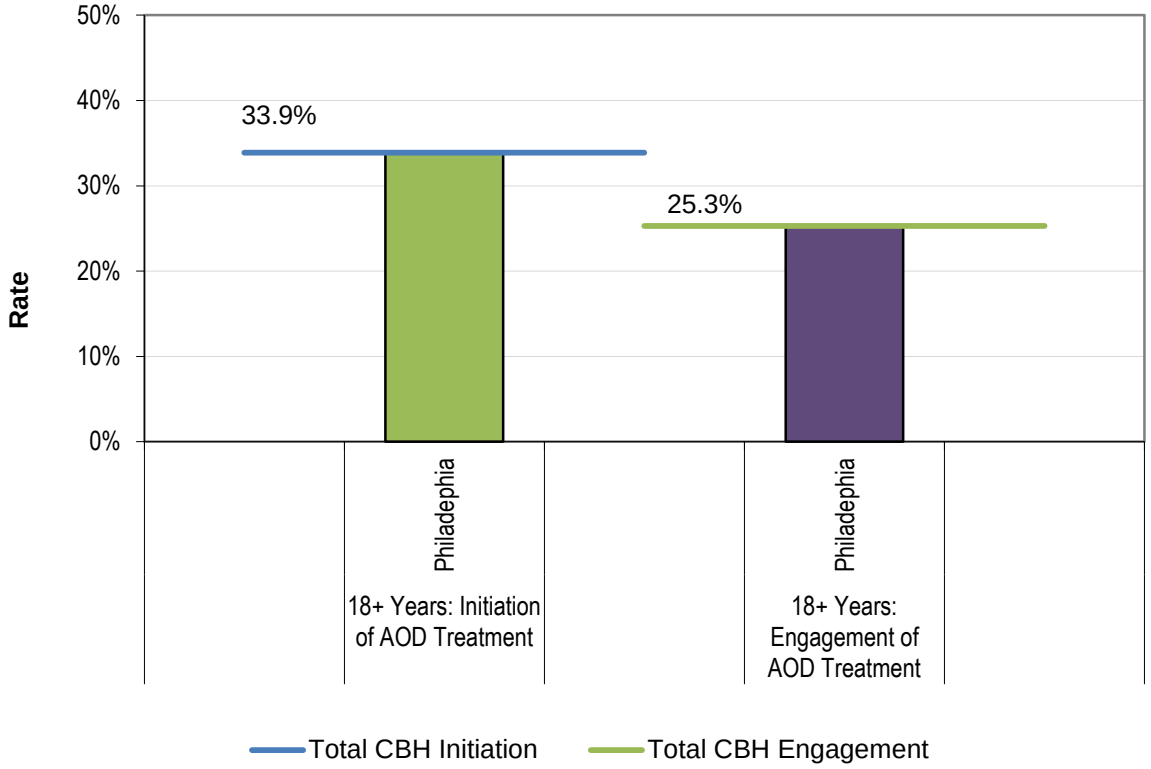
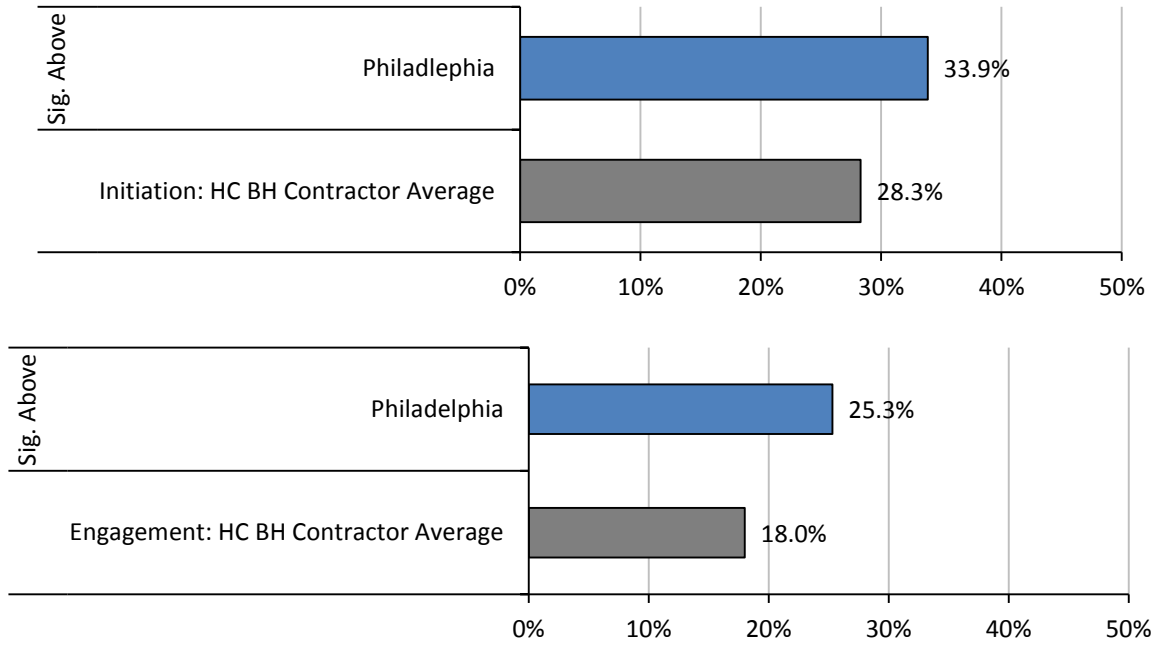


Figure 14: MY 2014 IET Rates Compared to HealthChoices HC BH Contractor Average – 18+ Years



(c) Age Group: 13+ Years Old

Table 15: MY 2014 IET Rates – 13+Years with Year-to-Year Comparisons

Measure	MY 2014 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	MY 2013 %	PPD	SD	Rate Comparison MY 2013 to HEDIS Benchmarks
Age Cohort: Total – Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	12,750	42,086	**30.3%**	29.9%	30.7%	29.1%	28.7%	29.9%	0.4	NO	Below 25th Percentile
CBH	3,921	11,321	**34.6%**	33.7%	35.5%			33.7%	0.9	NO	Below 50th, at or above 25th percentile
Philadelphia	3,921	11,321	**34.6%**	33.7%	35.5%			33.7%	0.9	NO	Below 25th Percentile
Age Cohort: Total – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	8,633	42,086	**20.5%**	20.1%	20.9%	19.1%	18.2%	20.6%	-0.1	NO	At or above 75th Percentile
CBH	2,941	11,321	**26.0%**	25.2%	26.8%			25.8%	0.2	NO	At or above 75th Percentile
Philadelphia	2,941	11,321	**26.0%**	25.2%	26.8%			25.8%	0.2	NO	At or above 75th Percentile

N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CI: confidence interval

The MY 2014 HealthChoices Aggregate Initiation rate for the total population was 30.3%, falling below the HEDIS 2015 Medicaid 25th percentile benchmark (**Table 15**). The MY 2014 HealthChoices Aggregate Engagement rate was at or above the HEDIS 75th percentile with a rate of 20.5%.

The total CBH MY 2014 initiation rate of 34.6% did not change statistically significantly from the MY 2013 rate of 33.7%, an increase of 0.9 percentage points (**Table 15**). The CBH MY 2014 engagement rate of 26.0% increased slightly from the MY 2013 rate of 25.8% by 0.2 percentage points; however, this change was not statistically significant. The CBH MY 2014 initiation rate of 34.6% was statistically significantly higher than the initiation HealthChoices BH-MCO average of 29.1% by 5.5 percentage points. The engagement rate of 26.0% was statistically significantly higher than the engagement HealthChoices BH-MCO Average of 19.1% by 6.9 percentage points. The CBH initiation rate for this age group was between the HEDIS 2015 25th percentile and 50th percentile, while the engagement rate was at or above the 75th percentile.

Figure 15 shows the MY 2013 IET rates in the 13+ year age cohort for CBH and Philadelphia. As depicted in **Figure 16**, both IET rates for Philadelphia were statistically significantly greater than the HC BH Contractor Average of 28.7% for Initiation and 18.2% for Engagement by 5.9 and 7.8 percentage points, respectively.

Figure 15: MY 2014 IET Rates: 13+Years

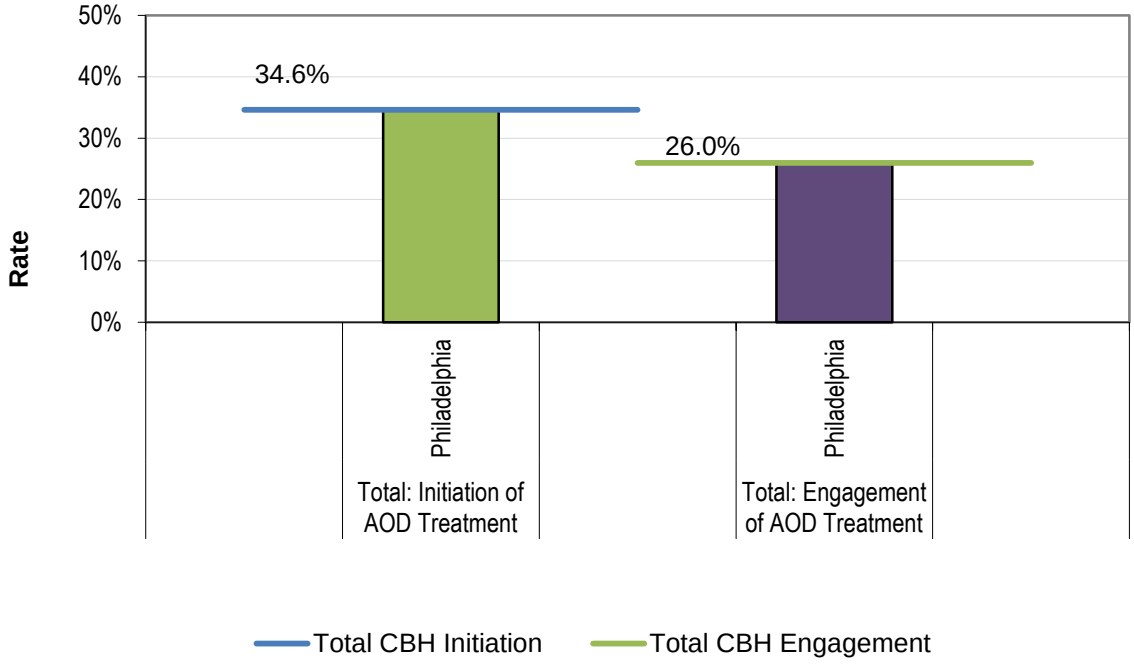
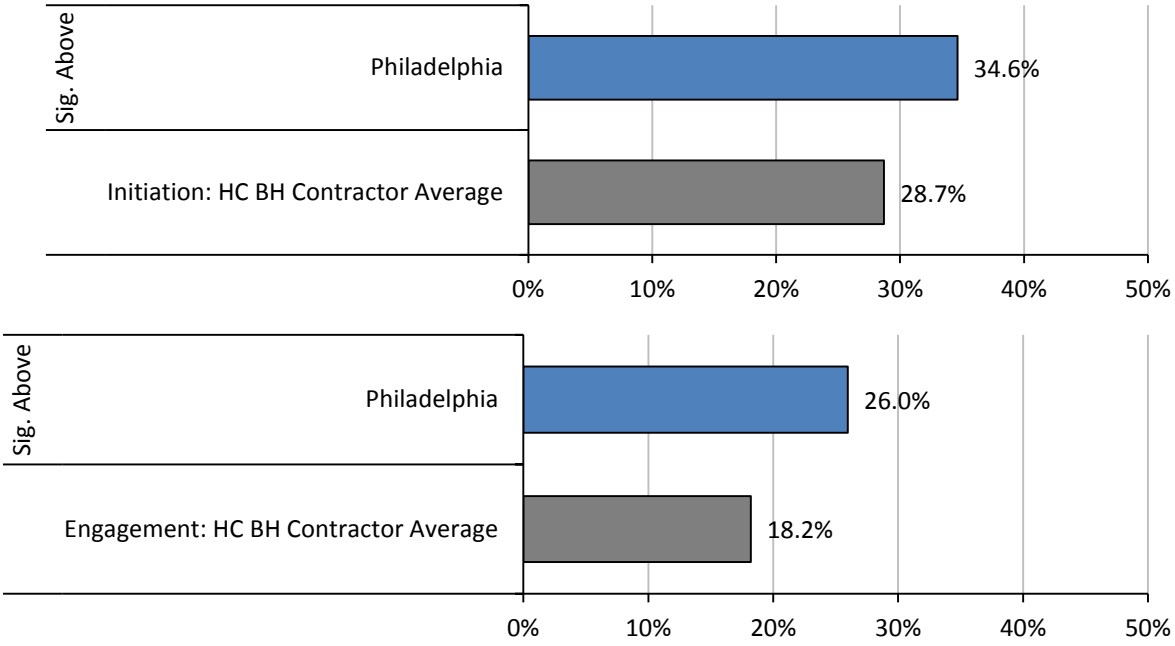


Figure 16: MY 2014 IET Rates Compared to HealthChoices HC BH Contractor Average: 13+ Years



Conclusion and Recommendations

For MY 2014, the aggregate HealthChoices rate for the Initiation numerator was 30.3%, and the Engagement rate was 20.5%. The Initiation rate was below the HEDIS 25th percentile while the Engagement rate was at or above the 75th percentile. There was no statistically significant difference for Initiation and Engagement from MY 2013. The following general recommendations are applicable to all five participating BH-MCOs:

- BH-MCOs should begin to implement programs to report this measure for their population on a regular basis. This will allow BH-MCOs to identify specific subpopulations with low performance for future interventions.
- BH-MCOs should identify high performing subpopulations to determine if any best practices exist for increasing the Initiation and Engagement rates.
- When developing reporting and analysis programs, BH-MCOs should focus on the Initiation rate, as four of the five BH-MCOs had a rate below the HEDIS 25th percentile for this numerator.

IV: Quality Study

The purpose of this section is to describe a quality study performed between 2014 and 2015 for the HealthChoices population. The study is included in this report as an optional EQR activity which occurred during the Review Year (42 CFR §438.358 (c)(5)).

Overview/Study Objective

DHS commissioned IPRO to conduct a study to identify risk factors for acute inpatient readmissions among members enrolled in the Pennsylvania Medicaid Behavioral Health HealthChoices program. The objective of this study was to combine physical health and behavioral health encounter data to identify risk factors across both domains of care. IPRO and DHS developed a claims based study to determine what demographic and clinical factors are correlated with increased readmission rates. The goal of this study was to provide data to guide targeted quality improvement interventions by identifying subpopulations with high readmission rates. Emphasis was placed on identifying factors across domains of care, i.e. physical health comorbidities that correlate with increased BH readmission rates and vice versa.

Data Collection and Analysis

This study was a claims based analysis of acute inpatient behavioral and physical health admissions between 12/2/2010 and 12/1/2011. The primary source of data was claims that were submitted to and accepted by the DHS PROMISe encounter system. One BH-MCO had significant data loss during the study period. For this BH-MCO, the Person Level Event (PLE) files that the BH-MCO submitted to OMHSAS for rate setting purposes were used in place of PROMISe data for this BH-MCO. Any claims not submitted to or not accepted by PROMISe are not included in this study. For the BH-MCO with data loss, any encounters not included in their PLE files are not included in this study. The analysis consisted of comparisons of 30-day readmission rates for various subpopulations. Subpopulations were distinguished by member demographics, diagnosis prior to and during the admission, and the number and type of encounters before and after the inpatient stay. Finally, regression analyses were done to identify what factors or combinations of factors correlate with a high readmission rate.

Results/Conclusions

There were a total of 17,245 behavioral health admissions and 64,222 physical health included in this study. The 30-day readmission rate for behavioral health admissions was 10.8%, and physical health readmissions had a readmission rate of 9.6%. The study was completed in September of 2015, and distributed to the BH-MCOs and HC BH Contractors in December 2015.

There were a number of demographic factors that were statistically significantly correlated with an increased readmission rate for behavioral health admissions. African Americans had a higher readmission rate than white members, and members in an urban county had a higher readmission rate than members in a rural county. Members with a history of mental health and/or substance abuse diagnosis within one year prior to their admission had significantly higher readmission rates than members without a history of these diagnoses. Alcohol-induced mental disorders, schizophrenic disorders and other nonorganic psychoses had the highest BH readmission rates (17.5%, 16.5% and 16.2%, respectively).

An analysis of physical health co-morbidities for behavioral health readmission showed that asthma, cardiovascular disease, developmental disability, diabetes and gastrointestinal disease co-morbidity are associated with significantly higher BH readmission rates. Members who had a follow-up visit with a behavioral health provider did not have statistically significant different readmission rates than members who did not. However, members who had a follow-up visit with a physical health provider had statistically significant lower readmission rates than members who did not.

For physical health readmission rates, African American members had significantly higher readmission rates than index stays for white members. Index stays for members receiving SSI benefits had statistically significantly higher readmissions rates compared to admissions for members receiving Temporary Assistance for Needy Families (TANF). The highest readmission rates are noted for hepatitis (30.6%) and liver disease (25.3%) admissions. Admissions for COPD, cardiovascular disease, gastrointestinal disease, and HIV all had readmission rates between 15% and 20%. Admissions for obstetric conditions have the lowest readmission rates, with a rate of 1.0% for admissions due to delivery

complications, 1.7% for admissions due to normal delivery, and 3.1% for admissions due to pregnancy complications. The presence of behavioral health co-morbidity is associated with significantly higher rates of physical health readmission; admissions with a behavioral health co-morbidity had a physical health readmission rate of 11.2%, while the rate is 7.6% for index stays without a behavioral health co-morbidity.

The results of the study were distributed to the BH-MCOs and HC BH Contractors in December 2015. The findings of the study assisted in the development of an integrated care project which is intended to increase the utilization and analysis of behavioral health data by physical health MCOs and vice versa.

V: 2014 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 2014 EQR Technical Reports, which were distributed in April 2015. The 2015 EQR Technical Report is the eighth report to include descriptions of current and proposed interventions from each BH-MCO that address the 2014 recommendations.

The BH-MCOs are required by OMHSAS to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the Pennsylvania Medicaid BH-MCOs. These activities follow a longitudinal format, and are designed to capture information relating to:

- follow-up actions that the BH-MCO has taken through September 30, 2015 to address each recommendation;
- future actions that are planned to address each recommendation;
- when and how future actions will be accomplished;
- the expected outcome or goals of the actions that were taken or will be taken; and
- the BH-MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of the end of 2015, as well as any additional relevant documentation provided by the BH-MCO.

Table 16 presents CBH's responses to opportunities of improvement cited by IPRO in the 2014 EQR Technical Report, detailing current and proposed interventions.

Table 16: Current and Proposed Interventions

Reference Number	Opportunity for Improvement	Follow-up Actions Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in RY 2011, RY 2012, and RY 2013 found CBH to be partially compliant with all Subparts associated with Structure and Operations Standards.		Follow-up Actions Taken Through 09/30/15	**See below. Address within each Subpart accordingly.**
		Future Actions Planned (Specify Dates)	**See below. Address within each Subpart accordingly.**
CBH 2014.01	CBH was partially compliant on one of seven categories within Subpart C: Enrollee Rights and Protections Regulations. The partially compliant category was Enrollee Rights.	Follow-up Actions Taken Through 09/30/15	CBH revised its training curriculum and submitted it to OMHSAS for approval in May 2015.  Quality Management Staff Training.ppt In June/July 2015, CBH trained all complaints and grievances staff to handle and respond to member complaints and grievances appropriately. All current and newly hired staff also received training on member rights and procedures for filing a complaint or grievance.  Quality Management Staff Training Sign-In
		Future Actions Planned (Specify Dates)	Newly hired complaints and grievances staff will be trained upon hire. Audits to monitor staff performance will continue to be conducted on a quarterly basis.
CBH 2014.02	CBH was partially compliant on four out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, and 4) Practice Guidelines,	Follow-up Actions Taken Through 09/30/15	CBH developed a policy for conducting utilization review according to medical necessity criteria as well as requirements for documentation.  Standard 28.1 Docs UR.docx  Standard 28.1 Documentation Requir The Utilization Review Policy and documentation requirements were reviewed with Medical Affairs staff on December 2, 2014 and January 6, 2015, respectively.

Reference Number	Opportunity for Improvement	Follow-up Actions Taken/Planned	MCO Response
			Standard 28.1 Docs Meeting December 2 2 Standard 28.1 Docs Meeting January 6 201
		Future Actions Planned (Specify Dates)	Newly hired Medical Affairs staff will be trained on utilization review and documentation requirements upon hire.
CBH 2014.03	CBH was partially compliant on nine out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.	Follow-up Actions Taken Through 09/30/15	CBH revised its letter templates; developed complaint protocols, a summary sheet, and hearing scripts; revised its training curriculum; and trained its complaints and grievances staff and panel members in July and August of 2015 to meet the requirements of Subpart F. Complaints Letter Template.doc Grievance Letter Template.doc First Level Complaint Protocol.doc Second Level Complaint Protocol.do Complaint Summary Sheet w How To Com Complaint Summary Sheet.doc Complaints Hearing Script.doc Grievance Hearing Script.doc
			Quality Management Staff Training.ppt Quality Management Staff Training Sign-In Panel Training 2015.pptx Panel Training Sign-In Sheets.pdf

Reference Number	Opportunity for Improvement	Follow-up Actions Taken/Planned	MCO Response
		Future Actions Planned (Specify Dates)	Newly hired complaints and grievances staff will be trained upon hire. Panel members will be trained as needed. Audits to monitor staff performance will continue to be conducted on a quarterly basis.
CBH 2014.04	CBH's rate for the MY 2013 Follow-up After Hospitalization for Mental Illness HEDIS performance measures did not meet the OMHSAS designated performance goal the HEDIS 75th percentile for ages 6-64 for either the 7-day follow-up or 30-day follow-up. CBH's rate for the MY 2013 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI A was statistically significantly lower than the QI A HealthChoices BH-MCO Average by 5.4 percentage points. CBH's QI B rate was also statistically significantly below the QI B HealthChoices BH-MCO Average by 8.3 percentage points, and CBH's rates for MY 2013 was statistically significantly lower than their MY 2012 rates for both QI A and B.	Follow-up Actions Taken Through 09/30/15	Please see accompanying Root Cause Analysis.
		Future Actions Planned (Specify Dates)	Please see accompanying Root Cause Analysis.
CBH 2014.05	CBH's rate for the MY 2013 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.	Follow-up Actions Taken Through 09/30/15	Please see accompanying Root Cause Analysis.
		Future Actions Planned (Specify Dates)	Please see accompanying Root Cause Analysis.

Corrective Action Plan for Partial and Non-compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2013, CBH began to address opportunities for improvement related to Standards 1, 28, 60, 68, 71 and 72. Proposed actions and evidence of actions taken by CBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring CBH into compliance with the relevant Standards.

Root Cause Analysis and Action Plan

The 2015 EQR is the seventh for which BH-MCOs are required to prepare a Root Cause Analysis and Action Plan for performance measures performing statistically significantly poorer than the BH-MCO Average and/or as compared to the prior MY. For performance measures that were noted as opportunities for improvement in the 2014 EQR Technical Report, BH-MCOs are required to submit:

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

IPRO reviewed each submission, and offered technical assistance to BH-MCO staff. The BH-MCOs were given the opportunity to revise and re-submit response forms as needed and as time permitted.

For the 2015 EQR, CBH was required to prepare a Root Cause Analysis and Action Plan for the following performance measures and quality indicators:

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6–64 Years (**Table 17**)
- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years (**Table 18**)
- Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day; **Table 19**)
- Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day; **Table 20**)

Table 17: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6–64 Years

Instructions: **For each measure where a root cause analysis and plan of action is required, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.**		
Managed Care Organization (MCO): *Community Behavioral Health (CBH)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day -Ages 6 to 64)*	***Response Date:***
Goal Statement: **(Please specify individual goals for each measure): Enhance strategies to increase the likelihood that members will receive follow-up.**		
Analysis**: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.**	***Findings***	
Policies (e.g., data systems, delivery systems, provider facilities)	***Initial Response***	
	Follow-up Status Response	
Procedures (e.g., payment/reimbursement, credentialing/collaboration) Delay in entering discharge information	***Initial Response***	
	When members are discharged from an inpatient psychiatric hospital, Clinical Care Managers enter discharge information into a discharge template. The Member Services Department runs a report on a daily basis which gives them a list of members that need to be contacted to remind them of their outpatient appointments. In some instances, there is a delay in entering the discharge information into the discharge template resulting in Member Services Representative not being able to follow-up with members in a timely manner.	
	Follow-up Status Response	
People (e.g., personnel, provider network, patients) Geographic access to care disparities.	***Initial Response***	
	CBH identified underutilization of acute partial hospitalization programs (APHP) post acute inpatient episode for children ages 6-13 years old. One hypothesis for this underutilization is that the services were located outside of Philadelphia County.	
	Follow-up Status Response	
Member missed appointments	***Initial Response***	
	According to recently released national data, 42% of people discharged from Acute Inpatient (AIP) care miss their initial outpatient appointment. People who miss their follow up appointments are less likely to take prescribed medication and participate in other treatment and two times more likely to be readmitted to the hospital. Research shows that reminders prevent unnecessary re-hospitalizations and decrease outpatient no-shows by 28-36%.	
	Follow-up Status Response	

Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)	***Initial Response*** ***Follow-up Status Response***
Other (specify)	***Initial Response*** ***Follow-up Status Response***

Measure: *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day -Ages 6 to 64)*

For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014. Documentation of actions should be continued on additional pages as needed.

Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	*Monitoring Plan* How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
A "script" will be developed to help Clinical Care Managers work with inpatient providers to address drug and alcohol issues and integrate drug and alcohol treatment in aftercare planning. Clinical Care Managers will be trained on how to identify substance use issues during reviews and the use of the "script". The discharge template will be revised to make it easier for Clinical Care Managers to enter discharge information.	October 2015 November 2015 December 2015	***Initial Response*** CBH will conduct an analysis of follow-up rates comparing 3rd and 4th quarter 2015 to 3rd and 4th quarter 2016 for individuals identified as having a substance use diagnosis. ***Follow-up Status Response***
CBH issued a RFP for APHP. CBH awarded three providers: Children's Crisis Treatment Center, Wordsworth and Resources for Human Development. All three began accepting referrals in late June 2014. CBH will continue to track and trend post AIP follow up rates across the system as part of our comprehensive quality monitoring program.	June 2014 On-going	***Initial Response*** CBH compared the rate of children ages 6-13 who participated in APHP services post AIP episode within 7 days for 3rd and 4th quarter 2013 to 3rd and 4th quarter 2014. From 2013-2014, 7-day APHP utilization rates post-discharge from AIP increased by 9% and 19% in quarters 3 & 4, respectively. 2013 7-day: 35% Q3, 21% Q4 2014 7-day: 44% Q3, 40% Q4 ***Follow-up Status Response*** The utilization of APHP services are reviewed on a bi-weekly basis by the Utilization Review Committee.
On July 14th, 2014, Re:MIND partnered with Friends Hospital and piloted the re:Mind program with CBH members.	July 2014	***Initial Response*** Our evaluation plan included an analysis of follow up

On October 6th, 2014, Re:MIND was made available at all CBH-contracted acute inpatient psychiatric hospitals.	October 2014	rates to community-based care following AIP discharge. The comparison was between those that opt in to re:MIND and those that did not. re:MIND enrollment during the pilot phase was too small to produce any significant findings showing difference between the follow-up among re:MIND members and non-re:MIND members. CBH hypothesis is that individuals with successful text messages will have higher follow-up rates post inpatient discharge. Between July 1 and Dec 31, 2014, 139 individuals enrolled in re:MIND at Friends, 115 of which were CBH members after removing duplicates. Out of the 115 CBH members, only 66 enrollees had complete follow-up information on file and were sent a successful text message. Just under half of all enrollees did not receive text messages, due primarily to outgoing failures and/or providing a landline number for the program.
CBH identified various implementation issues that contributed to the limited use and success of Re:MIND. Hence, CBH is developing a re-implementation plan for Re:Mind, which includes: • Form Redesign a. Creating forced fields (i.e. making default dropdown selections blank/null) b. Formatting fields to help to eliminate data entry errors • User Acceptance Testing a. Completed by both reMIND ,CBH staff, provider staff b. To include amended guidelines for facility staff on when reMIND data must be entered • Training Redesign a. Training of Super-users from each inpatient facility b. Update Supplemental Training • Incorporating re:MIND into discharge reviews done by CBH Care Management Staff	October 2015	***Follow-up Status Response*** We will conduct another analysis of follow up rates to community-based care following AIP discharge to see if the re-implementation plan has been effective. The comparison will be between those that opt in to re:MIND and those that did not. Re:Mind enrollment during the pilot phase was too small to produce any significant findings showing difference between the follow-up among Re:MIND members and non-Re:MIND members. CBH hypothesis is that individuals with successful text messages will have higher follow-up rates post inpatient discharge. Monitoring of the re-implementation plan and evaluation of re:MIND will be ongoing

Table 18: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years

Instructions: **For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.**		
Managed Care Organization (MCO): *Community Behavioral Health (CBH)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day -Ages 6 to 64)*	***Response Date:***
Goal Statement: **(Please specify individual goals for each measure):**		
Analysis**: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.**	***Findings***	
Policies (e.g., data systems, delivery systems, provider facilities)	***Initial Response***	
	Follow-up Status Response	
Procedures (e.g., payment/reimbursement, credentialing/collaboration) Same response as HEDIS 7-day	***Initial Response***	
	Follow-up Status Response	
People (e.g., personnel, provider network, patients) Same response as HEDIS 7-day	***Initial Response***	
	Follow-up Status Response	
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)	***Initial Response***	
	Follow-up Status Response	
Other (specify)	***Initial Response***	
	Follow-up Status Response	

Measure: *Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day -Ages 6 to 64)*		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
1.Same response as HEDIS 7-day	June 2014	***Initial Response*** Three APHP within Philadelphia county were added to the CBH network and began providing services in late June 2014. From 2013-2014, 30-day APHP utilization rates post-discharge from AIP increased

	On-going	by 9% and16 % in Quarters 3 & 4, respectively. 2013 30-day: 37% Q3,30% Q4 2014 30-day: 46% Q3,46% Q4
		Follow-up Status Response
2.Same response as HEDIS 7-day		***Initial Response***
		Follow-up Status Response

Table 19: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)

***Instructions*:** **For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.**		
Managed Care Organization (MCO): *Community Behavioral Health (CBH)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)*	***Response Date:***
Goal Statement: **(Please specify individual goals for each measure):**		
***Analysis*: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.**	***Findings***	
Policies (e.g., data systems, delivery systems, provider facilities)	***Initial Response***	
	Follow-up Status Response	
Procedures (e.g., payment/reimbursement, credentialing/collaboration) Same response as HEDIS 7-day	***Initial Response***	
	Follow-up Status Response	
People (e.g., personnel, provider network, patients) Same response as HEDIS 7-day	***Initial Response***	
	Follow-up Status Response	
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)	***Initial Response***	
	Follow-up Status Response	
Other (specify)	***Initial Response***	
	Follow-up Status Response	

Measure: *Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)*

For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014. Documentation of actions should be continued on additional pages as needed.

Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	*Monitoring Plan* How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
Same response as HEDIS 7-day		***Initial Response***
		Follow-up Status Response

Table 20: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)

Instructions: **For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.**		
Managed Care Organization (MCO): *Community Behavioral Health (CBH)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)*	***Response Date:***
Goal Statement: **(Please specify individual goals for each measure):**		
Analysis**: What factors contributed to poor performance?** **Please enter "N/A" if a category of factors does not apply.**	***Findings***	
Policies (e.g., data systems, delivery systems, provider facilities)	***Initial Response*** ***Follow-up Status Response***	
Procedures (e.g., payment/reimbursement, credentialing/collaboration) Same response as HEDIS 7-day	***Initial Response*** ***Follow-up Status Response***	
People (e.g., personnel, provider network, patients) Same response to HEDIS 7-day	***Initial Response*** ***Follow-up Status Response***	
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)	***Initial Response*** ***Follow-up Status Response***	
Other (specify)	***Initial Response*** ***Follow-up Status Response***	

Measure: *Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)*		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	***Implementation Date*** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
Same response as HEDIS 7-day		***Initial Response*** ***Follow-up Status Response***

VI: 2015 Strengths and Opportunities for Improvement

The review of CBH's 2015 (MY 2014) performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH-MCO.

Strengths

- CBH's rate for the MY 2014 Readmission Within 30 Days of Inpatient Psychiatric Discharge performance measure for Philadelphia (13.1%) was statistically significantly lower (better) than the HealthChoices BH-MCO Average of 14.3% by 1.2 percentage points.
- CBH's rate for the MY 2014 Initiation of AOD Treatment (Ages 13+) performance measure was statistically significantly higher than the MY 2014 HealthChoices BH-MCO Average of 29.1% by 5.5 percentage points.
- CBH's rate for the MY 2014 Engagement of AOD Treatment (Ages 13+) performance measure was statistically significantly higher than the MY 2014 HealthChoices BH-MCO Average of 19.1% by 6.9 percentage points.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2012, RY 2013, and RY 2014 found CBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
    - CBH was partially compliant on one out of seven categories within Subpart C: Enrollee Rights and Protections. The partially compliant category is Enrollee Rights.
    - CBH was partially compliant on four out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care) 2) Coordination and Continuity of Care 3) Coverage and Authorization of Services 4) Practice Guidelines.
    - CBH was partially compliant on nine out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.
- CBH's rate for the MY 2014 7-Day Follow-up After Hospitalization for Mental Illness – HEDIS Indicator (QI 1) for the 6+ population was statistically significantly lower than the MY 2014 HealthChoices BH-MCO Average of 47.1% by 1.4 percentage points.
- CBH's rate for the MY 2014 30-Day Follow-up After Hospitalization for Mental Illness – HEDIS Indicator (QI 2) for the 6+ population was statistically significantly lower than the MY 2014 HealthChoices BH-MCO Average of 67.6% by 5.6 percentage points.
- CBH's rate for the MY 2014 7-Day Follow-up After Hospitalization for Mental Illness – PA Indicator (QI A) was statistically significantly lower than the MY 2014 HealthChoices BH-MCO Average of 58.2% by 1.2 percentage points.
- CBH's rate for the MY 2014 30-Day Follow-up After Hospitalization for Mental Illness – PA Indicator (QI B) was statistically significantly lower than the MY 2014 HealthChoices BH-MCO Average of 74.8% by 3.1 percentage points.
- CBH's rates for the MY 2014 Follow-up After Hospitalization for Mental Illness HEDIS Follow-up indicators (QI 1 and QI 2) for ages 6-64 did not meet the OMHSAS interim goals for MY 2014, nor did they achieve the goal of meeting or exceeding the 75th percentile.
- CBH did not meet the OMHSAS designated performance goal of 10.0% for the Readmission Within 30 Days of Inpatient Psychiatric Discharge performance measure.

Performance Measure Matrices

The Performance Measure (PM) Matrices provide a comparative look at quality indicators (QIs) included in the External Quality Review (EQR) evaluation for Quality Performance of the HealthChoices BH-MCO. The comparisons are presented in matrices that are color-coded to indicate when the findings for these measures are notable and whether there is cause for action as described in **Table 21**.

Table 21: BH-MCO Performance and HEDIS Percentiles

Color Code	Definition
	PA-specific Follow-up After Hospitalization Measures: Indicates that the BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average and trends up from MY 2013. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Indicates that the BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average and trends down from MY 2013. HEDIS Follow-up After Hospitalization Measures– Ages 6–64: At or above 90th percentile. BH-MCOs may have internal goals to improve.
	PA-specific Follow-up After Hospitalization Measures: Either the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and trends up from MY 2013 or that the BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average but there is no change from MY 2013. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and trends down from MY 2013 or that the BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average but there is no change from MY 2013. HEDIS Follow-up After Hospitalization Measures– Ages 6–64: At or above 75th and below 90th percentile. BH-MCOs may identify continued opportunities for improvement.
	PA-specific Follow-up After Hospitalization Measures: The BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average and trends up from MY 2013 or the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and there is no change from MY 2013 or the BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average but trends down from MY 2013. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** The BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average and trends down from MY 2013 or the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and there is no change from MY 2013 or the BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average but trends up from MY 2013. HEDIS Follow-up After Hospitalization Measures– Ages 6–64: N/A No action is required although MCOs should identify continued opportunities for improvement.
	PA-specific Follow-up After Hospitalization Measures: Either the BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average and there is no change from MY 2013 or that the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and trends down from MY 2013. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average and there is no change from MY 2013 or that the BH-MCO's MY 2014 rate is equal to the MY 2014 HealthChoices BH-MCO Average and trends up from MY 2013. HEDIS Follow-up After Hospitalization Measures– Ages 6–64: At or above 50th and below 75th percentile. A root cause analysis and plan of action is required.
	PA-specific Follow-up After Hospitalization Measures: the BH-MCO's MY 2014 rate is statistically significantly below the MY 2014 HealthChoices BH-MCO Average and trends down from MY 2013. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** the BH-MCO's MY 2014 rate is statistically significantly above the MY 2014 HealthChoices BH-MCO Average and trends up from MY 2013. HEDIS Follow-up After Hospitalization Measures – Ages 6–64: At or below the 50th percentile. A root cause analysis and plan of action is required.

Table 22 is a three-by-three matrix depicting the horizontal comparison between the BH-MCO's performance and the applicable HealthChoices BH-MCO Average. When comparing a BH-MCO's rate to the HealthChoices BH-MCO Average for each indicator, the BH-MCO rate can be above average, equal to the average or below average. Whether or not a BH-MCO performed statistically significantly above or below average is determined by whether or not that BH-MCO's 95% confidence interval for the rate included the HealthChoices BH-MCO Average for the specific indicator.

Table 22: Performance Measure Matrix

Year to Year Statistical Significance Comparison	Trend	HealthChoices BH-MCO Average Statistical Significance Comparison		
		Below / Poorer than Average	Average	Above / Better than Average
	⬆	C FUH QI A FUH QI B	B	A
	No Change	D	C	B
	⬇	*F*	D	C REA[1]

[1] Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) is an inverted measure. Lower rates are preferable, indicating better performance.

Letter Key: A: Performance is notable. No action required. BH-MCOs may have internal goals to improve. B: No action required. BH-MCOs may identify continued opportunities for improvement. C: No action required although BH-MCOs should identify continued opportunities for improvement. D: Root cause analysis and plan of action required. F: Root cause analysis and plan of action required.

Color Key: See **Table 21.**

FUH QI A: Follow-up After Hospitalization for Mental Illness (PA-Specific 7-Day) FUH QI B: Follow-up After Hospitalization for Mental Illness (PA-Specific 30-Day)

Table 23 represents the BH-MCO's performance for each measure in relation to prior year's rates for the same indicator for MY 2011 to MY 2014. The BH-MCO's rate can be statistically significantly higher than the prior year's rate (▲), have no change from the prior year, or be statistically significantly lower than the prior year's rate (▼). For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the Z-ratio. A Z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

Table 23: Performance Measure Rates

Quality Performance Measure	MY 2011 Rate	MY 2012 Rate	MY 2013 Rate	MY 2014 Rate	MY 2014 HC BH-MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)	51.4% =	55.8% ▲	50.3% ▼	56.9% ▲	58.2%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)	67.2% =	69.7% ▲	63.9% ▼	71.7% ▲	74.8%
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	11.7% =	12.3% =	11.3% ▼	13.1% ▲	14.3%

[1] Readmission Within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.

Table 24 is a four-by-one matrix that represents the BH-MCO's performance as compared to the HEDIS 90th, 75th, 50th and 25th percentiles for the Follow-up After Hospitalization 7-Day/30-Day metrics (FUH7/FUH30). A root cause analysis and plan of action is required for items that fall below the 75th percentile.

Table 24: HEDIS Follow-up After Hospitalization 7-Day/30-Day Performance Measure Matrix

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

[1] Rates shown are for ages 6–64 years. These rates are slightly higher than the overall rate.
FUH QI 1: Follow-up After Hospitalization for Mental Illness (HEDIS 7-Day) FUH QI 2: Follow-up After Hospitalization for Mental Illness (HEDIS 30-Day)

Table 25 illustrates the rates achieved compared to the HEDIS 75th percentile goal. Results are not compared to the prior year's rates.

Table 25: HEDIS Follow-up After Hospitalization 7-Day/30-Day Performance Measure Rates Ages 6–64 Years

Quality Performance Measure	MY 2014		HEDIS MY 2014 Percentile
	Rate[1]	Compliance	
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day)	46.1%	Not Met	Below 50th and at or above 25th percentile
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	62.6%	Not Met	Below 50th and at or above 25th percentile

[1] Rates shown are for ages 6–64 years. These rates are slightly higher than the overall rate.

Table 26 summarizes the key points based on the findings of the performance measure matrix comparisons.

Table 26: Key Points of Performance Measure Comparisons

A – Performance is notable. No action required. BH-MCOs may have internal goals to improve.
• No CBH performance measure rate fell into this comparison category.
B – No action required. BH-MCO may identify continued opportunities for improvement.
• No CBH performance measure rate fell into this comparison category.
C – No action required although BH-MCO should identify continued opportunities for improvement.
• Readmission Within 30 Days of Inpatient Psychiatric Discharge[1] • Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day) • Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)
D – Root cause analysis and plan of action required.
• No CBH performance measure rate fell into this comparison category.
F – Root cause analysis and plan of action required.
• Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day – 6 to 64 years) • Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day – 6 to 64 years)

[1] Readmission Within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.

VII: Summary of Activities

Structure and Operations Standards

- CBH was partially compliant on Subparts C, D and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2014, RY 2013, and RY 2012 were used to make the determinations.

Performance Improvement Projects

- CBH submitted a final PIP proposal in 2015.

Performance Measures

- CBH reported all performance measures and applicable quality indicators in 2015.

2014 Opportunities for Improvement MCO Response

- CBH provided a response to the opportunities for improvement issued in 2014.

2015 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CBH in 2015. The BH-MCO will be required to prepare a response for the noted opportunities for improvement in 2016.

Appendices

Appendix A: Crosswalk of Required PEPS Substandards to Pertinent BBA Regulations

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of complaint and grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DHS.
	Standard 104.2	The BH-MCO must submit to the DHS data specified by the DHS that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.
	Standard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Standard 108.2	C/FST budget is sufficient to: hire staff proportionate to HC covered lives, have adequate office space, purchase equipment, travel and attend on-going training.
	Standard 108.5	The C/FST has access to providers and HC members to conduct surveys and employs of a variety of survey mechanisms to determine member satisfaction e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Standard 108.6	The problem resolution process specifies the role of the county, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
	Standard 108.7	The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
	Standard 108.8	The Annual Mailed/Telephonic survey results are representative of HC membership, identify systemic trends. Actions have been taken to address areas found deficient, as applicable.
	Standard 108.10	The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.
§438.206 Availability of Service	Standard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages. • Excel or Access data base with the following information: Name of Agency (include satellite sites). Address of Agency (and satellite sites) with zip codes. Level of Care (e.g. Partial Hospitalization, D&A Outpatient, etc). Population served (adult, child & adolescent). Priority Population. Special Population.
	Standard 1.2	100% of members given choice of 2 providers at each level of care within 30/60

BBA Category	PEPS Reference	PEPS Language
		urban/rural met.
	Standard 1.3	Provider Exception report submitted & approved when choice of two providers is not given.
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).
	Standard 1.5	BH-MCO has notified the Department of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of oral interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Standard 24.2	Provider network database contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, and Consumer satisfaction.
§438.208 Coordination and Continuity of Care	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.

BBA Category	PEPS Reference	PEPS Language
§438.210 Coverage and authorization of services	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.2104 Provider Selection	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as, other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, and Consumer satisfaction.
§438.240 Quality	Standard 91.1	QM program description outlines ongoing quality assessment, performance improvement activities, a continuous quality improvement process, and places

BBA Category	PEPS Reference	PEPS Language
assessment and performance improvement program		emphasis on, but not limited to, high volume/high-risk services and treatment and Behavioral Health Rehabilitation Services.
	Standard 91.2	QM work plan includes goal, aspect of care/service, scope of activity, frequency, data source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines the specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services; provider network adequacy; penetration rates; appropriateness of service authorizations; inter-rater reliability; complaint, grievance and appeal processes; denial rates; upheld and overturned grievance rates; and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other high volume/high risk services).
	Standard 91.8	The QM work plan includes monitoring activities conducted to evaluate the quality and performance of the provider network (quality of individualized service plans and treatment planning, adverse incidents, collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance).
	Standard 91.9	The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	The QM work plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator: Mental Health; and, Substance Abuse External Quality Review: Follow up After Mental Health Hospitalization QM Annual Summary Report.
	Standard 91.11	The identified Performance Improvement Projects must include the following: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality. 3. Evaluation of the effectiveness of the interventions. 4. Planning and initiation of activities for increasing or sustaining improvement. 5. Timeline for reporting status and results of each project to DHS. 6. Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year.
	Standard 91.12	The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.
	Standard 91.13	The BH-MCO has a process for its own evaluation of the impact and effectiveness of its quality management program annually. A report of this evaluation will be submitted to DHS by April 15th.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates,

BBA Category	PEPS Reference	PEPS Language
		Follow up after hospitalization rates, and Consumer satisfaction.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH-MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for coordination with other service agencies and schools.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DHS.
	Standard 104.2	The BH-MCO must submit to the DHS data specified by the DHS that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
§438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must b explanation and reason for the decision(s).
	Standard 68.4	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: • BBA Fair Hearing • 1st level • 2nd level

BBA Category	PEPS Reference	PEPS Language
		• External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of complaint and grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • Expedited
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decision letters must be written in clear, simple language that includes each issue identified in the member complaint decision letters must explanation and reason for the decision(s).
	Standard 68.4	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the

BBA Category	PEPS Reference	PEPS Language
		documentation can be obtained for review.
	Standard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: • BBA Fair Hearing • 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Standard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of oral interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Standard 24.2	Provider network database contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members according to required timeframes and use the

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

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

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

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

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of complaint and grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, 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 DPW.
	Standard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Standard 108.2	C/FST budget is sufficient to: hire staff proportionate to HC covered lives, has adequate office space, purchase equipment, travel and attend on-going training.
	Standard 108.5	The C/FST has access to providers and HC members to conduct surveys and employs of a variety of survey mechanisms to determine member satisfaction e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Standard 108.6	The problem resolution process specifies the role of the County, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
	Standard 108.7	The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
	Standard 108.8	The Annual Mailed/Telephonic survey results are representative of HC membership, identify systemic trends and actions have been taken to address areas found deficient, as applicable.
	Standard 108.10	The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.
§438.206 Availability of Service	Standard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages. • Excel or Access data base with the following information: Name of Agency (include satellite sites). Address of Agency (and satellite sites) with zip codes. Level of Care (e.g. Partial Hospitalization, D&A Outpatient, etc). Population served (adult, child & adolescent). Priority Population. Special Population.
	Standard 1.2	100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met.
	Standard 1.3	Provider Exception report submitted & approved when choice of two providers is not given.

BBA Category	PEPS Reference	PEPS Language
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).
	Standard 1.5	BH-MCO has notified DPW of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that was provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that was provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational/vocational status and Changes in living status.
§438.208 Coordination and Continuity of Care	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.210 Coverage and	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.

BBA Category	PEPS Reference	PEPS Language
authorization of services	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.2104 Provider Selection	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Re-credentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as, other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational/vocational status and Changes in living status.
§438.240 Quality assessment and performance	Standard 91.1	QM program description outlines the ongoing quality assessment and performance improvement activities, Continuous Quality Improvement process and places emphasis on, but not limited to High volume/high-risk services and treatment and Behavioral Health Rehabilitation services.
	Standard 91.2	QM work plan includes goal, aspect of care/service, scope of activity, frequency, data

BBA Category	PEPS Reference	PEPS Language
improvement program		source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines, the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services, provider network adequacy, penetration rates, appropriateness of service authorizations, inter-rater reliability, complaint, grievance and appeal process, denial rates, grievance upheld and overturn rates and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other HV/HR services).
	Standard 91.8	The QM work plan includes monitoring activities conducted to evaluate the quality and performance of the provider network (quality of individualized service plans and treatment planning, adverse incidents, collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance).
	Standard 91.9	The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	The QM work plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator for : ---Mental Health ---Substance Abuse External Quality Review: ---Follow up After Mental Health Hospitalization QM Annual Summary Report
	Standard 91.11	The identified Performance Improvement Projects must include the following: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality. 3. Evaluation of the effectiveness of the interventions. 4. Planning and initiation of activities for increasing or sustaining improvement. 5. Timeline for reporting status and results of each project to DPW. 6. Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year.
	Standard 91.12	The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.
	Standard 91.13	The BH-MCO has a process for its own evaluation of the impact and effectiveness of its quality management program annually. A report of this evaluation will be submitted to DPW by April 15th.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates,

BBA Category	PEPS Reference	PEPS Language
		Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational/vocational status and Changes in living status.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH-MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for Coordination with Other Service Agencies and School.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, 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 DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
§438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are 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).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st Level • 2nd Level • External

BBA Category	PEPS Reference	PEPS Language
		• Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of complaint and grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are 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).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing

BBA Category	PEPS Reference	PEPS Language
		• 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Standard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing

BBA Category	PEPS Reference	PEPS Language
		• 1st level • 2nd level • External • Expedited
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are 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).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.408 Resolution and notification: Grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External
	Standard 68.2	100% of complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

BBA Category	PEPS Reference	PEPS Language
	Standard 68.3	Complaint decisions letters are 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).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.410 Expedited resolution of appeals	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to

BBA Category	PEPS Reference	PEPS Language
		where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.414 Information about the grievance system to providers and subcontractors	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External • Expedited
§438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External • Expedited
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.424 Effectuation of reversed appeal resolutions	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. • BBA Fair Hearing • 1st level • 2nd level • External • Expedited

BBA Category	PEPS Reference	PEPS Language
	Standard 71.2	100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to county/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

Appendix B: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Care Management		
Care Management (CM) Staffing	Standard 27.7	Other: Significant onsite review findings related to Standard 27.
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
Second Level Complaints and Grievances		
Complaints	Standard 68.6	The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 68.9	Where applicable there is evidence of county oversight and involvement in the 2nd level complaint process.
Grievances and State Fair Hearings	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 71.8	Where applicable there is evidence of county oversight and involvement in the 2nd level grievance process.
Denials		
Denials	Standard 72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to **Appendix AA** requirements.
Executive Management		
County Executive Management	Standard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Standard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/ Family Satisfaction	Standard 108.3	County/BH-MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.
	Standard 108.4	The C/FST Director is responsible for setting program direction consistent with county direction, negotiating contract, prioritizing budget expenditures, recommending survey

Category	PEPS Reference	PEPS Language
		content and priority and directing staff to perform high quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2014, 16 substandards were considered OMHSAS-specific monitoring standards. Of the 16 OMHSAS-specific PEPS Substandards, 12 were evaluated for CBH and Philadelphia. Four substandards were not scheduled or not applicable for evaluation in RY 2014. **Table C.1** provides a count of these Items, along with the relevant categories.

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

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	PEPS Reviewed in RY 2012	Not Reviewed
Care Management					
Care Management (CM) Staffing (Standard 27)	1	0	0	0	1
Longitudinal Care Management (and Care Management Record Review) (Standard 28)	1	0	0	0	1
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	0	4	0	0
Grievances and State Fair Hearings (Standard 71)	4	0	4	0	0
Denials					
Denials (Standard 72)	1	1	0	0	0
Executive Management					
County Executive Management (Standard 78)	1	0	0	0	1
BH-MCO Executive Management (Standard 86)	1	0	0	0	1
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	3	0	0	0

Format

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

Findings

The OMHSAS-specific PEPS Substandards relating to Care Management are MCO-specific review standards. These two substandards were added to the PEPS Application for RY 2014. As CBH was not scheduled for review of Standards 27 or 28 during RY 2014, these substandards were not reviewed for CBH during the present review cycle. The status for these substandards is presented in **Table C.2**.

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

Category	PEPS Item	Review Year	Status
Care Management			
Care Management (CM) Staffing	Standard 27.7	N/A	Not Reviewed
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	N/A	Not Reviewed

N/A: not applicable

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards[2]. CBH was evaluated on eight of the eight applicable substandards. Of the eight substandards evaluated, CBH met two substandards, partially met two substandards, and did not meet four standards, as indicated in **Table C.3**.

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

Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
Complaints	Standard 68.1	RY 2013	Not Met
	Standard 68.6	RY 2013	Partially Met
	Standard 68.7	RY 2013	Not Met
	Standard 68.8	RY 2013	Not Met
Grievances and State Fair Hearings	Standard 71.1	RY 2013	Partially Met
	Standard 71.5	RY 2013	Met
	Standard 71.6	RY 2013	Met
	Standard 71.7	RY 2013	Not Met

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

CBH partially met the criteria for compliance on Substandards 68.6 and did not meet the criteria for compliance on Substandards 68.7, 68.8 and 68.1 (RY 2013):

Substandard 68.1: Where applicable there is evidence of county oversight and involvement in the second level complaint process.
Substandard 68.6: The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
Substandard 68.7: Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
Substandard 68.8: A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

PEPS Standard 71: Grievance and Fair Hearing rights and procedures are made known to EAP, members, BH-MCO Staff and the provider network through manuals, training, handbooks, etc.

CBH partially met the criteria for compliance on Substandards 71.1 and did not meet the criteria for compliance on Substandard 71.7 (RY 2013):

Substandard 71.1: Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.
Substandard 71.7: A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2014. CBH was evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

[2] Beginning with RY 2012, MCO-specific substandards 68.9 and 71.8 were changed to county-specific substandards and renumbered to 68.1 and 78.1 respectively under the county-specific standard set.

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

Category	PEPS Item	Review Year	Status
Denials			
Denials	Standard 72.3	RY 2014	Met

There are two OMHSAS-specific PEPS substandards relating to Executive Management; the County Executive Management substandard is a county-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. These substandards were added to the PEPS Application during RY 2014. As CBH and Philadelphia were not scheduled for review of Standards 78 and 86 during RY 2014, these substandards were not reviewed for CBH or its associated counties during the present review cycle. The status for these substandards is presented in **Table C.5**.

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

Category	PEPS Item	Review Year	Status
Care Management			
County Executive Management	Standard 78.5	N/A	Not Reviewed
BH-MCO Executive Management	Standard 86.3	N/A	Not Reviewed

N/A: not applicable

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

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

Category	PEPS Item	Review Year	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Standard 108.3	RY 2014	Met
	Standard 108.4	RY 2014	Met
	Standard 108.9	RY 2014	Met

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