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

2015 External Quality Review Report
Magellan Behavioral Health

FINAL
April 13, 2016

IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org

Table of Contents

List of Tables and Figures

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 second 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 is included in the 2015 EQR BBA Technical Report for the first time.

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.

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

Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. All counties associated with MBH are individual HC BH Contractors. **Table 1** shows the name of the HealthChoices Oversight Entity, the associated HealthChoices HC BH Contractor(s), and the county(ies) encompassed by each HC BH Contractor.

Table 1: HealthChoices Oversight Entities, HC BH Contractors and Counties

HealthChoices Oversight Entity	HC BH Contractor	County
Bucks County Behavioral Health	Bucks County	Bucks County
Delaware County – "DelCare Program"	Delaware County	Delaware County
Lehigh County HealthChoices	Lehigh County	Lehigh County
Montgomery County Behavioral Health	Montgomery County	Montgomery County
Northampton County	Northampton County	Northampton County

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of MBH 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 MBH, 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 MBH 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 MBH

Table 2: Substandards Pertinent to BBA Regulations Reviewed for MBH

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	17	2	4	1
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
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

For MBH and the five HealthChoices Oversight Entities/HC BH Contractors with the BH-MCO who were included in the structure and operations standards for RY 2014, 163 PEPS Items were identified as required to fulfill BBA regulations. Of the 163 PEPS Items, 162 Items were evaluated for MBH, and 1 Item was not scheduled or not applicable for evaluation for RY 2014.

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	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Partial	None	All MBH HC BH Contractors	12 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 12 substandards Each HC BH Contractor was compliant on 9 substandards and non-compliant on 3 substandards.
Provider-Enrollee Communications 438.102	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections E.4 (p.52) and A.4.a (p.20).
Marketing Activities 438.104	N/A	N/A	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	All MBH HC BH Contractors		Compliant as per PS&R sections A.9 (p.70) and C.2 (p.32).
Cost Sharing 438.108	Compliant	All MBH HC BH Contractors		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	All MBH HC BH Contractors		Compliant as per PS&R section 4 (p.37).
Solvency Standards 438.116	Compliant	All MBH HC BH Contractors		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

Based on the PEPS substandards reviewed, all MBH HC BH Contractors were compliant on four categories of Enrollee Rights and Protections Regulations as per the HealthChoices PS&R, and one category as per CMS Regulation 42 CFR 447.50-447.60. All MBH HC BH Contractors were partially compliant on Enrollee Rights. The category Solvency Standards was also compliant based on the 2014-2015 Solvency Requirement tracking report. One category, Marketing Activities, was Not Applicable.

Of the 12 PEPS substandards that were crosswalked to the category Enrollee Rights, all 12 were evaluated for each HC BH contractor. All HC BH contractors associated with MBH were compliant on 9 items and non-compliant on 3 items.

Enrollee Rights

All HC BH Contractors associated with MBH were partially compliant with Enrollee Rights due to non-compliance with three of twelve substandards within PEPS Standard 60: Substandards 1, 2, and 3 (RY 2013).

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.

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.
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	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Elements of State Quality Strategies 438.204	Compliant	All MBH HC BH Contractors		Compliant as per PS&R section G.3 (p.58).
Availability of Services (Access to Care) 438.206	Partial		All MBH HC BH Contractors	24 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards Each HC BH Contractors was compliant on 21 substandards, partially compliant on 1 substandard and non-compliant on 1 substandard.
Coordination and Continuity of Care 438.208	Partial		All MBH HC BH Contractors	2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards Each HC BH Contractors was partially compliant on 1 substandard and non-compliant on 1 substandard
Coverage and Authorization of Services 438.210	Partial		All MBH HC BH Contractors	4 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 4 substandards Each HC BH Contractor was compliant on 2 substandards, partially compliant on 1 substandard and non-compliant on 1 substandard.
Provider Selection 438.214	Compliant	All MBH HC BH Contractors		3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections D.2 (p.49), G.4 (p.59) and C.6.c (p.47).

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Subcontractual Relationships and Delegation 438.230	Compliant	All MBH HC BH Contractors		8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards and compliant on 8 substandards.
Practice Guidelines 438.236	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards. Each HC BH Contractor was compliant on 4 substandards, partially compliant on 1 substandard and non-complaint on 1 substandard
Quality Assessment and Performance Improvement Program 438.240	Compliant	All MBH HC BH Contractors		23 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards and compliant on 23 substandards.
Health Information Systems 438.242	Compliant	All MBH HC BH Contractors		1 substandard was crosswalked to this category. Each HC BH Contractor was evaluated on 1 substandard and compliant on this substandard.

Of the 10 Quality Assessment and Performance Improvement Regulations categories, MBH as a whole was compliant on six categories and partially compliant on four categories. Two of the six categories that MBH was compliant on – Elements of State Quality Strategies and Confidentiality – were not directly addressed by any PEPS Items, but were determined to be compliant as per the HealthChoices PS&R.

For this review, 71 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations. Each HC BH Contractor was evaluated on 70 substandards. There was 1 substandard not scheduled or not applicable for evaluation for RY 2014. All MBH HC BH Contractors were compliant on 62 substandards, partially compliant on 4 substandards, and non-compliant on 4 substandards. Some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

All HC BH Contractors associated with MBH were partially compliant with Availability of Services due to partial or non-compliance with substandards of PEPS Standard 28.

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

All MBH HC BH Contractors were non-compliant on one substandard of PEPS Standard 28, Substandard 1 (RY 2013):

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.

All MBH HC BH Contractors were partially compliant on one substandard of PEPS Standard 28, Substandard 2 (RY 2013):

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

All HC BH Contractors associated with MBH were partially compliant with Coordination and Continuity of Care due to partial or non compliance with two substandards of PEPS Standard 28.

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

All HC BH Contractors associated with MBH were partially compliant with Coverage and Authorization of Services due to partial or non-compliance with substandards of PEPS Standards 28.

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

Practice Guidelines

All HC BH Contractors associated with MBH were partially compliant with Practice Guidelines due to partial or non compliance with two substandards of PEPS Standard 28.

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	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All MBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant on 7 substandards, and non-compliant on 4 substandards.
General Requirements 438.402	Partial		All MBH HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards, compliant on 7 substandards and non-compliant on 7 substandards.
Notice of Action 438.404	Compliant	All MBH HC BH Contractors		13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards and compliant on 13 substandards.
Handling of Grievances and Appeals 438.406	Partial		All MBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant on 7 substandards and non-compliant on 4 substandards.

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Resolution and Notification: Grievances and Appeals 438.408	Partial		All MBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant on 7 substandards and non-compliant on 4 substandards.
Expedited Appeals Process 38.410	Compliant	All MBH HC BH Contractors		6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards and compliant on 6 substandards.
Information to Providers & Subcontractors 438.414	Partial		All MBH HC BH Contractors	2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards, compliant on 1 substandard and non-compliant on 1 substandard.
Recordkeeping and Recording Requirements 438.416	Compliant	All MBH HC BH Contractors		Compliant as per the required quarterly reporting of complaint and grievances data.
Continuation of Benefits 438.420	Compliant	All MBH HC BH Contractors		6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards and compliant on 6 substandards.
Effectuation of Reversed Resolutions 438.424	Compliant	All MBH HC BH Contractors		6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards and compliant on 6 substandards.

MBH was evaluated for compliance on the 10 categories of Federal and State Grievance System Standards. MBH was compliant on five categories and partially compliant on five categories. The category Recordkeeping and Recording Requirements was compliant per the quarterly reporting of complaint and grievances data. Each MBH HC BH Contractor was compliant on five categories and partially compliant on five categories.

For this review, 80 substandards were crosswalked to this Subpart for all five MBH HC BH Contractors, and each HC BH Contractor was evaluated on 80 substandards. The five HC BH Contractors were compliant on 60 substandards and non-compliant on 20 substandards. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

The five MBH HC BH Contractors were partially compliant with 5 of the 10 categories pertaining to Federal State and Grievance System Standards due to non-compliance with substandards within PEPS Standards 60 and 68.

Statutory Basis and Definitions

All HC BH Contractors associated with MBH were partially compliant with Statutory Basis and Definitions due to non-compliance with substandards of PEPS Standard 68.

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.

All MBH HC BH Contractors were non-compliant with four of the five substandards of Standard 68: Substandards 1, 3, 4 and 5 (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.

General Requirements

All HC BH Contractors associated with MBH were partially compliant with General Requirements due to partial or non-compliance with substandards of PEPS Standards 60 and 68.

PEPS Standard 60: See standard description and determination of compliance under Enrollee Rights on page 10 of this report.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions (above).

Handling of Grievances and Appeals

All HC BH Contractors associated with MBH were partially compliant with Handling of Grievances and Appeals due to partial or non-compliance with substandards of PEPS Standards 68.

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

Resolution and Notification: Grievances and Appeals

All HC BH Contractors associated with MBH were partially compliant with Resolution and Notification due to partial or non-compliance with substandards of PEPS Standards 68.

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

Information to Providers & Subcontractors

All HC BH Contractors associated with MBH were partially compliant with Information to Providers and Subcontractors due to partial compliance with Substandard 1 of PEPS Standard 68.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions on page 14 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

MBH 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 MBH. MBH was given the opportunity to schedule a technical assistance meeting to review their changes based on the initial review. MBH's assistance call occurred in August 2015.

MBH's proposal included objectives that align with the proposal objectives, and MBH included a rationale for conducting the PIP based on literature review, focus group results, and survey results. The rationale section included BH-MCO-specific data that related to the three objectives of the PIP. As the initial proposal was submitted prior to the availability

of complete baseline year (2014) data, no baseline rates were included in the proposal. With the exception of the DMP measure, where no data was yet available, the BH-MCO provided reasonable goals for each indicator. The BH-MCO provided estimates of the MY 2014 rates, based on current data.

MBH used a variety of methods to complete a barrier analysis including literature review, provider surveys, member surveys, and analysis of readmission rates and follow-up rates for their membership (overall, by admitting diagnosis, demographics, etc.)

The proposed interventions address the PIP's goals to reduce readmissions (mental health and/or substance abuse related), improve medication adherence post impatient discharge and increase follow up appointments post inpatient discharge. The BM-HCO worked with providers to select interventions related to identified barriers that were aligned with the HC BH Contractors' and BH-MCO's vision. The interventions are being implemented on a pilot basis; each provider has one or more assigned interventions rather than all of the providers implementing the same interventions. Each intervention will be analyzed following the pilot period for successful implementation and outcome, and a decision will be made to continue the intervention on a pilot basis, further expand an intervention to other providers and/or populations or end the intervention if deemed ineffective.

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).

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, 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
MBH	2,667	5,302	**50.3%**	48.9%	51.7%	52.5%	NO	51.5%	-1.2	-2.30%	NO	Above 50th Percentile, Below 75th Percentile
Bucks	459	880	**52.2%**	48.8%	55.5%	52.8%	NO	51.8%	0.4	0.69%	NO	Above 50th Percentile, Below 75th Percentile
Delaware	508	1,043	**48.7%**	45.6%	51.8%	47.6%	YES	46.7%	2.1	4.40%	NO	Above 50th Percentile, Below 75th Percentile
Lehigh	647	1,298	**49.8%**	47.1%	52.6%	53.6%	NO	52.6%	-2.7	-5.21%	NO	Above 50th Percentile, Below 75th Percentile
Montgomery	632	1,264	**50.0%**	47.2%	52.8%	52.1%	NO	51.1%	-1.1	-2.09%	NO	Above 50th Percentile, Below 75th Percentile
Northampton	421	817	**51.5%**	48.0%	55.0%	56.9%	NO	56.9%	-5.3	-9.36%	YES	Above 50th Percentile, Below 75th 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
MBH	3,587	5,302	**67.7%**	66.4%	68.9%	70.0%	NO	68.6%	-1.0	-1.42%	NO	Above 50th Percentile, Below 75th Percentile
Bucks	611	880	**69.4%**	66.3%	72.5%	68.5%	YES	67.2%	2.3	3.36%	NO	Above 50th Percentile, Below 75th Percentile
Delaware	677	1,043	**64.9%**	62.0%	67.9%	64.6%	YES	62.9%	2.0	3.15%	NO	Below 50th Percentile, Above 25th Percentile
Lehigh	878	1,298	**67.6%**	65.1%	70.2%	72.8%	NO	71.3%	-3.7	-5.16%	YES	Above 50th Percentile, Below 75th Percentile
Montgomery	829	1,264	**65.6%**	62.9%	68.2%	69.4%	NO	68.1%	-2.5	-3.64%	NO	Below 50th Percentile, Above 25th Percentile
Northampton	592	817	**72.5%**	69.3%	75.6%	75.0%	NO	75.0%	-2.5	-3.39%	NO	Above 50th Percentile, Below 75th 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.

The MY 2014 MBH HEDIS follow-up rates for members ages 6 to 64 were 50.3% for QI 1 and 67.7% for QI 2 (**Table 8**); both rates were lower than MBH's MY 2013 rates of 51.5% for QI 1 and 68.6% for QI 2. However, the year-to-year differences were not statistically significant for either rate. The MBH QI 1 rate for the 6 to 64 year old population was statistically significantly higher than the QI 1 HealthChoices BH-MCO Average of 47.4% by 2.9 percentage points, while the QI 2 rate for this age group was not statistically significantly different from the QI 2 HealthChoices BH-MCO Average of 68.0%. Both interim follow-up goals for MBH were not met in MY 2014, as MBH's rates were below its target goals of 52.5% for QI 1 and 70.0% for QI 2. Both HEDIS rates for this age group were between the HEDIS 2015 50th and 75th percentiles; therefore, the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by MBH in MY 2014 for either rate.

As presented in **Table 8**, the QI 1 rate for members 6 to 64 years old statistically significantly decreased for Northampton by 5.3 percentage points from MY 2013, while the QI 2 rate for Lehigh statistically significantly decreased by 3.7 percentage points. Of the five HC BH Contractors associated with MBH, Lehigh met its QI 2 interim goal in MY 2014, and Delaware met its QI 1 and QI 2 interim goals.

Figure 1 is a graphical representation of MY 2014 HEDIS follow-up rates in the 6 to 64 year old population for MBH and its associated HC BH Contractors. **Figure 2** shows the HC BH Contractor Averages for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rates for Northampton and Bucks were statistically significantly above the MY 2014 QI 1 HC BH Contractor Average of 47.6% by 3.9 and 4.6 percentage points respectively. The QI 2 rates for Montgomery and Delaware were statistically significantly lower than the QI 2 HC BH Contractor Average of 69.8% by 4.2 and 4.9 percentage points respectively.

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

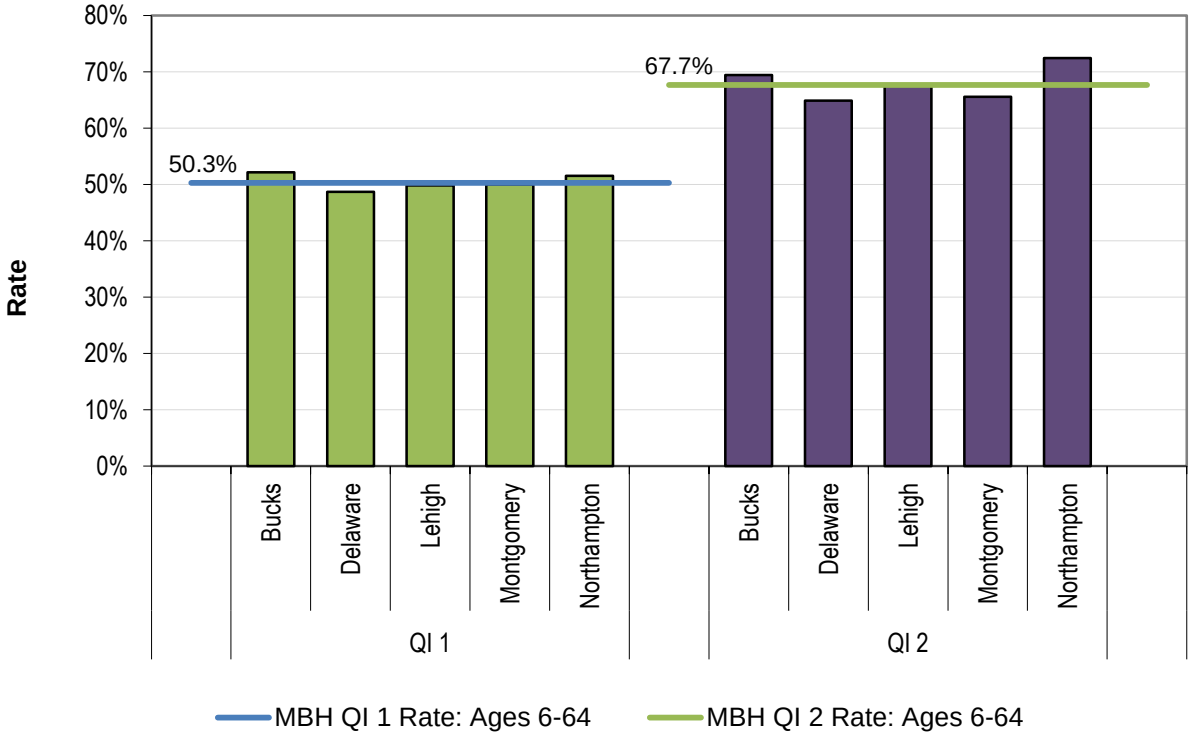
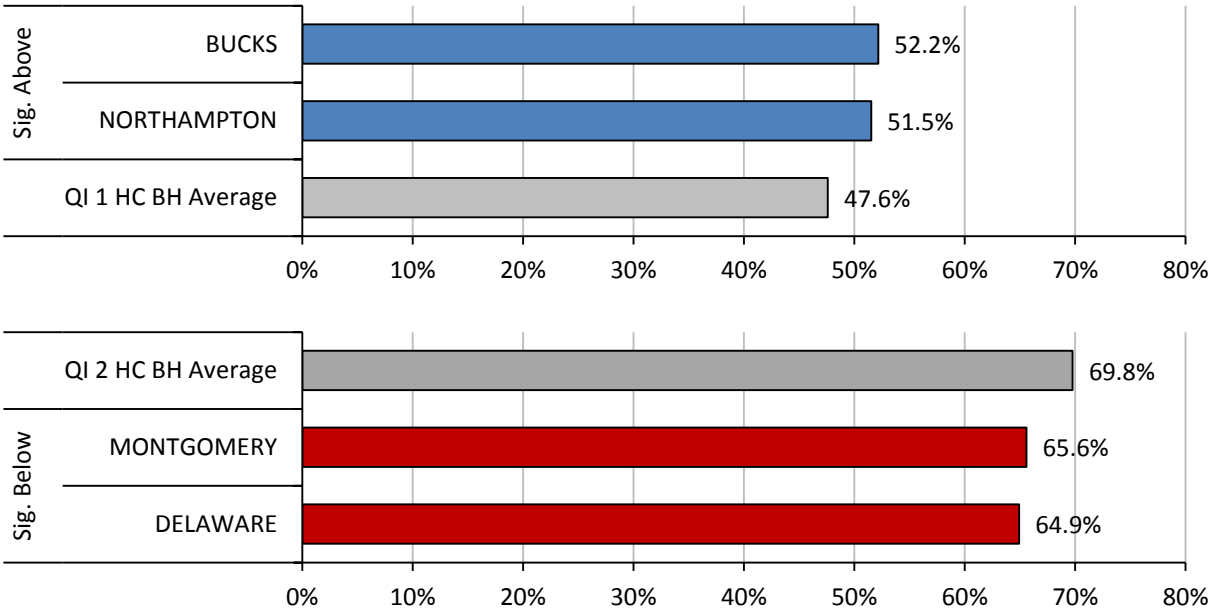


Figure 2: HEDIS Follow-up Rates Compared to MY 2014 HealthChoices HC BH Contractor Average: 6-64 Years Old



(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 %	Lower 95% CI	Upper 95% CI	BH-MCO Average	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
MBH	2,705	5,389	**50.2%**	48.9%	51.5%			51.3%	-1.1	NO	Above 50th Percentile, Below 75th Percentile
Bucks	462	888	**52.0%**	48.7%	55.4%			51.7%	0.3	NO	Above 50th Percentile, Below 75th Percentile
Delaware	526	1,069	**49.2%**	46.2%	52.2%			46.7%	2.5	NO	Above 50th Percentile, Below 75th Percentile
Lehigh	650	1,318	**49.3%**	46.6%	52.1%			52.3%	-3.0	NO	Above 50th Percentile, Below 75th Percentile
Montgomery	639	1,280	**49.9%**	47.1%	52.7%			51.0%	-1.0	NO	Above 50th Percentile, Below 75th Percentile
Northampton	428	834	**51.3%**	47.9%	54.8%			56.4%	-5.1	YES	Above 50th Percentile, Below 75th 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
MBH	3,637	5,389	**67.5%**	66.2%	68.7%			68.4%	-0.9	NO	Above 50th Percentile, Below 75th Percentile
Bucks	616	888	**69.4%**	66.3%	72.5%			67.0%	2.3	NO	Above 50th Percentile, Below 75th Percentile
Delaware	696	1,069	**65.1%**	62.2%	68.0%			63.0%	2.1	NO	Below 50th Percentile, Above 25th Percentile

Measure	MY 2014 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2013 %	Rate Comparison of MY 2014 against: MY 2013 PPD	SSD	HEDIS MY 2015 Percentile
Lehigh	884	1,318	**67.1%**	64.5%	69.6%			71.1%	-4.1	YES	Above 50th Percentile, Below 75th Percentile
Montgomery	839	1,280	**65.5%**	62.9%	68.2%			67.9%	-2.4	NO	Below 50th Percentile, Above 25th Percentile
Northampton	602	834	**72.2%**	69.1%	75.3%			74.4%	-2.2	NO	Above 50th Percentile, Below 75th 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 MBH, the MY 2014 HEDIS rates were 50.2% for QI 1 and 67.5% for QI 2; both rates were lower than MBH's MY 2013 rates of 51.3% for QI 1 and 68.4% for QI 2. However, the year-to-year differences were not statistically significant. The MBH QI 1 rate was statistically higher than the QI 1 HealthChoices BH-MCO Average of 47.1% by 3.1 percentage points, while the QI 2 rate was not statistically significantly different from the QI 2 HealthChoices BH-MCO Average of 67.6%. MBH had the highest QI 1 rate of the five BH-MCOs evaluated in MY 2014.

As presented in **Table 9**, the QI 1 rate in Northampton statistically significantly decreased by 5.1 percentage points from the corresponding MY 2013 rate, and the QI 2 rate in Lehigh statistically significantly decreased by 4.1 percentage points.

Figure 3 is a graphical representation of the MY 2014 HEDIS follow-up rates for MBH and its associated HC BH Contractors. **Figure 4** shows the HC BH Contractor Averages and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rates for Northampton and Bucks were statistically significantly above the MY 2014 QI 1 HC BH Contractor Average of 47.3% by 4.1 and 4.8 percentage points respectively. The QI 2 rates for Montgomery and Delaware were statistically significantly lower than the QI 2 HC BH Contractor Average of 69.3% by 3.8 and 4.2 percentage points respectively.

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

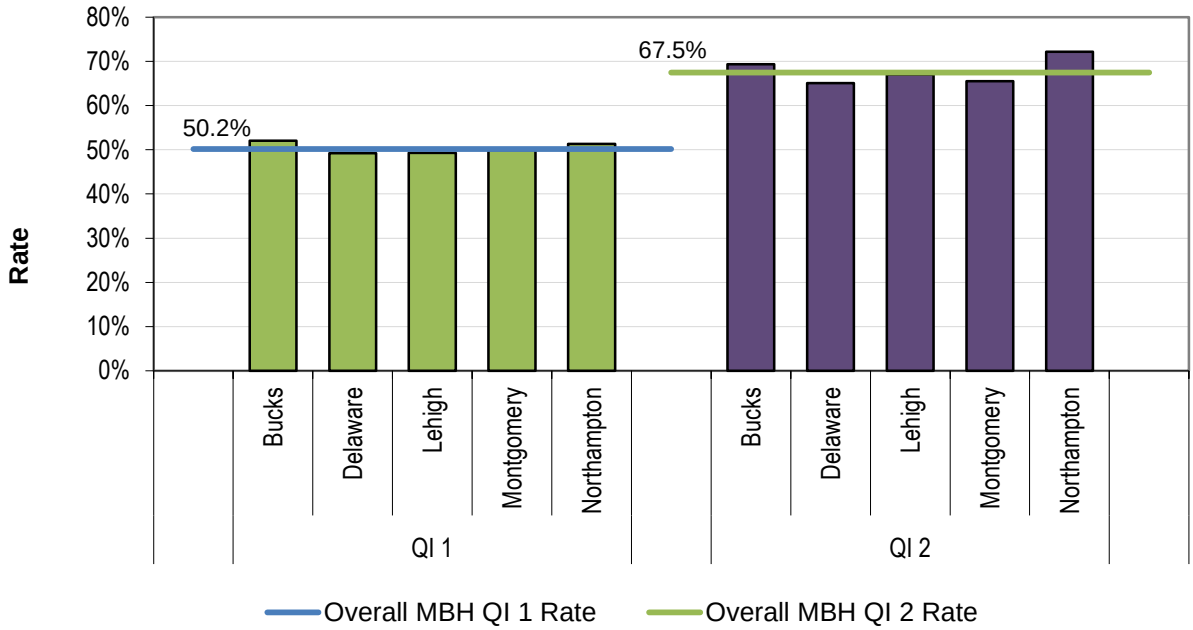
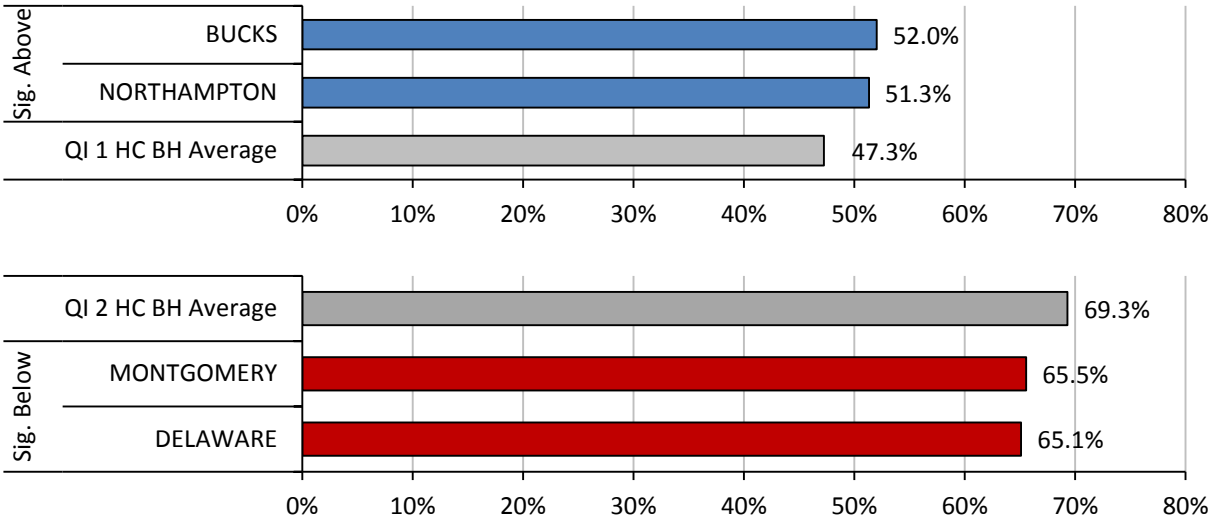


Figure 4: HEDIS Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average – Overall Population



(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
MBH	822	1,586	**51.8%**	49.3%	54.3%			51.9%	-0.1	NO
Bucks	131	240	**54.6%**	48.1%	61.1%			58.5%	-3.9	NO
Delaware	153	318	**48.1%**	42.5%	53.8%			45.4%	2.7	NO
Lehigh	200	385	**51.9%**	46.8%	57.1%			52.6%	-0.6	NO
Montgomery	206	394	**52.3%**	47.2%	57.3%			49.4%	2.9	NO
Northampton	132	249	**53.0%**	46.6%	59.4%			56.7%	-3.7	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
MBH	1,119	1,586	**70.6%**	68.3%	72.8%			71.1%	-0.5	NO
Bucks	172	240	**71.7%**	65.8%	77.6%			74.0%	-2.3	NO
Delaware	212	318	**66.7%**	61.3%	72.0%			64.1%	2.5	NO
Lehigh	276	385	**71.7%**	67.1%	76.3%			73.0%	-1.3	NO
Montgomery	270	394	**68.5%**	63.8%	73.2%			67.4%	1.1	NO
Northampton	189	249	**75.9%**	70.4%	81.4%			80.2%	-4.3	NO

[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 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. For MBH, the MY 2014 HEDIS follow-up rates for members ages 6 to 20 were 51.8% for QI 1 and 70.6% for QI 2; both rates were comparable to MBH's corresponding MY 2013

rates of 51.9% for QI 1 and 71.1% for QI 2. The MBH MY 2014 QI 1 rate for the 6 to 20 year old population was statistically lower than the QI 1 HealthChoices BH-MCO Average of 56.4% by 4.6 percentage points, while the QI 2 rate was statistically significantly lower than the QI 2 HealthChoices BH-MCO Average of 76.6% by 6.1 percentage points. In the 6 to 20 year old population, there were no statistically significant year-to-year changes in HEDIS follow-up rates for any of the five HC BH Contractors associated with MBH.

Figure 5 is a graphical representation of the MY 2014 HEDIS follow-up rates in the 6 to 20 year old population for MBH and its associated HC BH Contractors. **Figure 6** shows the HC BH Contractor Averages for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rate for Delaware was statistically significantly lower than the MY 2014 QI 1 HC BH Contractor Average of 56.5% by 8.4 percentage points. For QI 2, rates for Lehigh, Bucks, Montgomery and Delaware were statistically significantly lower than the QI 2 HC BH Contractor Average of 78.3% by 6.7 to 11.7 percentage points.

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

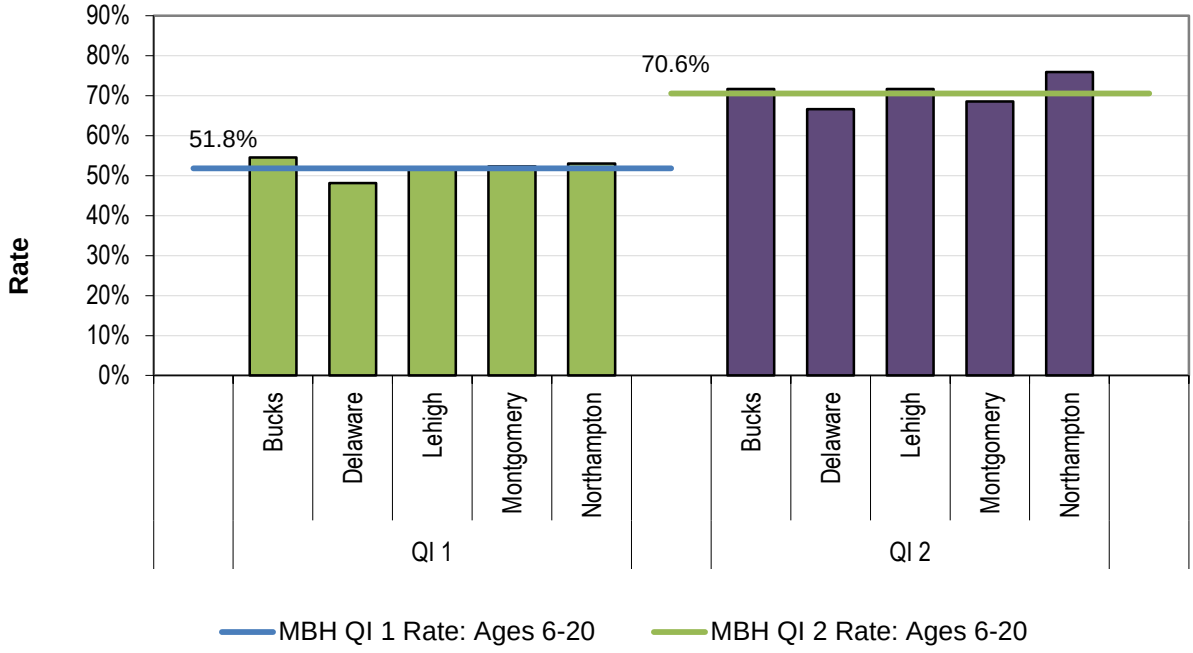
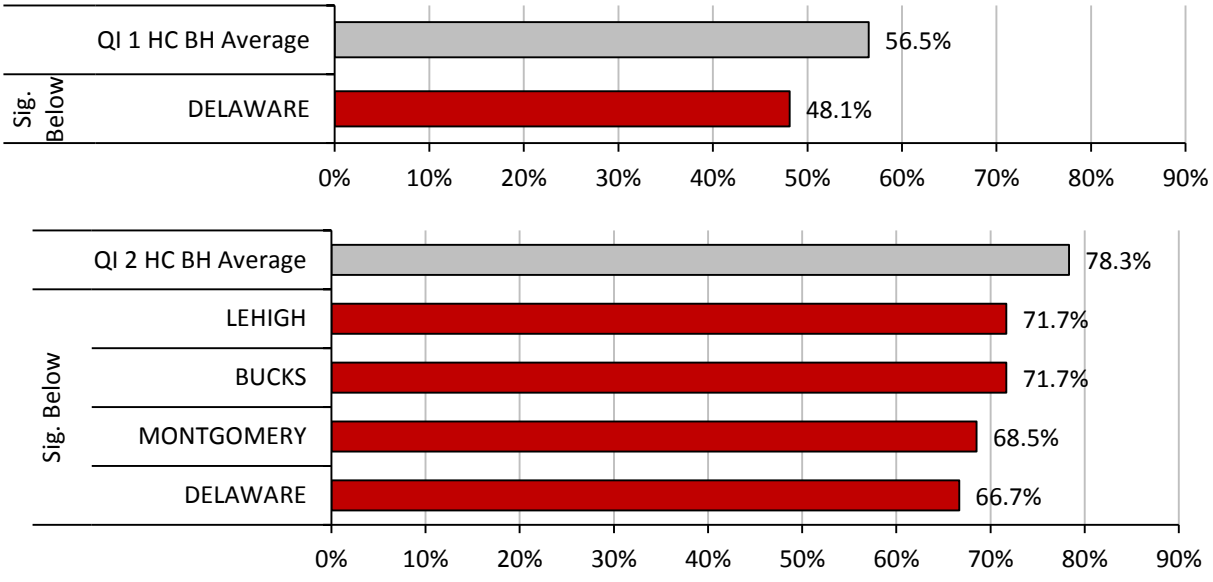


Figure 6: HEDIS Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average: 6-20 Years Old



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)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2013 %	Rate Comparison of MY 14 vs. MY 13 PPD	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
MBH	3,220	5,389	**59.8%**	58.4%	61.1%			62.5%	-2.7	YES
Bucks	549	888	**61.8%**	58.6%	65.1%			61.1%	0.8	NO
Delaware	635	1,069	**59.4%**	56.4%	62.4%			62.5%	-3.1	NO
Lehigh	763	1,318	**57.9%**	55.2%	60.6%			61.8%	-3.9	YES
Montgomery	757	1,280	**59.1%**	56.4%	61.9%			62.4%	-3.3	NO
Northampton	516	834	**61.9%**	58.5%	65.2%			65.1%	-3.3	NO
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
MBH	3,963	5,389	**73.5%**	72.4%	74.7%			75.3%	-1.8	YES
Bucks	666	888	**75.0%**	72.1%	77.9%			72.8%	2.2	NO
Delaware	762	1,069	**71.3%**	68.5%	74.0%			72.8%	-1.5	NO
Lehigh	969	1,318	**73.5%**	71.1%	75.9%			76.6%	-3.0	NO
Montgomery	918	1,280	**71.7%**	69.2%	74.2%			75.8%	-4.1	YES
Northampton	648	834	**77.7%**	74.8%	80.6%			79.1%	-1.4	NO

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 MBH MY 2014 PA-specific follow-up rates were 59.8% for QI A and 73.5% for QI B; both rates were statistically significantly lower than MBH's MY 2013 rates of 62.5% for QI A (2.7 percentage point difference) and 75.3% for QI B (1.8 percentage point difference). The QI A rate for MBH was statistically significantly above the QI A HealthChoices BH-MCO Average of 58.2% by 1.6 percentage points, while the QI B rate for MBH was statistically lower than the QI B HealthChoices BH-MCO Average of 74.8% by 1.3 percentage points. MBH had the highest QI A rate of the five BH-MCOs evaluated in MY 2014.

As presented in **Table 11**, the QI A rate in Lehigh statistically significantly decreased by 3.9 percentage points from the QI A rate in MY 2013, and the QI B rate in Montgomery statistically significantly decreased by 4.1 percentage points.

Figure 7 is a graphical representation of the MY 2014 PA-specific follow-up rates for MBH and its associated HC BH Contractors. **Figure 8** shows the HC BH Contractor Averages and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. QI A rates for Bucks and Northampton were statistically significantly above the MY 2014 QI A HC BH Contractor Average of 57.7% by 4.1 percentage points each. The QI B rates for Montgomery and Delaware were statistically significantly below the QI B HC BH Contractor Average of 75.5% by 3.8 and 4.2 percentage points respectively.

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

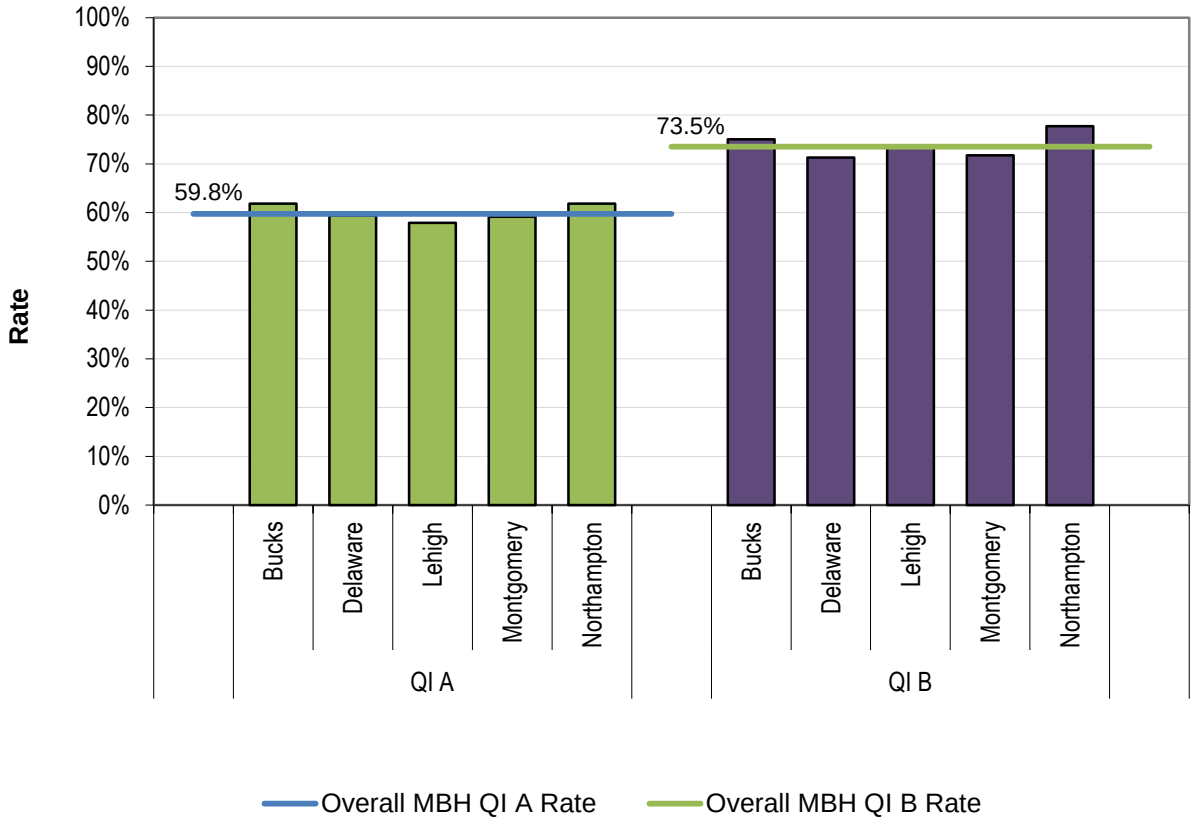
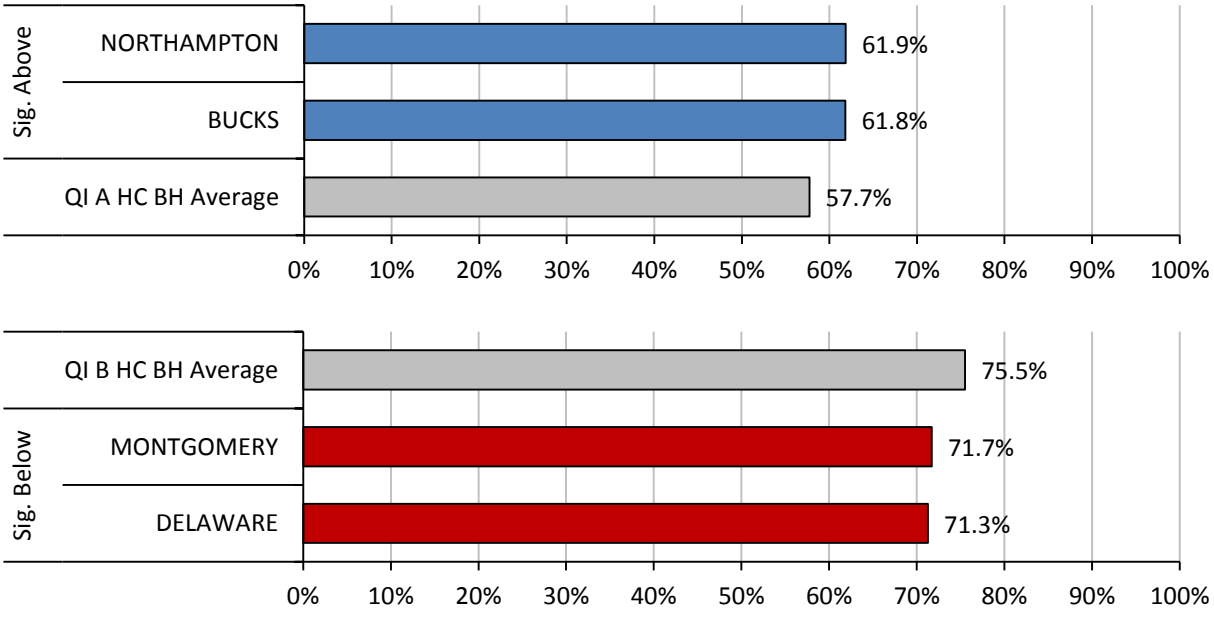


Figure 8: PA-Specific Follow-up Indicator Rates Compared to MY 2014 HealthChoices HC BH Contractor Average – Overall Population



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								MY 2013
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	BH-MCO Average	BH HC Contractor Average	2014 Goal Met?	%
Inpatient Readmission									
HealthChoices Aggregate	6,510	45,657	**14.3%**	14.0%	14.6%	14.3%	14.0%	NO	13.6%
MBH	1,136	7,376	**15.4%**	14.6%	16.2%			NO	14.9%
Bucks	217	1,301	**16.7%**	14.6%	18.8%			NO	15.4%
Delaware	189	1,455	**13.0%**	11.2%	14.8%			NO	13.4%
Lehigh	293	1,751	**16.7%**	14.9%	18.5%			NO	15.8%
Montgomery	272	1,791	**15.2%**	13.5%	16.9%			NO	14.4%
Northampton	165	1,078	**15.3%**	13.1%	17.5%			NO	15.5%

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

The MY 2014 HealthChoices Aggregate readmission rate was 14.3%, statistically significantly higher than the MY 2013 HealthChoices Aggregate rate of 13.6% by 0.7 percentage points (**Table 12**). The MBH MY 2014 Readmission rate of 15.4% increased slightly from the MY 2013 rate of 14.9%; however, this change is not statistically significant. The MBH Readmission rate of 15.4% was statistically significantly higher than the HealthChoices BH-MCO Average of 14.3% by 1.1 percentage points. Note that this measure is an inverted rate, in that lower rates indicate better performance. MBH did not meet the OMHSAS performance goal of a readmission rate below 10.0% in MY 2014.

None of the MBH HC BH Contractors had statistically significant changes in their readmission rates from the prior year. As presented in **Table 12**, none of the HC BH Contractors associated with MBH met the performance goal of a readmission rate below 10.0% in MY 2014.

Figure 9 is a graphical presentation of the MY 2014 readmission rates for MBH HC BH Contractors compared to the performance measure goal of 10.0%. **Figure 10** presents individual MBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor average readmission rate of 14.0%. This measure is an inverted rate, meaning that rates statistically significantly below the HC BH Contractor Average indicate good performance, and rates statistically significantly above the HC BH Contractor Average indicate poor performance. Both Bucks County's and Lehigh County's readmission rate of 16.7% was statistically significantly higher (poorer) than the HealthChoices HC BH Contractor average by 2.7 percentage points. Readmission rates for the remaining MBH HC BH Contractors were not statistically significantly different from the HC BH Contractor Average.

Figure 9: MY 2014 Readmission Rates

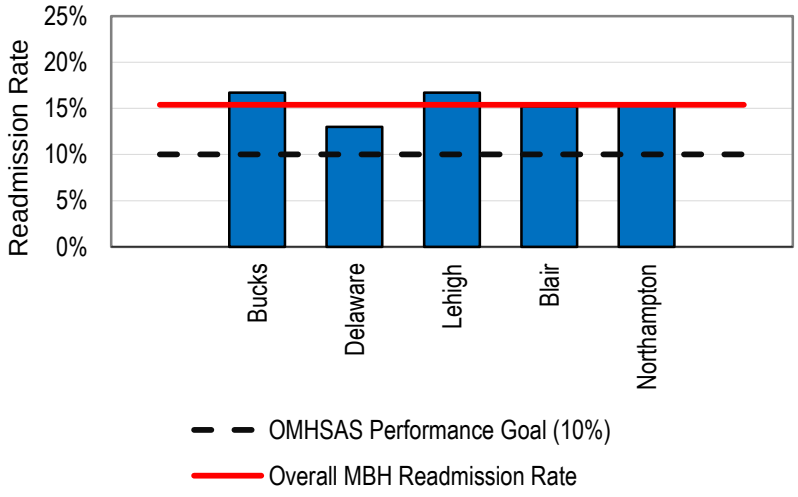
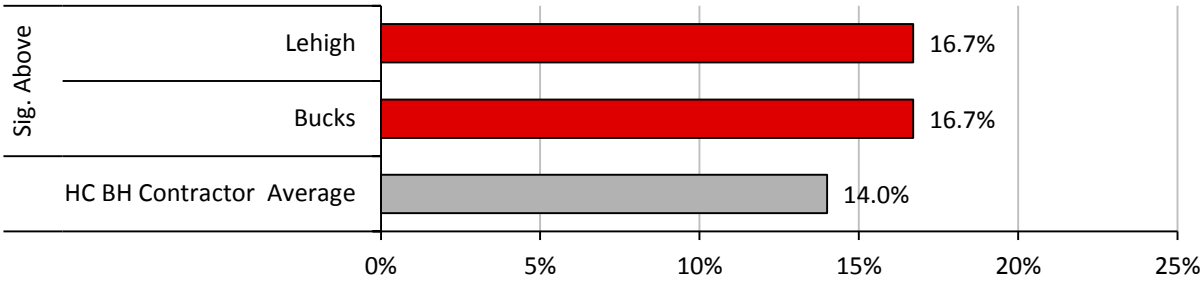


Figure 10: MY 2014 Readmission Rates Compared to HealthChoices HC BH Contractor Average



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 2014 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
MBH	121	419	**28.9%**	24.4%	33.4%			24.9%	4.0	NO	Below 25th Percentile
Bucks	22	69	**31.9%**	*20.2%*	*43.6%*			30.1%	1.8	NO	Below 25th Percentile
Delaware	34	94	**36.2%**	*26.0%*	*46.4%*			38.2%	-2.0	NO	Below 25th Percentile
Lehigh	20	109	**18.3%**	10.6%	26.0%			15.4%	2.9	NO	Below 25th Percentile
Montgomery	19	60	**31.7%**	*19.1%*	*44.3%*			17.5%	14.2	NO	Below 25th Percentile
Northampton	26	87	**29.9%**	*19.7%*	*40.1%*			28.3%	1.6	NO	Below 25th 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
MBH	80	419	**19.1%**	15.2%	23.0%			17.8%	1.3	NO	Below 75th, at or above 50th percentile
Bucks	16	69	**23.2%**	*12.5%*	*33.9%*			19.3%	3.9	NO	At or above 75th Percentile
Delaware	24	94	**25.5%**	*16.2%*	*34.8%*			30.3%	-4.8	NO	At or above 75th Percentile
Lehigh	14	109	**12.8%**	6.1%	19.5%			8.3%	4.5	NO	Below 50th, at or above 25th percentile
Montgomery	10	60	**16.7%**	*6.4%*	*27.0%*			14.0%	2.7	NO	Below 75th, at or above 50th percentile
Northampton	16	87	**18.4%**	*9.7%*	*27.1%*			22.8%	-4.4	NO	Below 75th, at or above 50th 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 (**Table 13**). These rates were comparable to the MY 2013 13-17 year old HealthChoices Aggregate rates of 35.4% and 24.9%, respectively. 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 MBH MY 2014 13-17 year old Initiation rate of 28.9% increased from the MY 2013 rate of 24.9% by 4.0 percentage points; however this change was not statistically significant (**Table 13**). The MBH MY 2014 13-17 year old Engagement rate of 19.1% did not statistically significantly change from the MY 2013 rate of 17.8%. The MBH MY 2014 13-17 year old Initiation rate of 28.9% was statistically significantly lower than the Initiation HealthChoices BH-MCO Average of 34.7% by 5.8 percentage points. The Engagement rate of 19.1% was statistically significantly lower than the Engagement

HealthChoices BH-MCO Average of 23.5% by 4.4 percentage points. The MBH Initiation rate for this age group was below the HEDIS 2015 25th percentile, while the Engagement rate for MBH was between the HEDIS 2015 50th and 75th percentile (**Table 13**).

As presented in **Table 13**, all HC BH Contractors associated with MBH were below the HEDIS 2015 50th percentile for Initiation. For MY 2014 Engagement rates for this age group, three HC BH Contractors were between the HEDIS 2015 50th and 75th percentile. Lehigh was between the 25th and 50th percentile, while Delaware was at or above the 75th percentile.

Figure 11 is a graphical representation of the 13-17 year old MY 2014 HEDIS Initiation and Engagement rates for MBH and its associated HC BH Contractors. **Figure 12** shows the HealthChoices HC BH Contractor Average rates for this age cohort and the individual MBH HC BH Contractor rates that were statistically significantly higher or lower than the HealthChoices HC BH Contractor Average. The Initiation rates for Lehigh was statistically significantly lower than the MY 2014 Initiation HC BH Contractor Average of 33.3% by 15.0 percentage points. The Engagement rate for Lehigh was statistically significantly lower than the Engagement HC BH Contractor Average of 19.7% by 6.9 percentage point. HEDIS rates for the remaining MBH HC BH Contractors were not statistically significantly different from the respective HC BH Contractor Averages.

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

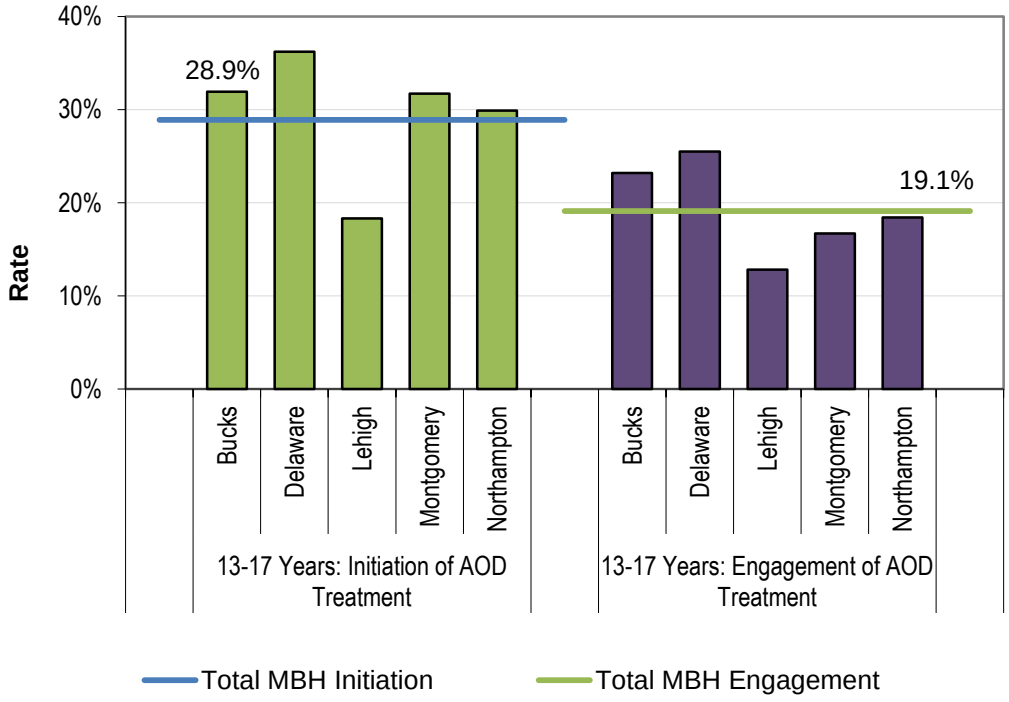
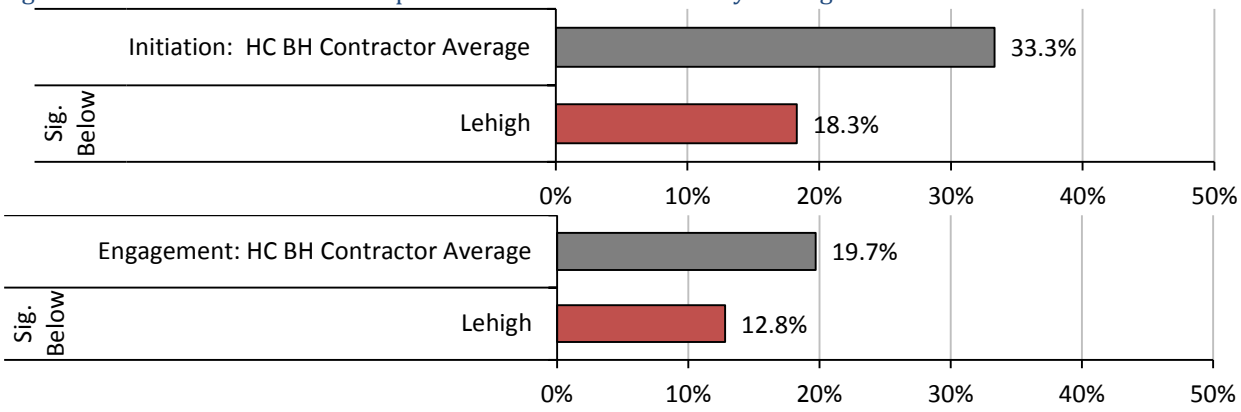


Figure 12: MY 2014 IET Rates Compared to HealthChoices County Average: 13–17 Years Old



(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 2014 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
MBH	1,311	4,982	**26.3%**	25.1%	27.5%			28.8%	-2.5	YES	Below 25th Percentile
Bucks	272	1,118	**24.3%**	21.7%	26.9%			31.3%	-7.0	YES	Below 25th Percentile
Delaware	370	1,374	**26.9%**	24.5%	29.3%			28.1%	-1.2	NO	Below 25th Percentile
Lehigh	218	735	**29.7%**	26.3%	33.1%			31.2%	-1.5	NO	Below 25th Percentile
Montgomery	268	1,159	**23.1%**	20.6%	25.6%			26.4%	-3.3	NO	Below 25th Percentile
Northampton	183	596	**30.7%**	26.9%	34.5%			27.7%	3.0	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
MBH	914	4,982	**18.3%**	17.2%	19.4%			20.1%	-1.8	YES	At or above 75th Percentile
Bucks	155	1,118	**13.9%**	11.8%	16.0%			20.5%	-6.6	YES	Below 75th, at or above 50th percentile
Delaware	287	1,374	**20.9%**	18.7%	23.1%			20.1%	0.8	NO	At or above 75th Percentile
Lehigh	160	735	**21.8%**	18.7%	24.9%			24.1%	-2.3	NO	At or above 75th Percentile
Montgomery	189	1,159	**16.3%**	14.1%	18.5%			16.9%	-0.6	NO	At or above 75th Percentile
Northampton	123	596	**20.6%**	17.3%	23.9%			20.5%	0.1	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 MBH Initiation rate of 26.3% in the 18+ year age group statistically significantly decreased by 2.5 percentage points from the MY 2013 Initiation rate (**Table 14**). The MY 2014 Engagement rate of 18.3% statistically significantly decreased from the MY 2013 rate of 20.1% by 1.8 percentage points. The MBH Initiation rate was statistically significantly lower than the HealthChoices BH-MCO Average of 28.7% by 2.4 percentage points. The MBH Engagement rate of 18.3% in this age cohort was not statistically significantly lower than the HealthChoices BH-MCO average rate of 18.8%. Compared to the HEDIS 2015 benchmarks for the 18+ year old age cohort, the Initiation rate for MBH was below the 25th percentile, while the Engagement rate was at or above the 75th percentile.

As presented in **Table 14**, Initiation rates in the 18+ age group were below the 25th percentile for all five MBH HC BH Contractors. Engagement rates in this age group were at or above the 75th percentile for all HC BH Contractors except Bucks, which fell between the 50th and 75th percentile.

Figure 13 is a graphical representation MY 2014 IET rates for MBH and its associated HC BH Contractors for the 18+ age group. **Figure 14** shows the HealthChoices HC BH Contractor Average rates and individual MBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. The Initiation rate for Bucks and Montgomery were statistically significantly lower than the HealthChoices HC BH Contractor Average Initiation rate of 28.3% by 4.0 and 5.2 percentage points, respectively. The Engagement rate for Bucks was statistically significantly lower than the HC BH Contractor Average of 18.0% by 4.1 percentage points. The Engagement rates for Lehigh and Delaware were statistically significantly above the HC BH Contractor Average of 18.0% by 3.8 and 2.9 percentage points, respectively.

Figure 13: MY 2014 IET Rates – 18+Years

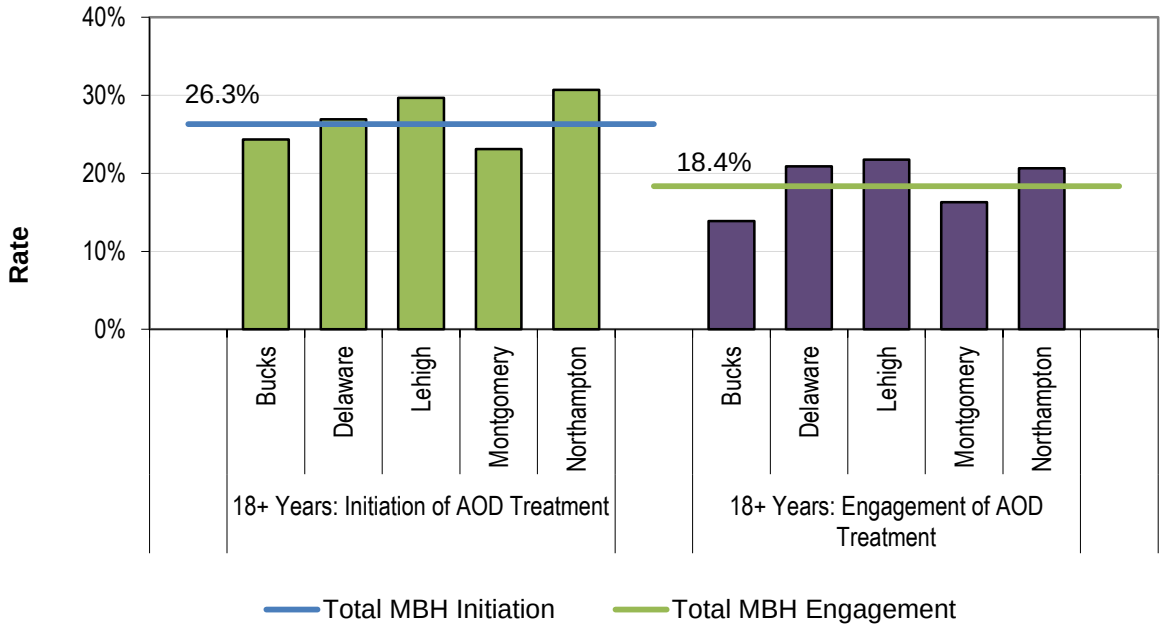
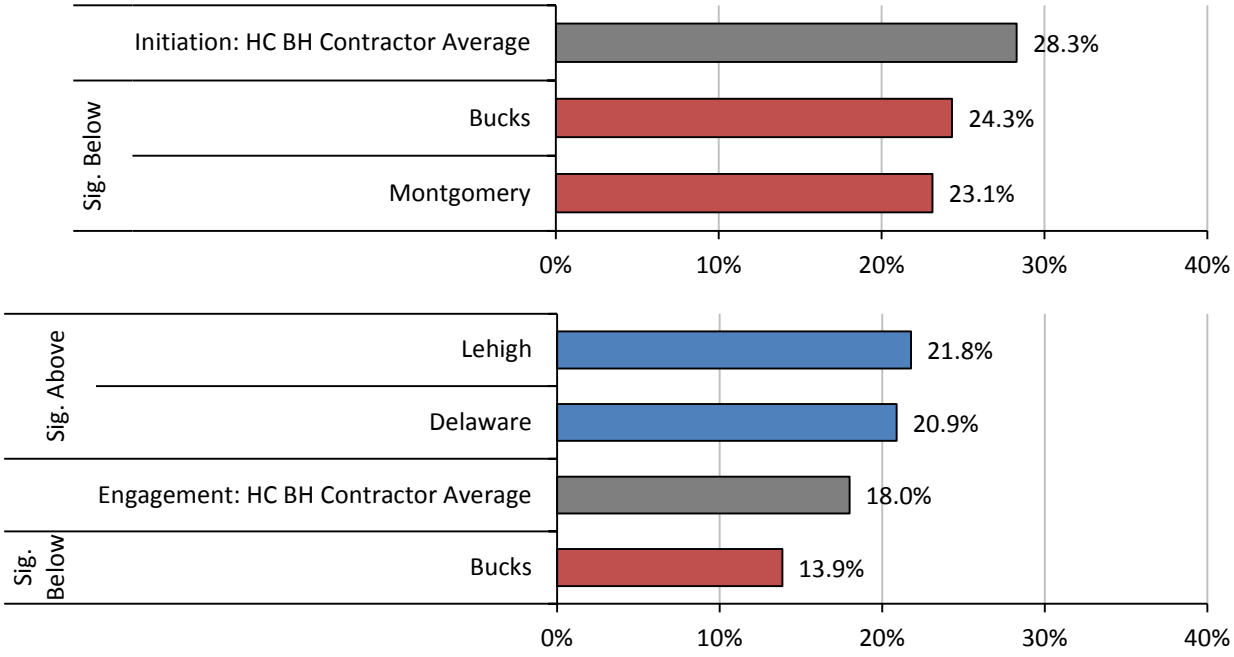


Figure 14: MY 2014 IET Rates Compared to HealthChoices HC BH Contractor Average – 18+ Years



(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 2014 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
MBH	1,432	5,401	**26.5%**	25.3%	27.7%			28.5%	-2.0	YES	Below 25th Percentile
Bucks	294	1,187	**24.8%**	22.3%	27.3%			31.2%	-6.4	YES	Below 25th Percentile
Delaware	404	1,468	**27.5%**	25.2%	29.8%			28.6%	-1.1	NO	Below 25th Percentile
Lehigh	238	844	**28.2%**	25.1%	31.3%			28.6%	-0.4	NO	Below 25th Percentile
Montgomery	287	1,219	**23.5%**	21.1%	25.9%			26.1%	-2.6	NO	Below 25th Percentile
Northampton	209	683	**30.6%**	27.1%	34.1%			27.8%	2.8	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
MBH	994	5,401	**18.4%**	17.4%	19.4%			19.9%	-1.5	NO	At or above 75th Percentile
Bucks	171	1,187	**14.4%**	12.4%	16.4%			20.4%	-6.0	YES	Below 75th, at or above 50th percentile
Delaware	311	1,468	**21.2%**	19.1%	23.3%			20.6%	0.6	NO	At or above 75th Percentile
Lehigh	174	844	**20.6%**	17.8%	23.4%			21.5%	-0.9	NO	At or above 75th Percentile
Montgomery	199	1,219	**16.3%**	14.2%	18.4%			16.8%	-0.5	NO	At or above 75th Percentile
Northampton	139	683	**20.4%**	17.3%	23.5%			20.8%	-0.4	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 MBH Initiation rate statistically significantly decreased from the MY 2013 rate of 28.5% by 2.0 percentage points (**Table 15**). The MBH Initiation rate of 26.5% was statistically significantly lower than the HealthChoices BH-MCO Average of 29.1% by 2.6 percentage points. The MBH Engagement rate of 18.4% was not statistically significantly lower than the HealthChoices BH-MCO Average rate of 19.1%. Compared to the HEDIS 2015 benchmarks, the Initiation rate for MBH was below the 25th percentile, while the Engagement rate was at or above the 75th percentile.

As presented in **Table 15**, Initiation rates were below the 25th percentile for all MBH HC BH Contractors. Engagement rates were at or above the 75th percentile for all MBH HC BH Contractors, except for Bucks, which had an Engagement rate between the 50th and 75th percentile.

Figure 15 is a graphical representation MY 2014 IET rates for MBH and its associated HC BH Contractors. **Figure 16** shows the HealthChoices HC BH Contractor Average rates and individual MBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. The Initiation rates for Bucks and Montgomery were statistically significantly lower than the HealthChoices HC BH Contractor Average Initiation rate of 28.7% by 3.9 and 5.2 percentage points, respectively. The Engagement rate for Bucks was statistically significantly lower than the HC BH Contractor Average of 18.2% by 3.8 percentage points, while the Engagement rate for Delaware was statistically significantly higher than the HC BH Contractor Average by 3.0 percentage points.

Figure 15: MY 2014 IET Rates: 13+Years

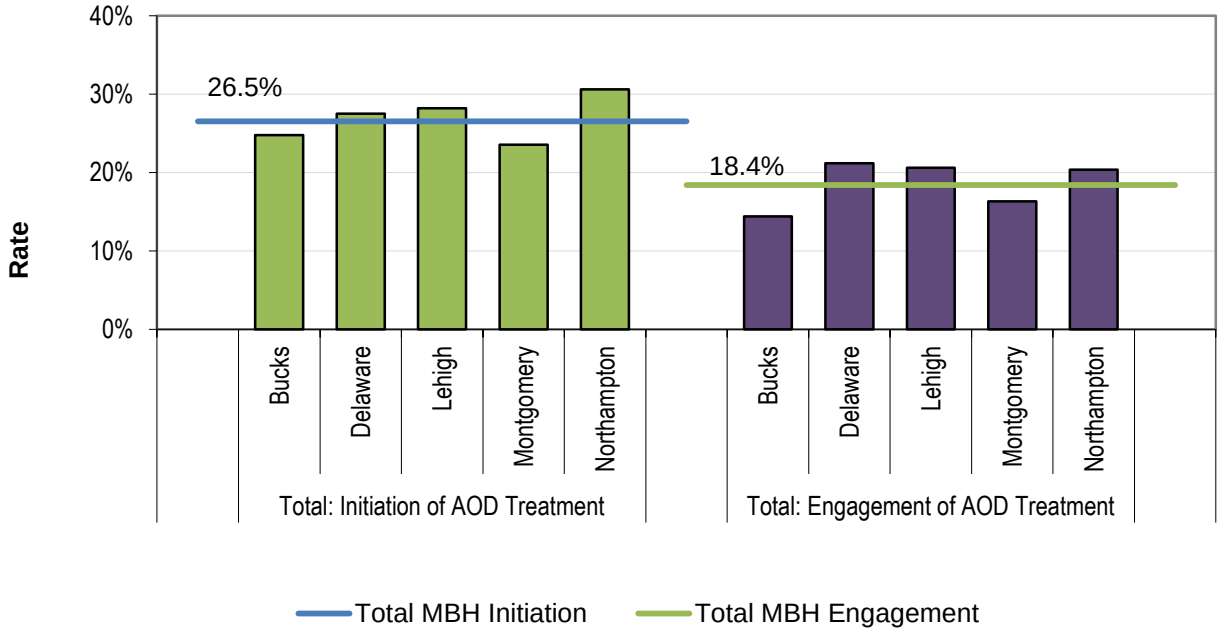
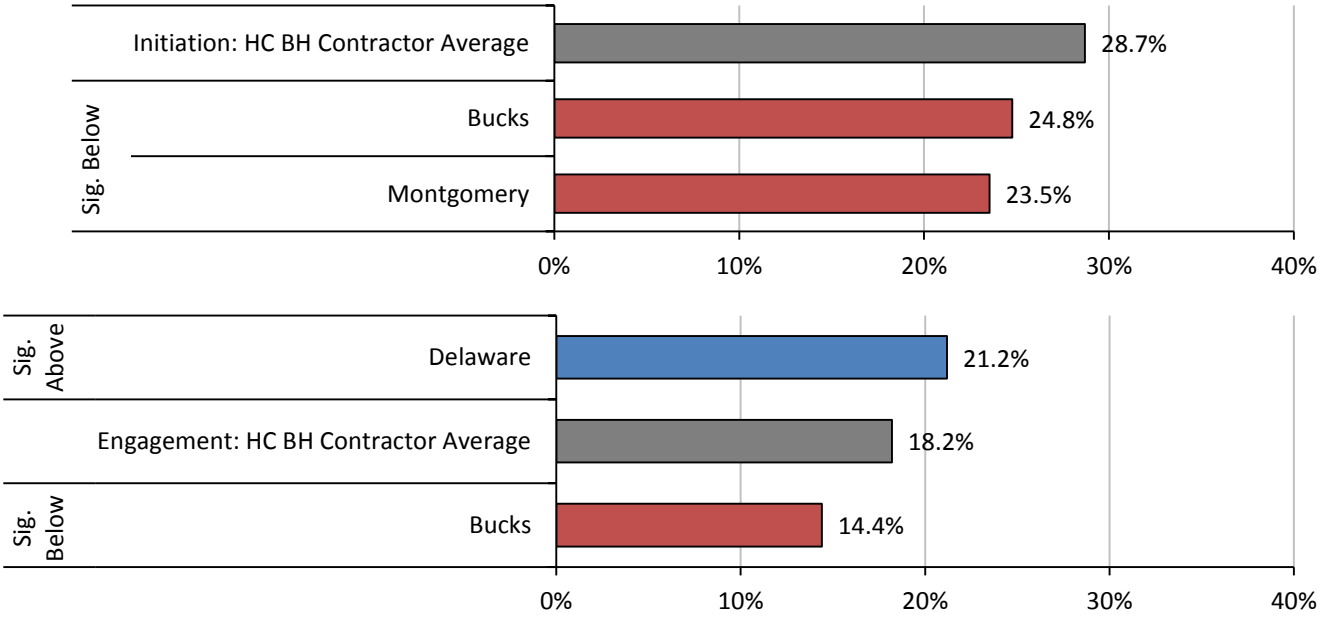


Figure 16: MY 2014IET Rates Compared to HealthChoices HC BH Contractor Average: 13+ Years



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. As seen with other performance measures, there is significant variation between the HC BH Contractors. 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 MBH'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 and Planned Through 10/31/15	Future Actions Planned (Specify Dates)
Review of compliance with standards conducted by the Commonwealth in RY 2011, RY 2012, and RY 2013 found MBH to be partially compliant with three Subparts associated with Structure and Operations Standards.		Please note that the findings which are addressed within this response are applicable across each of the five counties: Bucks, Delaware, Lehigh, Montgomery & Northampton. Items responded to in Sections MBH 2014.01, MBH 2014.02 and MBH 2014.03 have also been addressed through a Corrective Action Plan submitted to DHS-OMHSAS, Bureau of Quality Management and Data Review.	
MBH 2014.01	MBH was partially compliant on one out of seven categories within Subpart C: Enrollee Rights and Protections. The partially compliant category is Enrollee Rights.	**Standard 60, Substandard 1** To consolidate the processing of complaints and complaint investigating complaints under the Quality Management Department, as of 4/1/15, the Complaints and Grievances unit was moved from Compliance to the the Quality Improvement Department.  Compliance and QI Reorganization_2015 The practice of assigning clinical staff to investigate complaints was discontinued. The position of Compliance Care Manager, Senior, was added to conduct complaint investigations.  Compliance Care Manager, Senior- job **Standard 60, Substandard 2** In order to ensure that staff responsible for complaints have the ability to guide and direct the investigation, review and follow-up of complaint issues, on 4/24/15, Complaint Investigation and Decision Guidelines training curriculum was provided to staff at Magellan and the Counties who are involved in the handling and response for complaints and grievances.    2015 Complaint Investigation & Decisi Complaint Invest and Dec Guide - Lehigh At Complaint Invest and Dec Guide - Newtown The *Counties to continue to audit 1st level complaint records and provide feedback of their findings.*	***Standard 60, Substandard 1*** Actions completed. No further actions planned. ***Standard 60, Substandard 2*** Actions completed. No further actions planned.

Reference Number	Opportunity for Improvement	Follow-up Actions Taken and Planned Through 10/31/15	Future Actions Planned (Specify Dates)
		Standard 60, Substandard 3 In order to ensure that all Magellan staff are trained on the complaint process, on 1/28/15, the Complaints and Grievances Overview training curriculum was presented to all BH-MCO staff. This same training curriculum is reviewed with all new BH-MCO staff within 1 month of hire.  2015 C&G overview for all staff.pptx  2015 C&G Overview 2015 Attendance Rer  2015 C&G Overview 2015 Attendance Ons  2015 C&G Overview 2015 Achieve Attesta *Counties to continue to audit 1st level complaint records and provide feedback of their findings.*	***Standard 60, Substandard 3*** *Training curriculum will be presented annually to all Magellan staff.*
MBH 2014.02	MBH 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, and 4) Practice Guidelines.	**Standard 28, Substandard 1** In order to address deficiencies identified, clinical prompts within Magellan's IP system were developed. Areas addressed include: medical necessity determinations, particularly for children under 6; streamlining documentation of CM activities to focus on relevant case history, status updates and key clinical issues and follow up on key issues or open questions in each clinical review until the issue or question is resolved; and more active care management for individuals with SUD and children under 6.  PreCoded Note Prompts 2015.docx Clinical staff trained on documentation of MNC and new IP Prompts.  Clinical Training and Roster 6.10.15.pdf In order to ensure use of Magellan provider performance processes to address problems with providers' clinical judgment, CMs were trained on the use of PPIRs for clinical judgment issues, such as when a provider refuses to take a member into treatment or fails to respond to CM suggestions and requests.	***Standard 28, Substandard 1*** Monitoring of CM compliance through regular supervision, team meetings, training and review of denial documentation, 12/31/15 Actions completed. No further actions planned. PPIR Training will be provided annually to all Magellan clinical, medical and quality staff.

Reference Number	Opportunity for Improvement	Follow-up Actions Taken and Planned Through 10/31/15	Future Actions Planned (Specify Dates)
		 PPIRs and PEPS feedback.pdf  PPIR Training 2015 Attendance Onsite.pd  PPIR Training 2015 Attendance Remote.p To ensure coordination in the management of concerns with providers' performance across Magellan's QI, Clinical, Medical and Network departments, PPIR issues will be referred to the Network Strategy Committee for review and recommendations made by QI, Clinical and Network management.  Network Strategy Committee Minutes 04 **Standard 28, Substandard 2** In order to address deficiencies identified, clinical prompts within Magellan's IP system were developed. Areas addressed include:the need for Denial documentation to reflect that necessary steps are taken to seek additional clinical information to guide denial determinations, including diagnostic information, course of illness, response to treatment, symptom severity, environmental factors, and the availability of appropriate alternative services in the event of a denial and documentation of MNC. *Please see PreCoded Note Prompts inserted above.* Clinical staff trained on areas mentioned above. *Please see Clinical Training and Roster inserted above.* **Standard 72, Substandard 1** In order to address identified deficiencies, the denial letter templates were updated to include member identification number consistently for all Counties and to clarify effective decision dates on multiple service requests.	***Standard 28, Substandard 2*** Monitoring of CM compliance through regular supervision, team meetings, training and review of denial documentation, 12/31/15. ***Standard 72, Substandard 1*** Individual county audit results will be combined to offer findings and feedback from aggregated perspective. Please note that any opportunity identified for improvement which requires corrected correspondence with the member or provider will be completed immediately.

Reference Number	Opportunity for Improvement	Follow-up Actions Taken and Planned Through 10/31/15	Future Actions Planned (Specify Dates)
		Example_Bucks Full Denial rev 11.14.14.(Example_Bucks Denial Shorter Durati(Example_Bucks Denial Different Servi The denial letter workflow was revised to add additional review of letters before being distributed. Adverse Determination Letter *The Counties to continue to audit denial letters and provide feedback of their findings.*	
MBH 2014.03	MBH 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.	**Standard 68, Substandard 1** Complaint workflow and policies revised to reflect the reorganization, the composition and responsibilities of 1st level complaint level review committee, including status of investigation, documentation standards, identification of needed follow-up, final letter review and coordination with Network, QI and Clinical departments, as needed First Level Complaint Workflow_07232015. Complaint Script_201501.docx Member Complaint_Example- I The practice of assigning clinical staff to investigate complaints was discontinued. The position of Compliance Care Manager, Senior, was added to conduct complaint investigations. As of 4/1/15, the processing of complaints, including complaint investigations, was moved under the Quality Management Department. *The Counties to continue to audit 1st level complaint records and provide feedback of their findings.* *Please see documents embedded in response to Standard 60, Substandard 1 in Section MBH2014.01 above.* **Standard 68, Substandard 3** Complaint workflow and policies revised to reflect the reorganization, the composition and responsibilities of 1st level complaint level review committee, including status of investigation, documentation standards, identification of needed follow-up, final letter review and coordination with Network, QI and Clinical departments, as needed.	***Standard 68, Substandard 1*** Individual county audit results will be combined to offer findings and feedback from aggregated perspective. ***Standard 68, Substandard 3*** Individual county audit results will be combined to offer findings and feedback from aggregated perspective.

Reference Number	Opportunity for Improvement	Follow-up Actions Taken and Planned Through 10/31/15	Future Actions Planned (Specify Dates)
		The information provided in the complaint decision letters reflects all issued identified by the member and clearly demonstrates that Magellan is making the determination for each complaint issue. *Counties to continue to audit 1st level complaint records and provide feedback of their findings.* *Please see documents embedded in response to Standard 68, Substandard 1 above.* **Standard 68, Substandard 4** Complaint workflow and policies revised to reflect the reorganization, the composition and responsibilities of 1st level complaint level review committee, including status of investigation, documentation standards, identification of needed follow-up, final letter review and coordination with Network, QI and Clinical departments, as needed *Continue with ongoing practices of identifying any provider performance concerns.* *Counties to continue to audit 1st level complaint records and provide feedback of their findings.* *Please see documents embedded in response to Standard 68, Substandard 1 above.* **Standard 68, Substandard 5** Complaint workflow and policies revised to reflect the reorganization, the composition and responsibilities of 1st level complaint level review committee, including status of investigation, documentation standards, identification of needed follow-up, final letter review and coordination with Network, QI and Clinical departments, as needed. *Continue with ongoing practices of identifying any provider performance concerns.* *Counties to continue to audit 1st level complaint records and provide feedback of their findings.* *Please see documents embedded in response to Standard 68, Substandard 1 above.* **Standard 60, Substandards 1, 2 & 3** Please see response to these PEPS Standards/Substandards in Section MBH 2014.01	***Standard 68, Substandard 4*** Individual county audit results will be combined to offer findings and feedback from aggregated perspective. ***Standard 68, Substandard 5*** Individual county audit results will be combined to offer findings and feedback from aggregated perspective. . ***Standard 60, Substandards 1, 2 & 3*** Please see response to these PEPS Standards/Substandards in Section MBH 2014.01

Reference Number	Opportunity for Improvement	Follow-up Actions Taken and Planned Through 10/31/15	Future Actions Planned (Specify Dates)
		Standard 72, Substandard 1 Please see response to this PEPS Standards/Substandard in Section MBH 2014.02	***Standard 72, Substandard 1*** Please see response to this PEPS Standards/Substandard in Section MBH 2014.02
MBH 2014.04	MBH's rate for the MY 2013 Readmission Within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (poorer) than the MY 2013 HealthChoices' BH-MCO Average by 1.4 percentage points. MBH's rate did not meet the OMHSAS designated performance goal of 10.0%.	Magellan submitted the 30-day Readmission Rate RCA to IPRO and OMHSAS by the October 9, 2015 deadline.	*Implement actions identified in submitted RCA. Please see Frm_201 BH PM RCA Response_MBH_100915 for details.*
MBH 2014.05	MBH's rate for the MY 2013 Follow-up After Hospitalization for Mental Illness HEDIS performance measures did not meet the OMHSAS designated performance goal of the HEDIS 75th percentile for ages 6-64.	Magellan submitted the Follow-up After Hospitalization (FUH) Root Cause Analysis (RCA) to IPRO and OMHSAS by the October 9, 2015 deadline.	*Implement actions identified in submitted RCA. Please see Frm_201 BH PM RCA Response_MBH_100915 for details.*

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, MBH began to address opportunities for improvement related to Standards 28, 60, 68, and 72. Proposed actions and evidence of actions taken by MBH 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 MBH 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, MBH 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**)
- Readmission Within 30 Days of Inpatient Psychiatric Discharge (**Table 19**)

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 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):	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6-64*	***Response Date:***
Magellan Behavioral Health (MBH)		***10/9/15***

Goal Statement: **(Please specify individual goals for each measure): Based on the three year goal set by OMHSAS for the HEDIS 7-day performance measure for members ages 6 to 64 years for all HC BH Contractors and BH-MCOs to meet or exceed the HEDIS 75th percentiles, the methodology for interim goal setting was used to determine the goals for improvement expected for MY2014. Since Magellan's MY2013 results were in the 'Below 75th, at or above 50th percentile' category, a 2% increase to 48.05% is the goal for MY2014.**

***Analysis*:**
What factors contributed to poor performance?
Please enter "N/A" if a category of factors does not apply.

Findings

Magellan's MY2013 rate for this measure was 4.2 percentage points higher than the MY2012 rate. This 8.9% increase was a statistically significant improvement. Additionally, Magellan's rate was 4.4 percentage points higher than the HealthChoices' BH-MCO average. This 9.2% increase was also a statistically significant improvement. All Counties met their MY2013 Interim goals.

Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6-64

	MY2012	MY2013	% change from MY2012 to MY2013	2013 Goal met?	MY2014 Goal
HC Avg	47.50%	47.13%	-0.80%	No	48.07%
MBH	47.30%	51.49%	8.90%	Yes	52.52%
BU	45.80%	51.80%	12.98%	Yes	52.84%
DE	43.10%	46.65%	8.24%	Yes	47.59%
LE	47.90%	52.58%	9.86%	Yes	53.64%
MO	46.60%	51.07%	9.69%	Yes	52.09%
NH	55.10%	56.85%	3.25%	Yes	maintain/improve

Please note that barriers to further improvement in Follow-up rates for this measure in MY2013 are consistent with those identified in the analysis of barriers to Follow-up-HEDIS, 7-day in MY2012. To ensure alignment with barriers to actions implemented for the reader, the barriers are listed below.

Policies	***Initial Response***
(e.g., data systems, delivery systems, provider facilities)	
N/A	***Follow-up Status Response***
Procedures	***Initial Response***

(e.g., payment/reimbursement, credentialing/collaboration) • **Poor documentation of discharge plan** • **No process for specialized FUH attention for those likely to readmit or not attend FUH** • **No one calling to remind member of appointment** • **Medication not pre-authorized upon d/c** • **Focus on PA-specific accepted aftercare appointment** • **Providers not submitting claims to document treatment provided** • **Medication prescription from d/c not covering time until psychiatrist appt (more likely after 7 days post-dc)**	• *The delay that can result when the discharge plan is not communicated clearly to the member including the provider, date and time of the appointment.* • *The delay that can result when there are no specialized interventions employed to increase the likelihood of appointment adherence for individuals at high risk of readmission to the AIP unit or not keeping their FUH.* • *The delay that can result when an individual forgets their FUH appointment information including provider address, date and time of appointment.* • *The delay that can result when an individual is unable to obtain medications following discharge, due to a lack of preauthorization.* • *The delay that can result when provider focuses discharge plan on FUH appointments with levels of care that are not included in the HEDIS methodology i.e., targeted case management.* • *The incomplete data source regarding FUH services provided when claims are not submitted.* • *The delay that can result when an individual's supply of medication is exhausted prior to the FUH appointment* ***Follow-up Status Response***
People (e.g., personnel, provider network, patients) • **Mbr choosing not to accept care** • **Bad experience w/provider** • **Medication Changes** • **Substance use relapse** • **Co-morbid medical conditions** • **Medication prescription from d/c not covering time until psychiatrist appt (more likely after 7 days post-dc)**	***Initial Response*** • *The delay that can result when an individual chooses to not pursue treatment following discharge from an inpatient setting.* • *The delay that can result when an individual is dissatisfied with their interactions with a provider such that there is hesitation to return to the provider for treatment.* • *The delay that can result when an individual has difficulty managing the effects of new medications when in the community* • *The delay that can result when an individual resumes use of substances and a substance abusing lifestyle which causes distraction from and/or avoidance of treatment.* • *The delay that can occur, due to limited resources, when an individual requires specialized medical care concomitant with their psychiatric care upon discharge.* • *The delay that can result when an individual's supply of medication is exhausted prior to the FUH appointment.* ***Follow-up Status Response***

Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)	***Initial Response***
• **Inconvenient FUH appointment(s)** • **Appointment unavailability/immediate access** • **Open Access- no appointment** • **Open Access- no tracking of kept visit or f/u call** • **Transportation** • **OP scheduling flexibility** • **Lack of Psychiatrists** • **Open Access**	• *The delay that can result when an individual is unable to keep an FUH appointment due to practical reasons including, but not limited to, geographic location of provider or date/time of appointment.* • *The delay that can result when an individual becomes re-acclimated to their routine post discharge and becomes less likely over time to accommodate treatment into their established schedule.* • *The delay that can result when an individual has a date but no specific time commitment associated with the FUH appointment.* • *The delay that can result when an open access provider does not track individuals referred upon inpatient discharge and the subsequent lack of follow up with the individual if the 'appointment' is not kept.* • *The delay that can result when an individual is unable to secure means of transportation to and from an appointment.* • *The delay that can result when OP providers are unable to offer a wide array of appointment times throughout the business day i.e., early morning, evening, that may be more convenient for a number of reasons including, but not limited to, transportation, childcare, etc.* • *The delay that can result when there are a limited number of psychiatric appointments available, due to a shortage of psychiatrists.* • *The delay that can result when a provider does not adequately plan for a large influx of individuals utilizing Open Access that particular day and has no plan to accommodate the individuals that present. This can result in individuals who are turned away or cannot stay for the long wait time.*
	Follow-up Status Response
Other (specify): Treatment Process	***Initial Response***
• **Incomplete discharge plan at discharge** • **Lack of appropriate community-based services/resources** • **Lack of active treatment** • **Lack of involving member in own treatment** • **Why now? not addressed**	• *The delay that can result when the provider does not include critical elements in the discharge plan including appointment location, date of appointment, time of appointment, etc.* • *The delay that can result when an individual has a specialized need that cannot be met by traditional community-based services and results in the member disengaging from treatment.* • *The delay that can result from a more passive approach to treatment that may result in apathy toward treatment.* • *The delay that can result when individuals are not encouraged to participate in the treatment process and recovery. Infers relationship between recovery approach and delay in progress.* • *The delay that can result when the 'root cause' of the admission (vs.*

• **Lessened impact of treatment benefit from MH IP as time from tx episode increases (more likely as time from d/c increases)** • **Lack of understanding of d/c plan** • **Lack of family/support person's involvement to assist member w/adherence to d/c plan**	*presenting problem) is not adequately addressed by the provider.* • *The delay that can result when an individual becomes re-acclimated to their routine post discharge and becomes less likely over time to accommodate treatment into their established schedule.* • *The delay that can result when an individual is unclear on specifics of the discharge plan including location, date, time and their role in it i.e., securing own transportation, etc.* • *The delay that can result when an individual lacks the support of others in keeping the FUH appointment including, but not limited to, family/support persons providing appointment reminders, transportation, accompanying to appointment, etc.* ***Follow-up Status Response***

Complete next page of corresponding action plan.

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

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.
In 2012, ten mental health inpatient facilities accounted for 76% of the adult discharges across Magellan's five county partners: Bucks, Delaware, Lehigh, Montgomery and Northampton. An improvement in outcomes performance by these core providers, would considerably impact Magellan's results in OMHSAS's performance measures related to this level of care. Given the success demonstrated through the programmatic approach of the Partners in Care program with regard to clinical quality, operational practices, provider accountability and fiscal responsibility, Magellan and its partner counties	-January 2015 -Ongoing -Monthly involvement (either group or individual meeting) and quarterly performance data reporting to begin with 2015 data	***Initial Response*** The MH IP PIC was designed in the format of the extremely successful Children's Quality Collaborative (i.e., CQC) for BHRS. For providers who agree to participate, the program description and agreement includes: • Less intense utilization review process • Quarterly measurement of performance metrics (30-day readmission rates and 7-day FUH). As of 1/1/15, metrics of chart review scores and care manager discharge survey results were removed from the Quarterly performance metrics. It was found that these processes are more effective as ways to shape continuous quality improvement activities with the providers and that also using them as performance metrics mitigated that benefit. • Every other month group meetings to address: performance metric data; factors contributing to positive and negative results; provider program management processes; and sharing of ideas, challenges and strategies to continue quality improvement. • Providers will agree to the following expectations: 1) Ensure HEDIS approved services are scheduled within 7 days of discharge (this may be in addition to supportive/linkage services, such as TCM and CPS and 2) work with outpatient providers to allow Bridge appointments within the MH IP facility • Based on successful demonstration of improvement on performance metrics and collaboration in MH IP PIC program, providers may be moved to an alternative payment arrangement; Through August of 2015, there were 4 Group Program Management meetings held and all providers

developed the MH IP Partners in Care (MH IP PIC) program. While the quality improvement, data gathering and group development activities began in May 2014, the measurement period for the MH IP PIC began 1/1/15. Therefore, the ability to measure the impact of this intervention began at this same time and is considered the official start of the program.		participated in at least two individual on-site reviews with the assigned Magellan Care Manager. The first report of 2015 performance (Q1) will be presented at the October meeting. *As reported in 2013 RCA response to MY2012 performance, the following context is offered again for this program:* *In May 2014, the MH IP PIC program was introduced by Bucks, Delaware, Lehigh, Montgomery and Northampton Counties and Magellan to the ten providers. In July 2014, the initial group program management meeting was held. At that time, the providers were given their draft performance metric baselines, based on 2013 data. As the measurement period will officially begin 1/1/15 for this program, the 'draft' baseline data and goals were provided so the Magellan care managers and provider staff would have an opportunity to understand the data, what is included/excluded and from there, develop ways to positively impact the data.* *Also at the July 2014 group meeting, the providers were introduced to the PIP development process (Successful transition from inpatient care to ambulatory care). The providers have each been asked to complete a barrier analysis and develop at least one intervention to address those barriers. The PIC structure offers a forum in which to engage the providers into the interventions to decrease the need for readmission.* ***Follow-up Status Response***
MH IP PIC program – FUH targeted provider expectations. Since one of the drivers for development of the MH IP PIC program was to partner with the providers in order to improve FUH, there are 2 specific expectations targeted to improve FUH rates.	- July 20014 - Ongoing	***Initial Response*** The MH IP PIC Letter of Agreement specifically states that providers will agree to the following expectations: 1) Commit to ensure HEDIS approved services are scheduled within 7 days of discharge (this may be in addition to supportive/linkage services such as TCM and CPS) 2) Commit to work with outpatient provider(s) to allow Bridge or Mobile Mental Health appointments within the MH IP facility. Through the collaborative, quality improvement focused approach of the MH IP PIC, providers are working with Magellan's care managers and the network team to determine how the day of discharge service (either Bridge or Mobile Mental Health) will be implemented. ***Follow-up Status Response***
MH IP PIC providers were asked to develop interventions to improve members' transition from inpatient to ambulatory care, as part of Magellan's PIP developed as part of the statewide PIP process. Interventions developed which were meant to address barriers	- 3/1/15 (BGBH) and 10/1/15 (Fairmount) - Ongoing - Daily	***Initial Response*** This intervention offers a unique opportunity for members to conceptualize their first week after discharge in a practical and very 'real' way. Members will work with hospital staff to develop and write a schedule of their activities (treatment and non-treatment related) for their first week back in the community after discharge. Since there is another facility implementing a similar intervention, comparison will be made of the improvements found in each of the facilities. Based on those results, there will be an exploration of the specific processes to identify the practices which lead to success and then strive for consistent use of those 'best practices'.

also seen by Magellan and the BHHCs were included in the PIP. Those which address readmission (although measured by a different methodology) are included here: Brooke Glen Behavioral Hospital and Fairmount Behavioral Health System- Members will be discharged from inpatient unit with a daily schedule for their activities in the first week after discharge. This schedule will include treatment and non-treatment activities.		The initial analysis of this intervention at the two providers found that one facility implemented the intervention but did not have the compliance rate expected. That facility identified confusion with the forms being used to track the process. Those forms have been revised and the intervention implementation will be re-assessed. The other facility was not able to implement the intervention, due to unforeseen activities by oversight authorities which changes the facility's focus. The facility has been focused on regaining full licensure and was not able to dedicate resources to activities which were not directly tied to that goal. This facility plans to have the intervention fully implemented by 10/1/15 and will begin its pilot period then. Analysis of the impact on the objective to decrease readmission rates will be measured when the interventions are implemented and claims data is complete and available. ***Follow-up Status Response***
MH IP PIC provider intervention: Montgomery County Emergency Services (MCES) – Increase frequency of presenting consent forms to individuals on the inpatient unit.	- 2/1/15 - Ongoing - Monthly	***Initial Response*** This provider identified that, when a member does not sign a release form to allow collaboration with family members, this is a barrier to an individual's successful transition from inpatient to ambulatory services. The provider found that there was not a standard process for presenting these forms to members. The provider also found there was not a consistent frequency with which forms were presented to members who did not originally sign the release form. The provider established a process during which electronic release forms for all listed family contacts are presented to all members for signature during the admission process. When the forms are not signed during the admission process, they will be 'flagged' within the EMR system, to alert the Social Service Department of the need for that discipline to re-present the forms for signature. The expectation is that there will be three attempts made for this authorization within the initial seven days of the admission. This intervention addresses a root cause of why there is not always sufficient collaboration with a member's family members. This intervention is based on a recognition that an individual's understanding of the importance of collaboration with family, friends and treatment providers may change through the inpatient treatment episode. As an individual becomes more stable and experiences less symptom acuity, they are likely to be more understanding and accepting of the need for this collaboration, and therefore more willing to sign the release form. This approach is a refreshing shift to sharing the responsibility for this need for authorization for communication between the hospital staff and the member. The initial analysis of this intervention is that it is not being implemented as intended. The provider's transition to an EMR system was the main challenge identified. There were technical issues with the system, as well as operational changes that were not considered; such as not having computer workstations in all meeting rooms. The provider has implemented changes to the process and, as of 8/1/15, reported the intervention to be implemented.

		Analysis of the impact on the objective to increase FUH rates will be measured when the intervention is fully implemented for a period of time and claims data is complete and available.
		Follow-up Status Response
MH IP PIC provider intervention: Sacred Heart Hospital – Inpatient provider to establish relationships with local outpatient providers and develop program to have outpatient provider come onto the inpatient unit to meet the member prior to discharge.		***Initial Response***
		This provider identified the need to target outreach to local outpatient providers with a history of responsiveness, to focus on the review of referral processes, barriers (such as lack of availability of appointments within seven days of discharge) and opportunities for improvement. Another outpatient provider criterion is that they need to be able to accept Medicare funding so that these providers can be a treatment option for all members. The 'warm handoff' is a process where the outpatient provider will come onto the inpatient unit to meet the member before discharge. The intervention is based on the belief that, if the member has a connection to someone at the outpatient provider, they will already be engaged with the provider and be more likely to attend their after-care appointment. The initial analysis of this intervention is that it is being implemented as intended and it will continue. Analysis of the impact on the objective to increase FUH rates will be measured when claims data is complete and available.
		Follow-up Status Response
		Initial Response
		Follow-up Status Response

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): *Magellan Behavioral Health (MBH)*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)- Ages 6-64*	***Response Date:*** ***10/9/15***

Goal Statement: **(Please specify individual goals for each measure): Based on the three year goal set by OMHSAS for the HEDIS 7-day performance measure for members ages 6 to 64 years for all HC BH Contractors and BH-MCOs to meet or exceed the HEDIS 75th percentiles, the methodology for interim goal setting was used to determine the goals for improvement expected for MY2014. Since Magellan's MY2013 results were in the 'Below 75th, at or above 50th percentile' category, a 2% increase to 69.19% is the goal for MY2014**

***Analysis*:**
What factors contributed to poor performance?
Please enter "N/A" if a category of factors does not apply.

Findings

Magellan's MY2013 rate for this measure was 3.4 percentage points higher than the MY2012 rate. This 5.24% increase was a statistically significant improvement. Magellan and four of the Counties met their MY2013 goal for improvement.

Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 30-Day) – Ages 6-64

	MY2012	MY2013	% change from MY2012 to MY2013	2013 Goal met?	MY2014 Goal
HC Avg	68.10%	67.83%	-0.45%	No	69.19%
MBH	65.20%	68.63%	5.24%	Yes	70.00%
BU	64.20%	67.18%	4.63%	Yes	68.52%
DE	61.50%	62.93%	2.33%	No	64.63%
LE	65.70%	71.32%	8.62%	Yes	72.75%
MO	64.40%	68.06%	5.65%	Yes	69.42%
NH	72.20%	75.00%	3.95%	Yes	maintain/improve

Please note that barriers to further improvement in Follow-up rates for this measure in MY2013 are consistent with those identified in the analysis of barriers to Follow-up-HEDIS, 7-Day in MY2012. To ensure alignment with barriers to actions implemented for the reader, the barriers are listed below.

Policies (e.g., data systems, delivery systems, provider facilities) ***N/A***	***Initial Response***
	Follow-up Status Response
Procedures (e.g., payment/reimbursement, credentialing/collaboration) • **Poor documentation of discharge plan**	***Initial Response*** • *The delay that can result when the discharge plan is not communicated clearly to the member including the provider, date and time of the appointment.*

• **No process for specialized FUH attention for those likely to readmit or not attend FUH** • **No one calling to remind Mbr of appointment** • **Medication not pre-authorized upon d/c** • **Focus on PA-specific accepted aftercare appointment** • **Medication prescription from d/c not covering time until psychiatrist appt (more likely after 7 days post-dc)** • **Providers not submitting claims to document treatment provided**	• *The delay that can result when there are no specialized interventions employed to increase the likelihood of appointment adherence for individuals at high risk of readmission to the AIP unit or not keeping their FUH.* • *The delay that can result when an individual forgets their FUH appointment information including provider address, date and time of appointment.* • *The delay that can result when an individual is unable to obtain medications following discharge, due to a lack of preauthorization.* • *The delay that can result when provider focuses discharge plan on FUH appointments with levels of care that are not included in the HEDIS methodology i.e., targeted case management.* • *The delay that can result when an individual's supply of medication is exhausted prior to the FUH appointment.* • *The incomplete data source regarding FUH services provided when claims are not submitted.* ***Follow-up Status Response***
People *(e.g., personnel, provider network, patients)* • ***Mbr choosing not to accept care*** • ***Bad experience w/ provider*** • ***Medication Changes*** • ***Substance use relapse*** • ***Co-morbid medical conditions*** • ***Increased or new psycho-social stressors (more likely as time from d/c increases)***	*Initial Response* • *The delay that can result when an individual chooses to not pursue treatment following discharge from an inpatient setting.* • *The delay that can result when an individual is dissatisfied with their interactions with a provider such that there is hesitation to return to the provider for treatment.* • *The delay that can result when an individual has difficulty managing the effects of new medications when in the community* • *The delay that can result when an individual resumes use of substances and a substance abusing lifestyle which causes distraction from and/or avoidance of treatment.* • *The delay that can occur, due to limited resources, when an individual requires specialized medical care concomitant with their psychiatric care upon discharge.* • *The delay that can result when an individual experiences an increase in the number or intensity of new or chronic psychosocial stressors such that the stressor interferes with the ability to participate in treatment i.e.- loss of an automobile, loss of income to afford public transportation, loss of child care provider etc.* ***Follow-up Status Response***
Provisions	***Initial Response***

(e.g., screening tools, medical record forms, provider and enrollee educational materials) • **Inconvenient FUH appointment(s)** • **Appointment unavailability/immediate access** • **Open Access- no appointment** • **Open Access- no tracking of kept visit or f/u call** • **Transportation** • **OP scheduling flexibility** • **Lack of Psychiatrists** • **Open Access**	• *The delay that can result when an individual is unable to keep an FUH appointment due to practical reasons including, but not limited to, geographic location of provider or date/time of appointment.* • *The delay that can result when an individual becomes re-acclimated to their routine post discharge and becomes less likely over time to accommodate treatment into their established schedule.* • *The delay that can result when an individual has a date but no specific time commitment associated with the FUH appointment.* • *The delay that can result when an open access provider does not track individuals referred upon inpatient discharge and the subsequent lack of follow-up with the individual if the 'appointment' is not kept.* • *The delay that can result when an individual is unable to secure means of transportation to and from an appointment.* • *The delay that can result when OP providers are unable to offer a wide array of appointment times throughout the business day i.e.- early morning, evening, that may be more convenient for a number of reasons including, but not limited to, transportation, childcare, etc.* • *The delay that can result when there are a limited number of psychiatric appointments available due to a shortage of psychiatrists.* • *The delay that can result when a provider does not adequately plan for a large influx of individuals utilizing Open Access that particular day and has no plan to accommodate the individuals that present. This can result in individuals who are turned away or cannot stay for the long wait time.*
	Follow-up Status Response
Other (specify): Treatment Process	***Initial Response***
• **Incomplete discharge plan at discharge** • **Lack of appropriate community-based services/resources** • **Lack of active treatment** • **Lack of involving member in own treatment** • **Why now? not addressed**	• *The delay that can result when the provider does not include critical elements in the discharge plan including appointment location, date of appointment, time of appointment, etc.* • *The delay that can result when an individual has a specialized need that cannot be met by traditional community-based services and results in the member disengaging from treatment.* • *The delay that can result from a more passive approach to treatment that may result in apathy toward treatment.* • *The delay that can result when individuals are not encouraged to participate in the treatment process and recovery. Infers relationship between recovery approach and delay in progress.* • *The delay that can result when the 'root cause' of the admission (vs. presenting problem) is not adequately addressed by the provider.*

• **Lessened impact of treatment benefit from MH IP as time from tx episode increases (more likely as time from d/c increases)** • **Lack of understanding of d/c plan** • **Lack of family/support person's involvement to assist member w/adherence to d/c plan**	• *The delay that can result when an individual becomes re-acclimated to their routine post discharge and becomes less likely over time to accommodate treatment into their established schedule.* • *The delay that can result when an individual is unclear on specifics of the discharge plan including location, date, time and and their role in it i.e., securing own transportation, etc.* • *The delay that can result when an individual lacks the support of others in keeping the FUH appointment including, but not limited to, family/support persons providing appointment reminders, transportation, accompanying to appointment, etc.* ***Follow-up Status Response***

Complete next page of corresponding action plan.

Measure: *Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) –Ages 6-64*

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.
The Actions listed in the Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day- Ages 6-64) are all applicable to address the barriers identified for this measure (Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day- Ages 6-64). Improvement in any 7-day measure will also improve performance in the 30-Day measures. The Actions listed above include: • MH IP PIC program • Day of discharge appointments (i.e., Bridge or Mobile Mental Health) • Development of daily schedule of treatment and non-treatment activities for 1st week after inpatient discharge • Increase in frequency of presentation of consent forms to individuals while on inpatient unit • Establishment of direct 'warm transfer' process between inpatient facility and 2 identified outpatient providers.		***Initial Response*** *(See responses above)* ***Follow-up Status Response***

Table 19: RCA and Action Plan – Readmission Within 30 Days of Inpatient Psychiatric Discharge

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):	***Measure:***	***Response Date:***
Magellan Behavioral Health (MBH)	*Readmission Within 30 Days of Inpatient Psychiatric Discharge*	***10/9/15***

Goal Statement: **(Please specify individual goals for each measure): Decrease rate of 30-day readmissions to inpatient psychiatric level of care by a statistically significant amount. Based on MY 2013, a statistically significant (p = 0.05) decrease would be realized at 13.72%.**

***Analysis*:**
What factors contributed to poor performance?
Please enter "N/A" if a category of factors does not apply.

Findings

Although there was a decrease of 5.7%, Magellan's readmission rate remained statistically the same from MY2012 to MY2013. Magellan's performance was statistically significantly below/poorer than the MY2013 HealthChoices' BH MCO average of 13.5%. During this same time, the HealthChoices' aggregate increased by 7%, which was a statistically significant worsening in Statewide performance. (Note that this measure is an inverted rate and that lower rates indicate better performance.) The table below provides a comparison of the MY2010 to MY2011 to MY2012 to MY2013 performance per County, for MBH and the HC BH MCO average.

30-Day Readmission				
	MY2010	**MY2011**	**MY2012**	**MY2013**
BU	13.10%	10.88%	12.21%	15.41%
DE	12.64%	14.37%	14.31%	13.42%
LE	16.74%	16.18%	18.31%	15.82%
MO	15.83%	16.79%	16.40%	14.44%
NH	14.47%	13.29%	16.32%	15.55%
Magellan	14.69%	14.68%	15.75%	14.87%
HC BH MCO Average	12.40%	12.34%	12.80%	13.50%

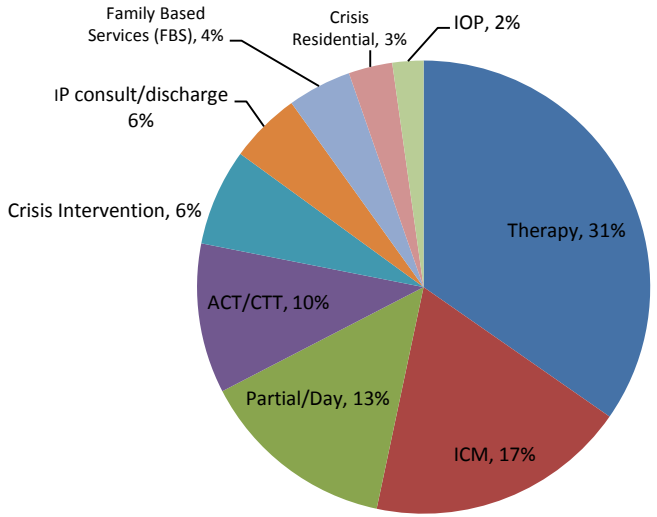
- Four of the five counties managed by Magellan and Magellan's combined rate improved (i.e., decreased) from MY2012 to MY2013.
- Of those five groups, Lehigh County's improvement demonstrates a statistically significant change.
- In Bucks County, a 26% increase was seen in this same comparison. This reflected a statistically significant increase in this comparison. As reported in the 2013 BH PM RCA Response, an analysis of Bucks County inpatient utilization was conducted. Through routine utilization and financial management activities, Bucks County and Magellan identified a 44% increase in the Per Member Per Month (PMPM) cost from Q1 2012 to Q1 2013. Initial data analysis identified acute inpatient psychiatric (AIP) services as a key cost driver to this PMPM change. This increase was unique to Bucks County, which led to the initiation of an RCA to further understand the underlying causes of this increase. The RCA activity addressed all factors contributing to the use of AIP, including factors of admission and readmission. Key findings related to readmission included:

- Lack of crisis residential programs within Bucks County
- Insufficient clinical engagement with members, such as: ACT/CTT teams not considering crisis residential services and members not contacting ACT/CTT services when challenges arise

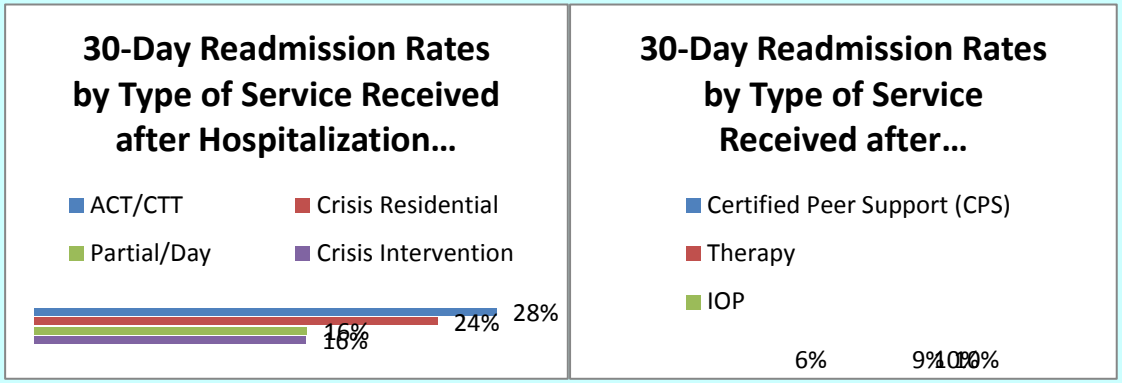
In the analysis of MY2013 performance, Magellan compared the types of services received after hospitalization, if any, for two distinct groups—those who readmitted within 30-days of discharge and those who did not readmit within 30 days of discharge—to better understand what factors may have contributed to readmission. This analysis showed that:

- ***Nearly 97% of members who readmitted within 30 days (503 of 519) in MY 2013 received HealthChoices' funded service(s) after hospitalization but prior to subsequent readmission.*** At a high level, this indicates that the issue is not necessarily on getting members to services after hospitalization, but on ensuring that members receive *appropriate* follow-up services and on ensuring that the services members are receiving after hospitalization are effective and of high-quality. (In contrast, 94% of members who did not readmit—3,544 out of 3,769—received HealthChoices' funded services in the 30-day period after admission.)
- The most common types of service received between hospitalization and subsequent admission for members who readmitted within 30 days were therapy (31%), intensive case management (17%) and partial hospitalization (13%). See **Figure 1** for more detail on the types of services received between hospitalization and readmission for members who readmitted in MY 2013.

Figure 1: Service Types Received After Hospitalization by Members who Readmitted within 30 Days of Discharge in MY 2013 (Top 90% shown)



- In addition, Magellan also analyzed the 30-day readmission rates by type of service received by members after discharge.

	Magellan found that the service type with the highest readmission rate was ACT/CTT at 28% (82 out of 298 members readmitted), and the lowest was certified peer specialist (CPS) services at 6% (6 out of 109 members readmitted).[2] This analysis provides some insight on the quality and effectiveness of different service types received after discharge from hospitalization. See figure below for more detail on the service types with the highest and lowest readmission rates. • Although members referred to ACT may be of a higher severity, in that the services are targeted to individuals with severe and persistent mental illnesses who have struggled to access or respond to traditional services, it is still concerning that over a quarter of members receiving this service type would readmit within 30 days of discharge. This is further addressed in the "Intervention" section below. • In contrast, only 6% of members who received stand-alone CPS services after discharge readmitted within 30 days of discharge. These positive findings are consistent with a Regional, five-county survey conducted by Magellan in early 2015, which found that nearly 96% of members (244 out of 255 responding to survey) receiving fee-for-service CPS services reported that their peer specialist helped them stay out of the hospital. 
Please note that barriers to improved (decreased) readmission rates in MY2013 are consistent with those identified in the analysis of barriers to this in MY2012. To ensure alignment with barriers to actions implemented for the reader, the barriers are listed below.	
Policies (e.g., data systems, delivery systems, provider facilities) ***N/A***	*Initial Response* *Follow-up Status Response*
Procedures (e.g., payment/reimbursement, credentialing/collaboration) • ***1st treatment episode- more thorough assessment needed*** • ***Illness vs. Recovery***	***Initial Response*** • *When an individual has no treatment history and more time is required to assess the effectiveness of treatment interventions, due to limited clinical information.* • *Staff's attitudes about treatment progress and how this translates into actual treatment interventions (e.g., individuals 'owning' their own recovery) Infers relationship between recovery orientation and pace of treatment.* • *When AIP providers do not collaborate with community-based providers to obtain already existing information regarding effective vs ineffective treatment interventions* • *When different disciplines on the AIP unit do not share information regarding the individual's care e.g., effective*

[2] This analysis was limited to those service types received by at least 50 members in MY 2013.

• ***Lack of Collaboration w/OP providers*** • ***Fragmentation of AIP services*** • ***Malingering Symptoms***	*treatment, d/c planning, etc.* • *When an individual misrepresents their symptoms e.g., reporting S/I when none exists and the physicians' obligation to respond to the individual's self report* ***Follow-up Status Response***
People (e.g., personnel, provider network, patients) • **AIP 'Culture'** • **Med Changes** • **Medication Adherence** • **Mbr financial issues** • **Acuity** • **Complex medical issues** • **Medication effectiveness**	***Initial Response*** • *The provider's underlying organizational attitudes and beliefs about treatment that influence clinical practices in all disciplines and dictate pace of treatment, interventions used, etc.* • *The effect of medication changes on an individual's symptom experience and how that can impact them once discharged from the hospital.* • *Impact of individuals not taking medications as prescribed.* • *Refers to individuals utilizing AIP units to meet their basic needs (shelter, food), because they are unable to meet their needs financially.* • *Effect on an individual's experience when their symptoms are non-responsive to treatment.* • *When an individual requires specialized medical care concomitant with their psychiatric care upon discharge.* • *When medications prescribed are not effective in reducing acuity.* ***Follow-up Status Response***
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials) • ***Wait lists for EAC*** • ***Complicated disposition (based on high needs, i.e., fire setting, medical issue)*** • ***Lack of appropriate community-based services/resources*** • ***Reduction in state hospital beds*** • ***Lack of PCHs*** • ***Homelessness*** • ***Pre-admission services inadequate***	***Initial Response*** • *When an individual meets MNC for EAC and there is limited to no availability.* • *When a d/c housing resource cannot be identified, due to the presence of behaviors that are frequently identified as exclusionary criteria for housing programs e.g., fire setting, pedophilia, etc.* • *Refers to the perception that there is a limited array of services within the community.* • *When an individual has reached his/her baseline however severe acuity persists, historically these individuals would be admitted to the State Hospital for further treatment which is no loner an option.* • *When a d/c housing resource cannot be identified, due to a lack of available Personal Care Home (PCH) placements.* • *When a d/c housing resource cannot be identified and the individual is unsafe for d/c to a shelter* • *When services that an individual received prior to admission were not effective in assisting the individual to remain in the community.* • ***Follow-up Status Response***

Other (specify) Treatment process	*Initial Response*
• ***Member comfort level***	• *When an individual's acclimation to/comfort level with the AIP environment is such that the individual experiences a lack of motivation toward treatment interventions.*
• ***Use of EBPs***	• *Refers to the limited success that can result when providers utilize clinical interventions that are not proven effective.*
• ***Lack of trauma informed care***	• *When an individual has significant trauma issues for which interventions employed are not designed to address.*
• ***D/C planning***	• *When d/c planning is not actively pursued by the provider.*
• ***'Why now?' not addressed***	• *When the 'root cause' of the admission (vs. presenting problem) is not adequately addressed by the provider.*
• ***COD***	• *When individual's symptoms are the result of the simultaneous presence of psychiatric symptoms and substance use and interventions are not designed to effectively address both issues.*
• ***Lack of Family Involvement***	• *When an individual's family is not engaged as a support in the treatment process.*
• ***Lack of Strength focused treatment***	• *Staff's attitudes about treatment progress and how this translates into actual treatment interventions (e.g., individuals 'owning' their own recovery). Infers relationship between the use of strength focused treatment approach and delay in progress.*
• ***Lack of active treatment***	• *When a more passive approach to treatment translates into a slower pace with which interventions in all disciplines are employed e.g., med changes, d/c planning, etc.*
• ***No clear assessment of need***	• *When there is an unclear understanding of areas which require intervention.*
• ***Lack of involving mbr in own treatment***	• *When individuals are not encouraged to actively participate in the treatment process and recovery. Infers relationship between recovery approach and delay in progress.*
• ***Institutionalization***	• *Refers to the delay in effective treatment that can result from an individual's development of excessive dependency on the AIP unit and its routines.*
	Follow-up Status Response

Complete next page of corresponding action plan.

Measure: *Readmission Within 30 Days of Inpatient Psychiatric Discharge*

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.
In 2012, ten mental health inpatient facilities accounted for over 75% of the	-January 2015 -Ongoing	***Initial Response*** The MH IP PIC was designed in the format of the extremely successful Children's Quality Collaborative (i.e.,

adult discharges across Magellan's five county partners: Bucks, Delaware, Lehigh, Montgomery and Northampton. An improvement in outcomes performance by these core providers, would considerably impact Magellan's results in OMHSAS's performance measures related to this level of care. Given the success demonstrated through the programmatic approach of the Partners in Care program with regard to clinical quality, operational practices, provider accountability and fiscal responsibility, Magellan and its partner counties developed the MH IP Partners in Care (MH IP PIC) program. While the quality improvement, data gathering and group development activities began in May 2014, the measurement period for the MH IP PIC began 1/1/15. Therefore, the ability to measure the impact of this intervention began at this same time and is considered the official start of the program.	-Monthly involvement (either group or individual meeting) and quarterly performance data reporting to begin with 2015 data	CQC) for BHRS. For providers who agree to participate, the program description and agreement includes: • Less intense utilization review process • Quarterly measurement of performance metrics (30-day readmission rates and 7-day FUH). As of 1/1/15, metrics of chart review scores and care manager discharge survey results were removed from the Quarterly performance metrics. It was found that these processes are more effective as ways to shape continuous quality improvement activities with the providers and that also using them as performance metrics mitigated that benefit. • Every other month group meetings to address: performance metric data; factors contributing to positive and negative results; provider program management processes; and sharing of ideas, challenges and strategies to continue quality improvement. • Providers will agree to the following expectations: 1) Ensure HEDIS approved services are scheduled within 7 days of discharge (this may be in addition to supportive/linkage services such as TCM and CPS and 2) work with outpatient providers to allow Bridge appointments within the MH IP facility • Based on successful demonstration of improvement on performance metrics and collaboration in MH IP PIC program, providers may be moved to an alternative payment arrangement. Through August of 2015, there were 4 Group Program Management meetings held and all providers participated in at least two individual on-site reviews with the assigned Magellan Care Manager. The first report of 2015 performance (Q1) will be presented at the October meeting. Preliminary analysis found that 6 of the 10 providers demonstrated improved (decreased) readmission rates when comparing Q4 2014 to Q1 2015. *As reported in 2013 RCA response to MY2012 performance, the following context is offered again for this program:* *In May 2014, the MH IP PIC program was introduced by Bucks, Delaware, Lehigh, Montgomery and Northampton Counties and Magellan to the ten providers. In July, the initial group program management meeting was held. At that time, the providers were given their draft performance metric baselines based on 2013 data. As the measurement period will officially begin 1/1/15 for this program, the 'draft' baseline data and goals were provided so the Magellan care managers and provider staff would have an opportunity to understand the data, what is included/excluded and from there, develop ways to positively impact the data.* *Also at the July 2014 group meeting, the providers were introduced to the PIP development process (Successful transition from inpatient care to ambulatory care). The providers have each been asked to complete a barrier analysis and develop at least one interventions address those barriers. The PIC structure offers a forum in which to engage the providers into the interventions to decrease the need for readmission.* ***Follow-up Status Response*** *<insert follow-up response here; leave blank for initial response submission>*
MH IP PIC providers were asked to develop interventions to improve members' transition from inpatient to ambulatory care, as part of Magellan's PIP developed as part of the statewide PIP process. Interventions developed which were meant	- 3/1/15 - Ongoing, pending modifications based on analysis	***Initial Response*** Mercy Fitzgerald decided to use its on-site retail pharmacy to offer a medication delivery service to members, before they leave the inpatient unit. It is expected that having a pharmacy to assist in navigating the formulary, pre-authorization and payment factors before the member leaves the unit will increase medication adherence. The pharmacist would have the ability to work directly with the psychiatrist for any support needed for pre-authorizations or any changes which could allow a

to address barriers also seen by Magellan and the BHHCs were included in the PIP. Those which address readmission (although measured by a different methodology) are included here: Mercy Fitzgerald Hospita l- Members will be discharged from inpatient unit with their medication prescription filled.	- Daily	comparable medication be prescribed for a lower cost. This would address barriers beyond the initial prescription fill. This intervention will be offered to 50% of the Magellan members on the psychiatric unit. This will provide a pilot and a control group for analysis of the impact of this intervention. The initial analysis of this intervention is that it is being implemented as intended and it will continue. Analysis of the impact on the objective to decrease readmission rates will be measured when claims data is complete and available. ***Follow-up Status Response***
MH IP PIC provider intervention: Brooke Glen Behavioral Hospital and Fairmount Behavioral Health System- Members will be discharged from inpatient unit with a daily schedule for their activities in the first week after discharge. This schedule will include treatment and non-treatment activities.	-3/1/15 (BGBH) and 10/1/15 (Fairmount) - Ongoing -Daily	***Initial Response*** This intervention offers a unique opportunity for members to conceptualize their first week after discharge in a practical and very 'real' way. Members will work with hospital staff to develop and write a schedule of their activities (treatment and non-treatment related) for their first week back in the community after discharge. Since there is another facility implementing a similar intervention, comparison will be made of the improvements found in each of the facilities. Based on those results, there will be an exploration of the specific processes to identify the practices which lead to success and then strive for consistent use of those 'best practices'. The initial analysis of this intervention at the two providers found that one facility implemented the intervention but did not have the compliance rate expected. That facility identified confusion with the forms being used to track the process. Those forms have been revised and the intervention implementation will be re-assessed. The other facility was not able to implement the intervention due to unforeseen activities by oversight authorities which changes the facility's focus. The facility has been focused on regaining full licensure and was not able to dedicate resources to activities which were not directly tied to that goal. This facility plans to have the intervention fully implemented by 10/1/15 and will begin its pilot period then. Analysis of the impact on the objective to decrease readmission rates will be measured when the interventions are implemented and claims data is complete and available. ***Follow-up Status Response***
MH IP PIC provider intervention: The Horsham Clinic - Evidence-supported relapse prevention group will be offered on inpatient unit which treats members with co-occurring mental health and substance use disorders.	-3/15/15 -Ongoing -Daily	***Initial Response*** The provider implementing this intervention is one which participated in the Provider Readmission Survey (described in the Barrier Analysis section). Through the analysis of the survey data, this provider found that individuals who were more likely to return within 30 days of their discharge were diagnosed with co-occurring mental health and substance abuse diagnoses. The members with this COD diagnosis identified using substances as the primary reason for their readmission, with feelings of depression and anxiety triggered through this use. Based on the information collected and analyzed, the provider decided to focus on increasing relapse prevention skills for members with this COD diagnosis combination. The provider has chosen to implement the Living in Balance (LIB): Moving From a Life of Addiction to a

		Life of Recovery manual-based comprehensive addiction treatment program which emphasizes relapse prevention. This evidence-based program is listed on NREPP (SAMHSA's National Registry of Evidence-based Programs and Practices). Members receiving inpatient treatment who have co-occurring mental health and substance abuse diagnoses will receive this program through the group therapy sessions while at this facility. The initial analysis of this intervention is that it is being implemented as intended and it will continue. Analysis of the impact on the object to decrease readmission rates will be measured when claims data is complete and available. ***Follow-up Status Response***
Establishment of Extended Acute Care (EAC) inpatient psychiatric program at Brooke Glen Behavioral Hospital for southeast counties. Magellan and CCBH, along with Bucks, Chester, Delaware and Montgomery Counties collaborated to use reinvestment funds to develop this program.	- October 2,2014 - ongoing - outcomes to be measured annually	***Initial Response*** The EAC unit at Brooke Glen Behavioral Hospital (BGBH) opened 10/2/14. Outcomes for the first quarter (Q4 2014) are in the process of being evaluated. Analysis of utilization related metrics will use a 60 day pre-admission and 60 day post-discharge comparison. These will be combined with the provider's analysis of changes in members' clinical systems as measured by the Basis 32, DBT-WCCL, BPRS and Stori-30. ***Follow-up Status Response***
Enhance Partner In Care program management model for ACT services to incorporate pay for performance measures.	- Under consideration - Ongoing - Metric attainment to be measured at regular intervals	***Initial Response*** As of October 2014, the ACT/CTT programs in all counties are overseen through the Partners In Care program management model. This model incorporates a combination of program-level data, direct care manager consultation and individual case support. Consideration is being given to moving the program-level data review portion of this program to an outcome metric model with associated payment rewards. ***Follow-up Status Response***
Comprehensive analysis of the effectiveness of CPS services. Develop actions for enhancement and expansion of this service based on findings.	- Q1 2016 - TBD	***Initial Response*** As a result of analyses and data sources pointing toward the effectiveness of CPS services in preventing readmission (as well as high levels of member satisfaction with this service), Magellan plans to complete the planned comprehensive analysis of this service in early 2016. This evaluation will incorporate member experience survey results and service utilization analysis to identify specific opportunities to enhance and expand the use of this service. ***Follow-up Status Response***
Bucks County Partners In Care program management model for ACT	-June 2014 -Ongoing -Quarterly	***Initial Response*** The key findings of the Bucks County inpatient RCA included insufficient clinical engagement of the ACT/CTT teams with the members in those programs. Magellan's experience with a programmatic approach (Partners in Care, PIC) with providers to clinical management has previously demonstrated success in this area. In order to have increased contact with the ACT/CTT programs, Bucks County and Magellan moved its ACT/CTT programs to this model in June 2014.

		Follow-up Status Response
Bucks County Expanding provider network to include Crisis Residential programs in and within close proximity to Bucks County • New Crisis Residential program being developed and expected to open in 2016 • Adding Haven House to provider network as Crisis Residential option within close proximity to Bucks County	-Mid-2016 - Early 2015	***Initial Response*** The Bucks County specific RCA identified the lack of Crisis Residential programs as a factor to increased readmissions. To address this barrier, work is being done to bring a Crisis Residential program in a neighboring county into the provider network. In addition, in a collaborative process between Bucks County Department of Behavioral Health and Bucks County Office of Mental Health and Developmental Programs and Magellan, a new Crisis Residential program is being developed within Bucks County. ***Follow-up Status Response***
Lehigh and Northampton Counties Partners In Care program management model for adult community-based services (TCM, ACT, CPS and Psych Rehab)	-October 1, 2014 -Ongoing _Quarterly	***Initial Response*** Given the success demonstrated through the programmatic approach of the Partners in Care (PIC) program with regard to clinical quality, operational practices, provider accountability and fiscal responsibility, the adult community-based services (TCM, ACT, CPS and Psych Rehab) are moving to this model in October 2014. The rationale for this programmatic approach for these levels of care include: • Increase IMPACT (intensive care management program) census and increase focus on complex members. The IMPACT census has averaged 24 members per month for Lehigh County and 20 for Northampton County over the past two years; while the total number of members eligible for IMPACT: 123 Lehigh and 156 Northampton. By moving to a PIC model we will be able to enroll all members who are eligible into the program. • Increase longitudinal care management, IMPACT Care Manager will follow member and review cases in all levels of care. Currently the members are followed by the Care Manager assigned to the facility. • Ability to shape providers at the program level versus case by case • Ensure consistency of care across providers • Share outcomes data with providers on a routine basis • Encourage and promote best practices across providers • Increase ambulatory follow up rates and decrease 30-day re-admission rates • Leverage clinical resources and increase program level knowledge • Low rates of denials for the identified providers going back to 2010. All proposed levels of care in the PIC Program Description have low admission rates to 24 hour levels of care (less than 5%) • Increase BH/PH collaborative efforts for Lehigh and Northampton County members. Care Managers who are currently completing reviews for ACT, CPS, Case Management and Psych Rehab would switch their focus to: coordinating care for members who are engaged with the NHCLV and Haven House integrated PH/BH program and participating in clinical rounds with PH-MCO's. ***Follow-up Status Response***

VI: 2015 Strengths and Opportunities for Improvement

The review of MBH'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

- MBH's rate for the MY 2014 7-Day Follow-up After Hospitalization for Mental Illness – HEDIS Indicator (QI 1) was statistically significantly higher than the MY 2014 HealthChoices BH-MCO Average of 47.1% by 3.1 percentage points.
- MBH's rate for the MY 2014 7-Day Follow-up After Hospitalization for Mental Illness – PA-specific Indicator (QI A) was statistically significantly higher than the MY 2014 HealthChoices BH-MCO Average of 58.2% by 1.6 percentage points.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2012, RY 2013, and RY 2014 found MBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
    - MBH was partially compliant on one out of seven categories within Subpart C: Enrollee Rights and Protections. The partially compliant category is Enrollee Rights.
    - MBH 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.
    - MBH was partially compliant with five out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Handling of Grievances and Appeals, 4) Resolution and Notification: Grievances and Appeals, 5) Information to Providers & Subcontractors.
- MBH's rate for the MY 2014 7-Day Follow-up After Hospitalization for Mental Illness – PA-specific Indicator (QI B) was statistically significantly lower than the MY 2014 HealthChoices BH-MCO Average of 74.8% by 1.3 percentage points.
- MBH's rate for the MY 2014 Readmission Within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (worse) than the MY 2014 HealthChoices BH-MCO Average of 14.3% by 1.1 percentage points. MBH did not meet the OMHSAS designated performance goal of 10.0%.
- MBH'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.
- MBH's rate for the MY 2014 Initiation of AOD Treatment performance measure (total population) was statistically significantly lower than the MY 2014 HealthChoices BH-MCO Average of 29.1% by 2.6 percentage points.

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 20**.

Table 20: 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 21 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 21: 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	B	A
	No Change	D REA[1]	C	B
	⬇	*F* FUH QI B	D	C FUH QI A

[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 20.**

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 22 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 22: Performance Measure Rates

Quality Performance Measure	MY 2011 Rate	MY 2012 Rate	MY 2013 Rate	MY 2014 Rate	MY 2014 BH-MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)	62.1% =	59.2% ▼	62.5% ▲	59.8% ▼	58.2%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)	75.6% =	73.2% ▼	75.3% ▲	73.5% ▼	74.8%
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	14.7% =	15.8% =	14.9% =	15.4% =	14.3%

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

Table 23 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 23: 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. **FUH QI 1** **FUH QI 2**
Indicators that are less than the 50th percentile.

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

Table 24: 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)	50.3%	Not Met	Below 75th and at or above 50th percentile
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	67.7%	Not Met	Below 75th and at or above 50th percentile

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

Table 25 summarizes the key points based on the findings of the performance measure matrix comparisons.

Table 25: Key Points of Performance Measure Comparisons

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

[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

- MBH was partially compliant on Subparts 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

- MBH submitted a final PIP proposal in 2015.

Performance Measures

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

2014 Opportunities for Improvement MCO Response

- MBH 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 MBH 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 MBH 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, 11 were evaluated for MBH and the five counties subcontracting with MBH. Five 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 MBH

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	3	0	1
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 MBH was not scheduled for review of Standards 27 or 28 during RY 2014, these substandards were not reviewed for MBH. 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

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards. Of the seven substandards evaluated, MBH met four substandards and did not meet three substandards, 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	Not Reviewed
	Standard 68.7	RY 2013	Not Met
	Standard 68.8	RY 2013	Not Met
Grievances and State Fair Hearings	Standard 71.1	RY 2013	Met
	Standard 71.5	RY 2013	Met
	Standard 71.6	RY 2013	Met
	Standard 71.7	RY 2013	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.

MBH did not meet the criteria for compliance for Substandards 68.1, 68.7, and 68.8:

Substandard 68.1: Where applicable there is evidence of county oversight and involvement in the second level complaint process.

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.

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. MBH was evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

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

Category	PEPS Item	Review Year	Status
Denials			
Denials	Standard 72.3	RY 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 MBH and its associated counties were not scheduled for review of Standards 78 and 86 during RY 2014, these substandards were not reviewed for MBH or its associated counties. 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

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

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

Category	PEPS Item	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

References

Adair C.E., McDougall, G.M., & Mitton, C.R. (2005). Continuity of Care and Health Outcomes Among Persons with Severe Mental Illness. *Psychiatric Services, 56(9)*, 1061-1069.

Arnaout, B., & Petrakis, I. (2008). Diagnosing Co-Morbid Drug Use in Patients With Alcohol Use Disorders. *Alcohol Research & Health, 31(2)*, 148–154.

Averyt, J.M., Kuno, E., Rothbard, A.B., & Culhane, D.P. (1997). Impact of Continuity of Care on Recurrence of Homelessness Following an Acute Psychiatric Episode. *Continuum* 4.3

Chien, C., Steinwachs, D.M., Lehman, A.F., et al. (2000). Provider Continuity and Outcomes of Care for Persons with Schizophrenia. *Mental Health Services Research, 2*, 201-211.

Cuffel, B.J., Held, M., & Goldman, W. (2002). Predictive Models and the Effectiveness of Strategies for Improving Outpatient Follow-up Under Managed Care. *Psychiatric Services, 53*, 1438-1443.

D'Mello, D.A., Boltz, M.K., & Msibi, B. (1995). Relationship between Concurrent Substance Abuse in Psychiatric Patients and Neuroleptic Dosage. *American Journal of Drug and Alcohol Abuse, 2, 257-265*.

Desai, M., Rosenheck, R.A., Druss, B.G., & Perlin, J.B. (2002) Mental Disorders and Quality of Diabetes Care in Veterans Health Administration. *American Journal of Psychiatry, 159*, 1584-1590.

Dombrovski A.,& Rosenstock, J. (2004). Bridging General Medicine and Psychiatry: Providing General Medical and Preventive Care for the Severely Mentally Ill. *Current Opinion in Psychiatry*, *17(6)*, 523-529.

Druss, B.G., Bradford, D.W., Rosenheck, R.A., et al. (2000). Mental Disorders and Use of Cardiovascular Procedures After Myocardial Infarction. *Journal of the American Medical Association, 283(4)*, 506-511.

Druss B.G., Rosenheck, R.A., Desai, M.M., & Perlin, J. B. (2002). Quality of Preventive Medical Care for Patients with Mental Disorders. *Medical Care, 40(2)*, 129–136.

Frayne, S.M., Halanych, J.H., Miller, D.R., et al. (2005). Disparities in Diabetes Care: Impact of Mental Illness. *Archive of Internal Medicine, 165(22)*, 2631-2638.

Gill, S.S. (2005). Stable Monotherapy with Clozapine or Olanzapine Increases the Incidence of Diabetes Mellitus in People with Schizophrenia. *Evidence Based Mental Health*, *8(1)*, 24.

Hermann, R.C. (2000) Quality measures for mental health care: results from a National Inventory. *Medical Care Research and Review, 57*, 136-154.

Insel, T.R. (2008). Assessing the Economic Costs of Serious Mental Illness. *American Journal of Psychiatry, 165*, 663-665.

Leslie, D.L., & Rosenheck, R.A. (2004). Incidence of Newly Diagnosed Diabetes Attributable to Atypical Antipsychotic Medications. *American Journal of Psychiatry, 161*, 1709–1711.

Mitton, C.R., Adair, C.E., McDougall, G.M., & Marcoux, G. (2005) Continuity of Care and Health Care Costs Among Persons with Severe Mental Illness. *Psychiatric Services, 56(9)*, 1070-1076.

Moran, M. (2009). Schizophrenia Patients Show High Rates of Comorbid Illness. *Psychiatric News*, *44(18)*, 22.

National Committee for Quality Assurance (2007). The State of Health Care Quality 2007. Retrieved from http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_2007.pdf.

National Institute on Drug Abuse (2011). DrugFacts: Drug-Related Hospital Emergency Room Visits. Retrieved from http://www.drugabuse.gov/publications/drugfacts/drug-related-hospital-emergency-room-visits.

National Institute of Mental Health — Statistics (2009). Retrieved from http://www.nimh.nih.gov/health/topics/statistics/index.shtml.

Nelson, E.A., Maruish, M.E., & Axler, J.L. (2000). Effects of Discharge Planning and Compliance with Outpatient Appointments on Readmission Rates. *Psychiatric Services, 51*, 885-889.

Quality of Care External Quality Review (EQR). (2012, September 1.) Retreived from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

U.S. Department of Health & Human Services (2008). Alcohol Alert. National Institute on Alcohol Abuse and Alcoholism, July 2008. Retrieved from http://pubs.niaaa.nih.gov/publications/AA76/AA76.htm.

van Walraven, C., Mamdani, M., Fang, J., & Austin, P.C. (2004). Continuity of Care and Patient Outcomes After Discharge. *Journal of General Internal Medicine, 19*, 624-631.

World Health Organization (2008). WHO Global Burden of Disease: 2004 Update. Retrieved from www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html