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

2016 External Quality Review Report
Magellan Behavioral Health

FINAL
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Glossary of Terms

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

Introduction

Purpose and Background

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

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

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

HealthChoices Behavioral Health is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2016 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. 2015 Opportunities for Improvement - MCO Response
VI. 2016 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 three Performance Measures – Follow-up After Hospitalization for Mental Illness Readmission Within 30 Days of Inpatient Psychiatric Discharge, and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

Section V, 2015 Opportunities for Improvement – MCO Response, includes the BH-MCO's responses to opportunities for improvement noted in the 2015 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 (2016) 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) 2015, 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 2015, 2014, 2014). 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 2015. 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 2016 and entered into the PEPS Application as of October 2016 for RY 2015. 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 2015 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 2015, RY 2014, and RY 2013 provided the information necessary for the 2016 assessment. Those standards not reviewed through the PEPS system in RY 2015 were evaluated on their performance based on RY 2014 or RY 3 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 2015	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	Not Reviewed[1]
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	2	7	3	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	23	9	2	1
Coordination and Continuity of Care	2	0	0	2	0
Coverage and Authorization of Services	4	2	0	2	0
Provider Selection	3	0	3	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	8	0	0	0
Practice Guidelines	6	4	0	2	0
Quality Assessment and Performance Improvement Program	23	23	0	0	0
Health Information Systems	1	1	0	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	2	0	9	0
General Requirements	14	2	0	12	0
Notice of Action	13	7	6	0	0
Handling of Grievances and Appeals	11	2	0	9	0
Resolution and Notification: Grievances and Appeals	11	2	0	9	0
Expedited Appeals Process	6	2	0	4	0
Information to Providers and Subcontractors	2	0	0	2	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	2	0	4	0
Effectuation of Reversed Resolutions	6	2	0	4	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 2015, 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 2016 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 2015, 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 2015.

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 8 substandards, partially compliant on 1 substandard, 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 2015-2016 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 2015-2016 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 8 items, partially compliant on 1 item, 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) and partially compliant with one of twelve substandards within PEPS Standard 104: Substandard 2 (RY 2015).

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.

PEPS Standard 104: QM Reporting: There is a provision for regular reporting to the Department of Human Services (DHS) on accurate and timely QM data.

Montgomery was partially compliant with substandard 2 of PEPS standard 104.

Substandard 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.

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 1 substandard, partially compliant on 2 substandards and non-compliant on 1 substandard.

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
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. Each HC BH Contractor was 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).
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. Each HC BH Contractor was 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	Partial	Bucks, Delaware, Lehigh, Northampton	Montgomery	23 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards. Montgomery was compliant on 22 substandards and partially compliant on 1 substandard. All other HC BH Contractors were compliant with 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. Each HC BH Contractor was compliant on this substandard.

Of the 10 Quality Assessment and Performance Improvement Regulations categories, MBH as a whole was compliant on five categories and partially compliant on five 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 2015. Montgomery was compliant with 60 substandards, partially compliant on 6 substandards, and non-compliant on 4 substandards. All other HC BH Contractors were compliant with 61 substandards, partially compliant with 5 substandards, and non-compliant with 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)(above).

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 and 72.

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) (above).

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

All MBH HC BH Contractors were partially compliant on one substandard of PEPS Standard 72, Substandard 2 (RY 2015):

Substandard 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.

Quality Assessment and Performance Improvement

All HC BH Contractors associated with MBH were partially compliant with Coverage and Authorization of Services due to partial compliance with one substandard of PEPS Standards 104.

PEPS Standard 104: 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) (above).

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 6 substandards, partially compliant on 1 substandard, 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 6 substandards, partially compliant on 1 substandard, and non-compliant on 7 substandards.
Notice of Action 438.404	Partial		All MBH HC BH Contractors	13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards,compliant on 12 substandards, and partially compliant on 1 substandard.
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 6 substandards, partially compliant on 1 substandard, and non-compliant on 4 substandards.
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 6 substandards, partially compliant on 1 substandard, and non-compliant on 4 substandards.
Expedited Appeals Process 38.410	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant on 5 substandards, and partially compliant on 1 substandard.
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	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant on 5 substandards, and partially compliant on 1 substandard.
Effectuation of Reversed Resolutions 438.424	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant on 5 substandards, and partially compliant on 1 substandard.

MBH was evaluated for compliance on the 10 categories of Federal and State Grievance System Standards. MBH was compliant on one category and partially compliant on nine 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 one category and partially compliant on nine 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 52 substandards, partially compliant on 8 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 9 of the 10 categories pertaining to Federal State and Grievance System Standards due to non-compliance with substandards within PEPS Standards 60 and 68, and partial compliance with substandards within PEPS Standard 72.

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, and partially compliant with one of two substandards of PEPS Standard 72.

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

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.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of services on page 13 of this report.

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, 68, and 72.

PEPS Standard 60: See standard description and determination of compliance under Enrollee Rights on page 11 of this report.

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

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of services on page 13 of this report.

Notice of Action

All HC BH Contractors associated with MBH were partially compliant with Notice of Action due to partial compliance with a substandard of PEPS Standards 72.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of services on page 13 of this report.

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 and 72.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions on page 16 of this report.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of services on page 13 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 and 72.

PEPS Standard 68: See standard description and determination of compliance under Statutory Basis and Definitions on page 16 of this report.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of services on page 13 of this report.

Expedited Appeals Process

All HC BH Contractors associated with MBH were partially compliant with Expedited Appeals Process due to partial compliance with a substandard of PEPS Standards 72.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of services on page 13 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 non-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 16 of this report.

Continuation of Benefits

All HC BH Contractors associated with MBH were partially compliant with Continuation of Benefits due to partial compliance with a substandard of PEPS Standards 72.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of services on page 13 of this report.

Effectuation of Reversed Resolutions

All HC BH Contractors associated with MBH were partially compliant with Effectuation of Reversed Resolutions due to partial compliance with a substandard of PEPS Standards 72.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of services on page 13 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 2016 for 2015 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:

- **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.
- **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.
- **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.
- **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. In 2016, OMHSAS elected to add an additional intervention year to the PIP cycle to allow sufficient time for the demonstration of outcomes. 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

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

report in June 2019. 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 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 2016 EQR is the 13th 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. 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

In 2016, OMHSAS elected to begin conducting quarterly PIP review calls with each BH-MCO. The purpose of these calls was discuss ongoing monitoring of PIP activity, discuss the status of implementing planned interventions, and to provide a forum for technical assistance as necessary. Plans were asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, BH-MCOs were asked to submit only one PIP interim report in 2016, rather than two semi-annual submissions.

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. Each element carries a separate weight. Scoring for

each element is based on full, partial, and non-compliance. Points are awared 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 compliance. As calendar year 2016 was an intervention year for all BH-MCOs, IPRO reviewed elements 1 through 9 for each BH-MCO.

Review Element Designation/Weighting

Calendar year 2016 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
Met	Met or exceeded the element requirements	100%
Partially Met	Met essential requirements, but is deficient in some areas	50%
Not met	Has not met the essential requirements of the element	0%

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

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements that have been completed during the review year. At the time of the review, a project is reviewed only for elements that are due according to the PIP submission schedule. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule. 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 Year 1 PIP Update document for review in June 2016. As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. IPRO provided feedback and comments to MBH on this submission. **Table 8** presents the PIP scoring matrix for the June 2016 Submission.

MBH's PIP 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. MBH identified three high volume inpatient diagnoses that also have high readmission rates (Schizophrenia, MDD, and Bipolar disorder), and also noted disparities in readmission rates between white and African American members, as well as between males and females. MBH included a discussion of SA penetration and readmission rates, including a comparison of readmission rates for SA vs. MH discharges. The BH-MCO provided a narrative of member and provider survey results relating to medication adherence, noting that members reported not being listened to regarding their Rx history and not being given a choice regarding their medications. A second member survey also reported a 38% rate of non-compliance with medication. The baseline DMP results were provided; MBH attributes low baseline DMP rates to a lack of documented medication reconciliation in thee of the four inpatient facilities selected. MBH also compared MY 2014 SAA rates to the MY 2013 HEDIS Average of 60.1%, and identified counties that fell below the MY 2013 average during the baseline year. Objectives are aligned with the proposal, and reasonable goals were provided for each performance indicator.

MBH used a variety of methods to complete a barrier analysis. Each barrier identified was supported by data. The majority of barriers were identified via survey results or performance measure data. MBH clearly explained the estimated magnitude of each barrier.

The 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. MBH provided an in-depth description of the development of the interventions to address barriers identified. Each intervention has clearly established mechanisms for tracking the effectiveness of the implementation of each intervention. The BH-MCO had planned eight interventions for the PIP. Seven of the interventions are clearly defined (daily schedules post discharge at two facilities, relapse prevention program, inpatient/outpatient provider collaboration, release form protocol, warm transition to outpatient provider and medication dispensed at discharge). The eighth intervention is the identification of best practices impacting successful transition among three facilities participating in the Mental Health Inpatient Partners in Care (MH IP PIC) program that have been chosen for evaluation of Discharge Management Planning. The initial interventions proposed showed promise, however, due to implementation issues, several of the planned interventions have been discontinued.

MBH measured and assessed the processes and impact of each intervention on the key outcome measures. Core outcome measures were measured outright and for populations touched by particular interventions. Improvement was not observed for the overall SAA core outcome measure. For some interventions, such as intervention #3, the plan reports negative impact on target outcomes.

Table 8: PIP Scoring Matrix: Successful Transition from Inpatient to Ambulatory Care

Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**50**
Review Element 10 – Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			**20%**	**N/A**
OVERALL PROJECT PERFORMANCE SCORE			**100%**	**N/A**

M – Met (100 points); PM – Partially Met (50 points); NM – Not Met (0 points); N/A – Not Applicable

III: Performance Measures

In 2016, 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 2015 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, 2015;
- 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, 2015, 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, 2015. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2016 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 2014 through MY 2016, 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 measurement year 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 measurement year 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 measurement year 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 measurement year 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 measurement year 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 measurement year is to increase their current year's rate by 5%.

Interim goals were provided to the BH-MCOs after the MY 2014 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 2015, 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 2014 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 2015 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 9** shows the MY 2015 results compared to their MY 2015 goals and HEDIS percentiles.

Table 9: MY 2014 HEDIS Follow-up Indicator Rates: 6–64 Years Old

	MY 2015							MY 2014	Rate Comparison MY14 to MY15			
Measure	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2015 Goal	2015 Goal Met?	%	PPD	% Change[1]	SSD	HEDIS MY 2016 Medicaid Percentiles
QI 1 – HEDIS 7-Day Follow-up for Ages 6–64 Years Old												
HealthChoices Aggregate	16,896	36,949	**45.7%**	45.2%	46.2%	48.5%	NO	47.6%	-1.8	-3.84%	YES	Above 50th Percentile, Below 75th Percentile
MBH	2,612	5,578	**46.8%**	45.5%	48.1%	51.3%	NO	50.3%	-3.5	-6.91%	YES	Above 50th Percentile, Below 75th Percentile
Bucks	481	1,029	**46.7%**	43.6%	49.8%	53.2%	NO	52.2%	-5.5	-10.38%	YES	Above 50th Percentile, Below 75th Percentile
Delaware	486	1,035	**47.0%**	43.9%	50.0%	49.7%	NO	48.7%	-1.7	-3.59%	NO	Above 50th Percentile, Below 75th Percentile
Lehigh	604	1,318	**45.8%**	43.1%	48.6%	50.8%	NO	49.8%	-4.0	-8.06%	YES	Above 50th Percentile, Below 75th Percentile
Montgomery	686	1,411	**48.6%**	46.0%	51.3%	51.0%	NO	50.0%	-1.4	-2.76%	NO	Above 50th Percentile, Below 75th Percentile
Northampton	355	785	**45.2%**	41.7%	48.8%	52.6%	NO	51.5%	-6.3	-12.24%	YES	Above 50th Percentile, Below 75th Percentile
QI 2 – HEDIS 30-Day Follow-up for Ages 6-64 Years Old												
HealthChoices Aggregate	24,408	36,949	**66.1%**	65.6%	66.5%	69.2%	NO	67.9%	-1.8	-2.65%	YES	Above 50th Percentile, Below 75th Percentile
MBH	3,561	5,578	**63.8%**	62.6%	65.1%	69.0%	NO	67.7%	-3.8	-5.64%	YES	Below 50th Percentile, Above 25th Percentile
Bucks	665	1,029	**64.6%**	61.7%	67.6%	70.8%	NO	69.4%	-4.8	-6.92%	YES	Above 50th Percentile, Below 75th Percentile
Delaware	638	1,035	**61.6%**	58.6%	64.7%	66.6%	NO	64.9%	-3.3	-5.03%	NO	Below 50th Percentile, Above 25th Percentile
Lehigh	813	1,318	**61.7%**	59.0%	64.3%	69.0%	NO	67.6%	-6.0	-8.81%	YES	Below 50th Percentile, Above 25th Percentile
Montgomery	925	1,411	**65.6%**	63.0%	68.1%	66.9%	NO	65.6%	0.0	-0.04%	NO	Above 50th Percentile, Below 75th Percentile
Northampton	520	785	**66.2%**	62.9%	69.6%	73.9%	NO	72.5%	-6.3	-8.58%	YES	Above 50th Percentile, Below 75th Percentile

[1] Percentage change is the percentage increase or decrease of the MY 2015 rate when compared to the MY 2014 rate. The formula is: (MY 2015 rate – MY 2014 rate)/MY 2014 rate.

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

The MY 2015 HealthChoices Aggregate HEDIS follow-up rates in the 6 to 64 year age group were 45.7% for QI 1 and 66.1% for QI 2 (**Table 9**). These rates were comparable to (i.e. not statistically significantly different from) the HealthChoices Aggregate rates for this age group in MY 2014, which were 47.6% and 67.9% respectively. The HealthChoices Aggregate rates were below the MY 2015 interim goals of 48.5% for QI 1 and 69.2% for QI 2; therefore, both interim goals were not met in MY 2015. 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 2015 for either rate.

The MY 2015 MBH HEDIS follow-up rates for members ages 6 to 64 were 46.8% for QI 1 and 63.8% for QI 2 (**Table 9**); both rates were lower than MBH's MY 2014 rates of 50.3% for QI 1 and 67.7% for QI 2. The year-to-year differences were statistically significant for both rates. The MBH QI 1 rate for the 6 to 64 year old population was slightly higher than the QI 1 HealthChoices BH-MCO Average of 45.7%; however, the change was not statistically significant. The QI 2 rate for this age group was statistically significantly lower than the QI 2 HealthChoices BH-MCO Average of 66.1% by 2.3 percentage points. Both interim follow-up goals for MBH were not met in MY 2015, as MBH's rates were below its target goals of 51.3% for QI 1 and 69.0% for QI 2. Both HEDIS rates for this age group were between the HEDIS 2016 50th and 75th percentiles; therefore, the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by MBH in MY 2015 for either rate.

As presented in **Table 9**, the QI 1 rate for members 6 to 64 years old statistically significantly decreased from MY 2014 for Bucks, Lehigh, and Northampton by 5.5, 4.0, and 6.3 percentage points, respectively. The QI 2 rate for Bucks, Lehigh and Northampton statistically significantly decreased by 4.8, 6.0, and 6.3 percentage points, respectively. None of the five HC BH Contractors associated with MBH met interim goals in MY 2015 for QI 1 and QI 2.

Figure 1 is a graphical representation of MY 2015 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 Montgomery were statistically significantly above the MY 2015 QI 1 HC BH Contractor Average of 45.4% by 3.2 percentage points. The QI 2 rates for Lehigh and Delaware were statistically significantly lower than the QI 2 HC BH Contractor Average of 67.4% by 5.7 and 5.8 percentage points respectively.

Figure 1: MY 2015 HEDIS Follow-up Indicator Rates: 6-64 Years Old

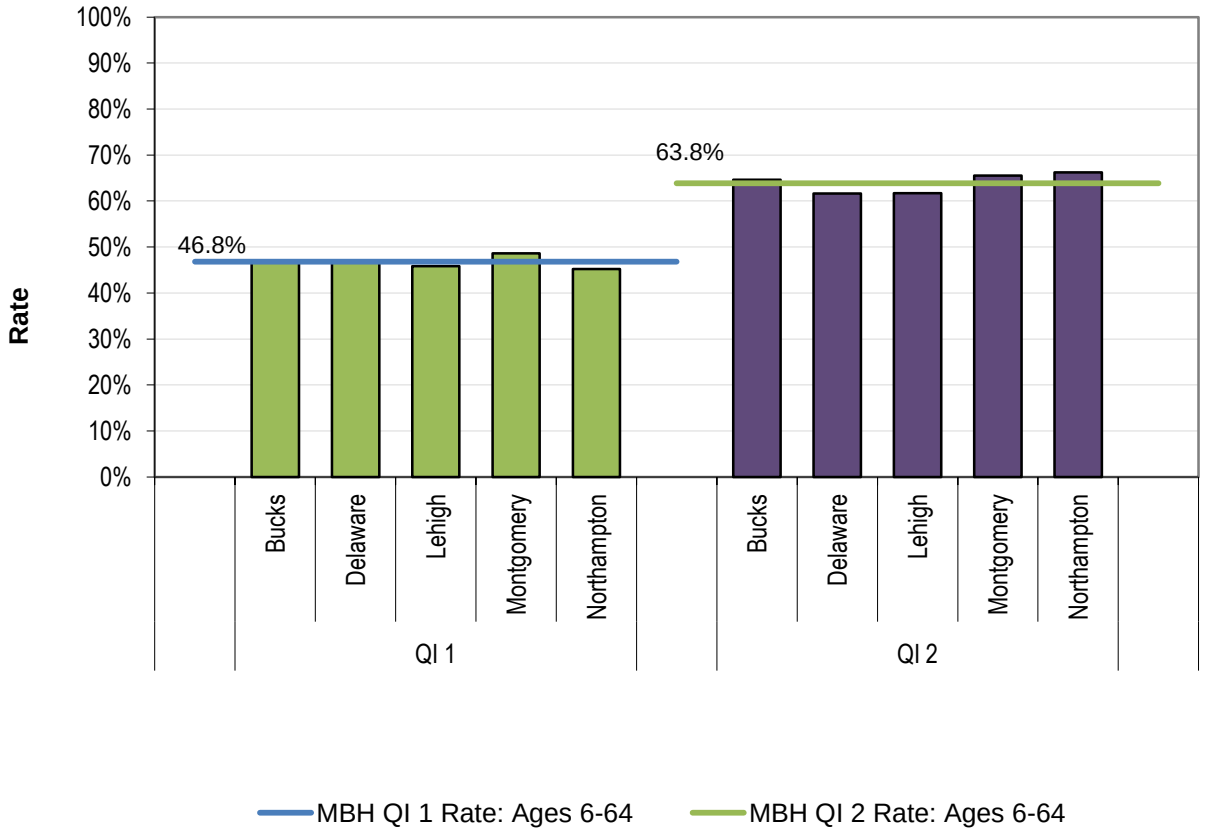
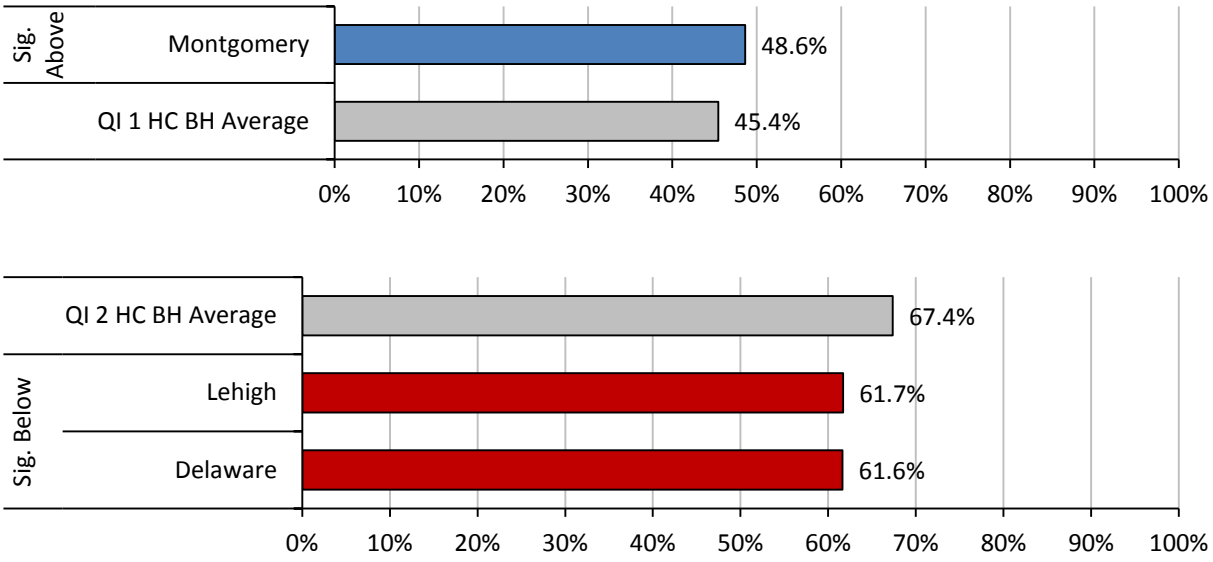


Figure 2: HEDIS Follow-up Rates Compared to MY 2015 HealthChoices HC BH Contractor Average: 6-64 Years Old



(b) Overall Population: 6+ Years Old

Table 10: MY 2015 HEDIS Follow-up Indicator Rates – Overall Population

Measure	MY 2015							MY 2014	Rate Comparison of MY 2015 against:		
									MY 2014		
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	%	PPD	SSD	HEDIS MY 2015 Percentile
QI 1 – HEDIS 7-Day Follow-up for Ages 6+ Years Old (Overall Population)											
HealthChoices Aggregate	17,076	37,505	**45.5%**	45.0%	46.0%	44.9%	45.2%	47.2%	-1.7	YES	Above 50th Percentile, Below 75th Percentile
MBH	2,644	5,660	**46.7%**	45.4%	48.0%			50.2%	-3.5	YES	Above 50th Percentile, Below 75th Percentile
Bucks	490	1,044	**46.9%**	43.9%	50.0%			52.0%	-5.1	YES	Above 50th Percentile, Below 75th Percentile
Delaware	491	1,047	**46.9%**	43.8%	50.0%			49.2%	-2.3	NO	Above 50th Percentile, Below 75th Percentile
Lehigh	609	1,334	**45.7%**	42.9%	48.4%			49.3%	-3.7	NO	Above 50th Percentile, Below 75th Percentile
Montgomery	696	1,434	**48.5%**	45.9%	51.2%			49.9%	-1.4	NO	Above 50th Percentile, Below 75th Percentile
Northampton	358	801	**44.7%**	41.2%	48.2%			51.3%	-6.6	YES	Above 50th Percentile, Below 75th Percentile
QI 2– HEDIS 30-Day Follow-up for Ages 6+ Years Old (Overall Population)											
HealthChoices Aggregate	24,662	37,505	**65.8%**	65.3%	66.2%	65.4%	67.0%	67.4%	-1.7	YES	Above 50th Percentile, Below 75th Percentile
MBH	3,606	5,660	**63.7%**	62.4%	65.0%			67.5%	-3.8	YES	Below 50th Percentile, Above 25th Percentile
Bucks	678	1,044	**64.9%**	62.0%	67.9%			69.4%	-4.5	YES	Above 50th Percentile, Below 75th Percentile
Delaware	645	1,047	**61.6%**	58.6%	64.6%			65.1%	-3.5	NO	Below 50th Percentile, Above 25th Percentile
Lehigh	820	1,334	**61.5%**	58.8%	64.1%			67.1%	-5.6	YES	Below 50th Percentile, Above 25th Percentile
Montgomery	939	1,434	**65.5%**	63.0%	68.0%			65.5%	-0.1	NO	Above 50th Percentile, Below 75th Percentile
Northampton	524	801	**65.4%**	62.1%	68.8%			72.2%	-6.8	YES	Above 50th Percentile, Below 75th Percentile

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

The MY 2015 HealthChoices Aggregate HEDIS follow-up rates were 45.5% for QI 1 and 65.8% for QI 2 (**Table 10**). These rates were comparable to the MY 2014 HealthChoices Aggregate rates, which were 47.2% for QI 1 and 67.4% for QI 2. For MBH, the MY 2015 HEDIS rates were 46.7% for QI 1 and 63.7% for QI 2; both rates were lower than MBH's MY 2014 rates of 50.2% for QI 1 and 67.5% for QI 2. The year-to-year differences were statistically significant. The MBH QI 1 rate was not statistically different than the QI 1 HealthChoices BH-MCO Average of 44.9%, while the QI 2 rate was statistically significantly lower thanthe QI 2 HealthChoices BH-MCO Average of 65.4% by 1.7 percentage points.

As presented in **Table 10**, the QI 1 rates in Bucks and Northampton statistically significantly decreased by 5.1 and 6.6 percentage points, respectively, from the corresponding MY 2014 rate, and the QI 2 rate in Bucks, Lehigh, and Northampton statistically significantly decreased by 4.5, 5.6, and 6.8 percentage points, respectively.

Figure 3 is a graphical representation of the MY 2015 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 rate for Montgomery was statistically significantly above the MY 2015 QI 1 HC BH Contractor Average of 45.4% by 3.1 percentage points. The QI 2 rates for Delaware and

Lehigh were statistically significantly lower than the QI 2 HC BH Contractor Average of 67.0%, both by 5.4 and 5.5 percentage points respectively.

Figure 3: MY 2015 HEDIS Follow-up Indicator Rates – Overall Population

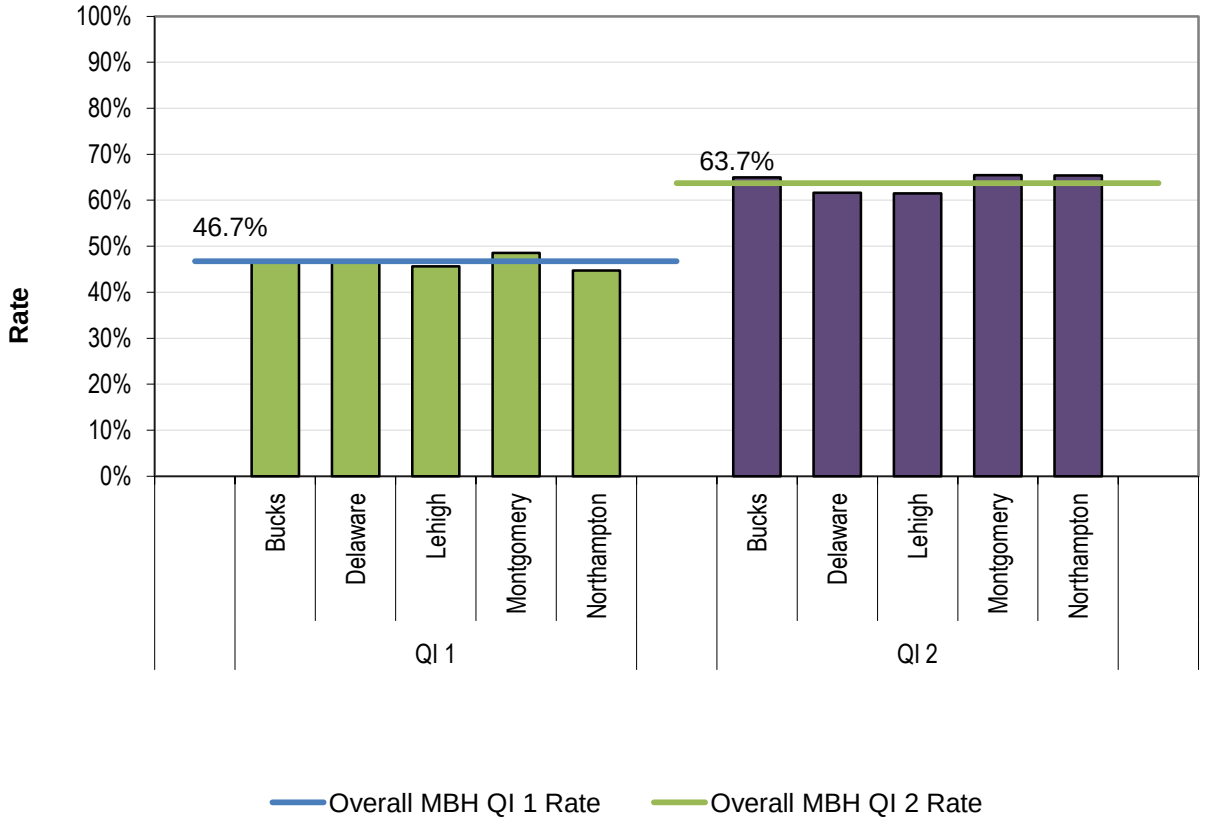
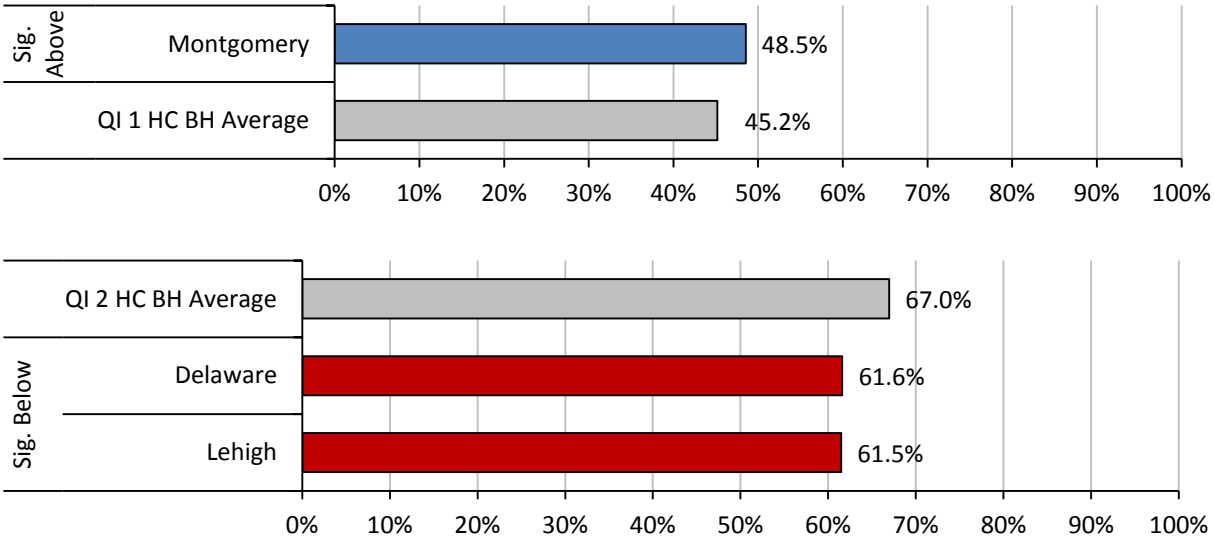


Figure 4: HEDIS Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average – Overall Population



(c) Age Group: 6–20 Years Old

Table 11: MY 2015 HEDIS Follow-up Indicator Rates: 6-20 Years Old

Measure	MY 2015 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2014 %	Rate Comparison: MY 15 to MY 14 PPD	SSD
QI 1 – HEDIS 7-Day Follow-up for Ages 6–20 Years Old										
HealthChoices Aggregate	5,736	10,108	**56.7%**	55.8%	57.7%	56.1%	55.7%	56.5%	0.2	NO
MBH	878	1,672	**52.5%**	50.1%	54.9%			51.8%	0.7	NO
Bucks	175	327	**53.5%**	48.0%	59.1%			54.6%	-1.1	NO
Delaware	180	341	**52.8%**	47.3%	58.2%			48.1%	4.7	NO
Lehigh	179	356	**50.3%**	44.9%	55.6%			51.9%	-1.7	NO
Montgomery	228	408	**55.9%**	50.9%	60.8%			52.3%	3.6	NO
Northampton	116	240	**48.3%**	41.8%	54.9%			53.0%	-4.7	NO
QI 2 – HEDIS 30-Day Follow-up for Ages 6-20 Years Old										
HealthChoices Aggregate	7,780	10,108	**77.0%**	76.1%	77.8%	76.4%	76.8%	77.0%	0.0	NO
MBH	1,168	1,672	**69.9%**	67.6%	72.1%			70.6%	-0.7	NO
Bucks	241	327	**73.7%**	68.8%	78.6%			71.7%	2.0	NO
Delaware	240	341	**70.4%**	65.4%	75.4%			66.7%	3.7	NO
Lehigh	237	356	**66.6%**	61.5%	71.6%			71.7%	-5.1	NO
Montgomery	284	408	**69.6%**	65.0%	74.2%			68.5%	1.1	NO
Northampton	166	240	**69.2%**	63.1%	75.2%			75.9%	-6.7	NO

[1] Percentage change is the percentage increase or decrease of the MY 2015 rate when compared to the MY 2014 rate. The formula is: (MY 2015 rate – MY 2014 rate)/MY 2014 rate.

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

The MY 2015 HealthChoices Aggregate HEDIS follow-up rates in the 6 to 20 year age group were 56.7% for QI 1 and 77.0% for QI 2 (**Table 11**). These rates were comparable to the MY 2014 HealthChoices Aggregate rates for the 6 to 20 year age cohort, which were 56.5% and 77.0% respectively. For MBH, the MY 2015 HEDIS follow-up rates for members ages 6 to 20 were 52.5% for QI 1 and 69.9% for QI 2. Both rates were comparable to MBH's corresponding MY 2014 rates of 51.8% for QI 1 and 70.6% for QI 2; however, there was no statistically significant change. The MBH MY 2015 QI 1 rate for the 6 to 20 year old population was statistically significantly lower than the QI 1 HealthChoices BH-MCO Average of 56.1% by 3.6 percentage points, while the QI 2 rate was statistically significantly lower than the QI 2 HealthChoices BH-MCO Average of 76.4% by 6.5 percentage points. There were no statistically significant year-to-year changes for any individual HC BH Contractor.

Figure 5 is a graphical representation of the MY 2015 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 rates for Lehigh and Northampton were statistically significantly lower than the QI 1 HC BH Contractor Average by 5.4 and 7.4 percentage points, respectively. The QI 2 rates for Delaware, Montgomery, Northampton and Lehigh were statistically sginificantly different from the QI 2 HC BH Contractor Average of 76.8%, with differences ranging from 6.4 to 10.2 percentage points.

Figure 5: MY 2015 HEDIS Follow-up Indicator Rates: 6-20 Years Old

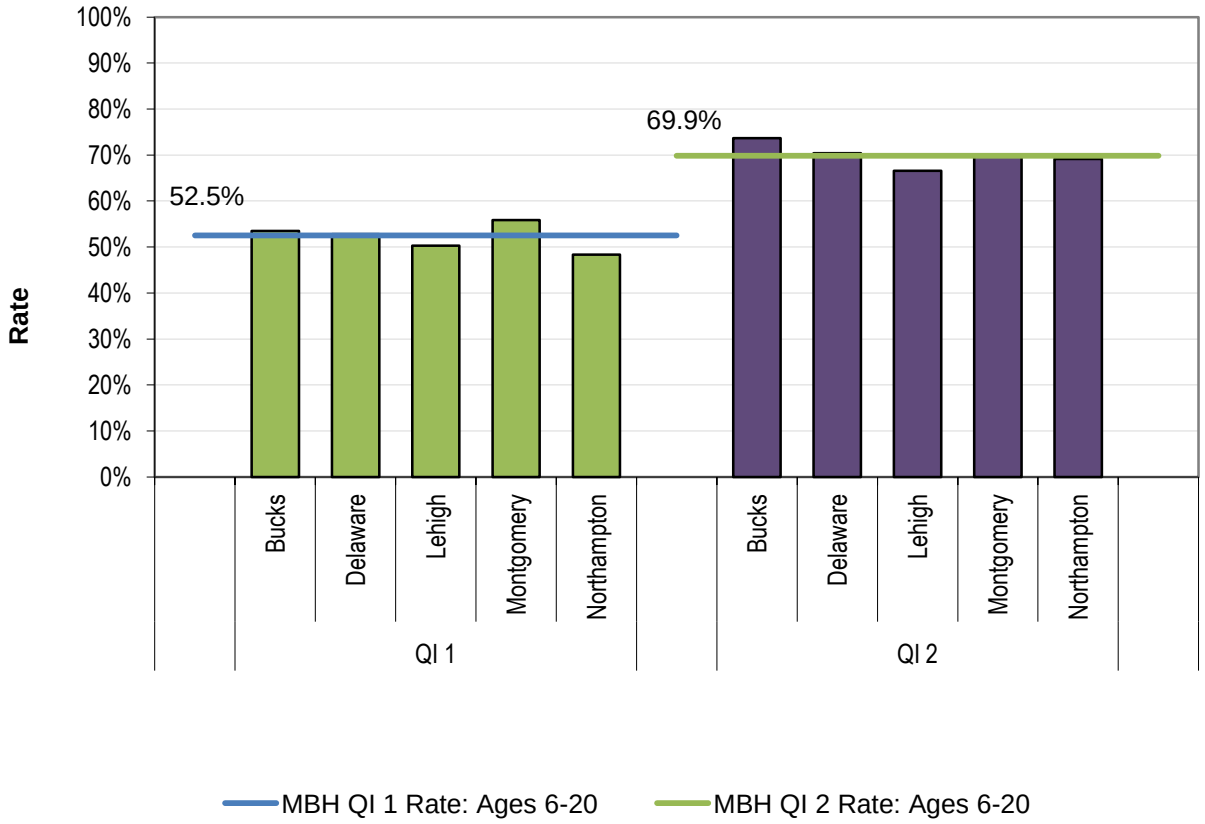
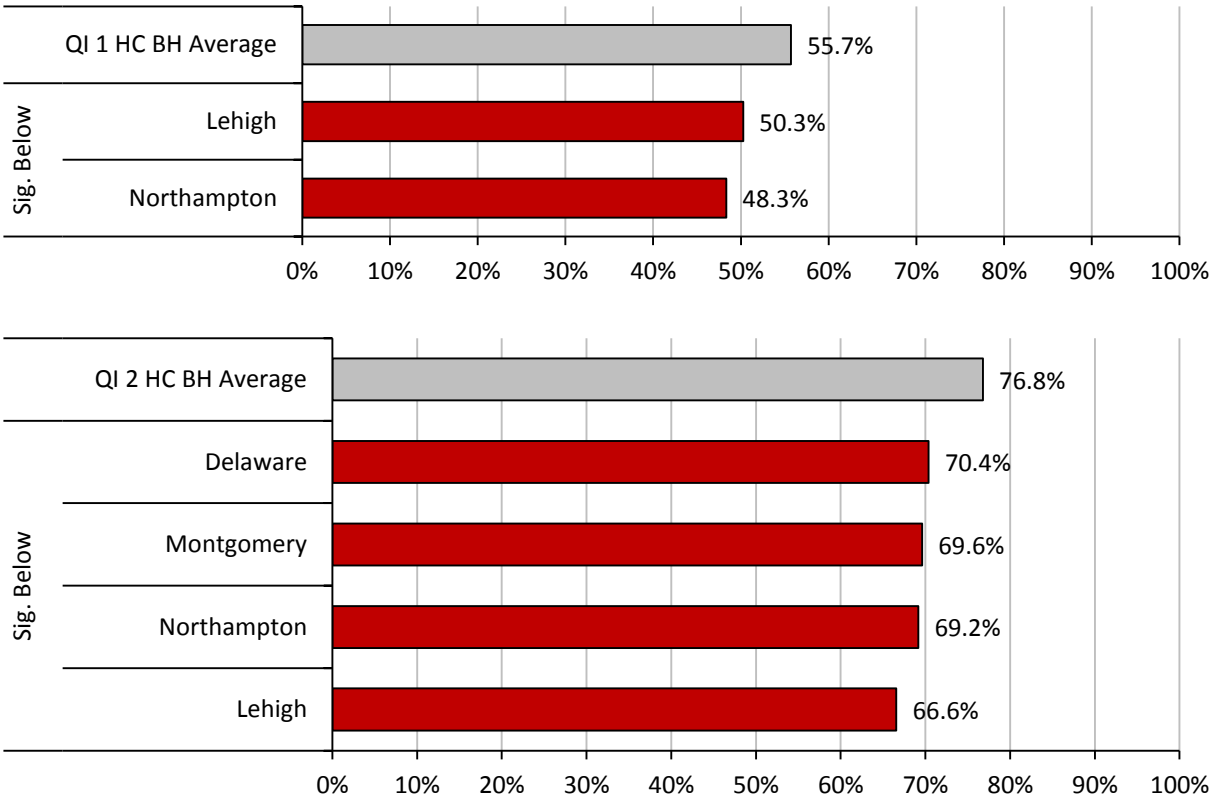


Figure 6: HEDIS Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average: 6-20 Years Old



II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

Table 12: MY 2015 PA-Specific Follow-up Indicator Rates with Year-to-Year Comparisons – Overall Population

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	MY 2015 Lower 95% CI	MY 2015 Upper 95% CI	MY 2015 BH-MCO Average	MY 2015 HC BH Contractor Average	Rate Comparison MY 2014 %	Rate Comparison MY 15 to MY 142 PPD	Rate Comparison MY 15 to MY 142 SSD
QI A – PA-Specific 7-Day Follow-up for Ages 6+										
HealthChoices Aggregate	21,216	37,505	**56.6%**	56.1%	57.1%	55.8%	55.7%	58.5%	-1.9	YES
MBH	3,161	5,660	**55.8%**	54.5%	57.2%			59.8%	-4.0	YES
Bucks	575	1,044	**55.1%**	52.0%	58.1%			61.8%	-6.7	YES
Delaware	595	1,047	**56.8%**	53.8%	59.9%			59.4%	-2.6	NO
Lehigh	728	1,334	**54.6%**	51.9%	57.3%			57.9%	-3.3	NO
Montgomery	823	1,434	**57.4%**	54.8%	60.0%			59.1%	-1.7	NO
Northampton	440	801	**54.9%**	51.4%	58.4%			61.9%	-7.0	YES
QI B – PA-Specific 30-Day Follow-up for Ages 6+										
HealthChoices Aggregate	27,371	37,505	**73.0%**	72.5%	73.4%	72.7%	73.5%	74.8%	-1.8	YES
MBH	3,958	5,660	**69.9%**	68.7%	71.1%			73.5%	-3.6	YES
Bucks	731	1,044	**70.0%**	67.2%	72.8%			75.0%	-5.0	YES
Delaware	701	1,047	**67.0%**	64.1%	69.9%			71.3%	-4.3	YES
Lehigh	938	1,334	**70.3%**	67.8%	72.8%			73.5%	-3.2	NO
Montgomery	1,015	1,434	**70.8%**	68.4%	73.2%			71.7%	-0.9	NO
Northampton	573	801	**71.5%**	68.3%	74.7%			77.7%	-6.2	YES

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

The MY 2015 HealthChoices Aggregate PA-specific follow-up rates were 56.6% for QI A and 73.0% for QI B (**Table 12**). Both of the PA-specific follow-up rates were statistically significantly higher than the MY 2014 HealthChoices Aggregate rates of 58.5% and 74.8% by 1.9 and 1.8 percentage points, respectively. The MBH MY 2015 PA-specific follow-up rates were 55.8% for QI A and 69.9% for QI B; both rates were statistically significantly lower than MBH's MY 2014 rates of 59.8% for QI A (4 percentage point difference) and 73.5% for QI B (3.6 percentage point difference). The QI A rate for MBH was not statistically significantly different than the QI A HealthChoices BH-MCO Average of 55.8%, while the QI B rate for MBH was statistically significantly lower than the QI B HealthChoices BH-MCO Average of 72.7% by 2.8 percentage points.

As presented in **Table 12**, the QI A rate in Bucks and Northampton statistically significantly decreased by 6.7 and 7.0 percentage points, respectively, from the QI A rate in MY 2014, and the QI B rate in Bucks, Delaware, and Northampton statistically significantly decreased by 5.0, 4.3, and 6.2 percentage points, respectively.

Figure 7 is a graphical representation of the MY 2015 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. The QI A rate was not statistically significantly different than the MY 2015 QI A HC BH Contractor Average of 55.7% for any HC BH Contractors. The QI B rates for Montgomery, Lehigh, Bucks, and Delaware were statistically significantly below the QI B HC BH Contractor Average of 73.5% by 2.7, 3.2, 3.5, and 6.5 percentage points respectively.

Figure 7: MY 2015 PA-Specific Follow-up Indicator Rates – Overall Population

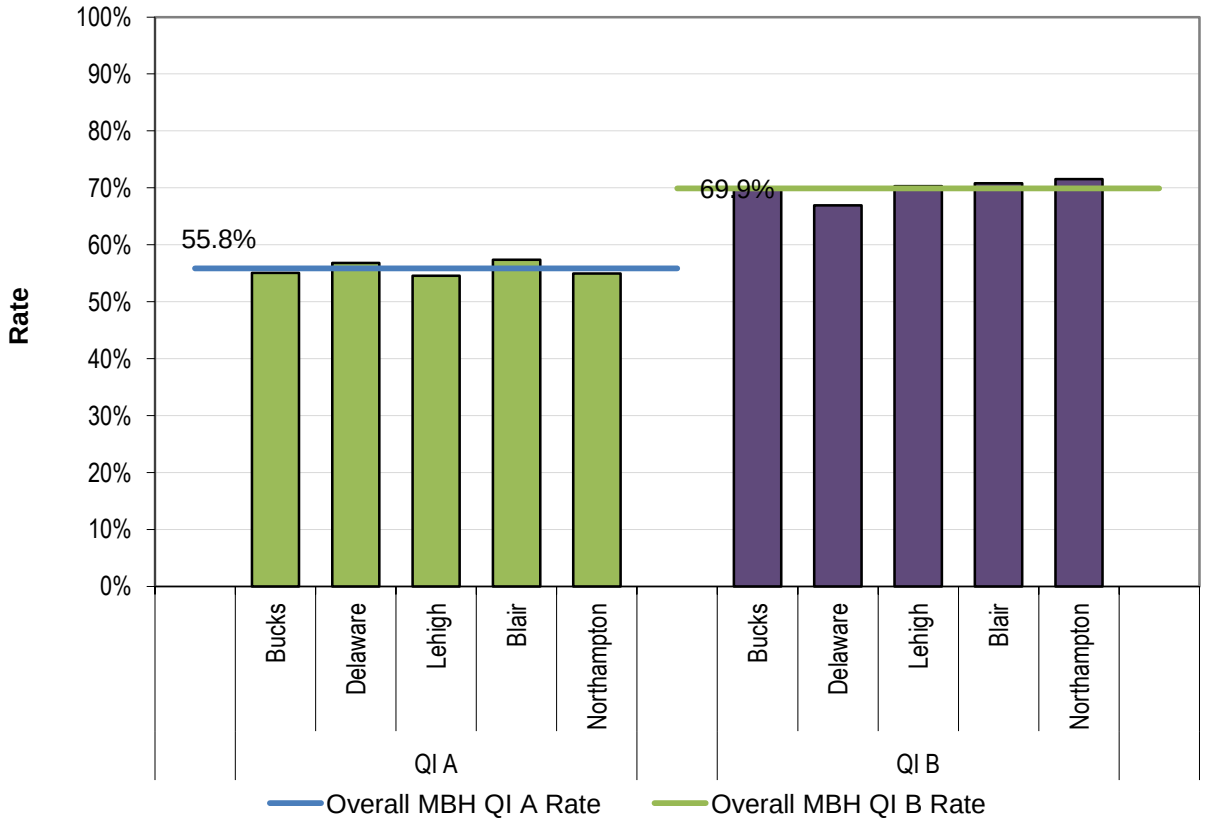
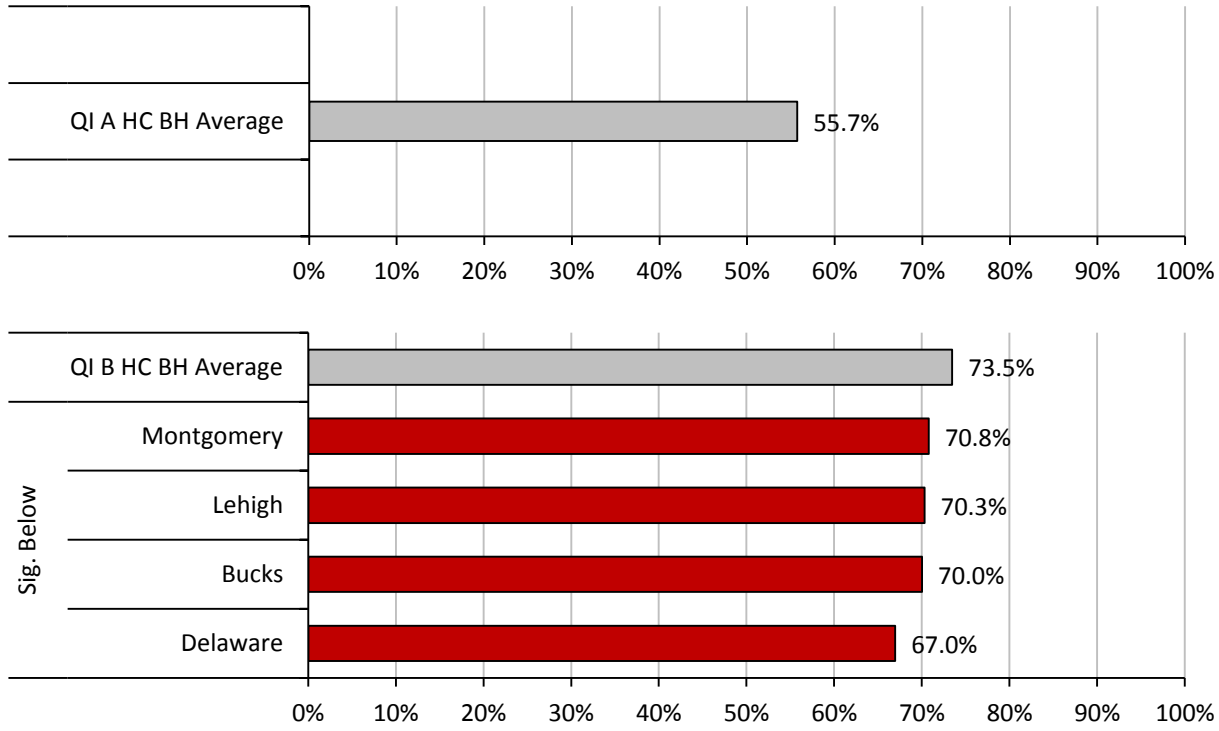


Figure 8: PA-Specific Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average – Overall Population



Conclusion and Recommendations

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

In response to the 2016 study, which included results for MY 2014 and MY 2015, the following general recommendations were made to all five participating BH-MCOs:

- 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 MY2015, 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 measurement years, and applicable to all groups. The findings of this re-measurement indicate that, despite some improvement over the last five measurement years, 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 2015 study conducted in 2016 was the nine 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 measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish 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 2015.

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 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 2015 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, 2015;
- 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. **For this measure, lower rates indicate better performance.**

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 2015 to MY 2014 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 13: MY 2015 Readmission Rates with Year-to-Year Comparisons

Measure	MY 2015 (N)	(D)	%[1]	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2014 %	Rate Comparison of MY 15 vs. MY 14 PPD	SSD
Inpatient Readmission										
HealthChoices Aggregate	6,737	48,239	**14.0%**	13.7%	14.3%	14.0%	13.4%	14.3%	-0.3	NO
MBH	1,174	7,733	**15.2%**	14.4%	16.0%			15.4%	-0.2	NO
Bucks	231	1,483	**15.6%**	13.7%	17.5%			16.7%	-1.1	NO
Delaware	179	1,400	**12.8%**	11.0%	14.6%			13.0%	-0.2	NO
Lehigh	295	1,773	**16.6%**	14.9%	18.4%			16.7%	-0.1	NO
Montgomery	322	2,037	**15.8%**	14.2%	17.4%			15.2%	0.6	NO
Northampton	147	1,040	**14.1%**	12.0%	16.3%			15.3%	-1.2	NO

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

The MY 2015 HealthChoices Aggregate readmission rate was 14.0%, equivalent to the MY 2014 HealthChoices Aggregate rate of 14.0 (**Table 13**). The MBH MY 2015 Readmission rate of 15.2% decreased slightly from the MY 2014 rate of 15.4%. There was no statistically significant change in either rate. The MBH Readmission rate of 15.2% was statistically significantly higher than the HealthChoices BH-MCO Average of 14.0% by 1.2 percentage points. Note that lower rates indicate better performance for this measure. MBH did not meet the OMHSAS performance goal of a readmission rate below 10.0% in MY 2015.

As presented in **Table 13**, none of the HC BH Contractors associated with MBH met the performance goal of a readmission rate below 10.0% in MY 2015. None of the MBH HC BH Contractors had statistically significant changes in their readmission rates from the prior year.

Figure 9 is a graphical presentation of the MY 2015 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 13.4%. Rates statistically significantly above the HC BH Contractor Average indicate poor performance. No HC BH Contractors performed lower (better) than the HC BH Contractor average. Bucks, Montgomery, and Lehigh Counties' readmission rates were statistically significantly higher (poorer) than the HealthChoices HC BH Contractor average by 2.2, 2.4, and 3.2 percentage points, respectively.

Figure 9: MY 2015 Readmission Rates

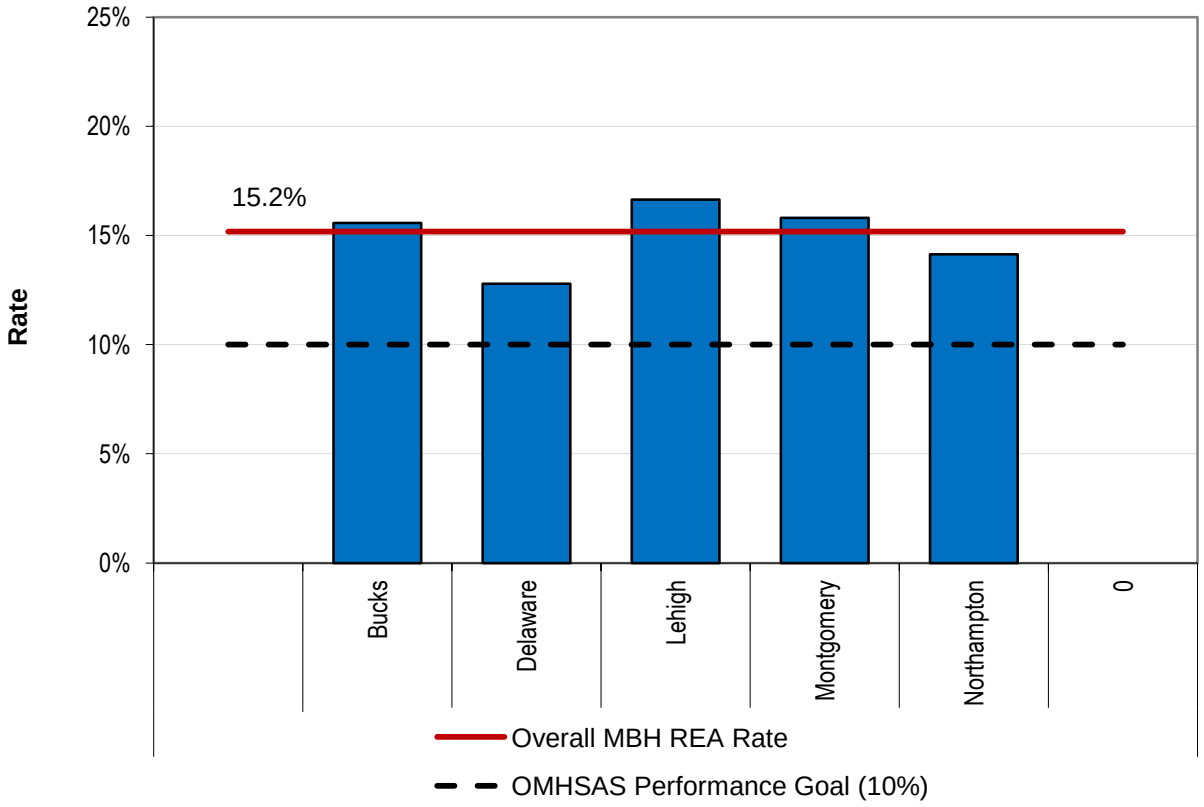
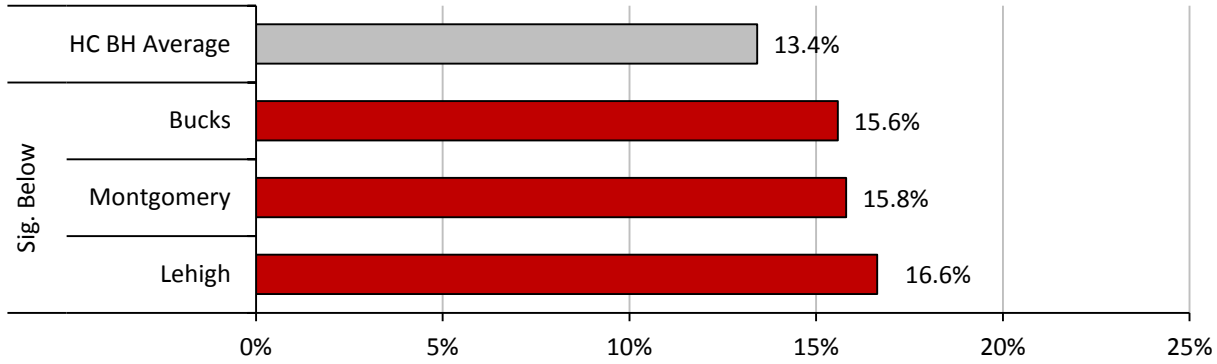


Figure 10: MY 2015 Readmission Rates Compared to HealthChoices HC BH Contractor Average



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 2015 (MY 2014) 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 2016 study, the following general recommendations are applicable to all five participating BH-MCOs:

- 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
- It is essential to ensure that improvements are consistent, sustained across measurement years, 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)
- 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 2014. 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 and 2016. The measure was produced according to HEDIS specifications. The data source was encounter data that was submitted to DHS by the BH-MCOs and the Physical Health MCOs (PH-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 used 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 2016 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 2015 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, 2015;
- 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.

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 14: MY 2015 IET rates with Year-to-Year Comparisons

Measure	MY 2015							MY 2014			Rate Comparison MY 2015 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	924	2,513	**36.8%**	34.9%	38.7%	33.6%	29.3%	37.0%	-0.3	NO	Below 50th Percentile, Above 25th Percentile
MBH	90	372	**24.2%**	19.7%	28.7%			28.9%	-4.7	NO	Below 25th Percentile
Bucks	11	57	**19.3%**	8.2%	30.4%			31.9%	-12.6	NO	Below 25th Percentile
Delaware	22	86	**25.6%**	15.8%	35.4%			36.2%	-10.6	NO	Below 25th Percentile
Lehigh	25	92	**27.2%**	17.5%	36.8%			18.3%	8.8	NO	Below 25th Percentile
Montgomery	13	43	**30.2%**	15.3%	45.1%			31.7%	-1.4	NO	Below 25th Percentile
Northampton	19	94	**20.2%**	11.6%	28.9%			29.9%	-9.7	NO	Below 25th Percentile
Age Cohort: 13–17 Years – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	645	2,513	**25.7%**	23.9%	27.4%	23.1%	18.9%	25.8%	-0.2	NO	At or Above 75th Percentile
MBH	66	372	**17.7%**	13.7%	21.8%			19.1%	-1.4	NO	Above 50th Percentile, Below 75th Percentile
Bucks	10	57	**17.5%**	6.8%	28.3%			23.2%	-5.6	NO	Above 50th Percentile, Below 75th Percentile
Delaware	17	86	**19.8%**	10.8%	28.8%			25.5%	-5.8	NO	Above 50th Percentile, Below 75th Percentile
Lehigh	16	92	**17.4%**	9.1%	25.7%			12.8%	4.5	NO	Above 50th Percentile, Below 75th Percentile

Measure	MY 2015 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	MY 2014 %	PPD	SSD	Rate Comparison MY 2015 to HEDIS Benchmarks
Montgomery	12	43	**27.9%**	13.3%	42.5%			16.7%	11.2	NO	At or Above 75th Percentile
Northampton	11	94	**11.7%**	4.7%	18.7%			18.4%	-6.7	NO	Below 50th Percentile, Above 25th Percentile

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

The MY 2015 HealthChoices Aggregate rates in the 13-17 year age group were 36.8% for Initiation and 25.7% for Engagement (**Table 14**). These rates were comparable to the MY 2014 13-17 year old HealthChoices Aggregate rates of 37.0% and 25.8%, 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 2015 13-17 year old Initiation rate of 24.2% decreased from the MY 2014 rate of 28.9% by 4.7 percentage points; however this change was not statistically significant (**Table 14**). The MBH MY 2015 13-17 year old Engagement rate of 17.7% did not statistically significantly change from the MY 2014 rate of 19.1%. The MBH MY 2015 13-17 year old Initiation rate of 24.2% was statistically significantly lower than the Initiation HealthChoices BH-MCO Average of 33.6% by 9.4 percentage points. The MBH MY 2015 Engagement rate of 17.7% was statistically significantly lower than the Engagement HealthChoices BH-MCO Average of 23.1% by 5.4 percentage points. The MBH Initiation rate for this age group was below the HEDIS 2016 25th percentile, while the Engagement rate for MBH was between the HEDIS 2016 50th and 75th percentile (**Table 14**).

As presented in **Table 14**, all HC BH Contractors associated with MBH were below the HEDIS 2016 25th percentile for Initiation. For MY 2015 Engagement rates for this age group, three HC BH Contractors were between the HEDIS 2016 50th and 75th percentile. Northampton was between the 25th and 50th percentile, while Montgomery was at or above the 75th percentile.

Figure 11 is a graphical representation of the 13-17 year old MY 2015 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 Northampton was statistically significantly lower than the MY 2015 Initiation HC BH Contractor Average of 29.3% by 9.1 percentage points. The Engagement rate for Northampton was statistically significantly lower than the Engagement HC BH Contractor Average of 18.9% by 7.2 percentage points. HEDIS rates for the remaining MBH HC BH Contractors were not statistically significantly different from the respective HC BH Contractor Averages.

Figure 11: MY 2015 IET Rates: 13–17 Years Old

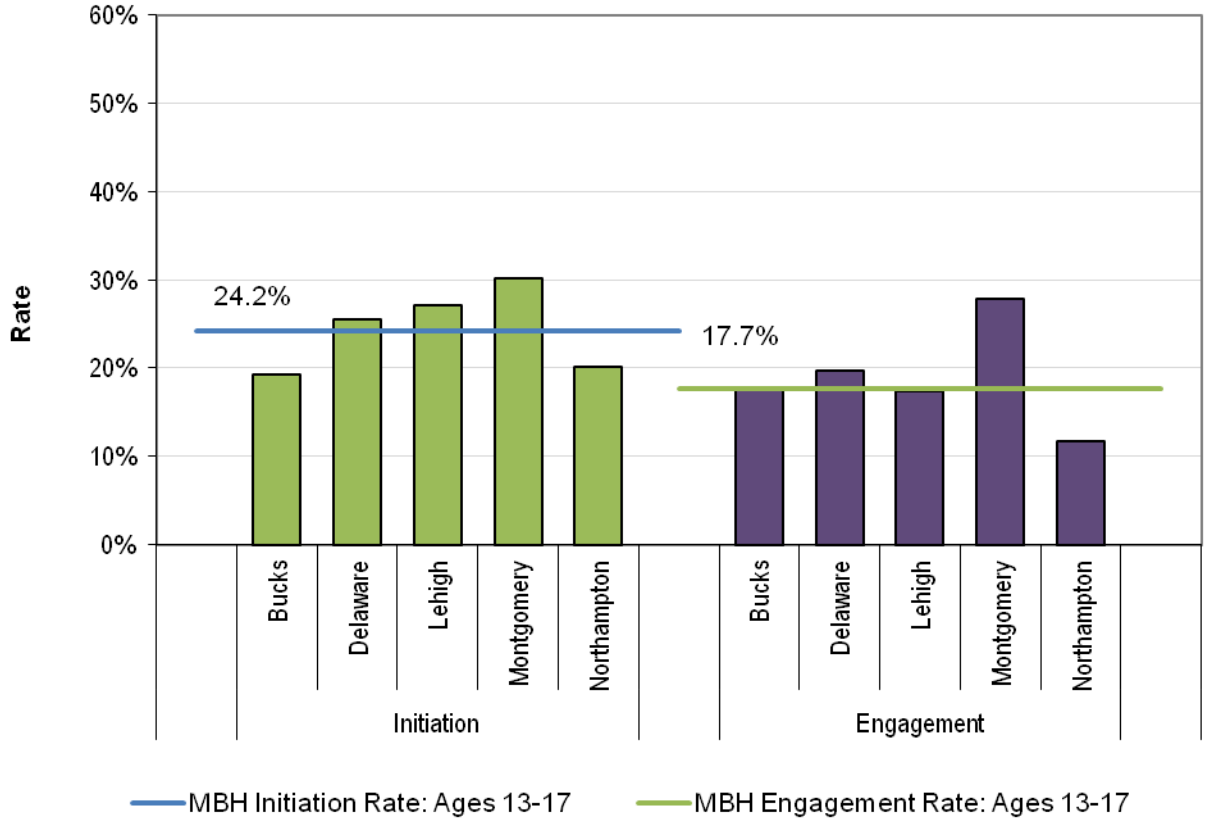
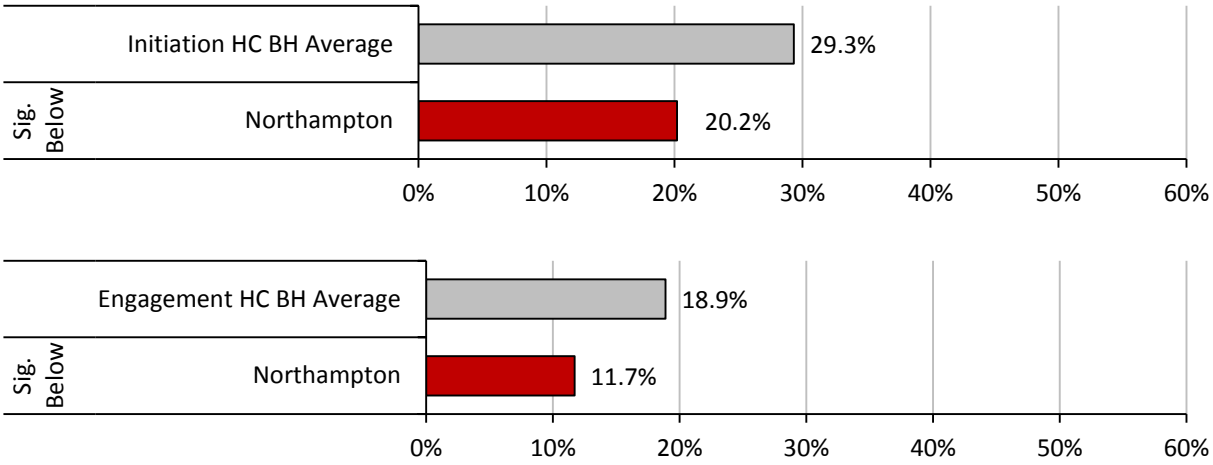


Figure 12: MY 2015 IET Rates Compared to HealthChoices County Average: 13–17 Years Old



(b) Age Group: 18+ Years Old

Table 15: MY 2015 IET Rates: 18+YearsWith Year-to-Year Comparisons

Measure	MY 2015 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	MY 2014 %	PPD	SSD	Rate Comparison MY 15 to HEDIS Benchmarks
Age Cohort: 18+ Years –Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	8,493	31,768	**26.7%**	26.2%	27.2%	26.7%	27.7%	29.8%	-3.1	YES	Below 25th Percentile
MBH	1,080	4,597	**23.5%**	22.3%	24.7%			26.3%	-2.8	YES	Below 25th Percentile

Measure	MY 2015							MY 2014			Rate Comparison MY 15 to HEDIS Benchmarks
	(N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	%	PPD	SSD	
Bucks	270	1,108	**24.4%**	21.8%	26.9%			24.3%	0.1	NO	Below 25th Percentile
Delaware	264	1,198	**22.0%**	19.6%	24.4%			26.9%	-4.9	YES	Below 25th Percentile
Lehigh	190	699	**27.2%**	23.8%	30.6%			29.7%	-2.5	NO	Below 25th Percentile
Montgomery	233	1,077	**21.6%**	19.1%	24.1%			23.1%	-1.5	NO	Below 25th Percentile
Northampton	123	515	**23.9%**	20.1%	27.7%			30.7%	-6.8	YES	Below 25th Percentile
Age Cohort: 18+ Years – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	5,899	31,768	**18.6%**	18.1%	19.0%	18.3%	19.4%	20.1%	-1.5	YES	Above 50th Percentile, Below 75th Percentile
MBH	758	4,597	**16.5%**	15.4%	17.6%			18.3%	-1.8	YES	Above 50th Percentile, Below 75th Percentile
Bucks	170	1,108	**15.3%**	13.2%	17.5%			13.9%	1.4	NO	Above 50th Percentile, Below 75th Percentile
Delaware	190	1,198	**15.9%**	13.7%	18.0%			20.9%	-5.0	YES	Above 50th Percentile, Below 75th Percentile
Lehigh	147	699	**21.0%**	17.9%	24.1%			21.8%	-0.8	NO	Above 50th Percentile, Below 75th Percentile
Montgomery	165	1,077	**15.3%**	13.1%	17.5%			16.3%	-1.0	NO	Above 50th Percentile, Below 75th Percentile
Northampton	86	515	**16.7%**	13.4%	20.0%			20.6%	-3.9	NO	Above 50th Percentile, Below 75th Percentile

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

The MY 2015 HealthChoices aggregate Initiation rate for the 18 and older age group was 26.7%, falling below the HEDIS 2016 Medicaid 25th percentile benchmark (**Table 15**). The MY 2015 HealthChoices aggregate Engagement rate in this age cohort was above the HEDIS 50th percentile but below the 75th percentile, with a rate of 18.6%.

The MBH Initiation rate of 23.5% in the 18+ year age group statistically significantly decreased by 2.8 percentage points from the MY 2014 Initiation rate (**Table 15**). The MY 2015 Engagement rate of 16.5% statistically significantly decreased from the MY 2014 rate of 18.3% by 1.8 percentage points. The MBH Initiation rate was statistically significantly lower than the HealthChoices BH-MCO Average of 26.7% by 3.2 percentage points. The MBH Engagement rate of 16.5% in this age cohort was statistically significantly lower than the HealthChoices BH-MCO average rate of 18.3% by 1.8 percentage points. Compared to the HEDIS 2016 benchmarks for the 18+ year old age cohort, the Initiation rate for MBH was below the 25th percentile, while the Engagement rate was aabove the 50th percentile but below the 75th percentile.

As presented in **Table 15**, 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 between the 50th and 75th percentiles.

Figure 13 is a graphical representation MY 2015 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, Northampton, Delaware and Montgomery were statistically significantly lower than the HealthChoices HC BH Contractor Average Initiation rate of 27.7% by 3.3, 3.8, 5.7, and 6.1 percentage points, respectively. The Engagement rates for Delaware, Bucks, and Montgomery were statistically significantly lower than the HC BH Contractor Average of 19.4% by 3.5, 4.1, and 4.1 percentage points, respectively.

Figure 13: MY 2015 IET Rates – 18+Years

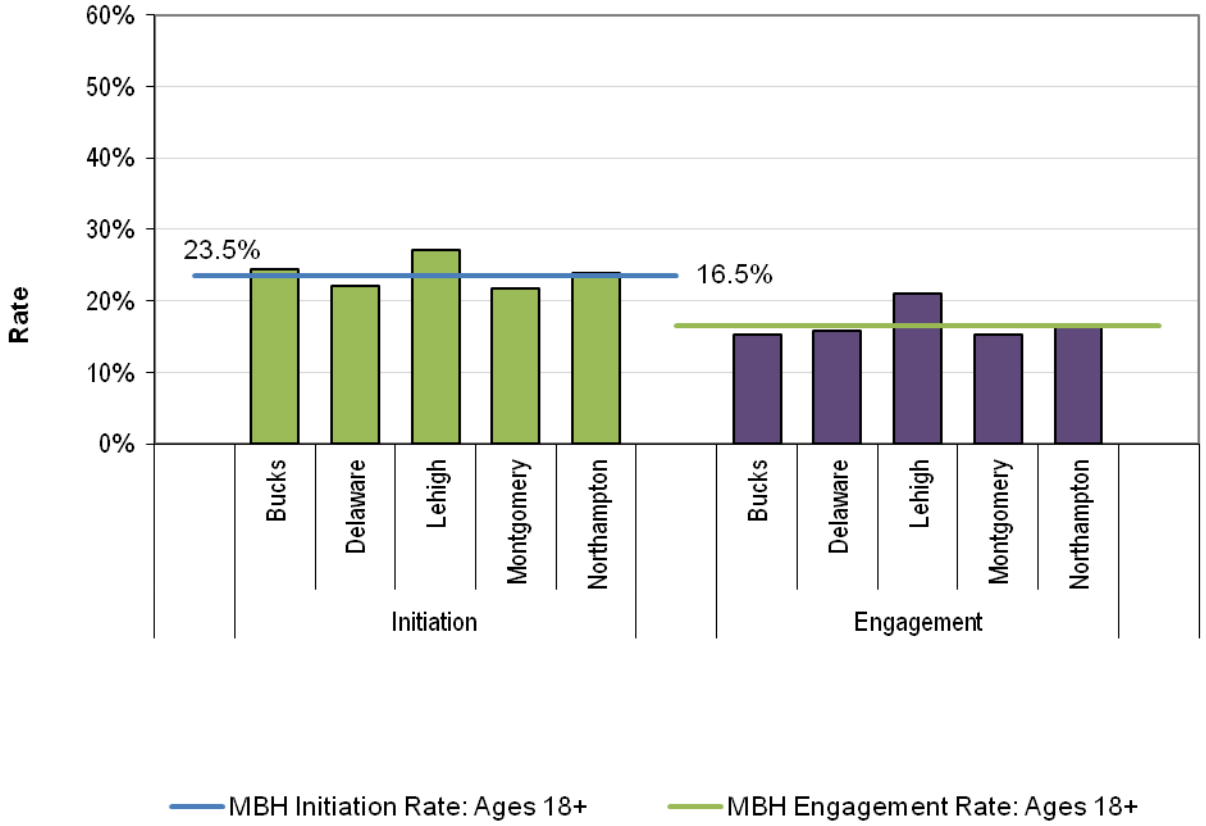
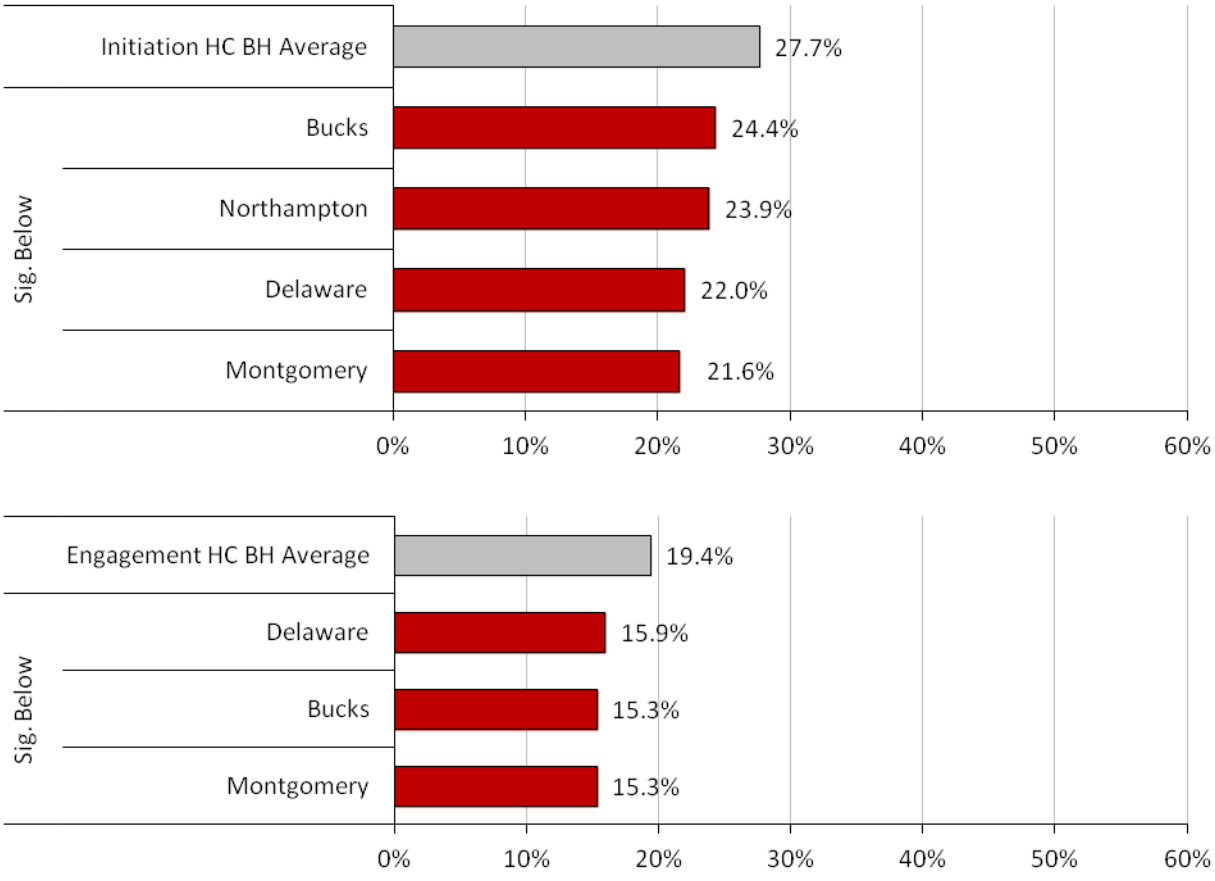


Figure 14: MY 2015 IET Rates Compared to HealthChoices HC BH Contractor Average – 18+ Years



(c) Age Group: 13+ Years Old

Table 16: MY 2015 IET Rates – 13+Years with Year-to-Year Comparisons

Measure	MY 2015 (N)	(D)	%	Lower 95% CI	Upper 95% CI	BH-MCO Average	BH HC Contractor Average	MY 2014 %	PPD	SSD	Rate Comparison MY 2015to HEDIS Benchmarks
Age Cohort: Total – Numerator 1: Initiation of AOD Treatment											
HealthChoices Aggregate	9,417	34,281	**27.5%**	27.0%	27.9%	27.2%	28.0%	30.3%	-2.8	YES	Below 25th Percentile
MBH	1,170	4,969	**23.5%**	22.4%	24.7%			26.5%	-3.0	YES	Below 25th Percentile
Bucks	281	1,165	**24.1%**	21.6%	26.6%			24.8%	-0.7	NO	Below 25th Percentile
Delaware	286	1,284	**22.3%**	20.0%	24.6%			27.5%	-5.2	YES	Below 25th Percentile
Lehigh	215	791	**27.2%**	24.0%	30.3%			28.2%	-1.0	NO	Below 25th Percentile
Montgomery	246	1,120	**22.0%**	19.5%	24.4%			23.5%	-1.5	NO	Below 25th Percentile
Northampton	142	609	**23.3%**	19.9%	26.8%			30.6%	-7.3	YES	Below 25th Percentile
Age Cohort: Total – Numerator 2: Engagement of AOD Treatment											
HealthChoices Aggregate	6,544	34,281	**19.1%**	18.7%	19.5%	18.7%	19.5%	20.5%	-1.4	YES	At or Above 75th Percentile
MBH	824	4,969	**16.6%**	15.5%	17.6%			18.4%	-1.8	YES	At or Above 75th Percentile
Bucks	180	1,165	**15.5%**	13.3%	17.6%			14.4%	1.1	NO	At or Above 75th Percentile
Delaware	207	1,284	**16.1%**	14.1%	18.2%			21.2%	-5.1	YES	At or Above 75th Percentile
Lehigh	163	791	**20.6%**	17.7%	23.5%			20.6%	0.0	NO	At or Above 75th Percentile
Montgomery	177	1,120	**15.8%**	13.6%	18.0%			16.3%	-0.5	NO	At or Above 75th Percentile
Northampton	97	609	**15.9%**	12.9%	18.9%			20.4%	-4.5	YES	At or Above 75th Percentile

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

The MY 2015 HealthChoices Aggregate Initiation rate for the total population was 27.5%, falling below the HEDIS 2016 Medicaid 25th percentile benchmark (**Table 16**). The MY 2015 HealthChoices Aggregate Engagement rate was at or above the HEDIS 75th percentile with a rate of 19.1%.

The total MBH Initiation rate statistically significantly decreased from the MY 2014 rate of 26.5% by 2.0 percentage points (**Table 16**). The MBH Initiation rate of 23.5% was statistically significantly lower than the HealthChoices BH-MCO Average of 27.2% by 3.7 percentage points. The MBH Engagement rate of 16.6% was statistically significantly lower than the HealthChoices BH-MCO Average rate of 18.7% by 2.1 percentage points. Compared to the HEDIS 2016 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 16**, 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.

Figure 15 is a graphical representation MY 2015 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, Northampton, Delaware, and Montgomery were statistically significantly lower than the HealthChoices HC BH Contractor Average Initiation rate of 28.0% by 3.9, 4.7, 5.7, and 6.0 percentage points, respectively. The Engagement rates for Delaware, Northampton, Montgomery, and Bucks were statistically significantly lower than the HC BH Contractor Average of 19.5% by 3.4, 3.6, 3.7, and 4.0 percentage points, respecctively.

Figure 15: MY 2015 IET Rates: 13+Years

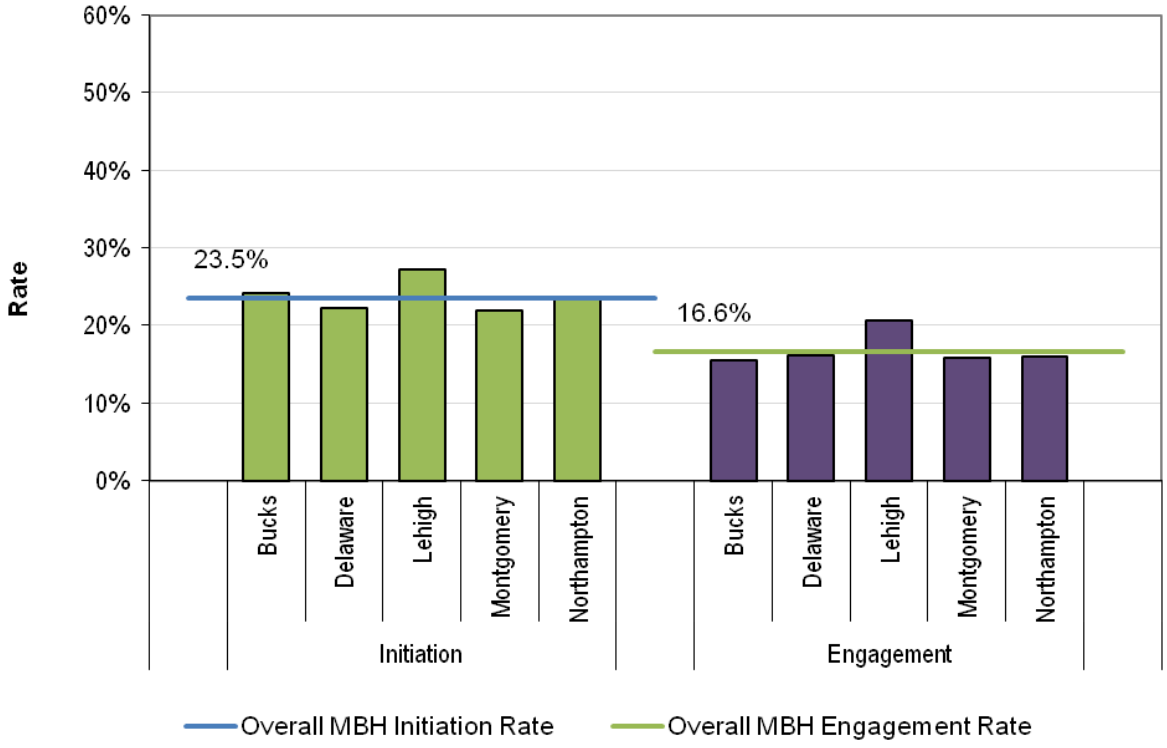
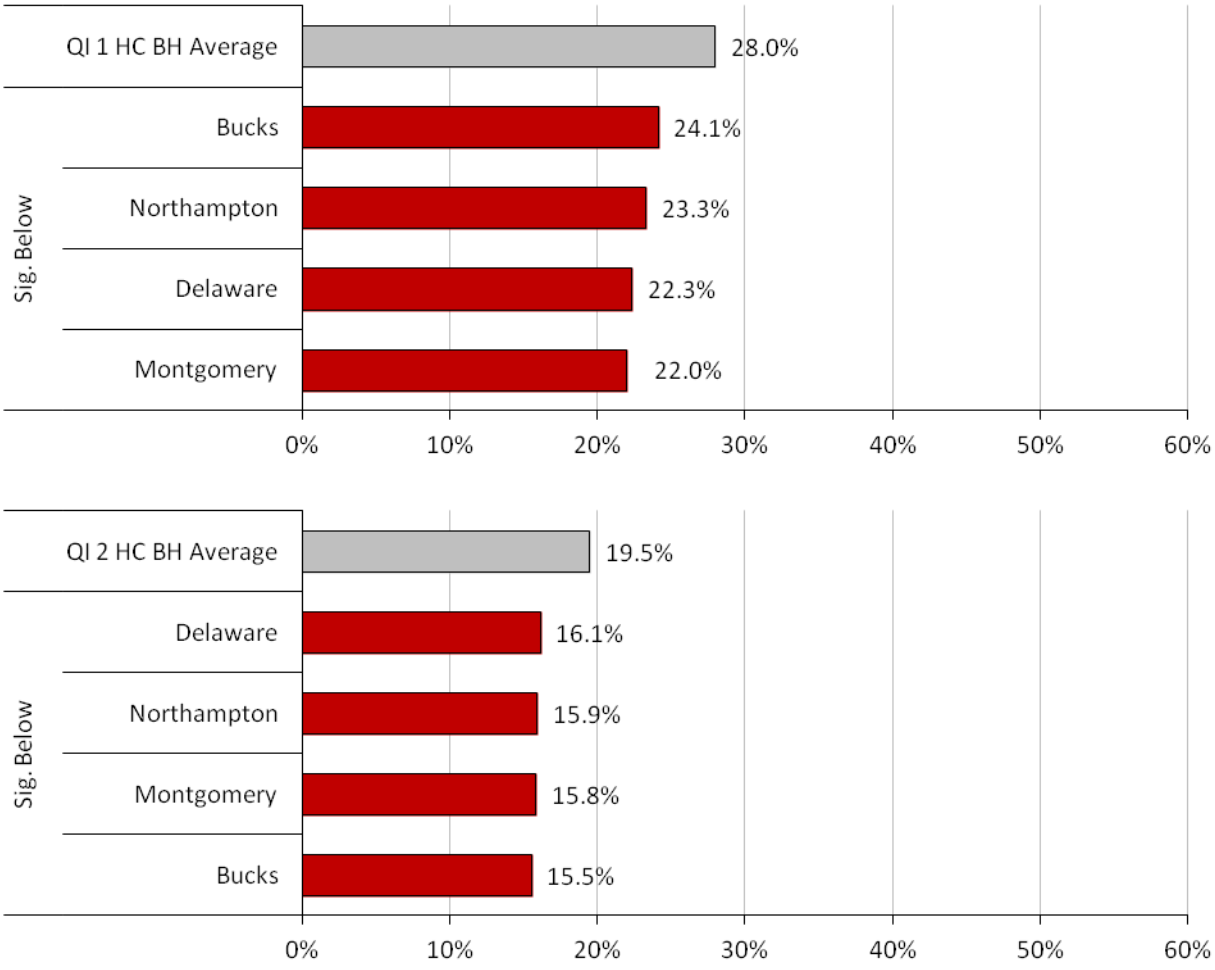


Figure 16: MY 2015 IET Rates Compared to HealthChoices HC BH Contractor Average: 13+ Years



Conclusion and Recommendations

For MY 2015, the aggregate HealthChoices rate in the 13+ population (overall population) was 27.5% for the Initiation rate, and 19.1% for the Engagement rate. The Initiation rate was below the HEDIS 25th percentile while the Engagement rate was above the 75th percentile.The Initiation and the Engagement rates both statistically significantly decreased from MY2014 rates. 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 all 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 2015 and 2016 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 factors associated with initiation and engagement rates among members enrolled in the Pennsylvania Medicaid Behavioral Health HealthChoices program who had a diagnosis of opioid abuse. A claims-based study was developed to determine what demographic and clinical factors are associated with lower initiation and engagement rates, with an objective of combining physical health and behavioral health encounter data to identify factors across both domains of care. The goal of this study was to provide data to guide targeted quality improvement interventions by identifying subpopulations with low initiation and engagement rates. Emphasis was placed on identifying factors across domains of care, i.e. physical and behavioral co-morbidities that are associated with lower initiation and engagement rates, and vice versa.

Data Collection and Analysis

This study analyzed behavioral and physical health encounter data for inpatient, outpatient, partial hospitalization, and intensive outpatient services for members with a primary or secondary diagnosis of opioid abuse between 1/1/14 and 11/15/14 in order to measure the percentage of members who receive these services after the opioid abuse diagnosis (defined as the index event). The primary source of data was claims that were submitted to and accepted by the DHS PROMISe encounter system through 10/28/15 and received by IPRO. Any claims not submitted to or not accepted by PROMISe were not included in this study. Additional analyses compared initiation and engagement rates for various subpopulations. Subpopulations were distinguished by member demographics, opioid diagnosis details, co-occurring substance abuse, and type of encounters/level of care, stratified by the behavioral and physical health domains. Analyses were done to identify what factors or combinations of factors correlate with the index event type, medication-assisted treatment for opioid dependence, and time to service initiation.

Results/Conclusions

There were a total of 10,829 members that met the denominator criteria that were included in this study, of which all had physical health and behavioral health encounters. The overall initiation rate for MY 2014 was 40.68%, and the overall engagement rate was 28.29%.

There were a number of demographic factors that were statistically significantly correlated with lower initiation and engagement rates. For both initiation and engagement, members from urban settings had lower rates than members from rural settings, African American members had lower rates than white members, and males had lower rates than females. It is noted that rates declined for both genders, though this was only statistically significant for initiation. The highest rates were for members aged 25-40.

Although opioid usage details were unspecified for about 85% of the sample, those with a continuous opioid diagnosis had lower initiation and engagement rates than members with any unspecified diagnosis, and lower initiation rates than members with any episodic opioid diagnosis. Members with a diagnosis of opioid dependence have higher initiation and engagement rates than those diagnosed with non-dependent abuse. Opioid diagnosis was the primary diagnosis for 74.6% members; these members had significantly higher rates than those with a non-opioid primary diagnosis (31.9% higher for initiation, and 26.0% higher for engagement). A co-occurring substance abuse diagnosis was associated with lower rates than opioid abuse alone (4.9% lower for initiation and 0.2% lower for engagement). Alcohol, cannabis, and cocaine were the most frequently co-diagnosed drugs; of these, alcohol had the lowest rates (34.3% for initiation and 24.1% for engagement).

Of the five types of index events (inpatient, emergency department, detoxification, outpatient/alternative levels of care, and outpatient/alternative levels of care stratified into behavioral and physical health encounters), intensive outpatient and methadone services had the highest initiation rates (86.7% and 85.4%, respectively) and engagement rates (80.1% and 68.8%, respectively). Members with a primary diagnosis of opioid abuse for the index event have higher initiation and engagement rates (31.9% and 26.0%, respectively) than members with a secondary diagnosis of opioid abuse.

Members with no active prescriptions for medication-assisted treatment for opioid dependence have an initiation rate 24.1% lower than those with an active prescription, and an engagement rate 21.7% lower. Members that initiated treatment within one week of the index event had a higher percentage of engagement than members who initiated treatment during the second week for all services except methadone.

V: 2015 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 2015 EQR Technical Reports, which were distributed in April 2016. The 2016 EQR Technical Report is the ninth report to include descriptions of current and proposed interventions from each BH-MCO that address the 2015 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 May 30, 2016 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 2016, as well as any additional relevant documentation provided by the BH-MCO.

Table 17 presents MBH's responses to opportunities of improvement cited by IPRO in the 2015 EQR Technical Report, detailing current and proposed interventions.

Table 17: Current and Proposed Interventions

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found MBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 5/30/16/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
MBH 2015.01	Within Subpart C: Enrollee Rights and Protections Regulations, MBH was partially compliant with one out of seven categories – Enrollee Rights.	Date(s) of follow-up action taken through 5/30/16	**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 Quality Improvement Department. 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 and QI Reorganization_2015 Compliance Care Manager, Senior- job
		Date(s) of future action planned- None	**Standard 60, Substandard 1**
		Date(s) of follow-up action taken through 5/30/16	**Standard 60, Substandard 2 & 3:** Complaint training curriculum revised based on organizational & functional changes, and in compliance with Appendix H & Act 68. All staff, including Peer Advisors & 2nd level panel members, will be trained on the revised complaint workflow and procedures. Complaints and Grievances for Care Managers training took place on 1/28/15; and Complaints & Grievances Investigations Training took place on 4/24/15. For 2016, CSA training for Complaints & Grievances took place on 1/13/16; and CM training on Complaints & Grievances took place 2/3/16. 1.28.2015 Complaints and Griev 4.24.2015 Complaints and Griev 30_34_2015 C&G overview for all staff. 30a_34a_2015 Complaint Investigati 2016 CG overview for all staff.pptx CSA Complaints and Grievances_2016.pdf

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found MBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 5/30/16/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			 CM Complaints and Grievances_Sign In_2  Complaints and Grievances CMs_2016  Complaints and Grievances SABA Rep The Counties to continue to audit 1st level complaint records and provide feedback of their findings.
		Date(s) of future action planned- Ongoing	**Standard 60, Substandard 2 & 3:** Customer Service Associates and Care Managers will continue to receive Complaints & Grievances training on an annual basis, at a minimum. The Counties to continue to audit 1st level complaint records and provide feedback of their findings.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found MBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 5/30/16/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
MBH 2015.02	MBH was partially compliant with four out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, and 4) Practice Guidelines.	Date(s) of follow-up action taken through 5/30/16	**<u>Standard 28, Substandard 1 & 2</u>** 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. The Care Management prompts were updated in May, 2016 to ensure that Care Managers are documenting the specific MNC in clinical notes (the prompts have since been updated again- please also see future action planned).  PreCoded Note Prompts 2015.docx  PreCoded Prompts Master 2016.docx Trainings on Operational Effectiveness, Clinical Documentation and Active Care Management have been conducted to address clinical reviews demonstrating consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.  Active CM Training 8 18 15 HM.pptx  Clinical Documentation Sign I  and Documentation 0  CM(Active CM) Sign ir

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found MBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 5/30/16/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			In order to ensure use of Magellan provider performance processes to address problems with providers' clinical judgment, on 1/7/15, 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. All clinical staff (added Field Care Workers, Follow Up Specialists and Care Workers) has the ability to file a PPIR in the QI database. The community support team often interacts with providers during bed searches and attempting to secure aftercare appointments and experience situations where providers are not willing to take our members for a variety of reasons. This team was trained on the PPIR process and will complete PPIR's as clinically appropriate moving forward.  PPIR Training 2015 Attendance Onsite.p  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 also be referred to the Network Strategy Committee for review and recommendations made by QI, Clinical and Network management. As of March 2016, Magellan has implemented monitoring audits to ensure that the medical necessity decision made by the Physician/ Advisor is supported by documentation in the denial record and reflects the appropriate medical necessity criteria. The findings of the audits are reviewed weekly with the Clinic Department.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found MBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 5/30/16/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of future action planned- 8/1/16	**<u>Standard 28, Substandard 1 & 2</u>** Active Care Management training is scheduled for all clinical staff on 8/1/16. Monitoring of CM compliance will be completed through regular supervision, team meetings, training and review of denial documentation. PPIR Training will be provided annually to all Magellan clinical, medical and quality staff. The Care Management prompts were updated in May, 2016 to ensure that Care Managers are documenting the specific MNC in clinical notes. The most recent version of the CM prompts (dated 8.5.16) are included here.  PreCoded Prompts Master 2016.docx Specific to substandard 2, Magellan implemented monitoring audits in March, 2016 to ensure that the medical necessity decision made by the Physician/ Advisor is supported by documentation in the denial record and reflects the appropriate medical necessity criteria. As of 8/8/16, of the denial audits completed for the week of 7/23/16 to 7/29/16, 90% of denials were supported by the Physician/ Advisor documentation found in the denial record. The goal is to achieve 100% for the denial rationale and other NCQA standard requirements and then the audits will resume monthly. Results will be reported in UM meetings.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found MBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 5/30/16/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
MBH 2015.03	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 and Subcontractors	Follow Up Actions Taken Through 5/30/16	**Standards 68, Substandard 1, 3, 4 & 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 (please note that Magellan's Complaints Policies are currently in revision and going through the standard approval process. The 2016 policies include updated language including the responsibilities of the Appeals and Comments Manager. We expect that the revised policies will be submitted to OMHSAS before the end of Sept.).  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 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. *Please see documents embedded in response to Standard 60, Substandard 1 in Section MBH2015.01 above.*
		Future Actions Planned-	**Standards 68, Substandard 1, 3, 4 & 5**

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found MBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 5/30/16/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Ongoing	Individual county audit results will be combined to offer findings and feedback from aggregated perspective. The Counties to continue to audit 1st level complaint records and provide feedback of their findings. Continue with ongoing practices of identifying any provider performance concerns. The Complaint policies are all under review and revision to conform with the changes to Appendix H. Updated complaint policies for all 5 counties will be issued in 2016.
MBH 2015.04	MBH's rate for the MY 2014 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (worse) than the BH-MCO Average of 14.3% by 1.1 percentage points. MBH's rate did not meet the OMHSAS performance goal of 10.0%.	Follow Up Actions Taken Through 5/30/16	Magellan submitted the 30-day Readmission Rate RCA to IPRO and OMHSAS by the August 12, 2016 deadline.
		Future Actions Planned (Specify Dates)	Implement actions identified in submitted RCA.
MBH 2015.05	MBH's rate for the MY 2014 30- Day Follow-up After Hospitalization for Mental Illness (PA Specific indicator QI B) was statistically significantly lower than the BH-MCO Average by 1.3 percentage points. MBH's rates for the MY 2014	Follow Up Actions Taken Through 5/30/16	Magellan submitted the Follow-up After Hospitalization (FUH) Root Cause Analysis (RCA) to IPRO and OMHSAS by the August 12, 2016 deadline.
		Future Actions Planned (Specify Dates)	Implement actions identified in submitted RCA.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found MBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 5/30/16/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
	Follow-up After Hospitalization for Mental Illness HEDIS indicators (QI 1 and QI 2) for ages 6-64 did not meet the OMHSAS interim goal, nor did they meet the goal of achieving or exceeding the 75th percentile.		

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 2014, MBH began to address opportunities for improvement related to Standards. 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 2016 EQR is the eighth 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 measurement year. 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.

For the 2016 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 18**)
- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years (**Table 19**)
- Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day) (**Table 20**)
- Readmission Within 30 Days of Inpatient Psychiatric Discharge (**Table 21**)

Table 18: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) – Ages 6–64 Years

Managed Care Organization (MCO): MBH	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) Ages 6–64	Response Date: 8/12/16

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 MY2015. Since Magellan's MY2014 results were in the 'Below 75th, at or above 50th percentile' category, a 2% increase to 48.05% is the goal for MY2015.

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

Findings: Magellan's MY2014 rate for this measure was 1.2 percentage points lower than the MY2013 rate. This 2.31% decline was not statistically significant. Magellan's rate was 2.7 percentage points above the HealthChoices' Aggregate rate. Magellan and four of the Counties (Bucks, Lehigh, Montgomery and Northampton) did not meet their MY2014 interim goals. Delaware County met its MY2014 interim goal, with a 4.39% increase from its MY 2013 rate.

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

	MY2013	MY2014 Goal	MY2014 Results	2014 Goal met?	(MY'13-comp to MY'14) PPD	(MY'13-comp to MY'14) % change	(MY'13-comp to MY'14) SSD	MY 2015 Goal
HC Avg	47.9%	48.07%	47.6%	No	-0.30	-0.63%	No	48.55%
MBH	51.5%	52.52%	50.3%	No	-1.19	-0.02	No	51.3%
BU	51.8%	52.84%	52.2%	No	0.40	0.77%	No	53.24%
DE	46.7%	47.59%	48.7%	Yes	2.05	4.39%	No	49.67%
LE	52.6%	53.64%	49.8%	No	-2.78	-5.29%	No	50.80%
MO	51.1%	52.09%	50.0%	No	-1.07	-2.10%	No	51.00%
NH	56.9%	maintain/ improve	51.5%	No	-5.35	-9.41%	Yes	52.53%

Policies (1) (e.g., data systems, delivery systems, provider facilities) ***N/A***	**Initial Response:** **Follow-up Status Response:**
Policies (2) (e.g., data systems, delivery systems, provider facilities) ***N/A***	**Initial Response:** **Follow-up Status Response:**
Policies (3) (e.g., data systems, delivery systems, provider facilities) ***N/A***	**Initial Response:** **Follow-up Status Response:**

Policies (4) (e.g., data systems, delivery systems, provider facilities) ***N/A***	**Initial Response:**
	Follow-up Status Response:
Policies (5) (e.g., data systems, delivery systems, provider facilities) ***N/A***	**Initial Response:**
	Follow-up Status Response:
Procedures (1) (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.
	Follow-up Status Response:
Procedures (2) (e.g., payment/reimbursement, credentialing/collaboration) **No process for specialized FUH attention for those likely to readmit or not attend FUH**	**Initial Response:** 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.
	Follow-up Status Response:
Procedures (3) (e.g., payment/reimbursement, credentialing/collaboration) **No one calling to remind member of appointment**	**Initial Response:** The delay that can result when an individual forgets their FUH appointment information including provider address, date and time of appointment.
	Follow-up Status Response:
Procedures (4) (e.g., payment/reimbursement, credentialing/collaboration) **Focus on PA-specific accepted aftercare appointment.**	**Initial Response:** 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.
	Follow-up Status Response:
Procedures (5) (e.g., payment/reimbursement, credentialing/collaboration) **N/A**	**Initial Response:**
	Follow-up Status Response:
People (1) (e.g., personnel, provider network, patients) **Mbr choosing not to pursue treatment**	**Initial Response:** The delay that can result when a member chooses to not pursue treatment following discharge from an inpatient setting.
	Follow-up Status Response:
People (2) (e.g., personnel, provider network, patients)	**Initial Response:** 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.
	Follow-up Status Response:

Bad experience w/provider	
People (3) (e.g., personnel, provider network, patients) **Substance use relapse**	**Initial Response:** 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.
	Follow-up Status Response:
People (4) (e.g., personnel, provider network, patients) **Co-morbid medical condition**	**Initial Response:** The delay that can occur, due to limited resources, when an individual requires specialized medical care concomitant with their psychiatric care upon discharge.
	Follow-up Status Response:
People (5) (e.g., personnel, provider network, patients) **N/A**	**Initial Response:**
	Follow-up Status Response:
Provisions (1) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Inconvenient FUH appointment(s)**	**Initial Response:** 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.
	Follow-up Status Response:
Provisions (2) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Lack of immediate appointment access**	**Initial Response:** 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.
	Follow-up Status Response:
Provisions (3) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Open Access Appointments**	**Initial Response: The delay that can result when a member does not have a specific date and time associated with the FUH appointment.**
	Follow-up Status Response:
Provisions (4) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **OP scheduling flexibility**	**Initial Response:** 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.
	Follow-up Status Response:
Provisions (5) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Lack of Psychiatrists**	**Initial Response:** The delay that can result when there are a limited number of psychiatric appointments available, due to a shortage of psychiatrists.
	Follow-up Status Response:
Other (specify): Treatment Process	**Initial Response:** The delay that can result when an individual has a specialized need that cannot be met by

Lack of appropriate community-based services/resources	traditional community-based services and results in the member disengaging from treatment.
	Follow-up Status Response:
Other (specify): Treatment Process Lack of involving member in own treatment	**Initial Response:** 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.
	Follow-up Status Response:
Other (specify): Treatment Process Lack of understanding of d/c plan	**Initial Response:** 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.
	Follow-up Status Response:
Other (specify): Treatment Process Lack of family/support person's involvement to assist member w/adherence to d/c plan	**Initial Response:** 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:

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 2015. 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.
Action (1) Training on HEDIS accepted aftercare services for Magellan's Care Managers (CMs). If Magellan CMs are informed of the services accepted in the HEDIS FUH measure, they can work with inpatient facilities to ensure these are included in a member's aftercare plan.	May 4, 2016 Will be repeated annually in clinical team's training series.	**Initial Response:** Initial training was recorded so it can be used for new employees. The initial presentation generated meaningful questions from the CMs, which will be used to develop future training curriculum. A handout with the key elements was created and posted on Magellan's intranet for CMs' reference.
		Follow-up Status Response:
Action (2) Developed & distributed Inpatient Discharge Best Practices to all inpatient facilities	June 21, 2016 Ongoing-will be used in daily concurrent clinical reviews between the inpatient facilities and Magellan	**Initial Response:** A document of best practices for discharge planning from an inpatient facility was developed, based on a combination of Magellan's experience, PIP analysis and research. This was presented to the group meeting of inpatient mental health facilities on 6/21/16 and then distributed via email on: 6/24/2016.
		Follow-up Status Response:
Action (3) (Delaware County) Participation in	July 5, 2016- CFF notified chosen as recipient of	**Initial Response:** In FY 15-16, Congress increased overall funding for the Community Mental Health

OMHSAS' RFP funded program for implementation of a First Episode Psychosis program.	OMHSAS funding.	Services Block Grant (CMHSBG) set aside for early intervention services for individuals with SMI/SED, with a focus on First Episode Psychosis (FEP) from 5% to 10%. With this, OMHSAS issued an RFP for providers, offering $250,000 per program to six sites with the goal of increasing access to these programs. With Delaware County's support, a prominent community based provider, Child and Family Focus (CFF), applied for the RFP and was notified they were awarded the funding in early July. The provider will be implementing the Coordinated Specialty Model, training will be in September 2016 and the provider is currently identifying staff for this. A 6 month implementation period is expected.
		Follow-up Status Response:
Action (4) Expansion of specialized intervention services for high risk population, such as those members with a co-occurring mental health and substance use disorders and those with forensic involvement. <u>Forensic ACT program</u> • Bucks County • Delaware County	• 8/2008 • 6/2014	**Initial Response:** Bucks and Delaware Counties created FACT (Forensic ACT) teams to help meet the needs of members who meet the ACT criteria and also have forensic involvement.
		Follow-up Status Response:
Action (5) Transition of Magellan's Mental Health Inpatient Partners In Care (MH IP PIC) to Magellan Facility Incentive Program (MFIP)	July 2016 – transition to MFIP model. - Data reported quarterly, with Tier changes every six months - Amount of direct work between facility & Magellan based on Tier assignment.	**Initial Response:** *Additional information regarding the MH IP PIC program can be found in the 2013 RCA response to MY2012 performance and the 2014 RCA response to MY2013 performance.* Continued success of the MH IP PIC program (In a comparison of FUH rates from Q1 2014 to Q2 2015, MH IP PIC providers outperformed inpatient facilities not in the program), has led to its expansion to all inpatient facilities (who serve more than 50 Magellan members annually), for all ages in July 2016. These changes are part of a transition from a facility-limited program to the way in which mental health inpatient services are managed. This transition includes a scorecard of data metrics which include a cost-mix adjusted ration measurement which drive the facilities' Tier assignment. Each Tier has a performance expectation and then associated incentives.
		Follow-up Status Response:
Action (6) PIP Interventions to address follow-up:	- 3/1/15 - Ongoing	**Initial Response:** This intervention offers a unique opportunity for members to conceptualize their

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 also seen by Magellan and the BHHCs were included in the PIP. Those which address FUH are included here: Brooke Glen Behavioral Hospital-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.	- Daily	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'. This intervention was determined to be successful (an increase of 15.23 percentage points in the FUH rate when pilot period was compared to same time period in the prior year). This intervention will continue; in fact, the provider has expanded this intervention to all patients, not only Magellan members. **Follow-up Status Response:**
Action (7) PIP Interventions to address follow-up: 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.	- 3/1/15 - Ongoing - Daily	**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 aftercare appointment. Although there was a decrease in FUH rates when the pilot period was compared to same time period in the prior year, this intervention is continuing. From a qualitative perspective, the facility and its members found value in this process and that making a connection with an outpatient provider before discharge was helpful in the transition process. The facility found that two outpatient providers were not enough to be included in this intervention. The facility has engaged a third provider in this initiative. **Follow-up Status Response:**
Action (8)	- 8/2015	**Initial Response:**

(Lehigh and Northampton Counties) Expansion of Medical Mobile Crisis program	- Ongoing - Daily	A team of Masters level clinicians and RNs who are community based and will see members who are in crisis and/or in need of medications. In cases where the member needs medication, the team has access to a psychiatrist and will prescribe medications, based on the clinical needs. This program re-started in August 2015, to assist with the closure of LVCMH and expanded to all HealthChoices' members in Lehigh and NH in April 2016, to assist with FUH and 30 day re-admission rates.
		Follow-up Status Response:
Action (9) (Delaware, Lehigh, Montgomery and Northampton Counties) Establishment of Dual Diagnosis Treatment Team (DDTT) programs for individuals with a co-existing mental health (MH) diagnosis and intellectual and developmental disability (IDD).	- 5/2015: Lehigh / Northampton Counties - 7/2015: Delaware / Montgomery Counties- - Ongoing - Daily	**Initial Response:** Dual Diagnosis Treatment Team (DDTT) is a voluntary, community-based, direct service that provides intensive supports for individuals who have a co-existing mental health (MH) diagnosis and intellectual and developmental disability (IDD). The goals of this program are crisis intervention, hospital diversion and community stabilization. Two programs began in 2015 (Lehigh/Northampton- May 2015 & Delaware/Montgomery- July 2015). As expected, these programs do not serve a large number of members and have had less than 10 discharges to date. Magellan, the provider (NHS in both regions) and the counties will review data such as inpatient admissions and inpatient readmissions as part of an evaluation of the effectiveness of the programs as more members are served.
		Follow-up Status Response:
Action (10) (Delaware, Lehigh, Montgomery and Northampton Counties) Establishment of Lehigh / Northampton Counties for transition-aged youth with emotional/behavioral difficulties.	- 9/2015: Montgomery County - 11/2015: Delaware County - 12/2015: Lehigh / Northampton Counties - Ongoing - Daily	**Initial Response:** Following successful implementation of the Transition to Independence Process (TIP) program in Bucks County, programs were established in the other Magellan-contracted counties. TIP is designed for youth ages 18 to 26 living with mental illness and/or intellectual disabilities. This evidence supported best-practice model is the only one for individuals in this age group with emotional/behavioral difficulties. For the youth and young adults, the TIP model aims to: engage them in their own future planning process; provide them with non-stigmatizing, culturally competent and appealing services and supports; and help them and their families move toward self-sufficiency and achievement of goals in the following domains: employment/career; educational opportunities; living situation; personal effectiveness/well-being; and community-life functioning.
		Follow-up Status Response:

Table 19: RCA and Action Plan – Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) – Ages 6–64 Years

Managed Care Organization (MCO): MBH	Measure: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day) Ages 6–64	Response Date: 8/12/16

Goal Statement: (Please specify individual goals for each measure): Based on the three year goal set by OMHSAS for the HEDIS 30 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 MY2015. Since Magellan's MY2014 results were in the 'Below 75th, at or above 50th percentile' category, a 2% increase to 69.26% is the goal for MY2015.

***The MY2015 goals for Delaware and Montgomery counties was approximated based on the above mentioned methodology for interim goals, combined with the information regarding performance provided in the MY2015 EQR Report (HEDIS MY 2015 Percentile- Below 50th Percentile, Above 25h Percentile). The lowest MY2014 rate which was Above the 50th Percentile (67.60%) was used as the 50th Percentile. The variance between the county's rate and that rate was determined. Based on the percent of variance, the appropriate MY2015 rate was determined (using the methodology for interim goal setting).**

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

Findings: Magellan's MY2014 rate was essentially the same as the MY2013 rate; as such, this slight increase was not statistically significant. Two of the counties (Bucks and Delaware) met their MY2014 goals; however, these improvements were not found to be statistically significant. Magellan and three of the counties (Lehigh, Montgomery and Northampton) saw decreases in their MY2014 performance. Lehigh County's decrease was statistically significant.

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

	MY2013	MY2014 Goal	MY2014 Results	2014 Goal met?	(MY'13-comp to MY'14) PPD	(MY'13-comp to MY'14) % change	(MY'13-comp to MY'14) SSD	MY2015 Goal
HC Avg	67.83%	69.19%	67.90%	No	0.07	0.10%	No	69.26%
MBH	68.63%	70.00%	67.70%	No	-0.93	-1.36%	No	69.05%
BU	67.18%	68.52%	69.40%	Yes	2.22	3.30%	No	70.79%
DE*	62.93%	64.63%	64.90%	Yes	1.97	3.13%	No	67.60%
LE	71.32%	72.75%	67.60%	No	-3.72	-5.22%	Yes	68.95%
MO*	68.06%	69.42%	65.60%	No	-2.46	-3.61%	No	67.60%
NH	75.00%	Maintain / improve	72.50%	No	-2.50	-3.33%	No	73.95%

Policies (1) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response**
Policies (2) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response**

Policies (3) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response**
Policies (4) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response**
Policies (5) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response**
Procedures (1) (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. **Follow-up Status Response:**
Procedures (2) (e.g., payment/reimbursement, credentialing/collaboration) **No process for specialized FUH attention for those likely to readmit or not attend FUH**	**Initial Response:** 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. **Follow-up Status Response:**
Procedures (3) (e.g., payment/reimbursement, credentialing/collaboration) **No one calling to remind member of appointment**	**Initial Response:** The delay that can result when an individual forgets their FUH appointment information including provider address, date and time of appointment. **Follow-up Status Response:**
Procedures (4) (e.g., payment/reimbursement, credentialing/collaboration) **Focus on PA-specific accepted aftercare appointment.**	**Initial Response:** 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. **Follow-up Status Response:**
Procedures (5) **N/A**	**Initial Response:** **Follow-up Status Response:**
People (1) (e.g., personnel, provider network, patients) **Mbr choosing not to pursue treatment**	**Initial Response:** The delay that can result when a member chooses to not pursue treatment following discharge from an inpatient setting. **Follow-up Status Response:**

People (2) (e.g., personnel, provider network, patients) **Bad experience w/provider**	**Initial Response:** 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.
	Follow-up Status Response:
People (3) (e.g., personnel, provider network, patients) **Substance use relapse**	**Initial Response:** 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.
	Follow-up Status Response:
People (4) (e.g., personnel, provider network, patients) **Co-morbid medical condition**	**Initial Response:** The delay that can occur, due to limited resources, when an individual requires specialized medical care concomitant with their psychiatric care upon discharge.
	Follow-up Status Response:
People (5) (e.g., personnel, provider network, patients) **N/A**	**Initial Response:**
	Follow-up Status Response:
Provisions (1) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Inconvenient FUH appointment(s)**	**Initial Response:** 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.
	Follow-up Status Response:
Provisions (2) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Lack of immediate appointment access**	**Initial Response:** 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.
	Follow-up Status Response:
Provisions (3) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Open Access Appointments**	**Initial Response:** The delay that can result when a member does not have a specific date and time associated with the FUH appointment.
	Follow-up Status Response:
Provisions (4) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **OP scheduling flexibility**	**Initial Response:** 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.
	Follow-up Status Response:
Provisions (5) (e.g., screening tools, medical record forms, provider and enrollee educational	**Initial Response:** The delay that can result when there are a limited number of psychiatric appointments available, due to a shortage of psychiatrists.

materials) **Lack of Psychiatrists**	**Follow-up Status Response:**
Other (specify): Treatment Process **Lack of appropriate community-based services/resources**	**Initial Response:** 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.
	Follow-up Status Response:
Other (specify): Treatment Process **Lack of involving member in own treatment**	**Initial Response:** 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.
	Follow-up Status Response:
Other (specify): Treatment Process **Lack of understanding of d/c plan**	**Initial Response:** 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.
	Follow-up Status Response:
Other (specify): Treatment Process **Lack of family/support person's involvement to assist member w/adherence to d/c plan**	**Initial Response:** 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:

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 2015. 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.
Action (1) 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 applicable Actions listed above include: • (1) Training on HEDIS accepted		**Initial Response:** **Follow-up Status Response:**

aftercare services • (2) Developed & distributed Inpatient Discharge Best Practices • (3) Implementation of First Episode Psychosis program (Delaware County) • (4) Expansion of specialized intervention services for high risk populations • (5) Transition of MH IP PIC program to MFIP • (6) Development of daily schedule of treatment and non-treatment activities for 1st week after inpatient discharge • (7) Establishment of direct 'warm transfer' process between inpatient facility and identified outpatient providers • (8) Expansion of medical mobile crisis program (Lehigh and Northampton Counties) • (9) Establishment of Dual Diagnosis Treatment Team (DDTT) programs (Delaware, Lehigh, Montgomery and Northampton Counties) • (10) Establishment of Transition to Independence Process (TIP) programs (Delaware, Lehigh, Montgomery and Northampton Counties)		

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

Managed Care Organization (MCO): MBH	**Measure: Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)**	**Response Date: 8/12/16**
Goal Statement: (Please specify individual goals for each measure): The MY2015 goals set are based on statistically significant improvement from Magellan's and each counties' MY2014 rates. The goals are based on an assumption of a consistent number of discharges in each year. Based on MY2014, a statistically significant (p=0.05) decrease would be realized at 74.93%. This MY2015 goal is a 2% increase from MY2014.		

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

Findings: Magellan's MY2014 rate was 1.8 percentage points less than its MY2013 rate. This 2.39% decrease was statistically significant. This rate was below the HealthChoices' BH-MCO average. Magellan and four of the Counties (Delaware, Lehigh, Montgomery and Northampton) had rates in MY2014 that were lower than in MY2013. Montgomery County's decrease was statistically significant. Bucks County increased its rate by 3.02% percent from MY2013 to MY2014.

QI B- FUH, PA-Specific 30 Day

	MY2013	MY2014 Results	(MY'13-comp to MY'14) PPD	(MY'13-comp to MY'14) % change	(MY'13-comp to MY'14) SSD	MY2015 Goal
HC Avg	73.9%	74.80%	0.90	1.22%	Yes	-
MBH	75.3%	73.5%	-1.80	-2.39%	Yes	74.93%
BU	72.8%	75.0%	2.20	3.02%	No	78.38%
DE	72.8%	71.3%	-1.50	-2.06%	No	74.46%
LE	76.6%	73.5%	-3.10	-4.05%	No	76.33%
MO	75.8%	71.7%	-4.10	-5.41%	Yes	74.61%
NH	79.1%	77.7%	-1.40	-1.77%	No	81.06%

Policies (1) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response:**
Policies (2) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response:**
Policies (3) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response:**
Policies (4) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response:**
Policies (5) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response:**
Procedures (1) (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. **Follow-up Status Response:**

Procedures (2) (e.g., payment/reimbursement, credentialing/collaboration) **No process for specialized FUH attention for those likely to readmit or not attend FUH**	**Initial Response:** 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.
	Follow-up Status Response:
Procedures (3) (e.g., payment/reimbursement, credentialing/collaboration) **No one calling to remind member of appointment**	**Initial Response:** The delay that can result when an individual forgets their FUH appointment information including provider address, date and time of appointment.
	Follow-up Status Response:
Procedures (4) (e.g., payment/reimbursement, credentialing/collaboration)	**Initial Response:**
	Follow-up Status Response:
Procedures (5) (e.g., payment/reimbursement, credentialing/collaboration)	**Initial Response:**
	Follow-up Status Response:
People (1) (e.g., personnel, provider network, patients) **Mbr choosing not to pursue treatment**	**Initial Response:** The delay that can result when a member chooses to not pursue treatment following discharge from an inpatient setting.
	Follow-up Status Response:
People (2) (e.g., personnel, provider network, patients) **Bad experience w/provider**	**Initial Response:** 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.
	Follow-up Status Response:
People (3) (e.g., personnel, provider network, patients) **Substance use relapse**	**Initial Response:** 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.
	Follow-up Status Response:
People (4) (e.g., personnel, provider network, patients) **Co-morbid medical condition**	**Initial Response:** The delay that can occur, due to limited resources, when an individual requires specialized medical care concomitant with their psychiatric care upon discharge.
	Follow-up Status Response:
People (5) (e.g., personnel, provider network, patients) **N/A**	**Initial Response:**
	Follow-up Status Response:
Provisions (1) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Inconvenient FUH appointment(s)**	**Initial Response:** 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.
	Follow-up Status Response:
Provisions (2) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Lack of immediate appointment access**	**Initial Response:** 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.
	Follow-up Status Response:
Provisions (3) (e.g., screening tools, medical record forms, provider and	**Initial Response:** The delay that can result when a member does not have a specific date and time associated with the FUH appointment.

enrollee educational materials) **Open Access Appointments**	**Follow-up Status Response:**
Provisions (4) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **OP scheduling flexibility**	**Initial Response:** 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.
	Follow-up Status Response:
Provisions (5) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Lack of Psychiatrists**	**Initial Response:** The delay that can result when there are a limited number of psychiatric appointments available, due to a shortage of psychiatrists.
	Follow-up Status Response:
Other (specify): Treatment Process **Lack of appropriate community-based services/resources**	**Initial Response:** 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.
	Follow-up Status Response:
Other (specify): Treatment Process **Lack of involving member in own treatment**	**Initial Response:** 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.
	Follow-up Status Response:
Other (specify): Treatment Process **Lack of understanding of d/c plan**	**Initial Response:** 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.
	Follow-up Status Response:
Other (specify): Treatment Process **Lack of family/support person's involvement to assist member w/adherence to d/c plan**	**Initial Response:** 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:

Corresponding Action Plan

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

For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2015. Documentation of actions should be continued on additional pages as needed.

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

Action (1) With the exception of Action (1)-Training on HEDIS accepted aftercare services, 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 B (PA-Specific 30 Day). Improvement in any 7 day or HEDIS measure will also improve performance in this 30 day measure. The Actions listed above include: • (2) Developed & distributed Inpatient Discharge Best Practices • (3) Implementation of First Episode Psychosis program (Delaware County) • (4) Expansion of specialized intervention services for high risk populations • (5) Transition of MH IP PIC program to MFIP • (6) Development of daily schedule of treatment and non-treatment activities for 1st week after inpatient discharge • (7) Establishment of direct 'warm transfer' process between inpatient facility and identified outpatient providers • (8) Expansion of medical mobile crisis program (Lehigh and Northampton Counties) • (9) Establishment of Dual Diagnosis Treatment Team (DDTT) programs (Delaware, Lehigh, Montgomery and Northampton Counties) • (10) Establishment of Transition to Independence Process (TIP) programs (Delaware, Lehigh, Montgomery and Northampton Counties)		**Initial Response:** **Follow-up Status Response:**

Table 21: RCA and Action Plan – Readmission Within 30 Days of Inpatient Psychiatric Discharge

Managed Care Organization (MCO): MBH	**Measure: Readmission Within 30 Days of Inpatient Psychiatric Discharge**	**Response Date: 8/12/16**
Goal Statement: (Please specify individual goals for each measure): The MY2015 goals set are based on statistically significant improvement from Magellan's and each counties' MY2014 rates. The goals are based on an assumption of a consistent number of discharges in each year. Based on MY2014, a statistically		

significant (p=0.05) decrease would be realized at 14.25%. This MY2015 goal is a 7.5% decrease from MY2014.

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

Findings: Although there was an increase of 3.54%, Magellan's readmission rate remained statistically the same from MY2013 to MY2014. This is consistent with comparisons of MY2011 and MY2012 as well. During this same time, the HealthChoices' aggregated increased by 11.72%. This decrease was a statistically significant change. Magellan's performance was statistically significantly below/poorer than the MY2014 HealthChoices' BH MCO average of 14.30%.

Two of the counties (Delaware and Northampton) saw improved (i.e., decreased) rates in MY2014.

	MY 2013	MY2014	(MY'13-comp to MY'14) PPD	(MY'13-comp to MY'14) % change	MY 2015 Goal
HC Avg	12.80%	14.30%	1.50	11.72%	
MBH	14.87%	15.40%	0.53	3.54%	14.25%
BU	15.41%	16.70%	1.29	8.34%	13.91%
DE	13.42%	13.00%	-0.42	-3.10%	10.58%
LE	15.82%	16.70%	0.88	5.58%	14.28%
MO	14.44%	15.20%	0.76	5.25%	12.90%
NH	15.55%	15.30%	-0.25	-1.59%	12.34%

Policies (1) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response:**
Policies (2) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response:**
Policies (3) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response:**
Policies (4) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response:**
Policies (5) (e.g., data systems, delivery systems, provider facilities) **N/A**	**Initial Response:** **Follow-up Status Response:**
Procedures (1) (e.g., payment/reimbursement, credentialing/collaboration) **Medication prescription not covering amount of time from discharge until psychiatrist appointment.**	**Initial Response:** When a member's medical supply is exhausted prior to the next psychiatrist appoint, this can lead to de-compensation and the need to return to the inpatient setting. **Follow-up Status Response:**
Procedures (2)	**Initial Response:** When inpatient facilities do not share information regarding the member's care,

(e.g., payment/reimbursement, credentialing/collaboration) **Lack of collaboration with OP providers**	e.g. effective treatment, d/c planning, medication trial results, etc.
	Follow-up Status Response:
Procedures (3) (e.g., payment/reimbursement, credentialing/collaboration) **Poor documentation of discharge plan**	**Initial Response:** When the discharge plan is not communicated clearly to the member, it can lead to missed appointments and a lack of the support needed upon discharge.
	Follow-up Status Response:
Procedures (4) (e.g., payment/reimbursement, credentialing/collaboration) **No process for specialized attention for follow-up for those likely to readmit**	**Initial Response:** When there are no specialized interventions employed to reduce the likelihood of community-based treatment adherence for members at high risk for readmission.
	Follow-up Status Response:
Procedures (5) (e.g., payment/reimbursement, credentialing/collaboration) **N/A**	**Initial Response:**
	Follow-up Status Response:
People (1) (e.g., personnel, provider network, patients) **Medication Changes**	**Initial Response:** The effect of medication changes on a member's symptom experience and how that can impact them once discharged from the hospital.
	Follow-up Status Response:
People (2) (e.g., personnel, provider network, patients) **Complex medical issues**	**Initial Response:** When a member requires specialized medical care concomitant with their psychiatric care upon discharge.
	Follow-up Status Response:
People (3) (e.g., personnel, provider network, patients) **Member choosing not to accept care**	**Initial Response:** When a member chooses to not pursue treatment following discharge
	Follow-up Status Response:
People (4) (e.g., personnel, provider network, patients) **Substance Use relapse**	**Initial Response:** An individual resumes use of substances and a substance abusing lifestyle which causes distraction from and/or avoidance of treatment.
	Follow-up Status Response:
People (5) (e.g., personnel, provider network, patients) **Lack of psychiatrists**	**Initial Response:** The shortage of psychiatrists leads to a limited number of available psychiatric appointments.
	Follow-up Status Response:
Provisions (1) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Reduction in state hospital beds**	**Initial Response:** When a member has reached his/her baseline behavior; however, severe acuity persists, historically these members would be admitted to the state hospital for further treatment, which is no longer an option.
	Follow-up Status Response:
Provisions (2) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **Waiting lists for extended acute care (EAC) inpatient units**	**Initial Response:** When a member meets medical necessity criteria for EAC and there is not an available bed.
	Follow-up Status Response:
Provisions (3) (e.g., screening tools, medical record forms, provider and	**Initial Response:** There can be a limited availability of community-based treatment services for members, either as a result of lack of programs for a specialized need or because of minimal

enrollee educational materials) **Lack of appropriate community based services/resources**	capacity. **Follow-up Status Response:**
Provisions (4) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **N/A**	**Initial Response:** **Follow-up Status Response:**
Provisions (5) (e.g., screening tools, medical record forms, provider and enrollee educational materials) **N/A**	**Initial Response:** **Follow-up Status Response:**
Other (specify): Treatment Process **Lack of involving member in own treatment**	**Initial Response:** When members are not encouraged to actively participate in the treatment process and recovery. Infers relationship between recovery approach and delay in progress. **Follow-up Status Response:**
Other (specify): Treatment Process **'Why now?" not adequately addressed**	**Initial Response:** When the 'root cause' of the admission (vs. presenting problem) is not adequately addressed by the provider. **Follow-up Status Response:**
Other (specify): Treatment Process **Lack of family involvement**	**Initial Response:** When a member's family is not engaged as a support in the treatment process **Follow-up Status Response:**

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 2015. 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.
Action (1) Some of 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 (Readmission Within 30 Days of Inpatient Psychiatric Discharge). The applicable Actions listed above include: • (2) Developed & distributed Inpatient Discharge Best Practices • (3) Implementation of First Episode Psychosis program (Delaware County)		**Initial Response:** **Follow-up Status Response:**

• (4) Expansion of specialized intervention services for high risk populations • (5) Transition of MH IP PIC program to MFIP • (8) Expansion of medical mobile crisis program (Lehigh and Northampton Counties) • (9) Establishment of Dual Diagnosis Treatment Team (DDTT) programs (Delaware, Lehigh, Montgomery and Northampton Counties) • (10) Establishment of Transition to Independence Process (TIP) programs (Delaware, Lehigh, Montgomery and Northampton Counties)		
Action (2) PIP Interventions to address readmission: 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 also seen by Magellan and the BHHCs were included in the PIP. Those which address Readmission are included here. It is important to note the methodology for readmission is different between the PIP and the Annual Performance Measure. Brooke Glen Behavioral Hospital-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 - 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'. This intervention was determined to be successful (a decrease of 1.67 percentage points in the readmission rate when pilot period was compared to same time period in the prior year). This intervention will continue; in fact, the provider has expanded this intervention to all patients, not only Magellan members. **Follow-up Status Response:**
Action (3) PIP Interventions to address readmission: Members discharged from inpatient unit with medication (Mercy Fitzgerald)	- 3/1/15 - Ongoing - Daily	**Initial Response:** This provider will 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, thereby reducing readmission.

		This intervention was determined to be successful, as there were notable rates of decrease in both of the PIP readmission measures (there is one for members with a MH diagnosis and one for members with any SA diagnosis during their inpatient treatment episode). When comparing the pilot period to the same time in the prior year, - there was a 100% decrease for members with a SA diagnosis (from 23.53% readmission to 0%), and - there was a 75.58% decrease for members with a MH diagnosis (from 9.52% readmission to 2.33%). This intervention will continue, in fact the provider has expanded this intervention to all patients.
		Follow-up Status Response:
Action (4) (Bucks, Delaware and Montgomery Counties) 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. Analysis of effectiveness of EAC program at Brooke Glen.	- October 2014 - Analysis completed, EAC program is Ongoing - Daily	**Initial Response:** The EAC unit at Brooke Glen Behavioral Hospital (BGBH) opened 10/2/14. Magellan completed an analysis of the effectiveness of this service, which combined member experience, utilization data and provider collected clinical outcomes. Although there was only a small sample of members (9) who had discharged from the program at the time the analysis was conducted, the results were positive When comparing the 60 days before admission to the 60 days after discharge, the evaluation found a 79% decline in the number of psychiatric inpatient admissions and a 92% decline in the number of inpatient days and a 21% decline of reported psychiatric symptoms such as anxiety and depression. 100% of members discharged to stable housing and the question of 'overall satisfaction with treatment' scored 75%. Internally, the report was shared with Magellan's clinical, medical, network and quality teams. As part of the ongoing support to the facility in the development of this program, the report was shared with the appropriate counties' representatives and the facility.
		Follow-up Status Response:
Action (5) Comprehensive analysis of the effectiveness of CPS services. Develop actions for enhancement and expansion of this service based on findings	- 1/1/15 – 6/30/16 - Completed	**Initial Response:** As a result of analyses and data sources pointing toward the effectiveness of CPS services in preventing readmission, Magellan completed an analysis of the effectiveness of this service which

		combined member experience survey results with utilization data. The evaluation found a 43% decline in the number of members with psychiatric inpatient admissions, a 16% decline in the use of crisis and 95.7% of the respondents agreed or strongly agreed that 'my CPS has helped me stay out of the hospital'. The report was shared with Magellan's clinical, medical, network and quality teams, the county offices and the member support organizations in the counties
		Follow-up Status Response:
Action (6) Expansion of specialized intervention services for high risk population, such as those members with a co-occurring mental health and substance use disorders and those with forensic involvement. <u>Certified Recovery Specialist services:</u> • Bucks County • Delaware County • Montgomery County <u>Certified Peer Support Services for those with forensic involvement:</u> • Delaware County • Lehigh County • Northampton County	• 4/2014 • TBD-2 program descriptions being reviewed by SSRC • 9/2015 • 10/2013 • 5/2016 • 5/2016	**Initial Response:** Magellan and the counties work together to expand our provider network to meet the needs of members, particularly those at higher risk for inpatient utilization or difficulty remaining in the community. Certified Recovery Specialist (CRS) services are currently offered by The Council of Southeastern PA in Bucks and Montgomery Counties. There are 2 programs in the development phase in Delaware County. The program descriptions are currently being reviewed by DHS' SSRC; as such, there is not yet a timeframe for when they will be able to begin providing services. Three counties are contracted with Peer Star, a CPS program which specializes in members with forensic involvement.
		Follow-up Status Response:
Action (7) (Delaware, Lehigh, Montgomery and Northampton Counties) Establishment of Dual Diagnosis Treatment Team (DDTT) programs for individuals with a co-existing mental health (MH) diagnosis and intellectual and developmental disability (IDD).	- 5/2015: Lehigh / Northampton Counties - 7/2015: Delaware / Montgomery Counties- - Ongoing - Daily	**Initial Response:** Dual Diagnosis Treatment Team (DDTT) is a voluntary, community-based, direct service that provides intensive supports for individuals who have a co-existing mental health (MH) diagnosis and intellectual and developmental disability (IDD). The goals of this program are crisis intervention, hospital diversion and community stabilization. Two programs began in 2015 (Lehigh/Northampton- May 2015 &

		Delaware/Montgomery- July 2015). As expected, these programs do not serve a large number of members and have had less than 10 discharges to date. Magellan, the provider (NHS in both regions) and the counties will evaluate the effectiveness of the programs as more members are served.
		Follow-up Status Response:

VI: 2016 Strengths and Opportunities for Improvement

The review of MBH's 2016 (MY 2015) 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 2015 7-Day Follow-up After Hospitalization for Mental Illness – HEDIS Indicator (QI 1) was slightly higher than the MY 2015 HealthChoices BH-MCO Average, albeit not statistically significant, for Ages 6-64 Years Old and Overall Population.
- MBH's rate for the MY 2015 7-Day Follow-up After Hospitalization for Mental Illness – HEDIS Indicator (QI 1) was slightly higher than the MY 2014 7-Day Follow-up After Hospitalization for Mental Illness – HEDIS Indicator (QI 1), albeit not statistically significant, for Ages 6-20 Years Old.
- MBH's rate for the MY 2015 Inpatient Readmission rate was slightly lower than the MY 2014 Inpatient Readmission rate, albeit not statistically significant.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2013, RY 2014, and RY 2015 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 five 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, and 5) Quality Assessment and Performance Improvement Program.
    - MBH was partially compliant with 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.
- MBH's rate for the MY 2015 30-Day Follow-up After Hospitalization for Mental Illness – PA-specific Indicator (QI B) was statistically significantly lower than the MY 2015 HealthChoices BH-MCO Average of 73.0% by 3.1 percentage points.
- MBH's rate for the MY 2015 Readmission Within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (worse) than the MY 2015 HealthChoices BH-MCO Average of 14.0% by 1.2 percentage points. MBH did not meet the OMHSAS designated performance goal of 10.0%.
- MBH's rates for the MY 2015 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 2015, nor did they achieve the goal of meeting or exceeding the 75th percentile.
- MBH's rate for the MY 2015 Initiation of AOD Treatment performance measure (total population) was statistically significantly lower than the MY 2015 HealthChoices BH-MCO Average of 27.5% by 4.0 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 21**.

Table 21: BH-MCO Performance and HEDIS Percentiles

Color Code	Definition
	PA-specific Follow-up After Hospitalization Measures: Indicates that the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Indicates that the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014. 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 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014 or that the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average but there is no change from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014 or that the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average but there is no change from MY 2014. 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 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014 or the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average but trends down from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** The BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014 or the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or the BH-MCO's MY 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average but trends up from MY 2014. 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 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or that the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** Either the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and there is no change from MY 2014 or that the BH-MCO's MY 2015 rate is equal to the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014. 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 2015 rate is statistically significantly below the MY 2015 HealthChoices BH-MCO Average and trends down from MY 2014. **Readmission Within 30 Days of Inpatient Psychiatric Discharge:** the BH-MCO's MY 2015 rate is statistically significantly above the MY 2015 HealthChoices BH-MCO Average and trends up from MY 2014. HEDIS Follow-up After Hospitalization Measures – Ages 6–64: At or below the 50th percentile. A root cause analysis and plan of action is required.

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

Table 22: Performance Measure Matrix

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

[1] For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.

Letter Key: A: Performance is notable. 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); REA: Readmission Within 30 Days of Inpatient Psychiatric Discharge

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

Table 23: Performance Measure Rates

Quality Performance Measure	MY 2012 Rate	MY 2013 Rate	MY 2014 Rate	MY 2015 Rate	MY 2015 BH-MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)	59.2%▼	62.5% ▲	59.8%▼	55.8%▼	56.6%▼
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)	73.2%▼	75.3% ▲	73.5% ▼	69.9%▼	73.0%▼
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	15.8%═	14.9%═	15.4%═	15.2%═	14.0%═

[1]For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.

Table 24 is a four-by-one matrix that represents the BH-MCO's performance as compared to the HEDIS 90th, 75th, 50th and 25th percentiles for the Follow-up After Hospitalization 7-day/30-day metrics (QI 1/QI2). A root cause analysis and plan of action is required for items that fall below the 75th percentile.

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

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

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

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

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

Quality Performance Measure	MY 2015 Rate[1]	MY 2015 Compliance	HEDIS MY 2015 Percentile
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day)	46.8%	Not Met	Below 75th and at or above 50th percentile
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	62.6%	Not Met	Below 50th and at or above 25th percentile

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

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

Table 26: Key Points of Performance Measure Comparisons

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

For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.

VII: Summary of Activities

Structure and Operations Standards

- MBH was partially compliant on Subparts C, D and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2015, RY 2014, and RY 2013 were used to make the determinations.

Performance Improvement Projects

- MBH submitted a Year 1PIP Update in 2016. MBH participated in quarterly meetings with OMHSAS and IPRO throughout 2016 to discuss ongoing PIP activities.

Performance Measures

- MBH reported all performance measures and applicable quality indicators in 2016.

2015 Opportunities for Improvement MCO Response

- MBH provided a response to the opportunities for improvement issued in 2015.

2016 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for MBH in 2016. 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 2015, 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 2015. **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 2015	PEPS Reviewed in RY 2014	PEPS Reviewed in RY 2013	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	0	3	1
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	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	0	3	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 2015, 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 2015	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 2015, 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
Executive 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