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

2016 External Quality Review Report
PerformCare

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. During RY 2013, three Counties, Blair, Clinton, and Lycoming, held a contract with PerformCare through June 30, 2013 and contracted with another BH-MCO as of July 1, 2013.

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.

Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties formed an HC Oversight Entity called Capital Area Behavioral Health Collaborative (CABHC). The Tuscarora Managed Care Alliance and Behavioral Health Services of Somerset and Bedford Counties (BHSSBC) oversee the HC BH program for Franklin, Fulton, Bedford and Somerset Counties respectively. The latter two HC Oversight Entities hold contracts with PerformCare. **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
Capital Area Behavioral Health Collaborative (CABHC)	Cumberland County	Cumberland County
	Dauphin County	Dauphin County
	Lancaster County	Lancaster County
	Lebanon County	Lebanon County
	Perry County	Perry County
Behavioral Health Services of Somerset and Bedford Counties (BHSSBC)	Behavioral Health Services of Somerset and Bedford Counties (BHSSBC) Otherwise known as Bedford-Somerset for review.	Bedford County
		Somerset County
The Tuscarora Managed Care Alliance	The Tuscarora Managed Care Alliance Otherwise known as Franklin-Fulton for review.	Franklin County
		Fulton 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 PerformCare by OMHSAS monitoring staff within the past three review years (RYs 2015, 2014, 2013).

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 2013 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. Because Blair, Clinton, and Lycoming Counties contracted with two BH-MCOs in the review period, and because all applicable standards were reviewed for both BH-MCOs within the three-year time frame, these HealthChoices Oversight Entity review findings were not included in the assessment of compliance for either BH-MCO.

For PerformCare, 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 PerformCare 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 PerformCare

Table 2: Substandards Pertinent to BBA Regulations Reviewed for PerformCare

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	9	3	0	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	24	18	2	4	0
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	2	2	0	0
Provider Selection	3	3	0	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	8	0
Practice Guidelines	6	0	2	4	0
Quality Assessment and Performance Improvement Program	23	16	0	7	0
Health Information Systems	1	0	0	1	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	2	9	0	0
General Requirements	14	2	12	0	0
Notice of Action	13	13	0	0	0
Handling of Grievances and Appeals	11	2	9	0	0
Resolution and Notification: Grievances and Appeals	11	2	9	0	0
Expedited Appeals Process	6	2	4	0	0
Information to Providers and Subcontractors	2	0	2	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	2	4	0	0
Effectuation of Reversed Resolutions	6	2	4	0	0

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

For RY 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 PerformCare and the seven HC BH Contractors associated with the BH-MCO that were included in the structure and operations standards for RY 2015, 163 PEPS Items were identified as required to fulfill BBA regulations. The seven HC BH Contractors were evaluated on 163 PEPS Items during the review cycle. Because two HC BH Contractors, Blair and Lycoming-Clinton, contracted with two BH-MCOs in the review period, and because all applicable standards were

reviewed for both BH-MCOs within the three-year time frame, these HealthChoices Oversight Entity review findings are not included in the assessment of compliance for either BH-MCO.

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		All PerformCare HC BH Contractors	12 substandards were crosswalked to this category. All PerformCare HC BH Contractors were evaluated on 12 substandards. Franklin-Fulton was compliant with 10 substandards, and non-compliant with 2 substandards. Cumberland, Dauphin, Lancaster, Lebanon, Perry, and Bedford-Somerset were compliant with 9 substandards, partially compliant with 1 substandard, and non-compliant with 2 substandards.
Provider-Enrollee Communications 438.102	Compliant	All PerformCare 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 PerformCare HC BH Contractors		Compliant as per PS&R sections A.9 (p.70) and C.2 (p.32).
Cost Sharing 438.108	Compliant	All PerformCare 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 PerformCare HC BH Contractors		Compliant as per PS&R section 4 (p.37).
Solvency Standards 438.116	Compliant	All PerformCare 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

There are seven categories within Enrollee Rights and Protections Standards. PerformCare was compliant with five categories and partially compliant with one category. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were

compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50-447.60. The remaining category, Solvency Standards, was compliant based on the 2015-2016 Solvency Requirement tracking report.

Of the 12 PEPS Substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated for each HC BH contractor. Franklin-Fulton was compliant with 10 substandards and non-compliant with 2 substandards. Cumberland, Dauphin, Lancaster, Lebanon, Perry and Bedford-Somerset were compliant with 9 substandards, partially compliant with 1 substandard, and non-compliant with 2 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.

Enrollee Rights

Franklin-Fulton was partially compliant with Enrollee Rights due to partial compliance with 1 substandard within PEPS Standard 108 and non-compliance on substandards 2 and 3 within PEPS Standard 60.

PEPS Standard 60: Complaint/Grievance Staffing. The County Contractor/BH-MCO: a) shall identify a lead person responsible for overall coordination of the complaint and grievance process, including the provision of information and instructions to members; b) 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; and c) staff shall be educated concerning member rights and the procedure for filing complaints and grievances.

All HC BH Contractors were non-compliant with two substandards of Standard 60: Substandards 2 and 3 (RY 2014).

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

PEPS Standard 108: Consumer / Family Satisfaction. The County Contractor/BH-MCO: a) incorporates consumer satisfaction information in provider profiling and quality improvement process; b) collaborates with consumers and family members in the development of an annual satisfaction survey that meets the requirements of Appendix L; c) provides the department with quarterly and annual summaries of consumer satisfaction activities, consumer issues identified and resolution to problems, and d) provides an effective problem identification and resolution process.

Cumberland, Dauphin, Lancaster, Lebanon, Perry, and Bedford-Somerset were partially compliant with one substandard of Standard 108: Substandard 8 (RY 2015).

> **Substandard 8:** The annual mailed/telephonic survey results are representative of HealthChoices membership, and identify systemic trends. Actions have been taken to address areas found deficient, as applicable.

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	Compliant	All PerformCare HC BH		Compliant as per PS&R section G.3 (p.58).

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
438.204		Contractors		
Availability of Services (Access to Care) 438.206	Partial		All PerformCare HC BH Contractors	24 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 24 substandards, compliant with 23substandards, and partially compliant with 1 substandard.
Coordination and Continuity of Care 438.208	Partial		All PerformCare HC BH Contractors	2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 items, compliant with 1 substandard, and partially compliant with 1 substandard.
Coverage and Authorization of Services 438.210	Partial		All PerformCare HC BH Contractors	4 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 4 substandards, compliant with 2 substandards, and partially compliant with 2 substandards.
Provider Selection 438.214	Compliant	All PerformCare HC BH Contractors		3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards and compliant on 3 substandards.
Confidentiality 438.224	Compliant	All PerformCare 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	Partial		All PerformCare HC BH Contractors	8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards, compliant with 6 substandards, and partially compliant with 2 substandards.
Practice Guidelines 438.236	Partial		All PerformCare HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 5 substandards, and partially compliant with 1 substandard.
Quality Assessment and Performance Improvement Program 438.240	Partial		All PerformCare HC BH Contractors	23 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 23 substandards, compliant with 21 substandards, and partially compliant with 2 substandards.
Health Information Systems 438.242	Compliant	All PerformCare HC BH Contractors		1 Substandard was crosswalked to this category. Each HC BH Contractor was evaluated on 1 Substandard and was compliant on this Item.

There are 10 categories in the Quality Assessment and Performance Improvement Regulations Standards. PerformCare was compliant with four of the 10 categories and partially compliant wish six categories. Two of the five categories that PerformCare was compliant with – Elements of State Quality Strategies and Confidentiality – were not directly addressed by any PEPS substandards, but were determined to be compliant as per the HealthChoices PS&R.

For this review, 71 Items were crosswalked to Quality Assessment and Performance Improvement Regulations, and the seven HC BH Contractors associated with PerformCare were evaluated on all 71 Items. All of the PerformCare HC BH Contractors reviewed were compliant with 62 substandards and partially compliant with 9 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.

Availability of Services (Access to Care)

All HC BH Contractors associated with PerformCare were partially compliant with Availability of Services (Access to Care) due to partial compliance substandard 1 within PEPS Standard 28.

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

All of the PerformCare HC BH Contractors were partially compliant with one substandard of Standard 28: Substandards 1 (RY 2014).

> **Substandard 1:** Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.

Coordination and Continuity of Care

All HC BH Contractors associated with PerformCare were partially compliant with Coordination and Continuity of Care due to partial compliance with one substandard of PEPS Standard 28.

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 14 of this report.

Coverage and Authorization of Services

All HC BH Contractors associated with PerformCare were partially compliant with Coverage and Authorization of Services due to partial compliance with one substandard within PEPS Standard 28 and partial compliance with one substandard within PEPS Standard 72.

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 14 of this report.

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

All HC BH Contractors were partially compliant with one substandard of Standard 72: Substandard 2 (RY 2015).

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

Subcontractual Relationships and Delegations

All HC BH Contractors were partially compliant with Subcontractual Relationships and Delegation due to partial compliance with two substandards of PEPS Standard 99.

PEPS Standard 99: Provider Performance. The BH-MCO Evaluates the Quality and Performance of the Provider Network. Monitor and evaluate the quality and performance of provider network to include, but not limited to Quality of individualized service plans and treatment planning, adverse incidents, Collaboration and cooperation with member

complaint, grievance and appeal procedures as well as other medical and human service programs and Administrative compliance. Procedures and outcome measures are developed to profile provider performance.

All PerformCare HC BH Contractors were partially compliant with two substandards of Standard 99: Substandard 6 and Substandard 8 (RY 2013).

> **Substandard 6:** Provider profiles and individual monitoring results are reviewed with providers.
> **Substandard 8:** The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.

Practice Guidelines

All HC BH Contractors were partially compliant with Practice Guidelines due to partial compliance with one substandard of PEPS Standard 28.

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care) on page 14 of this report.

Subpart F: Federal and State Grievance System Standards

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances. The PEPS documents include an assessment of the HC BH Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 5** presents the findings by categories consistent with the regulations.

Table 5: Compliance with Federal and State Grievance System Standards

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All PerformCare HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 4 substandards, partially compliant with 4 substandards, and non-compliant with 3 substandards.
General Requirements 438.402	Partial		All PerformCare HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards, compliant with 5 substandards, partially compliant with 4 substandards, and non-compliant with 5 substandards.
Notice of Action 438.404	Partial		All PerformCare HC BH Contractors	13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards, compliant with 12 substandards, and partially compliant with 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All PerformCare HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 4 substandards, partially compliant with 4 substandards, and non-compliant with 3 substandards.

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Resolution and Notification: Grievances and Appeals 438.408	Partial		All PerformCare HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 4 substandards, partially compliant with 4 substandards, and non-compliant with 3 substandards.
Expedited Appeals Process 438.410	Partial		All PerformCare HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 3 substandards, and partially compliant with 3 substandards.
Information to Providers & Subcontractors 438.414	Compliant	All PerformCare HC BH Contractors		2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards and compliant with both.
Recordkeeping and Recording Requirements 438.416	Compliant	All PerformCare HC BH Contractors		Compliant as per the required quarterly reporting of complaint and grievances data.
Continuation of Benefits 438.420	Partial		All PerformCare HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 3 substandards and partially compliant with 3 substandards.
Effectuation of Reversed Resolutions 438.424	Partial		All PerformCare HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 3 substandards and partially compliant with 3 substandards.

There are 10 categories in the Federal and State Grievance System Standards. PerformCare was compliant with two categories and partially compliant with eight categories. The category Recordkeeping and Recording Requirements was compliant as per the quarterly reporting of Complaint and Grievances data.

For this review, 80 substandards were crosswalked to Federal and State Grievance System Standards for all HC BH Contractors associated with PerformCare. Each HC BH Contractor was compliant with 40 substandards, partially compliant with 26 substandards, and non-compliant with 14 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.

All PerformCare HC BH Contractors were deemed partially compliant with 8 of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance or non-compliance with substandards within PEPS Standards 60, 68, 71, and 72.

Statutory Basis and Definitions

The seven HC BH Contractors associated with PerformCare were partially compliant with Statutory Basis and Definitions due to non-compliance with 3 substandards within PEPS Standard 68 and partial compliance with 1 substandard within PEPS Standard 68, 2 substandards within PEPS Standards 71, and 1 substandard within PEPS Standard 72.

PEPS Standard 68: Complaints. 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.

All PerformCare HC BH Contractors were non-compliant with three substandards of Standard 68: Substandard 2, Substandard 3, and Substandard 4 (RY 2014).

Substandard 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.
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.

All PerformCare HC BH Contractors were partially compliant with one substandard of Standard 68: Substandard 5 (RY 2014).

Substandard 5: Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.

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

All PerformCare HC BH Contractors were partially compliant with two substandards of Standard 71: Substandard 3 and Substandard 4 (RY 2014).

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

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services on page 14 of this report.

General Requirements

All HC BH Contractors associated with PerformCare were partially compliant with General Requirements due to partial or non-compliance with substandards within PEPS standards 60, 68, 71 and 72.

PEPS Standard 60: See Standard description and determination of compliance under Enrollee Rights on page 12 of this report.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and determinatino of compliance under Coverage and Authorization of Services on page 14 of this report.

Notice of Action

All HC BH Contractors associated with PerformCare were partially compliant with Notice of Action due to partial compliance with one substandard within PEPS Standard 72.

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 14 of this report.

Handling of Grievances and Appeals

All HC BH Contractors associated with PerformCare were partially compliant with Handling of Grievances and Appeals due to partial or non-compliance with substandards within PEPS standards 68, 71 and 72.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services on page 14 of this report.

Resolution and Notification: Grievances and Appeals

All HC BH Contractors associated with PerformCare were partially compliant with Resolution and Notification: Grievances and Appeals due to partial or non-compliance with substandards within PEPS standards 68, 71 and 72.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services on page 14 of this report.

Expedited Appeals Process

All HC BH Contractors associated with PerformCare were partially compliant with Expedited Appeals Process due to partial compliance with substandards within Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services on page 14 of this report.

Continuation of Benefits

All HC BH Contractors associated with PerformCare were partially compliant with Continuation of Benefits due to partial compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services on page 14 of this report.

Effectuation of Reversed Resolutions

All HC BH Contractors associated with PerformCare were partially compliant with Effectuation of Reversed Resolutions due to partial compliance with substandards of Standards 71 and 72.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions on page 17 of this report.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services on page 14 of this report.

II: Performance Improvement Projects

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

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

This PIP project will extend from January 2014 through December 2017, with initial PIP proposals submitted in 2014 and a final report due in June 2018. 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 report in June 2019. BH-MCOs are required to develop performance indicators and implement interventions based on

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

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 to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance as necessary. Plans 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. 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

PerformCare 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 PerformCare on this submission. **Table 8** presents the PIP scoring matrix for the June 2016 Submission.

PerformCare listed the study objectives, along with associated barriers and a brief analysis plan. PerformCare identified the three core performance measures (BHR, SAA, and DMP) and an optional measure (7 and 30 day follow-up visits for members discharged with a diagnosis of serious mental illness or substance abuse, abbreviated as "SAS") as outcome measures for this project. PerformCare provided a discussion of previous years' readmission rates along with a table of volume and readmission rates for three diagnoses (mood disorders, Schizophrenia, and SA). PerformCare provided additional analysis of medication adherence rates and provided readmission rates for those that adhered to medication vs. those that did not. PerformCare provided a rationale for increasing medication adherence based on this analysis.

IPRO identified several opportunties for improvement in their review of this PIP. In general, the barrier analysis was not supported member-specific data and literature review, and barrire analysis was not clearly tied to interventions. For instance, one of the main barriers identified in the barrier analysis was access to transportation. PerformCare identified an intervention to include transportation in the Recovery Management Plan, however it was unclear how this was expected to increase access to transportation for members. Another intervention surrounding access to care/medication was described as encouraging utilization of delivery pharmacy, hoewver it was not clear how the intervention was initiated. It is recommended that PerformCare elaborate on how barriers/interventions are related to the study objectives, and that the plan should support this discussion with data.

PerformCare listed barriers and interventions with a potential to impact the objectives of the project if fully implemented. However, these interventions were not thoroughly described. PerformCare's PIP did not include a satisfactory data analysis plan. Key elements, such as data sources and target populations, were not described. Although process measures were presented, they were not clearly defined and it was not clear which interventions were being assessed by each process measure.

Several opportunities for improvement are related to the interpretation of study results. PerformCare provided partial baseline and intervention year results, but they did not provide plan-wide results for all core mesaures. The plan did not provide a year-to-year comparison between baseline and the first intervention year, nor did they do additional drill-down analysis. Discussion of the impact of key interventions was limited.

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)	PM	50	5%	2.5
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	NM	0	20%	0
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**37.5**
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 2016. 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 2013 rates were received. The interim goals will be updated from MY 2013 to MY 2015. The interim goals are used the BH-MCOs progress in achieving the OMHSAS goal of the 75th percentile.

HEDIS percentiles for the 7-day and 30-day FUH indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis for these indicators. As noted in Section V of this report, beginning with MY 2012 performance, and continuing through MY 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+ year 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 2015 HEDIS Follow-up Indicator Rates: 6–64 Years Old

	MY 2015							MY 2014	Rate Comparison			
Measure	(N)	(D)	%	Lower 95% CI	Upper 95% CI	MY 2015 Goal	2015 Goal Met?	%	PPD: MY 14 to MY 15	% Change: MY 14 to MY 15[1]	SSD: MY 14 to MY 15	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
PerformCare	1,529	3,580	**42.7%**	41.1%	44.3%	46.2%	NO	45.3%	-2.6	-5.80%	YES	Below 50th Percentile, Above 25th Percentile
Bedford-Somerset	134	307	**43.6%**	37.9%	49.4%	45.5%	NO	43.3%	0.3	0.70%	NO	Below 50th Percentile, Above 25th Percentile
Cumberland	155	361	**42.9%**	37.7%	48.2%	46.2%	NO	45.1%	-2.2	-4.83%	NO	Below 50th Percentile, Above 25th Percentile
Dauphin	364	946	**38.5%**	35.3%	41.6%	41.9%	NO	39.9%	-1.4	-3.57%	NO	Below 50th Percentile, Above 25th Percentile
Franklin-Fulton	159	317	**50.2%**	44.5%	55.8%	52.4%	NO	51.4%	-1.2	-2.34%	NO	Above 50th Percentile, Below 75th Percentile
Lancaster	520	1,202	**43.3%**	40.4%	46.1%	47.1%	NO	46.2%	-2.9	-6.35%	NO	Below 50th Percentile, Above 25th Percentile
Lebanon	182	372	**48.9%**	43.7%	54.1%	56.0%	NO	54.9%	-6.0	-10.89%	NO	Above 50th Percentile, Below 75th Percentile
Perry	15	75	**20.0%**	10.3%	29.7%	33.7%	NO	32.1%	-12.1	-37.69%	NO	Below 25th 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
PerformCare	2,386	3,580	**66.6%**	65.1%	68.2%	71.0%	NO	69.6%	-2.9	-4.19%	YES	Above 50th Percentile, Below 75th Percentile
Bedford-Somerset	203	307	**66.1%**	60.7%	71.6%	69.0%	NO	67.7%	-1.6	-2.30%	NO	Above 50th Percentile, Below 75th Percentile
Cumberland	243	361	**67.3%**	62.3%	72.3%	70.9%	NO	69.5%	-2.2	-3.20%	NO	Above 50th Percentile, Below 75th Percentile
Dauphin	606	946	**64.1%**	60.9%	67.2%	65.5%	NO	62.4%	1.7	2.64%	NO	Above 50th Percentile, Below 75th Percentile
Franklin-Fulton	238	317	**75.1%**	70.2%	80.0%	75.3%	NO	82.7%	-7.6	-9.16%	YES	At or Above 75th Percentile
Lancaster	793	1,202	**66.0%**	63.3%	68.7%	70.9%	NO	69.5%	-3.5	-5.04%	NO	Above 50th Percentile, Below 75th Percentile
Lebanon	266	372	**71.5%**	66.8%	76.2%	75.3%	NO	78.4%	-6.9	-8.83%	YES	Above 50th Percentile, Below 75th Percentile
Perry	37	75	**49.3%**	37.4%	61.3%	66.1%	NO	63.0%	-13.6	-21.65%	NO	Below 25th 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 statistically significantly lower than 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 PerformCare follow-up rates for members ages 6 to 64 were 42.7% for QI 1 and 66.6% for QI 2 (**Table 9**). These rates were statistically significantly lower than PerformCare's rates for this age group in MY 2014, which were 45.3% for QI 1 and 69.6% for QI 2. PerformCare's QI 1 rate for the 6 to 64 year old population was statistically significantly lower than the QI 1 HealthChoices BH-MCO Average of 45.1% by 2.4 percentage points, while its QI 2 rate for this age group was not statistically significantly different from the QI 2 HealthChoices BH-MCO Average of 65.8%. PerformCare's rates were below its target MY 2015 goals of 46.2% for QI 1 and 71.0% for QI 2, therefore both interim follow-up goals were not met in MY 2015. The QI 1 rate was between the HEDIS 25th and 50th percentiles, while the QI 2 rate was between the HEDIS 50th and 75th percentiles, therefore the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by PerformCare in 2015.

From MY 2014 to MY 2015, QI 2 rates for members 6 to 64 years old statistically significantly decreased in Lebanon and Franklin-Fulton by 6.9 and 7.6 percentage points, respectively (**Table 9**). None of PerformCare's HC BH Contractors met their MY 2015 interim goals for QI 1 or QI 2. One HC BH Contractor, Franklin-Fulton achieved the final OMHSAS goal of meeting or exceeding the NCQA 75th percentile for QI 2.

Figure 1 is a graphical representation of MY 2015 HEDIS follow-up rates in the 6 to 64 year old population for PerformCare 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 Dauphin and Perry were statistically significantly below the MY 2015 QI 1 HC BH Contractor Average of 45.4% by 6.9 and 25.4 percentage points, respectively. The QI 2 rate for Franklin-Fulton was statistically significantly higher than the QI 2 HC BH Contractor Average of 67.4% by 7.7 percentage points, while rates for Dauphin and Perry were statistically significantly below the Average by 3.3 and 18.1 percentage points, respectively.

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

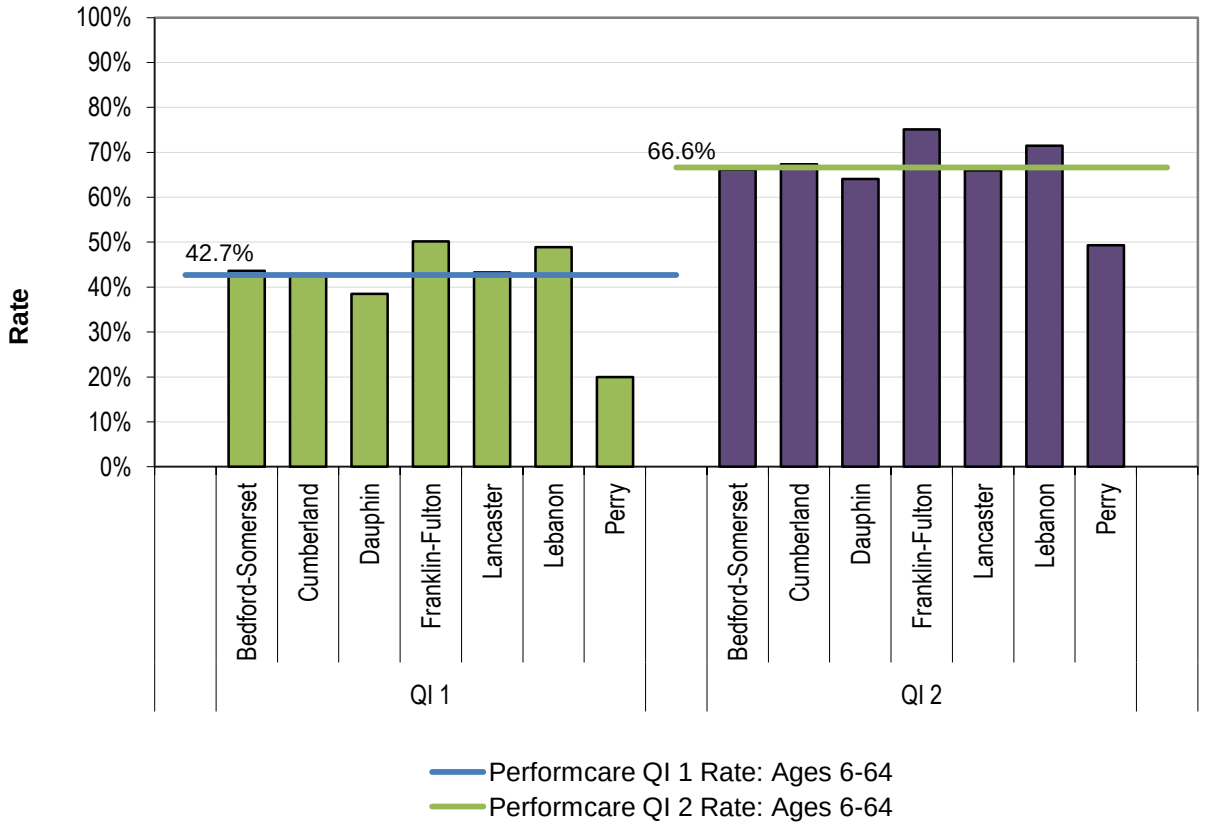
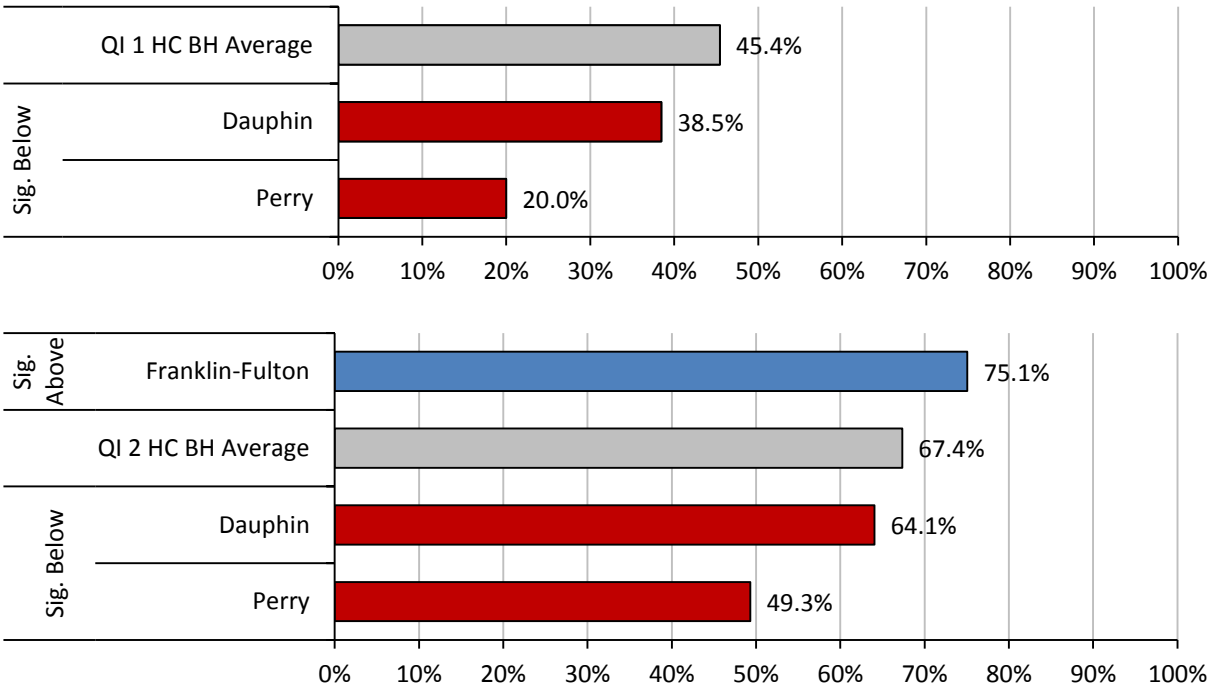


Figure 2: HEDIS Follow-up Rates Compared to MY 2015 HealthChoices HC BH Contractor Average: 6-64 Years Old



(b) Overall Population: 6+ Years Old

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

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2014 %	Rate Comparison of MY 2015 against: MY 2014 PPD	MY 2014 SSD	HEDIS MY 2016 Percentile
QI 1 – HEDIS 7-Day Follow-up for Ages 6+ Years Old											
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
PerformCare	1543	3642	**42.4%**	40.7%	44.0%			44.9%	-2.6	YES	Below 50th Percentile, Above 25th Percentile
Bedford-Somerset	136	311	**43.7%**	38.1%	49.4%			43.1%	0.6	NO	Below 50th Percentile, Above 25th Percentile
Cumberland	155	367	**42.2%**	37.0%	47.4%			44.2%	-2.0	NO	Below 50th Percentile, Above 25th Percentile
Dauphin	367	962	**38.1%**	35.0%	41.3%			39.6%	-1.4	NO	Below 50th Percentile, Above 25th Percentile
Franklin-Fulton	161	322	**50.0%**	44.4%	55.6%			50.5%	-0.5	NO	Above 50th Percentile, Below 75th Percentile
Lancaster	525	1,223	**42.9%**	40.1%	45.7%			45.9%	-3.0	NO	Below 50th Percentile, Above 25th Percentile
Lebanon	184	380	**48.4%**	43.3%	53.6%			54.6%	-6.1	NO	Above 50th Percentile, Below 75th Percentile
Perry	15	77	**19.5%**	10.0%	29.0%			32.1%	-12.6	NO	Below 25th Percentile
QI 2– HEDIS 30-Day Follow-up for Ages 6+ Years Old											
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
PerformCare	2410	3642	**66.2%**	64.6%	67.7%			69.0%	-2.9	YES	Above 50th Percentile, Below 75th Percentile
Bedford-Somerset	205	311	**65.9%**	60.5%	71.3%			67.7%	-1.7	NO	Above 50th Percentile, Below 75th Percentile
Cumberland	245	367	**66.8%**	61.8%	71.7%			68.5%	-1.7	NO	Above 50th Percentile, Below 75th Percentile
Dauphin	613	962	**63.7%**	60.6%	66.8%			62.0%	1.7	NO	Below 50th Percentile, Above 25th Percentile
Franklin-Fulton	240	322	**74.5%**	69.6%	79.4%			81.4%	-6.9	YES	At or Above 75th Percentile
Lancaster	802	1,223	**65.6%**	62.9%	68.3%			69.0%	-3.5	NO	Above 50th Percentile, Below 75th Percentile
Lebanon	268	380	**70.5%**	65.8%	75.2%			77.8%	-7.3	YES	Above 50th Percentile, Below 75th Percentile
Perry	37	77	**48.1%**	36.2%	59.9%			63.0%	-14.9	NO	Below 25th 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 statistically significantly lower than the HealthChoices Aggregate rates in MY 2014, which were 47.2% and 67.4% respectively. For PerformCare, the MY 2015 QI 1 rate was 42.4%, which was statistically significantly lower than the MY 2014 QI 1 rate of 44.9%. The QI 2 rate was 66.2%, which was statistically significantly lower than the MY 2014 QI 2 rate of 69.0%. The PerformCare QI 1 rate was statistically lower than the QI 1 HealthChoices BH-MCO Average of 44.9% by 2.5 percentage points, while the QI 2 rate was not statistically significantly different from the QI 2 HealthChoices BH-MCO Average of 65.4%.

From MY 2014 to MY 2015, the QI 2 rates for Franklin-Fulton and Lebanon statistically significantly decreased by 6.9 and 7.3 percentage points, respectively (**Table 10**). None of the other HC BH Contractors associated with PerformCare had statistically significant changes in HEDIS follow-up rates from MY 2014 to MY 2015.

Figure 3 is a graphical representation of the MY 2015 HEDIS follow-up rates for PerformCare and its associated HC BH Contractors. **Figure 4** shows the HC BH Contractor Averages and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rates for Dauphin and Perry were statistically significantly below the MY 2015 QI 1 HC BH Contractor Average of 45.2% by 7.1 and 25.7 percentage points, respectively. The QI 2 rate for Franklin-Fulton was statistically significantly higher than the QI 2 HC BH Contractor Average of 67.0% by 7.6 percentage points, while the QI 2 rates for Dauphin and Perry were below the Average by 3.2 and 18.9 percentage points, respectively.

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

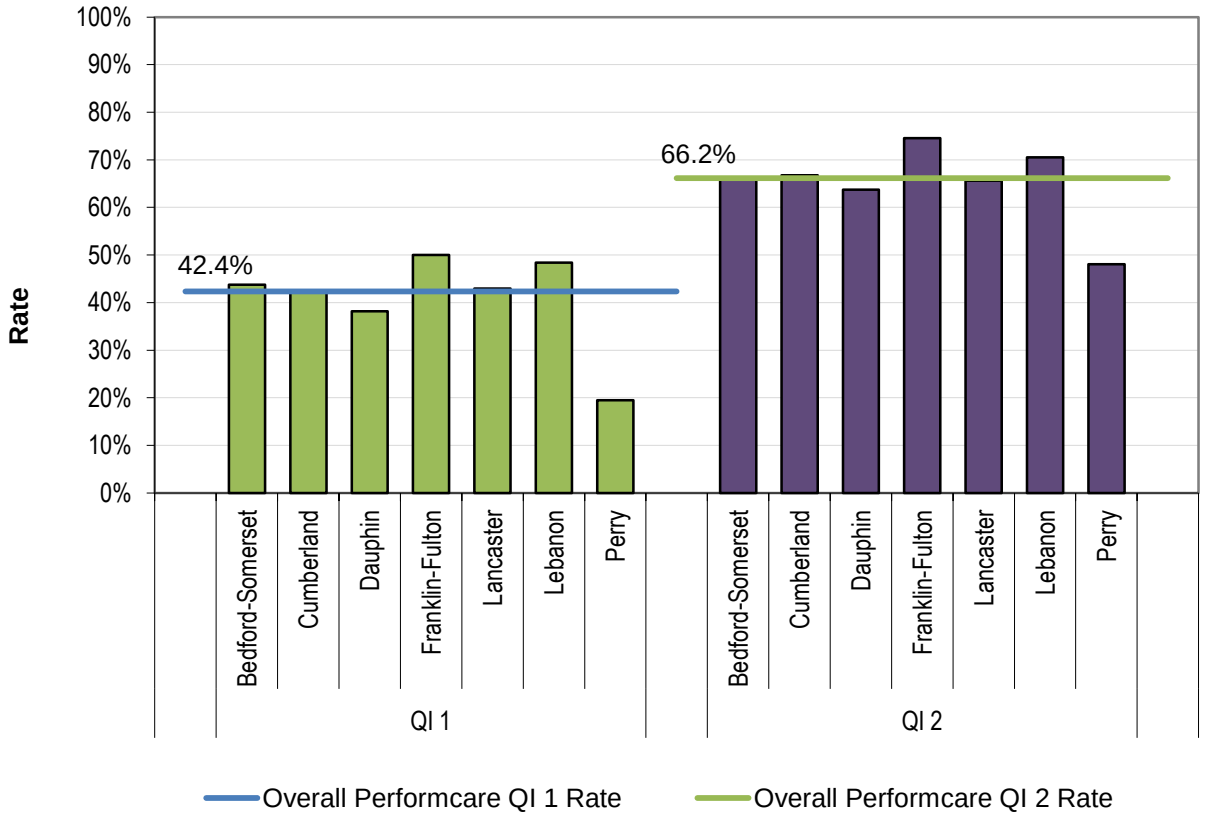
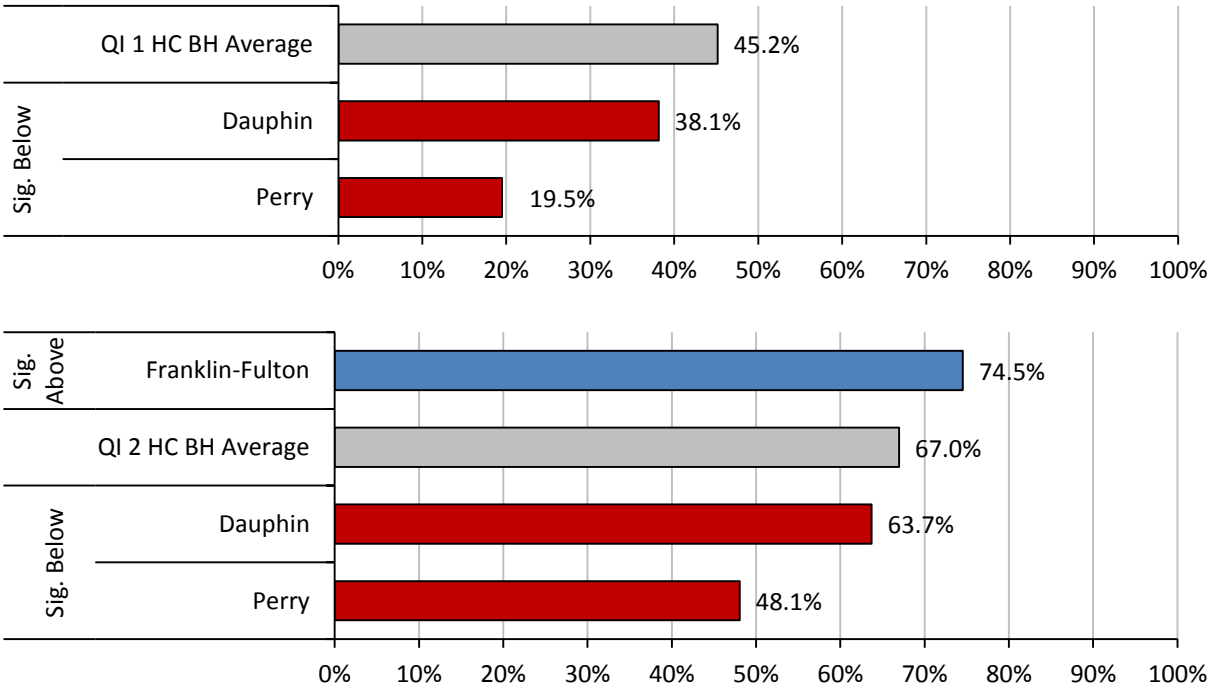


Figure 4: HEDIS Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average – Overall Population



(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 vs. 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
PerformCare	645	1,170	**55.1%**	52.2%	58.0%			56.3%	-1.2	NO
Bedford-Somerset	62	106	**58.5%**	48.6%	68.3%			50.0%	8.5	NO
Cumberland	69	140	**49.3%**	40.6%	57.9%			54.2%	-4.9	NO
Dauphin	135	263	**51.3%**	45.1%	57.6%			53.8%	-2.5	NO
Franklin-Fulton	67	112	**59.8%**	50.3%	69.3%			54.5%	5.3	NO
Lancaster	215	377	**57.0%**	51.9%	62.2%			58.2%	-1.2	NO
Lebanon	89	143	**62.2%**	53.9%	70.5%			64.9%	-2.7	NO
Perry	8	29	**27.6%**	9.6%	45.6%			36.0%	-8.4	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
PerformCare	910	1,170	**77.8%**	75.4%	80.2%			78.0%	-0.2	NO
Bedford-Somerset	79	106	**74.5%**	65.8%	83.3%			83.3%	-8.8	NO
Cumberland	105	140	**75.0%**	67.5%	82.5%			75.8%	-0.8	NO
Dauphin	204	263	**77.6%**	72.3%	82.8%			76.1%	1.5	NO
Franklin-Fulton	92	112	**82.1%**	74.6%	89.7%			82.7%	-0.6	NO
Lancaster	291	377	**77.2%**	72.8%	81.6%			75.6%	1.6	NO
Lebanon	120	143	**83.9%**	77.5%	90.3%			84.1%	-0.2	NO
Perry	19	29	**65.5%**	46.5%	84.5%			68.0%	-2.5	NO

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

The MY 2015 HealthChoices Aggregate 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. PerformCare's MY 2015 HEDIS follow-up rates for members ages 6 to 20 were 55.1% for QI 1 and 77.8% for QI 2; both rates were lower than PerformCare's MY 2014 rates of 56.3% for QI 1 and 78.0% for QI 2; however, the year-to-year rate differences were not statistically significant for either rate. The HEDIS follow-up rates for PerformCare's 6 to 20 year old population were not statistically different from the HealthChoices BH-MCO Averages of 56.1% for QI 1 and 76.4% for QI 2. There weren't any statistically significant year-to-year changes in QI 1 or QI 2 for any of the HC BH Contractors associated with PerformCare.

Figure 5 is a graphical representation of the MY 2015 HEDIS follow-up rates in the 6 to 20 year old population for PerformCare and its associated HC BH Contractors. **Figure 6** shows the HC BH Contractor Averages for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. The QI 1 rate for Perry was statistically significantly lower than the MY 2015 QI 1 HC BH Contractor Average of 55.7% by 28.1 percentage points. The QI 2 rate for Lebanon was statistically significantly higher than the QI 2 HC BH Contractor Average of 76.8% by 7.1 percentage points.

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

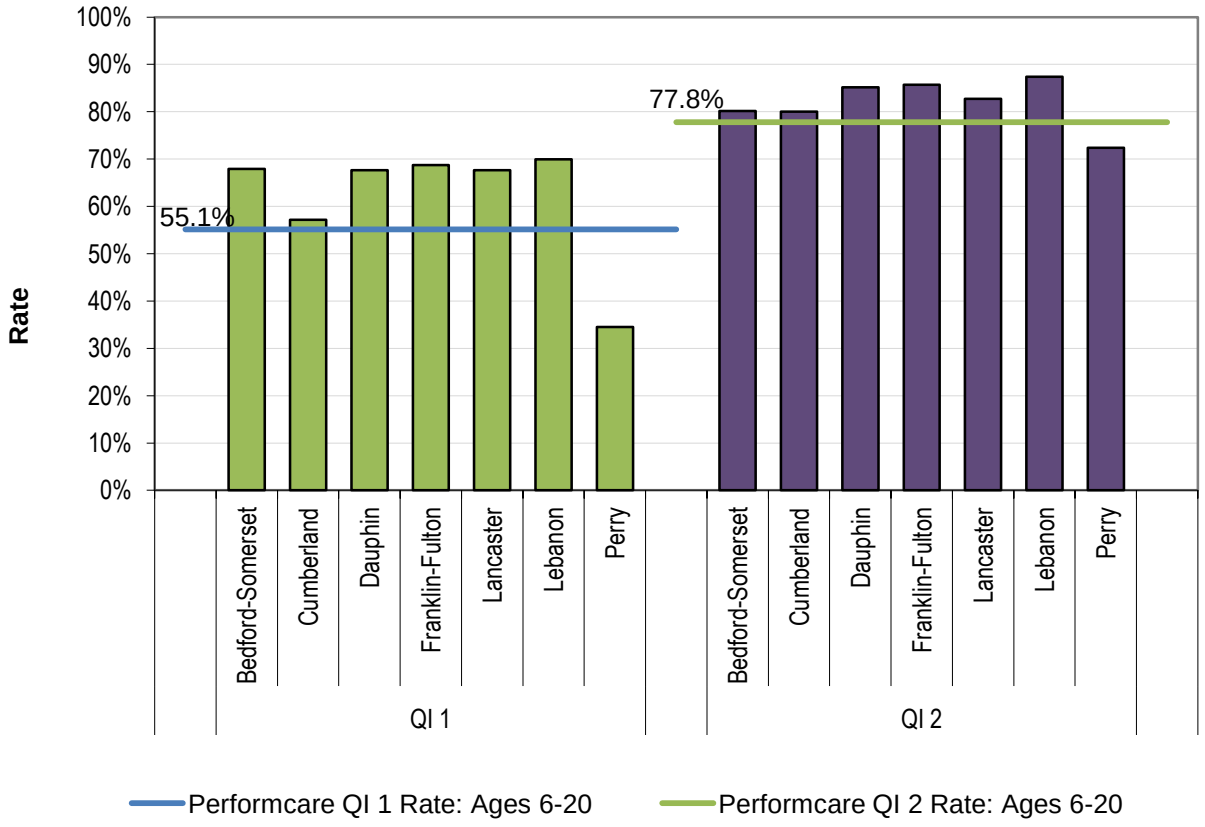
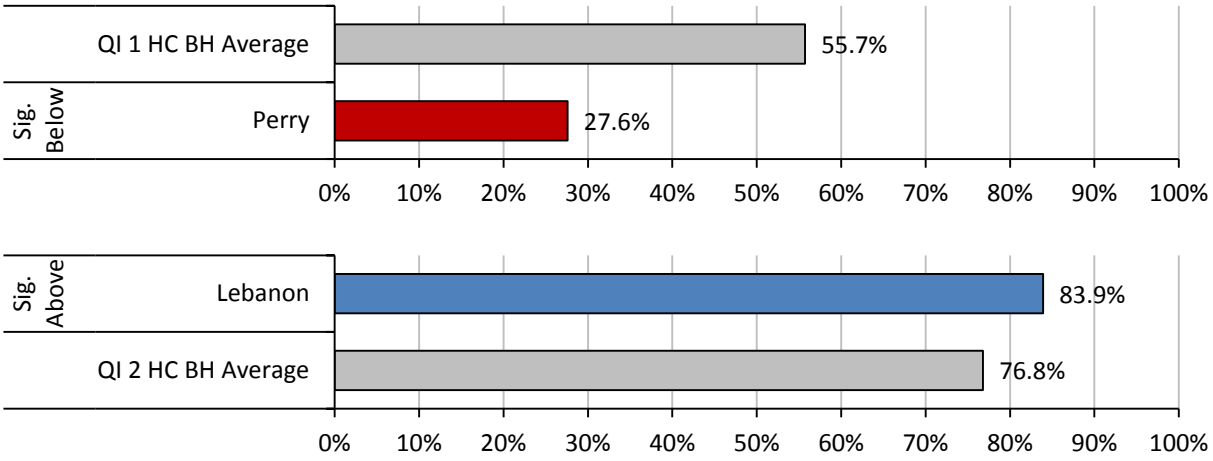


Figure 6: HEDIS Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average: 6-20 Years Old



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 %	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	MY 2014 %	Rate Comparison of MY 15 vs. MY 14 PPD	Rate Comparison of MY 15 vs. MY 14 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
PerformCare	2,072	3,642	**56.9%**	55.3%	58.5%			56.9%	0.0	NO
Bedford-Somerset	170	311	**54.7%**	49.0%	60.4%			56.5%	-1.8	NO
Cumberland	193	367	**52.6%**	47.3%	57.8%			51.5%	1.1	NO
Dauphin	580	962	**60.3%**	57.1%	63.4%			61.2%	-0.9	NO
Franklin-Fulton	205	322	**63.7%**	58.3%	69.1%			62.1%	1.6	NO
Lancaster	684	1,223	**55.9%**	53.1%	58.8%			54.1%	1.8	NO
Lebanon	215	380	**56.6%**	51.5%	61.7%			60.9%	-4.3	NO
Perry	25	77	**32.5%**	21.4%	43.6%			42.0%	-9.5	NO
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
PerformCare	2,754	3,642	**75.6%**	74.2%	77.0%			76.4%	-0.8	NO
Bedford-Somerset	233	311	**74.9%**	69.9%	79.9%			74.0%	0.9	NO
Cumberland	273	367	**74.4%**	69.8%	79.0%			73.2%	1.2	NO
Dauphin	743	962	**77.2%**	74.5%	79.9%			76.5%	0.7	NO
Franklin-Fulton	260	322	**80.7%**	76.3%	85.2%			85.0%	-4.3	NO
Lancaster	912	1,223	**74.6%**	72.1%	77.1%			74.0%	0.6	NO
Lebanon	288	380	**75.8%**	71.4%	80.2%			81.4%	-5.6	NO
Perry	45	77	**58.4%**	46.8%	70.1%			76.5%	-18.1	YES

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

The MY 2015 HealthChoices Aggregate rates were 56.6% for QI A and 73.0% for QI B (**Table 12**). Both rates demonstrated statistically significant decreases from the MY 2014 PA-specific follow-up rates: the QI A rate decreased

from the MY 2014 rate of 58.5% by 1.9 percentage points, while the QI B rate decreased from the MY 2014 rate of 74.8% percentage points by 1.8 percentage points. PerformCare's MY 2015 PA-specific follow-up rates were 56.9% for QI A and 75.6% for QI B; both rates were comparable to MY 2014 rates of 56.9% for QI A and 76.4% for QI B. The QI A rate for PerformCare was not statistically significantly different from the QI A HealthChoices BH-MCO Average of 55.8%, while the QI B rate for PerformCare was statistically significantly higher than the QI B HealthChoices BH-MCO Average of 72.7% by 2.9 percentage points. PerformCare had the highest QI B rate of the five BH-MCOs evaluated in MY 2015.

From MY 2014 to MY 2015, the QI 2 rate for Perry statistically significantly decreased 18.1 percentage points (**Table 12**). None of the other HC BH Contractors associated with PerformCare had statistically significant changes in PA-specific follow-up rates from MY 2014 to MY 2015.

Figure 7 is a graphical representation of the MY 2015 PA-specific follow-up rates for PerformCare and its associated HC BH Contractors. **Figure 8** shows the HC BH Contractor Averages and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Average. QI A rates for Dauphin and Franklin-Fulton were statistically significantly above the MY 2015 QI A HC BH Contractor Average of 55.7% by 4.6 and 8.0 percentage points, respectively, while the QI A rate for Perry was statistically significantly lower than the Average by 23.2 percentage points. The QI B rates for Dauphin and Franklin-Fulton were statistically significantly above the QI B HC BH Contractor Average of 73.5% by 3.7 and 7.2 percentage points respectively. The QI B rate for Perry was statistically significantly lower than the Average by 15.1 percentage points.

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

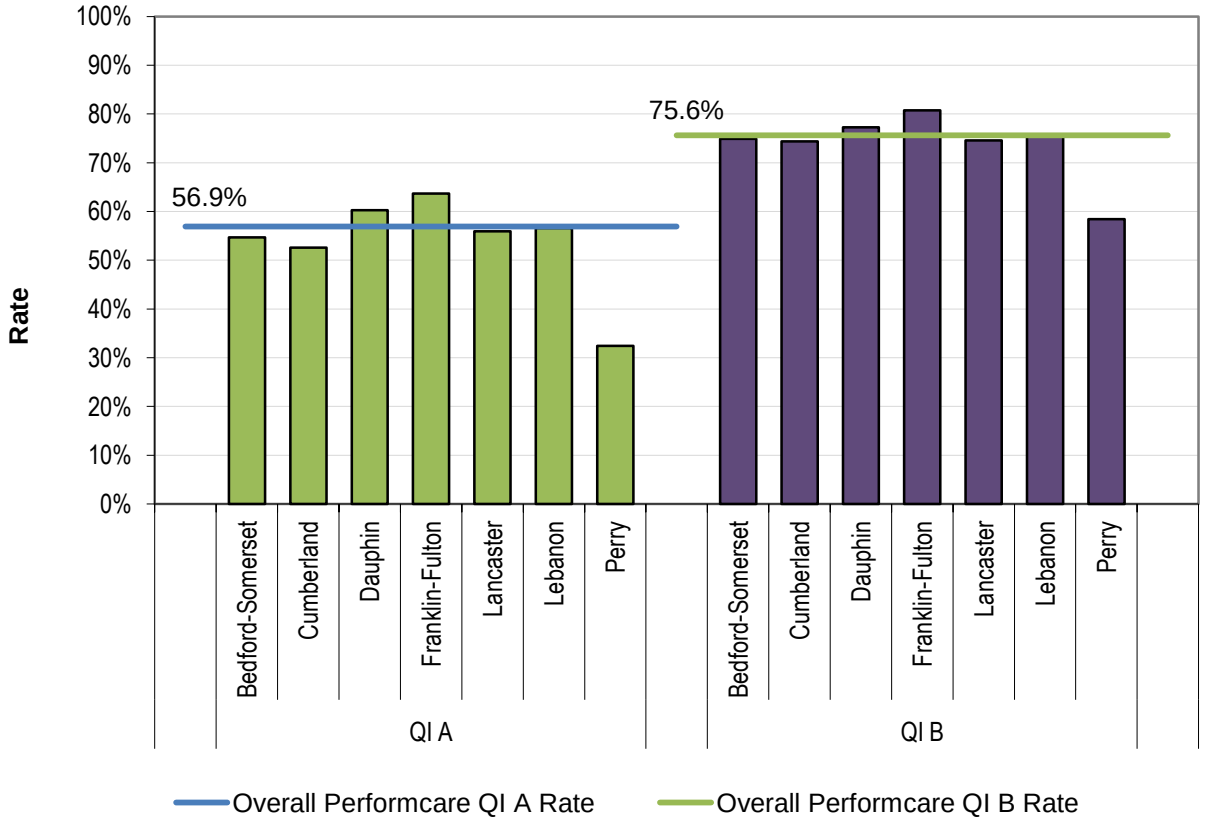
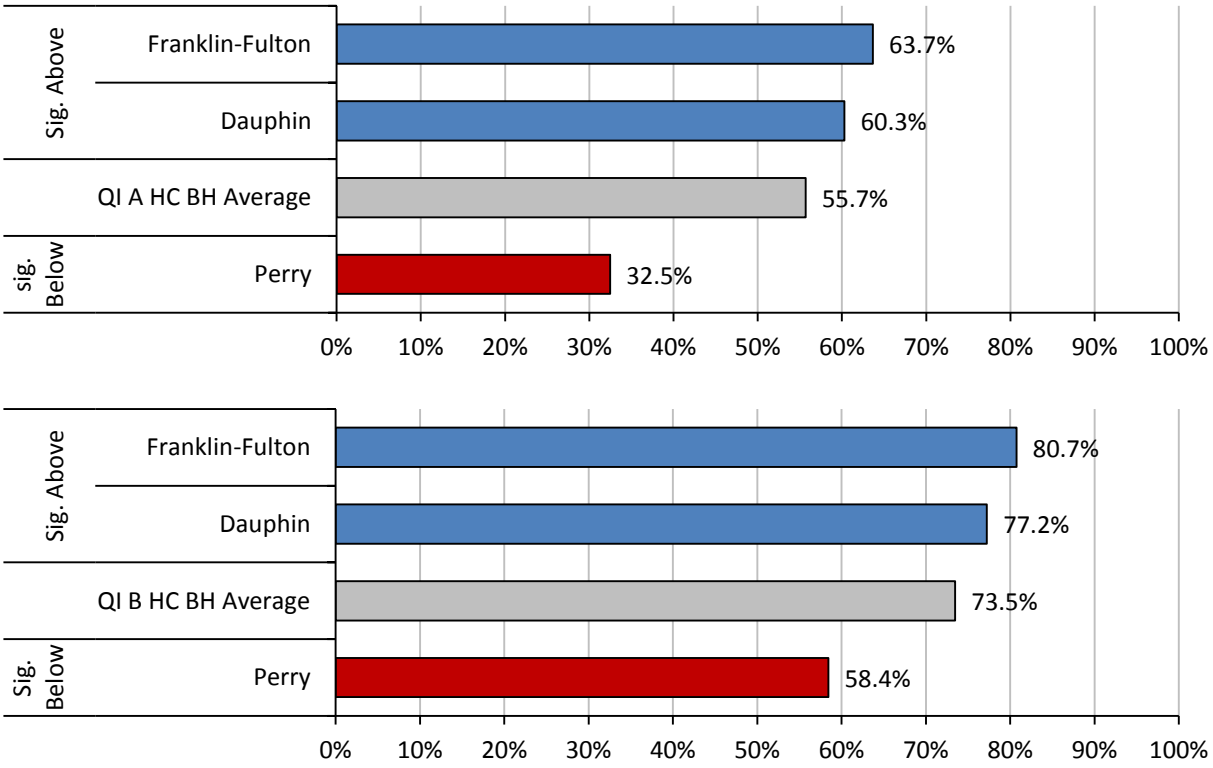


Figure 8: PA-Specific Follow-up Indicator Rates Compared to MY 2015 HealthChoices HC BH Contractor Average – Overall Population



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 2015 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 2013 on MY 2009, 2010, and 2011 data, respectively. The MY 2015 study conducted in 2016 was the ninth re-measurement of this indicator. Four clarifications were made to the specifications for MY 2014. 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 2014.

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

	MY 2015							MY 2014		
									Rate Comparison of MY 15 vs. MY 14	
Measure	(N)	(D)	%[1]	Lower 95% CI	Upper 95% CI	BH-MCO Average	HC BH Contractor Average	%	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
PerformCare	751	4,826	**15.6%**	14.5%	16.6%			15.9%	-0.3	NO
Bedford-Somerset	29	371	**7.8%**	5.0%	10.7%			11.9%	-4.1	NO
Cumberland	64	477	**13.4%**	10.3%	16.6%			16.0%	-2.6	NO
Dauphin	245	1,327	**18.5%**	16.3%	20.6%			19.4%	-0.9	NO
Franklin-Fulton	30	373	**8.0%**	5.1%	10.9%			10.7%	-2.7	NO
Lancaster	275	1,647	**16.7%**	14.9%	18.5%			14.9%	1.8	NO
Lebanon	93	531	**17.5%**	14.2%	20.8%			17.0%	0.5	NO
Perry	15	100	**15.0%**	7.5%	22.5%			15.3%	-0.3	NO

[1]The OMHSAS-designated performance measure goal is a readmission rate at or below 10%.
N: numerator; D: denominator; CI: confidence interval

The MY 2015 HealthChoices Aggregate readmission rate was 14.0%, and represents a decrease from the MY 2014 HealthChoices Aggregate rate of 14.3% by 0.3 percentage points (**Table 13**); this difference was not statistically significant. The PerformCare MY 2015 readmission rate of 15.6% was not statistically significantly different from the PerformCare MY 2014 rate of 15.9% by 0.3 percentage points. Note that this measure is an inverted rate, in that the lower rates indicate better performance. The PerformCare MY 2015 readmission rate of 15.6% was statistically significantly higher than the HealthChoices BH-MCO Average of 14.0% by 1.6 percentage points. Overall, PerformCare had the highest readmission rate of the five BH-MCOs evaluated in MY 2015. PerformCare did not meet the OMHSAS performance goal of a readmission rate at or below 10.0% in MY 2015. There were no statistically significant year-to-year differences for any of the HC BH Contractors associated with PerformCare. Two HC BH Contractors, Bedford-Somerset and Franklin-Fulton, met the performance goal of a readmission rate below 10.0% in MY 2015.

Figure 9 is a graphical representation of the MY 2015 readmission rates for PerformCare HC BH Contractors compared to the performance measure goal of 10.0%. **Figure 10** shows the Health Choices HC BH Contractor Average readmission

rates and the individual PerformCare HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Averages. Franklin-Fulton and Bedford-Somerset had readmission rates that were statistically significantly lower (better) than the HC BH Contractor Average of 13.4% by 5.4 and 5.6 percentage points, respectively. Lancaster, Lebanon and Dauphin had rates that were statistically significantly higher than the Average, with differences that ranged from 3.3 percentage points for Lancaster and 5.1 percentage points for Dauphin.

Figure 9: MY 2015 Readmission Rates

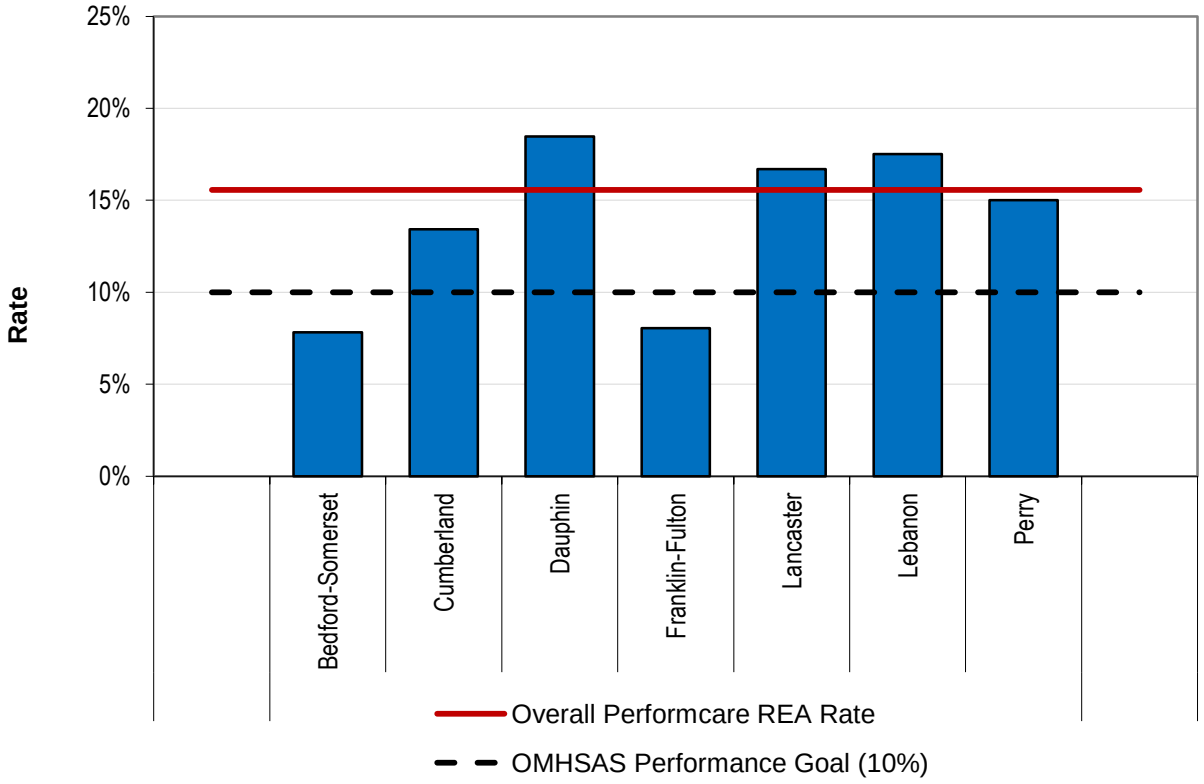
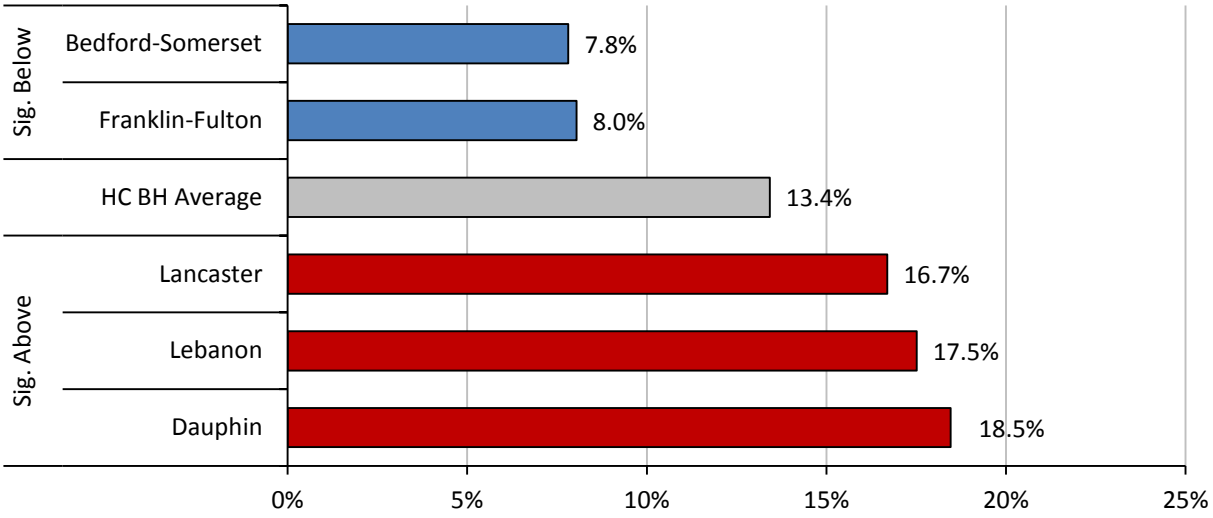


Figure 10: MY 2015 Readmission Rates Compared to HealthChoices HC BH Contractor Average



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 2013. Due to several implementation issues identified with BH-MCO access to all applicable data and at DHS' request, this measure was produced by IPRO. IPRO began development of this measure in 2014 for MY 2013, and continued to produce the measure in 2015 and 2016. The measure was produced according to HEDIS 2016 specifications. The data source was encounter data 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 HC BH 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 HC BH 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
PerformCare	77	263	**29.3%**	23.6%	35.0%			30.8%	-1.6	NO	Below 25th Percentile
Bedford-Somerset	3	10	**30.0%**	0.0%	63.4%			37.5%	-7.5	NO	Below 25th Percentile
Cumberland	4	28	**14.3%**	0.0%	29.0%			27.3%	-13.0	NO	Below 25th Percentile
Dauphin	35	92	**38.0%**	27.6%	48.5%			28.7%	9.3	NO	Below 50th Percentile, Above 25th Percentile
Franklin-Fulton	10	25	**40.0%**	18.8%	61.2%			53.6%	-13.6	NO	Below 50th Percentile, Above 25th Percentile
Lancaster	19	77	**24.7%**	14.4%	35.0%			24.5%	0.1	NO	Below 25th Percentile
Lebanon	6	27	**22.2%**	4.7%	39.8%			39.4%	-17.2	NO	Below 25th Percentile
Perry	0	4	**0.0%**	0.0%	12.5%			42.9%	-42.9	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

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	
PerformCare	47	263	**17.9%**	13.1%	22.7%			14.7%	3.2	NO	Above 50th Percentile, Below 75th Percentile
Bedford-Somerset	2	10	**20.0%**	0.0%	49.8%			0.0%	20.0	NO	Above 50th Percentile, Below 75th Percentile
Cumberland	3	28	**10.7%**	0.0%	24.0%			21.2%	-10.5	NO	Below 50th Percentile, Above 25th Percentile
Dauphin	21	92	**22.8%**	13.7%	31.9%			16.5%	6.3	NO	At or Above 75th Percentile
Franklin-Fulton	5	25	**20.0%**	2.3%	37.7%			28.6%	-8.6	NO	Above 50th Percentile, Below 75th Percentile
Lancaster	11	77	**14.3%**	5.8%	22.8%			10.9%	3.4	NO	Above 50th Percentile, Below 75th Percentile
Lebanon	5	27	**18.5%**	2.0%	35.0%			6.1%	12.5	NO	Above 50th Percentile, Below 75th Percentile
Perry	0	4	**0.0%**	0.0%	12.5%			14.3%	-14.3	NO	Below 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 50th percentiles, while the HealthChoices Aggregate rate for Engagement was above the 75th percentile.

The PerformCare MY 2015 13-17 year old Initiation rate was 29.3% and the Engagement rate was 17.9%. Neither rate was statistically significantly different from the corresponding MY 2014 rates (**Table 14**). Compared to the HealthChoices BH-MCO Averages, the PerformCare Initiation rate was not statistically significantly different from the BH-MCO Average of 33.6%, and the PerformCare Engagement rate was statistically significantly lower than the BH-MCO Average of 23.1% by 5.2 percentage points. The PerformCare Initiation rate was below the HEDIS 25th percentile, and the Engagement rate was between the HEDIS 50th and 75th percentiles.

As presented in **Table 14**, none of the HC BH Contractors had statistically significant rate changes from MY 2014 to MY 2015. For Initiation rates, five HC BH Contractors were below the HEDIS 2016 25th percentile and two HC BH Contractors were between the HEDIS 2016 25th and 50th percentile, Perry was between the 50th and 75th percentile, and Franklin-Fulton was above the 75th percentile. For Engagement rates, Perry was below the HEDIS 25th percentile and Dauphin was above the HEDIS 75th percentile; all other HC BH Contractors were between the HEDIS 50th and 75th percentiles.

Figure 11 is a graphical representation of the 13-17 year old MY 2015 HEDIS Initiation and Engagement rates for PerformCare and its associated HC BH Contractors. **Figure 12** shows the HealthChoices HC BH Contractor Average rates for this age cohort and the individual PerformCare HC BH Contractor rates that were statistically significantly higher or lower than the HealthChoices HC BH Contractor Average. The Initiation rates for Cumberland and Perry were statistically significantly lower than the MY 2015 HC BH Contractor Initiation Average of 29.3% by 15.0 and 29.3 percentage points, respectively. The Engagement rate for Perry was statistically significantly below the MY 2015 HC BH Contractor Average of 18.9% by 18.9 percentage points.

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

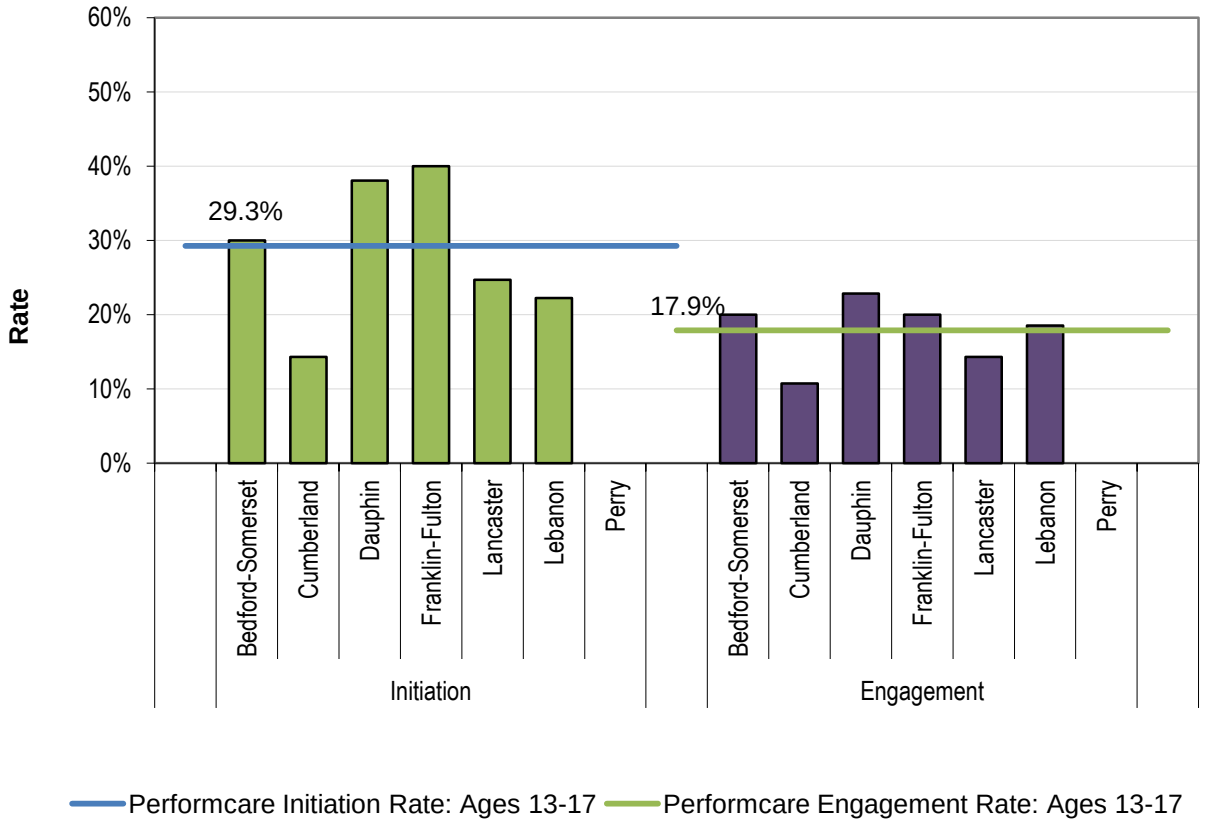
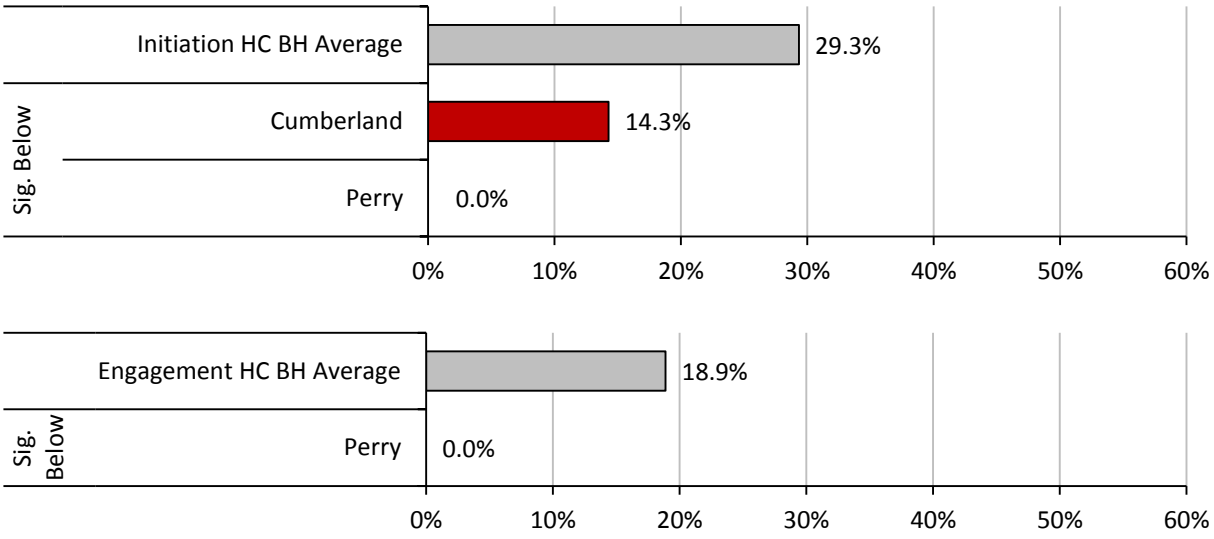


Figure 12: MY 2015 IET Rates Compared to HealthChoices County Average: 13–17 Years Old



(b) Age Group: 18+ Years Old

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

Measure	MY 2015 (N)	MY 2015 (D)	MY 2015 %	MY 2015 Lower 95% CI	MY 2015 Upper 95% CI	MY 2015 BH-MCO Average	MY 2015 BH HC Contractor Average	MY 2014 %	MY 2014 PPD	MY 2014 SSD	Rate Comparison MY 2015 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
PerformCare	698	2,519	**27.7%**	25.9%	29.5%			26.7%	1.0	NO	Below 25th Percentile
Bedford-Somerset	54	230	**23.5%**	17.8%	29.2%			19.2%	4.3	NO	Below 25th Percentile
Cumberland	68	244	**27.9%**	22.0%	33.7%			25.0%	2.9	NO	Below 25th Percentile
Dauphin	158	686	**23.0%**	19.8%	26.3%			26.2%	-3.2	NO	Below 25th Percentile
Franklin-Fulton	67	226	**29.6%**	23.5%	35.8%			29.3%	0.3	NO	Below 25th Percentile
Lancaster	262	821	**31.9%**	28.7%	35.2%			27.7%	4.2	NO	Below 25th Percentile
Lebanon	78	260	**30.0%**	24.2%	35.8%			33.8%	-3.8	NO	Below 25th Percentile
Perry	11	52	**21.2%**	9.1%	33.2%			25.9%	-4.7	NO	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
PerformCare	403	2,519	**16.0%**	14.5%	17.4%			13.8%	2.2	YES	Above 50th Percentile, Below 75th Percentile
Bedford-Somerset	24	230	**10.4%**	6.3%	14.6%			7.7%	2.7	NO	Below 50th Percentile, Above 25th Percentile
Cumberland	39	244	**16.0%**	11.2%	20.8%			13.3%	2.7	NO	Above 50th Percentile, Below 75th Percentile
Dauphin	75	686	**10.9%**	8.5%	13.3%			13.9%	-3.0	NO	Below 50th Percentile, Above 25th Percentile
Franklin-Fulton	42	226	**18.6%**	13.3%	23.9%			18.4%	0.2	NO	Above 50th Percentile, Below 75th Percentile
Lancaster	157	821	**19.1%**	16.4%	21.9%			13.3%	5.8	YES	Above 50th Percentile, Below 75th Percentile
Lebanon	58	260	**22.3%**	17.1%	27.6%			21.1%	1.2	NO	At or Above 75th Percentile
Perry	8	52	**15.4%**	4.6%	26.2%			13.6%	1.8	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 rates in the 18 and older age group were 26.7% for Initiation and 18.6% for Engagement (**Table 15**). Both rates were statistically significantly lower than the corresponding MY 2014 rates: the HealthChoices Aggregate Initiation rate decreased by 3.1 percentage points and the Engagement rate decreased by 1.5 percentage points from the prior year. The MY 2015 HealthChoices Aggregate Initiation rate in this age cohort was below the HEDIS 2016 25th percentile, while the Engagement rate was between the 50th and 75th percentiles.

The PerformCare MY 2015 Initiation rate for the 18+ population was 27.7% (**Table 15**). This rate was below the HEDIS 2016 25th percentile, and was not statistically significantly different from the MY 2014 Initiation rate. Compared to the HealthChoices BH-MCO Average of 26.7% for Initiation, the PerformCare rate was statistically significantly higher by 1.0 percentage points. The PerformCare MY 2015 Engagement rate for this age cohort was 16.0%, and was between the HEDIS 50th and 75th percentiles. The PerformCare Engagement rate was statistically significantly higher than the MY 2014 rate of 13.8%, and was statistically significantly lower than the BH-MCO Average of 18.3% by 2.3 percentage points.

As presented in **Table 15**, all HC BH Contractors associated with PerformCare had Initiation rates below the 25th percentile. Engagement rates in this age group were between the 25th and 50th percentiles for Bedford-Somerset and Dauphin, above the HEDIS 75th percentile for Lebanon, and between the HEDIS 50th and 75th percentiles for all other HC BH Contractors. The Engagement rate for Lancaster statistically significantly increased 5.8 percentage points from MY 2014.

Figure 13 is a graphical representation MY 2015 IET rates for PerformCare and its associated HC BH Contractors for the 18+ age group. **Figure 14** shows the HealthChoices HC BH Contractor Average rates and individual PerformCare HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. The Initiation rate for Lancaster was statistically significantly higher than the HealthChoices HC BH Contractor Average Initiation rate of 27.7% by 4.2 percentage points, and the Initiation rate for Dauphin was below the Average by 4.7 percentage points. The Engagement rates for Dauphin, and Bedford-Somerset were statistically significantly lower than the HC BH Contractor Average of 19.4% by 8.5 and 9.0 percentage points, respectively.

Figure 13: MY 2015 IET Rates – 18+Years

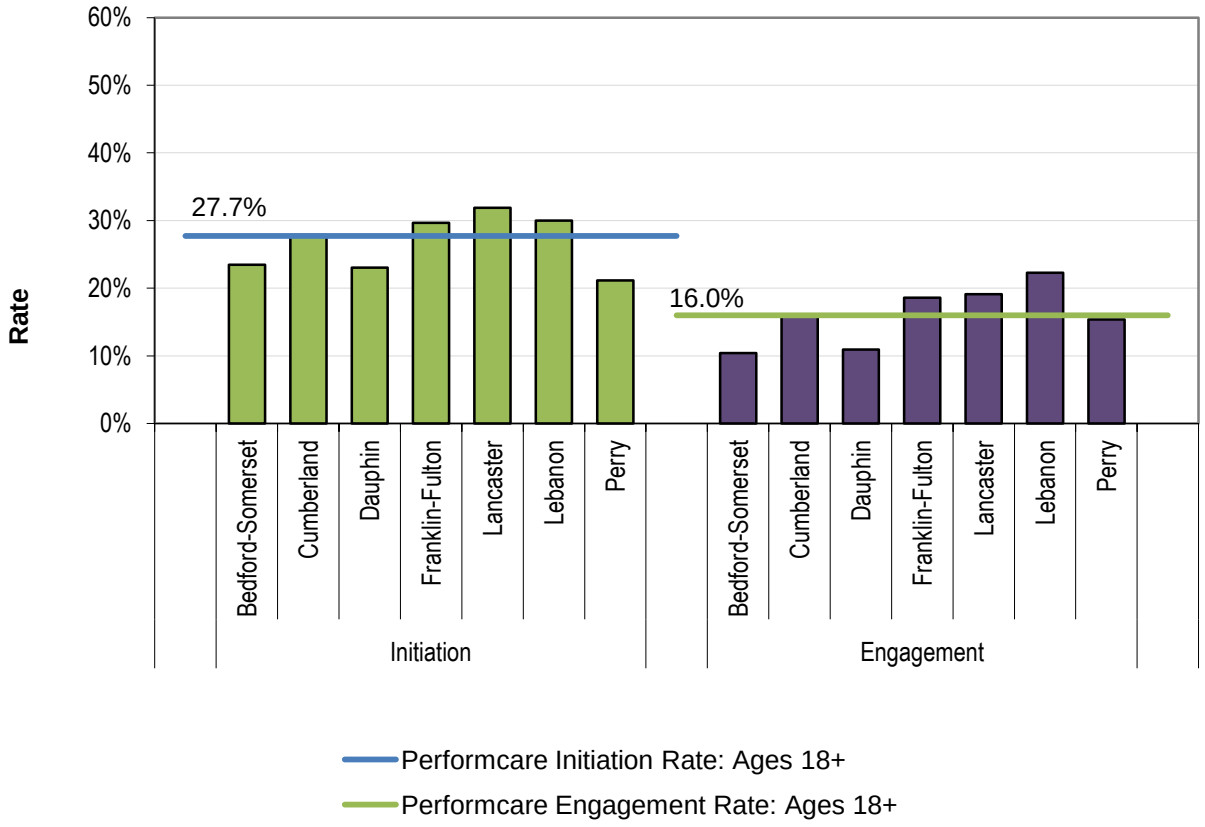
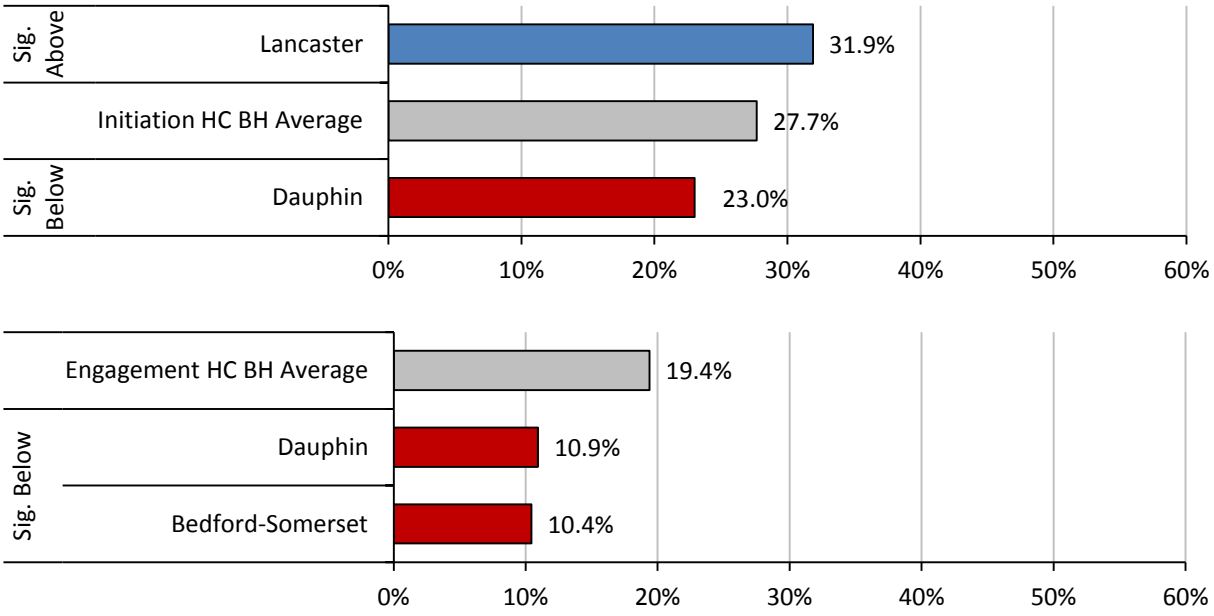


Figure 14: MY 2015 IET Rates Compared to HealthChoices HC BH Contractor Average – 18+ Years



(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 2015 to 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
PerformCare	775	2,782	**27.9%**	26.2%	29.5%			27.1%	0.8	NO	Below 25th Percentile
Bedford-Somerset	57	240	**23.8%**	18.2%	29.3%			19.6%	4.2	NO	Below 25th Percentile
Cumberland	72	272	**26.5%**	21.0%	31.9%			25.3%	1.2	NO	Below 25th Percentile
Dauphin	193	778	**24.8%**	21.7%	27.9%			26.5%	-1.7	NO	Below 25th Percentile
Franklin-Fulton	77	251	**30.7%**	24.8%	36.6%			31.8%	-1.1	NO	Below 25th Percentile
Lancaster	281	898	**31.3%**	28.2%	34.4%			27.4%	3.9	NO	Below 25th Percentile
Lebanon	84	287	**29.3%**	23.8%	34.7%			34.4%	-5.1	NO	Below 25th Percentile
Perry	11	56	**19.6%**	8.3%	30.9%			27.3%	-7.7	NO	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
PerformCare	450	2,782	**16.2%**	14.8%	17.6%			13.9%	2.3	YES	At or Above 75th Percentile
Bedford-Somerset	26	240	**10.8%**	6.7%	15.0%			7.5%	3.3	NO	Above 50th Percentile, Below 75th Percentile
Cumberland	42	272	**15.4%**	11.0%	19.9%			14.1%	1.3	NO	At or Above 75th Percentile
Dauphin	96	778	**12.3%**	10.0%	14.7%			14.3%	-2.0	NO	Above 50th Percentile, Below 75th Percentile
Franklin-Fulton	47	251	**18.7%**	13.7%	23.8%			19.5%	-0.8	NO	At or Above 75th Percentile

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	
Lancaster	168	898	**18.7%**	16.1%	21.3%			13.1%	5.6	YES	At or Above 75th Percentile
Lebanon	63	287	**22.0%**	17.0%	26.9%			19.3%	2.7	NO	At or Above 75th Percentile
Perry	8	56	**14.3%**	4.2%	24.3%			13.6%	0.7	NO	At or Above 75th Percentile

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

The MY 2015 HealthChoices Aggregate rates in the 13 and older age group were 27.5% for Initiation and 19.1% for Engagement (**Table 16**). The Initiation rate was statistically significantly lower than the MY 2014 Initiation rate by 2.8 percentage points, and the Engagement rate was statistically significantly lower than the MY 2014 Engagement rate by 1.4 percentage points. The MY 2015 HealthChoices Aggregate Initiation rate was below the HEDIS 2016 25th percentile, while the Engagement rate was above and 75th percentile.

The PerformCare MY 2015 Initiation rate for the 13+ population was 27.9% (**Table 15**). This rate was below the HEDIS 2016 25th percentile, and was not statistically significantly different from the MY 2014 Initiation rate. Compared to the HealthChoices BH-MCO Average of 27.2% for Initiation, the PerformCare rate was not statistically significantly different. The PerformCare MY 2015 Engagement rate for this age cohort was 16.2%, and was above the HEDIS 75th percentile. The PerformCare Engagement rate was statistically significantly higher than the MY 2014 rate of 13.9%, and was statistically significantly lower than the BH-MCO Average of 18.7% by 2.5 percentage points.

As presented in **Table 15**, all HC BH Contractors associated with PerformCare had Initiation rates below the 25th percentile. Engagement rates in this age group were between the 50th and 75th percentiles for Bedford-Somerset and Dauphin, while all other HC BH Contractors had rates that were above the HEDIS 2016 75th percentiles. The Engagement rate for Lancaster statistically significantly increased 5.6 percentage points from MY 2014.

Figure 13 is a graphical representation MY 2015 IET rates for PerformCare and its associated HC BH Contractors for the 18+ age group. **Figure 14** shows the HealthChoices HC BH Contractor Average rates and individual PerformCare HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. The Initiation rate for Lancaster was statistically significantly higher than the HealthChoices HC BH Contractor Average Initiation rate of 28.0% by 3.3 percentage points, and the Initiation rate for Dauphin was below the Average by 3.1 percentage points. The Engagement rates for Dauphin, and Bedford-Somerset were statistically significantly lower than the HC BH Contractor Average of 19.5% by 7.1 and 8.6 percentage points, respectively.

Figure 15: MY 2015 IET Rates: 13+Years

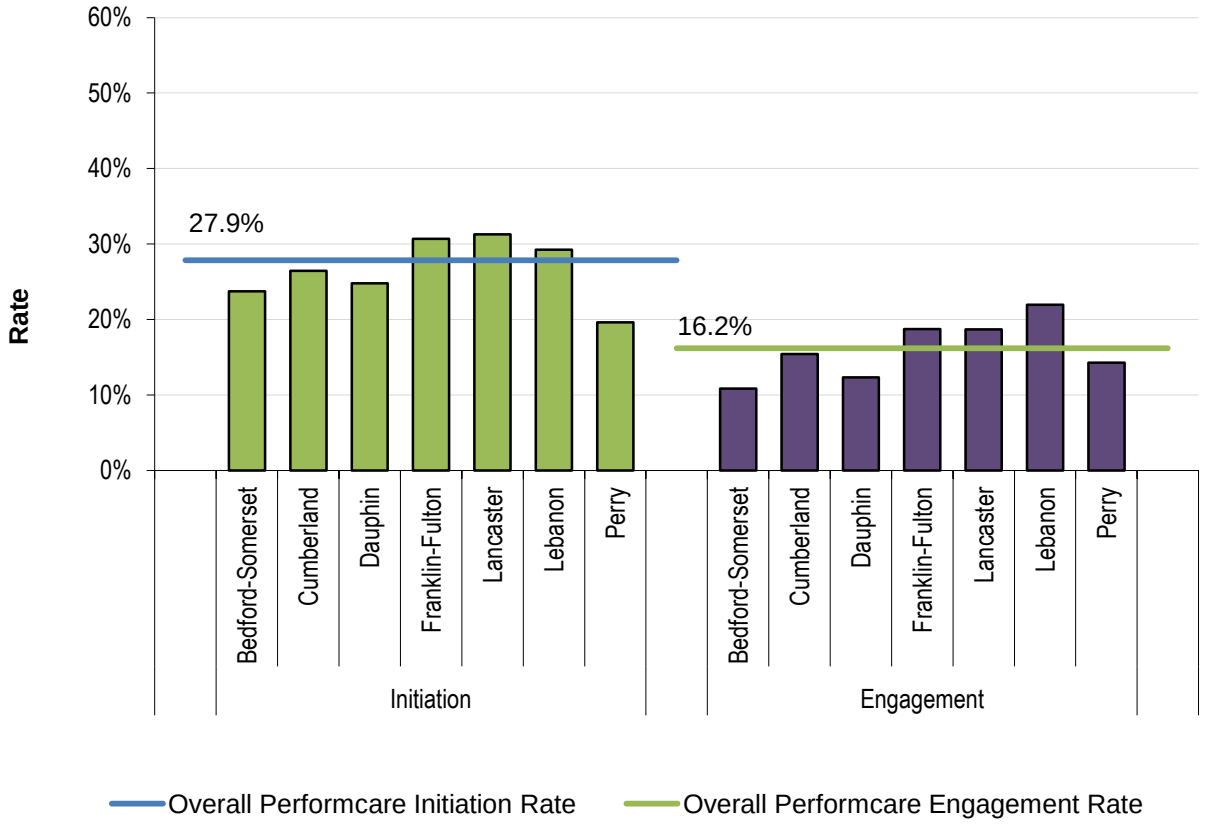
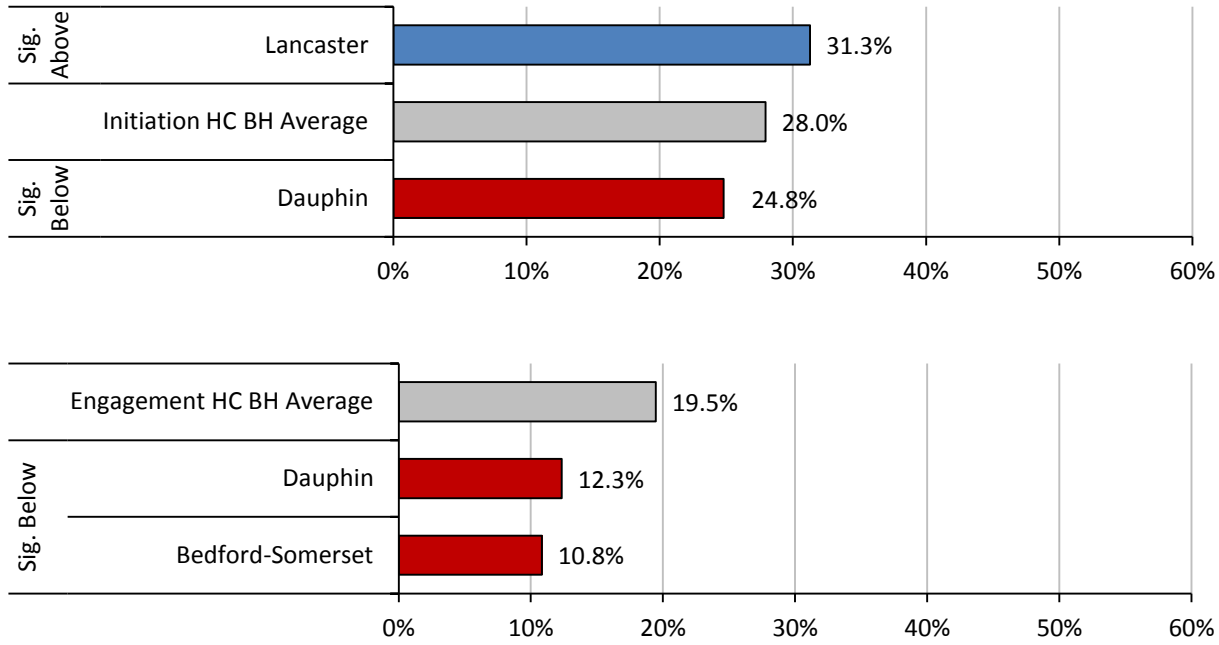


Figure 16: MY 2015IET Rates Compared to HealthChoices HC BH Contractor Average: 13+ Years



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 MY 2014 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 PerformCare'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 PerformCare 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.
PerformCare 2015.01	Within Subpart C: Enrollee Rights and Protections Regulations, PerformCare was partially compliant on one out of seven categories – Enrollee Rights. **PEPS Standard 60:** All HealthChoices Behavioral Health (HC BH) Contractors were non-compliant on two sub standards of Standard 60: Sub standards 2 and 3. **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.	Date(s) of follow-up action(s) taken: None	PEPS Standard 108 -Substandard 1: This is a county specific Tuscarora Managed Care Alliance (TMCA) standard requirement. TMCA completed the CAP in 2014.
		Date(s) of follow-up action(s) taken: None	PEPS Standard 108 -Substandard 5: This is a county specific TMCA standard requirement. TMCA completed the CAP in 2014.
		Date(s) of follow-up action(s) taken: None	PEPS Standard 108 -Substandard 6: This is a county specific TMCA standard requirement. TMCA completed the CAP in 2014.
		Date(s) of follow-up action(s) taken: None	PEPS Standard 108 -Substandard 7: This is a county specific TMCA standard requirement. TMCA completed the CAP in 2014.
		Date(s) of follow-up action(s) taken: None	PEPS Standard 108 -Substandard 10: This is a county specific TMCA standard requirement. TMCA completed the CAP in 2014.
		Date(s) of follow-up action(s) taken: 1. 07/14/15 2. 10/19/15 3. 12/31/15 4. 12/31/15 5. 12/31/15 6. 12/31/15	PEPS Standard 60 – Substandard 2: 1. Developed a standardized training roster 2. Developed a centralized tracking system to track/document training provision and the dissemination of procedural changes 3. Developed training curriculum to ensure inclusion of all Appendix H requirements – see attached below 4. Revised training presentations to ensure compliance with the training curriculum 5. Developed and implemented an annual training plan on complaint, grievance and enrollee rights including receiving, processing and responding to complaints and grievances 6. Established, documented and tracked facilitator credentials  Complaint Training Curriculum.pdf
		Date(s) of follow-up action(s) taken: 1. 07/14/15 2. 10/19/15 3. 12/31/15	PEPS Standard 60 – Substandard 3: 1. Developed a standardized training roster 2. Developed a centralized tracking system to track/document training provision and the dissemination of procedural changes 3. Developed a training curriculum to ensure inclusion of all Appendix H

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 PerformCare 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.
		4. 12/31/15 5. 12/31/15 6. 12/31/15	requirements – see attached above 4. Revised training presentations to ensure compliance with the training curriculum 5. Developed and implemented an annual training plan on complaint, grievance and enrollee rights including receiving, processing and responding to complaints and grievances 6. Established, documented and tracked facilitator credentials
		Date(s) of future action(s) planned / None	Describe one follow-up action. Leave blank, if none.
PerformCare 2015.02	PerformCare was partially compliant on five 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)* **PEPS Standard 23:** All HC BH Contractors were partially compliant on 2 sub-standards of Standard 23: **Substandard 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 contracts that were provided. **Substandard 5:** BH-MCO has provided documentation to confirm if Written	Date(s) of follow-up action(s) taken: 1. PEPS Standard 23 – Substandard 4: 12/04/15 2. PEPS Standard 23 – Substandard 5: 11/30/15 3. PEPS Standard 28 – Substandard 1:6/24/16	***1) Availability of Services (Access to Care)*** PEPS Standard 23 – Substandard 4: • Revised Oral Translation work statement to reflect separate codes for each contract; revised Member Services, Complaints & Grievance, and Clinical Care Management protocols to reflect new coding; retrained all appropriate staff on protocols for Oral Interpretation services. • Evidence of completion submitted to the Office of Mental Health and Substance Abuse Services (OMHSAS) PEPS Standard 23 – Substandard 5: • Revised Written Translation billing process and request process; trained appropriate staff on revised process; and integrated into desk manual • Evidence of completion submitted to OMHSAS PEPS Standard 28 – Substandard 1: • Developed and implemented a Clinical Department Documentation audit process and training program; created and filled a Clinical Auditor position; incorporated on-site and virtual training program into the Annual Training Plan; and revised Supervisor Protocols and expectations. • Evidence of completion submitted to OMHSAS

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 PerformCare 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.
	Translation services ere provided for the calendar year being reviewed. The document includes the actual number of services, by contracts, that were provided. **PEPS Standard 28:** Longitudinal Care Management. The BH-MCO has a comprehensive, defined program of care that incorporates longitudinal disease management. All HC BH Contractors were partially compliant on one substandard of Standard 28: **Substandard 1:** Clinical/chart review reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. *2) Coordination and Continuity of Care* **PEPS Standard 28:** Longitudinal Care Management. The BH-MCO has a comprehensive, defined program of care that incorporates longitudinal disease management. All HC BH Contractors were partially compliant on one substandard of Standard 28: **Substandard 1:** Clinical/chart review reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. *3) Coverage and Authorization of Services*	Date(s) of follow-up action(s) taken: 06/24/16	***2) Coordination and Continuity of Care*** PEPS Standard 28 - Substandard 1: • Developed and implemented a Clinical Department Documentation audit process and training program; created and filled a Clinical Auditor position; incorporated on-site and virtual training program into the Annual Training Plan; and revised Supervisor Protocols and expectations. • Evidence of completion submitted to OMHSAS
		Date(s) of follow-up action(s) taken: 1. PEPS Standard 28 – Substandard 1: 06/24/16 2. PEPS Standard 72 – Substandard 2: 06/24/16	***3) Coverage and Authorization of Services*** PEPS Standard 28 - Substandard 1: • Developed and implemented a Clinical Department Documentation audit process and training program; created and filled a Clinical Auditor position; incorporated on-site and virtual training program into the Annual Training Plan; and revised Supervisor Protocols and expectations. • Evidence of Completion Submitted to OMHSAS PEPS Standard 72 - Substandard 2: • Developed and implemented Denial Letter audit tool; developed and implemented Clinical Care Management – 060 (CM-060) Denial Letter Review and Auditing Policy and Procedure (P&P); revised Appendix AA templates and CM-013 Denial Notice Procedure P&P; and implemented and completed revised training for all Clinical Department Associates. • Evidence of Completion Submitted to OMHSAS
		Date(s) of follow-up action(s) taken: 1. PEPS Standard 99 – Substandard 6: 03/08/16 2. PEPS Standard 99 – Substandard 8: 03/08/16	***4) Sub contractual Relationships and Delegation*** PEPS Standard 99 - Substandard 6: • Initiated work group to review and revise Provider Performance and Provider Profiling; developed work plan; developed proposal to change Provider Performance and Provider profiling; and determined milestones/timeline for work plan completion. • See attached work plan PEPS Standard 99 - Substandard 8: • Initiated work group to review and revise Provider Performance and Provider Profiling; developed work plan; developed proposal to change Provider Performance and Provider profiling; and determined milestones/timeline for work plan completion.

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Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found PerformCare 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.
	PEPS Standard 28: Longitudinal Care Management. The BH-MCO has a comprehensive, defined program of care that incorporates longitudinal disease management. All HC BH Contractors were partially compliant on one substandard of Standard 28: **Substandard 1:** Clinical/chart review reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. **PEPS Standard 72:** Denials. Denials or reduction of services are provided, in writing, to the member, parent/custodian of a child/adolescent, and/or county child and youth agency for children in substitute care. The denial note includes: a) specific reason for denial, b) service approved at a lesser rate, c) service approved for a lesser amount than requested, d) service approved for shorter duration than requested, e) service approved using a different service or item than requested and description of the alternate service, if given, f) date decision will take effect, g) name of contact person, h) notification that member may file a grievance and/or DHS Fair Hearing, and i) if currently receiving services, the right to continue to receive services during the grievance and/or Fair Hearing process. All HC BH Contractors were partially compliant on one substandard of		• See attached work plan  Workplan Provider Profiling and Provider
		Date(s) of future action(s) planned: 11/30/16	***4) Sub contractual Relationships and Delegation*** PEPS Standard 99 – Sub standards 6 & 8: Review Provider Profiling and Individual Monitoring results with Providers in accordance with the Work Plan attached above
		Date(s) of follow-up action(s) taken: 06/24/16	***5) Practice Guidelines*** PEPS Standard 28 - Substandard 1: • Developed and implemented a Clinical Department Documentation audit process and training program; created and filled a Clinical Auditor position; incorporated on-site and virtual training program into the Annual Training Plan; and revised Supervisor Protocols and expectations. • Provided evidence of completion to OMHSAS

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Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found PerformCare 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.
	Standard 72: **Substandard 2:** The content of the notices adhere to OMHSAS requirements. *4) Sub contractual Relationships and Delegation* **PEPS Standard 99:** Provider Performance. The BH-MCO Evaluates the Quality and Performance of the Provider Network. Monitor and evaluate the quality and performance of provider network to include, but not limited to Quality of individualized service plans and treatment planning, adverse incidents, Collaboration and cooperation with Member complaint, grievance and appeal procedures as well as other medical and human service programs and Administrative compliance. Procedures and outcome measure are developed to provide provider performance. All HC BH Contractors were partially compliant complaint on two sub standards of standard 99: **Substandard 6:** Provider profiles and individual monitoring results are reviewed with providers. **Substandard 8:** The BH_MCO demonstrates that provider profiling results are incorporated into the network management strategy. *5) Practice Guidelines* **PEPS Standard 28:** Longitudinal Care Management. The BH-MCO has a		

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Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found PerformCare 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.
	comprehensive, defined program of care that incorporates longitudinal disease management. All HC BH Contractors were partially compliant on one substandard of Standard 28: **Substandard 1:** Clinical/chart review reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.		
PerformCare 2015.03	PerformCare was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: *1) Statutory Basis and Definitions* **PEPS Standard 68:** All HC BH Contractor were non-compliant on three sub-standards of Standard 68: **Substandard 2** **Substandard 3** **Substandard 4** All HC BH Contractors were partially compliant on one substandard of Standard 68: **Substandard 5** **PEPS Standard 71:** All HC BH Contractors were partially compliant on two sub standards of Standard 71: **Substandard 3** **Substandard 4**	Date(s) of follow-up action(s) taken: 1. PEPS Standard 23 – Substandard 4: 03/08/16 2. PEPS Standard 23 – Substandard 5: 03/08/16	***3) Notice of Action*** PEPS Standard 23 – Substandard 4: • Revised Oral Translation work statement to reflect separate codes for each contract; revised Member Services, Complaints & Grievance, and Clinical Care Management protocols to reflect new coding; retrained all appropriate staff on protocols for Oral Interpretation services. • Evidence of completion submitted to OMHSAS PEPS Standard 23 – Substandard 5: • Revised Written Translation billing process and request process; trained appropriate staff on revised process; and integrated into desk manual • Evidence of completion submitted to OMHSAS
		Date(s) of follow-up action(s) taken: • 07/14/15 • 10/19/15 • 12/31/15	***1) General Requirements*** PEPS Standard 60 – Substandard 3: • Developed a standardized training roster • Developed a centralized tracking system to track/document training provision and the dissemination of procedural changes • Developed a training curriculum to ensure inclusion of all Appendix H requirements – see attached above
		Date(s) of follow-up action(s) taken: 1. PEPS Standard 68 – Substandard 2:	***1) Statutory Basis and Definitions*** ***4) Handling of Grievances and Appeals*** ***5) Resolution & Notification: Grievances & Appeals*** PEPS Standard 68 - Substandard 2:

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Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found PerformCare 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.
	PEPS Standard 72: All HC BH Contractors were partially compliant on one substandard of Standard 72: **Substandard 2** *2) General Requirements* **PEPS Standard 60:** All HC BH Contractors were non-compliant on two sub standards of Standard 60: **Substandard 2** **Substandard 3** **PEPS Standard 71:** All HC BH Contractors were partially compliant on two sub standards of Standard 71: **Substandard 3** **Substandard 4** **PEPS Standard 72:** All HC BH Contractors were partially compliant on one substandard of Standard 72: **Substandard 2** *3) Notice of Action* **PEPS Standard 23:** All HC BH Contractors were partially compliant on two sub standards of Standard 23: **Substandard 4** **Substandard 5** **PEPS Standard 72:** All HC BH Contractors were partially compliant on one substandard of Standard 72: **Substandard 2** *4) Handling of Grievances & Appeals;* *5) Resolution & Notification: Grievances*	• 09/30/15 • 11/30/15 2. PEPS Standard 68 – Substandard 3: • 05/01/15 • 10/02/15 3. PEPS Standard 68 – Substandard 4: • 11/30/15 • 10/30/15	• Retrained/provided reminder to associates on Appendix H requirement specific to the filing of an extension • Revised documentation audit tool to include review of the use of the appropriate letter template PEPS Standard 68 - Substandard 3: • Developed a description of the Complaint Review Committee (CRC) including leadership, composition, roles/ responsibilities and reporting. Revise documentation audit tool to include review of the use of the appropriate letter template • Revamped the CRC to ensure CRC lead has the necessary knowledge, qualification and training to determine the adequacy of complaint investigation and any needed follow-up prior to and following complaint resolution PEPS Standard 68- Substandard 4: • Revamped the CRC to ensure CRC lead has the necessary knowledge, qualification and training to determine the adequacy of complaint investigation and any needed follow-up prior to and following complaint resolution • Revised complaints investigation process to eliminate the rebuttal aspect; to formally facilitate the submission of additional documentation/information by Members; to discontinue the practice of including direct quotes in decision letters, and to ensure the first level review committee's summary includes each complaint issue and demonstrates that an impartial determination was made.
		Date(s) of follow-up action(s) taken: • 01/31/16 • 01/31/16 • 10/19/15	***1) Statutory Basis and Definitions*** ***2) General Requirements*** ***4) Handling of Grievances & Appeals*** ***5) Resolution & Notification: Grievances & Appeals*** ***6) Expedited Appeals Process*** ***7) Continuation of Benefits*** ***8) Effectuation of Reversed Resolutions*** PEPS Standard 71 – Substandard 3 & 4: • Developed training curriculum to ensure inclusion of all Appendix H requirements • Revised training presentations to ensure compliance with the training curriculum • Develop a centralized tracking system to track/document training provision to all staff and the dissemination of procedural changes

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 PerformCare 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.
	and Appeals **PEPS Standard 68:** All HC BH Contractor were non-compliant on three sub-standards of Standard 68: **Substandard 2** **Substandard 3** **Substandard 4** All HC BH Contractors were partially compliant on one substandard of Standard 68: **Substandard 5** **PEPS Standard 71:** All HC BH Contractors were partially compliant on two sub standards of Standard 71: **Substandard 3** **Substandard 4** **PEPS Standard 72:** All HC BH Contractors were partially compliant on one substandard of Standard 72: **Substandard 2** *6) Expedited Appeals Process;* *7) Continuation of Benefits; and* *8) Effectuation of Reversed Resolutions.* **PEPS Standard 71:** All HC BH Contractors were partially compliant on two sub standards of Standard 71: **Substandard 3** **Substandard 4** **PEPS Standard 72:** All HC BH Contractors were partially compliant on one substandard of Standard 72:	Date(s) of follow-up action(s) taken: • 08/12/15 • 08/12/15 • 01/31/16 • 06/24/16	***1) Statutory Basis and Definitions*** ***2) General Requirements*** ***3) Notice of Action*** ***4) Handling of Grievances & Appeals*** ***5) Resolution & Notification: Grievances & Appeals*** ***6) Expedited Appeals Process*** ***7) Continuation of Benefits*** ***8) Effectuation of Reversed Resolutions*** PEPS Standard 72 – Substandard 2: • Develop denial letter audit tool reflecting PEPS 72.2 requirements • Develop and implement an audit procedure • Utilize the revised AA templates • Revise PerformCare's CM-013 Denial Notice Procedure P&P template attachments Update electronic templates Train PerformCare staff on revised templates as required in Appendix AA
		Date(s) of future action(s) planned / None	Describe one follow-up action. Leave blank, if none.

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Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2012, RY 2013, and RY 2014 found PerformCare 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.
	Substandard 2		
PerformCare 2015.04	PerformCare'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 by 1.6 percentage points. PerformCare's rate did not meet the OMHSAS designated performance goal of 10.0%.	Date(s) of follow-up action(s) taken: 04/2016	PerformCare has improved their reporting capability by expanding Informatics' reporting on follow up rates, length of stay, and readmission rates. PerformCare produced Benchmark reports with a focus on Mental Health Inpatient (MH IP)and Substance Abuse Inpatient (SA IP) Providers initially • The Enhanced Care Management (ECM) department monitors the following reports to assist in identifying Members for the program: • Ongoing use of the report identifying Members that have entered into acute inpatient treatment 5 times (Capital Area Behavioral Health Collaborative - CABHC contract) or 3 times (Behavioral Health Services of Somerset and Bedford Counties – BHSSBC and Tuscarora Managed Care Alliance – TMCA contracts) within a 12 month period. • Effective fall of 2015 to the present: Report of 18 years and older adults that could potentially benefit from ECM based on the types and frequency of treatments they recently have received (ECM predictive modeling algorithm). • Effective beginning of 2014 to fall of 2015: Report of Members with high utilization of substance abuse services including a recidivism breakdown for substance abuse levels of care. • Review of the report identifying Members in the chronic, target populations and/or health and safety categories (Designator report). This includes the completion of Recovery Management Plans (ECM plans for assisting the Members on their caseloads) • Reports to begin accessing routinely starting Quarter 3 of 2016 (in interim to new platform): o Review of report showing all inpatient admissions within a given date range with option of filtering by age. o Admission/Discharge treatment report used for identification and tracking of Members with 30 and 60 day re-admissions to the same or higher level of care by provider (both MH IP and SA IP). o Clinical leadership weekly review of Members in MH IP over 14 calendar days.

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned: 2016-2017	A Benchmark report will be developed for ambulatory services including Mental Health Outpatient (MH OP), Blended Case Management (BCM), Peer Support (PSS), and Psychiatric Rehabilitations Services (Psych Rehab), Partial Hospitalization (PHP), Family Based Mental Health Services (FBMHS), and Behavioral Health Rehabilitation Services (BHRS) in 2017. These Benchmark reports will allow for improved correlations and educate providers on their own network scores based on PerformCare data. Reports that have been/will be requested in 2016-2017: • Real time data regarding the completion of Adult Needs and Strengths Assessments (ANSA) for inpatient admissions • Report identifying the frequency of Members identified as high scoring in the specific categories of the assessment (ANSA). • Report providing inpatient discharge status of unique Members (i.e. leaving against medical advice for Substance Abuse (SA) facilities, successful discharge, behavioral discharges etc.) • Report providing the status of Members in the ECM program that are engaged with the supports offered as well as status of Members that are not responsive to the ECM outreach. • Report providing real time information related to the ECMs completion of a comprehensive assessment within 30 calendar days of assignment. • Outcomes measures reports to include status of member upon discharge from the ECM program (successful, no longer eligible with HealthChoices etc) • Reports to identify member satisfaction with their involvement in the ECM program. • Report that provides information on the frequency and variety of ECM contacts with member and on behalf of the member.
		Date(s) of follow-up action(s) taken: 01/2015 – 05/2016	Increase Adequate providers with the appropriate training, certification and license to provide specialized services such as Dialectical Behavior Therapy (DBT), Trauma Focused – Cognitive Behavior Therapy (TF-CBT), Eye Movement Desensitization and Reprocessing (EMDR) and Co-Occurring disorders (COD) • Network Operations will monitor network capacity of providers who are specialized in trauma informed care and specialization such as DBT and EMDR. • PerformCare will continue to offer stipends for providers to attend trainings in the several areas including trauma informed care and co-occurring treatment

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			and be reimbursed monetarily by PerformCare. • Quality Improvement Manager will explore incentive options for providers who develop and implement specialized outpatient services which are more effective in meeting Member needs. • Quality Improvement Staff will monitor the number of providers who utilize training stipends and will promote the use of these funds so that providers are adequately informed to develop specialized services. • PerformCare will continue to support the development of CCISC practices to meet the individual needs of each contract through the local participation in the various CCISC workgroups. • TF-CBT training and certification for Bedford, Somerset, Franklin, and Fulton providers occurred in 2015 for 24 providers. Case consultations are still ongoing. • Opportunity to request an automated directory, county and age specific for providers certified/trained in these areas for CCMs to access for discharge planning and for education to inpatient units, for ECMs to assist Members in connecting to community based supports to help divert IP stays etc. (currently can go to Provider Connect to find resources – cumbersome in the midst of a review) • Co-occurring competency credential - this is a provider incentive program, in which MH OP providers must pass the COD audit with a score of 75% in all three rating areas in order to be certified for an enhanced rate. Additionally, the provider must agree to use the COD outcomes tool in order to qualify as well. In 2015, two out of 5 providers audited received a passing score and will get an enhanced rate. In 2016, two out of two providers audited received a passing score and will get an enhanced rate.

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned: 06/2016 – 07/2016	• TR-CBT training is scheduled for 6/13 and 6/14 for BHSSBC and TMCA Providers • FBA training is scheduled for 6/30 and 7/1
		Date(s) of follow-up action(s) taken: 01/2015 – 05/2016	Continue Quality Treatment Record Reviews (including indicators related to discharge instructions/summary, recovery orientation, and resolution of barriers). Reviews to occur every three years based on the re-credentialing cycle, or more frequently, depending on the performance of the provider • Quality Treatment Record reviews will continue to be completed every three years based on the re-credentialing cycle, or more frequently depending on the provider's performance. PerformCare continues to monitor the TRR scores, and utilizes information from low scoring LOC, sections, and indicators to develop future webinars, technical assistance, and provider education. • Any provider that does not achieve the performance goal for the total score is required to submit a Quality Improvement Plan (QIP). Quarterly collaboration occurs between the provider and PerformCare in order to assess progress on the QIP, as well as to offer technical assistance to support the provider to achieve their planned actions to improve. Even if the provider meets the overall benchmark score, if section score is below 80%, the provider is asked to provide PerformCare with a brief response regarding how they plan to address indicators within the section that scored below 80%.
		Date(s) of follow-up action(s) taken: 05/2015 – 05/2016	Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex needs • Local Care Managers are continuing to expand their caseloads. Active Care Management strategies continue for PerformCare Clinical Care Managers through Enhanced Care Management (ECM). In 2015, we added the FF LCM, increasing the ECM to nine PerformCare staff, with plans to expand in 2016. • All CCMs who complete preauthorizations for mental health inpatient treatment also complete initial ANSA to identify and refer those who would benefit from ECM, and to identify any barriers that should be addressed during the MHIP stay. In doing so, the CCM will then partner with the MHIP facility to ensure barriers are addressed; with the intent of ensuring Member has a successful transition to ambulatory care. • During the course of the inpatient stay, PerformCare Clinical Care Managers (UM and ECM) provide information to the inpatient unit regarding Members treatment history, patterns of follow through with recommendations, barriers to

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			following their recovery plan, and their pattern of engagement with Providers, in an effort to arm the unit with information to engage and motivate the Members to attend follow up care. a. PC CCM continues to encourage collaboration among providers and team members. b. PC CCM continues to encourage the use of non-traditional services such as MPN, Psych Rehab, diversion programs, and other services as appropriate and based on the Members needs. c. ECM will inform the inpatient facility of services the Members is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. The ECM will request a treatment team meeting with the inpatient unit to include the Members, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan. • ECMS develop a Recovery Management Plan (RMP) within the first month of assignment to a Members which outlines the barriers and individualized needs the Members and provider/support team has identified regarding the Members's ability to maintain successful community tenure

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of follow-up action(s) taken: 04/2015 – 05/2016	• CCISC meeting continue in the North Central Contracts. Change Agent Meetings continue in the North Central contracts. There was a Complex condition training started on 2/20/14 in the Franklin/Fulton region, level of care specific treatment plan trainings were completed in 2015 and Motivational Interviewing trainings completed for April and June 2016. A Provider networking day was held on June 16, 2016. • PerformCare also has an ECM now attending the CCISC implementation group meetings and change agent meetings (along with local QI and AE representation).
		Date(s) of follow-up action(s) taken: 01/2016 – 06/2016	• PerformCare conducted meetings with all 4 hospitals selected for the Discharge Management Plan Audits in July and August of 2015 to review the results of the DMP audit, to review opportunities for improvement, and to review expectations. A review of these facilities was completed, and • Meetings were also held with the second round of four facilities in May 2016. During these visits, PeformCare reviewed the results of the audit, and again held extensive discussions regarding the need for Providers to assess barriers early during a MHIP and address identified barriers to completing follow-up appointments with Providers
		Date(s) of future action(s) planned: 06/2016 – 12/2016	PerformCare will continue to encourage the implementation of PSS into the network MH IP units and complete an analysis on why it is underutilized • Encourage MH IP units to utilize PSS/Recovery Specialist in the MH IP unit. • Monitor the Capital Reinvestment plans: to place certified peer specialist In MH IP units. • Monitor the number of PSS in the network actively seeking employment to determine if there is adequate peer support certified and available. • PerformCare will explore the feasibility of recommended documentation guidelines for PSS and engage all contracts in the review of proposed guidelines. • Increase capacity of Providers of Peer Support Services • Monitor the readmission rates for the four MH IP units that will have the PSS on staff compare to those MH IP facilities that do not have PSS staff. • QI Staff will continue to participate in the PSS workgroup at CABHC. • QI will continue to monitor the utilization of Peer Support Services in the QI/UM meetings. • Network Operations will monitor the capacity of Peer Support Providers in the network. • PC CCM (UM and ECM) care managers will encourage engagement of Certified

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			Peer Support Specialist with Member when CPSs are imbedded on the inpatient unit and encourage continuation of use of peer support as part of a discharge plan to the community. • PC CCM care managers will encourage the Certified Peer Support as part of an aftercare plan for members who would benefit from increased support in the community. • If a member is readmitted to a high level of care and has existing certified peer support specialists, CCM's encourage collaboration with the CPS as part of the larger treatment team to assist with transitioning member back into the community.

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned: 06/2016 – 12/2017	Enhance Care Management and Active Case Management will assess Members needs and address barriers to prevent readmission. • PC UM CCMs will encourage providers to explore current supports/treatment of a member who is experiencing a first admission. If there is a need, a request for referral to county case management will occur. PC CCM will also work with provider to explore barriers to aftercare and assist in development of a recovery oriented discharge management plan for the member. • If there is a lack of timely after care appointment availability, PC CCM will work with provider to explore other treatment/support options to avoid having a lapse of treatment in the time following an inpatient admission. • During the member's prior authorization request for their first inpatient admission, the UM CCM will complete a comprehensive assessment (ANSA) to determine if the member has complex conditions (i.e. significant behavioral issues: psychosis, trauma, substance use, suicidality; significant physical health concerns and limited engagement in their recovery plan) and will refer the member to the Enhanced Care Management Program. For Members assigned to ECM: • Effective Quarter 1 of 2016, during a member's admission to inpatient treatment, if assigned to an ECM, the ECM will conduct all utilization management functions regarding the authorizations for treatment and gathering of clinical information related to progress. The ECM will inform the inpatient facility of services the member is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. The ECM will request a treatment team meeting with the inpatient unit to include the member, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan. • ECM contacts the Member the next business day after discharge from IP to ensure the member understands their discharge instructions, to confirm date and time of the scheduled follow-up appointment(s); to verify whether the Member plans to attend the follow-up appointment(s); to assist with rescheduling appointments when necessary; to verify contact telephone number and address; to provide warm linkages to community resources to mitigate or minimize barriers to successful participation in aftercare instructions. • The ECM will call the Member weekly until the follow-up appointment date to provide any assistance needed and to remind Member of the follow-up

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			appointment date and time, ECM will call the Member the business day following the scheduled follow-up appointment to verify that the Member attended the appointment. If Member did not attend, ECM will elicit and assist with barriers to treatment and assist with rescheduling the follow-up appointment, as necessary. • To support education to new members regarding the significance of follow up and their role in their own recovery, an ECM will outreach to the inpatient provider and as noted above, request treatment team meetings that include the member, request to speak directly to the member, when appropriate go on the unit to meet with the member and upon return to the community, the ECM outreaches to the member to ensure the member understands their options and their recovery plan. The ECM will help the member assess the success of the plan and work with the member and community based providers on revisions needed to make the plan continue to be successful.

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned: 12/2017	PerformCare does not currently have a report built that identifies Members new to Inpatient treatment with a readmission within 30 days and a correlation to after care compliance. This will be recommended once Jiva is started in 1/2017
		Date(s) of follow-up action(s) taken: 03/2016 – 05/2016	**Monitoring of Hospitals involved with the Successful Transition PIP and encouragement of improvement on current process** Monitoring of Medication Reconciliation through MHIP TRRs-started Nov 2015 • PC will monitor scores for indicators • PC will refer Providers to the Medication toolkit if additional support required during TRR exit interviews (i.e. low scores). Creation of Medication reconciliation toolkit-completed in December 2015 • Toolkit was posted to the website on: Feb 2016. Providers were notified via iContact. • All PIP participating providers were notified of the toolkit, and it was emailed to one provider following the on-site visit by PC staff
		Date(s) of future action(s) planned: 06/2016 – 12/2017	Complete the PIP and fully implement interventions that have demonstrable outcomes – reduced readmission and increased follow up.

		Date(s) of follow-up action(s) taken: 01/2016 – 05/2016	Enhanced Care Management and Active Care Management to prompt Providers for Med reconciliation prior to discharge and Members for medication adherence
			• PC CCMs (UM and ECM) prompt providers for medication reconciliation starting in 2016.
			• Ensure new CCM electronic health record prompts for collection of information
			  ○ In the future, there will be prompts within the new electronic health record prompting CCM's to ensure medication reconciliation was completed at both admission and discharge, along with ensuring that the Member understands plan for medications and has been provided with paperwork that is easy to read and has recovery oriented language in it. CCM's will also be prompted to ensure a teach back has occurred prior to discharge.
			• Member ECM post-discharge follow-up
			  ○ ECM will routinely check in with the Member/supports to ensure the Member understands their medication regimen. For Members that are uncertain of their medication plans, the ECM will seek resources to aid the Member in education and adherence to the prescription protocol (i.e. outreach to the prescribing physician, community/natural supports, referral to additional services as appropriate such as Mobile Psychiatric Nursing,

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			options for injectable medications, Assertive Community Treatment Programs, Peer Support Services and Targeted Case Management).
		Date(s) of future action(s) planned: 06/2016 – 12/2017	Complete the PIP and fully implement interventions that have demonstrable outcomes – reduced readmission and increased follow up.
PerformCare 2015.05	PerformCare's overall rates for the MY 2014 7-Day Follow-up After Hospitalization for Mental Illness (HEDIS indicator QI 1) was statistically significantly lower than the BH-MCO Average by 2.1 percentage points. PerformCare reported the lowest QI 1 rate of all the BH-MCOs evaluated for MY 2014. PerformCare's rates for the MY 2014 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 for MY 2014, nor did they achieve the goal of meeting or exceeding the 75th percentile.	Date(s) of follow-up action(s) taken: 03/2016 – 05/2016	PerformCare has improved reporting capability by expanding Informatics' reporting on follow up rates, length of stay, and readmission rates. PerformCare produced Benchmark reports with a focus on Mental Health Inpatient and Substance Abuse Inpatient in Spring of 2016.
		Date(s) of future action(s) planned: 06/2016 – 12/2017	A Benchmark report will be developed for Partial Hospitalization, FBMHS, and BHRS in 2017. These Benchmark reports will allow for improved correlations and educate providers on their own network scores based on PerformCare data.
		Date(s) of follow-up action(s) taken: 05/2015– 06/2016	Reporting related to Enhanced Care Management (ECM) -Various reports utilized by Care Managers have been developed over the past year. • Ongoing use of the report identifying Members that have entered into acute inpatient treatment 5 times (Capital area contract) or 3 times (Bedford/Somerset and Franklin/Fulton contracts) within a 12 month period. • Effective fall of 2015: A report of 18 year olds and older adults that could potentially benefit from ECM based on the types and frequency of treatments they recently have received (ECM predictive modeling algorithm). • Effective beginning of 2014 to fall of 2015: A report of Members with high utilization of substance abuse services including a recidivism breakdown for substance abuse levels of care was developed. • Review of the report identifying Members in the chronic, target populations and/or health and safety categories (Designator report). This includes the completion of Recovery Management Plans (ECM plans for assisting the Members on their caseloads)
		Date(s) of follow-up action(s) taken: 03/2014 – 05/2016	BHSSBC and PerformCare will continue to meet periodically with Cornerstone and Somerset Hospital to evaluate the Crisis Bridge Program. Data is presented by PerformCare and Somerset Hospital. In the fall of 2014, as result of the presentation of data and the above discussions, the Bedford/Somerset model was adjusted so that participation shifted from an Option-In approach to an Option-Out approach.
		Date(s) of follow-up action(s) taken: 04/2014 – 05/2016	Holcomb Diversion Program (PerformCare meets regularly with Holcomb staff, along with county crisis and administrators in Lancaster County. Discussions surround ongoing use of the crisis diversion program instead of mental health inpatient

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			treatment, barriers faced in referrals and ways to increase utilization.
		Date(s) of follow-up action(s) taken: 01/2015 – 05/2016	Bedford/Somerset expanded to two new providers in 2015. Franklin/Fulton Counties an additional provider was added in 2015.Discussions with additional providers will occur as interest increases. Family Behavioral Resources (FBR) opened three OP clinics, one in Franklin County, one in Fulton County, and one in Somerset County in 2015. Pyramid Healthcare opened an additional OP clinic in Franklin County (dually licensed) in 2015. The Capital region added three tele psychiatry providers since in FY 2014/2015. Fourteen new psychiatrists were added to the Capital network during the same time period. From January 2015-July, 2016 five new providers of tele psychiatry were added (over six different sites).
		Date(s) of follow-up action(s) taken: 01/2016 – 05/2016	BHSSBC has also recently partnered with the PA Psychiatric Leadership Council (PPLC) to work towards common goals related to psychiatric recruitment and retention. BHSSBC contracted with a psychiatric recruiter to bring psychiatrists into the Bedford/Somerset area. This recruiter is providing monthly updates to PerformCare. TMCA engaged Network Providers in the process of developing open intake access and just in time prescriber, Psychiatry, scheduling; 8 Providers are engaged in developing these programs.
		Date(s) of follow-up action(s) taken: 01/2016 – 05/2016	U7 modifier with psychiatric evaluations does not currently have differential payment for psychiatry evaluations. Consequently the Fee Schedule was adjusted and PerformCare will recommend to county Primary Contractors to consider providing a U7 modifier financial incentive for psychiatry evaluations that meet the 7 day standard.
		Date(s) of follow-up action(s) taken: 2015/2016	Through a partnership between TrueNorth Wellness and the Federally Qualified Health Center (FQHC) located in Fulton County is being expanded which will target an increase in Member knowledge regarding MH services available.
		Date(s) of follow-up action(s) taken: 2015/2016	To date, two providers have received the official tele psychiatry site status. ACRP added 2 tele psychiatrists for the Bedford/Somerset region. Footsteps completed their Service Description (SD) and the Provider is currently in the submission process with the state for Tele psychiatry. DLP Conemaugh hired a psychiatrist for their Adult Inpatient Unit that will be starting July 1, 2016. They have extended a contract to another psychiatrist but no definite confirmation or start date. They continue to actively recruit.
		Date(s) of follow-up action(s) taken: 06/2015	During utilization reviews, PC CCM's encourage providers to look at other options to ensure medication continuation based on both Member barriers, and location.

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		– 06/2016	Examples would be the use of tele psychiatry for those Members in rural areas. Another example would be the use of FQHCs in available counties.
		Date(s) of follow-up action(s) taken: Fall 2015	Created and Distribute survey to individuals that have been readmitted within 30 days to gather information related to discharge process and Member's engagement and their perception of the planning and available supports within the community. The survey is an intervention developed for the Readmission Performance Improvement Project and will be monitored through that process quarterly Franklin and Fulton Counties are moving forward with survey development and was conducted in 2015. However, response rates were extremely low. The survey was not completed in other regions this time due to limited resources, however, PerformCare believes this is still a valuable intervention, and we are working towards possible completion in 2017.
		Date(s) of follow-up action(s) taken: 05/2015 – 05/2016	Enhance the Care Management Process: • Members with complex conditions (i.e. significant behavioral issues: psychosis, trauma, substance use, suicidality; significant physical health concerns and limited engagement in their recovery plan – determined by the comprehensive assessment, ANSA, done at the prior authorization request for inpatient treatment) are assigned to the Enhanced Care Management Program. • Members with significant and primary substance abuse diagnoses are assigned to the ECM with certifications in addiction issues or extensive knowledge and training on co-occurring concerns. • The ECM works with the member across the continuum of care, collaborating with involved Providers and supports as the member works on implementing and adjusting their recovery plan. The ECM works to tie together the various services to ensure the team is working collaboratively on behalf of the member and has the necessary information to provide assistance and treatment. • The ECM outreaches to the member when they are in the community on a routine basis regardless of the member's location or involvement in services to continue engagement and status updates on member stability and recovery. • During a member's admission to inpatient treatment, if assigned to an ECM, the ECM will conduct all utilization management functions regarding the authorizations for treatment and gathering of clinical information related to progress. The ECM will inform the inpatient facility of services the member is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge

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			planning. • The ECM will request a treatment team meeting with the inpatient unit to include the member, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan. • Upon discharge from the inpatient unit, the ECM then requests clarification of the discharge plan provided to the member. If the discharge instructions differ from prior meeting discussion plans, the ECM will follow up on the rationale for the changes and will also outreach to the member and other individuals of the team to provide an update and assess the Members current needs/status.
		Date(s) of follow-up action(s) taken: 01/2016 – 05/2016	Quality Treatment Record reviews are conducted every three years based on the re-credentialing cycle. The benchmark for performance is 80%. Any provider with scores below 80% is asked to complete a Quality Improvement Plan. Once the Quality Improvement Plan has been accepted, the provider will be monitored every three months for improvements. Additionally, providers who meet the threshold are now asked (starting with providers credentialed January 2016) to provide a brief statement of improvement for any section score that did not meet 80%. PerformCare continues to monitor the TRR scores, and utilizes information from low scoring LOC, sections, and indicators to develop future webinars, technical assistance, and provider education.
		Date(s) of follow-up action(s) taken: 01/2015 – 05/2016	Local Care Managers are continuing to expand their caseloads. Active Care Management strategies continue for PerformCare Clinical Care Managers through Enhanced Care Management (ECM). In 2015, we added the FF Field Care Managers (FCMs), increasing the ECM to nine PerformCare staff, with plans to expand in 2016. Active Care Management staff has increased to five local care management staff. • PerformCare achieved a 100% score on the NCQA accreditation survey in 2015. • All CCMs who complete pre-authorizations for mental health inpatient treatment also complete initial ANSA to identify and refer those who would benefit from ECM, and to identify any barriers that should be addressed during the MHIP stay. In doing so, the CCM will then partner with the MHIP facility to ensure barriers are addressed; with intent of ensuring Member has a successful transition to ambulatory care. • During the course of the inpatient stay, PerformCare Clinical Care Managers (UM and ECM) provide information to the inpatient unit regarding Members treatment history, patterns of follow through with recommendations, barriers to following their recovery plan, and their pattern of engagement with Providers, in

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			an effort to engage and motivate the Members to attend follow up care. PC CCM continue to encourage collaboration and encourage the use of non-traditional services such as MPN, Psych Rehab, diversion programs, and other services as appropriate and based on the Members needs. ECM will inform the inpatient facility of services the Members is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning.
		Date(s) of follow-up action(s) taken: 07/2015 – 05/2016	PerformCare conducted meetings with all 4 hospitals selected for the Discharge Management Plan Audits in July and August of 2015 to review the results of the DMP audit, to review opportunities for improvement, and to review expectations. A review of these facilities was completed, and Meetings were also held with the second round of four facilities in May 2016. During these visits, PerformCare reviewed the results of the audit, and again held extensive discussions regarding the need for Providers to assess barriers early during a MHIP and address identified barriers to completing follow-up appointments with Providers.
		Date(s) of follow-up action(s) taken: 01/2015 – 05/2016	• Pyramid Healthcare expanded existing services within the TMCA contract to include a dually licensed Mental Health/Substance Abuse (MH/SA) OP Clinic. • Guadenzia began providing SA OP services in Fulton County in March 2016 and added SA IOP services in June 2016. • VisionQuest/LodgeQuest Behavioral Health began providing MH OP clinic services in the Franklin/Fulton contract with the clinic being located in Chambersburg, PA. • Keystone Rural Health Center FQHC hired a LCSW to work out of their Pediatric office in order to assess all Members that the Pediatricians want to refer for MH/BH services. This allows for a brief amount of therapy sessions to be conducted by the LCSW or referral for those who may be in need of longer term therapy services. Resources and referral information will also be provided to families upon request. • Cornerstone continues to provide the Crisis Bridge Program in cooperation with Somerset Hospital. Utilization of this service has been lower than anticipated. This may be due to the exclusion criteria which states any Member involved with Blended Case Management cannot receive this service
		Date(s) of follow-up action(s) taken: 07/2015 – 05/2016	Provider trainings have been / will be offered to support the recovery initiative, discharge planning. PerformCare continues to offer reimbursement to all Network Providers for trainings on best practice topics such as recovery, autism, CANS.

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			• PerformCare has reimbursed 4 different providers for staff trainings. Here is a list of some trainings provided by PerformCare: • MH IP/EAC webinar on August 26, 2015, a TRR tool changes and updates webinar for 2016 on August 27, 2015, and MH OP Treatment Record Review webinar on August 28, 2015. • Mental Health First Aid for youth one or two day trainings were held on July 8, 2015 and July 9, 2015, July 29, 2015 and July 30, 2015, August 10, 2015 and August 11, 2015, August 17, 2015, October 9, 2015 and October 16, 2015, October 12, 2015, October 19, 2015, November 24, 2015 and November 25, 2015, January 15, 2016 and January 16, 2016. March 18, 2016. • Mental Health First Aid for adults or older adults one and two day trainings were held with providers or community agencies on August 10, 2015 and August 11, 2015, August 13, 2015 and August 14, 2015, September 15, 2015 and September 22, 2015, September 21, 2015, September 23, 2015 and September 30, 2015, October 7, 2015 and October 14, 2015, November 5, 2015 and November 6, 2015, January 28, 2016 and January 29, 2016, March 29, 2016 and March 31, 2016, April 19, 2016, • CANS trainings were held on October 13 & 14, 2015. • WRAP trainings were held on October 15, 2015 and October 16, 2015, March 31, 2016, April 4, 2016, • Motivational Interviewing trainings were held on January 21, 2016 and January 22, 2016. • Safetalk trainings were held on June 9, 2016 and June 10, 2016. • Assist trainings were held on May 23, 2016 and May 24, 2016. • Question, Persuade and Refer (QPR) Suicide Prevention Trainings were held on April 24, 2016, March 21, 2016 and May 10, 2016. • Suicide Prevention Resource Center (SPRC) training was held on March 30, 2016. • First Call Trainings was held on May 25, 2016. • TF-CBT (Trauma-focused Cognitive Behavioral therapy) training was held on May 19 & 20, 2016. • Mental Health First Aid for youth one or two day trainings were held on July 8, 2015 and July 9, 2015, July 29, 2015 and July 30, 2015, August 10, 2015 and August 11, 2015, August 17, 2015, October 9, 2015 and October 16, 2015, October 12, 2015, October 19, 2015, November 24, 2015 and November 25, 2015, January 15, 2016 and January 16, 2016. March 18, 2016.

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			• The following webinars are posted to the PerformCare website, available to providers: o Mindfulness, Compassion & Resilience in Trauma Therapy o Understanding & Treating Complex Trauma in Children
		Date(s) of future action(s) planned: 06/13 & 06/14/2016 06/30 & 07/01/2016	Scheduled Provider trainings TF-CBT – BHSSBC and TMCA selected Providers – targeted audience is Therapist working in OP, BHRS and FBMH FBA – All Network Providers
		Date(s) of follow-up action(s) taken: 08/2015 – 05/2016	Expand MHIP TRR indicators to include PIP DMP requirements-completed August 2015. • The QI department has added indicators to the TRR tools for MHIP to assess for: complete medication reconciliation on admission, complete appointment information on the discharge paperwork provided to Member (to include names of provider, provider address, appointment date and time, phone number, and level of care for all aftercare resources), and Medication reconciliation at discharge to include all components as noted in the PIP DMP components. – started utilizing tool in November 2015. TRR tools are re-evaluated and updated on an annual basis. During this re-evaluation, PerformCare analyzing individual scores on each indicator to determine whether or not an indicator will remain or be removed. • TRR results are monitored yearly by the QI Department. Results are reported at monitoring meetings such as Credentialing Committee, QI-UM Committee, and at PAC. • A TRR Webinar was held on August 26, 2015. In addition, the webinar was posted to the PerformCare website following the initial training, to ensure that all providers have the opportunity to view, even if they are unable to attend the live webinar. –completed. • PIP indicators are monitored by PerformCare staff assigned to this project following each DMP abstraction. • PIP follow-up visits with facilities stressing the importance of clear and legible discharge instructions. As of July 2016, 8 on-site visits have occurred, and five additional phone discussions were held offering technical assistance and additional education re: the importance of clear, legible discharge instructions.
		Date(s) of follow-up	Monitor PIP Indicators

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		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		action(s) taken: 04/2016	• PerformCare Clinical Care Managers complete discharge reviews on all members and discuss any barriers to aftercare. They also confirm that medication reconciliation has been completed on member's leave services. This began in April 2016. • In the future, templates created in Jiva will prompt CCM's to ensure that discharge instructions have been reviewed with member, that they are understandable and completed in recovery-oriented language. An example would be shortened versions of the aftercare plan that a member can place on his/her refrigerator or purse/wallet in addition the required information needed at time of discharge. • PerformCare staff (ECM/MSS) will continue follow up calls to ensure Member understands d/c instructions, confirm date and time of f/u appointment, verify plan to attend appointment, and assist with rescheduling appointments when necessary. PerformCare staff also verifies contact phone number and address. • ECM/MSS will call the Member weekly until the follow-up appointment date to provide any assistance needed and to remind Member of the follow-up appointment date and time, MSS will call the Member the business day following the scheduled follow-up appointment to verify that the Member attended the appointment o If Member did not attend, MSS will elicit and assist with barriers to treatment and assist with rescheduling the follow-up appointment, as necessary. o If a member is involved with TCM/ACT, MSS/ECM will request the caseworker outreach as well to the member regarding aftercare services when the ECM/MSS has not been successful with contact.

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, PerformCare began to address opportunities for improvement related to Standards 23, 28, 60, 68, 71, 72 and 99. Proposed actions and evidence of actions taken by PerformCare 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 PerformCare 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 2015 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, PerformCare 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**)
- Readmission Within 30 Days of Inpatient Psychiatric Discharge (**Table 20**)

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

RCA: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)		
Instructions: **For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.**		
Managed Care Organization (MCO): *PerformCare*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)*	***Response Date:*** July 27, 2016
Goal Statement: (Please specify individual goals for each measure): Short-Term Goal: Increase QI 1 HEDIS 7 Day Performance to 50% (minimum performance goal plus 1%) by the end of Measurement Year (MY) 2016. Long-Term Goal: Increase QI 1 HEDIS 7 Day Performance to 52% (2015 benchmark plus 1%) by the end of MY 2017. Please see Attachment 1: 2016 Ambulatory Follow Up Fishbone: PerformCare Ambulatory Follow UP		
***Analysis*:** **What factors contributed to poor performance?** **Please enter "N/A" if a category of factors does not apply.**	**Findings:** PerformCare's rate for MY 2014 for Q1 HEDIS 7 Day was 45.3%, an increase from PerformCare's rate for MY 2013 which was 43.1% (an increase of 2.2%); for 2012 rate was 47.2%.	
Policies (1) (e.g., data systems, delivery systems, provider facilities) 1. Provider Network 2. HealthChoices Contract Specifications 3. Health Insurance Portability and Accountability Act (HIPAA) of 1996	***Initial Response*** • PerformCare's reporting capabilities have improved through the development and expansion of an Informatics department. Challenges to timely and efficient data handling to support the identification of trends and details related to ambulatory follow up exist. Additional attention should be focused on improving the clinical documentation system (eCura™, Information System). • The quality control of PerformCare's measurement year (MY) 2014 Follow-Up rates for PerformCare identified that numerator compliant codes were not being captured. This information was presented to the programmer responsible for preparing the outbound files. Research revealed that the Structured Query Language (SQL) code was silent for 8 National Codes: 90832, 90833, 90834, 90836, 90837, 90838, 90839 and 90840. The SQL code was amended to contain these codes. PerformCare provided full disclosure of this error and its associated impacts to Office of Mental Health and Substance Abuse Services (OMHSAS) in 2015. • PerformCare is currently unable to rely on the current formal reporting to include details on race, correlations to readmissions, Targeted Case Management (TCM) involvement, and medication compliance. • The data collection to support Provider Profiling is limited by the data stored within the clinical documentation system (eCura™); Provider-specific follow-up rates, average length of stay, and readmission rates are accessible in this system. • PerformCare Associates continue to complete some data collection/processing manually which is labor intense • eCura™, utilized by clinical care managers (CCM), inhibits the ability to pull meaningful data;	

PerformCare is moving towards a new system by January 2017

Root Cause: PerformCare does not consistently use their available data for quality improvement initiatives and some reportable data does not allow for correlations and trending that could guide appropriate interventions or make changes in the system.

Follow-up Status Response

Policies (2)
(e.g., data systems, delivery systems, provider facilities)

1. Provider-Psychiatrists

Initial Response

- The current network of psychiatric service Providers may impede follow up. There is a shortage of psychiatrists within PerformCare's Provider Network. The rural counties of Bedford, Fulton and Somerset have been issued a Professional Shortage Designation by the Department of Health. While tele psychiatry has been developed throughout the network, opportunities to expand this resource along with traditional psychiatrists continue to be pursued through Network Operations.
- Interventions aimed at improving access to psychiatric appointments include encouraging Providers to take advantage of the Professional Shortage Designation status. Once Providers become an official site, they are able to attract psychiatrists with J1 visas and the psychiatrist can then benefit from student and education loan forgiveness.
- From January 1, 2015-May 30, 2016, three new Providers of tele psychiatry were added (over six different sites), throughout the PerformCare network.
- Enhancements to PerformCare's Behavioral Health Services of Somerset and Bedford Counties (BHSSBC), Capital Area Behavioral Health Collaborative (CABHC) and Tuscarora Managed Care Alliance (TMCA) contracts for 2015 included Fifty Six (56) new Providers (46 were individual practitioners including 19 psychiatrists.
- Table 1 below provides an overview of Mental Health Outpatient (MH OP) Therapy and Evaluation Routine Access (7 day Standard) for 2015:

Table 1: MH OP Therapy and Psychiatric Evaluations Routine Access 2015

	BHSSBC	CABHC	TMCA	Network
MH OP Therapy				
0-17	71.9%	74.9%	72.1%	74.4%
18+	68.0%	71.8%	77.3%	72.0%
Total	69.7%	73.3%	74.5%	73.1%
MH OP Psych Evals				
0-17	24.1%	9.0%	36.1%	15.5%
18+	8.7%	6.5%	30.3%	10.5%
Total	14.1%	7.5%	33.0%	12.6%

Root Cause Analysis: There is a shortage of psychiatrists across the network which could lead to

inability to be seen within the 7 day timeframe.

Follow-up Status Response

Procedures (1)
(e.g., payment/reimbursement, credentialing/collaboration)

1. Quality Improvement (QI) Treatment Record Review Process
2. Discharge Management Planning.

Initial Response

- The treatment record review (TRR) process for Mental Health Inpatient Providers includes a section related to adequate discharge planning and adherence to recovery principles. While scores have improved, results from 2015 reveal Providers are still in need of education regarding discharge planning best practices. Table 2 presents the scores.

Table 2: Discharge Planning and Recovery Orientation TRR section scores

	Discharge Planning/Summary	2015	2014	2013
8.4	Does the record contain evidence that attempts were made to strengthen community and natural supports throughout treatment, to assist the Member in preparing for discharge?	76%	78%	not on tool
8.8	Was the TCM included in the discharge planning process (if currently involved)?	90%	79%	59%
8.9	Is there a relapse prevention plan (post-discharge) that reflects what steps the Member should take if symptoms escalate which includes activities based on strengths? (Must consist of phone numbers for all) A) Natural supports, B) Provider(s), and C) Crisis Intervention.	32%	44%	27%
8.11	Is there documentation that Provider ensured Member had adequate transportation to attend aftercare services (given information on MA transportation, public transportation, discussion of use of natural supports)?	73%	not on tool	not on tool
8.12	Are the discharge instructions recovery-oriented (not medical model)? (include Member words, recovery principles, relapse management)	57%	66%	32%
	Recovery Orientation (all sections)	**2015**	**2014**	**2013**
9	Does the record contain evidence of person-centered language (i.e. avoiding use of "client" or "patient"; including Member and family names; record is individualized)?	22%	52%	26%

9.3	Does the record contain evidence that efforts were made to strengthen natural and community supports (i.e. supports used in treatment; suggestions made for increasing natural supports; review of the Member's social role or strengthening involvement with community supports)?	81%	83%	72%
9.7	Are Member strengths incorporated into all areas of treatment (intake, treatment plans, recovery/crisis plans, groups)?	53%	28%	8%
9.8	Is there documentation that educational/vocational options/strategies were discussed with the Member?	55%	76%	69%

- The 2014 Performance Improvement Project (PIP), Successful Transition to Ambulatory Care, required that PerformCare conduct a structured review of inpatient facility discharge management plans (DMP). The initial four pilot hospitals were chosen because we based on IPRO parameters and PerformCare's decision to engage hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our CABHC network. The additional two hospitals, Chambersburg Hospital and Somerset Community Hospital, are representative of our TMCA and BHSSBC contracts respectively. The second phase of the DMP core measure included four additional hospitals that serve more than 100 Members in a calendar year. These four facilities included: Lancaster General Hospital, Lancaster Regional Hospital, Pennsylvania Psychiatric Institute, and Holy Spirit Hospital. The DMP audit tool included an analysis on medication reconciliation. The findings are provided in Table 3.

Table 3: PIP DMP results for 2014 and 2015

Outcome Measures: PIP DMP	2014 Baseline			2015y Measurement		
	N	D	%	N	D	%
DMP Pilot Facilities:						
N1: Presence of a DMP	120	120	**100.0**	119	120	**99.2**
N2: Documentation DMP was sent home	40	120	**33.3**	43	120	**35.9**
N3: Complete Medication Reconciliation	21	120	**17.5**	44	120	**36.7**
N4: F/U visit scheduled 0-7 days	60	120	**50.0**	68	120	**56.7**
N5: F/U visit scheduled 0-14 days	77	120	**64.2**	89	120	**74.2**
N6: F/U visit scheduled 0-14 days and kept	58	77	**75.3**	60	89	**67.4**
DMP Phase II Facilities:						
N1: Presence of a DMP	n/a	n/a	n/a	119	120	**99.2**
N2: Documentation DMP was sent home	n/a	n/a	n/a	83	120	**69.2**
N3: Complete Medication Reconciliation	n/a	n/a	n/a	26	120	**21.7**

N4: F/U visit scheduled 0-7 days	n/a	n/a	n/a	75	120	**62.5**
N5: F/U visit scheduled 0-14 days	n/a	n/a	n/a	92	120	**76.7**
N6: F/U visit scheduled 0-14 days and kept	n/a	n/a	n/a	67	92	**72.8**

- This data indicates low scores for follow-up rates. PerformCare found that Providers are not consistently scheduling Members for appointments within 0-14 days and rates are higher when these appointments are scheduled.
- During reviews and follow-up meetings with Providers, the following reasons were mentioned for not scheduling appointments as required: Against Medical Advice (AMA) discharges, lack of available Providers and/or appointments with preferred Providers, Member preference to schedule themselves, blatant refusal to attend aftercare, Member relocation outside of area, Provider reporting walk-in accommodations, and outpatient Providers did not return phone calls to discharge coordinator before Member was discharged.
- Medication reconciliation of the eight PIP hospitals revealed multiple examples of medication reconciliation sheets not matching discharge plans. These examples included missing home medications, changes in dosage, and avoidance of opioids and other controlled substances. As noted above, even after an initial review and education, pilot hospital scores remain low, with improvement only to 36.7%. Mental Health Outpatient Providers (MH OP) have reported to PerformCare that the incongruence between the discharge plan and the outpatient discharge list confuses the Member, leading to non-compliance and readmission.
- PerformCare recognizes that Providers are not doing early discharge planning, and collaborating among other team members. This has been identified primarily during care management activities.

Root Cause: Best Practice Discharge procedures are not completely being followed by many Mental Health Inpatient (MH IP) Providers. This could lead to Member's lack of engagement in aftercare and compliance with medications. There is a lack of involvement from family and natural supports, as well as a lack of collaboration with Member's team members, including Primary Care Physicians (PCP), case managers (CM), Juvenile Probation Office (JPO), Children and Youth Services (CYS), Mental Health (MH) /Substance Abuse (SA) Providers and school at times.

Follow-up Status Response

People (1)
(e.g., personnel, provider network, patients)

1. Member
2. Quality Care Manager
3. Provider Network

Initial Response

- Providers appear to lack the knowledge, ability and skills to engage or motivate the Member into treatment through while on the MH IP unit. Some Providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way.
- There appears to be a lack of Member understanding of Recovery principles, treatment options and the link between follow up treatment and relapse prevention. Staff including Enhanced Care Managers, Utilization Management Care Managers, and Follow-up Specialists, have reported that Members report a lack of involvement in discharge planning and the significance of follow-up

appointments.

- Additional indicators supporting the lack of Member engagement are noted in the Table 4 (other indicators regarding Recovery/discharge planning were reported earlier).

Table 4: Other TRR Indicators for Recovery/Discharge Planning

3	***Multidisciplinary Treatment Plan***	**2015**	**2014**	**2013**
3.6	Does the treatment plan contain measurable discharge criteria and clear aftercare plan?	42%	not on tool	not on tool
3.10	Is the treatment plan recovery-oriented (use of Member words, actions, plans, goals)?	36%	46%	19%
10	***Quality Indicator Multidisciplinary Treatment Plan***	**2015**	**2014**	**2013**
10.3	Are empirically-based or evidence-based treatment packages being utilized?	58%	33%	16%

- Provided education on various topics related to evidenced base practice, engagement, and recovery
- During the Performance Improvement Project DMP (Discharge Management Plan) record reviews, it was noted that Provider discharge instructions do not always clearly identify the Provider name, address, phone number, and level of care (LOC) along with appointment dates/times. PerformCare added indicators to the MH IP Treatment Record Review tool for 2015 and 2016. PerformCare provided technical assistance to Providers during DMP follow-up visits and during TRRs to address this. PerformCare CCMs changed their process to ensure collaboration and Member-focused discharge planning occurs throughout the MH IP stay, and addresses barrier interventions to ensure Members are able to remain in the community.
- PerformCare staff educated Providers on the importance of recovery, and encouraged the use of evidence-based programming during MH IP treatment record reviews. Provider scores increased, and some Providers reported that they are now utilizing workbooks and programs identified on the National Registry of Evidence-based Programming and Practices (NREPP).

Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.

Follow-up Status Response

People (2)
(e.g., personnel, provider network, patients)

Initial Response

- PerformCare has currently 130 adult Members designated as complex, 357 Members in Care Monitoring, 384 adults in Enhanced Care Management, 119 adult Members designated as chronic

RCA: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)	
1. Members with co-occurring 2. Members complex medical conditions 3. Children/Adolescents with Autism	and 124 Members designated as SA Active Case Management. • PerformCare has identified 1,992 children and adolescents in treatment for Autism and an additional 483 children with Developmental Disabilities Complex designation and 783 children designated as complex. • Members with complex and co-occurring disorders make recovery more challenging. They have psychosocial stressors, additional barriers, physical health conditions, and lack supports. PerformCare implemented the Adult Needs and Strength Assessment (ANSA) in May of 2016. CCMs were certified to use the ANSA. This provides a better overall understanding for CCMs on barriers to treatment. • During the PIP it was also noted that Providers of MHIP treatment are reluctant to address co-occurring issues, including opioids and benzodiazepines. • PerformCare CCMs complete Provider performance for MH IP Providers who do not screen for SA issues. Account Executives use these indicators to provide regular feedback to Providers. • PerformCare CCMs complete referrals to physician advisors for Providers who are not appropriately addressing co-occurring concerns or prescribing inappropriately. If concerns continue, these quality issues are sent to the quality department for further review. • The need for release of information (ROI) creates an added barrier and time delay, in Provider's ability communicate. Additionally, PA and Federal Protection Laws regarding the transmission of information for Members with SA/HIV concerns create additional barriers. • Members with complex needs require additional input from team Members, and Providers of all LOC report multiple barriers to coordination; including but not limited to a lack of Member reporting MHOP/SAOP Providers to the MH IP Provider, a lack of releases for communication, difficulty connecting telephonically during a short hospitalization. • Members who are struggling with SMI may be unable to provide reliable information to MHIP Providers, further contributing to an inability to locate and coordinate with OP Providers. • PerformCare has created a TRR tool for Providers of FQHC services, and met with the four Providers of services in the capital and Franklin/Fulton regions to review the tool. In doing so, PerformCare QI staff reviewed the expectation that all Members over the age of 10 have appropriate SA and trauma screenings to ensure appropriate referrals and treatment. The tool is expected to be released to Providers by the end of 2016. • There was an increase in utilization of behavioral health treatment in the FQHC settings in 2014. There were 3438 Members treated in 2014, in comparison to 1405 Members in 2013. Table 5 provides the breakdown by county and age group. Table 5: Members in Treatment at a FQHC

Age Group	CU	DA	LA	LB	PE	FF	BS
0-17	80	71	32	8	6	516	12
18 >	178	383	80	39	28	977	29
Totals	**258**	**454**	**112**	**47**	**34**	**1493**	**41**

This data shows that TMCA has the largest number of Members utilizing treatment at a FQHC.

Root Cause: Co-Occurring and other Complex Conditions makes recovery more difficult for the Member and coordination among Providers more challenging.

Follow-up Status Response

People (3)
(e.g., personnel, provider network, patients)

1. Mental Health Inpatient Providers

Initial Response

- The PIP process revealed an underutilization of community based recovery services (Mobile Psychiatric nursing, Psych Rehab, Peer Support Specialist), a lack of clinically sound discharge management plans created by Mental Health Inpatient Providers, poor medication adherence upon discharge, and lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there was a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay. There is a lack of active discharge planning. There are insufficient protocols by the Providers on the needs and time frames for medication reconciliation, engagement in recovery services, and successful scheduling of follow up visits.
- Fractured discharge/transition programs – as IPRO's literature review notes, a clinically sound discharge/transition program is essential for successful transitions to ambulatory care. In our analysis, we have found that the bridge programs in our network are lacking in the following areas:
  - Communication & follow-through deficits through the inpatient and transition processes
    - Within PerformCare – there is no one, central document where a discharge management plan of a consumer is developed and tracked over time. While every client has a chart in PerformCare's electronic medical record (EMR) in eCura™, each event is distinct.
    - While the notes can be looked at back and forth, one central Member Recovery Management Plan (RMP) located in PerformCare's EMR and developed over time would allow us to better manage the communication within and beyond, see below, our organization in regards to cases transitioning to ambulatory care.
    - Beyond PerformCare – if communication within PerformCare is fractured, amongst different entities (case management firms, the hospital, psychiatric outpatient Providers, etc.) working with one Member is even more fractured. For instance, through the focus groups we learned that it is not uncommon for a treatment team meeting to come to a conclusion on a Member's discharge that is not communicated to the case manager leading the discharge (because of shift changes in the hospital, different case managers

come in and out, and communication can be porous). Thus, a centralized Recovery Management Plan that is built with all relevant parties while a Member is in the hospital and that PerformCare can use to track the Member's progress through his/her inpatient stay and beyond, as well as prompt all Providers to adhere to, would significantly improve communication.

- Although the utilization of mobile psychiatric nursing (MPN) has increased over the past two years, this is part due to the addition of another Provider. Utilization of MPN could increase to meet the needs of Members who are not successful in traditional outpatient. Additionally, the use of peer support specialists (PSS), assertive community team (ACT) and Psychiatric Rehabilitation (Psych Rehab) are underutilized as noted in the tables 6 through 9 below:

Table 6: Number of Unique Members receiving MPN

	10/1/2014-9/30/2015	10/1/2013-9/30/2014	10/1/2012-9/30/2013
Number of Members receiving MPN	283	214	189

Table 7: Number of Unique Members receiving PSS

	April 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2016	Jan 2016	Feb 2016	Mar 2016
Unique Members in PSS	205	215	193	203	209	216	226	226	226	216	210	230

Table 8: Number of Unique Members receiving ACT

	CY 2013	CY 2014	CY 2015
Unique Members in ACT	186	173	178

	12 month average (April 2014-March 2015)	12 month average (April 2015-March 2016)
Unique Members in Psych Rehab	97	105

Table 9: Number of Unique Members receiving Psych Rehab

- Provider Education through the PIP DMP visits by PC, including Medical Director, Executive Director, and representatives from the Clinical Department, Quality Management Department, and Informatics. These visits included lengthy and thorough discussions on discharge procedures, the importance of involving natural supports, community supports, and Providers in discharge discussions, and early discussions of aftercare to alleviate barriers.

<table>
<tr><th colspan="2">RCA: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)</th></tr>
<tr><td></td><td>
PerformCare TRR's also reveal that Providers of MHIP services are not educating Members on the services available to them upon discharge, such as Peer Support Services. The TRR indicator and results are noted in Table 10:
Table 10: Coordination and Continuity of Care TRR Indicators
<table>
<tr><th></th><th>Coordination and Continuity of Care</th><th>2015</th><th>2014</th><th>2013</th></tr>
<tr><td>6.2</td><td>Is there documentation that Members was educated on PSS and offered a referral?</td><td>18%</td><td>20%</td><td>13%</td></tr>
</table>
Root Cause: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare.

Follow-up Status Response
</td></tr>
<tr><td><u>Provisions (1)</u>
(e.g., screening tools, medical record forms, provider and enrollee educational materials)

1. Discharge instructions
2. Provider Education
3. Enrollee Education
4. Health Records (electronic/paper)
5. Screening/assessment tools</td><td>
Initial Response

There was evidence during the DMP reviews that discharge instructions did not include clear, concise medication reconciliation; did not include appointment details (including LOC, address, phone number, and date/time), and contained information that was included to fulfill regulatory compliance guidelines. This information (such as tobacco cessation/national quit lines) at times makes the discharge instructions lengthy and difficult to navigate to important information such as appointments and medications.

Issues identified during the PIP DMP reviews in regards to discharge instructions included the following:

Multiple page discharge instructions
Poorly handwritten instructions, making them illegible
Medications including medical abbreviations such as BID, TID or not including generic and brand name

PerformCare's MH IP TRR tool for 2016 was updated to align with the PIP expectations, and PerformCare reviewed expectations regarding discharge instructions, appointments, and medication reconciliation during the TRR webinar held on 8/29/15.

Root Cause: Due to regulatory requirements, discharge instructions sheets are often lengthy and complicated, and not completed in recovery-oriented language.

Follow-up Status Response
</td></tr>
<tr><td colspan="2">Complete next page of corresponding action plan.</td></tr>
</table>

Action Plan: 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***	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
# 1 Root Cause: PerformCare does not consistently use their available data for quality improvement initiatives and some reportable data does not allow for correlations and trending that could guide appropriate interventions or make changes in the system. ***Action (1)*** • Create Benchmark Report and distribute to Providers for educational purposes and correlations. • Request Improvement of current reports to improve correlations and to improve quantitative and qualitative analysis • Develop/revise reports after integration with Jiva system – to be initiated in January 2017	• 05/216 • 09/2014 – 12/2015 • 09/2016 – 12/2017	***Initial Response*** • PerformCare has improved their reporting capability by expanding Informatics' reporting on follow up rates, length of stay, and readmission rates. Initially, PerformCare produced Benchmark reports for MH IP and SA Inpatient (IP) Providers. A Benchmark report will be developed for ambulatory services including MH OP, Blended Case Management (BCM), Peer Support, and Psychiatric Rehabilitations Services, Partial Hospitalization PHP, FBMHS, and BHRS in 2017. These Benchmark reports will allow for improved correlations and educate Providers on their own network scores based on PerformCare data. • Various reports utilized by Care Managers have been developed over the past year. o Members that have entered into acute inpatient treatment 5 times (Capital area contract) or 3 times (Bedford/Somerset and Franklin/Fulton contracts) within a 12 month period. o Effective the fall of 2015 to the present: Report of 18 and older adults that could potentially benefit from ECM based on the types and frequency of treatments they recently have received (Enhanced Care Management predictive modeling algorithm). o Effective beginning of 2014 to fall of 2015: Report of Members with high utilization of SA services including a recidivism breakdown for SA levels of care. o Review of the report identifying Members in the chronic, target populations and/or health and safety categories (Designator report). This includes the completion of Recovery Management Plans (ECM plans for assisting the Members on their caseloads) • Reports to be developed accessing routinely in fall of 2016 and through 2017 include: o Review of report showing all inpatient admissions within a given date range with option of filtering by age o Admission/Discharge treatment report used for identification and tracking of Members with 30 and 60 day re-admissions to the same or higher level of care by Provider (both MH IP and SA IP) o Clinical leadership weekly review of Members in MH IP over 14 calendar days • Reports that have been/will be requested in 2016-2017: o Real time data regarding the completion of assessments (ANSA) for inpatient admissions o Report identifying the frequency of Members identified as high scoring in the specific categories of the assessment (ANSA). o Report providing inpatient discharge status of unique Members (i.e. leaving against medical advice for SA facilities, successful discharge, behavioral discharges etc.) o Report providing the status of Members, in the ECM program, who are engaged with the supports offered as well as status of Members that are not responsive to the ECM outreach

Action Plan: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)		
		○ Report providing real time information related to the ECMs completion of a comprehensive assessment within 30 calendar days of assignment ○ Outcomes measures reports to include status of member upon discharge from the ECM program (successful, no longer eligible with HealthChoices etc.) ○ Reports to identify Member satisfaction with their involvement in the ECM program ○ Report that provides information on the frequency and variety of ECM contacts with Member and on behalf of the Member
		Follow-up Status Response
#2 Root Cause: There is a shortage of psychiatrists across the network which could lead to inability to be seen within the 7 day timeframe. ***Action (2)*** • Expand diversion programs to improve opportunities for Members to remain stable and recover in the community.	• 10/2014 – 12/2016	***Initial Response*** • BHSSBC and PerformCare will continue to meet with Cornerstone and Somerset Hospital to evaluate the Crisis Bridge Program. Data is presented by PerformCare and Somerset Hospital at these meetings which occur periodically. In the fall of 2014, as result of the presentation of data and the above discussions, the Bedford/Somerset model was adjusted so that participation shifted from an Option-In approach to an Option-Out approach. • Holcomb Diversion Program Staff and PerformCare meet regularly along with Lancaster County Crisis staff and County Administrators. Discussions surround ongoing use of the crisis diversion program instead of MH IP treatment, barriers faced in referrals and ways to increase utilization. Ninety PerformCare Members utilized this program. PerformCare considers to be an underutilization service. ***Follow-up Status Response***
#2 Root Cause: There is a shortage of psychiatrists across the network which could lead to inability to be seen within the 7 day timeframe. ***Action (3)*** • Expand tele-psychiatry and psychiatric services across the network to improve the Member opportunity and access to remain in treatment in the community	• 01/2015 – 05/2016 • 12/2016	***Initial Response*** • The total number of tele-psychiatry Providers increased in 2014 and 2015 and will be monitored through various meetings. Access to psychiatry will be monitored monthly through QI/UM. Bedford/Somerset expanded to two new Providers in 2015. Franklin/Fulton Counties an additional Provider was added in 2015.Discussions with additional Providers will occur as interest increases. Family Behavioral Resources opened three OP clinics, one in Franklin County, one in Fulton County, and one in Somerset County in 2015. Pyramid Healthcare opened an additional OP clinic in Franklin County (dually licensed) in 2015. The Capital region added three tele psychiatry Providers since in FY 2014/2015. Fourteen new psychiatrists were added to the Capital network during the same time period. • From January 2015-July, 2016 five new Providers of tele psychiatry were added (over six different sites). • BHSSBC has also recently partnered with the PA Psychiatric Leadership Council (PPLC) to work towards common goals related to psychiatric recruitment and retention. BHSSBC contracted with a psychiatric recruiter to bring psychiatrists into the Bedford/Somerset area. This recruiter is

Action Plan: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day - Ages 6-64)		
		providing monthly updates to PerformCare. • U7 modifier with psychiatric evaluations does not currently have differential payment for psychiatry evaluations. Consequently the Fee Schedule was adjusted and PerformCare will recommend to county Primary Contractors to consider providing a U7 modifier financial incentive for psychiatry evaluations that meet the 7 day standard. ***Follow-up Status Response***
#2 Root Cause: There is a shortage of psychiatrists across the network which could lead to inability to be seen within the 7 day timeframe. ***Action (4)*** • Work with Providers to brainstorm ideas related to bringing more psychiatrists to rural areas through the Professional Shortage Designation. [Bedford/Somerset (BESO) and Franklin/Fulton (FF) Counties]	• 12/2015	***Initial Response*** • A partnership between TrueNorth Wellness and the Federally Qualified Health Center (FQHC) located in Fulton County is being expanded which will target an increase in Member knowledge regarding available MH services. • To date, two Providers have received the official site status. • ACRP added 2 tele psychiatrists for the Bedford/Somerset region. • Footsteps completed their Service Description and will be submitting to the state for Telepsychiatry very soon. • DLP Conemaugh hired a psychiatrist for their Adult Inpatient Unit that will be starting July 1. They have extended a contract to another psychiatrist but no definite confirmation or start date. They continue to actively recruit. • Franklin Behavioral Resources, Franklin County, is providing tele psychiatry. ***Follow-up Status Response***
#2 Root Cause: There is a shortage of psychiatrists across the network which could lead to inability to be seen within the 7 day timeframe. ***Action (5)*** • Utilization Review Process to address barriers	• 12/2016	***Initial Response*** • During utilization reviews, PC CCM's encourage Providers to look at other options to ensure medication continuation based on both Member barriers and location. Examples would be the use of tele psychiatry for those Members in rural areas. Another example would be the use of FQHCs in available counties. ***Follow-up Status Response***
Root Cause #3: Best Practice Discharge procedures are not completely being followed by many MH IP Providers. This could lead to Member's lack of engagement in aftercare and compliance with medications. There is a lack of involvement from family and natural supports and a lack of	• 09/2015 – 12/2017	***Initial Response*** • The survey is an intervention developed for the PIP and will be monitored through that process quarterly Franklin and Fulton Counties are moving forward with survey development and was conducted in 2015. However, response rates were extremely low. The survey was not completed in other regions this time due to limited resources, however, PerformCare believes this is still a valuable intervention, and we are working towards possible completion in 2017.

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collaboration with Member's team members, including PCP, case managers, school, JPO, CYS, MH/SA Providers at times. ***Action (6)*** • Create and Distribute survey to individuals that have been readmitted within 30 days to gather information related to discharge process and Member's engagement and their perception of the planning and available supports within the community.		***Follow-up Status Response***
Root Cause #3: Best Practice Discharge procedures are not completely being followed by many MH IP Providers. This could lead to Member's lack of engagement in aftercare and compliance with medications. There is a lack of involvement from family and natural supports and a lack of collaboration with Member's team members, including PCP, case managers, school, JPO, CYS, MH/SA Providers at times. ***Action (7)*** • Engage inpatient facilities in follow up (CABHC CAP) to motivate and support the Member through transition times and improve the likelihood of follow up care	• 12/31/16	***Initial Response*** • Benchmark reports have been completed, and in the final stages of approval for distribution to mental health inpatient and SA Providers. This could motivate Providers to be more proactive with engaging natural supports when their follow up rates and readmission rates are shared. ***Follow-up Status Response***
Root Cause #3: Best Practice Discharge procedures are not completely being followed by many MH IP Providers. This could lead to Member's lack of engagement in aftercare and compliance with medications. There is a lack of involvement from family and natural supports and a lack of collaboration with Member's team members, including PCP, case managers, school, JPO, CYS, MH/SA Providers at times. ***Action (8)*** • Enhance Care Management (ECM) and Follow Up Specialists process to further encourage Member	• 04/2016 to 12/2016	***Initial Response*** • Member Services Specialists (MSS) completed a six month rapid experimentation phase, April to October 2915, to assess if this intervention improves the PerformCare HEDIS scores. ECM also completed follow up activities. The rapid experimentation phase results lead to the continuation of MSS and ECM follow up activities in 2016. This process improved the relationships with Members, encouraged Members to access and maintained community services and supports. Member Wellness calls continued the effort to engage Members at the time of MH IP discharge and increased the likelihood of Member follow up with MH OP services. • ECM/MSS contacts the Member the next business day after discharge from IP/PHP to ensure the Member understands their discharge instructions, to confirm date and time of the scheduled follow-up appointment(s); to verify whether the Member plans to attend the follow-up appointment(s); to assist with rescheduling appointments when necessary; to verify contact telephone number and address; to provide warm linkages to community resources to mitigate or

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follow up and decrease barriers.		minimize barriers to successful participation in aftercare instructions. • The ECM/MSS will call the Member weekly until the follow-up appointment date to provide any assistance needed and to remind Member of the follow-up appointment date and time, MSS will call the Member the business day following the scheduled follow-up appointment to verify that the Member attended the appointment. • If Member did not attend, MSS will elicit and assist with barriers to treatment and assist with rescheduling the follow-up appointment, as necessary. If a Member is involved with TCM/ACT, MSS/ECM will request the caseworker outreach as well to the Member regarding aftercare services when the ECM/MSS has not been successful with contact • During a Member's admission to inpatient treatment, if assigned to an ECM, the ECM will conduct all utilization management functions regarding the authorizations for treatment and gathering of clinical information related to progress. The ECM will inform the inpatient facility of services the Member is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. The ECM will request a treatment team meeting with the inpatient unit to include the Member, natural/community supports • Upon discharge from the unit, the ECM then requests clarification of the discharge plan provided to the Member. If the discharge instructions differ from prior meeting discussion plans, the ECM will follow up on the rationale for the changes and will also outreach to the Member and other individuals of the team to provide an update and assess the Members current needs/status. • PerformCare Utilization CCM's encourage discharge planning from the beginning of treatment during hospital reviews. They encourage and review Member's engagement in treatment, overall adherence with involvement in services/recovery and work with Providers on engaging family and natural supports in the treatment process, along with other important supports/services in the Member's life. This encourages a best practice approach to discharge planning. ***Follow-up Status Response***
Root Cause #4: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery. ***Action (9)*** • Provider trainings have been/ will be offered to support the recovery initiative, discharge planning. PerformCare reimburses Providers for trainings for	• 01/2015 to 06/16	***Initial Response*** • Provider Training: ○ PerformCare has reimbursed 4 different Providers for staff trainings. Here is a list of some training provided by PerformCare. There was a MH IP/EAC webinar on August 26, 2015, a TRR tool changes and updates webinar for 2016 on August 27, 2015, and MH OP Treatment Record Review webinar on August 28, 2015. ○ Mental Health First Aid for youth one or two day trainings were held on July 8, 2015 and July 9, 2015, July 29, 2015 and July 30, 2015, August 10, 2015 and August 11, 2015, August 17, 2015, October 9, 2015 and October 16, 2015, October 12, 2015, October 19, 2015, November 24, 2015 and November 25, 2015, January 15, 2016 and January 16, 2016. March 18, 2016. ○ Mental Health First Aid for adults or older adults one and two day trainings were held with

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best practice topics such as recovery, autism, CANS.		Providers or community agencies on August 10, 2015 and August 11, 2015, August 13, 2015 and August 14, 2015, September 15, 2015 and September 22, 2015, September 21, 2015, September 23, 2015 and September 30, 2015, October 7, 2015 and October 14, 2015, November 5, 2015 and November 6, 2015, January 28, 2016 and January 29, 2016, March 29, 2016 and March 31, 2016, April 19, 2016, ○ CANS trainings were held on October 13 & 14, 2015. ○ WRAP trainings were held on October 15, 2015 and October 16, 2015, March 31, 2016, April 4, 2016, ○ Motivational Interviewing trainings were held on January 21, 2016 and January 22, 2016. ○ Safetalk trainings were held on June 9, 2016 and June 10, 2016. ○ Assist trainings were held on May 23, 2016 and May 24, 2016. ○ QPR (Question, Persuade and Refer) Suicide Prevention Trainings were held on April 24, 2016, March 21, 2016 and May 10, 2016. ○ SPRC (Suicide Prevention Resource Center) training was held on March 30, 2016. ○ First Call Trainings was held on May 25, 2016. ○ TF-CBT (Trauma-focused Cognitive Behavioral therapy) training was held on May 19 & 20, 2016 and June 13 & 14, 2016. ○ The following webinars are posted to the PerformCare website, available to Providers: ➢ Mindfulness, Compassion & Resilience in Trauma Therapy ➢ Understanding & Treating Complex Trauma in Children
		Follow-up Status Response
Root Cause #4: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery. ***Action (10)*** • Enhanced Care Management Processes to further ensure Members understand the need for a good discharge management plan and natural supports to remain in the community	• 01/2016 to 12/2016	***Initial Response*** • During utilization reviews, PerformCare Clinical Care Managers discuss the importance of engaging Members in treatment decisions and ask for Member specific goals, along with a discharge management plan that Member has been a part of developing. • Effective Quarter 1 of 2016, during a Member's admission to inpatient treatment, if assigned to an ECM, the ECM will conduct all utilization management functions regarding the authorizations for treatment and gathering of clinical information related to progress. The ECM will inform the inpatient facility of services the Member is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. The ECM will request a treatment team meeting with the inpatient unit to include the Member, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan. • Upon discharge from the unit, the ECM then requests clarification of the discharge plan provided to the Member. If the discharge instructions differ from prior meeting discussion plans, the ECM will follow up on the rationale for the changes and will also outreach to the Member and other individuals of the team to provide an update and assess the Members current needs/status. • During the course of the inpatient stay, PerformCare Clinical Care Managers (UM and ECM)

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		provide information to the inpatient unit regarding Member treatment history, patterns of follow through with recommendations, barriers to following their recovery plan, and their pattern of engagement with Providers, in an effort to arm the unit with information to engage and motivate the Member to attend follow up care. • To support education to Members regarding the significance of follow up and their role in their own recovery, an ECM will outreach to the inpatient Provider and as noted above, request treatment team meetings that include the Member, request to speak directly to the Member, when appropriate go on the unit to meet with the Member and upon return to the community, the ECM outreaches to the Member to ensure the Member understands their options and their recovery plan. The ECM will help the Member assess the success of the plan and work with the Member and community based Providers on revisions needed to make the plan continue to be successful. ***Follow-up Status Response***
Root Cause #5: Co-Occurring and other Complex Conditions makes recovery more difficult for the Member and coordination among Providers more challenging. ***Action (11)*** • Member education re: importance of recovery and team approach • Provider education re: importance of recovery and team approach. • Policy and Procedure change	• 08/2015 – 12/16	***Initial Response*** • PerformCare ECMs will make outreach to Member to encourage and educate on role of team Members in assisting in successful recovery. • PerformCare will obtain ROI as necessary • The Clinical department in conjunction with the county Single County Authorities (SCAs) will be partnering to develop county specific trainings for the Targeted Case Management units on the impact of substance use/addiction on mental health issues, access to SA services, and effective discharge planning. These trainings will occur at the end of 2016 beginning of 2017 and will include presentation by the county SCA and the PerformCare county specific ECM. • For 2016, PerformCare began Provider trainings on the TRR process and tools, by means of webinars. PerformCare conducted a webinar reviewing TRR tool changes and updates for 2016 in August 2015, to prepare Providers for 2016 TRRs, which began in November 2015. Specific level of care TRR webinars began in the fall of 2015, and started with the levels of care with network averages that are the lowest. In addition, the webinars will be posted to the PerformCare website following the initial training, to ensure that all Providers have the opportunity to view, even if they are unable to attend the live webinar. • The MH IP/EAC webinar occurred on 8/26/15. • A survey to Providers will be sent to measure their experience re: coordination and collaboration with other Providers is planned for 2016. • In the BESO and FF regions, the CCISC Implementation team and Change Agent meetings do stress this and engage in brainstorming on ways to engage Members and improve coordination and collaboration between treatment team Members. PerformCare representatives actively participate in these meetings.

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		Follow-up Status Response
Root Cause #5: Co-Occurring and other Complex Conditions makes recovery more difficult for the Member and coordination among Providers more challenging. ***Action (12)*** • Provider Expansion to increase Member access to specialized treatment	• 08/2015 – 04/2016	***Initial Response*** • Pyramid Healthcare expanded existing services within the FF contract to include a dually licensed Mental Health/SA (MH/SA) OP Clinic. • Guadenzia began providing SA OP services in Fulton County in March 2016 and added SA IOP services in June 2016. • VisionQuest/LodgeQuest Behavioral Health began providing MH OP clinic services in the Franklin/Fulton contract with the clinic being located in Chambersburg, PA. • Keystone Rural Health Center FQHC hired a LCSW to work out of their Pediatric office in order to assess all Members that the Pediatricians want to refer for MH/BH services. This allows for a brief amount of therapy sessions to be conducted by the LCSW or referral for those who may be in need of longer term therapy services. Resources and referral information will also be provided to families upon request. • Cornerstone continues to provide the Crisis Bridge Program in cooperation with Somerset Hospital. Utilization of this service has been lower than anticipated. This may be due to the exclusion criteria which states any Member involved with Blended Case Management cannot receive this service. ***Follow-up Status Response***
Root Cause #5: Co-Occurring and other Complex Conditions makes recovery more difficult for the Member and coordination among Providers more challenging. ***Action (13)*** • Franklin/Fulton Co-occurring competency credential to increase qualified Providers in network	• 01/2015 – 12/2016	***Initial Response*** • This is a Provider incentive program, in which MH OP Providers must pass the COD audit with a score of 75% in all three rating areas in order to be certified for an enhanced rate. Additionally, the Provider must agree to use the COD outcomes tool in order to qualify as well. In 2015, two out of 5 Providers audited received a passing score and will get an enhanced rate. In 2016, two out of two Providers audited received a passing score and will get an enhanced rate. ***Follow-up Status Response***
Root Cause #5: Co-Occurring and other Complex Conditions makes recovery more difficult for the Member and coordination among Providers more challenging. ***Action (14)*** • Enhance care management processes to assist the Member with a recovery plan to maintain stability in the community	• 01/2015 – 12/2016	***Initial Response*** • Members with complex conditions (i.e. significant behavioral issues: psychosis, trauma, substance use, suicidality; significant physical health concerns and limited engagement in their recovery plan – determined by the comprehensive assessment, ANSA, done at the prior authorization request for inpatient treatment) are assigned to the Enhanced Care Management Program. • Members with significant and primary SA diagnoses are assigned to the ECM with certifications in addiction issues or extensive knowledge and training on co-occurring concerns. • The ECM works with the Member across the continuum of care, collaborating with involved

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		Providers and supports as the Member works on implementing and adjusting their recovery plan. The ECM works to tie together the various services to ensure the team is working collaboratively on behalf of the Member and has the necessary information to provide assistance and treatment. • The ECM outreaches to the Member when they are in the community on a routine basis regardless of the Member's location or involvement in services to continue engagement and status updates on Member stability and recovery. • During a Member's admission to inpatient treatment, if assigned to an ECM, the ECM will conduct all utilization management functions regarding the authorizations for treatment and gathering of clinical information related to progress. The ECM will inform the inpatient facility of services the Member is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. • The ECM will request a treatment team meeting with the inpatient unit to include the Member, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan. • Upon discharge from the inpatient unit, the ECM then requests clarification of the discharge plan provided to the Member. If the discharge instructions differ from prior meeting discussion plans, the ECM will follow up on the rationale for the changes and will also outreach to the Member and other individuals of the team to provide an update and assess the Members current needs/status. • The TMCA contract implemented Field Care Management in December 2015 at Roxbury and Chambersburg Hospitals. The field care managers are providing ECM and active care management for those eligible Members admitted to either hospital. ***Follow-up Status Response***
Root Cause #6: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (15)*** • Continue Quality Treatment Record (including indicators related to discharge instructions/summary, recovery orientation, and resolution of barriers.	• 01/2016 – 12/2016	***Initial Response*** • Quality Treatment Record reviews are conducted every three years based on the re-credentialing cycle. The benchmark for performance is 80%. Any Provider with scores below 80% is asked to complete a Quality Improvement Plan. Once the Quality Improvement Plan has been accepted, the Provider will be monitored every three months for improvements. Additionally, Providers who meet the threshold are now asked (starting with Providers credentialed January 2016) to provide a brief statement of improvement for any section score that did not meet 80%. • PerformCare continues to monitor the TRR scores, and utilizes information from low scoring LOC, sections, and indicators to develop future webinars, technical assistance, and Provider education. ***Follow-up Status Response***
Root Cause #6: When barriers are noted in regards to discharge from a MHIP unit, Providers are not	• 04/2016 –	***Initial Response*** • Preliminary outcomes reporting has been developed and implemented and is being

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collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (16)*** • Perform Care is making improvements to outcomes reporting specific to level of care and Provider. The outcomes reports will give detailed information on Provider Performance.	12/2017	operationalized through Quality Improvement/Utilization Management (QI/UM) Committee for monitoring so further interventions can be planned. The report is still being refined for the inpatient level of care mental health and SA. Benchmark reports are awaiting approval before distribution to Providers. ***Follow-up Status Response***
Root Cause #6: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (17)*** • Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex needs	• 01/2015 – 12/2016	***Initial Response*** (October 2016) • Local Care Managers are continuing to expand their caseloads. Active Care Management strategies continue for PerformCare Clinical Care Managers through Enhanced Care Management (ECM). In 2015, we added the TMCA Field Care Management, increasing the ECM to nine PerformCare staff, with plans to expand in 2016. Active Care Management staff has increased to five local care management staff. • PerformCare achieved a 100% score on the NCQA accreditation survey in 2015. • All CCMs who complete preauthorizations for mental health inpatient treatment also complete initial ANSA to identify and refer those who would benefit from ECM, and to identify any barriers that should be addressed during the MHIP stay. In doing so, the CCM will then partner with the MHIP facility to ensure barriers are addressed; with intent of ensuring Member has a successful transition to ambulatory care. • During the course of the inpatient stay, PerformCare Clinical Care Managers (UM and ECM) provide information to the inpatient unit regarding Members treatment history, patterns of follow through with recommendations, barriers to following their recovery plan, and their pattern of engagement with Providers, in an effort to arm the unit with information to engage and motivate the Members to attend follow up care. o PC CCM continues to encourage collaboration among Providers and team members. o PC CCM continue to encourage the use of non-traditional services such as MPN, Psych Rehab, diversion programs, and other services as appropriate and based on the Members needs. o ECM will inform the inpatient facility of services the Members is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. The ECM will request a treatment team meeting with the inpatient unit to include the Members, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan • ECMS develop a Recovery Management Plan (RMP) within the first month of assignment to a Member. The RMP outlines the Member's barriers and individualized needs identified by the Provider/support team to assist the Member in achieving a successful community tenure.

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		Follow-up Status Response
Root Cause #6: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (18)*** • Comprehensive Continuous Integrated System of Care (CCISC) Implementation has occurred in Bedford/Somerset and Franklin/Fulton Counties. • CCISC meetings and Change Agent Meetings/Trainings have occurred and are ongoing.	• 01/2015 – 12/2016	***Initial Response*** • CCISC meetings continue in the North Central Contracts. • Change Agent Meetings continue in the North Central contracts. • There was a Complex condition training started on 2/20/14 in the TMCA region • Level of care specific treatment plan trainings were completed in 2015 • Motivational Interviewing trainings completed for April and June 2016. • A Provider networking day was held on June 16, 2016. • PerformCare also has an ECM now attending the CCISC implementation group meetings and change agent meetings (along with local QI and AE representation). ***Follow-up Status Response***
Root Cause #6: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (19)*** • Discharge Management Educational Meetings through the PIP	• 07/2015 – 12/2016	***Initial Response*** • PerformCare conducted meetings with all 4 hospitals selected for the Discharge Management Plan Audits in July and August of 2015 to review the results of the DMP audit, to review opportunities for improvement, and to review expectations. A review of these facilities was completed, and Meetings were also held with the second round of four facilities in May 2016. During these visits, PeformCare reviewed the results of the audit, and again held extensive discussions regarding the need for Providers to assess barriers early during a MHIP and address identified barriers to completing follow-up appointments with Providers. ***Follow-up Status Response***
Root Cause #7: Due to regulatory requirements, discharge instructions sheets are often lengthy and complicated, and not completed in recovery-oriented language. ***Action (20)*** • Expand and Monitor TRR indicators to ensure recovery oriented principles are utilized inpatient	• 08/2015 – 06/2016	***Initial Response*** • Expand MHIP TRR indicators to include PIP DMP requirements-completed August 2015. ○ The QI department has added indicators to the TRR tools for MHIP to assess for: complete medication reconciliation on admission, complete appointment information on the discharge paperwork provided to Member (to include names of Provider, Provider address, appointment date and time, phone number, and level of care for all aftercare resources), and Medication reconciliation at discharge to include all components as noted in the PIP DMP components. –started utilizing tool in November 2015. TRR tools are re-evaluated and updated on an annual basis. During this re-evaluation, PerformCare analyzing individual scores on each indicator to determine whether or not an indicator will remain or be removed. ○ TRR results are monitored yearly by the QI Department. Results are reported at monitoring meetings such as Credentialing Committee, QI-UM Committee, and at PAC.

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		• A TRR Webinar was held on August 26, 2015. In addition, the webinar was posted to the PerformCare website following the initial training, to ensure that all Providers have the opportunity to view, even if they are unable to attend the live webinar. –completed. • PIP indicators are monitored by PerformCare staff assigned to this project following each DMP abstraction. • PIP follow-up visits with facilities stressing the importance of clear and legible discharge instructions. As of July 2016, 8 on-site visits have occurred, and five additional phone discussions were held offering technical assistance and additional education re: the importance of clear, legible discharge instructions. ***Follow-up Status Response***
Root Cause #7: Due to regulatory requirements, discharge instructions sheets are often lengthy and complicated, and not completed in recovery-oriented language. ***Action (21)*** • Monitor PIP indicators for improvement • Educate All Providers on significance of recovery principles and the correlation to follow up and readmissions.	• 04/2016 – 12/16	***Initial Response*** • PC Clinical Care Managers complete discharge reviews on all Members and discuss any barriers to aftercare. CCMs review medication reconciliation prior to Member discharge from MH IP. This began in April 2016. • In the future, templates created in Jiva Information System will prompt CCM's to ensure that discharge instructions have been reviewed with Member, are understandable and are completed in recovery-oriented language. An example would be shortened versions of the aftercare plan that a Member can place on his/her refrigerator or purse/wallet in addition the required information needed at time of discharge. • PerformCare staff (ECM/MSS) will continue follow up calls to ensure Member understands d/c instructions, confirm date and time of f/u appointment, verify plan to attend appointment, and assist with rescheduling appointments when necessary. PC staff also verifies contact phone number and address. • ECM/MSS will call the Member weekly until the follow-up appointment date to provide any assistance needed and to remind Member of the follow-up appointment date and time, MSS will call the Member the business day following the scheduled follow-up appointment to verify that the Member attended the appointment o If Member did not attend, MSS will elicit and assist with barriers to treatment and assist with rescheduling the follow-up appointment, as necessary. o If a Member is involved with TCM/ACT, MSS/ECM will request the caseworker outreach as well to the Member regarding aftercare services when the ECM/MSS has not been successful with contact. ***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

RCA: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)		
Instructions: **For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.**		
Managed Care Organization (MCO): *PerformCare*	***Measure:*** *Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)*	***Response Date:*** July 27, 2016
Goal Statement: (Please specify individual goals for each measure): Short-Term Goal: Increase QI 2 HEDIS 30 Day Performance to 74.25% (minimum performance goal plus 1%) by the end of 2016. Long-Term Goal: Increase QI 2 HEDIS 30 Day Performance to 75.25% (2015 benchmark plus 1%) by the end of 2017. Please see Attachment 1: 2016 Ambulatory Follow Up Fishbone: PerformCare Ambulatory Follow UP		
***Analysis*:** **What factors contributed to poor performance?** **Please enter "N/A" if a category of factors does not apply.**	**Findings:** PerformCare's rate for MY 2014 for QI 2 HEDIS 30 Day was 69.0%, an increase from PerformCare's rate for MY 2013 which was 66.2% (an increase of 2.9%) The rate for ages 6-64 was 69.6%. PerformCare's rate was 71.5% in MY 2012.	
Policies (1) (e.g., data systems, delivery systems, provider facilities) 1. Provider Network 2. HealthChoices Contract Specifications 3. Health Insurance Portability and Accountability Act (HIPAA) of 1996	***Initial Response*** • PerformCare's reporting capabilities have improved through the development and expansion of an Informatics department. Challenges to timely and efficient data handling to support the identification of trends and details related to ambulatory follow up exist. Additional attention should be focused on improving the clinical documentation system (eCura™, Information System). • The quality control of PerformCare's measurement year (MY) 2014 Follow-Up rates for PerformCare identified that numerator compliant codes were not being captured. This information was presented to the programmer responsible for preparing the outbound files. Research revealed that the Structured Query Language (SQL) code was silent for 8 National Codes: 90832, 90833, 90834, 90836, 90837, 90838, 90839 and 90840. The SQL code was amended to contain these codes. PerformCare provided full disclosure of this error and its associated impacts to Office of Mental Health and Substance Abuse Services (OMHSAS) in 2015. • PerformCare is currently unable to rely on the current formal reporting to include details on race, correlations to readmissions, Targeted Case Management (TCM) involvement, and medication compliance. • The data collection to support Provider Profiling is limited by the data stored within the clinical documentation system (eCura™); Provider-specific follow-up rates, average length of stay, and readmission rates are accessible in this system. • PerformCare Associates continue to complete some data collection/processing manually which is labor intense • eCura™, utilized by clinical care managers (CCM), inhibits the ability to pull meaningful data; PerformCare is moving towards a new system by January 2017	

Root Cause: PerformCare does not consistently use their available data for quality improvement initiatives and some reportable data does not allow for correlations and trending that could guide appropriate interventions or make changes in the system.

Follow-up Status Response

Policies (2)
(e.g., data systems, delivery systems, provider facilities)

1. Provider-Psychiatrists

Initial Response

- have been issued a Professional Shortage Designation by the Department of Health. While tele psychiatry has been developed throughout the network, opportunities to expand this resource along with traditional psychiatrists continue to be pursued through Network Operations.
- Interventions aimed at improving access to psychiatric appointments include encouraging Providers to take advantage of the Professional Shortage Designation status. Once Providers become an official site, they are able to attract psychiatrists with J1 visas and the psychiatrist can then benefit from student and education loan forgiveness.
- From January 1, 2015-May 30, 2016, three new Providers of tele psychiatry were added (over six different sites), throughout the PerformCare network.
- Enhancements to PerformCare's Behavioral Health Services of Somerset and Bedford Counties (BHSSBC), Capital Area Behavioral Health Collaborative (CABHC) and Tuscarora Managed Care Alliance (TMCA) contracts for 2015 included Fifty Six (56) new Providers (46 were individual practitioners including 19 psychiatrists.
- Table 1 below provides an overview of Mental Health Outpatient (MH OP) Therapy and Evaluation Routine Access (7 day Standard) for 2015:

Table 1: MH OP Therapy and Psychiatric Evaluations Routine Access 2015

	BHSSBC	CABHC	TMCA	Network
MH OP Therapy				
0-17	71.9%	74.9%	72.1%	74.4%
18+	68.0%	71.8%	77.3%	72.0%
Total	69.7%	73.3%	74.5%	73.1%
MH OP Psych Evals				
0-17	24.1%	9.0%	36.1%	15.5%
18+	8.7%	6.5%	30.3%	10.5%
Total	14.1%	7.5%	33.0%	12.6%

Root Cause Analysis: There is a shortage of psychiatrists across the network which could lead to inability to be seen within the 7 day timeframe.

Follow-up Status Response

Procedures (1)

(e.g., payment/reimbursement, credentialing/collaboration)

1. Quality Improvement (QI) Treatment Record Review Process
2. Discharge Management Planning.

Initial Response

- The record review (TRR) process for Mental Health Inpatient Providers includes a section related to adequate discharge planning and adherence to recovery principles. While scores have improved, results from 2015 reveal Providers are still in need of education regarding discharge planning best practices. Table 2 presents the scores.

Table 2: Discharge Planning and Recovery Orientation TRR section scores

	Discharge Planning/Summary	2015	2014	2013
8.4	Does the record contain evidence that attempts were made to strengthen community and natural supports throughout treatment, to assist the Member in preparing for discharge?	76%	78%	not on tool
8.8	Was the TCM included in the discharge planning process (if currently involved)?	90%	79%	59%
8.9	Is there a relapse prevention plan (post-discharge) that reflects what steps the Member should take if symptoms escalate which includes activities based on strengths? (Must consist of phone numbers for all) A) Natural supports, B) Provider(s), and C) Crisis Intervention.	32%	44%	27%
8.11	Is there documentation that Provider ensured Member had adequate transportation to attend aftercare services (given information on MA transportation, public transportation, discussion of use of natural supports)?	73%	not on tool	not on tool
8.12	Are the discharge instructions recovery-oriented (not medical model)? (include Member words, recovery principles, relapse management)	57%	66%	32%
	Recovery Orientation (all sections)	**2015**	**2014**	**2013**
9	Does the record contain evidence of person-centered language (i.e. avoiding use of "client" or "patient"; including Member and family names; record is individualized)?	22%	52%	26%
9.3	Does the record contain evidence that efforts were made to strengthen natural and community supports (i.e. supports used in treatment; suggestions made for	81%	83%	72%

	increasing natural supports; review of the Member's social role or strengthening involvement with community supports)?			
9.7	Are Member strengths incorporated into all areas of treatment (intake, treatment plans, recovery/crisis plans, groups)?	53%	28%	8%
9.8	Is there documentation that educational/vocational options/strategies were discussed with the Member?	55%	76%	69%

- The 2014 Performance Improvement Project (PIP), Successful Transition to Ambulatory Care, required that PerformCare conduct a structured review of inpatient facility discharge management plans (DMP). The initial four pilot hospitals were chosen because we based on IPRO parameters and PerformCare's decision to engage hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our CABHC network. The additional two hospitals, Chambersburg Hospital and Somerset Community Hospital, are representative of our TMCA and BHSSBC contracts respectively. The second phase of the DMP core measure included four additional hospitals that serve more than 100 Members in a calendar year. These four facilities included: Lancaster General Hospital, Lancaster Regional Hospital, Pennsylvania Psychiatric Institute, and Holy Spirit Hospital. The DMP audit tool included an analysis on medication reconciliation. The findings are provided in Table 3.

Table 3: PIP DMP results for 2014 and 2015

Outcome Measures: PIP DMP	**2014 Baseline**			**2015y Measurement**		
	N	D	**%**	N	D	%
DMP Pilot Facilities:						
N1: Presence of a DMP	120	120	**100.0**	119	120	**99.2**
N2: Documentation DMP was sent home	40	120	**33.3**	43	120	**35.9**
N3: Complete Medication Reconciliation	21	120	**17.5**	44	120	**36.7**
N4: F/U visit scheduled 0-7 days	60	120	**50.0**	68	120	**56.7**
N5: F/U visit scheduled 0-14 days	77	120	**64.2**	89	120	**74.2**
N6: F/U visit scheduled 0-14 days and kept	58	77	**75.3**	60	89	**67.4**
DMP Phase II Facilities:						
N1: Presence of a DMP	n/a	n/a	n/a	119	120	**99.2**
N2: Documentation DMP was sent home	n/a	n/a	n/a	83	120	**69.2**
N3: Complete Medication Reconciliation	n/a	n/a	n/a	26	120	**21.7**
N4: F/U visit scheduled 0-7 days	n/a	n/a	n/a	75	120	**62.5**
N5: F/U visit scheduled 0-14 days	n/a	n/a	n/a	92	120	**76.7**
N6: F/U visit scheduled 0-14 days and kept	n/a	n/a	n/a	67	92	**72.8**

- This data indicates low scores for follow-up rates. PerformCare found that Providers are not

<table>
<tr><th colspan="2">RCA: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)</th></tr>
<tr><td></td><td>consistently scheduling Members for appointments within 0-14 days and rates are higher when these appointments are scheduled.

• During reviews and follow-up meetings with Providers, the following reasons were mentioned for not scheduling appointments as required: Against Medical Advice (AMA) discharges, lack of available Providers and/or appointments with preferred Providers, Member preference to schedule themselves, blatant refusal to attend aftercare, Member relocation outside of area, Provider reporting walk-in accommodations, and outpatient Providers did not return phone calls to discharge coordinator before Member was discharged.

• Medication reconciliation of the eight PIP hospitals revealed multiple examples of medication reconciliation sheets not matching discharge plans. These examples included missing home medications, changes in dosage, and avoidance of opioids and other controlled substances. As noted above, even after an initial review and education, pilot hospital scores remain low, with improvement only to 36.7%. Mental Health Outpatient Providers (MH OP) have reported to PerformCare that the incongruence between the discharge plan and the outpatient discharge list confuses the Member, leading to non-compliance and readmission.

• PerformCare recognizes that Providers are not doing early discharge planning, and collaborating among other team members. This has been identified primarily during care management activities.

Root Cause: Best Practice Discharge procedures are not completely being followed by many Mental Health Inpatient (MH IP) Providers. This could lead to Member's lack of engagement in aftercare and compliance with medications. There is a lack of involvement from family and natural supports, as well as a lack of collaboration with Member's team members, including Primary Care Physicians (PCP), case managers (CM), Juvenile Probation Office (JPO), Children and Youth Services (CYS), Mental Health (MH) /Substance Abuse (SA) Providers and school at times.</td></tr>
<tr><td></td><td>Follow-up Status Response</td></tr>
<tr><td><u>People (1)</u>
(e.g., personnel, provider network, patients)

1. Member
2. Quality Care Manager
3. Provider Network</td><td>Initial Response

• Providers appear to lack the knowledge, ability and skills to engage or motivate the Member into treatment through while on the MH IP unit. Some Providers may not be presenting the need for follow up and the role of MH OP treatment after discharge in a positive and impelling way.

• There appears to be a lack of Member understanding of Recovery principles, treatment options and the link between follow up treatment and relapse prevention. Staff including Enhanced Care Managers, Utilization Management Care Managers, and Follow-up Specialists, have reported that Members report a lack of involvement in discharge planning and the significance of follow-up appointments.

• Additional indicators supporting the lack of Member engagement are noted in the Table 4 (other indicators regarding Recovery/discharge planning were reported earlier).</td></tr>
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Table 4: Other TRR Indicators for Recovery/Discharge Planning

3	***Multidisciplinary Treatment Plan***	**2015**	**2014**	**2013**
3.6	Does the treatment plan contain measurable discharge criteria and clear aftercare plan?	42%	not on tool	not on tool
3.10	Is the treatment plan recovery-oriented (use of Member words, actions, plans, goals)?	36%	46%	19%
10	***Quality Indicator Multidisciplinary Treatment Plan***	**2015**	**2014**	**2013**
10.3	Are empirically-based or evidence-based treatment packages being utilized?	58%	33%	16%

- Provided education on various topics related to evidenced base practice, engagement, and recovery
- During the Performance Improvement Project DMP (Discharge Management Plan) record reviews, it was noted that Provider discharge instructions do not always clearly identify the Provider name, address, phone number, and level of care (LOC) along with appointment dates/times. PerformCare added indicators to the MH IP Treatment Record Review tool for 2015 and 2016. PerformCare provided technical assistance to Providers during DMP follow-up visits and during TRRs to address this. PerformCare CCMs changed their process to ensure collaboration and Member-focused discharge planning occurs throughout the MH IP stay, and addresses barrier interventions to ensure Members are able to remain in the community.
- PerformCare staff educated Providers on the importance of recovery, and encouraged the use of evidence-based programming during MH IP treatment record reviews. Provider scores increased, and some Providers reported that they are now utilizing workbooks and programs identified on the National Registry of Evidence-based Programming and Practices (NREPP).

Root Cause: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery.

Follow-up Status Response

People (2)
(e.g., personnel, provider network, patients)

1. Members with co-occurring
2. Members complex medical conditions
3. Children/Adolescents with Autism

Initial Response

- PerformCare has currently 130 adult Members designated as complex, 357 Members in Care Monitoring, 384 adults in Enhanced Care Management, 119 adult Members designated as chronic and 124 Members designated as SA Active Case Management.
- PerformCare has identified 1,992 children and adolescents in treatment for Autism and an additional 483 children with Developmental Disabilities Complex designation and 783 children designated as complex.

- Members with complex and co-occurring disorders make recovery more challenging. They have psychosocial stressors, additional barriers, physical health conditions, and lack supports. PerformCare implemented the Adult Needs and Strength Assessment (ANSA) in May of 2016. CCMs were certified to use the ANSA. This provides a better overall understanding for CCMs on barriers to treatment.
- During the PIP it was also noted that Providers of MHIP treatment are reluctant to address co-occurring issues, including opioids and benzodiazepines.
- PerformCare CCMs complete Provider performance for MH IP Providers who do not screen for SA issues. Account Executives use these indicators to provide regular feedback to Providers.
- PerformCare CCMs complete referrals to physician advisors for Providers who are not appropriately addressing co-occurring concerns or prescribing inappropriately. If concerns continue, these quality issues are sent to the quality department for further review.
- The need for release of information (ROI) creates an added barrier and time delay, in Provider's ability communicate. Additionally, PA and Federal Protection Laws regarding the transmission of information for Members with SA/HIV concerns create additional barriers.
- Members with complex needs require additional input from team Members, and Providers of all LOC report multiple barriers to coordination; including but not limited to a lack of Member reporting MHOP/SAOP Providers to the MH IP Provider, a lack of releases for communication, difficulty connecting telephonically during a short hospitalization.
- Members who are struggling with SMI may be unable to provide reliable information to MHIP Providers, further contributing to an inability to locate and coordinate with OP Providers.
- PerformCare has created a TRR tool for Providers of FQHC services, and met with the four Providers of services in the capital and Franklin/Fulton regions to review the tool. In doing so, PerformCare QI staff reviewed the expectation that all Members over the age of 10 have appropriate SA and trauma screenings to ensure appropriate referrals and treatment. The tool is expected to be released to Providers by the end of 2016.
- There was an increase in utilization of behavioral health treatment in the FQHC settings in 2014. There were 3438 Members treated in 2014, in comparison to 1405 Members in 2013. Table 5 provides the breakdown by county and age group.

Table 5: Members in Treatment at a FQHC

Age Group	CU	DA	LA	LB	PE	FF	BS
0-17	80	71	32	8	6	516	12
18 >	178	383	80	39	28	977	29
Totals	**258**	**454**	**112**	**47**	**34**	**1493**	**41**

This data shows that TMCA has the largest number of Members utilizing treatment at a FQHC.

RCA: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)	
	Root Cause: Co-Occurring and other Complex Conditions makes recovery more difficult for the Member and coordination among Providers more challenging.
	Follow-up Status Response
People (3) (e.g., personnel, provider network, patients) 1. Mental Health Inpatient Providers	***Initial Response*** • The PIP process revealed an underutilization of community based recovery services (Mobile Psychiatric nursing, Psych Rehab, Peer Support Specialist), a lack of clinically sound discharge management plans created by Mental Health Inpatient Providers, poor medication adherence upon discharge, and lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there was a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay. There is a lack of active discharge planning. There are insufficient protocols by the Providers on the needs and time frames for medication reconciliation, engagement in recovery services, and successful scheduling of follow up visits. • Fractured discharge/transition programs – as IPRO's literature review notes, a clinically sound discharge/transition program is essential for successful transitions to ambulatory care. In our analysis, we have found that the bridge programs in our network are lacking in the following areas: o Communication & follow-through deficits through the inpatient and transition processes ➢ Within PerformCare – there is no one, central document where a discharge management plan of a consumer is developed and tracked over time. While every client has a chart in PerformCare's electronic medical record (EMR) in eCura™, each event is distinct. ➢ While the notes can be looked at back and forth, one central Member Recovery Management Plan (RMP) located in PerformCare's EMR and developed over time would allow us to better manage the communication within and beyond, see below, our organization in regards to cases transitioning to ambulatory care. ➢ Beyond PerformCare – if communication within PerformCare is fractured, amongst different entities (case management firms, the hospital, psychiatric outpatient Providers, etc.) working with one Member is even more fractured. For instance, through the focus groups we learned that it is not uncommon for a treatment team meeting to come to a conclusion on a Member's discharge that is not communicated to the case manager leading the discharge (because of shift changes in the hospital, different case managers come in and out, and communication can be porous). Thus, a centralized Recovery Management Plan that is built with all relevant parties while a Member is in the hospital and that PerformCare can use to track the Member's progress through his/her inpatient stay and beyond, as well as prompt all Providers to adhere to, would significantly improve communication. • Although the utilization of mobile psychiatric nursing (MPN) has increased over the past two years, this is part due to the addition of another Provider. Utilization of MPN could increase to meet the needs of Members who are not successful in traditional outpatient. Additionally, the use of peer

support specialists (PSS), assertive community team (ACT) and Psychiatric Rehabilitation (Psych Rehab) are underutilized as noted in the tables 6 through 9 below:

Table 6: Number of Unique Members receiving MPN

	10/1/2014-9/30/2015	10/1/2013-9/30/2014	10/1/2012-9/30/2013
Number of Members receiving MPN	283	214	189

Table 7: Number of Unique Members receiving PSS

	April 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2016	Jan 2016	Feb 2016	Mar 2016
Unique Members in PSS	205	215	193	203	209	216	226	226	226	216	210	230

Table 8: Number of Unique Members receiving ACT

	CY 2013	CY 2014	CY 2015
Unique Members in ACT	186	173	178

Table 9: Number of Unique Members receiving Psych Rehab

	12 month average (April 2014-March 2015)	12 month average (April 2015-March 2016)
Unique Members in Psych Rehab	97	105

- Provider Education through the PIP DMP visits by PC, including Medical Director, Executive Director, and representatives from the Clinical Department, Quality Management Department, and Informatics. These visits included lengthy and thorough discussions on discharge procedures, the importance of involving natural supports, community supports, and Providers in discharge discussions, and early discussions of aftercare to alleviate barriers.
- PerformCare TRR's also reveal that Providers of MHIP services are not educating Members on the services available to them upon discharge, such as Peer Support Services. The TRR indicator and results are noted in Table 10:

Table 10: Coordination and Continuity of Care TRR Indicators

	Coordination and Continuity of Care	2015	2014	2013
6.2	Is there documentation that Members was educated on PSS and offered a referral?	18%	20%	13%

Root Cause: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare.

RCA: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)	
	Follow-up Status Response
Provisions (1) (e.g., screening tools, medical record forms, provider and enrollee educational materials) 2. Discharge instructions 3. Provider Education 4. Enrollee Education 5. Health Records (electronic/paper) 6. Screening/assessment tools	***Initial Response*** • There was evidence during the DMP reviews that discharge instructions did not include clear, concise medication reconciliation; did not include appointment details (including LOC, address, phone number, and date/time), and contained information that was included to fulfill regulatory compliance guidelines. This information (such as tobacco cessation/national quit lines) at times makes the discharge instructions lengthy and difficult to navigate to important information such as appointments and medications. o Issues identified during the PIP DMP reviews in regards to discharge instructions included the following: ➢ Multiple page discharge instructions ➢ Poorly handwritten instructions, making them illegible ➢ Medications including medical abbreviations such as BID, TID or not including generic and brand name • PerformCare's MH IP TRR tool for 2016 was updated to align with the PIP expectations, and PerformCare reviewed expectations regarding discharge instructions, appointments, and medication reconciliation during the TRR webinar held on 8/29/15. **Root Cause: Due to regulatory requirements, discharge instructions sheets are often lengthy and complicated, and not completed in recovery-oriented language.** ***Follow-up Status Response***
Complete next page of corresponding action plan.	

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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***	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
# 1 Root Cause: PerformCare does not consistently use their available data for quality improvement initiatives and some reportable data does not allow for correlations and trending that could guide appropriate interventions or make changes in the system. ***Action (1)*** • Create Benchmark Report and distribute to Providers for educational purposes and correlations. • Request Improvement of current reports to improve correlations and to improve quantitative and qualitative analysis • Develop/revise reports after integration with Jiva system – to be initiated in January 2017	• 05/216 • 09/2014 – 12/2015 • 09/2016 – 12/2017	***Initial Response*** • PerformCare has improved their reporting capability by expanding Informatics' reporting on follow up rates, length of stay, and readmission rates. Initially, PerformCare produced Benchmark reports for MH IP and SA Inpatient (IP) Providers. A Benchmark report will be developed for ambulatory services including MH OP, Blended Case Management (BCM), Peer Support, and Psychiatric Rehabilitations Services, Partial Hospitalization PHP, FBMHS, and BHRS in 2017. These Benchmark reports will allow for improved correlations and educate Providers on their own network scores based on PerformCare data. • Various reports utilized by Care Managers have been developed over the past year. o Members that have entered into acute inpatient treatment 5 times (Capital area contract) or 3 times (Bedford/Somerset and Franklin/Fulton contracts) within a 12 month period. o Effective the fall of 2015 to the present: Report of 18 and older adults that could potentially benefit from ECM based on the types and frequency of treatments they recently have received (Enhanced Care Management predictive modeling algorithm). o Effective beginning of 2014 to fall of 2015: Report of Members with high utilization of SA services including a recidivism breakdown for SA levels of care. o Review of the report identifying Members in the chronic, target populations and/or health and safety categories (Designator report). This includes the completion of Recovery Management Plans (ECM plans for assisting the Members on their caseloads) • Reports to be developed accessing routinely in fall of 2016 and through 2017 include: o Review of report showing all inpatient admissions within a given date range with option of filtering by age o Admission/Discharge treatment report used for identification and tracking of Members with 30 and 60 day re-admissions to the same or higher level of care by Provider (both MH IP and SA IP) o Clinical leadership weekly review of Members in MH IP over 14 calendar days • Reports that have been/will be requested in 2016-2017: o Real time data regarding the completion of assessments (ANSA) for inpatient admissions o Report identifying the frequency of Members identified as high scoring in the specific categories of the assessment (ANSA). o Report providing inpatient discharge status of unique Members (i.e. leaving against medical advice for SA facilities, successful discharge, behavioral discharges etc.) o Report providing the status of Members, in the ECM program, who are engaged with the supports offered as well as status of Members that are not responsive to the ECM outreach o Report providing real time information related to the ECMs completion of a comprehensive

Action Plan: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)		
		assessment within 30 calendar days of assignment ○ Outcomes measures reports to include status of member upon discharge from the ECM program (successful, no longer eligible with HealthChoices etc.) ○ Reports to identify Member satisfaction with their involvement in the ECM program ○ Report that provides information on the frequency and variety of ECM contacts with Member and on behalf of the Member
		Follow-up Status Response
#2 Root Cause: There is a shortage of psychiatrists across the network which could lead to inability to be seen within the 7 day timeframe. ***Action (2)*** • Expand diversion programs to improve opportunities for Members to remain stable and recover in the community.	• 10/2014 – 12/2016	***Initial Response*** • BHSSBC and PerformCare will continue to meet with Cornerstone and Somerset Hospital to evaluate the Crisis Bridge Program. Data is presented by PerformCare and Somerset Hospital at these meetings which occur periodically. In the fall of 2014, as result of the presentation of data and the above discussions, the Bedford/Somerset model was adjusted so that participation shifted from an Option-In approach to an Option-Out approach. • Holcomb Diversion Program Staff and PerformCare meet regularly along with Lancaster County Crisis staff and County Administrators. Discussions surround ongoing use of the crisis diversion program instead of MH IP treatment, barriers faced in referrals and ways to increase utilization. Ninety PerformCare Members utilized this program. PerformCare considers to be an underutilization service. ***Follow-up Status Response***
#2 Root Cause: There is a shortage of psychiatrists across the network which could lead to inability to be seen within the 7 day timeframe. ***Action (3)*** • Expand tele-psychiatry and psychiatric services across the network to improve the Member opportunity and access to remain in treatment in the community	• 01/2015 – 05/2016 • 12/2016	***Initial Response*** • The total number of tele-psychiatry Providers increased in 2014 and 2015 and will be monitored through various meetings. Access to psychiatry will be monitored monthly through QI/UM. Bedford/Somerset expanded to two new Providers in 2015. Franklin/Fulton Counties an additional Provider was added in 2015.Discussions with additional Providers will occur as interest increases. Family Behavioral Resources opened three OP clinics, one in Franklin County, one in Fulton County, and one in Somerset County in 2015. Pyramid Healthcare opened an additional OP clinic in Franklin County (dually licensed) in 2015. The Capital region added three tele psychiatry Providers since in FY 2014/2015. Fourteen new psychiatrists were added to the Capital network during the same time period. • From January 2015-July, 2016 five new Providers of tele psychiatry were added (over six different sites). • BHSSBC has also recently partnered with the PA Psychiatric Leadership Council (PPLC) to work towards common goals related to psychiatric recruitment and retention. BHSSBC contracted with a psychiatric recruiter to bring psychiatrists into the Bedford/Somerset area. This recruiter is providing monthly updates to PerformCare.

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		• U7 modifier with psychiatric evaluations does not currently have differential payment for psychiatry evaluations. Consequently the Fee Schedule was adjusted and PerformCare will recommend to county Primary Contractors to consider providing a U7 modifier financial incentive for psychiatry evaluations that meet the 7 day standard. ***Follow-up Status Response***
#2 Root Cause: There is a shortage of psychiatrists across the network which could lead to inability to be seen within the 7 day timeframe. ***Action (4)*** • Work with Providers to brainstorm ideas related to bringing more psychiatrists to rural areas through the Professional Shortage Designation (BHSSBC and TMCA)	• 12/2015	***Initial Response*** • A partnership between TrueNorth Wellness and the Federally Qualified Health Center (FQHC) located in Fulton County is being expanded which will target an increase in Member knowledge regarding available MH services. • To date, two Providers have received the official site status. • ACRP added 2 tele psychiatrists for the Bedford/Somerset region. • Footsteps completed their Service Description and will be submitting to the state for Telepsychiatry very soon. • DLP Conemaugh hired a psychiatrist for their Adult Inpatient Unit that will be starting July 1. They have extended a contract to another psychiatrist but no definite confirmation or start date. They continue to actively recruit. • Franklin Behavioral Resources, Franklin County, is providing tele psychiatry. ***Follow-up Status Response***
#2 Root Cause: There is a shortage of psychiatrists across the network which could lead to inability to be seen within the 7 day timeframe. ***Action (5)*** • Utilization Review Process to address barriers	• 12/2016	***Initial Response*** • During utilization reviews, PC CCM's encourage Providers to look at other options to ensure medication continuation based on both Member barriers and location. Examples would be the use of tele psychiatry for those Members in rural areas. Another example would be the use of FQHCs in available counties. ***Follow-up Status Response***
Root Cause #3: Best Practice Discharge procedures are not completely being followed by many MH IP Providers. This could lead to Member's lack of engagement in aftercare and compliance with medications. There is a lack of involvement from family and natural supports and a lack of collaboration with Member's team members, including PCP, case managers, school, JPO, CYS,	• 09/2015 – 12/2017	***Initial Response*** • The survey is an intervention developed for the PIP and will be monitored through that process quarterly Franklin and Fulton Counties are moving forward with survey development and was conducted in 2015. However, response rates were extremely low. The survey was not completed in other regions this time due to limited resources, however, PerformCare believes this is still a valuable intervention, and we are working towards possible completion in 2017.

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MH/SA Providers at times. ***Action (6)*** • Create and Distribute survey to individuals that have been readmitted within 30 days to gather information related to discharge process and Member's engagement and their perception of the planning and available supports within the community.		***Follow-up Status Response***
Root Cause #3: Best Practice Discharge procedures are not completely being followed by many MH IP Providers. This could lead to Member's lack of engagement in aftercare and compliance with medications. There is a lack of involvement from family and natural supports and a lack of collaboration with Member's team members, including PCP, case managers, school, JPO, CYS, MH/SA Providers at times. ***Action (7)*** • Engage inpatient facilities in follow up (CABHC CAP) to motivate and support the Member through transition times and improve the likelihood of follow up care	• 12/31/16	***Initial Response*** • Benchmark reports have been completed, and in the final stages of approval for distribution to mental health inpatient and SA Providers. This could motivate Providers to be more proactive with engaging natural supports when their follow up rates and readmission rates are shared. ***Follow-up Status Response***
Root Cause #3: Best Practice Discharge procedures are not completely being followed by many MH IP Providers. This could lead to Member's lack of engagement in aftercare and compliance with medications. There is a lack of involvement from family and natural supports and a lack of collaboration with Member's team members, including PCP, case managers, school, JPO, CYS, MH/SA Providers at times. ***Action (8)*** • Enhance Care Management (ECM) and Follow Up Specialists process to further encourage Member follow up and decrease barriers.	• 04/2016 to 12/2016	***Initial Response*** • Member Services Specialists (MSS) completed a six month rapid experimentation phase, April to October 2915, to assess if this intervention improves the PerformCare HEDIS scores. ECM also completed follow up activities. The rapid experimentation phase results lead to the continuation of MSS and ECM follow up activities in 2016. This process improved the relationships with Members, encouraged Members to access and maintained community services and supports. Member Wellness calls continued the effort to engage Members at the time of MH IP discharge and increased the likelihood of Member follow up with MH OP services. • ECM/MSS contacts the Member the next business day after discharge from IP/PHP to ensure the Member understands their discharge instructions, to confirm date and time of the scheduled follow-up appointment(s); to verify whether the Member plans to attend the follow-up appointment(s); to assist with rescheduling appointments when necessary; to verify contact telephone number and address; to provide warm linkages to community resources to mitigate or minimize barriers to successful participation in aftercare instructions. • The ECM/MSS will call the Member weekly until the follow-up appointment date to provide any assistance needed and to remind Member of the follow-up appointment date and time, MSS will call the Member the business day following the scheduled follow-up appointment to verify that the

Action Plan: Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day - Ages 6-64)		
		Member attended the appointment. • If Member did not attend, MSS will elicit and assist with barriers to treatment and assist with rescheduling the follow-up appointment, as necessary. If a Member is involved with TCM/ACT, MSS/ECM will request the caseworker outreach as well to the Member regarding aftercare services when the ECM/MSS has not been successful with contact • During a Member's admission to inpatient treatment, if assigned to an ECM, the ECM will conduct all utilization management functions regarding the authorizations for treatment and gathering of clinical information related to progress. The ECM will inform the inpatient facility of services the Member is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. The ECM will request a treatment team meeting with the inpatient unit to include the Member, natural/community supports • Upon discharge from the unit, the ECM then requests clarification of the discharge plan provided to the Member. If the discharge instructions differ from prior meeting discussion plans, the ECM will follow up on the rationale for the changes and will also outreach to the Member and other individuals of the team to provide an update and assess the Members current needs/status. • PerformCare Utilization CCM's encourage discharge planning from the beginning of treatment during hospital reviews. They encourage and review Member's engagement in treatment, overall adherence with involvement in services/recovery and work with Providers on engaging family and natural supports in the treatment process, along with other important supports/services in the Member's life. This encourages a best practice approach to discharge planning.
		Follow-up Status Response
Root Cause #4: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery. ***Action (9)*** • Provider trainings have been/ will be offered to support the recovery initiative, discharge planning. PerformCare reimburses Providers for trainings for best practice topics such as recovery, autism, CANS.	• 01/2015 to 06/16	***Initial Response*** • Provider Training: o PerformCare PerformCare has reimbursed 4 different Providers for staff trainings. Here is a list of some training provided by PerformCare. There was a MH IP/EAC webinar on August 26, 2015, a TRR tool changes and updates webinar for 2016 on August 27, 2015, and MH OP Treatment Record Review webinar on August 28, 2015. o Mental Health First Aid for youth one or two day trainings were held on July 8, 2015 and July 9, 2015, July 29, 2015 and July 30, 2015, August 10, 2015 and August 11, 2015, August 17, 2015, October 9, 2015 and October 16, 2015, October 12, 2015, October 19, 2015, November 24, 2015 and November 25, 2015, January 15, 2016 and January 16, 2016. March 18, 2016. o Mental Health First Aid for adults or older adults one and two day trainings were held with Providers or community agencies on August 10, 2015 and August 11, 2015, August 13, 2015 and August 14, 2015, September 15, 2015 and September 22, 2015, September 21, 2015, September 23, 2015 and September 30, 2015, October 7, 2015 and October 14, 2015, November 5, 2015 and November 6, 2015, January 28, 2016 and January 29, 2016, March 29, 2016 and March 31, 2016, April 19, 2016,

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		○ CANS trainings were held on October 13 & 14, 2015. ○ WRAP trainings were held on October 15, 2015 and October 16, 2015, March 31, 2016, April 4, 2016, ○ Motivational Interviewing trainings were held on January 21, 2016 and January 22, 2016. ○ Safetalk trainings were held on June 9, 2016 and June 10, 2016. ○ Assist trainings were held on May 23, 2016 and May 24, 2016. ○ QPR (Question, Persuade and Refer) Suicide Prevention Trainings were held on April 24, 2016, March 21, 2016 and May 10, 2016. ○ SPRC (Suicide Prevention Resource Center) training was held on March 30, 2016. ○ First Call Trainings was held on May 25, 2016. ○ TF-CBT (Trauma-focused Cognitive Behavioral therapy) training was held on May 19 & 20, 2016 and June 13 & 14, 2016. ○ The following webinars are posted to the PerformCare website, available to Providers: ➢ Mindfulness, Compassion & Resilience in Trauma Therapy ➢ Understanding & Treating Complex Trauma in Children ***Follow-up Status Response***
Root Cause #4: Lack of understanding of the significance of building a therapeutic alliance with the Member to engage and motivate the Member to attend follow up care. Additionally, some Members are not educated on the significance of follow up and their role in their own recovery. ***Action (10)*** • Enhanced Care Management Processes to further ensure Members understand the need for a good discharge management plan and natural supports to remain in the community	• 01/2016 to 12/2016	***Initial Response*** • During utilization reviews, PerformCare Clinical Care Managers discuss the importance of engaging Members in treatment decisions and ask for Member specific goals, along with a discharge management plan that Member has been a part of developing. • Effective Quarter 1 of 2016, during a Member's admission to inpatient treatment, if assigned to an ECM, the ECM will conduct all utilization management functions regarding the authorizations for treatment and gathering of clinical information related to progress. The ECM will inform the inpatient facility of services the Member is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. The ECM will request a treatment team meeting with the inpatient unit to include the Member, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan. • Upon discharge from the unit, the ECM then requests clarification of the discharge plan provided to the Member. If the discharge instructions differ from prior meeting discussion plans, the ECM will follow up on the rationale for the changes and will also outreach to the Member and other individuals of the team to provide an update and assess the Members current needs/status. • During the course of the inpatient stay, PerformCare Clinical Care Managers (UM and ECM) provide information to the inpatient unit regarding Member treatment history, patterns of follow through with recommendations, barriers to following their recovery plan, and their pattern of engagement with Providers, in an effort to arm the unit with information to engage and motivate the Member to attend follow up care. • To support education to Members regarding the significance of follow up and their role in their own

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		recovery, an ECM will outreach to the inpatient Provider and as noted above, request treatment team meetings that include the Member, request to speak directly to the Member, when appropriate go on the unit to meet with the Member and upon return to the community, the ECM outreaches to the Member to ensure the Member understands their options and their recovery plan. The ECM will help the Member assess the success of the plan and work with the Member and community based Providers on revisions needed to make the plan continue to be successful. ***Follow-up Status Response***
Root Cause #5: Co-Occurring and other Complex Conditions makes recovery more difficult for the Member and coordination among Providers more challenging. ***Action (11)*** • Member education re: importance of recovery and team approach • Provider education re: importance of recovery and team approach. • Policy and Procedure change	• 08/2015 – 12/16	***Initial Response*** • PerformCare ECMs will make outreach to Member to encourage and educate on role of team Members in assisting in successful recovery. • PerformCare will obtain ROI as necessary • The Clinical department in conjunction with the county Single County Authorities (SCAs) will be partnering to develop county specific trainings for the Targeted Case Management units on the impact of substance use/addiction on mental health issues, access to SA services, and effective discharge planning. These trainings will occur at the end of 2016 beginning of 2017 and will include presentation by the county SCA and the PerformCare county specific ECM. • For 2016, PerformCare began Provider trainings on the TRR process and tools, by means of webinars. PerformCare conducted a webinar reviewing TRR tool changes and updates for 2016 in August 2015, to prepare Providers for 2016 TRRs, which began in November 2015. Specific level of care TRR webinars began in the fall of 2015, and started with the levels of care with network averages that are the lowest. In addition, the webinars will be posted to the PerformCare website following the initial training, to ensure that all Providers have the opportunity to view, even if they are unable to attend the live webinar. • The MH IP/EAC webinar occurred on 8/26/15. • A survey to Providers will be sent to measure their experience re: coordination and collaboration with other Providers is planned for 2016. • In the BESO and FF regions, the CCISC Implementation team and Change Agent meetings do stress this and engage in brainstorming on ways to engage Members and improve coordination and collaboration between treatment team Members. PerformCare representatives actively participate in these meetings. ***Follow-up Status Response***
Root Cause #5: Co-Occurring and other Complex Conditions makes recovery more difficult for the Member and coordination among Providers more	• 08/2015 – 04/2016	***Initial Response*** • Pyramid Healthcare expanded existing services within the FF contract to include a dually licensed Mental Health/SA (MH/SA) OP Clinic.

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challenging. ***Action (12)*** • Provider Expansion to increase Member access to specialized treatment		• Guadenzia began providing SA OP services in Fulton County in March 2016 and added SA IOP services in June 2016. • VisionQuest/LodgeQuest Behavioral Health began providing MH OP clinic services in the Franklin/Fulton contract with the clinic being located in Chambersburg, PA. • Keystone Rural Health Center FQHC hired a LCSW to work out of their Pediatric office in order to assess all Members that the Pediatricians want to refer for MH/BH services. This allows for a brief amount of therapy sessions to be conducted by the LCSW or referral for those who may be in need of longer term therapy services. Resources and referral information will also be provided to families upon request. • Cornerstone continues to provide the Crisis Bridge Program in cooperation with Somerset Hospital. Utilization of this service has been lower than anticipated. This may be due to the exclusion criteria which states any Member involved with Blended Case Management cannot receive this service. ***Follow-up Status Response***
Root Cause #5: Co-Occurring and other Complex Conditions makes recovery more difficult for the Member and coordination among Providers more challenging. ***Action (13)*** • Franklin/Fulton Co-occurring competency credential to increase qualified Providers in network	• 01/2015 – 12/2016	***Initial Response*** • This is a Provider incentive program, in which MH OP Providers must pass the COD audit with a score of 75% in all three rating areas in order to be certified for an enhanced rate. Additionally, the Provider must agree to use the COD outcomes tool in order to qualify as well. In 2015, two out of 5 Providers audited received a passing score and will get an enhanced rate. In 2016, two out of two Providers audited received a passing score and will get an enhanced rate. ***Follow-up Status Response***
Root Cause #5: Co-Occurring and other Complex Conditions makes recovery more difficult for the Member and coordination among Providers more challenging. ***Action (14)*** • Enhance care management processes to assist the Member with a recovery plan to maintain stability in the community	• 01/2015 – 12/2016	***Initial Response*** • Members with complex conditions (i.e. significant behavioral issues: psychosis, trauma, substance use, suicidality; significant physical health concerns and limited engagement in their recovery plan – determined by the comprehensive assessment, ANSA, done at the prior authorization request for inpatient treatment) are assigned to the Enhanced Care Management Program. • Members with significant and primary SA diagnoses are assigned to the ECM with certifications in addiction issues or extensive knowledge and training on co-occurring concerns. • The ECM works with the Member across the continuum of care, collaborating with involved Providers and supports as the Member works on implementing and adjusting their recovery plan. The ECM works to tie together the various services to ensure the team is working collaboratively on behalf of the Member and has the necessary information to provide assistance and treatment. • The ECM outreaches to the Member when they are in the community on a routine basis regardless of the Member's location or involvement in services to continue engagement and status updates on Member stability and recovery.

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		• During a Member's admission to inpatient treatment, if assigned to an ECM, the ECM will conduct all utilization management functions regarding the authorizations for treatment and gathering of clinical information related to progress. The ECM will inform the inpatient facility of services the Member is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. • The ECM will request a treatment team meeting with the inpatient unit to include the Member, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan. • Upon discharge from the inpatient unit, the ECM then requests clarification of the discharge plan provided to the Member. If the discharge instructions differ from prior meeting discussion plans, the ECM will follow up on the rationale for the changes and will also outreach to the Member and other individuals of the team to provide an update and assess the Members current needs/status. • The TMCA contract implemented Field Care Management in December 2015 at Roxbury and Chambersburg Hospitals. The field care managers are providing ECM and active care management for those eligible Members admitted to either hospital. ***Follow-up Status Response***
Root Cause #6: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (15)*** • Continue Quality Treatment Record (including indicators related to discharge instructions/summary, recovery orientation, and resolution of barriers.	• 01/2016 – 12/2016	***Initial Response*** • Quality Treatment Record reviews are conducted every three years based on the re-credentialing cycle. The benchmark for performance is 80%. Any Provider with scores below 80% is asked to complete a Quality Improvement Plan. Once the Quality Improvement Plan has been accepted, the Provider will be monitored every three months for improvements. Additionally, Providers who meet the threshold are now asked (starting with Providers credentialed January 2016) to provide a brief statement of improvement for any section score that did not meet 80%. • PerformCare continues to monitor the TRR scores, and utilizes information from low scoring LOC, sections, and indicators to develop future webinars, technical assistance, and Provider education. ***Follow-up Status Response***
Root Cause #6: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (16)*** • Perform Care is making improvements to outcomes reporting specific to level of care and	• 04/2016 – 12/2017	***Initial Response*** • Preliminary outcomes reporting has been developed and implemented and is being operationalized through Quality Improvement/Utilization Management (QI/UM) Committee for monitoring so further interventions can be planned. The report is still being refined for the inpatient level of care mental health and SA. Benchmark reports are awaiting approval before distribution to Providers. ***Follow-up Status Response***

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Provider. The outcomes reports will give detailed information on Provider Performance.		
Root Cause #6: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (17)*** • Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex needs	• 01/2015 – 12/2016	***Initial Response*** (October 2016) • Local Care Managers are continuing to expand their caseloads. Active Care Management strategies continue for PerformCare Clinical Care Managers through Enhanced Care Management (ECM). In 2015, we added the TMCA Field Care Management, increasing the ECM to nine PerformCare staff, with plans to expand in 2016. Active Care Management staff has increased to five local care management staff. • PerformCare achieved a 100% score on the NCQA accreditation survey in 2015. • All CCMs who complete preauthorizations for mental health inpatient treatment also complete initial ANSA to identify and refer those who would benefit from ECM, and to identify any barriers that should be addressed during the MHIP stay. In doing so, the CCM will then partner with the MHIP facility to ensure barriers are addressed; with intent of ensuring Member has a successful transition to ambulatory care. • During the course of the inpatient stay, PerformCare Clinical Care Managers (UM and ECM) provide information to the inpatient unit regarding Members treatment history, patterns of follow through with recommendations, barriers to following their recovery plan, and their pattern of engagement with Providers, in an effort to arm the unit with information to engage and motivate the Members to attend follow up care. o PC CCM continues to encourage collaboration among Providers and team members. o PC CCM continue to encourage the use of non-traditional services such as MPN, Psych Rehab, diversion programs, and other services as appropriate and based on the Members needs. o ECM will inform the inpatient facility of services the Members is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. The ECM will request a treatment team meeting with the inpatient unit to include the Members, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan • ECMS develop a Recovery Management Plan (RMP) within the first month of assignment to a Member. The RMP outlines the Member's barriers and individualized needs identified by the Provider/support team to assist the Member in achieving a successful community tenure. ***Follow-up Status Response***
Root Cause #6: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers,	• 01/2015 – 12/2016	***Initial Response*** • CCISC meetings continue in the North Central Contracts. • Change Agent Meetings continue in the North Central contracts.

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and to ensure a successful transition to meaningful aftercare. ***Action (18)*** • Comprehensive Continuous Integrated System of Care (CCISC) Implementation has occurred in Bedford/Somerset and Franklin/Fulton Counties. • CCISC meetings and Change Agent Meetings/Trainings have occurred and are ongoing.		• There was a Complex condition training started on 2/20/14 in the TMCA region • Level of care specific treatment plan trainings were completed in 2015 • Motivational Interviewing trainings completed for April and June 2016. • A Provider networking day was held on June 16, 2016. • PerformCare also has an ECM now attending the CCISC implementation group meetings and change agent meetings (along with local QI and AE representation). ***Follow-up Status Response***
Root Cause #6: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (19)*** • Discharge Management Educational Meetings through the PIP	• 07/2015 – 12/2016	***Initial Response*** • PerformCare conducted meetings with all 4 hospitals selected for the Discharge Management Plan Audits in July and August of 2015 to review the results of the DMP audit, to review opportunities for improvement, and to review expectations. A review of these facilities was completed, and Meetings were also held with the second round of four facilities in May 2016. During these visits, PeformCare reviewed the results of the audit, and again held extensive discussions regarding the need for Providers to assess barriers early during a MHIP and address identified barriers to completing follow-up appointments with Providers. ***Follow-up Status Response***

Root Cause #7: Due to regulatory requirements, discharge instructions sheets are often lengthy and complicated, and not completed in recovery-oriented language.
 	
Action (20)
• Expand and Monitor TRR indicators to ensure recovery oriented principles are utilized inpatient
	• 08/2015 – 06/2016	***Initial Response***
		• Expand MHIP TRR indicators to include PIP DMP requirements-completed August 2015.
		  ○ The QI department has added indicators to the TRR tools for MHIP to assess for: complete medication reconciliation on admission, complete appointment information on the discharge paperwork provided to Member (to include names of Provider, Provider address, appointment date and time, phone number, and level of care for all aftercare resources), and Medication reconciliation at discharge to include all components as noted in the PIP DMP components. – started utilizing tool in November 2015. TRR tools are re-evaluated and updated on an annual basis. During this re-evaluation, PerformCare analyzing individual scores on each indicator to determine whether or not an indicator will remain or be removed.
		  ○ TRR results are monitored yearly by the QI Department. Results are reported at monitoring meetings such as Credentialing Committee, QI-UM Committee, and at PAC.
		• A TRR Webinar was held on August 26, 2015. In addition, the webinar was posted to the PerformCare website following the initial training, to ensure that all Providers have the opportunity to view, even if they are unable to attend the live webinar. –completed.
		• PIP indicators are monitored by PerformCare staff assigned to this project following each DMP abstraction.
		• PIP follow-up visits with facilities stressing the importance of clear and legible discharge instructions.

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		As of July 2016, 8 on-site visits have occurred, and five additional phone discussions were held offering technical assistance and additional education re: the importance of clear, legible discharge instructions. ***Follow-up Status Response***
Root Cause #7: Due to regulatory requirements, discharge instructions sheets are often lengthy and complicated, and not completed in recovery-oriented language. ***Action (21)*** • Monitor PIP indicators for improvement • Educate All Providers on significance of recovery principles and the correlation to follow up and readmissions.	• 04/2016 – 12/16	***Initial Response*** • Clinical Care Managers complete discharge reviews on all Members and discuss any barriers to aftercare. CCMs review medication reconciliation prior to Member discharge from MH IP. This began in April 2016. • In the future, templates created in Jiva Information System will prompt CCM's to ensure that discharge instructions have been reviewed with Member, are understandable and are completed in recovery-oriented language. An example would be shortened versions of the aftercare plan that a Member can place on his/her refrigerator or purse/wallet in addition the required information needed at time of discharge. • PerformCare staff (ECM/MSS) will continue follow up calls to ensure Member understands d/c instructions, confirm date and time of f/u appointment, verify plan to attend appointment, and assist with rescheduling appointments when necessary. PC staff also verifies contact phone number and address. • ECM/MSS will call the Member weekly until the follow-up appointment date to provide any assistance needed and to remind Member of the follow-up appointment date and time, MSS will call the Member the business day following the scheduled follow-up appointment to verify that the Member attended the appointment o If Member did not attend, MSS will elicit and assist with barriers to treatment and assist with rescheduling the follow-up appointment, as necessary. o If a Member is involved with TCM/ACT, MSS/ECM will request the caseworker outreach as well to the Member regarding aftercare services when the ECM/MSS has not been successful with contact. ***Follow-up Status Response***

Table 20: RCA and Action Plan – Readmission Within 30 Days of Inpatient Psychiatric Discharge

RCA: Readmission Within 30 Days of Inpatient Psychiatric Discharge		
Instructions: **For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.**		
Managed Care Organization (MCO): *PerformCare*	***Measure:*** RCA: Readmission Within 30 Days of Inpatient Psychiatric Discharge	***Response Date:*** July 29, 2016
Goal Statement: (Please specify individual goals for each measure): Short-Term Goal: Decrease 30 day readmission rate to 15.3% by January 1, 2017. Long-Term Goal: Decrease 30 day readmission rate to 13.6% by January 1, 2018. Please see Attachment 1: 2014 Re-admission Fishbone		
***Analysis*: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.**	**Findings:** PerformCare's rate for MY 2014 for Readmission (30 day) was 15.9%, which indicates no change from the prior year (MY 2013 rate of 15.5%). PerformCare's rate for MY 2012 was 14.1%.	
Policies (1) (e.g., data systems, delivery systems, provider facilities) 1. Data Systems	***Initial Response*** • Current reporting is reviewed quarterly, however, it lacks the detail necessary to determine trends, identify barriers or Member specific details. Detail is reviewed manually and is not always feasible for the volume of Members served in all contracts. The data that is collected is based on claims and is therefore not considered to be "real time" reporting. • A comparison of 30 Day Readmission (REA) Rates, see Table 01, over the last three years reveals that the efforts made to reduce the Readmission Rates have been successful. All PerformCare counties, except Fulton County (remained the same) have demonstrated an overall decrease in the rates from 2014 to 2015. The network average increased from 2013 to 2014 but the 2015 rate is lower than the 2013 rate displaying an overall decrease in readmissions throughout the network.	

Table 11: Readmission Rates by County 2013 - 2015

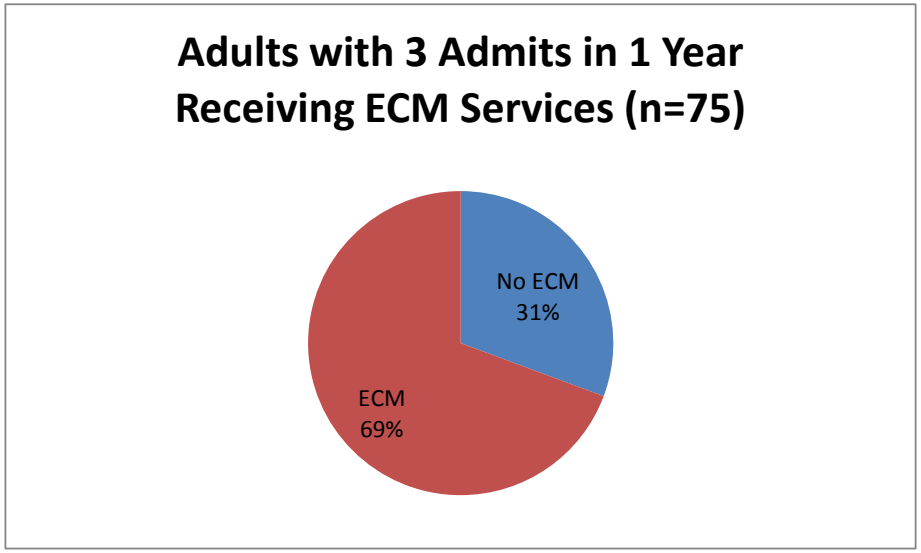
COUNTY	2013 RATE	2014 RATE	2015 RATE
Bedford	13%	15%	5%
Cumberland	12%	15%	11%
Dauphin	17%	19%	15%
Franklin	15%	11%	8%
Fulton	14%	9%	9%
Lancaster	13%	15%	13%
Lebanon	17%	18%	14%
Perry	16%	16%	10%
Somerset	14%	11%	8%
Network	14%	16%	12%

Caution should be exercised when interpreting results for small populations because large differences in rates do not necessarily mean there is a statistically significant difference in rates.

- The County specific data indicates that there is a mixture of increases and decreases amongst the individual counties across the four year period (MY 2013 to 2015):

- Franklin, Fulton, and Somerset show a rate decrease from 2013 to 2014.
- Bedford, Cumberland, Dauphin, Lancaster, and Lebanon showed readmission rate increases from 2013 to 2014.
- Perry County held steady at 16% from 2013 to 2014 but showed a 6 percentage point decrease in 2015.
- To ensure active care management, inpatient discharges are reviewed daily by clinical management to identify Members to be referred to the ECM program and other Member Monitoring initiatives.
- Analysis of recidivists in regards to appropriate profiling and active care managing
- Recognizing our problematic numbers in regards to recidivism, PerformCare wanted to do an analysis to better understand if we are identifying Members and managing Members appropriately within our care management programs. Thus we did an analysis on our current care management profiling, and how good of a job we are doing in identifying recidivists.
  - A preliminary analysis done on SMI Members with an inpatient readmit within 30 days of last discharge in the 120 day period prior, PerformCare found that all such Members are in Enhanced Care Management (N=38) – thus while this population is a driver of readmits, it is not being missed by ECM staff.
  - We then did the analysis all Adult Members with Inpatient Readmit within 30 days of last discharge in the 120 day period prior; are they being care managed at our most active care management level (Enhanced Care Management)? We identified 172 Members with at least one 30-day recidivist episode in the last 120 days, and then checked how many of them are in any of our care management programs. We found that 63% of such people are in no ECM program.
  - Next, we looked at Adult (21 and over) Members with 3 or More MHIP Admits in 1 year period prior to end date, and looked to see if they are receiving any level of ECM. We found that 31% of Members with this profile are not receiving any ECM services.

Figure 1 – Adults with 3 Admits in Year with ECM



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<tr><th colspan="2">RCA: Readmission Within 30 Days of Inpatient Psychiatric Discharge</th></tr>
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Our conclusion is that ECM services are not getting to the people who are driving our recidivism rates, and we need to improve our system of profiling and getting people into the program

Qualitative analysis of Member profiling barriers - The IPRO literature review demonstrates that good Member profiling helps identify people in need of intervention, and allows for quick and successful intervention. At this point, however, PerformCare's profiling system in regards to recidivism poses barriers.

Deficits on when we profile – In the baseline year, PerformCare only did an annual profile of recidivists. This list of names is then given to care managers to add to our enhanced care management program. This process is too slow and disjunctive from the real world realities of these Members who need to be identified right when they hit an inpatient setting, and managed appropriately while they are in crisis, not 12 months later.
Deficits of who/how we are profiling - In the baseline year, our logic for who gets on the list to be managed more intensely was limited (we primarily looked at Members hospitalized 3 times over the last year.) This is insufficient. We need to identify people who have the deficits as noted above (transportation deficits, D&A use, housing deficits, medication adherence problems, etc.) and instantly begin to address their needs and document in our PerformCare Recovery Management Plan (discussed below). Further, our profiling should not just be claims based, but must be based on information picked up during the authorization process, so that we can instantly start working with Members to help them have a successful discharge.
Deficits on what we do with profiled information. In the baseline year, our profiled patients were referred for an enhanced care management program that is not necessarily connected to managing their transition out of inpatient care. We need to have an active case management program that begins when someone is in the inpatient setting, and then follows them out into the community and to their ambulatory transition.
Business Review meetings are occurring monthly at a Director level. Quality indicators are reviewed and interventions are planned.

During follow-up visits from the PIP, several Providers noted their readmission rates were below the 10% benchmark gold standard. This was based on their own data, which includes only those Members who returned to their facility. PerformCare had previously identified that it is important to track and report readmission rates to Providers, and was in the process of developing Provider benchmark reports, which will provide more accurate readmission rates.

Root Cause: PerformCare has improved use of available data for continuous quality improvement; however, we are unable to accurately determine ALL readmission until the 30 day report is run. Additionally, Providers do not realize what their true Readmission Rate is since they do not have access to all readmission information.
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<tr><td></td><td>Follow-up Status Response</td></tr>
<tr><td></td><td></td></tr>
<tr><td><u>Procedures (1)</u>
(e.g., payment/reimbursement, credentialing/collaboration)

1. Adequate Providers with the appropriate training,</td><td>Initial Response

MH IP units report that there are not adequate Providers to provide specialized services such as DBT, TF-CBT, and EMDR for Members.
Lack of co-occurring competent Providers in the network to work with Members who are more complex which could lead to readmission instead of remaining in the community. So Perform provided trainings to improve
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certification and license to provide specialized services such as DBT, TF-CBT, EMDR and Co-Occurring disorders	competency ○ PerformCare provided Trauma Focus Cognitive Behavioral Therapy (TF-CBT) Bedford, Somerset, Franklin and Fulton Counties. Trainings in June 2015 and March 2016 for MH- OP clinicians who were seeking certification for TF-CBT. These clinicians are now eligible to take the TF-CBT Certification Test. PerformCare has received about half of the TF-CBT Certificates and will be sending out a notification to the Provider system of TF-CBT and the clinicians certified. PerformCare held an additional TF-CBT Training on June 13, 2016 and June 14, 2016 and targeted therapists working in OP, BHRS, and FBMH. ○ PerformCare provided TF-CBT trainings for Providers in the Capital region on May 19 & 20, 2016. • PerformCare provided Functional Behavioral Assessment (FBA) Training Series in July 2015 and June 2016 for all regions, and also has a webinar on Autism and Asperger Syndrome posted to the PerformCare website. **Root Cause: There are an inadequate number of Providers who are certified to provide specialized services such as Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), TF-CBT, and Providers who are Co-occurring competent in the Provider network. Without specialized services available to address specific issues such as trauma and SA Members may not receive adequate treatment needed to stay in the community.**
	Follow-up Status Response
Procedures (2) (e.g., payment/reimbursement, credentialing/collaboration) 1. Provider discharge instructions	***Initial Response*** • The PIP process revealed an underutilization of community based recovery services, a lack of clinically sound discharge management plans created by Mental Health Inpatient Providers, poor medication adherence upon discharge, and lack of adequate diversion plans for Members discharging from Mental Health Inpatient Stays. In addition, there was a lack of follow up with helpful recovery support services during the key transition period after a Mental Health Inpatient stay. There is a lack of active discharge planning. There are insufficient protocols by the Providers on the needs and time frames for medication reconciliation, engagement in recovery services, and successful scheduling of follow up visits. • Fractured discharge/transition programs – as IPRO's literature review notes, a clinically sound discharge/transition program is essential for successful transitions to ambulatory care. In our analysis, we have found that the bridge programs in our network are lacking in the following area: ○ Communication & follow-through deficits through the inpatient and transition processes ➢ Within PerformCare – there is no one, central document where a discharge management plan of a consumer is developed and tracked over time. While every client has a chart in PerformCare's EMR (eCura®), each event is distinct. While the notes can be looked at back and forth, one central Recovery Management Plan (RMP) document located in PerformCare's EMR that is developed over time would allow us to better manage the communication within our organization (and without, as we discuss below) in regards to cases transitioning to ambulatory care. ➢ Beyond PerformCare – if communication within PerformCare is fractured, amongst different entities (case management firms, the hospital, psychiatric outpatient Providers, etc.) working with one Member is even more fractured. For instance, through the focus groups we learned that it is not uncommon for a treatment team meeting to come to a conclusion on a Member's discharge, which is then not communicated to the case manager leading the discharge (because of shift

changes in the hospital, different case managers come in and out, and communication can be porous). Thus, a centralized RMP that is built with all relevant parties while a Member is in the hospital and that PerformCare can then use to track the client's progress through his/her inpatient stay and beyond, and prompt all Providers to adhere to, would significantly improve communication.

- Although the utilization of MPN has increased over the past two years, this is part due to the addition of another Provider. Utilization of MPN could increase to meet the needs of Members who are not successful in traditional outpatient. Additionally, the use of PSS, ACT and Psych Rehab are underutilized as noted below:

Table 12: Numbers of Members receiving MPN

	10/1/2014-9/30/2015	10/1/2013-9/30/2014	10/1/2012-9/30/2013
Number of Members receiving MPN	283	214	189

Table 13: Unique Members in PSS

	April 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2016	Jan 2016	Feb 2016	March 2016
Unique members in PSS	205	215	193	203	209	216	226	226	226	216	210	230

Table 14: Unique Members in ACT

	CY 2013	CY 2014	CY 2015
Unique Members in ACT	186	173	178

Table 15: Unique Members in Psych Rehab

	12 month average (April 2014-March 2015)	12 month average (April 2015-March 2016)
Unique Members in Psych Rehab	97	105

- PerformCare TRR's also reveal that Providers of MHIP services are not educating Members on the services available to them upon discharge, such as Peer Support Services. The TRR indicator and results are noted in Table 16:

Table 16: Coordination and Continuity of Care TRR Indicators

	Coordination and Continuity of Care	2015	2014	2013
6.2	Is there documentation that Members was educated on PSS and offered a referral?	18%	20%	13%

- Provider Education through the PIP DMP visits by PC, including Medical Director, Executive Director, and representatives from the Clinical Department, Quality Management Department, and Informatics. These visits included lengthy and thorough discussions on discharge procedures, the importance of involving natural

supports, community supports, and Providers in discharge discussions, and early discussions of aftercare to alleviate barriers.

Root Cause: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Member to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. When this does not occur Members are more likely to return to the hospital.

Follow-up Status Response

People (1)

(e.g., personnel, provider network, patients)

1. Clinical Care Manager
2. Follow Up Specialist
3. Member
4. QI Clinical/Manager
5. Providers- MH IP, MH OP, TCM
6. Peer Support Specialist in MH IP units
7. MHIP discharge planner

Initial Response

- Member(s) reported that they feel the discharge instructions are too confusing, they are not always included in the planning process with no input into times and dates, Provider choice of the follow up appointment and day of discharge planning appears rushed. Lastly, some Members felt the Discharge Planner was "too busy" to talk to them about details or that they needed a family Member or natural support person to be present with them when discharge information was reviewed.
- There is a lack of identified EBP initiatives to address the needs of this population; a potential barrier to reducing readmissions.
- Results of the MH IP audits indicate:
  - Collaboration with other MH Provider at the time of admission is occurring but not 100% of the time
  - Member strengths and barriers to follow up are not always identified/addressed
  - Discharge planning lacks collaboration and coordination
  - Crisis planning needs to be more inclusive of the Member's support system and supportive of recovery

Table 17: Discharge Summary and Recovery Orientation TRR Indicators

Discharge Summary:	2012	2013	2014
Were aftercare and follow-up plans identified including Natural Supports?	63%	63%	87%
Is there documentation that the Member was present and in agreement with appointments that were made for follow up?	90%	74%	86%
Was the TCM (Targeted Case Management) included in the discharge planning process (if currently involved)?	100%	59%	79%
Is there a relapse prevention plan (post-discharge) that reflects what steps the Member should take if symptoms escalate which includes activities based on strengths? (must consist of phone numbers for all) A) Natural supports, B) Provider(s), and C) Crisis Intervention.)	0%	31%	44%
Was the follow up treatment date within 7 days of discharge?	88%	65%	78%
Is there documentation in the record that the	0%	11%	17%

PerformCare Member letter was offered to Member at time of discharge?			
Are the discharge instructions recovery-oriented (not medical model)? (include Member words, recovery principles, relapse management)	0%	32%	66%
Recovery Orientation (all sections)			
Is there evidence of person-centered language?	0%	26%	52%
Is there evidence of clinician as consultant and Member as expert?	11%	67%	N/A- removed from tool
Is progress defined by Member/family?	0%	59%	86%
Have efforts been made to strengthen natural supports?	100%	72%	83%
Is the focus not simply on symptom reduction (i.e. addresses needs of Member; improves quality of life, etc.)?	100%	58%	90%
Are Member strengths incorporated into all areas of treatment (intake, treatment plans, recovery/crisis plans, groups)?	0%	8%	28%
Is there documentation that educational/vocational options/strategies were discussed with the Member?	100%	69%	76%

- A review of the TRR data over the above three year period indicates that improvements have been made in the areas of documentation of Member's barriers to follow up, the initiation of discharge planning at admission, inclusion of Natural Supports in aftercare and follow up, and Member involvement/agreement in discharge planning. PerformCare conducted a structured audit in 2014 of discharge management plans from inpatient facilities as part of the PIP in four different hospitals. The hospitals were chosen because we were prompted by IPRO to identify four hospitals for the PIP, and we thus sought out hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our network. Then, to ensure that we were generating data relevant to contracts outside of the Capital Area, we chose large hospitals in two of our other contracts, Chambersburg Hospital for Franklin/Fulton counties, and Somerset Community Hospital for Bedford/Somerset. The DMP audit tool included an analysis on medication reconciliation. The findings were:
  - Only 17.3% of 120 reviewed charts in the four identified Providers, demonstrated correct medicine reconciliation.
  - These scores are low, and as we see from the literature IPRO provides, low scores could be one of the profound negative impacts on our recidivist rates. Intervention here would be helpful, and could be tracked (Details below.)
  - PerformCare does not pay for injectable medication (J-codes) therefore we do not have claims data on this treatment.
- The PIP revealed a lack of clinically sound discharge management plans created by Mental Health Inpatient Providers, poor medication adherence upon discharge, and a lack of adequate diversion plans for Members

discharging from Mental Health Inpatient Stays.
  - Deficits in medication reconciliation from entry to exit of the hospital.

- PerformCare conducted a structured audit of discharge management plans from inpatient facilities in four different hospitals. The hospitals were chosen because we were prompted by IPRO to identify four hospitals for the PIP, and we thus sought out hospitals that are representative of our network. Two of the hospitals Philhaven Psychiatric Hospital and Roxbury Psychiatric Hospital are recidivist drivers in our network. Then, to ensure that we were generating data relevant to contracts outside of the Capital Area, we chose large hospitals in two of our other contracts, Chambersburg Hospital for Franklin/Fulton counties, and Somerset Community Hospital for Bedford/Somerset.
- The DMP audit tool included an analysis on medication reconciliation, see the above findings.
- Deficits in the utilization of sub-acute mental health programs (AKA "Recovery Services") that help with achieving successful transitions to ambulatory care. PerformCare has worked hard to help develop a whole continuum of services we refer to as "recovery services." These are services that provide Members supports so that they can function well in the community without the need for re-hospitalization. For our purposes here, these services include:
  - D&A ICM
  - D&A Recovery Specialist/Recovery Services
  - Peer Support Services
  - Medication services:
  - Community Treatment Teams
  - Assertive Community Treatment
  - Mobile Psychiatric Nursing
  - Targeted Case Management:
    - Resource Coordination
    - Intensive Case Management
    - Blended Case Management
    - Crisis Bridge/Hotline programs
- PerformCare did an analysis to see why these programs are not having the expected impact on recidivism. Here are some of our findings:
  - Under referral by inpatient facilities of Peer Support Services (PSS). In only 20% of reviewed mental health inpatient charts, was there evidence that peer support services were discussed with a Member, and a referral was made.
    - Table 18 below shows the volume of Peer Support Utilization for those Members recently hospitalized, by days after admission. It demonstrates the low numbers of PSS use, considering the numbers of admissions to MH IP in our network (3,850 mental health inpatient discharges in 2013, with 561 mental health inpatient readmissions – a rate of 15.9%):

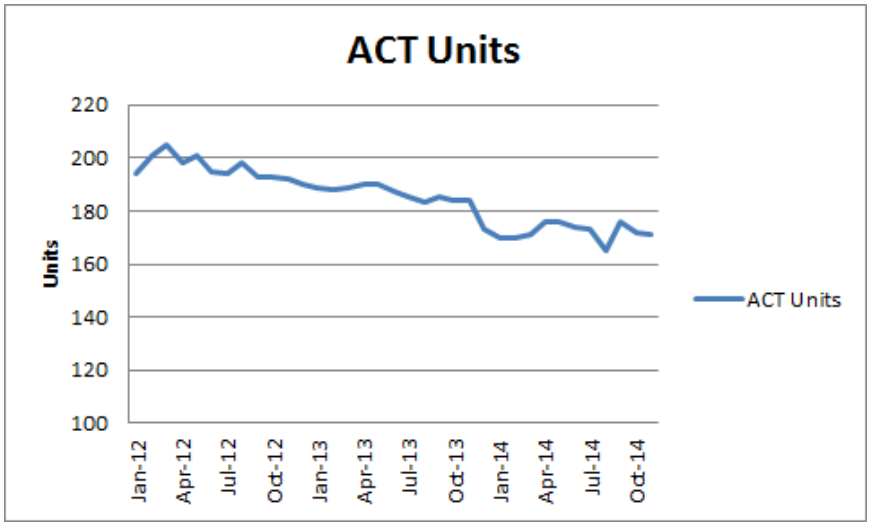
Table 18: Peer Support Utilization after MH IP Admission

Days after hospitalization	Member Count
30 Days after admission	30
60 days after admission	22
90 days after admission	19
180 days after admission	24
Greater than 180 days after admission	24

- The fact that so many people are starting PSS more than 30 days after inpatient discharge (i.e. 75% of post MHIP PSS service starts are beyond 30 days) shows that there is sustained demand for the service, but something is blocking a successful, immediate, hand-off.

- ACT and CTT Data shows that it is underused. There has been a steady, though slow, reduction in use of comprehensive community based mental health services like CTT (and ACT, which is a hi-fidelity version of CTT that is evidence-based). It is important to note that there has been no concomitant reduction in population, and in fact population of covered lives for PerformCare has gone up during this time.

Figure 2: ACT Units



- Crisis bridge program – the Crisis Bridge program allows crisis intervention units to follow up with consumers for the 30 days after discharge. It is available in our BHSSBC contract. Of the 252 unique BHSSBC Member discharges in 2014, only 22 utilized the Crisis Bridge service. Of those who did receive the service, 90% received it within 7 days (demonstrating that the program can have a quick turnaround). Increased use of this program would get acute Members support quickly to help with successful transitions.
- Mobile psych nursing – mobile psych nursing is a program that targets SMI Members. It utilizes an RN that goes to Members' homes and administers medication and provides education. Over the last year, its utilization has remained stable (approximately 2055 units a month). And it is unclear if the "right" Members are getting this service, so that our recidivism numbers would be impacted.

<table>
<tr><th colspan="2">RCA: Readmission Within 30 Days of Inpatient Psychiatric Discharge</th></tr>
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Drug and Alcohol Sub-acute recovery services. PerformCare has been working with its counties and oversights to develop innovative sub-acute options for Members who have acute drug and alcohol treatment needs, but who could be given these supports outside of the hospital setting, and thus have a more successful transition to ambulatory care. These programs are currently being supported by PerformCare and its partner counties through other funding streams than MA, because they are still pilot programs utilizing grant and/or reinvestment funds. These programs are having their outcomes monitored, to see which are successful, and which thus should be brought into the fee structure. These programs include:

SA Supportive Housing – There are a number of individuals who, when completing non-hospital rehabilitation or halfway house services for the treatment of SA issues, require some form of transitional housing to support their recovery. This may include individuals who are homeless or whose prior living situation would have undermined their recovery efforts. A local network of Recovery Houses is being developed to provide a living environment that reinforces recovery. Capital Area Behavioral Health Collaborative (CABHC) has been issuing scholarships to assist eligible individuals.
D&A Recovery Specialists – Targets individuals in the five-county Capital Area who are in need of one-on-one recovery coaching to assist them with overcoming obstacles that otherwise may keep them from succeeding in the process of recovering from SA. Program participants are matched with a Recovery Specialist who meets with them regularly and assists them in learning the skills necessary to live successfully and maintain their sobriety.
Drug and Alcohol Recovery Services - These target MA eligible adults (18 years or older) who are experiencing a SA disorder. These are peer operated programs that offer support and sober recreation services, but not treatment.

The Franklin-Fulton contract has seen an increase in the use of Peer Support Services over the last several years to a high of 71 Members receiving services in December 2015. Providers continue to note some difficulty in engaging Members in PSS; however, efforts to educate Members and other Providers on PSS continue within the regional network.
PerformCare identified through data that one of the drivers of readmissions for PerformCare are Members admitted for their first MHIP admission, and often return for a readmission within 30 days.

Root Cause: Utilization of Certified Peer Support (PSS) in the community and MH IP units is poor. PSS are able to assist Members with discharge planning and connecting with natural supports in the community setting that can lead to better involvement with follow-up treatment and decrease readmission to MH IP. Additionally there may be an inadequate pool of certified peer specialists who are actively looking for employment. This needs to be reviewed and examined to rule out as a possible cause.
</td></tr>
<tr><td></td><td>Follow-up Status Response</td></tr>
<tr><td></td><td></td></tr>
<tr><td><u>People (2)</u>
(e.g., personnel, provider network, patients)</td><td>Initial Response</td></tr>
<tr><td></td><td>

Lack of timely appointments for Members new to psychiatric services (access to psychiatrist time is limited) and are more likely to seek readmission to have their behavioral health needs met.

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</table>

RCA: Readmission Within 30 Days of Inpatient Psychiatric Discharge	
1. Members new to MH treatment/PerformCare	• Members may run out of medication prior to appointments with no prescriber for refill and may relapse. • New Members may not be aware of all the mental health services available and barriers to treatment may not have been addressed prior to discharge • New Members may be concerned about stigma and not seek treatment post discharge and readmit. • PerformCare does not currently have a report built that identifies Members new to Inpatient treatment with a readmission within 30 days and a correlation to after care compliance. This will be recommended once JIVA is started in 1/2017 **Root Cause: Members, who are unfamiliar with the Mental Health system and experience a first MHIP admission, may require additional assistance and support which is not being provided by MHIP Providers, in order to avoid a readmission.**
	Follow-up Status Response
Provisions (1) (e.g., screening tools, medical record forms, provider and enrollee educational materials) 1. Medication reconciliation	***Initial Response***
	• PerformCare held a subcommittee for medication reconciliation on April 20, 2015, which included PerformCare staff, county representatives, Provider representatives, and Member representatives. The group recognized that accurate and complete medication reconciliation can prevent numerous prescribing and administration errors. Medication reconciliation should be done in every transition of care, especially when new medications are ordered, or existing medications are re-written. Feedback from Providers included that discrepancies from the discharge instructions, prescriptions, and the discharge exist, which adds to the confusion. Additionally there is a slow response from MHIP units when requesting a correct/reconciled version in the OP setting. Furthermore, non-formulary medications are often prescribed by locum tenens that are not familiar with MA formularies. MHIP admit that human error can occur, and there are multiple forms being reviewed at time of discharge, and input from multiple staff, which can further hinder best practice discharge procedures. • Eight hospitals were reviewed as part of the PIP, which included review of medication reconciliation. Requirements for this indicator include: o Evidence in the chart that the facility documented information on the medications the patient is currently taking when he or she is admitted to the hospital (home meds). o Documentation in the DMP that the Member was given a list of all medications prescribed at discharge including: ➢ Drug Name ➢ Dosage ➢ Schedule ➢ Reason for Medication ➢ If any home meds were discontinued, the DMP must also include a list of the discontinued medications OR a notation that the Member is not to take any additional medications not listed on the DMP. o Findings from the review of the eight hospitals are noted in Table 19.

Table 19: PIP DMP Outcomes

Outcome Measures: PIP DMP	2014 Baseline			2015y Measurement		
	N	D	%	N	D	%
DMP Pilot Facilities:						
N1: Presence of a DMP	120	120	**100.0**	119	120	**99.2**
N2: Documentation DMP was sent home	31	120	**25.8**	43	120	**35.9**
N3: Complete Medication Reconciliation	21	120	**17.5**	44	120	**36.7**
DMP Phase II Facilities:						
N1: Presence of a DMP	n/a	n/a	n/a	119	120	**99.2**
N2: Documentation DMP was sent home	n/a	n/a	n/a	83	120	**69.2**
N3: Complete Medication Reconciliation	n/a	n/a	n/a	26	120	**21.7**

- As evident above, results for medication reconciliation are poor. The following findings were noted during the review:
  - Missing change in dose
  - Missing home meds, including over the counter, antibiotics, ointments, etc.
  - Missing controlled substances such as benzodiazepines, opiates
  - Missing the reason/rationale for medications

- Additional findings that were noted included that at times, medical terms such as BID/HS were being utilized, as opposed to Member friendly language (Twice a day, at night). Providers were also not always ensuring medications were labeled in the language Members used (i.e. generic vs. brand name), thus ensuring they were recognizable to the Member.

Root Cause: Incomplete Medication reconciliation at time of discharge from a MHIP, which can lead to Member confusion concerning prescribed medication list.

Follow-up Status Response

Complete next page of corresponding action plan.

Action Plan: 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***	***Monitoring Plan*** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
# 1 Root Cause: PerformCare has improved use of available data for continuous quality improvement; however, we are unable to accurately determine ALL readmission until the 30 day report is run. Additionally, Providers do not realize what their true Readmission Rate is since they do not have access to all readmission information. ***Action (1)*** • Create Benchmark Report Cards reports and distribute to Providers • Request Improvement of current reports for better correlations and quantitative and qualitative analysis	• 10/2016 – 12/2016 • 10/2016 – 12/2016	***Initial Response*** • PerformCare has improved their reporting capability by expanding Informatics' reporting on follow up rates, length of stay, and readmission rates. Initially PerformCare produced Benchmark reports with a focus on Mental Health Inpatient and SA Inpatient Providers. A Benchmark report will be developed for ambulatory services including Mental Health Outpatient, Blended Case Management, Peer Support, and Psychiatric Rehabilitation Services, Partial Hospitalization, FBMHS, and BHRS in 2017. These Benchmark reports will allow for improved correlations and educate Providers on their own network scores based on PerformCare data. • The Enhanced Care Management department monitors the following reports to assist in identifying Members for the program: • Ongoing use of the report identifying Members that have entered into acute inpatient treatment 5 times (Capital area contract) or 3 times (Bedford/Somerset and Franklin/Fulton contracts) within a 12 month period. • Effective fall of 2015 to the present: Report of 18 and older adults that could potentially benefit from ECM based on the types and frequency of treatments they recently have received (Enhanced Care Management predictive modeling algorithm). • Effective beginning of 2014 to fall of 2015: Report of Members with high utilization of SA services including a recidivism breakdown for SA levels of care. • Review of the report identifying Members in the chronic, target populations and/or health and safety categories (Designator report). This includes the completion of Recovery Management Plans (ECM plans for assisting the Members on their caseloads) • Reports to begin accessing routinely starting Quarter 3 of 2016 (in interim to new platform): • Review of report showing all inpatient admissions within a given date range with option of filtering by age. • Admission/Discharge treatment report used for identification and tracking of Members with 30 and 60 day re-admissions to the same or higher level of care by Provider (both MH IP and SA IP). • Clinical leadership weekly review of Members in MH IP over 14 calendar days. ***Follow-up Status Response***
# 1 Root Cause: PerformCare has improved use of	• 07/2016 –	***Initial Response***

Action Plan: Readmission Within 30 Days of Inpatient Psychiatric Discharge		
available data for continuous quality improvement; however, we are unable to accurately determine ALL readmission until the 30 day report is run. Additionally, Providers do not realize what their true Readmission Rate is since they do not have access to all readmission information. ***Action (2)*** • Initiate report changes in January 2017 to improve correlation and respond in real-time to assist Members in maintaining stability	01/2017	• Reports that have or will be requested in 2016-2017**:** o Real time data regarding the completion of assessments (ANSA) for inpatient admissions o Report identifying the frequency of Members identified as high scoring in the specific categories of the assessment (ANSA). o Report providing inpatient discharge status of unique Members (i.e. leaving against medical advice for SA facilities, successful discharge, behavioral discharges etc.) o Report providing the status of Members in the ECM program who are engaged with the supports offered as well as status of Members that are not responsive to the ECM outreach. o Report providing real time information related to the ECMs completion of a comprehensive assessment within 30 calendar days of assignment. o Outcomes measures reports to include status of Member upon discharge from the ECM program (successful, no longer eligible with HealthChoices etc.) o Reports to identify Member satisfaction with their involvement in the ECM program. o Report that provides information on the frequency and variety of ECM contacts with Member and on behalf of the Member. ***Follow-up Status Response***
#2 Root Cause: There are an inadequate number of Providers who are certified to provide specialized services such as Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), TF-CBT, and Providers who are Co-occurring competent in the Provider network. Without specialized services available to address specific issues such as trauma and SA Members may not receive adequate treatment needed to stay in the community. ***Action (3)*** • Increase the number of Providers with the appropriate training, certification and license to provide specialized services such as DBT, TF-CBT, EMDR and Co-Occurring disorders	• 01/2015 – 06/2016	***Initial Response*** • Network Operations will monitor network capacity of Providers who are specialized in trauma informed care and specialization such as DBT and EMDR. • PerformCare will continue to offer stipends for Providers to attend trainings in the several areas including trauma informed care and co-occurring treatment and be reimbursed monetarily by PerformCare. • Quality Improvement Manager will explore incentive options for Providers who develop and implement specialized outpatient services which are more effective in meeting Member needs. • Quality Improvement Staff will monitor the number of Providers who utilize training stipends and will promote the use of these funds so that Providers are adequately informed to develop specialized services. • PerformCare will continue to support the development of CCISC practices to meet the individual needs of each contract through the local participation in the various CCISC workgroups. • TF-CBT training and certification for Bedford, Somerset, Franklin, and Fulton Providers occurred in 2015 for 24 Providers. May and June 2016 training sessions were held. The June training targeted therapist working in MH OP, BHRS and FBMH. Case consultations are still ongoing. • Opportunity to request an automated directory, county and age specific for Providers certified/trained in these areas for CCMs to access for discharge planning and for education to inpatient units, for ECMs to assist Members in connecting to community based supports to help divert IP stays etc. (currently can go to Provider Connect to find resources – cumbersome in the midst of a review)

Action Plan: Readmission Within 30 Days of Inpatient Psychiatric Discharge		
		• In Franklin/Fulton: Co-occurring competency credential is a Provider incentive program, in which MH OP Providers must pass the COD audit with a score of 75% in all three rating areas in order to be certified for an enhanced rate. Additionally, the Provider must agree to use the COD outcomes tool in order to qualify as well. In 2015, two out of 5 Providers audited received a passing score and will get an enhanced rate .In 2016; two out of two Providers audited received a passing score and will get an enhanced rate. ***Follow-up Status Response***
#3 Root Cause: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Members to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (4)*** • Continue Quality Treatment Record Reviews (including indicators related to discharge instructions/summary, recovery orientation, and resolution of barriers). Reviews to occur every three years based on the re-credentialing cycle, or more frequently, depending on the performance of the Provider	• 01/2015 – 06/2016	***Initial Response*** • Quality Treatment Record reviews will continue to be completed every three years based on the re-credentialing cycle, or more frequently depending on the Provider's performance. PerformCare continues to monitor the TRR scores, and utilizes information from low scoring LOC, sections, and indicators to develop future webinars, technical assistance, and Provider education. • Any Provider that does not achieve the performance goal for the total score is required to submit a Quality Improvement Plan (QIP). Quarterly collaboration occurs between the Provider and PerformCare in order to assess progress on the QIP, as well as to offer technical assistance to support the Provider to achieve their planned actions to improve. Even if the Provider meets the overall benchmark score, if section score is below 80%, the Provider is asked to provide PerformCare with a brief response regarding how they plan to address indicators within the section that scored below 80%. ***Follow-up Status Response***
#3 Root Cause: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Members to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (5)*** • Perform Care is making improvements to outcomes reporting specific to level of care and Provider. The outcomes reports will give detailed information on Provider Performance.	• 04/2016 – 12/2016	***Initial Response*** • Benchmark reports have been completed and are in the final stages of approval for distribution to Providers. Those that are completed and ready for distribution by September are: MHIP, SAIP. Adult Ambulatory (Psych Rehab, PSS, BCM and OP) will be completed in 2017. ***Follow-up Status Response***
#3 Root Cause: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Members to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful	• 05/2015 – 12/2016	***Initial Response*** • Local Care Managers are continuing to expand their caseloads. Active Care Management strategies continue for PerformCare Clinical Care Managers through Enhanced Care Management (ECM) PerformCare achieved a 100% score on the NCQA accreditation survey in 2015. In 2015, we added the FF LCM, increasing the ECM to nine PerformCare staff, with plans to expand in 2016. Active Care

Action Plan: Readmission Within 30 Days of Inpatient Psychiatric Discharge		
aftercare. ***Action (6)*** • Active Care Management and Local Care Management Expansion to more closely monitor Members with more complex needs		Management staff has increased to five local care management staff. • All CCMs who complete preauthorizations for mental health inpatient treatment also complete initial ANSA to identify and refer those who would benefit from ECM, and to identify any barriers that should be addressed during the MHIP stay. In doing so, the CCM will then partner with the MHIP facility to ensure barriers are addressed; with intent of ensuring Member has a successful transition to ambulatory care. • During the course of the inpatient stay, PerformCare Clinical Care Managers (UM and ECM) provide information to the inpatient unit regarding Members treatment history, patterns of follow through with recommendations, barriers to following their recovery plan, and their pattern of engagement with Providers, in an effort to arm the unit with information to engage and motivate the Members to attend follow up care. o PC CCM continues to encourage collaboration among Providers and team members. o PC CCM continue to encourage the use of non-traditional services such as MPN, Psych Rehab, diversion programs, and other services as appropriate and based on the Members needs. o ECM will inform the inpatient facility of services the Members is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. The ECM will request a treatment team meeting with the inpatient unit to include the Members, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan. • ECMs develop a RMP within the first month of assignment to a Member. The RMP outlines the identified Member barriers and individualized needs that the Provider/support team has identified during treatment. The team assists in developing interventions focused on successful community tenure. ***Follow-up Status Response***
#3 Root Cause: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Members to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (7)*** • Active Care Management and Local Care Comprehensive Continuous Integrated System of Care (CCISC) Implementation has occurred in Bedford/Somerset and Franklin/Fulton Counties. • CCISC meetings and Change Agent Meetings/Trainings have occurred and are ongoing.	• 04/2015 – 12/2016	***Initial Response*** • CCISC meeting continue in the North Central Contracts. Change Agent Meetings continue in the North Central contracts. There was a Complex condition training started on 2/20/14 in the Franklin/Fulton region, level of care specific treatment plan trainings were completed in 2015 and Motivational Interviewing trainings completed for April and June 2016. A Provider networking day was held on June 16, 2016. • PerformCare also has an ECM now attending the CCISC implementation group meetings and change agent meetings (along with local QI and AE representation). ***Follow-up Status Response***

Action Plan: Readmission Within 30 Days of Inpatient Psychiatric Discharge		
#3 Root Cause: When barriers are noted in regards to discharge from a MHIP unit, Providers are not collaborating with the Members to develop interventions that address the identified barriers, and to ensure a successful transition to meaningful aftercare. ***Action (8)*** • Discharge Management Educational Meetings through the PIP.	• 07/2015 – 12/2016	***Initial Response*** • PerformCare conducted meetings with all 4 hospitals selected for the Discharge Management Plan Audits in July and August of 2015 to review the results of the DMP audit, to review opportunities for improvement, and to review expectations. • Meetings were also held with the second round of four facilities in May 2016. During these visits, PeformCare reviewed the results of the audit, and again held extensive discussions regarding the need for Providers to assess barriers early during a MHIP and address identified barriers to completing follow-up appointments with Providers ***Follow-up Status Response***
Root Cause #4: Utilization of Certified Peer Support (PSS) in the community and MH IP units is poor. PSS are able to assist Members with discharge planning and connecting with natural supports in the community setting that can lead to better involvement with follow-up treatment and decrease readmission to MH IP. Additionally there may be an inadequate pool of certified peer specialists who are actively looking for employment. This needs to be reviewed and examined to rule out as a possible cause. ***Action (9)*** • PerformCare will continue to encourage the implementation of PSS into the network MH IP units and complete an analysis on why it is underutilized	• 04/2016 – 12/2016	***Initial Response*** • Encourage MH IP units to utilize PSS/Recovery Specialist in the MH IP unit. • Monitor the Capital Reinvestment plan to place certified peer specialist In MH IP units. • Monitor the number of PSS in the network actively seeking employment to determine if there is adequate peer support certified and available. • PerformCare will explore the feasibility of recommended documentation guidelines for PSS and engage all contracts in the review of proposed guidelines. • Increase capacity of Providers of Peer Support Services • Monitor the readmission rates for the four MH IP units that will have the PSS on staff compare to those MH IP facilities that do not have PSS staff. • QI Staff will continue to participate in the PSS workgroup at CABHC. • QI will continue to monitor the utilization of Peer Support Services in the QI/UM meetings. • Network Operations will monitor the capacity of Peer Support Providers in the network. • PC CCM (UM and ECM) care managers will encourage engagement of Certified Peer Support and Member when they are imbedded on the inpatient unit and encourage continuation of use of peer support as part of a discharge plan to the community. • PC CCM care managers will encourage the Certified Peer Support as part of an aftercare plan for Members who would benefit from increased support in the community. • If a Member is readmitted to a high level of care and has existing certified peer support specialists, CCM's encourage collaboration with the CPS as part of the larger treatment team to assist with transitioning Member back into the community. ***Follow-up Status Response***

Action Plan: Readmission Within 30 Days of Inpatient Psychiatric Discharge		
Root Cause #5: Members, who are unfamiliar with the Mental Health system and experience a first MHIP admission, may require additional assistance and support which is not being provided by MHIP Providers, in order to avoid a readmission. ***Action (10)*** • Enhance Care Management and Active Case Management will assess Members needs and address barriers to prevent readmission.	• 05/2015 – 06/2013	***Initial Response*** • PC UM CCMs will encourage Providers to explore current supports/treatment of a Member who is experiencing a first admission. If there is a need, a request for referral to county case management will occur. PC CCM will also work with Provider to explore barriers to aftercare and assist in development of a recovery oriented discharge management plan for the Member. • If there is a lack of timely after care appointment availability, PC CCM will work with Provider to explore other treatment/support options to avoid having a lapse of treatment in the time following an inpatient admission. • During the Member's prior authorization request for their first inpatient admission, the UM CCM will complete a comprehensive assessment (ANSA) to determine if the Member has complex conditions (i.e. significant behavioral issues: psychosis, trauma, substance use, suicidality; significant physical health concerns and limited engagement in their recovery plan) and will refer the Member to the Enhanced Care Management Program. • For Members assigned to ECM: o Effective Quarter 1 of 2016, during a Member's admission to inpatient treatment, if assigned to an ECM, the ECM will conduct all utilization management functions regarding the authorizations for treatment and gathering of clinical information related to progress. The ECM will inform the inpatient facility of services the Member is involved with and recommend the IP obtain consents to outreach to these services for coordination of treatment and collaboration regarding discharge planning. The ECM will request a treatment team meeting with the inpatient unit to include the Member, natural/community supports in addition to other professional supports in an effort to develop an effective discharge plan. o ECM contacts the Member the next business day after discharge from IP to ensure the Member understands their discharge instructions, to confirm date and time of the scheduled follow-up appointment(s); to verify whether the Member plans to attend the follow-up appointment(s); to assist with rescheduling appointments when necessary; to verify contact telephone number and address; to provide warm linkages to community resources to mitigate or minimize barriers to successful participation in aftercare instructions. o The ECM will call the Member weekly until the follow-up appointment date to provide any assistance needed and to remind Member of the follow-up appointment date and time, ECM will call the Member the business day following the scheduled follow-up appointment to verify that the Member attended the appointment. If Member did not attend, ECM will elicit and assist with barriers to treatment and assist with rescheduling the follow-up appointment, as necessary. o To support education to new Members *regarding the* significance of follow up and their role in their own recovery, an ECM will outreach to the inpatient Provider and as noted above, request treatment team meetings that include the Member, request to speak directly to the Member, when appropriate go on the unit to meet with the Member and upon return to the community, the ECM outreaches to the Member to ensure the Member understands their options and their recovery plan. The ECM will help the Member assess the success of the plan and work with the Member and community based Providers on revisions needed to make the plan continue to be

Action Plan: Readmission Within 30 Days of Inpatient Psychiatric Discharge		
		successful. o PerformCare does not currently have a report built that identifies Members new to Inpatient treatment with a readmission within 30 days and a correlation to after care compliance. This will be recommended once JIVA is started in 1/2017. ***Follow-up Status Response***
Root Cause #6: Incomplete Medication reconciliation at time of discharge from a MHIP, which can lead to Member confusion concerning prescribed medication list. ***Action (11)*** • Ongoing monitoring of Hospitals involved with the PIP and encouragement of improvement on current process	• 04/2015 – 12/2016	***Initial Response*** • Monitoring of Medication Reconciliation through MHIP TRRs-started Nov 2015 o PC will monitor scores for indicators o PC will refer Providers to the Medication toolkit if additional support required during TRR exit interviews (i.e. low scores). • Creation of Medication reconciliation toolkit-completed in December 2015 o Toolkit was posted to the website on: Feb 2016. Providers were notified via iContact. o All PIP participating Providers were notified of the toolkit, and it was emailed to one Provider following the on-site visit by PC staff ***Follow-up Status Response***
Root Cause #6: Incomplete Medication reconciliation at time of discharge from a MHIP, which can lead to Member confusion concerning prescribed medication list. ***Action (12)*** • Ongoing monitoring of Hospitals involved with the PIP and encouragement of improvement on current process	• 01/2016 – 01/2017	***Initial Response*** • PC CCMs (UM and ECM) prompt Providers for medication reconciliation starting in 2016. • Ensure new CCM electronic health record prompts for collection of information o In the future, there will be prompts within the new electronic health record prompting CCM's to ensure medication reconciliation was completed at both admission and discharge, along with ensuring that the Member understands plan for medications and has been provided with paperwork that is easy to read and has recovery oriented language in it. CCM's will also be prompted to ensure a teach back has occurred prior to discharge. • Member ECM post-discharge follow-up o ECM will routinely check in with the Member/supports to ensure the Member understands their medication regimen. For Members that are uncertain of their medication plans, the ECM will seek resources to aid the Member in education and adherence to the prescription protocol (i.e. outreach to the prescribing physician, community/natural supports, referral to additional services as appropriate such as Mobile Psychiatric Nursing, options for injectable medications, Assertive Community Treatment Programs, Peer Support Services and Targeted Case Management). ***Follow-up Status Response***

VI: 2016 Strengths and Opportunities for Improvement

The review of PerformCare'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

- PerformCare's rate for the MY 2015 Follow-up After Hospitalization for Mental Illness PA Specific indicator QI B was statistically significantly above the BH-MCO Average by 2.9 percentage points.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2013, RY 2014, and RY 2015 found PerformCare to be partially compliant with all three Subparts associated with Structure and Operations Standards.
    - Within Subpart C: Enrollee Rights and Protections Regulations, PerformCare was partially compliant with one out of seven categories – Enrollee Rights.
    - PerformCare was partially compliant with six 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, 4) Subcontractual Relationships and Delegation, 5) Practice Guidelines, and 6) Quality Assessment and Performance Improvement Program.
    - PerformCare was partially compliant on eight 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) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.
- PerformCare's rate for the MY 2015 Readmission Within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly higher (worse) than the BH-MCO average by 1.6 percentage points. PerformCare's rate did not meet the OMHSAS designated performance goal of 10.0%.
- PerformCare's rates for the MY 2015 Follow-up After Hospitalization for Mental Illness HEDIS indicators QI 1 (Total Population) was statistically significantly lower than the BH-MCO Average by 2.5 percentage points.
- PerformCare's rates for the MY 2015 Follow-up After Hospitalization for Mental Illness HEDIS indicators (QI 1 and QI 2) for ages 6-64 did not meet the goal of meeting or exceeding the 75th percentile.
- PerformCare's rate for the MY 2015 Engagement of AOD Treatment performance masure for ages 13+ was statistically significantly lower than the MY 2015 HealthChoices BH-MCO Average by 2.5 percentage points.

Additional strengths and targeted opportunities for improvement can be found in the BH-MCO-specific 2016 (MY 2015) Performance Measure Matrices that follow.

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 FUH QI A	B FUH QI B
	⬇	*F*	D	C

[1] For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) rate, lower rates reflect better performance. Therefore a year-to-year 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 21.**

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

Table 23 represents the BH-MCO's performance for each measure in relation to prior year's rates for the same indicator for MY 2012 to MY 2015. 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 HC BH-MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7-Day)	59.4%═	54.1%▼	56.9%▲	56.9%═	55.8%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30-Day)	78.0%═	73.1%▼	76.4%▲	75.6%═	72.7%
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	14.1%═	15.5% ▲	15.9% ═	15.6% ═	14.0%

[1] For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) rate, lower rates reflect better performance. Therefore a year-to-year 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 (FUH7/FUH30). A root cause analysis and plan of action is required for items that fall below the 75th percentile.

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

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

[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)	42.7%	Not Met	Below 50th and at or above 25th percentile
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	66.6%	Not Met	Below 75th and at or above 50th percentile

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

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

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

VII: Summary of Activities

Structure and Operations Standards

- PerformCare 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

- PerformCare submitted an Interim PIP Report in 2016.

Performance Measures

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

2015 Opportunities for Improvement MCO Response

- PerformCare 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 PerformCare 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 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 PerformCare 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, 16 were evaluated for PerformCare and the seven HC BH Contractors contracting with PerformCare. **Table C.1** provides a count of these Items, along with the relevant categories.

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

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	1	0	0
Longitudinal Care Management (and Care Management Record Review) (Standard 28)	1	0	1	0	0
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	0	4	0	0
Grievances and State Fair Hearings (Standard 71)	4	0	4	0	0
Denials					
Denials (Standard 72)	1	1	0	0	0
Executive Management					
County Executive Management (Standard 78)	1	0	1	0	0
BH-MCO Executive Management (Standard 86)	1	0	1	0	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	3	0	0	0

Format

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

Findings

The OMHSAS-specific PEPS Substandards relating to Care Management are MCO-specific review standards. These two substandards were added to the PEPS Application for RY 2014. Of the two substandards, PerformCare met one substandard and partially met one substandard. 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	RY 2014	Partially Met
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	RY 2014	Met

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

PerformCare partially met the criteria for compliance for Substandard 27.7 (RY 2014).

Substandard 27.7: Other: Significant onsite review findings related to Standard 28.

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO-specific review standards. Of the seven substandards evaluated, PerformCare met one substandard, partially met two substandards, and did not meet five 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 2014	Partially Met
	Standard 68.6	RY 2014	Not Met
	Standard 68.7	RY 2014	Not Met
	Standard 68.8	RY 2014	Not Met
Grievances and State Fair Hearings	Standard 71.1	RY 2014	Met
	Standard 71.5	RY 2014	Partially Met
	Standard 71.6	RY 2014	Not Met
	Standard 71.7	RY 2014	Not Met

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

PerformCare partially met the criteria for compliance on Substandards 68.1 and did not meet the criteria for compliance on Substandards 68.6, 68.7, and 68.8 (RY 2014).

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

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

PerformCare partially met the criteria for compliance on Substandards 71.5 and did not meet the criteria for compliance on Substandards 71.6 and 71.7 (RY 2014).

Substandard 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.
Substandard 71.6: Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
Substandard 71.7: A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2014. PerformCare 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. PerformCare met the criteria for compliance for substandard 78. 5 and partially met the criteria for compliance for substandard 86.3. The status for these substandards is presented in **Table C.5**.

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

Category	PEPS Item	Review Year	Status
Care Management			
County Executive Management	Standard 78.5	RY 2014	Met
BH-MCO Executive Management	Standard 86.3	RY 2014	Partially Met

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

PerformCare partially met the criteria for compliance on Substandards 86.3 RY 2014).

Substandard 86.3: Significant onsite review findings related to Standard 86.

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are county-specific review standards. All three substandards crosswalked to this category were evaluated for PerformCare counties. Counties contracted with PerformCare met two substandards, and partially met one substandard. The status 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 2015	Met
	Standard 108.4	RY 2015	Met
	Standard 108.9	RY 2015	Partially Met

PEPS Standard 108: The County Contractor/BH-MCO: a. Incorporates consumer satisfaction information in provider profiling and quality improvement process; b. Collaborates with consumers and family members in the development of an annual satisfaction survey that meets the requirements of Appendix L; c. Provides the Department with Quarterly and Annual summaries of consumer satisfaction activities, consumer issues identified and resolution to problems; and d. Provides an effective problem identification and resolution process.

PerformCare partially met the criteria for compliance on Substandards 108.9 (RY 2015).

Substandard 108.9: Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.

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