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

2018 External Quality Review Report
PerformCare

FINAL
April 30, 2019

IPRO
Better healthcare,
realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

List of Tables and Figures

Introduction

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs). 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.

Overview

HealthChoices (HC) Behavioral Health (BH) 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 (Island Peer Review Organization) as its EQRO to conduct the 2018 EQRs for HC BH MCOs and to prepare the technical reports. The subject of this report is one HC BH MCO, PerformCare. Subsequent references to "MCO" in this report refer specifically to this HC BH MCO.

Objectives

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.

Report Structure

This technical report includes seven core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures
IV. Quality Study
V. 2017 Opportunities for Improvement - MCO Response
VI. 2018 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the MCO, the information for the compliance with the Structure and Operations Standards section of the report is derived from monitoring and reviews conducted by OMHSAS, as well as the oversight functions of the county or contracted entity when applicable, against 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 IPRO's validation of the 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, 2017 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2017 EQR Technical Report and presents the degree to which the MCO addressed each opportunity for improvement. Section VI has a summary of the MCO's strengths and opportunities for improvement for this review period (2018), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH Quality Performance of the MCO. Lastly, Section VII provides a summary of EQR activities for the 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.

Supplemental Materials

Upon request, the following supplemental materials can be made available:

- The MCO's BBA Report for RY 2017, and
- The MCO's Annual PIP Review for RY 2018.

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) 2017, 67 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 (43) 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 (24) 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 1.1** 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 1.1: HealthChoices Oversight Entities, HC BH Contractors and Counties

HealthChoices Oversight Entity	HC BH Contractor	County
Capital Area Behavioral Health Collaborative (CABHC)	Capital Area Behavioral Health Collaborative (CABHC)	Cumberland County
		Dauphin County
		Lancaster County
		Lebanon 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
Tuscarora Managed Care Alliance	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 2017, 2016, 2015). 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 2017. 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 time frame, 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 2018 and entered into the PEPS Application as of October 2018 for RY 2017. 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. Substandards are sometimes added or otherwise changed on the crosswalk which may change the category-tally of standards from year to year. As was done for prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The RY 2017 findings for selected OMHSAS-specific Substandards are reported in **Appendix C**. The crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in **Appendix A** and **Appendix B**, respectively.

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 2017, RY 2016, and RY 2015 provided the information necessary for the 2018 assessment. Those standards not reviewed through the PEPS system in RY 2017 were evaluated on their performance based on RY 2016 or RY 2015 decisions, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year time frame 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, a total of 165 substandards were applicable for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2015–2017). In addition, 16 OMHSAS-specific substandards 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 substandard may contribute more than once to the total number of BBA Categories required and/or reviewed. 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 1.2 tallies the PEPs substandards used to evaluate the HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2015–2017). Because compliance categories (first column) may contain substandards that are reviewed either annually or triennially, the total number of PEPS substandards applicable to this year's (RY 2017) evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations for any given category may not equal the sum of those substandard counts.

Table 1.2: Tally of Substandards Pertinent to BBA Regulations Reviewed for PerformCare

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	RY 2017	RY 2016	RY 2015
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	14	0	7	0	7
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	N/A	N/A	N/A	N/A	N/A
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	25	0	8	4	13
Coordination and Continuity of Care	3	0	3	0	0
Coverage and Authorization of Services	5	0	5	0	0
Provider Selection	3	0	0	0	3
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	8	0
Practice Guidelines	7	0	3	4	0
Quality Assessment and Performance Improvement Program	25	0	18	7	0
Health Information Systems	1	0	0	1	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	0	11	0	0
General Requirements	14	0	14	0	0
Notice of Action	13	0	7	0	6
Handling of Grievances and Appeals	11	0	11	0	0
Resolution and Notification: Grievances and Appeals	11	0	11	0	0
Expedited Appeals Process	6	0	6	0	0
Information to Providers and Subcontractors	2	0	2	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	RY 2017	RY 2016	RY 2015
Continuation of Benefits Pending Appeal & State Fair Hearings	6	0	6	0	0
Effectuation of Reversed Resolutions	6	0	6	0	0
Total	171	0	118	24	29

[1] The total number of required substandards required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations. Any PEPS substandards not reviewed indicate retired substandards previously used to evaluate the BH-MCO.
[2] The number of substandards that came under active review during the cycle specific to the review year. Due to substandards coming under active review both annually and triennially for each review year, the sum of the substandards that came under review in RY 2017, 2016, and 2015 may not equate to the total number of applicable PEPS substandards for evaluation of the BH-MCO (165 in RY 2017).
RY: Review Year.
NR: Not reviewed.
N/A: Not applicable.

For RY 2017, 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 of 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 2018 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 with 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.

In MY 2017, PEPS Standards 91 and 104 changed from County-Specific Standards to BH-MCO-Specific Standards.

Format

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

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

Findings

Of the 171 PEPS substandards that were used to evaluate PerformCare and the seven HC BH Contractors associated with the BH-MCO that were included in the structure and operations standards for compliance of BBA regulations in RY 2017, 118 substandards were under active review in RY 2017.

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 CFR 438.100 [a], [b]). **Table 1.3** presents the findings by categories consistent with the regulations.

Table 1.3: 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	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards. Bedford- Somerset and Capital Area 5 were compliant with 11 substandards, partially compliant with 2 substandards, and non-compliant with 1 substandard. Franklin-Fulton was compliant with 12 substandards, partially compliant with 1 substandard, and non-compliant with 1 substandard.
Provider-Enrollee Communications 438.102	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R sections E.4 (p. 55) and A.4.a (p. 21).
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. 73) and C.2 (p. 28).

Subpart C: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
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. 30).
Solvency Standards 438.116	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R sections A.3 (p. 68) and A.9 (p. 73), and 2016-2017 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 2017–2018 Solvency Requirement tracking report.

Of the 14 PEPS Substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 14 were evaluated for each HC BH Contractor. Bedford-Somerset and the Capital Area 5 Counties were compliant with 11 substandards, partially compliant with 1 substandard, and non-compliant with 2 substandards. Franklin-Fulton was compliant on 12 substandards, partially compliant with 1 substandard, and non-compliant with 1 substandard. 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

All HC BH Contractors were partially compliant with Enrollee Rights due to partial compliance with one substandard within PEPS Standard 108 (Substandard 8) and both partial compliance and non-compliance with Substandards 2 and 3 within PEPS Standard 60.

PEPS Standard 60:

- The BH-MCO shall identify a lead person responsible for overall coordination of the complaint and grievance process, including the provision of information and instructions to members [Appendix H, A., 9., p. 1]. (Responsibility includes HIPAA Privacy duties related to complaints and mechanisms for tracking and reporting of HIPAA-related complaints.)
- The BH-MCO shall designate and train sufficient staff responsible for receiving, processing and responding to member complaints and grievances in accordance with the requirements contained in Appendix H [Appendix H, A., 8., p. 1].
- All BH-MCO staff shall be educated concerning member rights and the procedure for filing complaints and grievances [C.4., p. 44].

All HC BH Contractors were non-compliant with one substandard of Standard 60: Substandards 3 (RY 2017).

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.

All HC BH Contractors were partially compliant with one substandard of Standard 60: Substandards 2 (RY 2017).

> **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.

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.

All HC BH Contractors except for Franklin-Fulton 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 CFR 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 1.4** presents the findings by categories consistent with the regulations.

Table 1.4: Compliance with Quality Assessment and Performance Improvement Regulations

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Elements of State Quality Strategies 438.204	Compliant	All PerformCare HC BH Contractors		Compliant as per PS&R section G.3 (p. 61).
Availability of Services (Access to Care) 438.206	Partial		All PerformCare HC BH Contractors	25 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 25 substandards, compliant with 23 substandards, and non-compliant with 2 substandards.
Coordination and Continuity of Care 438.208	Non-Compliant			3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 items compliant with 1 substandard, and non-compliant with 2 substandards.
Coverage and Authorization of Services 438.210	Partial		All PerformCare HC BH Contractors	5 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 5 substandards, compliant with 1 substandard, partially compliant with 2 substandards, and non-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 with 3 substandards.
Confidentiality 438.224	Compliant	All PerformCare HC BH		Compliant as per PS&R sections D.2 (p. 50), G.4 (p. 62) and C.6.c (p. 48).

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
		Contractors		
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 7 substandards, and partially compliant with 1 substandard.
Practice Guidelines 438.236	Partial		All PerformCare HC BH Contractors	7 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 7 substandards, compliant with 5 substandards, and non-compliant with 2 substandards.
Quality Assessment and Performance Improvement Program 438.240	Compliant	All PerformCare HC BH Contractors		25 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 25 substandards and compliant with 25 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 with this item.

There are 10 categories in the Quality Assessment and Performance Improvement Regulations Standards. PerformCare was compliant with 5 of the 10 categories, partially compliant with 4, and non-compliant with 1 category. Two (2) of the five (5) categories with which PerformCare was compliant– 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, 77 items were crosswalked to Quality Assessment and Performance Improvement Regulations, and the seven HC BH Contractors associated with PerformCare were evaluated on all 77 items. All of the PerformCare HC BH Contractors reviewed were compliant with 66 substandards, partially compliant with 3 substandards, and non-compliant with 8. 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 with Substandard 1 and 2 within PEPS Standard 28.

PEPS Standard 28: 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 two substandards of Standard 28: Substandards 1 and 2 (RY 2017).

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

Substandard 2: The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.

Coordination and Continuity of Care

All HC BH Contractors associated with PerformCare were non-compliant with Coordination and Continuity of Care due to non-compliance with two substandard of PEPS Standard 28.

PEPS Standard 28: See Standard and partially compliant Substandard descriptions under Availability of Services (Access to Care). All PerformCare HC BH Contractors were non-compliant with Substandards 1 and 2 of PEPS Standard 28 (RY 2017).

Coverage and Authorization of Services

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

PEPS Standard 28: See Standard and partially compliant Substandard descriptions under Availability of Services (Access to Care). All PerformCare HC BH Contractors were non-compliant with Substandards 1 and 2 of PEPS Standard 28 (RY 2017).

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

All HC BH Contractors were partially compliant with two substandard of Standard 72: Substandards 1 and 2 (RY 2017).

> **Substandard 1:** Denial notices are issued to members according to required time frames and use the required template language.
>
> **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 one substandard of PEPS Standard 99.

PEPS Standard 99: 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 one substandard of Standard 99: Substandard 2 (RY 2016).

> **Substandard 2:** The BH-MCO reports monitoring results for Adverse Incidents.

Practice Guidelines

All HC BH Contractors were partially compliant with Practice Guidelines due to non-compliance with two substandard of PEPS Standard 28.

PEPS Standard 28: See Standard and partially compliant Substandard descriptions under Availability of Services (Access to Care). All PerformCare HC BH Contractors were non-compliant with Substandard 1 and 2 of PEPS Standard 28 (RY 2017).

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 1.5** presents the findings by categories consistent with the regulations.

Table 1.5: 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 1 substandards, partially compliant with 8 substandards, and non-compliant with 2 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 2 substandards, partially compliant with 9 substandards, and non-compliant with 3 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 11 substandards, and partially compliant with 2 substandards.
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 1 substandards, partially compliant with 8 substandards, and non-compliant with 2 substandards.
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 1 substandards, partially compliant with 8 substandards, and non-compliant with 2 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 1 substandards, and partially compliant with 5 substandards.
Information to Providers & Subcontractors 438.414	Partial	All PerformCare HC BH Contractors		2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards, and compliant with 1 substandard, non-compliant with 1 substandard.
Recordkeeping and Recording Requirements 438.416	Compliant	All PerformCare HC BH Contractors		Compliant as per the required quarterly reporting of complaint and grievances data.

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
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 1 substandard, and partially compliant with 5 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 1 substandards, and partially compliant with 5 substandards.

There are 10 categories in the Federal and State Grievance System Standards. PerformCare was compliant with 1 category and partially compliant with 9 categories. The category of 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 20 substandards, partially compliant with 50 substandards, and non-compliant with 10 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 9 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 2 substandards within PEPS Standard 68 and partial compliance with 3 substandards within PEPS Standard 68, 3 substandards within PEPS Standards 71, and 2 substandards within PEPS Standard 72.

PEPS Standard 68: Complaint (and BBA fair hearing) rights and procedures are made known to Independent Enrollment Assistance Program (IEAP) members, BH-MCO staff, and the provider network through manuals, training, handbooks, etc. [Appendix H, A., 4 and 5] [E.2.a, b, f., pp. 38] [IV-5, C.4., p. 44].

All PerformCare HC BH Contractors were non-compliant with two substandards of Standard 68: Substandard 1 and Substandard 4 (RY 2017).

> **PEPS Standard 68, Substandard 1:** Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how the compliant rights and procedures are made known to members, BH-MCO staff and the provider network: 1. BBA fair hearing, 2. 1st level, 3. 2nd level, 4. External, 5. Expedited.
>
> **PEPS Standard 68, Substandard 4:** 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 three substandards of Standard 68: Substandard 2, 3, and 5 (RY 2017).

> **PEPS Standard 68, 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.

PEPS Standard, 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).

PEPS Standard, 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 complaint/grievance (C/G) staff, either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.

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

All PerformCare HC BH Contractors were partially compliant with three substandards of Standard 71: Substandards 2, 3, and 4 (RY 2017).

PEPS Standard 71, Substandard 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.

PEPS Standard 71, Substandard 3: Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.

PEPS Standard 71, 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 and partially compliant Substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with Substandards 1 and 2 of Standard 72 (RY 2017).

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 and non-compliant Substandard descriptions under Enrollee Rights. All HC BH Contractors were non-compliant with Substandard 2 and partially compliant with Substandard 3 (RY 2017).

PEPS Standard 68: See Standard and non-compliant Substandard descriptions under Statutory Basis and Definitions. All PerformCare HC BH Contractors were non-compliant with Substandards 1 and 4 and partially compliant with Substandard 2, Substandard 3, and Substandard 5 (RY 2017).

PEPS Standard 71: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions. All PerformCare HC BH Contractors were partially compliant with Substandards 2, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant Substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with Substandards 1 and 2 (RY 2017).

Notice of Action

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

PEPS Standard 72: See Standard and partially compliant Substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with Substandards 1 and 2 (RY 2017).

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 and non-compliant Substandard descriptions under Statutory Basis and Definitions. All PerformCare HC BH Contractors were non-compliant with three Substandards 1 and Substandard 4 and partially compliant with Substandards 2, 3, and 5 (RY 2017).

PEPS Standard 71: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions. All PerformCare HC BH Contractors were partially compliant with Substandards 2, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant Substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with Substandards 1 and 2 (RY 2017).

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 and non-compliant Substandard descriptions under Statutory Basis and Definitions. All PerformCare HC BH Contractors were non-compliant with three Substandards 1 and Substandard 4 and partially compliant with Substandards 2, 3, and 5 (RY 2017).

PEPS Standard 71: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions. All PerformCare HC BH Contractors were partially compliant with Substandards 2, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant Substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with Substandards 1 and 2 (RY 2017).

Expedited Appeals Process

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

PEPS Standard 71: See Standard and partially compliant Substandard descriptions under Statutory Basis and Definitions. All PerformCare HC BH Contractors were partially compliant with Substandards 2, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant Substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with Substandards 1 and 2 (RY 2017).

Information to Subcontractors and Providers

All HC BH Contractors associated with PerformCare were partially compliant with Information to Subcontractors and Providers due to non-compliance with one substandard within Standard 68.

PEPS Standard 68: See Standard and non-compliant Substandard descriptions under Statutory Basis and Definitions. All PerformCare HC BH Contractors were non-compliant with Substandard 1 (RY 2017).

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 and partially compliant Substandard descriptions under Statutory Basis and Definitions. All PerformCare HC BH Contractors were partially compliant with Substandards 2, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant Substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with Substandards 1 and 2 (RY 2017).

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 and partially compliant Substandard descriptions under Statutory Basis and Definitions. All PerformCare HC BH Contractors were partially compliant with Substandards 2, 3, and 4 (RY 2017).

PEPS Standard 72: See Standard and partially compliant Substandard descriptions under Coverage and Authorization of Services. All HC BH Contractors were partially compliant with Substandards 1 and 2 (RY 2017).

II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for the MCO. Under the existing HC BH agreement with OMHSAS, HC BH Contractors, along with the responsible subcontracted entities (i.e., MCOs), are required to conduct a minimum of two focused studies per year. The HC BH Contractors and 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, MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2018 for 2017 activities.

Background

A new EQR PIP cycle began for 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 HC BH 30-day Readmission Rate has consistently not met the OMHSAS goal of a rate of 10% or less. In addition, all MCOs continue to remain below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS®) 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 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 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 that 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 extended from January 2014 through December 2018, with initial PIP proposals submitted in 2014 and a final report due in June 2019. 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. MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. MCOs were required to submit interim reports in 2016 and 2017. MCOs will be required to submit an additional interim report in 2018, as well as a final report in 2019. MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH Contractor-level and MCO-level data, including clinical

history and pharmacy data. This PIP is a collaboration between the HC BH Contractors and MCOs. The MCOs and each of their HC BH Contractors are required to collaboratively develop a root cause/barrier analysis that identifies potential barriers at the 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 addressing the barriers within their specific service areas. Each MCO will submit the single root cause/barrier analysis according to the PIP schedule. This PIP was formally introduced to the 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 MCOs and HC BH Contractors, as needed.

The 2018 EQR is the 15th review to include validation of PIPs. With this PIP cycle, all 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 MCOs/HC BH Contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness. The 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 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 in *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 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, MCOs were asked to submit only one PIP interim report in starting in 2016, rather than two semiannual submissions.

Validation Methodology

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (*EQR Protocol 3: Validating Performance Improvement Projects [PIPs], Version 2.0, September 2012*) and meets the requirements of the final rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 10 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 9 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 2017 was an intervention year for all MCOs

(which was then extended into 2018, as well), IPRO reviewed elements 1 through 9 for each MCO and provided preliminary feedback and guidance pertaining to sustainability.

Review Element Designation/Weighting

Calendar year 2017 was the second year of the Demonstrable Improvement stage. This section describes the scoring elements and methodology for reviewing the demonstrable improvement of the PIPs.

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 2.1** presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 2.1: 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 MCO's overall performance score for a PIP. Review elements 1 through 9 are for demonstrable improvement and have a total weight of 80% (**Table 2.2**). The highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for full compliance). The MCO must sustain improvement relative to the baseline after achieving demonstrable improvement.

Table 2.2: 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%

*At the time of this report, this standard was not yet reportable, in accordance with the PIP implementation schedule.

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. The project 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%.

Findings

MCO submitted their Year 3 PIP Update document for review in August 2018. IPRO provided feedback and comments to MCO on this submission. **Table 2.3** presents the PIP scoring matrix for this August 2018 Submission, which corresponds to the key findings of the review described in the following paragraphs. PerformCare received a total demonstrable improvement score of 55 out of 80 points (68.6%). Overall, this PIP was partially compliant for demonstrable improvement.

Table 2.3: 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	PM	50	5%	2.5
Review Element 2 – Study Question (AIM Statement)	M	100	5%	5
Review Element 3 – Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 – Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 – Data Collection Procedures	PM	50	10%	5
Review Element 7 – Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 – Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**55**
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.
*At the time of this report, this standard was not yet reportable, in accordance with the PIP implementation schedule.

As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. The MCO was partially compliant with review element 1, specifically in regard to the project identifiers. The MCO did not update or provide Section 1.7, Attestation, for the Annual PIP Project Update, reflecting approval of the project and assurance of involvement throughout the course of the project, with the undersigned's printed name, signed and date, as well as the associated title and organization. IPRO recommended that, if the signatures are to be provided on a separate document, the supporting documentation must be complete and submitted in tandem with the Annual PIP Project Update. There were no other issues or concerns with the requirements for the PIP topic and relevance; the PIP incorporated comprehensive data collection and analysis of aspects of enrollee needs, care and services, and addressed a broad spectrum of these appropriately.

The MCO had no issues or concerns with requirements for the aim statement; the study questions were clearly reported and linked to the methodology. The methodology used study variables (performance indicators) that met requirements; indicators were objective, clearly defined, measureable, time-specific, and designed to track outcomes (including the capacity to assess change and strengths of association). Furthermore, there were no issues or concerns with requirements for identification of study populations and methodology for sampling.

The MCO had an issue with data collection procedures, specifically with the data sources. In the submission, the MCO provided a schematic for their data collection and integration workflow for their electronic reporting warehouse, and indicated that the primary source changed from the eRW data warehousing system to the AmeriHealth Carita EDWH. This repository was noted to contain migrated health plan data from PerformCare's retired transaction system (eCura), and this warehouse was refreshed on a nightly basis. The EDWH used a similar process outlined previously. However, it was unclear which specific data sources the performance indicators used. For example, the data sources for the SAA

measure could have included ambulatory, inpatient, and pharmacy claims. There was no description of the data sources for the process measures. IPRO recommended that, in the next submission, each measure and the data source(s) should be listed and described clearly, especially in light of the changeover from the eRW to the AmeriHealth Carita EDWH. IPRO recommended that similar depictions of processes in the schematic should be updated accurately reflect the transition (and may be an opportunity to present automatic and/or manual data collection processes). The MCO was recommended to also clarify the data collection methodology (automated versus manual) for each measure, especially in light of the changeover from the eRW to the AmeriHealth Carita EDWH. Significant issues were noted with prospective data analysis planning and time lines for data collection, analysis, and reporting. The MCO did not provide updates, including description of data collection tasks. As in the previous submission, no comprehensive data analysis plan, specific to each indicator, were included. The MCO did not clearly indicate who will collect/analyze the data, and how these activities will be done for each measure. The MCO did not provide updates, including the time line of data collection and analysis activities.

The MCO also had several issues with improvement strategies (interventions). For identification of barriers and incorporation into the PIP, the MCO noted the following barriers in the baseline year: based on the DMP measure results, the MCO identified that there is a low percentage of members with Rx reconciliation done at discharge, and noted that the MCO does not receive claims for injectable medications; based on focus group results, the MCO determined that lack of transportation to pharmacies is a barrier for Rx adherence; lack of a central discharge process within the MCO; under-utilization of sub-acute MH programs (peer support, ACT and CTT were noted); and lack of timely member profiling. The MCO provided no substantial updates in regard to barrier analyses and interventions (including for intervention planning and ongoing implementation). There was insufficient evidence of regard to improvement strategies, the MCO's interpretations of study results (demonstrable improvement), and validity of reported improvement in the PIP during the measurement year. IPRO reviewed quarterly documentation for evidence to support the MCO's status. Furthermore, the MCO insufficiently discussed the results in terms of meaningful change in performance relative to baseline. Quarterly documentation provide some evidence in support of demonstrable improvement, although, for BHR-MH, the MY 2017 rate was 12.41% compared to 11.12% at baseline (2014). For BHR-SA, the MY 2017 rate was 12.93% compared to 13.4% at baseline. For SAA, the MY2017 rate was 63.71% compared to 47.34% at baseline. For DMP combination #3 numerator, the (simple) average MY 2017 rate was 11.43% compared to 9.17% in 2014. The MCO provided no statistical analysis and meaningful comparisons in the Annual Update, although there appeared to be some improvement. Improvement in SAA would need to be fully explained in terms of the interventions; overall, it was not clear if and how the PIP contributed to the reported improvement in SAA (if at all). The MCO had not sufficiently documented the facility implementation of interventions, dates of occurrence of intervention, and numbers impacted. IPRO recommended the MCO conduct appropriate analyses to determine whether interventions were (or were not) driving statistically significant improvement.

Findings for sustainability of documented improvement were not yet applicable; IPRO will review sustainability in the final report submission in terms of documentation of ongoing, additional, or modified interventions, and repeated measurements over comparable time periods.

III: Performance Measures

In 2018, 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 2017. OMHSAS also elected to implement a statewide measure that focuses on substance abuse services, based on 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 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge. The measure continues to be of interest to OMHSAS for the purpose of comparing county, 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 during which 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 during which 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 its performance measures. Based on these reviews, minor inconsistencies were found in how each BH-MCO produces its 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 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge.

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

Eligible Population

The entire eligible population was used for all 29 HC BH Contractors participating in the MY 2017 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, 2017;
- A principal ICD-9- or ICD-10-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, 2017, 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, 2017. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2018 methodology for the Follow-up after Hospitalization for Mental Illness measure.

HEDIS Follow-up Indicators

Quality Indicator 1 (QI 1): Follow-up After Hospitalization for Mental Illness within 7 Days after Discharge (Calculation based on Industry Standard codes used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner on the date of discharge up to 7 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

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

Numerator: An ambulatory visit with a mental health practitioner on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standards 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 7 Days after Discharge (Calculation based on Numerator 1 codes and additional PA-specific codes not used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 7 days after hospital discharge with one of the qualifying industry standards 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 standards 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 in 2008, mental illnesses and mental disorders represent 6 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% of overall disease burden in the United States (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. 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% 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 was 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 2017. For MY 2013 through MY 2017, BH-MCOs were 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 (Note: If any of the following rules generate a goal lower than the previous year's goal, then the new goal = last year's goal, even if this amounts to a greater than 5% improvement):

1. If the yearly rate is below the NCQA Quality Compass® 50th percentile, then:
    a. If rate ≥ 5 percentage points (PPs) below the Quality Compass 50th percentile, then new goal = last year's rate + 5% improvement over last year's rate.
    b. If rate ≥ 2 PPs and < 5 PPs below the Quality Compass 50th percentile, then new goal = last year's rate + 5% improvement over last year's rate, or the Quality Compass 50th percentile, whichever is less.
    c. If rate < 2 PPs below the Quality Compass 50th percentile, then new goal = the Quality Compass 50th percentile.
2. If the yearly rate is rate is above or equal to the Quality Compass 50th percentile and below the 75th percentile, then:
    a. If rate ≥ 2 PPs below the Quality Compass 75th percentile, then new goal = last year's rate + 2% improvement over last year's rate
    b. If rate < 2 PPs below the Quality Compass 75th percentile, then new goal = last year's rate + 2% improvement over last year's rate, or the Quality Compass 75th percentile, whichever is less.
3. If rate is above or equal to the Quality Compass 75th percentile, then new goal = last year's goal.

Interim goals were provided to the BH-MCOs after the MY 2016 rates were received. The interim goals were updated from MY 2013 to MY 2017. 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 2017, 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 of qualifying events or members and a denominator of qualifying events or members, defined according to the specifications of the measure. The HealthChoices Aggregate (Statewide) for each indicator was the total numerator divided by the total denominator, which represented the rate derived for the Statewide population of denominator-qualifying events or members. Year-to-year comparisons to MY 2016 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *z* statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

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

Where:

*N*1 = Current year (MY 2017) numerator
*N*2 = Prior year (MY 2016) numerator
*D*1 = Current year (MY 2017) denominator
*D*2 = Prior year (MY 2016) denominator

The single proportion estimate was then used for estimating the standard error (SE).

Z-test-statistic was obtained by dividing the difference between the proportions by the standard error of the difference. Analysis that uses the *z* test assumes that the data and their test statistics approximate a normal distribution. To correct for approximation error, the Yates correction for continuity was applied:

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

Where:

*p*1 = Current year (MY 2017) quality indicator rate
*p*2 = Prior year (MY 2016) quality indicator rate

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

$$H_0: p1 = p2$$

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

It should be noted that Pennsylvania continued its Medicaid expansion under the Affordable Care Act in 2017. Due to data quality concerns with identifying the Medicaid expansion subpopulation, however, the decision was made not to compare rates for this subpopulation: thus any potential impacts on rates from the Medicaid expansion were not evaluated for MY 2017. The plan is to incorporate this analysis in next year's BBA report.

Limitations

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

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 to 20 years old age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old only.

The results are presented at the BH-MCO- and 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 Aggregate (Statewide) rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HealthChoices BH Statewide rates 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 Statewide rate for the indicator. Statistically significant BH-MCO differences are noted.

HC BH Contractor-specific rates were also compared to the HealthChoices BH Statewide rates 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 BH Statewide rate for the indicator. Statistically significant HC BH Contractor-specific differences are noted.

The HEDIS follow-up results for the 6 to 64 years old age group and the 6+ years old age groups are compared to the MY 2017 HEDIS national percentiles. NCQA produces annual HEDIS Follow-up After Mental Health benchmarks for the 6+ years old age band only; therefore results for the 6 to 64 year old age group are compared to percentiles for the 6+ years old age bands. The percentile comparison for the ages 6 to 64 years 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 2017. HEDIS percentile comparisons for the ages 6+ years old age group are presented for illustrative purposes only. The HEDIS follow-up results for the 6 to 20 years old age group are not compared to HEDIS benchmarks for the 6+ years old 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 was for all HC BH Contractor and BH-MCO rates to meet or exceed the HEDIS 75th percentile by MY 2017. For MYs 2013 through 2017, BH-MCOs were 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 3.1** shows the MY 2017 results compared to their MY 2017 goals and HEDIS percentiles, as well as to MY 2016.

The MY 2017 HealthChoices Aggregate (Statewide) HEDIS follow-up rates in the 6 to 64 years age group were 39.3% for QI 1 and 60.9% for QI 2 (**Table 3.1**). These rates were statistically significantly lower than the HealthChoices Aggregate rates for this age group in MY 2016, which were 43.7% and 63.5% respectively. The HealthChoices Aggregate rates were below the MY 2017 interim goals of 48.5% for QI 1 and 69.2% for QI 2; therefore, statewide, neither of the interim goals were met in MY 2017. Both HealthChoices Aggregate rates were between the NCQA 50th and 75th percentiles; therefore, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile was not achieved by the HealthChoices population in MY 2017 for either rate.

The MY 2017 PerformCare QI 1 rate for members ages 6 to 64 years was 39.2%, a 0.1 percentage point increase from the MY 2016 rate of 39.1 % (**Table 3.1**). PerformCare's corresponding QI 2 rate was 62.1%, a 0.3 percentage point decrease from the MY 2016 rate of 62.4%. None of the rates were statistically significantly different from the prior year. PerformCare's rates were below its target goals of 46.2% for QI 1 and 71% for QI 2; therefore, neither of the interim follow-up goals were met in MY 2017. Both HEDIS rates for this age group were between the HEDIS 2018 50th and 75th percentiles; therefore, the OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by PerformCare in MY 2017 for either rate.

From MY 2016 to MY 2017, PerformCare HC BH contractor rates were not statistically significantly different compared to prior year and none of them met MY 2017 interim goals. The only notable change was 7.1 percentage point increase for QI 1 rate in Franklin-Fulton (**Table 3.1**). Of the PerformCare Contractors, only Franklin-Fulton met the HEDIS MY2017 goal of meeting of exceeding the 75th percentile for both QI 1 and QI 2. Cumberland's QI 2 rate met the HEDIS MY2017 goal of meeting or exceeding the 75th percentile.

Table 3.1: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Indicators (6–64 Years)

MY 2017								MY 2016	MY 2017 Rate Comparison		
				95% CI		Goal			To MY 2016		To MY 2017 HEDIS Medicaid
Measure	(N)	(D)	%	Lower	Upper	%	Met?	%	PPD	SSD	Percentiles
QI1 – HEDIS 7-Day Follow-up (6–64 Years)											
HealthChoices (Statewide)	16,420	41,778	**39.3%**	38.8%	39.8%	48.5%	No	43.7%	-4.4	Yes	Below 75th percentile, above 50th percentile
PerformCare	1,538	3,926	**39.2%**	37.6%	40.7%	46.2%	No	39.1%	0.1	No	Below 75th percentile, above 50th percentile
Bedford-Somerset	115	266	**43.2%**	37.1%	49.4%	47.0%	No	46.2%	-3.0	No	Below 75th percentile, above 50th percentile
Cumberland	185	431	**42.9%**	38.1%	47.7%	46.2%	No	42.4%	0.5	No	Below 75th percentile, above 50th percentile
Dauphin	366	1,017	**36.0%**	33.0%	39.0%	41.9%	No	35.2%	0.8	No	Below 50th percentile, above 25th percentile
Franklin-Fulton	158	339	**46.6%**	41.1%	52.1%	52.4%	No	39.5%	7.1	No	At or above 75th percentile
Lancaster	469	1,287	**36.4%**	33.8%	39.1%	47.1%	No	39.1%	-2.7	No	Below 50th percentile, above 25th percentile
Lebanon	211	480	**44.0%**	39.4%	48.5%	56.0%	No	42.9%	1.1	No	Below 75th percentile, above 50th percentile
Perry	34	106	**32.1%**	22.7%	41.4%	36.9%	No	35.1%	-3.0	No	Below 50th percentile, above 25th percentile
QI2 – HEDIS 30-Day Follow-up (6–64 Years)											
HealthChoices (Statewide)	25,425	41,778	**60.9%**	60.4%	61.3%	69.2%	No	63.5%	-2.6	Yes	Below 75th percentile, above 50th percentile
PerformCare	2,438	3,926	**62.1%**	60.6%	63.6%	71.0%	No	62.4%	-0.3	No	Below 75th percentile, above 50th percentile
Bedford-Somerset	178	266	**66.9%**	61.1%	72.8%	69.0%	No	67.6%	-0.7	No	Below 75th percentile, above 50th percentile

MY 2017								MY 2016	MY 2017 Rate Comparison		
				95% CI		Goal			To MY 2016		To MY 2017 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper	%	Met?	%	PPD	SSD	
Cumberland	299	431	**69.4%**	64.9%	73.8%	70.9%	No	66.3%	3.1	No	At or above 75th percentile
Dauphin	599	1,017	**58.9%**	55.8%	62.0%	65.5%	No	58.1%	0.8	No	Below 50th percentile, above 25th percentile
Franklin-Fulton	250	339	**73.7%**	68.9%	78.6%	75.3%	No	72.0%	1.7	No	At or above 75th percentile
Lancaster	735	1,287	**57.1%**	54.4%	59.9%	70.9%	No	60.3%	-3.2	No	Below 50th percentile, above 25th percentile
Lebanon	314	480	**65.4%**	61.1%	69.8%	75.3%	No	67.8%	-2.4	No	Below 75th percentile, above 50th percentile
Perry	63	106	**59.4%**	49.6%	69.3%	66.1%	No	60.6%	-1.2	No	Below 50th percentile, above 25th percentile

N: numerator; D: denominator; CI: confidence interval; PPD: percentage point difference; SSD: statistically significant difference; N/A: Confidence intervals were not calculated if denominators of rates contained less than 100 members.

Figure 3.1 is a graphical representation of MY 2017 HEDIS FUH 7- and 30-Day follow-up rates in the 6 to 64 years old population for PerformCare and its associated HC BH Contractors.

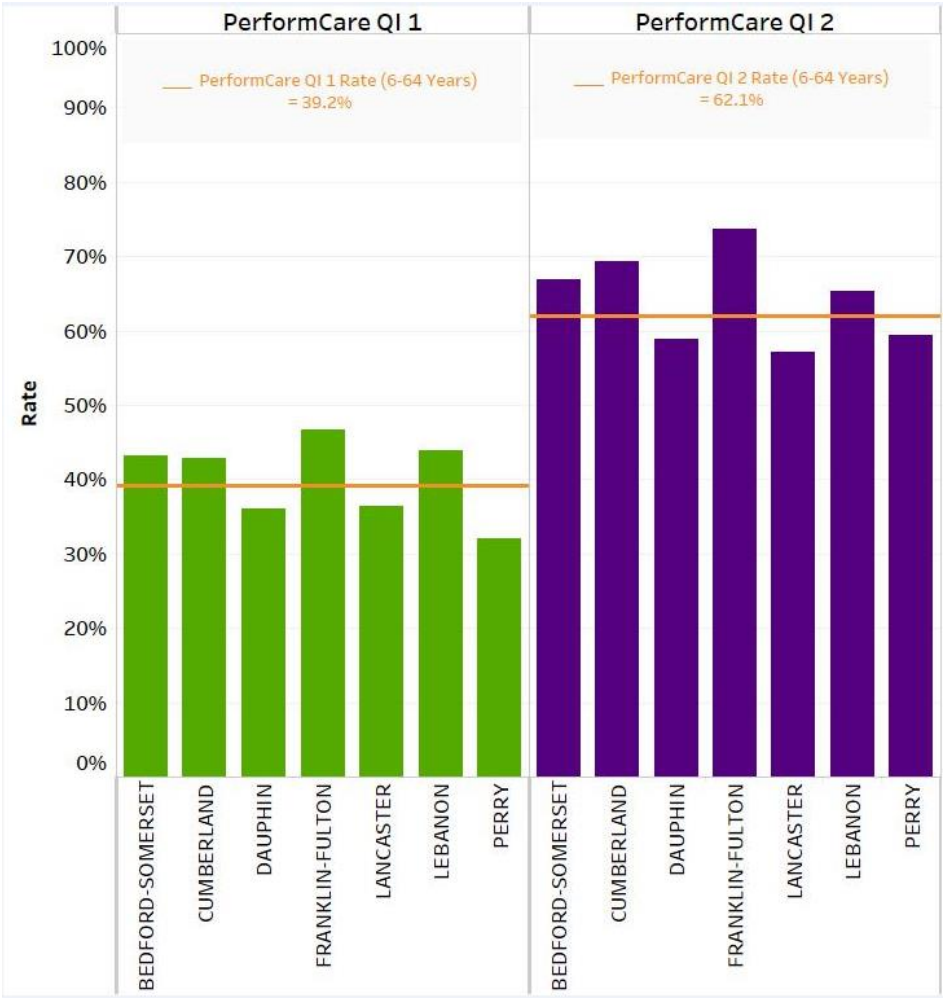


Figure 3.1: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (6–64 Years).

Figure 3.2 shows the HC BH (Statewide) rates for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the HC BH (Statewide) rate. Both Lancaster and Dauphin turned in QI 1 rates that were statistically significantly below the MY 2017 QI 1 HC BH rate of 39.3% by 2.9 and 3.3 percentage points, respectively. QI 1 rates were statistically significantly above the Statewide rate for Lebanon and Franklin-Fulton by 4.7 and 7.3 percentage points, respectively. For QI 2, Lancaster produced a rate significantly below (by 3.8 percentage points) the QI 2 HC BH rate of 60.9%, while Lebanon, Cumberland, and Franklin-Fulton produced rates that were statistically significantly above the Statewide rate by a range of 4.5 to 12.8 percentage points.

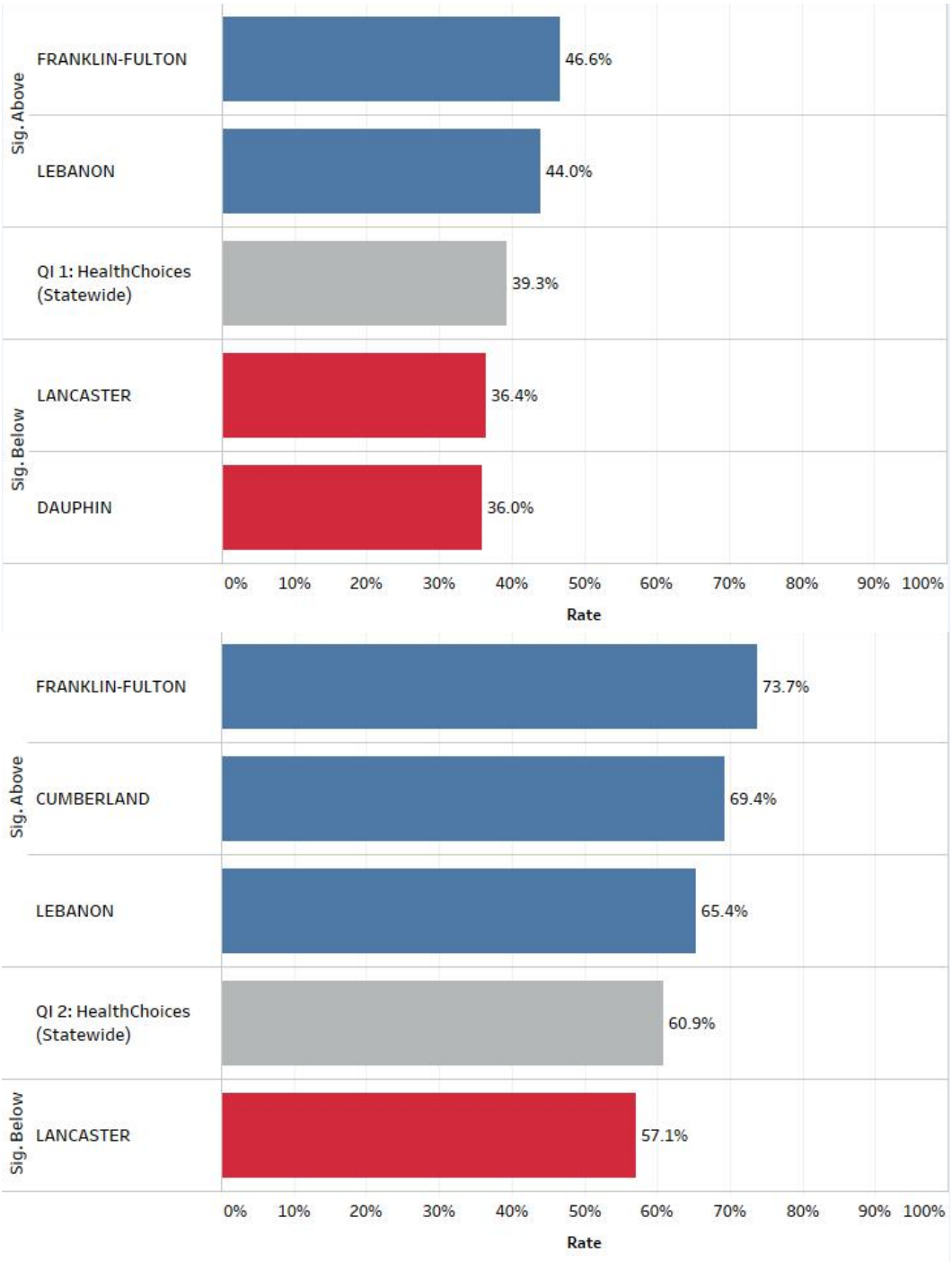


Figure 3.2: Comparison of PerformCare Contractor MY 2017 HEDIS FUH Follow-up Rates (6–64 Years) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (6–64 Years).

(b) Overall Population: 6+ Years Old

The MY 2017 HealthChoices Aggregate HEDIS follow-up rates were 39.1% for QI 1 and 60.6% for QI 2 (**Table 3.2**). These rates were statistically significantly lower than the HealthChoices Aggregate rates in MY 2016, which were 43.5% and 63.2%, respectively. For PerformCare, the MY 2017 QI 1 rate was 39.1% (an increase of 0.2 percentage point compared to MY 2016) and QI 2 rate was 61.9% (a drop of 0.2 percentage point compared to MY 2016). None of these changes were statistically significant. None of the HC BH Contractors' rates changed significantly from MY2016 to MY 2017. Franklin-Fulton's QI 1 and QI 2 rates met the HEDIS MY 2017 goal of meeting or exceeding the 75th percentile. Cumberland performed at or above the 75th percentile in QI 2 (**Table 3.2**).

Table 3.2: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Indicators (Overall)

MY 2017						MY 2016	MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD	
QI1 – HEDIS 7-Day Follow-up (Overall)									
Statewide	16,536	42,283	**39.1%**	38.6%	39.6%	43.5%	-4.3	Yes	Below 75th percentile, above 50th percentile
PerformCare	1,547	3,960	**39.1%**	37.5%	40.6%	38.9%	0.2	No	Below 75th percentile, above 50th percentile
Bedford-Somerset	116	271	**42.8%**	36.7%	48.9%	46.1%	-3.3	No	Below 75th percentile, above 50th percentile
Cumberland	185	433	**42.7%**	38.0%	47.5%	42.1%	0.6	No	Below 75th percentile, above 50th percentile
Dauphin	368	1,026	**35.9%**	32.9%	38.9%	34.9%	1.0	No	Below 50th percentile, above 25th percentile
Franklin-Fulton	161	344	**46.8%**	41.4%	52.2%	39.3%	7.5	No	At or above 75th percentile
Lancaster	472	1,298	**36.4%**	33.7%	39.0%	38.9%	-2.5	No	Below 50th percentile, above 25th percentile
Lebanon	211	482	**43.8%**	39.2%	48.3%	42.4%	1.4	No	Below 75th percentile, above 50th percentile
Perry	34	106	**32.1%**	22.7%	41.4%	35.1%	-3.0	No	Below 50th percentile, above 25th percentile
QI2 – HEDIS 30-Day Follow-up (Overall)									
Statewide	25,630	42,283	**60.6%**	60.1%	61.1%	63.2%	-2.6	Yes	Below 75th percentile, above 50th percentile
PerformCare	2,453	3,960	**61.9%**	60.4%	63.5%	62.1%	-0.2	No	Below 75th percentile, above 50th percentile
Bedford-Somerset	180	271	**66.4%**	60.6%	72.2%	67.1%	-0.7	No	Below 75th percentile, above 50th percentile
Cumberland	299	433	**69.1%**	64.6%	73.5%	66.0%	3.1	No	At or above 75th percentile
Dauphin	601	1,026	**58.6%**	55.5%	61.6%	58.0%	0.6	No	Below 50th percentile, above 25th percentile
Franklin-Fulton	255	344	**74.1%**	69.4%	78.9%	71.6%	2.5	No	At or above 75th percentile
Lancaster	740	1,298	**57.0%**	54.3%	59.7%	60.0%	-3.0	No	Below 50th percentile, above 25th percentile
Lebanon	315	482	**65.4%**	61.0%	69.7%	67.2%	-1.8	No	Below 75th percentile, above 50th percentile
Perry	63	106	**59.4%**	49.6%	69.3%	60.6%	-1.2	No	Below 50th percentile, above 25th percentile

N: numerator; D: denominator; CI: confidence interval; PPD: percentage point difference; SSD: statistically significant difference; N/A: Confidence intervals were not calculated if denominators of rates contained less than 100 members.

Figure 3.3 is a graphical representation of the MY 2017 HEDIS follow-up rates for PerformCare and its associated HC BH Contractors.

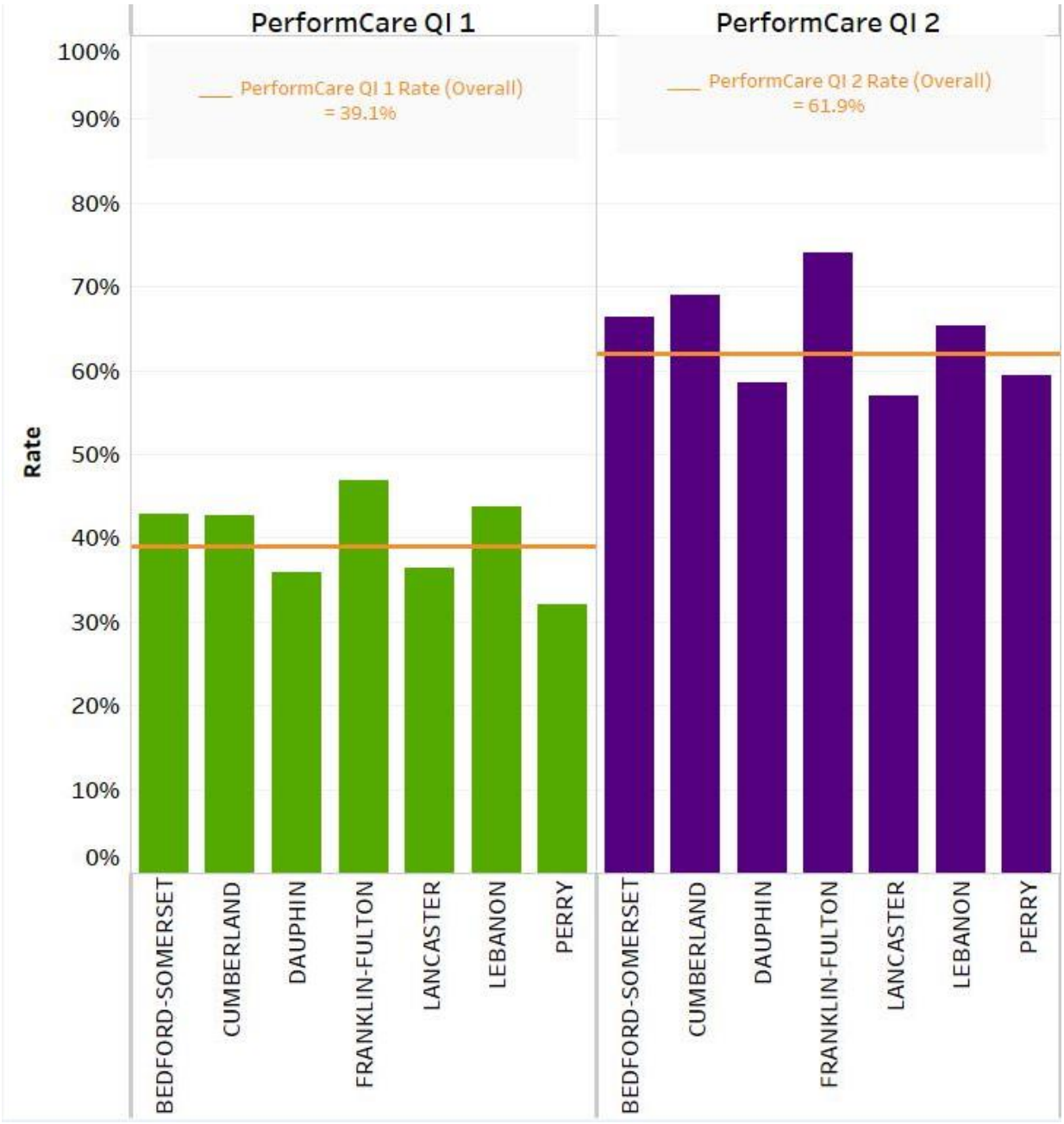


Figure 3.3: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (Overall).

Figure 3.4 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than its Statewide benchmark. Lancaster's and Dauphin's QI 1 rates were statistically significantly below the MY 2017 QI 1 HC BH rate of 39.1% by between 2.7 and 3.2 percentage points. QI 1 rates were statistically significantly above the statewide rate for Lebanon and Franklin-Fulton by 4.7 and 7.7 percentage points, respectively. For QI 2, Lancaster produced a rate significantly below (by 3.6 percentage points) the QI 2 HC BH rate of 60.6%, while Lebanon, Cumberland, and Franklin-Fulton produced rates that were statistically significantly above the Statewide rate by a range of 4.8 to 13.5 percentage points.

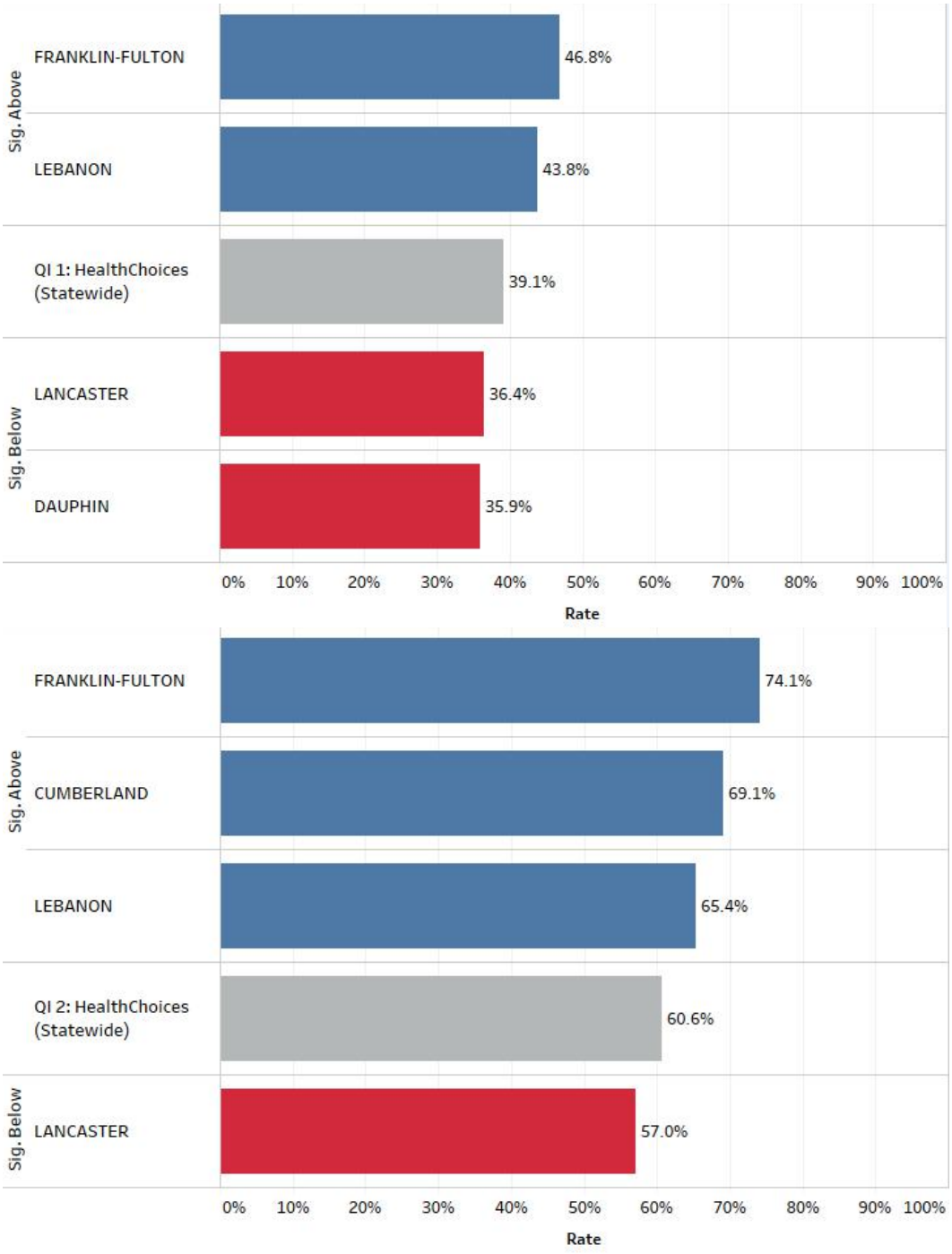


Figure 3.4: Comparison of PerformCare Contractor MY 2017 HEDIS FUH Follow-up Rates (Overall) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (Overall).

(c) Age Group: 6–20 Years Old

The MY 2017 HealthChoices Aggregate rates in the 6 to 20 years old age group were 51.1% for QI 1 and 74.0% for QI 2 (**Table 3.3**). These rates were statistically significantly lower than the MY 2016 HealthChoices Aggregate rates for the 6 to 20 years old age cohort, which were 56.1% and 77.4%, respectively. The PerformCare MY 2017 HEDIS rates for members ages 6 to 20 years were 53.7% for QI 1 and 75.8% for QI 2, which are comparable to last year's rates (**Table 3.3**). Of the PerformCare Contractors with sufficiently large denominators to compare, there were no notable changes in rates for this age group from MY 2016.

Table 3.3: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Indicators (6–20 Years)

MY 2017						MY 2016 %	MY 2017 Rate Comparison to MY 2016	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD
QI1 – HEDIS 7-Day Follow-up (6–20 Years)								
Statewide	5,792	11,325	**51.1%**	50.2%	52.1%	56.1%	-5.0	Yes
PerformCare	629	1,171	**53.7%**	50.8%	56.6%	53.6%	0.1	No
Bedford-Somerset	48	74	**64.9%**	N/A	N/A	57.6%	7.3	N/A
Cumberland	74	136	**54.4%**	45.7%	63.2%	54.1%	0.3	No
Dauphin	121	236	**51.3%**	44.7%	57.9%	54.1%	-2.8	No
Franklin-Fulton	64	115	**55.7%**	46.1%	65.2%	54.1%	1.6	No
Lancaster	201	388	**51.8%**	46.7%	56.9%	55.6%	-3.8	No
Lebanon	100	177	**56.5%**	48.9%	64.1%	49.1%	7.4	No
Perry	21	45	**46.7%**	N/A	N/A	29.4%	17.3	N/A
QI2 – HEDIS 30-Day Follow-Up (6–20 Years)								
Statewide	8,380	11,325	**74.0%**	73.2%	74.8%	77.4%	-3.4	Yes
PerformCare	888	1,171	**75.8%**	73.3%	78.3%	77.3%	-1.5	No
Bedford-Somerset	63	74	**85.1%**	N/A	N/A	81.2%	3.9	N/A
Cumberland	99	136	**72.8%**	64.9%	80.6%	79.7%	-6.9	No
Dauphin	174	236	**73.7%**	67.9%	79.6%	78.0%	-4.3	No
Franklin-Fulton	92	115	**80.0%**	72.3%	87.7%	85.9%	-5.9	No
Lancaster	286	388	**73.7%**	69.2%	78.2%	74.7%	-1.0	No
Lebanon	143	177	**80.8%**	74.7%	86.9%	74.5%	6.3	No
Perry	31	45	**68.9%**	N/A	N/A	67.6%	1.3	N/A

N: numerator; D: denominator; CI: confidence interval; PPD: percentage point difference; SSD: statistically significant difference; N/A: Confidence intervals were not calculated if denominators of rates contained less than 100 members.

Figure 3.5 is a graphical representation of the MY 2017 HEDIS follow-up rates in the 6 to 20 years old population for PerformCare and its associated HC BH Contractors.

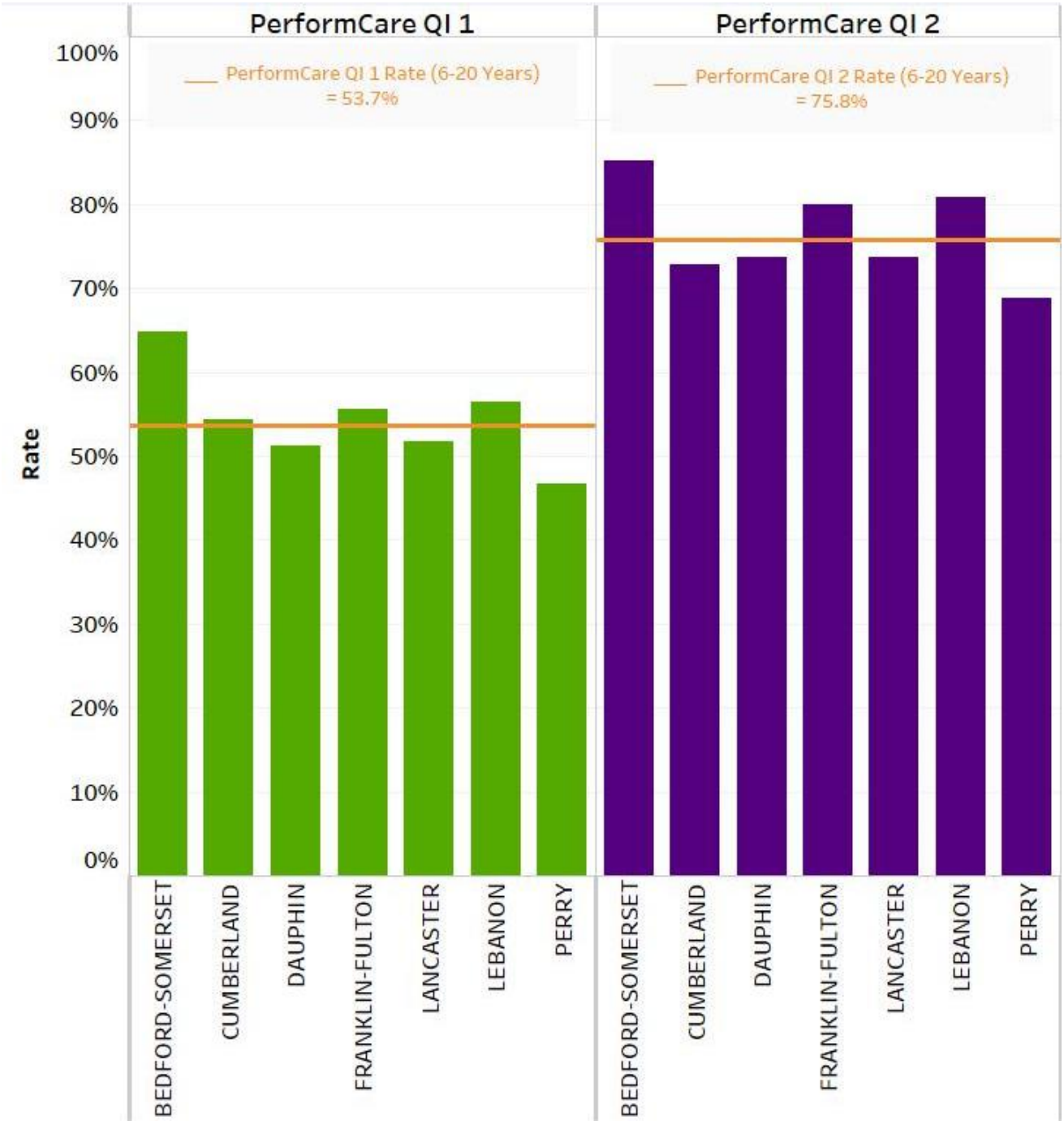


Figure 3.5: MY 2017 HEDIS FUH 7- and 30-Day Follow-up Rates (6–20 Years).

Figure 3.6 shows the HC BH (Statewide) rates for this age cohort and the individual HC BH Contractor rates that would have been statistically significantly higher or lower than the Statewide rates. Out of the Contractors with sufficient denominators, the QI 1 rate was not statistically significantly different from the HC QI 1 rate of 51.1%, while the QI 2 rate for Lebanon was statistically significantly above the Statewide QI 2 rate of 74.0% by 6.8 percentage points.

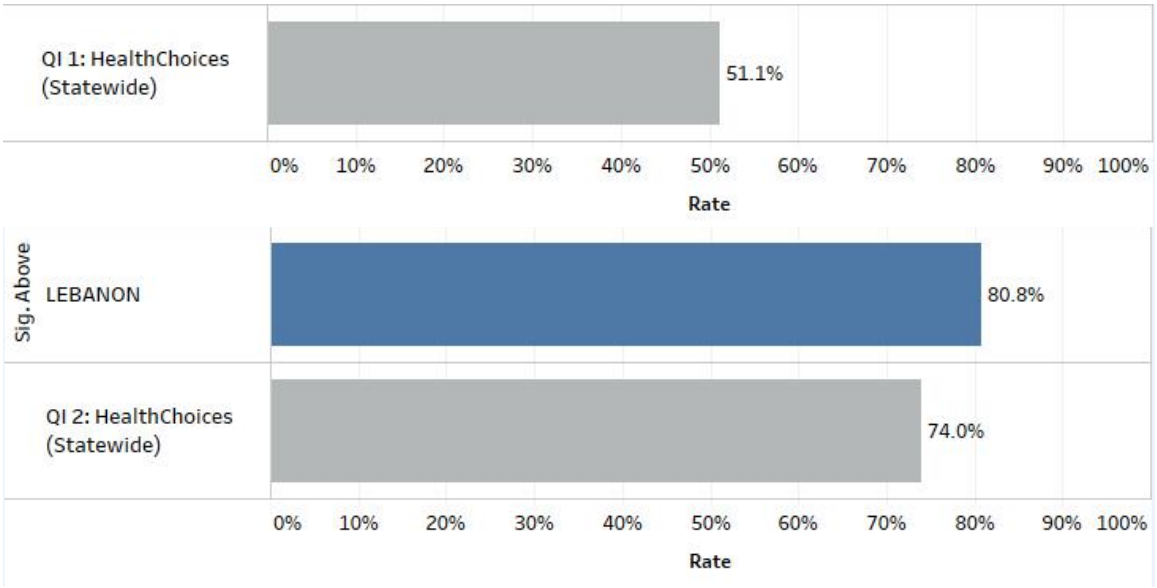


Figure 3.6: Comparison of PerformCare Contractor MY 2017 HEDIS FUH Follow-up Rates (6–20 Years) versus HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (6–20 Years).

II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

The MY 2017 HealthChoices Aggregate rates were 52.2% for QI A and 69.6% for QI B (**Table 3.4**). Both rates demonstrated statistically significant decreases from the MY 2016 PA-specific follow-up rates: the QI A rate decreased from the MY 2016 rate of 53.8% by 1.6 percentage points, while the QI B rate decreased from the MY 2016 rate of 70.4% by 0.8 percentage points. The MY 2017 PerformCare QI A rate was 51.4%, which represents a 0.2 percentage point decrease from the prior year, and the PerformCare QI B rate was 70.9%, which represents a 1.3 percentage point decrease from the prior year. These year-to-year decreases were not statistically significant.

From MY 2016 to MY 2017, none of the Contractors with PerformCare experienced significant changes in their QI A and QI B rates. The only notable Contractor was Franklin-Fulton, whose rate increased by 7.7 percentage points for QI A and 2.2 percentage points for QI B.

Table 3.4: MY 2017 PA-Specific FUH 7- and 30-Day Follow-up Indicators (Overall)

MY 2017						MY 2016 %	MY 2017 Rate Comparison to MY 2016	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD
QI A – PA-Specific 7-Day Follow-up (Overall)								
Statewide	22,071	42,280	**52.2%**	51.7%	52.7%	53.8%	-1.6	Yes
PerformCare	2,034	3,960	**51.4%**	49.8%	52.9%	51.6%	-0.2	No
Bedford-Somerset	152	271	**56.1%**	50.0%	62.2%	57.9%	-1.8	No
Cumberland	227	433	**52.4%**	47.6%	57.2%	52.7%	-0.3	No
Dauphin	546	1,026	**53.2%**	50.1%	56.3%	54.4%	-1.2	No
Franklin-Fulton	208	344	**60.5%**	55.2%	65.8%	52.8%	7.7	No
Lancaster	610	1,298	**47.0%**	44.2%	49.7%	48.8%	-1.8	No
Lebanon	244	482	**50.6%**	46.1%	55.2%	49.1%	1.5	No
Perry	47	106	**44.3%**	34.4%	54.3%	42.6%	1.7	No

MY 2017						MY 2016 %	MY 2017 Rate Comparison to MY 2016	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD
QI B – PA-Specific 30-Day Follow-up (Overall)								
Statewide	29,440	42,280	**69.6%**	69.2%	70.1%	70.4%	-0.8	Yes
PerformCare	2,807	3,960	**70.9%**	69.5%	72.3%	72.2%	-1.3	No
Bedford-Somerset	205	271	**75.6%**	70.4%	80.9%	77.1%	-1.5	No
Cumberland	321	433	**74.1%**	69.9%	78.4%	74.9%	-0.8	No
Dauphin	731	1,026	**71.2%**	68.4%	74.1%	73.0%	-1.8	No
Franklin-Fulton	273	344	**79.4%**	74.9%	83.8%	77.2%	2.2	No
Lancaster	863	1,298	**66.5%**	63.9%	69.1%	69.2%	-2.7	No
Lebanon	340	482	**70.5%**	66.4%	74.7%	71.2%	-0.7	No
Perry	74	106	**69.8%**	60.6%	79.0%	66.0%	3.8	No

N: numerator; D: denominator; CI: confidence interval; PPD: percentage point difference; SSD: statistically significant difference; N/A: Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

Figure 3.7 is a graphical representation of the MY 2017 PA-specific follow-up rates for PerformCare and its associated HC BH Contractors.

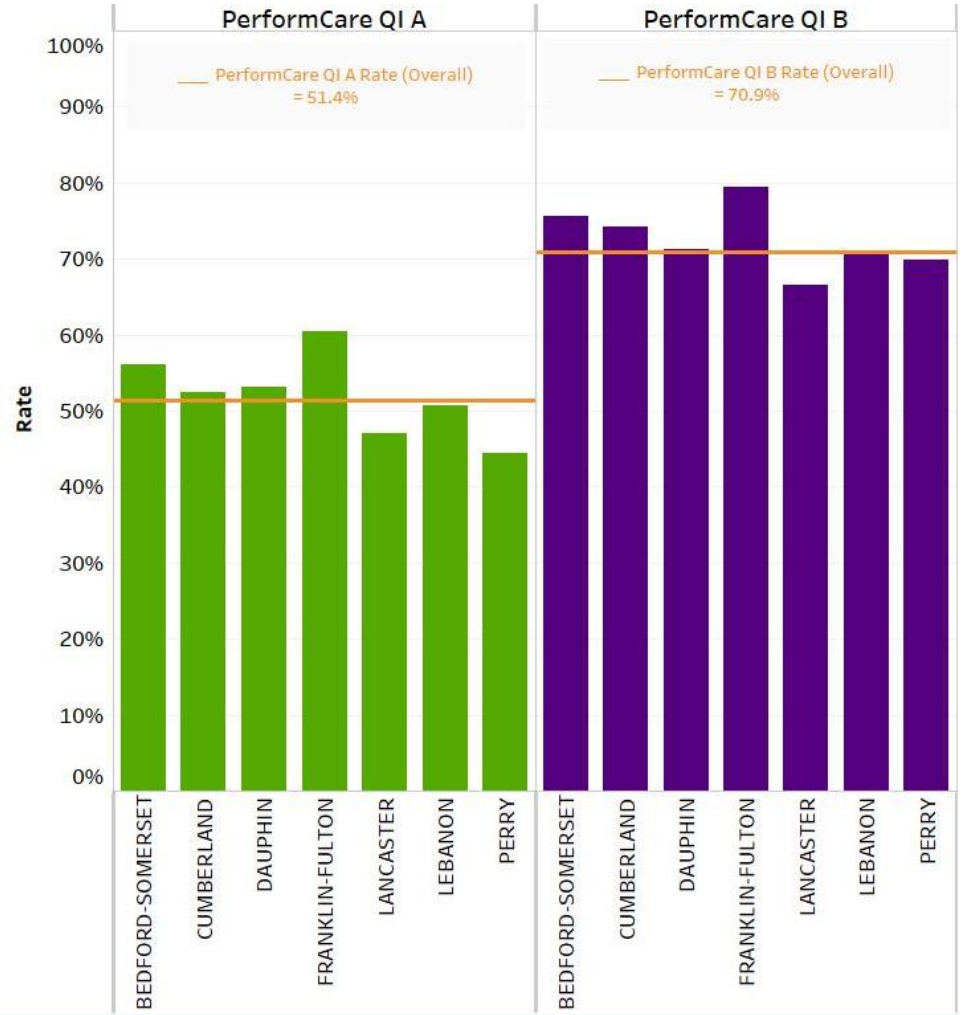


Figure 3.7: MY 2017 PA-Specific FUH 7- and 30-Day Follow-up Rates (Overall).

Figure 3.8 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. The QI A rate for Franklin-Fulton was statistically significantly higher than the QI A HC rate of 52.2% (by 8.3 percentage points), while Lancaster's QI A rate was statistically significantly below the QI A HC rate by 5.2 percentage points in MY 2017. For QI B, Cumberland, Bedford-Somerset, and Franklin-Fulton all returned rates that were statistically significantly higher than the QI B HC rate of 69.6%, with differences ranging from 4.5 and 9.8 percentage points. Lancaster's QI B rate decreased statistically significantly below the QI B Statewide rate by 3.1 percentage points.

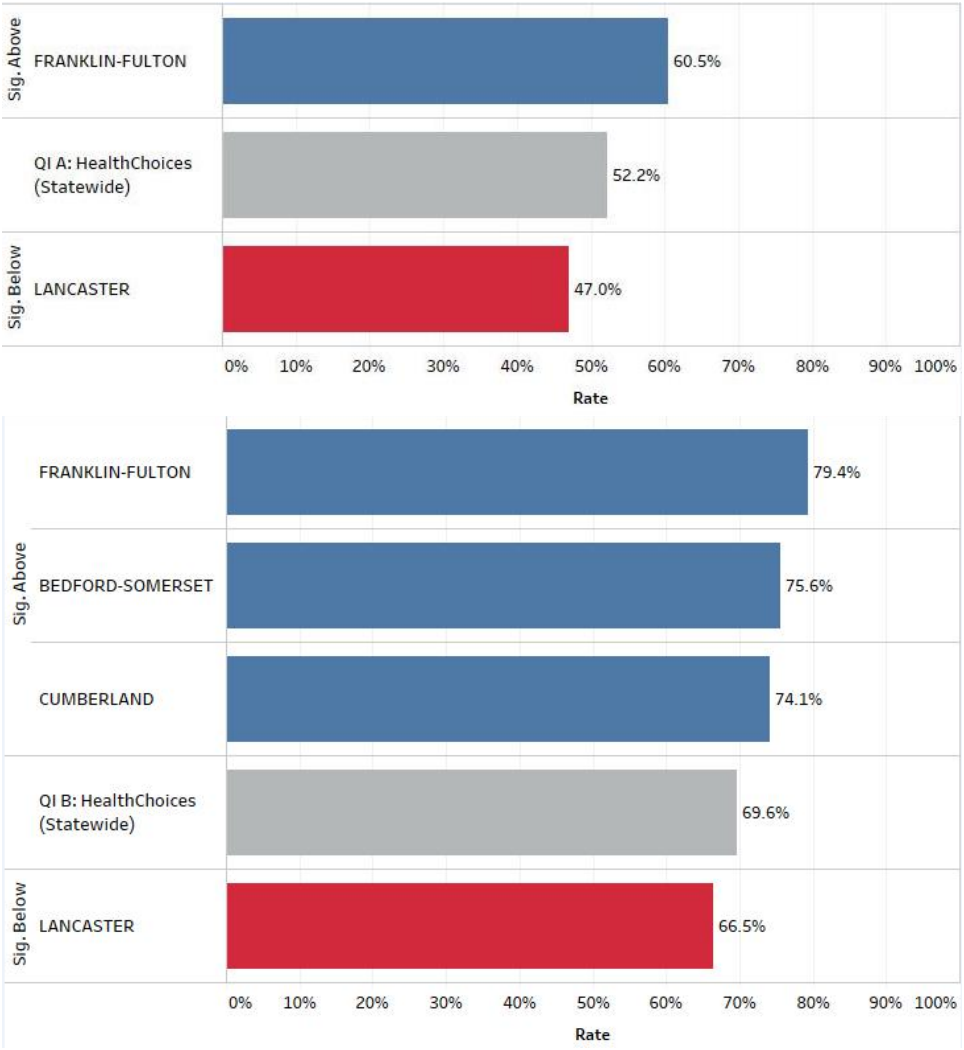


Figure 3.8: Comparison of PerformCare Contractor MY 2017 PA-Specific FUH Follow-up Rates (Overall) versus HealthChoices (Statewide) MY 2017 PA-Specific FUH Follow-up Rates (Overall).

Conclusion and Recommendations

As with most reporting years, it is important to note that there were some changes to the HEDIS 2018 specifications, including the numerator exclusion of visits that occur on the date of discharge (although this exclusion did not extend to the PA-specific measure). That said, 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 Statewide rate. Following are recommendations that are informed by both the MY 2017 review as well as by the 2015 follow-up (care) study, which included results for MY 2014 and MY 2015:

- 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 between 2012 and 2016, which included the first year of the current

PIP cycle, to promote continuous quality improvement with regard to timely 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. BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in the next few years as a result of their 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 care 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. OMHSAS's shift in 2017 to a prospective RCA and CAP process should assist with this effort.

- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. This year's findings indicate that, with some notable HC BH Contractor exceptions, FUH rates have, for the most part, decreased (worsened), both for the State and for the BH-MCO. In some cases, the change was a continuation or even acceleration of existing trends. As previously noted, this analysis was not able to carry out more detailed examination of rates associated with the Medicaid expansion subpopulation. The potential impact on rates from the Medicaid expansion in 2017 could not be evaluated in this report. However, BH-MCOs and HC BH Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For one, 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. Further, it is important to examine regional trends in disparities. For instance, previous studies indicate that African Americans in rural areas have disproportionately low follow-up rates, which stands in contrast to the finding that overall follow-up rates are generally 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 did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-up After Hospitalization for Mental Illness, OMHSAS elected to retain and re-measure the Readmission Within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Re-measurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2017 study conducted in 2018 was the ninth re-measurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish a same-day readmission from a transfer to another acute facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH (Statewide) level for MY 2017. 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. In order to identify the administrative numerator-positives, date-of-service, and diagnosis/procedure code criteria were outlined, as well as were 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 29 HC BH Contractors participating in the MY 2017 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, 2017;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim that was 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 2017 to MY 2016 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the *z* score. Statistically significant difference (SSD) at the 0.05 level between groups is noted, as well as the PPD between the rates.

Individual rates were 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% confidence interval (CI) included the average for the indicator.

Lastly, aggregate rates were 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.

The MY 2017 HealthChoices Aggregate (Statewide) readmission rate was 13.4%, which represents a decrease from the MY 2016 HealthChoices Aggregate rate of 13.9% by 0.5 percentage points (**Table 3.5**); this difference was statistically significant. The PerformCare MY 2017 readmission rate was 11.1%. The MY 2016 rate was 15.4%; this change was statistically significant. PerformCare did not meet the performance goal of a readmission rate at or below 10.0% in MY 2017.

From MY 2016 to MY 2017, the psychiatric readmission rate for Bedford-Somerset, Dauphin and Lancaster decreased (improved) significantly by 7.7, 5.5, 4.7 percentage points, respectively. The REA rates for Cumberland, Franklin-Fulton, Lebanon, and Perry also decreased, but the change was not statistically significant. Only Bedford-Somerset and Lancaster met or surpassed the OMHSAS performance goal of 10%.

Table 3.5: MY 2017 REA Readmission Indicators

MY 2017						Goal Met?[1]	MY 2016 %	MY 2017 Rate Comparison to MY 2016	
				95% CI					
Measure	(N)	(D)	%	Lower	Upper			PPD	SSD
Inpatient Readmission									
Statewide	7,121	52,977	**13.4%**	13.2%	13.7%	No	13.9%	-0.5	Yes
PerformCare	527	4,745	**11.1%**	10.2%	12.0%	No	15.4%	-4.3	Yes
Bedford-Somerset	23	307	**7.5%**	4.4%	10.6%	Yes	15.2%	-7.7	Yes
Cumberland	54	518	**10.4%**	7.7%	13.2%	No	12.6%	-2.2	No
Dauphin	163	1,254	**13.0%**	11.1%	14.9%	No	18.5%	-5.5	Yes
Franklin-Fulton	53	423	**12.5%**	9.3%	15.8%	No	15.3%	-2.8	No
Lancaster	148	1,514	**9.8%**	8.2%	11.3%	Yes	14.5%	-4.7	Yes
Lebanon	70	591	**11.8%**	9.2%	14.5%	No	14.2%	-2.4	No
Perry	16	138	**11.6%**	5.9%	17.3%	No	5.5%	6.1	No

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

Figure 3.9 is a graphical representation of the MY 2017 readmission rates for PerformCare HC BH Contractors compared to the OMHSAS performance goal of 10.0%.

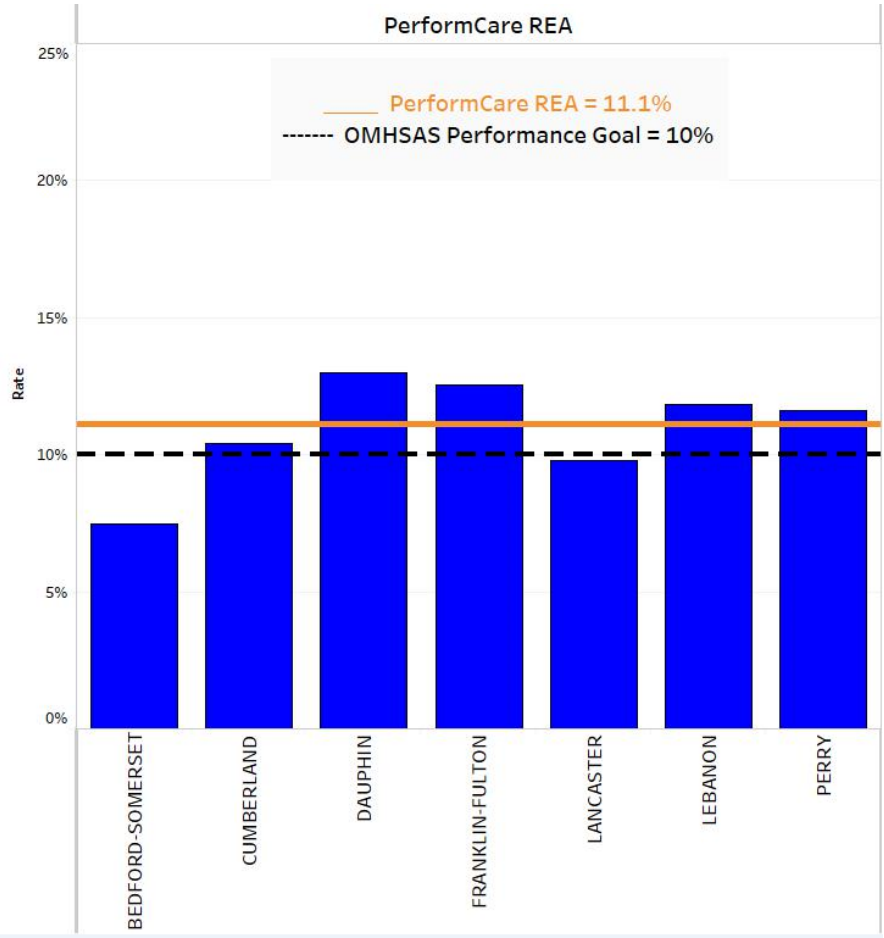


Figure 3.9: MY 2017 REA Readmission Rates.

Figure 3.10 shows the HealthChoices BH (Statewide) readmission rate and the individual PerformCare HC BH Contractors that performed statistically significantly higher (red) or lower (blue) than the Statewide rate. Lancaster's and Bedford-Somerset's rates were statistically significantly better (lower) than the Statewide rate of 13.4% by 3.6 and 5.9 percentage points, respectively.

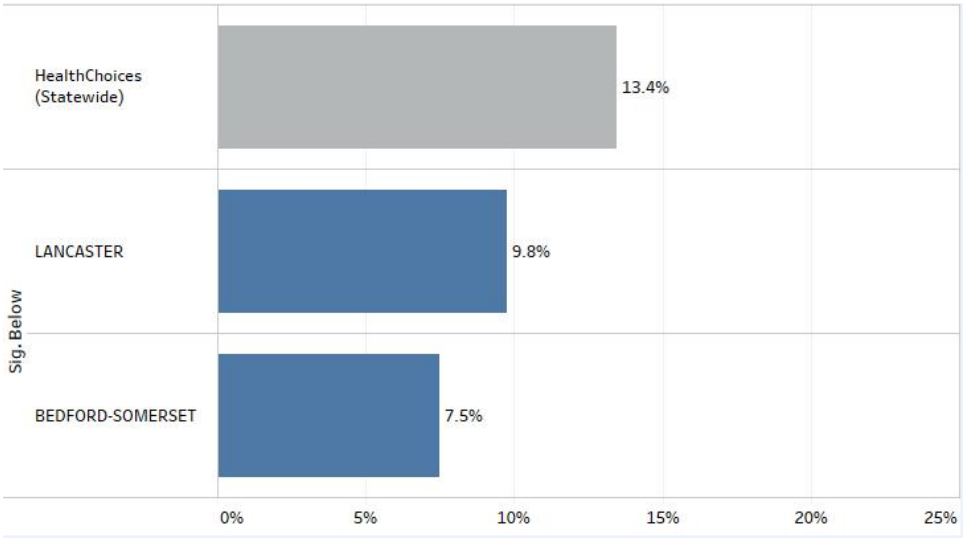


Figure 3.10: Comparison of PerformCare Contractor MY 2017 REA Readmission Rates (Overall) versus HealthChoices (Statewide) MY 2017 REA Readmission Rates (Overall).

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 Statewide rate.

Despite a number of years of data collection and interventions, readmission rates after psychiatric discharge have, for the most part, not improved and, for some BH-MCOs and their Contractors, rates have worsened (increased). The HC BH Statewide rate showed a statistically significant decrease of 0.5 percentage points in 2017. 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 2018 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 between 2012 and 2017 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. Building on the current cycle of performance improvement projects, which entered its first (non-baseline) year in 2017, 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. It is important for BH-MCOs and HC BH Contractors to target the demographic populations that do not perform as well as their counterparts. 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 did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

As part of the CMS's Adult Quality Measure Grant Program, the 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's 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's 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 2017 and 2018. The measure was produced according to HEDIS 2018 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 2018 specifications, with one modification: members must be enrolled in the same PH-MCO and BH MCO during the continuous enrollment period (60 days prior to the index event, to 48 days after the index event). 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 34 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% of adults had an alcohol use disorder problem, 2% met the criteria for a drug use disorder, and 1.1% 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 vice 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). The opioid crisis has only added to the urgency. Deaths from opioid overdoses alone reached 28,647 in 2014 (The Surgeon General's Report on Alcohol, Drugs, and Health, 2017).

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 (ED), will be decreased. In 2009 alone, there were nearly 4.6 million drug-related ED visits nationwide (National Institute on Drug Abuse, 2011). Social determinants of health are also themselves impacted by AOD. Improvement in the socioeconomic situation of patients and lower crime rates will follow if suitable treatments are implemented.

Eligible Population[1]

The entire eligible population was used for all 29 HC BH Contractors participating in the MY 2017 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, 2017;
- Continuously enrolled in both HealthChoices Behavioral Health and Physical Health from 60 days prior to the AOD diagnosis to 48 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 in the measurement year 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 a primary or secondary 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 primary or secondary diagnosis of AOD within 34 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 of both Physical Health and Behavioral Health encounters, only members who were enrolled in both Behavioral Health and Physical Health HealthChoices were 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 on all encounters used in this measure. This incomplete information 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 Contractor. For each of these rates, the 95% CI was reported. The HealthChoices BH Statewide rate was also calculated for this measure for each age group.

BH-MCO-specific rates were compared to the HealthChoices Statewide rate to determine if they were statistically significantly above or below that value. Whether or not a BH-MCO performed statistically significantly above or below

[1] HEDIS 2018 Volume 2 Technical Specifications for Health Plans (2018).

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 differences in BH-MCO rates are noted.

HC BH Contractor-specific rates were compared to the HealthChoices BH Statewide rate 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 differences in HC BH Contractor-rates are noted.

The performance measure results for the three age cohorts (13 to 17 years old, ages 18+ years, and ages 13+ years) 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

The MY 2017 HealthChoices Aggregate (Statewide) rates in the 13–17 years age group were 46.3% for Initiation and 34.6% for Engagement (**Table 3.6**). These rates were statistically significantly higher than the MY 2016 13–17 years HealthChoices Aggregate rates of 38.5% and 26.0%, respectively. In MY 2017, the HealthChoices Aggregate rate for Initiation was between the HEDIS 50th and 75th percentiles, while the HealthChoices Aggregate rate for Engagement was above the 75th percentile. The PerformCare MY 2017 13–17 years Initiation rate was 46.2%, which was significantly higher than the MY 2016 PerformCare rate of 33.7% (**Table 3.6**). Similarly, the PerformCare MY 2017 13–17 years Engagement rate increased significantly to 33.8%, compared to the MY 2016 rate of 17.1%. PerformCare's Initiation rate for MY 2017 was between the HEDIS 50th and 75th percentile, while the BH-MCO's Engagement rate was at or above the 75th percentile.

None of PerformCare HC BH Contractors had sufficiently large denominators to test for year-over-year change. For Initiation rate, two of the Contractors met OMHSAS goal of meeting or exceeding the HEDIS 75th percentile (Franklin-Fulton and Perry), four of the Contractors returned decreased rates between the 50th and 75th percentiles (Cumberland, Dauphin, Lancaster, Lebanon), and Bedford-Somerset returned decreased rates below the 25th percentile. All of the Contractors performed better on the Engagement rate, returning rates at or above the 75th percentile, except for Bedford-Somerset, which performed between the 50th and 75th percentile.

Table 3.6: MY 2017 IET Initiation and Engagement Indicators (13–17 Years)

MY 2017						MY 2016 %	MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (13–17) Years									
Statewide	1,316	2,843	**46.3%**	44.4%	48.1%	38.5%	7.8	Yes	Below 75th percentile, above 50th percentile
PerformCare	145	314	**46.2%**	40.5%	51.9%	33.7%	12.5	Yes	Below 75th percentile, above 50th percentile
Bedford-Somerset	4	12	**33.3%**	N/A	N/A	21.4%	11.9	N/A	Below 25th percentile
Cumberland	26	54	**48.1%**	N/A	N/A	19.4%	28.7	N/A	Below 75th percentile, above 50th percentile
Dauphin	37	79	**46.8%**	N/A	N/A	36.9%	9.9	N/A	Below 75th percentile, above 50th percentile
Franklin-Fulton	16	30	**53.3%**	N/A	N/A	41.2%	12.1	N/A	At or above 75th percentile
Lancaster	42	95	**44.2%**	N/A	N/A	34.9%	9.3	N/A	Below 75th percentile, above 50th percentile
Lebanon	14	33	**42.4%**	N/A	N/A	36.8%	5.6	N/A	Below 75th percentile, above 50th percentile
Perry	6	11	**54.5%**	N/A	N/A	33.3%	21.2	N/A	At or above 75th percentile

MY 2017						MY 2016 %	MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	Medicaid Percentiles
Numerator 2: Engagement of AOD Treatment (13–17) Years									
Statewide	984	2,843	**34.6%**	32.8%	36.4%	26.0%	8.6	Yes	At or above 75th percentile
PerformCare	106	314	**33.8%**	28.4%	39.1%	17.1%	16.7	Yes	At or above 75th percentile
Bedford-Somerset	2	12	**16.7%**	N/A	N/A	14.3%	2.4	N/A	Below 75th percentile, above 50th percentile
Cumberland	21	54	**38.9%**	N/A	N/A	9.7%	29.2	N/A	At or above 75th percentile
Dauphin	30	79	**38.0%**	N/A	N/A	15.4%	22.6	N/A	At or above 75th percentile
Franklin-Fulton	12	30	**40.0%**	N/A	N/A	29.4%	10.6	N/A	At or above 75th percentile
Lancaster	27	95	**28.4%**	N/A	N/A	16.9%	11.5	N/A	At or above 75th percentile
Lebanon	10	33	**30.3%**	N/A	N/A	15.8%	14.5	N/A	At or above 75th percentile
Perry	4	11	**36.4%**	N/A	N/A	16.7%	19.7	N/A	At or above 75th percentile

N: numerator; D: denominator; CI: confidence interval; PPD: percentage point difference; SSD: statistically significant difference; N/A: Confidence intervals were not calculated if denominators of rates contained less than 100 members.

Figure 3.11 is a graphical representation of the 13–17 years MY 2017 HEDIS Initiation and Engagement rates for PerformCare and its associated HC BH Contractors.

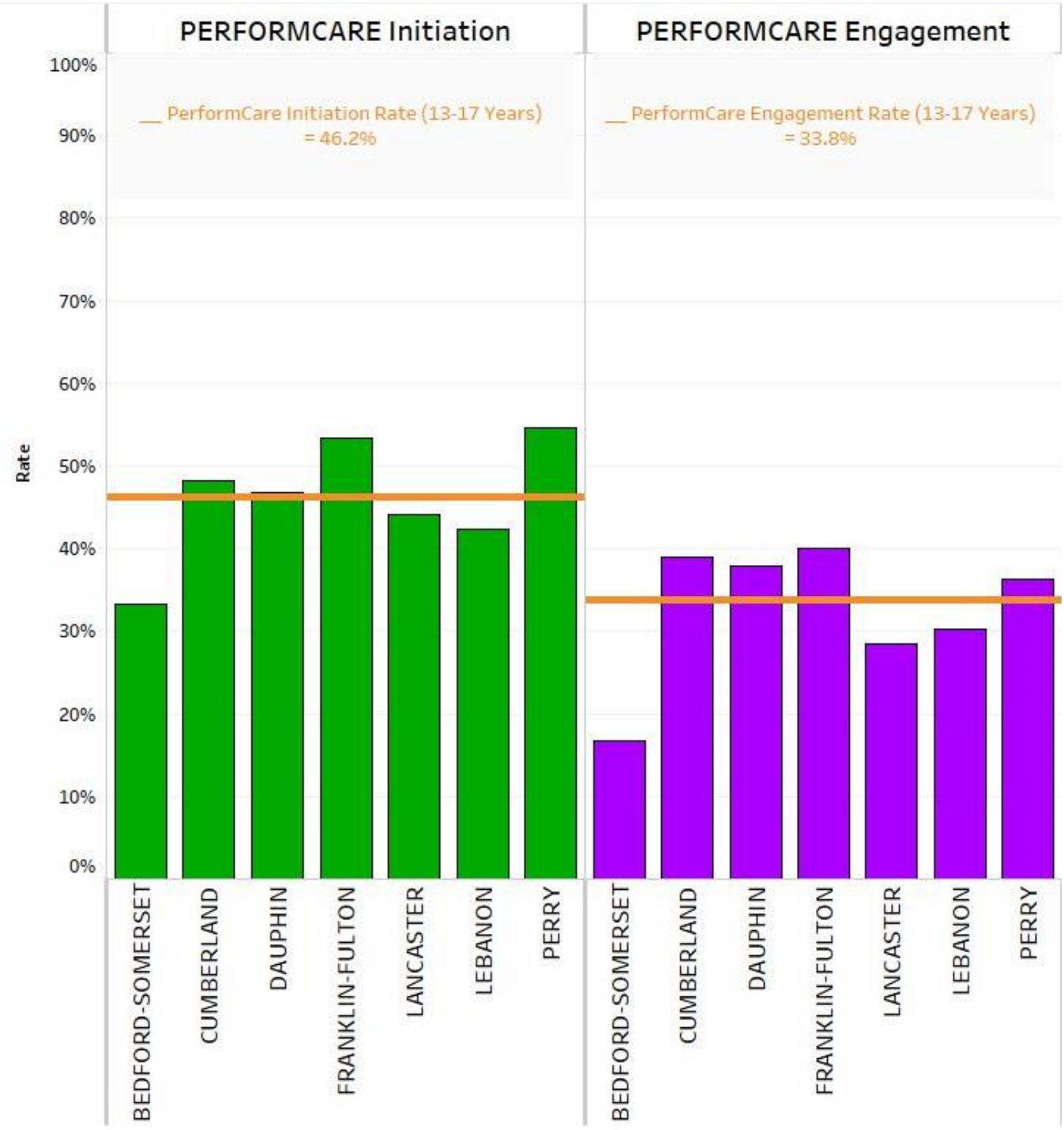


Figure 3.11: MY 2017 IET Initiation and Engagement Rates (13–17 Years).

Figure 3.12 shows the HealthChoices HC BH Contractor Average rates for this age cohort and the individual PerformCare HC BH Contractor rates that would have been statistically significantly higher or lower than the HealthChoices HC BH Statewide rate. In MY 2017, none of the PerformCare HC BH Contractors had sufficient denominator counts to test for statistical significance.

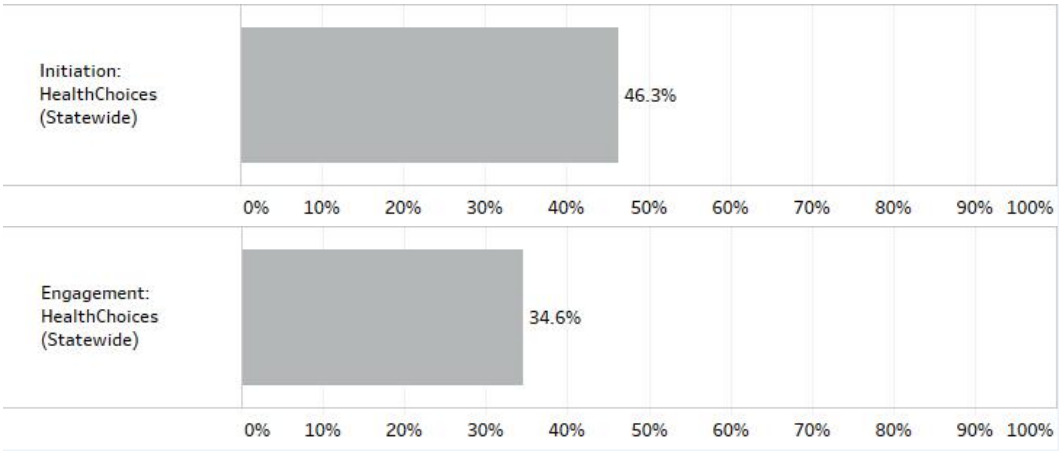


Figure 3.12: Comparison of PerformCare Contractor MY 2017 IET Rates (13–17 Years) versus HealthChoices (Statewide) MY 2017 IET Rates (13–17 Years).

(b) Age Group: 18+ Years Old

The MY 2017 HealthChoices Aggregate rates in the 18+ years age group were 41.1% for Initiation and 33.7% for Engagement (**Table 3.7**). Both rates were statistically significantly higher than the corresponding MY 2016 rates: the HealthChoices Aggregate Initiation rate increased by 15.4 percentage points and the Engagement rate increased by 16.9 percentage points from the prior year. The MY 2017 HealthChoices Aggregate Initiation rate in this age cohort was between the HEDIS 25th and 50th percentiles for 2018, while the Engagement rate was at or above the 75th percentiles.

The PerformCare MY 2017 Initiation rate for the 18+ years population was 39.0% (**Table 3.7**). This rate was between the HEDIS 25th and 50th percentiles for 2018 and significantly higher than the MY 2016. The PerformCare MY 2017 Engagement rate for this age cohort was 30.1% and was at or above the HEDIS 75th percentile for 2018. This rate represented a statistically significant increase of 12.1 percentage points from 2016.

As presented in **Table 3.7**, of all PerformCare HC BH contractors, Initiation rates increased statistically significantly for Cumberland, Dauphin, Lancaster, and Lebanon by 10.1, 15.5, 10.6, and 19.9 percentage points, respectively. Engagement rates increased significantly for all Contractors, except Bedford-Somerset and Perry. For Initiation rates, Lebanon performed at or above the 75th percentile, Dauphin and Lancaster returned rates between the 25th and 50th percentiles, and the rest decreased below the 25th percentile. The PerformCare Contractors performed better in the Engagement submeasure, with all Contractors meeting the OMHSAS goal of achieving the HEDIS 75th percentile.

Table 3.7: MY 2017 IET Initiation and Engagement Indicators (18+ Years)

MY 2017						MY 2016 %	MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (18+ Years)									
Statewide	27,307	66,505	**41.1%**	40.7%	41.4%	25.6%	15.5	Yes	Below 50th percentile, above 25th percentile
PerformCare	2,115	5,420	**39.0%**	37.7%	40.3%	28.6%	10.4	Yes	Below 50th percentile, above 25th percentile
Bedford-Somerset	129	387	**33.3%**	28.5%	38.2%	34.8%	-1.5	No	Below 25th percentile
Cumberland	238	656	**36.3%**	32.5%	40.0%	26.2%	10.1	Yes	Below 25th percentile
Dauphin	557	1,381	**40.3%**	37.7%	43.0%	24.8%	15.5	Yes	Below 50th percentile, above 25th percentile
Franklin-Fulton	174	543	**32.0%**	28.0%	36.1%	31.0%	1.0	No	Below 25th percentile
Lancaster	714	1,758	**40.6%**	38.3%	42.9%	30.0%	10.6	Yes	Below 50th percentile, above 25th percentile
Lebanon	258	552	**46.7%**	42.5%	51.0%	26.8%	19.9	Yes	At or above 75th percentile
Perry	45	143	**31.5%**	23.5%	39.4%	27.6%	3.9	No	Below 25th percentile
Numerator 2: Engagement of AOD Treatment (18+ Years)									
Statewide	22,379	66,505	**33.7%**	33.3%	34.0%	16.8%	16.9	Yes	At or above 75th percentile
PerformCare	1,630	5,420	**30.1%**	28.8%	31.3%	18.0%	12.1	Yes	At or above 75th percentile
Bedford-Somerset	91	387	**23.5%**	19.2%	27.9%	25.1%	-1.6	No	At or above 75th percentile
Cumberland	177	656	**27.0%**	23.5%	30.5%	16.1%	10.9	Yes	At or above 75th percentile
Dauphin	411	1,381	**29.8%**	27.3%	32.2%	15.2%	14.6	Yes	At or above 75th percentile
Franklin-Fulton	138	543	**25.4%**	21.7%	29.2%	19.2%	6.2	Yes	At or above 75th percentile
Lancaster	546	1,758	**31.1%**	28.9%	33.2%	18.3%	12.8	Yes	At or above 75th percentile
Lebanon	234	552	**42.4%**	38.2%	46.6%	17.7%	24.7	Yes	At or above 75th percentile
Perry	33	143	**23.1%**	15.8%	30.3%	17.9%	5.2	No	At or above 75th percentile

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

Figure 3.13 is a graphical representation MY 2017 IET rates for PerformCare and its associated HC BH Contractors for the 18+ years age group.

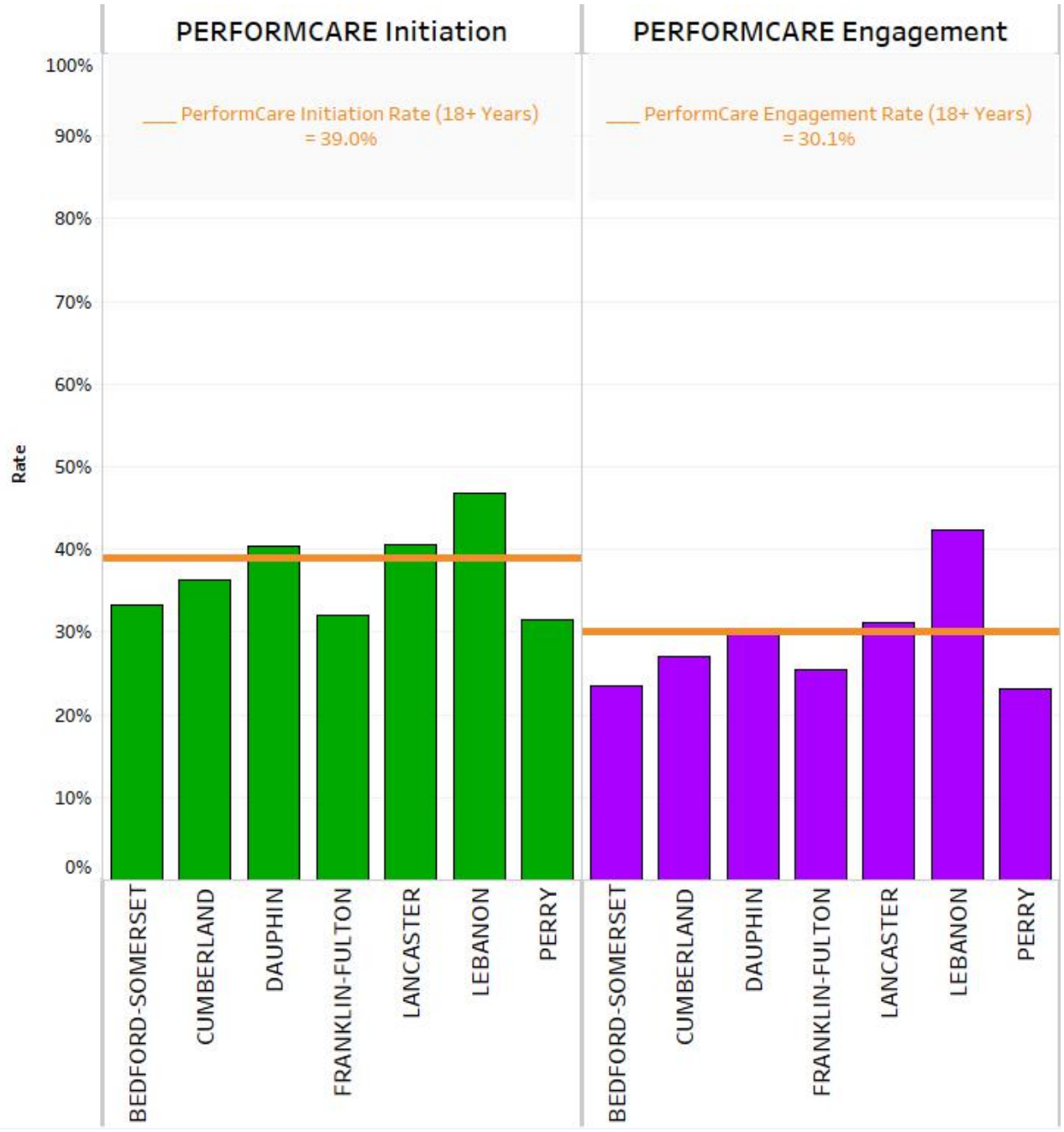


Figure 3.13: MY 2017 IET Initiation and Engagement Rates (18+ Years).

Figure 3.14 shows the HealthChoices HC BH Statewide rates and individual PerformCare HC BH Contractors that performed statistically significantly higher or lower than the Statewide rate. Cumberland, Bedford-Somerset, Franklin-Fulton, and Perry all produced Initiation rates that were statistically significantly lower than the Statewide rate of 41.1% by between 4.8 and 9.6 percentage points. Lebanon's Initiation rate was statistically significantly above the Statewide Initiation rate by 5.6 percentage points. All PerformCare HC BH Contractors (except Lebanon) returned Engagement rates that were statistically significantly lower than the Statewide rate of 33.7%. Lebanon's Engagement rate was statistically significantly higher than the Statewide rate by 8.7 percentage points.

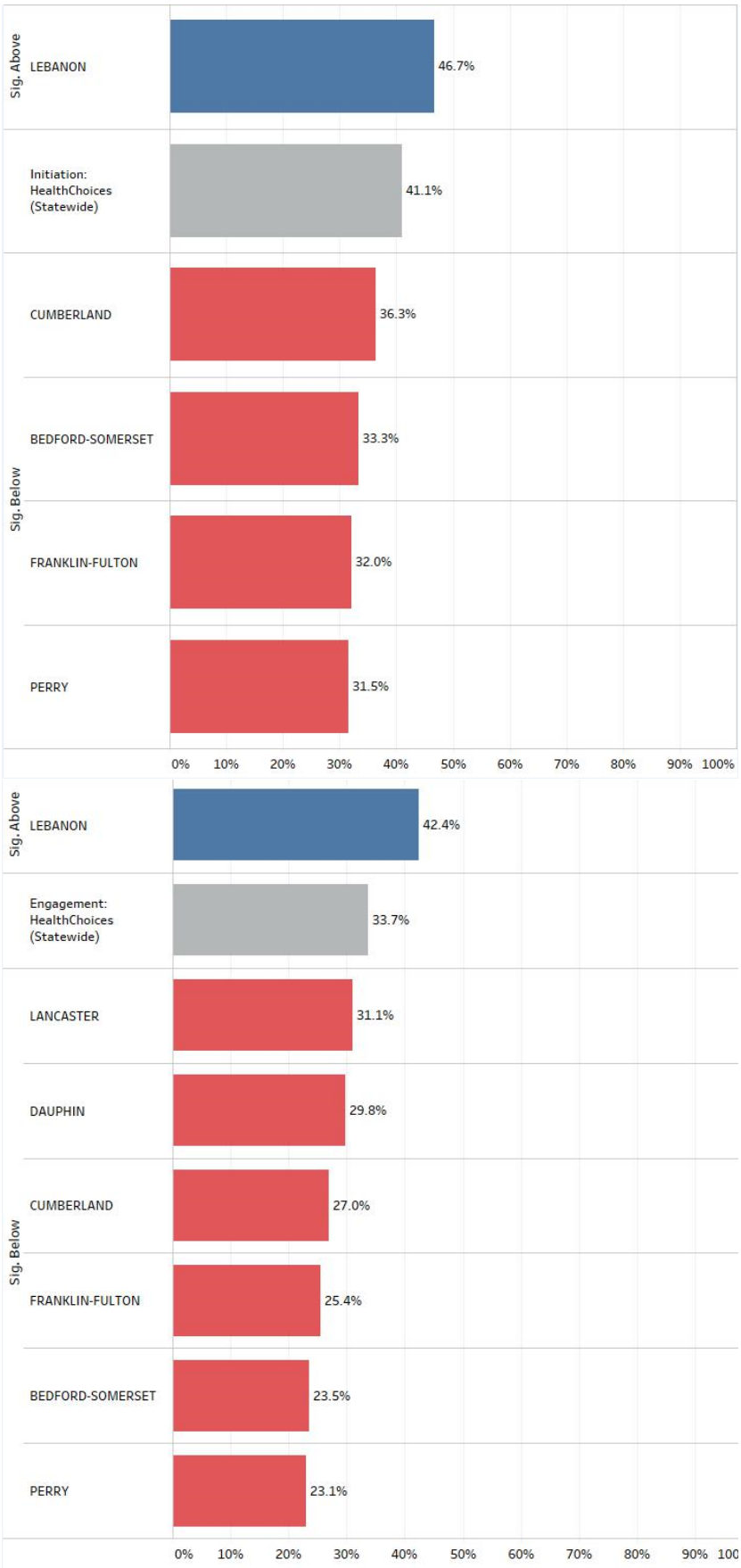


Figure 3.14: Comparison of PerformCare Contractor MY 2017 IET Rates (18+ Years) versus HealthChoices (Statewide) MY 2017 IET Rates (18+ Years).

(c) Age Group: 13+ Years Old

The MY 2017 HealthChoices Aggregate rates in the 13+ years age group were 41.3% for Initiation and 33.7% for Engagement (**Table 3.8**). Both Initiation and Engagement rates changed statistically significantly compared to the corresponding rates for the MY 2016 Initiation rate by 15.1 and 16.5 percentage points, respectively. The MY 2017 HealthChoices Aggregate Initiation rate was between the HEDIS 25th and 50th percentiles for 2018, while the Engagement rate was at or above the 75th percentile.

The PerformCare MY 2017 Initiation rate for the 13+ years population was 39.4% (**Table 3.8**). This rate was between the HEDIS 25th and 50th percentiles for 2018 and statistically significantly higher than the MY 2016 rate by 10.6 percentage points. The PerformCare MY 2017 Engagement rate was 30.3%, which met the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile for this measure. The PerformCare Engagement rate was also statistically significantly higher than the MY 2016 rate by 12.3 percentage points.

As presented in **Table 3.8**, of all PerformCare HC BH Contractors, Initiation rate increased statistically significantly for Cumberland, Dauphin, Lancaster, and Lebanon by 11.4, 15.3, 10.6, and 19.3 percentage points, respectively. Engagement rates increased significantly for all Contractors, except Bedford-Somerset and Perry. For Initiation rates, Lebanon performed at or above the 75th percentile, Dauphin and Lancaster returned rates between the 25th and 50th percentiles, and the rest fell below the 25th percentile. The PerformCare Contractors performed better on the Engagement submeasure, with all Contractors meeting the OMHSAS goal of achieving the HEDIS 75th percentile.

Table 3.8: MY 2017 IET Initiation and Engagement Indicators (Overall)

MY 2017						MY 2016	MY 2017 Rate Comparison		
				95% CI			To MY 2016		To MY 2017 HEDIS
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD	Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (Overall)									
Statewide	28,623	69,348	**41.3%**	40.9%	41.6%	26.2%	15.1	Yes	Below 50th percentile, above 25th percentile
PerformCare	2,260	5,734	**39.4%**	38.1%	40.7%	28.8%	10.6	Yes	Below 50th percentile, above 25th percentile
Bedford-Somerset	133	399	**33.3%**	28.6%	38.1%	34.4%	-1.1	No	Below 25th percentile
Cumberland	264	710	**37.2%**	33.6%	40.8%	25.8%	11.4	Yes	Below 25th percentile
Dauphin	594	1,460	**40.7%**	38.1%	43.2%	25.4%	15.3	Yes	Below 50th percentile, above 25th percentile
Franklin-Fulton	190	573	**33.2%**	29.2%	37.1%	31.7%	1.5	No	Below 25th percentile
Lancaster	756	1,853	**40.8%**	38.5%	43.1%	30.2%	10.6	Yes	Below 50th percentile, above 25th percentile
Lebanon	272	585	**46.5%**	42.4%	50.6%	27.2%	19.3	Yes	At or above 75th percentile
Perry	51	154	**33.1%**	25.4%	40.9%	27.9%	5.2	No	Below 25th percentile
Numerator 2: Engagement of AOD Treatment (Overall)									
Statewide	23,363	69,348	**33.7%**	33.3%	34.0%	17.2%	16.5	Yes	At or above 75th percentile
PerformCare	1,736	5,734	**30.3%**	29.1%	31.5%	18.0%	12.3	Yes	At or above 75th percentile
Bedford-Somerset	93	399	**23.3%**	19.0%	27.6%	24.8%	-1.5	No	At or above 75th percentile
Cumberland	198	710	**27.9%**	24.5%	31.3%	15.7%	12.2	Yes	At or above 75th percentile
Dauphin	441	1,460	**30.2%**	27.8%	32.6%	15.2%	15.0	Yes	At or above 75th percentile
Franklin-Fulton	150	573	**26.2%**	22.5%	29.9%	19.8%	6.4	Yes	At or above 75th percentile
Lancaster	573	1,853	**30.9%**	28.8%	33.1%	18.2%	12.7	Yes	At or above 75th percentile
Lebanon	244	585	**41.7%**	37.6%	45.8%	17.6%	24.1	Yes	At or above 75th percentile
Perry	37	154	**24.0%**	17.0%	31.1%	17.8%	6.2	No	At or above 75th percentile

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

Figure 3.15 is a graphical representation MY 2017 IET rates for PerformCare and its associated HC BH Contractors for the 18+ years age group.

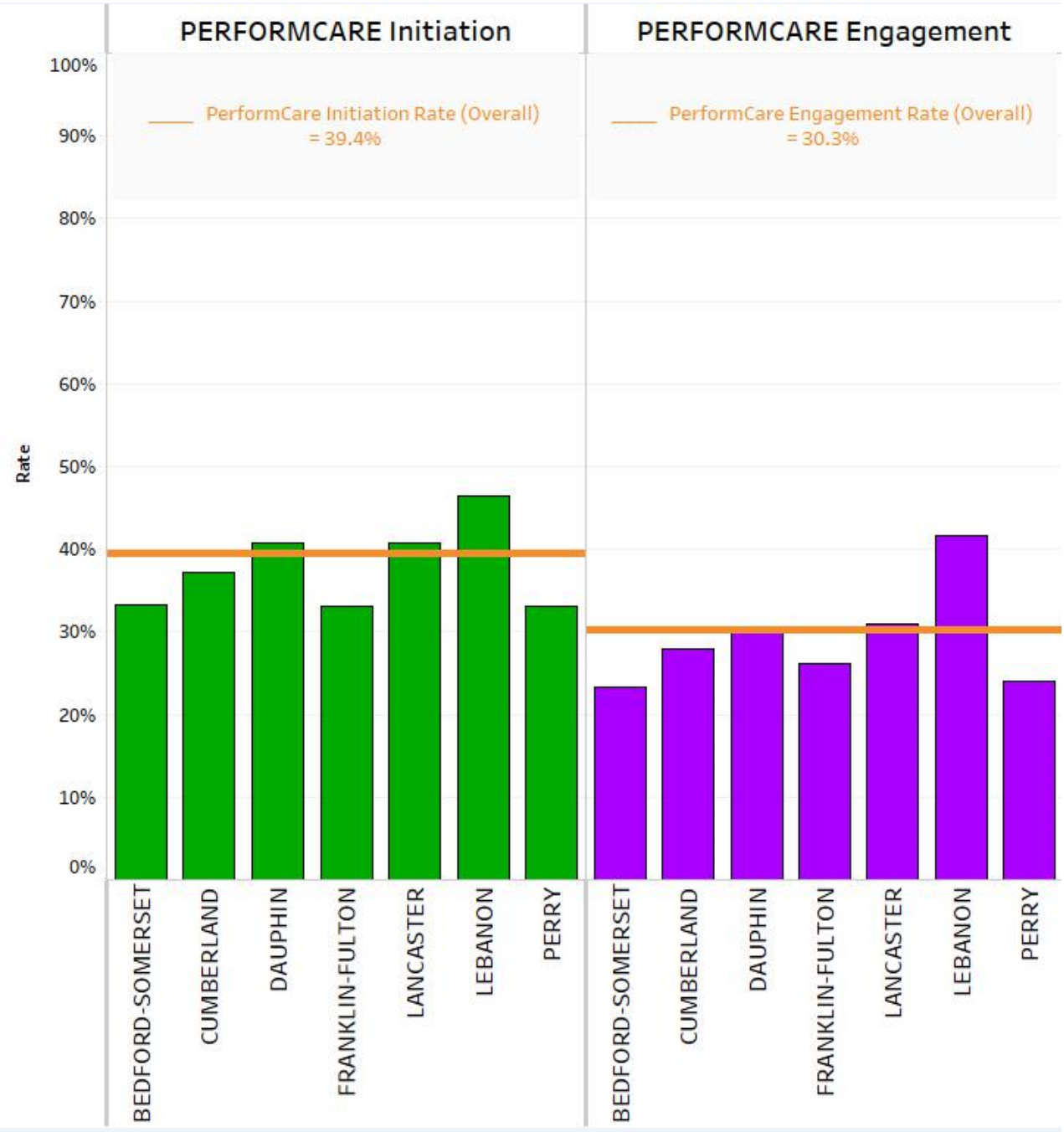
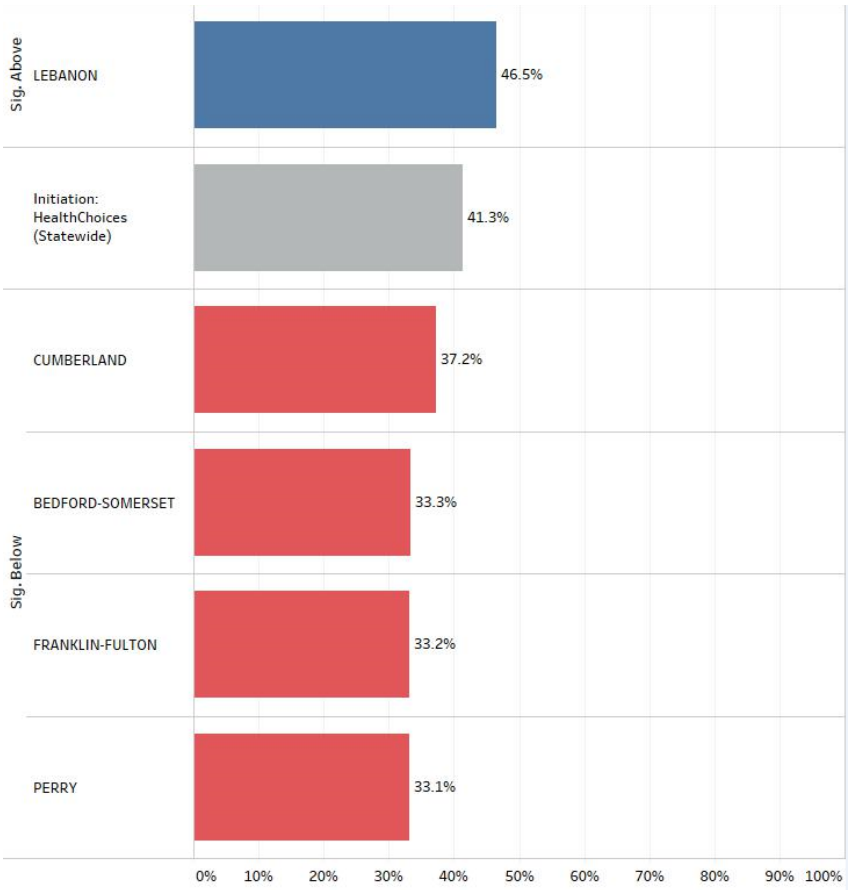


Figure 3.15: MY 2017 IET Initiation and Engagement Rates (Overall).

Figure 3.16 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. Cumberland, Bedford-Somerset, Franklin-Fulton, and Perry all produced Initiation rates that were statistically significantly lower than the Statewide rate of 41.3% by between 4.1 and 8.2 percentage points. Lebanon's Initiation rate was statistically significantly above the Statewide Initiation rate by 5.2 percentage points. All PerformCare HC BH Contractors (except Lebanon) returned Engagement rates that were statistically significantly lower than the Statewide rate of 33.7%. Lebanon's Engagement rate was statistically significantly higher than the Statewide rate by 8.0 percentage points.



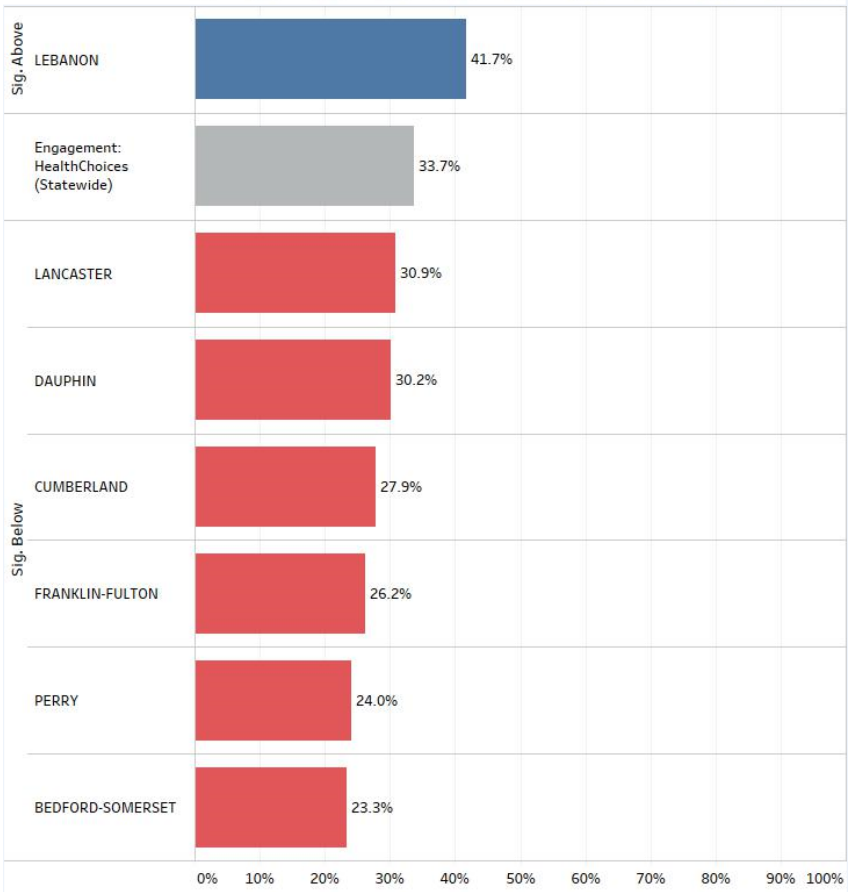


Figure 3.16: Comparison of PerformCare Contractor MY 2017 IET Rates (Overall) versus HealthChoices (Statewide) MY 2017 IET Rates (Overall).

Conclusion and Recommendations

For MY 2017, the Aggregate HealthChoices rate in the 13+ years population (Overall population) was 41.3% for the Initiation rate and 33.7% for the Engagement rate. The Initiation rate was between the HEDIS 25th and 50th percentiles, while the Engagement rate was at or above the 75th percentile. Both the Initiation and the Engagement rates statistically significantly increased from MY 2016 rates. As seen in other performance measures, there is significant variation between the HC BH Contractors. Overall, PerformCare BH HC Contractors performed better in Engagement rates, with all Contractors meeting or exceeding the HEDIS goal of the 75th percentile. As with most reporting years, it is important to note that there were some changes to the HEDIS 2018 specifications, including the extension of the Engagement of AOD Treatment time frame to 34 days from 30 days and the addition of Medication Assisted Treatment. The following general recommendations are applicable to all five participating BH-MCOs:

- BH-MCOs should further develop 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, PerformCare should focus on the Initiation rate, as it was below the 75th percentile for this measure.

IV: Quality Studies

The purpose of this section is to describe quality studies performed in 2017 for the HealthChoices population. The studies are included in this report as optional EQR activities that occurred during the Review Year (42 CFR 438.358 (c)(5)).

Certified Community Behavioral Health Clinics

On July 1 2017, Pennsylvania launched its SAMHSA-funded Certified Community Behavioral Health Clinics (CCBHCs) Demonstration Project ("Demonstration"), to run through June 30, 2019. The purpose of the Demonstration is to develop and test an all-inclusive (and all-payer) prospective payment system model for community clinics to integrate behavioral and physical health care services in a more seamless manner. The model is centered on the provision of nine core services. Crisis services, screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services are provided directly by the CCBHCs. The other services may be provided through a contract with a Designated Collaborating Organization (DCO). To receive CCBHC certification, clinics also had to provide a minimum set of Evidence-Based Practices (EBP), which was selected based on community needs assessments and centered on recovery-oriented care and support for children, youth, and adults. Seven clinics were eventually certified and participated: Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA). In several cases, CCBHC-certified clinics share agreements with one or more DCOs to supplement the core services provided at the clinic. The counties covered by these clinics span three BH-MCOs: CBH, CCBH, and MBH.

In 2017, activities focused on implementing and scaling up the CCBHC model within the seven clinic sites. Data collection and reporting is a centerpiece of this quality initiative in two important ways. First, the CCBHC Demonstration in Pennsylvania features a process measure Dashboard, hosted by the EQRO through REDCap, whereby clinics are able to monitor progress on the implementation of their CCBHC model. From July through December 2017—the Dashboard was operational in October 2017—clinics tracked and reported on clinical activities in a range of quality domains reflecting the priorities of the initiative: clinic membership, process, access and availability, engagement, evidence-based practices, and satisfaction. The dashboard provides for each clinic a year-to-date (YTD) comparative display that shows clinic and statewide results on each process measure, as well as average scores for three domains of the satisfaction surveys: convenience of provider location, satisfaction with provider services, and timeliness and availability of appointments. In support of this, and to ensure alignment with SAMHSA reporting requirements, a Data Dictionary (and spreadsheet template) was developed for the clinics to use in reporting their monthly, quarterly, and YTD results in the Dashboard. These Dashboard results were reported out to a CCBHC Stakeholder Committee at the end of the two quarters.

A second important feature of the Demonstration is an assessment, to be completed at its conclusion by the EQRO, to test whether the CCBHC clinics perform significantly better over the demonstration period compared to a control group of clinics located under the same HC BH contractors as the CCBHC clinics. Measurement of performance, in terms of both quality as well as overall cost, will span multiple areas and scales, involving a variety of administrative sources, medical records, and other sources. Several measures in the CCBHC measure set, including those reported directly by clinics (primarily medical record-based), are placed in a Quality Bonus Payment (QBP) program. To support this reporting, clinics in 2017 collected and reported baseline data on quality measures. The EQRO also used SurveyMonkey to support the administration and collecting of person-experience-of-care surveys for adults (PEC) as well as for children and youth (Y/FEC). Finally, in the latter half of 2017, clinics began to collect and report, on a quarterly basis, consumer level files documenting various relevant characteristics of their CCBHC consumers, including housing, veteran, and insurance statuses. Throughout the process, OMHSAS and EQRO provided technical assistance focused on data collection, management, and reporting, where much of the focus was on walking through the quality and process measures and their operationalization using the clinics' data plans. In this respect, 2017 was a period of building up the capacity of the clinics to bring the vision of the CCBHC Demonstration to its full fruition. Results from demonstration year (DY) 1 will be reported in next year's BBA report.

V: 2017 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 2017 EQR Technical Reports, which were distributed in April 2017. The 2017 EQR Technical Report is the 11th report to include descriptions of current and proposed interventions from each BH-MCO that address the (2017) 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 June 30, 2017, 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 2017, as well as any additional relevant documentation provided by the BH-MCO. **Table 5.1** presents PerformCare's responses to opportunities of improvement cited by IPRO in the 2017 EQR Technical Report, detailing current and proposed interventions.

Table 5.1: PerformCare's Responses to Opportunities for Improvement Cited by IPRO in the 2017 EQR Technical Report

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) 2014, RY 2015, and RY 2016 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 6/30/18/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
PerformCare 2017.01	Within Subpart C: Enrollee Rights and Protections Regulations, PerformCare was partially compliant with one out of seven categories – Enrollee Rights.	**Date(s) of follow-up action(s)** 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

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) 2014, RY 2015, and RY 2016 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 6/30/18/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			 Complaint Training Curriculum.pdf
		PEPS Standard 60 – Substandard 2: **Established ongoing process**	**Enrollee Rights and Protections is now an annual mandatory training requirement. Compliance with the standard is evidenced by the annual curriculum and by the completed training roster to ensure full compliance. Evidence of training plan, curriculum and rosters are available upon request**
		Date(s) of follow-up action(s) 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 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 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
		PEPS Standard 60 – Substandard 3: **Established ongoing process**	**Enrollee Rights and Protections is now an annual mandatory training requirement. Compliance with the standard is evidenced by the annual curriculum and by the completed training roster to ensure full compliance. Evidence of training plan, curriculum and rosters are available upon request**
		PEPS Standard 108: Substandard 8:	PEPS Standard 108: Substandard 8:

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) 2014, RY 2015, and RY 2016 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 6/30/18/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		None	This was erroneously reported as a Partially Compliant Standard for Franklin and Fulton Counties for RY 2015. According to the OMHSAS Annual Review Report for RY 2015 Franklin and Fulton Counties were compliant.
		PEPS Standard 108: Substandard 8: None	PEPS Standard 108: Substandard 8: See above note
PerformCare 2017.02	PerformCare was partially compliant with 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), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Subcontractual Relationships and Delegation, and 5) Practice Guidelines	**Date(s) of follow-up action** 12/04/15 11/30/15	***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 23 - Substandard 4: **Established ongoing process**	**Process implemented as stated above. Continuous training is provided to staff and processes are reviewed annually and updated as needed.**
		Date(s) of follow-up action 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

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) 2014, RY 2015, and RY 2016 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 6/30/18/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			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 28 – Substandard 1: **Established ongoing process**	**Process implemented as stated above. Future - Continue to provide annual trainings; conduct semi-annual Interrater Reliability; and perform quarterly documentation audits. Evidence of completion is available upon request.**
		PEPS Standard 99 – Substandard 2: 2017	***4) Sub contractual Relationships and Delegation*** PEPS Standard 99 – Substandard 2: • An analysis by Provider is completed on a quarterly basis by the internal workgroup, QOCC Sub-Committee, to determine trends among providers and determine need for further follow up as described in PerformCare QI-004 Internal Documentation, Review, and Follow up of Quality of Care Issues.
		PEPS Standard 99 – Substandard 2: **Established ongoing process**	**Process implemented as stated above. Analysis will continue on a quarterly basis to determine trends and determine if follow up is needed. On an annual basis the policy is reviewed and updated as needed and trainings performed for staff and providers.**
PerformCare 2017.03	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:	**Date(s) of future action(s) planned – None** 09/30/15 11/30/15	***1) Statutory Basis and Definitions*** ***4) Handling of Grievances and Appeals*** ***5) Resolution & Notification: Grievances & Appeals*** PEPS Standard 68 - Substandard 2: • Retrained/provided reminder to associates on Appendix H requirement specific to the filing of an extension

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) 2014, RY 2015, and RY 2016 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 6/30/18/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
	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.	05/01/15 10/02/15 11/30/15 10/30/15	• 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.
		PEPS Standard 68 – Substandard 2: Substandard 3: Substandard 4: **Established ongoing process**	**Complaints and Grievance training is an annual mandatory training requirement. Compliance with the standard is evidenced by the annual curriculum and by the completed training roster to ensure full compliance. Evidence of training plan, curriculum and rosters are available upon request. Policies and processes are reviewed on an annual basis and revised as needed.**

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) 2014, RY 2015, and RY 2016 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 6/30/18/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of follow-up action(s) 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
		PEPS Standard 71 - Substandard 3: Substandard 4: **Established ongoing process**	**Complaints and Grievance training is an annual mandatory training requirement. Compliance with the standard is evidenced by the annual curriculum and by the completed training roster to ensure full compliance. Evidence of training plan, curriculum and rosters are available upon request. Policies and processes are reviewed on an annual basis and revised as needed.**
		Date(s) of follow-up action(s) 08/12/15 08/12/15 01/31/16	***Statutory Basis and Definitions*** ***General Requirements*** ***Notice of Action*** ***Handling of Grievances & Appeals*** ***Resolution & Notification: Grievances & Appeals*** ***Expedited Appeals Process*** ***Continuation of Benefits*** ***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

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) 2014, RY 2015, and RY 2016 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 6/30/18/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		06/24/16	• 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
		PEPS Standard 72 - Substandard 2: **Established ongoing process**	**Appendix AA templates are revised as needed. Mandatory training is required on an annual basis. All Policies and Procedures are reviewed at least annually and updated as needed. Audit procedure is in place and continues on a monthly basis by clinical auditor and Primary Contractor as appropriate. Evidence of training *plan, curriculum and rosters are available upon request.***
		Date(s) of follow-up action(s) 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

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) 2014, RY 2015, and RY 2016 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 6/30/18/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		PEPS Standard 60 - Substandard 2: **Established ongoing process**	**Complaints and Grievance training is an annual mandatory training requirement. Compliance with the standard is evidenced by the annual curriculum and by the completed training roster to ensure full compliance. Evidence of training plan, curriculum and rosters are available upon request. Policies and processes are reviewed on an annual basis and revised as needed.**
		Date(s) of follow-up action(s) 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 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 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
		PEPS Standard 60 - Substandard 3: **Established ongoing process**	**Complaints and Grievance training is an annual mandatory training requirement. Compliance with the standard is evidenced by the annual curriculum and by the completed training roster to ensure full compliance. Evidence of training plan, curriculum and rosters are available upon request. Policies and processes are reviewed on an annual basis and revised as needed.**

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 2016, PerformCare began to address opportunities for improvement related to compliance categories within Subparts: C (Enrollee Rights), D (Access to Care, Coordination and Continuity of Care, Coverage and Authorization of Services, Subcontractual Relationships and Delegation, and Practice Guidelines), and F (Federal and State Grievance System Standards Regulations). The partially compliant categories within Subpart F were: 1) Statutory Basis and Definitions, 2) Notice of Action, 3) Handling of Grievances and Appeals, 4) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions. 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 2017 EQR would have been the 10th year for which BH-MCOs would have been required to prepare a Root Cause Analysis and Action Plan for performance measures that were performing statistically significantly poorer than the BH-MCO Average and/or as compared to the prior measurement year. For performance measures that are noted as opportunities for improvement in the 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.

Following several years of underperformance in the key quality indicator areas; however, OMHSAS deemed in 2017 that it was necessary to change the EQR process from a retrospective to more of a prospective process. This meant, among other things, eliminating the requirement to complete root cause analyses (RCAs) and corresponding action plans (CAPs) responding to MY 2015. Instead, BH-MCOs were required to submit member level files for MY 2016 in the summer of 2017, from which rates were calculated and validated by IPRO. MY 2016 Results of HEDIS Follow-up After Hospitalization for Mental Illness (7- and 30-day) were then used to determine RCA and CAP assignments. The change coincided with the coming phase-in of Value-Based Payment (VBP) at the HC BH Contractor level in January 2018. Thus, for the first time, RCA and CAP assignments were made at the Contractor level as well as at the BH-MCO level. Contractors receiving assignments completed their RCAs and CAPs in November 2017, while BH-MCOs completed their RCAs and CAPs by December 31, 2017. In 2018, coinciding with the carve-in of long-term care, OMHSAS directed BH-MCOs to begin focusing their RCA and CAP work on the HEDIS FUH All Ages measure and implemented a new goal-setting logic to spur performance improvement in the measure. Based on the MY 2017 performance, all five BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and CAPs to achieve their MY 2019 goals. HC BH Contractors that scored below the 75th NCQA Quality Compass Percentile were also asked to submit RCAs and CAPs. All five BH-MCOs submitted their RCAs and CAPs on April 1, 2019. HC BH Contractors will be submitting their RCAs and CAPs by April 30, 2019.

MY 2016 RCAs and CAPs, already completed last year, are included in this 2018 BBA report. **Table 5.2** presents PerformCare's submission of its RCA and CAP for the FUH 6-64 years 7- and 30-day measures.

Table 5.2: PerformCare RCA and CAP for the FUH 7- and 30-Day Measures (6–64 Years)

HealthChoices BH Contractor:	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date:

Goal Statement: (Please specify individual goals for each measure):
The PerformCare MY 2017 HEDIS 7-Day FUH goal is 46.26%
The PerformCare MY 2017 HEDIS 30-Day FUH goal is 70.95%
The OMHSAS goal is to achieve the 75th percentile for ages 6-64, based on the annual HEDIS published benchmarks for 7-day and 30-day FUH

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

People (1) (All Causes)
(e.g., personnel, patients)

1) MY 2016 data demonstrates that the follow-up rate is driven by Members with single discharge episodes from IP.
2) MY 2016 data demonstrates the lack of follow-up is driven by adult Members over age 18.
   - TMCA data demonstrates a specific population of ages 31 -50.
3) MY 2016 data demonstrates the lack of follow-up is driven by MDD diagnoses.
4) BHSSBC

4a) Members report feeling better and don't need their follow-up appointments; Members will only seek help to manage crisis situations.
4b) Members often do not understand the importance of follow-up visits.
4c) Members lack education on diagnosis, medication and treatment adherence.

Initial Response:

1) MY 2016 FUH data breakout by age and admissions

		Admissions			% Admissions	
Age Band	County	Single Admissions	Multiple Admissions	Total	Single Admissions	Admissions
14-17	Cumberland	51	18	69	73.91%	26.09%
	Dauphin	72	34	106	67.92%	32.08%
	Lancaster	133	34	167	79.64%	20.36%
	Lebanon	40	4	44	90.91%	9.09%
	Perry	14	0	14	100.00%	0.00%
	Franklin	30	15	45	66.67%	33.33%
	Fulton	1	0	1	100.00%	0.00%
	Bedford	17	4	21	80.95%	19.05%
	Somerset	23	14	37	62.16%	37.84%
14-17 Total		**381**	**123**	**504**	**75.60%**	**24.40%**
18 & Older	Cumberland	237	69	306	77.45%	22.55%
	Dauphin	617	321	938	65.78%	34.22%
	Lancaster	774	326	1,100	70.36%	29.64%
	Lebanon	217	62	279	77.78%	22.22%
	Perry	53	12	65	81.54%	18.46%
	Franklin	178	36	214	83.18%	16.82%
	Fulton	13	2	15	86.67%	13.33%
	Bedford	66	10	76	86.84%	13.16%
	Somerset	95	35	130	73.08%	26.92%
18 & Older Total		**2,250**	**873**	**3,123**	**72.05%**	**27.95%**
Grand Total		**2,631**	**996**	**3,627**	**72.54%**	**27.46%**

2) MY 2016 FUH data age group breakout

2016 Age Group Breakout			
HEDIS FOLLOW-UP			
Age Band	7-DAY	30-DAY	Did Not Meet FUH Standard
0 - 13 years	231	312	41
14 - 17 years	255	380	124
18 years & Older	1,055	1,774	1,349

TMCA data:

Persons between the ages of 7 and 30 (50.4% of total cases) had the highest rates of follow-up
- 50.32% 7-day
- 81.04% 30-day

Persons between the ages of 31 and 50 (32.3% of total cases) had the lowest rates of follow-up

HealthChoices BH Contractor:	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date:

- 27.55% 7-day
- 60.20% 30-day

3) MY 2016 diagnosis breakout

Diagnosis	Description	Overall Percentage	Total Number of M
F332	MDD - recurrent severe, without psychotic features	17.69%	198
F329	MDD - single episode, unspecified	12.51%	140
F333	MDD - recurrent severe, with psychotic features	6.17%	69
F319	Bipolar disorder, unspecified	4.11%	46
F331	MDD - recurrent, moderate	4.02%	45
F250	Schizoaffective disorder	3.04%	34
F39	Unspecified mood (affective) disorder	2.06%	23
F200	Schizophrenia - paranoid type	1.51%	17
			452
			572
		Overall % of MDD diagnosis at discharge	**79.02%**
		Overall % (1,119) members:	**40.39%**

4) CABHC RCA findings indicate:

- The member does not understand due to lack of supports involvement in the treatment planning of recovery principles, treatment options, and the link between follow up treatment and relapse prevention. A recent member satisfaction survey completed in 2017 noted that members reported that only 48% of the time the provider was informing them of self-help or support groups that would benefit the member in discharge. Additionally, providers only discussed including their family or friends in counseling 57% of the time.
- The member's physical health condition taking precedence over their behavioral health condition.
- The family of the member does not believe the member's behavioral health condition is important.
- The member's accountability is lacking because of:
  - Weak support systems, or
  - Not being registered with their County's Base Service Units (BSUs), or
  - Listed as closed in their County system so no additional support services are applied
- Education of the member – the member has not been adequately educated on the discharge plan, or other important matters prior to discharge from the inpatient facility.
  - Inpatient facilities/hospitals:
    - Sometimes do not complete referrals until after discharging the member, resulting in lost time that could be used to transition the member
    - Do not fully explain the program to members when they discharge
    - Do not recognize that members have difficulty with verbal or written instructions, or who to ask for assistance
    - Communicate effectively with partial hospitalization programs (PHP)

<table>
<tr><th>HealthChoices BH Contractor:</th><th>Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)</th><th>Response Date:</th></tr>
<tr><td></td><td colspan="2">▪ Do not effectively consult with the member in regards to their availability to schedule and attend follow up appointments
▪ Ask that the member call back and schedule a follow up appointment (see also member's accountability above)</td></tr>
<tr><td></td><td colspan="2">Follow-up Status Response:
Root Cause statement - PerformCare adult Members over the age of 18 are the drivers of the follow-up rate. Members lack education on diagnosis, medication and treatment adherence.</td></tr>
<tr><td>Providers (1)
(e.g. provider facilities, provider network)
1) Access and availability.
1a) Psychiatric and therapy access.
● Scheduling of appointments.
1b) Somerset County does not have a Children's PHP.
1c) CABHC findings
1d) TMCA: There is a noted difference in the follow-up rates between integrated health systems and stand-alone MH IP or OP Providers.</td><td colspan="2">Initial Response:
1a) PerformCare network data demonstrates a lack of 7-day access
<table>
<tr><th colspan="4">7-day Access</th></tr>
<tr><th></th><th>CABHC</th><th>BHSSBC</th><th>TMCA</th></tr>
<tr><td>MH OP Therapy</td><td></td><td></td><td></td></tr>
<tr><td>0-17</td><td>74.9%</td><td>69.3%</td><td>59.8%</td></tr>
<tr><td>18+</td><td>71.8%</td><td>65.6%</td><td>73.9%</td></tr>
<tr><td>Total</td><td>73.3%</td><td>67.6%</td><td>66.9%</td></tr>
<tr><td>MH OP Psych Evals</td><td></td><td></td><td></td></tr>
<tr><td>0-17</td><td>9.0%</td><td>5.4%</td><td>25.3%</td></tr>
<tr><td>18+</td><td>6.5%</td><td>15.4%</td><td>20.8%</td></tr>
<tr><td>Total</td><td>7.5%</td><td>11.9%</td><td>22.8%</td></tr>
</table>
1b) BHSSBC conducted a needs assessment by surveying Somerset County schools in April 2017. 11 schools participated in the survey and reported approximately 87 total students ages 5-13 were diagnosed with a severe mental or emotional disorder and, of those students, 47% (41) met the criteria for MH PHP services. There is no MH PHP Provider for children ages 5-13 in Somerset County.

1c) CABHC RCA findings indicate:
● Inflexibility in the ways in which some community services are scheduled (i.e. PHP offers specific days and times for intakes, making it difficult to meet the member's scheduling needs).
● Member dissatisfaction with their doctor; creates difficulty to "right-fit" the member with a doctor (to the member's satisfaction). When members are frustrated with their doctor, they avoid re-engaging with their provider, and do not attend appointments.
● Lengthy intake processes for new patients prior to meeting with their therapist or psychiatrist creates member frustration; impeding on follow up performance.
● Ineffective scheduling processes by community providers to meet member's needs; specifically, their ability to accommodate the member's schedule, the capability to do scheduling effectively (i.e. properly resourced; having services available).
● Community providers lack the ability to do scheduling of follow up appointments because of limited capacity.</td></tr>
</table>

HealthChoices BH Contractor:	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date:
	1d) TMCA IHS vs. stand-alone: ● The 2 integrated health systems in the area account for 58% of the follow-up appointments. The remainders were shared between 13 stand-alone private Providers. ● It appears that large health systems' performance is poorer than private stand-alone agencies. ● Of the 160 cases Chambersburg Hospital served, 106 had 30-day follow-up appointments, for a rate of 66.25%. ● Of the 39 cases Roxbury IP served, 30 had 30-day follow-up appointments, for a rate of 76.92%. ● Of the 37 cases Brook Lane Psychiatric Hospital served, 35 had 30-day follow-up appointments for a rate of 94.59%. ● Of the 17 The Meadows served, 12 had 30-day follow-up appointments, for a rate of 70.58%. ● Of all other 50 cases (22 different Providers), 34 had 30-day follow-up appointments, for a rate of 68.0% collectively. ● The decrease in follow-up rates is tied back to the health systems IP facility in the contract. ● The highest follow-up rates are from stand-alone, MH-only hospital Providers.	
	Follow-up Status Response: Root cause statement - The provider network has inadequate post-discharge treatment resources.	
Providers (2) (e.g. provider facilities, provider network) 1) Discharge planning. ● Average length of stay. ● Members who have a length of stay greater than 3 days have a significantly higher follow-up rate. ● Outpatient Providers scheduling and business practices.	**Initial Response:** TMCA: Data mining of the 303 cases measured for 7 or 30-day follow-up presented the following trends: ● 190 cases or 63%, who stayed in the hospital between 4 and 15 days, had 30-day follow-up rates of 76.31%. ● 82 cases or 27%, who stayed in the hospital between 1 and 3 days, had 30-day follow-up rates of 59.75%. ● 31 cases or 10% stayed beyond 15 days. CABHC RCA findings indicate: ● Lack of coordination between the discharging facility and the follow up community provider; because the discharge plan does not address all the barriers. The discharge plan/planning process: ○ Does not facilitate "warm hand-off" to the community provider ○ Does not fully identify and address the barriers that contribute to the person not being able to follow the discharge plan. ○ Does not identify and connect with the responsible community support person(s) who can assist with follow-through with FUH appointment(s). ○ Community providers do not work together effectively to remove barriers for members to meet their FUH responsibilities. ● The 2016 Discharge Management Plan (DMP) results revealed that discharge instructions did not include clear, concise medication reconciliation; did not include appointment details (including LOC,	

HealthChoices BH Contractor:	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date:
	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. DMP issues identified: a.) Multiple page discharge instructions; b.) Poorly handwritten instructions, making them illegible; and, c.) Medications including medical abbreviations such as BID, TID or not including generic and brand name.	
	Follow-up Status Response: Root cause statement - Incomplete discharge planning with Members.	
Policies / Procedures(1) (e.g., data systems, delivery systems, payment/reimbursement) 1) Discharge planning. ● Inadequate communication process. ● PCP/Prescriber collaboration.	**Initial Response:** BHSSBC data demonstrates: ● Treatment Record Reviews conducted in 2016 and 2017 of two (2) of Bedford-Somerset's highest volume MH IP Providers demonstrated an average score of 76% in the overall Discharge Planning/Summary section and an average score of 54% for Continuity and Coordination of Care (when applicable) with other mental health Providers. ● Identified areas of improvement include: ○ Coordination and Member involvement in scheduling appointments. ○ Better staff rapport with Members with timely discharge planning. CABHC data demonstrates: ● Treatment record reviews conducted in 2016 demonstrated that, among 7 MH IP facilities serving the Capital Region, scores for the Coordination and Continuity of Care section (when applicable) were 69% overall, and 71% for those facilities located within the Capital Region. The overall Discharge Planning/Summary sections scores averaged 80% overall and 88% for those located within the region. The specific indicator for collaboration on admission scored at 95% overall for facilities serving Capital Providers, and was at 100% for those located within the Capital Region. ● Treatment record reviews conducted in 2017 demonstrated that, among 10 MH IP facilities serving the Capital Region, scores for the Coordination and Continuity of Care section (when applicable) were 67% overall, and 78% for those facilities located within the Capital Region. The overall Discharge Planning/Summary sections scores averaged 84% overall, and 84% for those located within the region. The specific indicator for collaboration on admission scored at 82% overall for facilities serving Capital Providers, but was at 70% for those located within the Capital Region. ● CABHC RCA finding indicate: ○ Ineffective scheduling processes by community providers to meet member's needs; specifically, their ability to accommodate the member's schedule, the capability to do scheduling effectively (i.e. properly resourced; having services available). TMCA data demonstrates:	

HealthChoices BH Contractor:	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date:

- In the TMCA large community health system, the 2016 7-day MH routine access rates were over 66%. The psychiatric evaluation 7-day access rate was less than 34%. IP Providers are attempting to schedule a LOC that has historically been the lower access rate by a large margin.
- The largest health system Provider in network has limiting hours of operation: Monday to Friday 9 a.m. to -5 p.m., no evening hours and limits the number of available appointments.

All Contracts

- PIP DMP data demonstrates:
  1a. The majority of Members (70 to 83%) are discharged with follow-up appointments within 14 days of discharge.
  1b. The majority of Members (65 to 74 %) with follow-up appointments do not keep the appointments.

Successful Transition to Ambulatory Care Outcome Measures	2014 Baseline			2015 Measurement			2016 Measurement		
	N	D	%	N	D	%	N	D	%
DMP Pilot Facilities (Phase I):									
N4: F/U visit scheduled 0-7-days	60	120	**50.0**	68	120	**56.7**	70	120	**58.3**
N5: F/U visit scheduled 0-14 days	77	120	**64.2**	89	120	**74.2**	85	120	**70.8**
N6: F/U visit sched. 0-14 days and kept	58	77	**75.3**	60	89	**67.4**	56	85	**65.9**
DMP Facilities (Phase II):									
N4: F/U visit scheduled 0-7-days	N/A	N/A	N/A	75	120	**62.5**	85	120	**70.8**
N5: F/U visit scheduled 0-14 days	N/A	N/A	N/A	92	120	**76.7**	100	120	**83.3**
N6: F/U visit sched. 0-14 days & kept	N/A	N/A	N/A	67	92	**72.8**	65	99	**65.6**

HealthChoices BH Contractor:	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date:
	● Limited access to PCP/prescriber follow-up appointments. 2a. The MY 2016 HEDIS follow-up data specifications do not capture data on those Members who chose to follow-up with a PCP or any other healing arts practitioner outside the MH system of care.	
	Follow-up Status Response: Root cause statement - Inadequate functioning of discharge planning at the Member level.	
Provisions (1) (e.g., screening tools, medical record forms, transportation) 1) Member resources.	**Initial Response:** ● The volume of paperwork with which a Member is discharged from MH IP can be overwhelming, and discharge instructions and the importance of the follow-up appointment(s) can "get lost" in the pile. ● Members are not aware of the level of resource information available through PerformCare Member Service Specialists. ● CABHC RCA findings indicate: ○ Member' basic needs are not being met; related barriers as a result are: a.) the member has difficulty understanding or following the discharge plan; b.) no supports at the time of discharge, no access to telephone / communications; c.) lack / breakdown of comprehensive communication to coordinate treatment or community team members to prepare for discharge. ○ Transportation ▪ The member does not have access to transportation to keep FUH appointment(s). ▪ The member does not understand how to access the Medical Assistance Transportation Program (MATP). ▪ There are limited other reliable options for transportation to FUH appointment(s). ▪ Logistical time difficulties to arrange transportation upon discharge within 7 days. ▪ Transportation from rural communities is more difficult to arrange due to limited availability of times for shared rides. ○ Access to Communications ▪ The member does not have access to phone, mobile phone, or other communication technology. ▪ Lack of communication options provides barrier for discharge instructions; resulting in paper copies (that can be incomplete, or lost) that are not easily shared with OP service providers and the member's support system(s).	
	Follow-up Status Response: Root cause statement - Members lack the knowledge of resources and where to find the information.	
Provisions (2) (e.g., screening tools, medical record forms, transportation) 1) Recovery-oriented treatment.	**Initial Response:** ● There is 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	

HealthChoices BH Contractor:	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date:
	discharge planning and an understanding of the significance of follow-up appointments. ○ Supporting evidence: ▪ 2015 TRR Recovery/Discharge Planning results for MH IP (all contracts) reveal that 35% of discharge treatment plans were recovery-oriented (use of Member word, actions, plans, and goals). 2016 TRR Recovery/Discharge Planning results for MH IP (all contracts) reveal that 52% of discharge treatment plans were recovery-oriented (use of Member word, actions, plans, and goals). 2017 TRR Recovery/Discharge Planning results for MH IP (all contracts) reveal that 52% of discharge treatment plans were recovery-oriented (use of Member word, actions, plans, and goals). ▪ 2015 TRR Recovery/Discharge Planning results for MH IP (all contracts) reveal that 42% of discharge treatment plans contain measureable criteria and a clear aftercare plan. 2016 TRR Recovery/Discharge Planning results for MH IP (all contracts) reveal that 60% of discharge treatment plans contain measureable criteria and a clear aftercare plan. 2017 TRR Recovery/Discharge Planning results for MH IP (all contracts) reveal that 35% of discharge treatment plans contain measureable criteria and a clear aftercare plan.	
	Follow-up Status Response: Root cause statement – Members lack an understanding of mental health treatment, mental illness and the recovery model.	
Provisions (3) (e.g., screening tools, medical record forms, transportation) 1) Discharge planning. ● Coordination of ambulatory treatment. ● Discharge instructions. ● Follow-up appointments.	**Initial Response:** ● Discharge paperwork can be extensive. ○ Appointment is not easily identified in the discharge paperwork. ○ Communication and coordination of outpatient treatment. ● CABHC RCA findings indicate: ○ The 2016 Discharge Management Plan (DMP) results revealed 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. DMP issues identified: a.) Multiple page discharge instructions; b.) Poorly handwritten instructions, making them illegible; and, c.) Medications including medical abbreviations such as BID, TID or not including generic and brand name.	

HealthChoices BH Contractor:	Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)	Response Date:
	○ Providers do not have the ability to effectively measure FUH because discharge plans are not clearly communicated; community providers are therefore unclear of conditions prohibiting the routine FUH standards. ○ Discharge instructions key to follow up are not following discharge best practices; not clear or concise. The 2016 treatment record review (TRR) results reveal that Providers do not adequately follow discharge planning best practices. ○ Changes to discharge plans (such as medication orders or changes) are not communicated effectively from the inpatient facility; and / or, the community provider may not receive the discharge plan or medication orders. ▪ Community outpatient providers (OP) may change medications prescribed by IP physician(s), or make appointments that are beyond the previous prescription refill dates.	
	Follow-up Status Response: Root cause statement - Lack of a standardized discharge planning process.	

Corresponding Action Plan		
Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2016. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	**Implementation Date** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
#1 Root Cause: PerformCare adult Members over the age of 18 are the drivers of the follow-up rate. Members' lack education of diagnosis, medication and treatment adherence. **Action (1)** 1. Implement training to ensure that Providers as well as other community support systems understand, develop, and improve recovery awareness resources. 2. Promote the expansion of the use of peer support throughout the Provider Network. 2a. Encourage Members and Providers to increase the utilization of peer support. ● Develop a peer support focused education piece to be included in the Member newsletters. ● Develop a peer support training resource	1. Throughout the calendar year2018. 2. Throughout the calendar year 2018. 3. Throughout the calendar year 2018.	**Initial Response (1):** 1. Schedule and track Provider training. Provider Advisory Committee (PAC) will monitor the development of training resources. Network Operations will track and distribute Provider notices regarding resources. Quarterly reports will be presented to the QIUM Committees. 2. Peer support 2a. Monitor and review Member newsletters for the inclusion of peer support information;

Corresponding Action Plan		
Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2016. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	**Implementation Date** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
and make it available on the PerformCare website. 2b. CABHC – Enhance the use of peer specialists; increase the number of peer specialists to be used as facilitators between IP and ambulatory services. 3. Redirect the focus of discharge planning. 3a. CABHC - continue Project RED implementation as a pilot project. ● Ascertain the need for and obtain language assistance. ● Make appointments for follow-up medical appointments (post-discharge). ● Plan for follow-up of results of tests or studies that are pending at discharge. ● Organize post-discharge outpatient services. ● Identify the correct medicines and plan for the Member to obtain and take them. ● Reconcile the discharge plan according to national guidelines. ● Teach a written discharge plan the Member can understand. ● Educate the Member about his or her diagnosis. ● Assess the degree of the Member's understanding of the discharge plan. ● Review with the Member what to do if a problem arises. ● Expedite transmission of the discharge summery to the clinicians accepting care of the Member. ● Provide telephone reinforcement of the discharge plan. 3b. Provide education to encourage IP best practice discharge planning.		monitor the Provider use of the website training resource to determine if the education piece had an influence on website usage within the first three months of publication.2b. CABHC – Monitor the utilization of peer support at the quarterly QIUM Committee meetings. 3. Discharge planning. 3a. CABHC - Ongoing monthly updates will occur at the Steering Committee. Quarterly updates will occur via the PIP and QIUM. The local MH IP programs have outcome measures that are part of the Project RED contract. PerformCare provides an individualized dashboard to each facility These will be compared with data analytics of those hospitals that do not use Project RED to see the efficacy on FUH HEDIS measures. Improved performance can lead to expand and contracting terms that require the adoption of Project RED. 3b. Schedule and track Provider training. TRRs will be used to assess Provider use of best practice discharge planning. Results will be reported at QIUM Committees.
		Follow-up Status Response (1):

Corresponding Action Plan		
Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2016. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	**Implementation Date** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
		Follow-up after hospitalization for mental illness 7-day and 30-day HEDIS measures will be monitored for impact on at least a quarterly basis.
#2 Root Cause: The provider network has inadequate post discharge treatment resources **Action (2)** 1. CABHC - Implementation of value-based purchasing incentive plan (to be determined upon OMHSAS approval of all contracts). 1a. Continue implementation of OMHSAS approved Provider value-based purchasing incentive plan for MH OP and PHP Providers who meet the HEDIS 7-day FUH performance target. This is monitored by the use of encounter data and reported to Providers on a quarterly basis. Educational sessions will also be held with Providers to assess barriers within their systems to improve their performance on this measure. 1b. Explore steps to change payment models to promote "whole person" treatment (i.e. case rate). 2. PerformCare will collaborate with BHSSBC, CABHC and TMCA to address Provider recruitment and retention. 2a. BHSSBC – Development and implementation of children's PHP. 2b. CABHC ● Implement a process to attract/retain clinicians; address staffing shortages (i.e. residency programs, tuition forgiveness, partnerships with hospital systems, non-financial incentives, attracting and using Certified Registered Nurse Practitioners (CRNP) or Physician's Assistants (PA)). Determine if the Provider recruitment	1. CABHC - To be determined upon OMHSAS approval of all contracts. 2. Throughout the calendar year 2018. 3. Identification of Providers and methods of examination will occur in April of 2018. 4. The end of CY 2018.	**Initial Response (2):** 1. Value-based purchasing incentive plan. 1a. CABHC - FUH HEDIS measure scores will be the measure to determine if this action step achieves improved scoring. 1b. Meetings will be held to discuss payment models. 2. Collaboration: 2a. BHSSBC – Monitor progress of the children's PHP. 2b. CABHC - Provider recruitment reinvestment plan for potential expansion (improved access in 6 of the MH OP Clinics). 2c. TMCA - MHOP Providers who engaged in scheduling practice changes had baseline rates for 7-day MH routine access and 7-day psychiatric access. Those rates are reviewed with Providers at each meeting they have with PerformCare's account executives, and are monitored during each quarterly QIUM meeting.

Corresponding Action Plan		
Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2016. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	**Implementation Date** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
reinvestment plan improved access in 6 of the MH OP clinics, and if so, expand funding of this initiative. ● Measure the efficacy of the existing open access/any time model of scheduling to support Member needs and, if effective, expand this to all MH OP clinics. Look to reduce the incidence of appointment no-shows and mitigate the impact of Members who fail to attend appointments. ● Further expand Telepsych capabilities to tap into additional available treatment resources. 2c. TMCA – Collaboration with MH OP Providers to address access rates for outpatient services. 3. TMCA, in collaboration with PerformCare, will examine methodologies and interventions of the inpatient Providers who have follow-up success. 4. CABHC – Facilitate warm handoff to community ambulatory care Provider through the use of a certified peer specialist or designated staff at the OP clinic. 4a. Establish a point person (i.e. case worker; social worker) to coordinate, facilitate, and navigate system on behalf of the Member at the OP clinic. 4b. Identify a resource to facilitate better follow-up between 7 and 30 days (i.e. Navigator or a person such as a peer specialist to help Members to make/keep appointments).		3. TMCA - Record reviews of large health systems and stand-alone Providers will be compared. Differences in practice and process by provider rates will be analyzed. The work group, through meeting notes, will record factors that influence practice and determine the methods of enacting change with Providers. 4. CABHC – This will be assessed via the annual Member Satisfaction Survey and the results will be reviewed by the QIUM Committee. **Follow-up Status Response (2):** Follow-up after hospitalization for mental illness 7-day and 30-day HEDIS measures will be monitored for impact on at least a quarterly basis.
#3:Root cause: Incomplete discharge planning with Members ***#4:Root cause: Inadequate functioning of discharge planning at the Member level*** **Action (3)** 1. CABHC - Implementation of Project RED (CABHC) pilot with 3 facilities. Implementation of the Re-engineered Discharge (RED)	1. November 2017 2. Throughout the calendar year 2018; technical assistance will be	**Initial Response (3):** The local MH IP programs have outcome measures that are part of the Project RED contract. PerformCare provides an individualized dashboard to each facility. These will be combined with comparing data analytics to those hospitals that do not use Project RED to see

Corresponding Action Plan		
Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2016. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	**Implementation Date** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
– to address education of the Member and advocate for them in order to best prepare them and their caregivers for discharge and success following discharge from the hospital (i.e. the role of the discharge educator). See a more complete description of Project RED: http://www.bu.edu/fammed/projectred/components.html). **Project RED; Re-Engineered Discharge; Boston University School of Medicine.* Clearly define "care coordination" (i.e. standards, requirements, practices) - **a component of the current implementation of the Re-engineered Discharge (RED) process. See also Discharge Planning Inadequate section below.)* Explore the establishment of a point person within Project Red. 2. Provider education on best practice discharge planning. 3. Member education on best practice discharge planning. Inpatient Providers shall educate and document Member discharge planning. Development and implementation of PerformCare Member follow-up specialists. 4. CABHC - Implement training to assure that Providers as well as other community support systems understand what "recovery" means (recovery principles), and to develop the training resources and develop awareness of available resources. 5. CABHC - Explore technology solution (i.e. health information exchange) to enable the electronic transfer of discharge plans from the IP Provider to their community OP Provider, and support system(s). Consult with PerformCare Provider Advisory Committee regarding potential technology solutions. 6. CABHC - Establish process and procedures to provide communication for Members with an IP encounter, who are already involved with an	provided as needed. 3. Throughout the calendar year 2018. 4. Throughout the calendar year 2018. 5. First discussions no later than the end of the second quarter of 2018. 6. This process will be completed by the end of the second quarter of 2018. 7. This process will be completed by the end of the second quarter of 2018	the efficacy on FUH HEDIS measures. Improved performance can lead to expand and contracting terms that require the adoption of RED. 2. PerformCare will monitor Provider trainings regarding discharge planning on a quarterly basis via attendance. The impact of the training on discharge planning will be assessed by treatment record reviews.3. PerformCare will monitor this through the treatment record review process, the performance improvement plan, and the discharge management plan review process. 4. CABHC - PerformCare will monitor Provider trainings regarding discharge planning on a quarterly basis via attendance. The impact of the training on discharge planning will be assessed by treatment record reviews. 5. CABHC – QIUM Committee will monitor PAC minutes for viable technology solutions. 6. CABHC - PerformCare will monitor through the PIP discharge management plan review process. 7. CABHC – PerformCare will publish resource information in our Member newsletters and a Provider email blast through iContact.
		Follow-up Status Response (3): Follow-up after hospitalization

Corresponding Action Plan		
Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2016. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	**Implementation Date** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
ambulatory care Provider (OP, TCM, ACT, PHP), to coordinate with the ambulatory care Provider to re-engage when the hospital is ready to discharge. 7. CABHC - Provide time-limited mobile phones to Members being discharged so that service Providers can call for follow-up support. PerformCare will provide Member and Provider resource information on applying for free mobile phones and services.		for mental illness 7-day and 30-day HEDIS measures will be monitored for impact on at least a quarterly basis.
Root cause: Members lack the knowledge of resources and where to get the information **Action (4)** 1. Promote Member Service 24/7 availability. 1a. PerformCare flyers and newsletter. 1b. PerformCare Provider notices. 1c. PerformCare website. 1d. Recommend statement be added to Provider discharge form instructing Members to call insurance company customer service to assist in identifying resources. 1e. Development of resource guides (BHSSBC, CABHC and TMCA). 1f. CABHC - Establish a process or resource to provide transportation for FUH. Establish transportation banks, MATP navigator to assist in securing transportation, and engage hospitals to provide/participate in the delivery of transportation solutions to assist with their discharge plans.	1. 1a-c. Ongoing - Standard statement in every Member newsletter. 1d. No later than the end of the second quarter of 2018. 1e. No later than 12/31/18. 1f. No later than 12/31/18.	**Initial Response (4):** 1a-c. Quality Improvement Department will review and ensure inclusion of the standard statement. 1d. Quality Improvement Department will monitor through the PIP DMP process. 1e. Member and Provider notification of the availability of the resource guides. 1f. CABHC – to be determined. **Follow-up Status Response (4):** Follow-up after hospitalization for mental illness 7-day and 30-day HEDIS measures will be monitored for impact on at least a quarterly basis.
Root cause: Lack of standardized discharge planning process **Action (5)** 1. Recommendation to inpatient Providers to use educational methodologies such as teach-back to review both medications and appointments at the time of discharge. (Excluding the 3 hospitals in project RED)	1. Provider notices will be completed in the first quarter of 2018. 2. Provider notices will be completed in the first quarter of 2018.	**Initial Response (5):** 1. Monitoring the impact on the 7 and 30-day HEDIS measures, treatment record reviews and the DMP process. 2. Monitoring the impact on the 7 and 30-day HEDIS measures, Treatment Record Reviews and the

Corresponding Action Plan		
Measure: Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7-Day) and/or Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30-Day)		
For the barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2016. Documentation of actions should be continued on additional pages as needed.		
Action Include those planned as well as already implemented.	**Implementation Date** Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
1a. Develop and distribute iContact related to discharge planning by referring Providers to the link below: https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html 2. PerformCare will provide technical assistance on standardized discharge planning.		DMP process. **Follow-up Status Response (5):** Follow-up after hospitalization for mental illness 7-day and 30-day HEDIS measures will be monitored for impact on at least a quarterly basis.

VI: 2018 Strengths and Opportunities for Improvement

The review of PerformCare's 2018 (MY 2017) performance against structure and operations standards, performance improvement projects, and performance measures identified strengths and opportunities for improvement in the quality outcomes, and in the timeliness of and access to services for Medicaid members served by this BH-MCO.

Strengths

- PerformCare's MY 2017 Initiation and Engagement of AOD Treatment rate for ages 13+ years increased (improved) significantly compared to prior year rates by 10.6 and 12.3 percentage points, respectively.
- PerformCare's MY 2017 Engagement of AOD Treatment rate for ages 13+ years achieved the goal of meeting or exceeding the HEDIS 75th percentile.
- PerformCare's MY 2017 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate was statistically significantly below (better) compared to the MY 2017 HC BH (Statewide) rate by 2.3 percentage points.
- PerformCare's MY 2017 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate statistically significantly decreased (improved) compared to the prior year rate by 4.3 percentage points.

Opportunities for Improvement

- PerformCare was partially compliant with the following four elements under review for Year 3 of the Performance Improvement Project:
    - Review Element 1 - Project Topic and Relevance.
    - Review Element 6 – Data Collection Procedures.
    - Review Element 7 - Improvement Strategies (Interventions).
    - Review Elements 8/9 – Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement.
- Review of compliance with standards conducted by the Commonwealth in RY 2015, RY 2016, and RY 2017 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 1 out of 7 categories – Enrollee Rights.
    - PerformCare was partially compliant with 4 out of 10 categories and non-compliant with 1 category within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, 3) Subcontractual Relationships and Delegation, and 4) Practice Guidelines. The non-compliant category is: Coordination and Continuity of Care.
    - PerformCare was partially compliant with 9 out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers and Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.
- PerformCare's MY 2017 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.
- PerformCare's MY 2017 HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for ages 6–64 years did not meet the OMHSAS interim goals for MY 2017, nor did they achieve the goal of meeting or exceeding the HEDIS 75th percentiles.
- PerformCare's MY 2017 HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for ages 6–64 years did not improve significantly compared to MY 2016 rates.
- PerformCare's MY 2017 Initiation of AOD Treatment performance rate for ages 13+ years did not achieve the goal of meeting or exceeding the HEDIS 75th percentile.
- PerformCare's MY 2017 Initiation and Engagement of AOD Treatment rate for ages 13+ years were statistically significantly lower (worse) compared to the MY 2017 HC BH (Statewide) rates by 1.9 and 3.4 percentage points, respectively.

Additional strengths and targeted opportunities for improvement can be found in the BH-MCO-specific 2018 (MY 2017) Performance Measure Matrices that follow.

Performance Measure Matrices

The Performance Measure (PM) Matrices provide a comparative look at quality indicators (QIs) included in the 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.

Table 6.1 is a three-by-three matrix depicting the horizontal same-year comparison between the BH-MCO's performance and the applicable HC BH (Statewide) rate and the vertical comparison of the BH-MCO's MY 2017 performance to its prior year performance. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly: above (▲), below (▼), or no difference (═). This comparison is determined by whether or not the 95% CI for the BH-MCO rate included the benchmark rate. However, the qualitative placement of the performance in the matrix depends on the measure. For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) measure, lower rates reflect better performance.

Table 6.1: BH-MCO Performance Matrix for MY 2017 PA-Specific 7- and 30-Day Follow-up After Hospitalization and MY 2017 Readmission Within 30 Days of Inpatient Psychiatric Discharge (Overall)

BH-MCO Year to Year Statistical Significance Comparison	Trend	BH-MCO versus HealthChoices Rate Statistical Significance Comparison		
		Poorer	No difference	Better
	Improved	C	B	A REA[1]
	No Change	D	C FUH QI A FUH QI B	B
	Worsened	F	D	C

[1] For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.
Letter Key: Performance is notable. BH-MCOs may have internal goals to improve. B: BH-MCOs may identify continued opportunities for improvement. C-F: Recommend BH-MCOs identify continued opportunities for improvement.
FUH QI A: PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness (Overall).
FUH QI B: PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall).
REA: Readmission Within 30 Days of Inpatient Psychiatric Discharge.

Table 6.2 quantifies the performance information contained in **Table 6.1**. It compares the BH-MCO's MY 2017 7- and 30-Day Follow-up After Hospitalization and Readmission Within 30 Days of Inpatient Psychiatric Discharge rates to prior years' rates for the same indicator for measurement years 2013 through 2017. The last column compares the BH-MCO's MY 2017 rates to the corresponding MY 2017 HC BH (Statewide) rates. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly: above (▲), below (▼), or no difference (═). This comparison is determined by whether or not the 95% CI for the BH-MCO rate included the benchmark rate.

Table 6.2: MY 2017 PA-Specific 7- and 30-Day Follow-up After Hospitalization and MY 2017 Readmission Within 30 Days of Inpatient Psychiatric Discharge Rates, Compared Year-over-Year and to HC BH Statewide (Overall)

Quality Performance Measure	MY 2013 Rate	MY 2014 Rate	MY 2015 Rate	MY 2016 Rate	MY 2017 Rate	MY 2017 HC BH (Statewide) Rate
QI A – PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness (Overall)	54.1%▼	56.9%▲	56.9%═	51.6%▼	51.4%=	52.2%=
QI B – PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall)	73.1%▼	76.4%▲	75.6%═	72.2%▼	70.9%=	69.6%=
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	15.5%▲	15.9%═	15.6%═	15.4%═	11.1%▲	13.4%▲

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

Table 6.3 is a four-by-one matrix that represents the BH-MCO's MY 2017 performance as compared to the HEDIS 90th, 75th, 50th, and 25th percentiles for the MY 2017 HEDIS FUH 7-Day (QI 1) and 30-Day Follow-up (QI 2) After Hospitalization metrics. A root cause analysis and plan of action is required for rates that fall below the 75th percentile.

Table 6.3: BH-MCO Performance Matrix for MY 2017 HEDIS FUH 7- and 30-Day Follow-up After Hospitalization (6–64 Years)

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

[1] Rates shown are for ages 6–64 years.
FUH QI 1: HEDIS 7-Day Follow-up After Hospitalization for Mental Illness (6–64 Years).
FUH QI 2: HEDIS 30-Day Follow-up After Hospitalization for Mental Illness (6–64 Years).

Table 6.4 shows the BH-MCO's MY 2017 performance for HEDIS (FUH) 7- and 30-day Follow-up After Hospitalization for Mental Illness (6–64 Years) relative to the corresponding HEDIS MY 2017 NCQA Quality Compass percentiles.

Table 6.4: BH-MCO's MY 2017 FUH Rates Compared to Corresponding MY 2017 HEDIS 75th Percentiles (6–64 Years)

Quality Performance Measure	MY 2017		HEDIS MY 2017 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-up After Hospitalization for Mental Illness (6–64 Years)	39.2%	Not met	Below 75th and at or above 50th percentile
QI 2 – HEDIS 30-Day Follow-up After Hospitalization for Mental Illness (6–64 Years)	62.1%	Not met	Below 75th and at or above 50th percentile

[1] Rates shown are for ages 6–64 years.

VII: Summary of Activities

Structure and Operations Standards

- PerformCare was partially compliant with Subparts C, D, and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2017, RY 2016, and RY 2015 were used to make the determinations.

Performance Improvement Projects

- PerformCare submitted a Year 3 PIP Update in 2018. PerformCare participated in quarterly meetings with OMHSAS and IPRO throughout 2018 to discuss ongoing PIP activities.

Performance Measures

- PerformCare reported all performance measures and applicable quality indicators in 2018.

2017 Opportunities for Improvement MCO Response

- PerformCare provided a response to the opportunities for improvement issued in 2017.

2018 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for PerformCare in 2018. The BH-MCO will be required to prepare a response in 2019 for the noted opportunities for improvement.

References

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

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

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

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

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

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

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

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

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

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

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

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

HEDIS 2018 Volume 2 Technical Specifications for Health Plans (2018).

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

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

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

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

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

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

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

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

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

Quality of Care External Quality Review (EQR). (2013, September 1). Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html .

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

U.S. Department of Health & Human Services. (2016). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf .

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

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

Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for Required PEPS Substandards pertinent to BBA Regulations.

Table A.1: Required PEPS Substandards Pertinent to 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 104.3	Performance Improvement Plans status reported within the established time frames.
	Standard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly PEPS Reports
	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 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).

BBA Category	PEPS Reference	PEPS Language
	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.
	Standard 28.3	Other: Significant onsite review findings related to Standard 28.
§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 28.3	Other: Significant onsite review findings related to Standard 28.
	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

BBA Category	PEPS Reference	PEPS Language
		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 28.3	Other: Significant onsite review findings related to Standard 28.
	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 assessment and performance improvement program	Standard 91.1	QM program description outlines ongoing quality assessment, performance improvement activities, a 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 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

BBA Category	PEPS Reference	PEPS Language
		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 91.14	The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the Annual Evaluation and any Corrective Actions required from previous reviews.
	Standard 91.15	The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outline in the program description and the work plan.
	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.
	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

BBA Category	PEPS Reference	PEPS Language
		member satisfaction including Consumer Satisfaction Team reports to DHS.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
	Standard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly PEPS Reports
§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 ● 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 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 ● 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
§438.402 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 ● 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 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

BBA Category	PEPS Reference	PEPS Language
		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 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 ● 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 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

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 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).
§438.408 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 • 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 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

BBA Category	PEPS Reference	PEPS Language
		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).
§438.410 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 ● Expedited
	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

BBA Category	PEPS Reference	PEPS Language
§438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending	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).
§438.424 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).

Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-Specific PEPS Substandards.

Table B.1: 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

Category	PEPS Reference	PEPS Language
		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 2017, 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 substandards, along with the relevant categories. Because compliance categories (first column) may contain substandards that are reviewed either annually or triennially, the total number of PEPS substandards applicable to this year's (RY 2017) evaluation of HealthChoices Oversight Entity/BH-MCO compliance for any given category may not equal the sum of those substandard counts.

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

Category (PEPS Standard)	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	RY 2017	RY 2016	RY 2015
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)	5	0	5	0	0
Grievances and State Fair Hearings (Standard 71)	5	0	5	0	0
Denials					
Denials (Standard 72)	1	0	1	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	0	3	0	0
Total	18	0	18	0	0

[1] The total number of OMHSAS-Specific substandards required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with OMHSAS standards. Any PEPS substandards not reviewed indicate retired substandards previously used to evaluate the BH-MCO.

[2] The number of OMHSAS-Specific substandards that came under active review during the cycle specific to the review year. Because compliance categories (first column) may contain substandards that are either annually or triennially reviewed, the total number of PEPS substandards applicable to this year's (RY 2017) evaluation of HealthChoices Oversight Entity/BH-MCO compliance with any given category may not equal the sum of those substandard counts.

RY: Review Year.

NR: Not reviewed.

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 with 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 2015. Of the two substandards, PerformCare met both 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 2017	Met
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	RY 2017	Met

The OMHSAS-specific PEPS Substandards relating to second-level complaints and grievances are MCO-specific review standards. Of the 10 substandards evaluated, PerformCare met 6 substandards, partially met 3 substandards, and did not meet 1 substandard, 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 2017	Not Met
	Standard 68.6	RY 2017	Partially Met
	Standard 68.7	RY 2017	Met
	Standard 68.8	RY 2017	Met
	Standard 68.9	RY 2017	Partially Met
Grievances and State Fair Hearings	Standard 71.1	RY 2017	Met
	Standard 71.5	RY 2017	Partially Met
	Standard 71.6	RY 2017	Met
	Standard 71.7	RY 2017	Met
	Standard 71.8	RY 2017	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 met the criteria for compliance with Substandards 68.7 and 68.8, partially met the criteria for compliance with Substandards 68.6 and 68.9, and did not meet the criteria for compliance with Substandards 68.1 and 68.7 (RY 2017).

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 68.8: 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.

Substandard 68.9: Where applicable, there is evidence of County oversight and involvement in the 2nd-level complaint process.

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 with Substandard 71.5 (RY 2017).

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.

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2017. 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 2017	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 2015. PerformCare partially met the criteria for compliance for Substandard 78. 5 and 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 2017	Partially Met
BH-MCO Executive Management	Standard 86.3	RY 2017	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 of experience in mental health and substance abuse; Chief Financial Officer; Director of Quality Management; Director of Utilization Management; Management Information Systems; Director of Prior/service authorization; Director of member Services; and Director of Provider Services.

PerformCare was compliant with Substandards 86.3 RY 2017).

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 was partially compliant with 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.