Commonwealth of Pennsylvania

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

2019 External Quality Review Report
Beacon Health Options of Pennsylvania

FINAL

April 2020

Better healthcare, realized.

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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 2019 EQRs for HC BH-MCOs and to prepare the technical reports. The subject of this report is one HC BH-MCO: Beacon Health Options of Pennsylvania (BHO). 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. 2018 Opportunities for Improvement – MCO Response
VI. 2019 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the MCO, the information for 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, 2018 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2018 (RY 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 (RY 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 2018, 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) 2018, 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. In such cases, the Department holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH Contractors, who, in turn, sub-contract with a private-sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Forty-three (43) of the 67 counties have signed agreements using the right of first opportunity and have sub-contracted with a BH-MCO. 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. 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 HC BH Contractor, whether contracting with an Oversight Entity arrangement or not, 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.

Beaver, Fayette, and the Southwest Six counties (comprising Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland Counties) hold contracts with Value Behavioral Health (VBH). The Oversight Entity for the Southwest Six counties is Southwest Behavioral Health Management, Inc. Two other Oversight Entities – Behavioral Health of Cambria County (BHoCC) and Northwest Behavioral Health Partnership, Inc. ([NWBHP] comprising Crawford, Mercer, and Venango Counties) hold contracts with VBH. The Department contracts directly with BHO to manage the HC BH program for Greene County. In Calendar Year 2017, Cambria County moved from BHO to Magellan Behavioral Health (MBH). If a county is contracted with more than one BH-MCO in the review period, compliance findings for that county are not included in the Structure and Operations section for either BH-MCO for a three-year period. **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

<table>
<tr><th>HealthChoices Oversight Entity</th><th>HC BH Contractor</th><th>County</th></tr>
<tr><td>Beaver County Behavioral Health</td><td>Beaver County Behavioral Health</td><td>Beaver County</td></tr>
<tr><td rowspan="3">Northwest Behavioral Health Partnership, Inc. (NWBHP)</td><td rowspan="3">Northwest Behavioral Health Partnership, Inc. (NWBHP)</td><td>Crawford County</td></tr>
<tr><td>Mercer County</td></tr>
<tr><td>Venango County</td></tr>
<tr><td>Fayette County Behavioral Health Administration (FmbhA)</td><td>Fayette County Behavioral Health Administration</td><td>Fayette County</td></tr>
<tr><td>PA Department of Human Services</td><td>Value Behavioral Health of Pennsylvania, otherwise known as Greene County for this review</td><td>Greene County</td></tr>
<tr><td rowspan="6">Southwest Behavioral Health Management, Inc. (Southwest Six)</td><td rowspan="4">Southwest Behavioral Health Management, Inc. (Southwest Six)</td><td>Armstrong County</td></tr>
<tr><td>Indiana County</td></tr>
<tr><td>Butler County</td></tr>
<tr><td>Lawrence County</td></tr>
<tr><td>Westmoreland County</td><td>Westmoreland County</td></tr>
<tr><td>Washington County</td><td>Washington County</td></tr>
</table>

HC: HealthChoices; BH: behavioral health.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of MBH by OMHSAS monitoring staff within the past three review years (RYs 2018, 2017, and 2016). 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 2018. 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 time frame 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 March 2019 for RY 2018. 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 in which to capture additional reviewer comments. Based on the PEPS Application, a HealthChoices Oversight Entity/BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations ("categories"), as well as against 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 PEPS 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 and 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.

From time to time standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions. Standards or substandards that are introduced or retired are done so following the rotating three-year schedule for all five BH-MCOs. This may in turn change the category-tally of standards from one reporting year to the next. In 2018, two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). ID numbers for some existing substandard also changed. For this report, in order to distinguish substandards, a parenthetical notation "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020).

As was done for prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The review findings for selected OMHSAS-specific Substandards are reported in **Appendix C**. The RY 2018 crosswalks of PEPS Substandards to pertinent BBA regulations and to pertinent 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 three-year period is alternatively referred to as the Active Review period. The PEPS Substandards from RY 2018, RY 2017, and RY 2016 provided the information necessary for the 2018 assessment. Those triennial standards not reviewed through the PEPS system in RY 2018 were evaluated on their performance based on RY 2017 and/or RY 2016 determinations, 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.

For BHO, a total of 79 unique substandards were applicable for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2016, 2017, 2018). In addition, 16 OMHSAS-specific Substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. Some PEPS Substandards crosswalk to more than one BBA category while each BBA category crosswalks to multiple substandards. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific Substandards that are not required as part of BBA regulations but are reviewed within the three-year cycle to evaluate the BH-MCO and the associated HealthChoices Oversight Entity against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for BHO

Table 1.2 tallies the PEPs Substandard reviews 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 2016–2018). Substandard counts under RY 2018 include both annual and triennial substandards; Substandard counts under RYs 2017 and 2016 comprise only triennial substandards. By definition, only the last review of annual substandards is counted in the three-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 1.2**, 175, differs from the unique count of substandards that came under active review (79).

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

	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
BBA Regulation	**Total**	**NR**	**RY 2018**	**RY 2017**	**RY 2016**
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	14	0	11	3	0
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	24	0	19	2	3
Coordination and Continuity of Care	2	0	0	2	0
Coverage and Authorization of Services	4	0	2	2	0
Provider Selection	3	0	3	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	0	0	8

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
Practice Guidelines	6	0	1	2	3
Quality Assessment and Performance Improvement Program	26	0	20	0	6
Health Information Systems	1	0	0	0	1
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	0	2	9	0
General Requirements	14	0	2	12	0
Notice of Action	13	0	13	0	0
Handling of Grievances and Appeals	11	0	2	9	0
Resolution and Notification: Grievances and Appeals	11	0	2	9	0
Expedited Appeals Process	6	0	2	4	0
Information to Providers and Subcontractors	9	0	0	9	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	0	2	4	0
Effectuation of Reversed Resolutions	6	0	2	4	0
Total	**175**	**0**	**83**	**71**	**21**

[1] The total number of substandards required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations. Any PEPS Substandards not reviewed indicate substandards that were deemed not applicable to the HealthChoices Oversight Entity/BH-MCO.
[2] The number of sub-standards that came under active review during the cycle specific to the review year. Because sub-standards may cross-walk to more than one category, the total tally of sub-standard reviews (175) differs from the unique count of substandards that came under active review (79).
BBA: Balanced Budget Act; MBH: Magellan Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: Sub-standards not reviewed; RY: review year; NR: sub-standards not reviewed; N/A: category not applicable.

For RY 2018, nine of the above 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. For this 2019 (RY 2018) report, IPRO reviewed the Solvency tracking reports and the quarterly reporting of Complaint and Grievances data to determine compliance with Solvency and Recordkeeping and Recording Requirement, 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 (category) 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. A value of not applicable (N/A) was assigned to provisions for which a compliance review was not required. 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 within a given category were aggregated to arrive at a summary compliance status for the category. For example, all compliance findings relating to enrollee rights are summarized under Enrollee Rights - 438.100.

Format

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in *CMS EQR Protocol #1: Assessment of Compliance with Medicaid Managed Care Regulations* ("Quality of Care External Quality Review," 2012)[1]. Under each general subpart heading are the individual regulatory categories appropriate to those headings. IPRO's findings are therefore organized under 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

Eighty-two unique PEPS Substandards were used to evaluate BHO and its Oversight Entities compliance with BBA regulations in RY 2018.

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.

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	Non Compliant	
Enrollee Rights 438.100	Partial		All BHO HC BH Contractors		14 substandards were crosswalked to this category. Each HC BH Contractor was compliant with 11 substandards, partially compliant with 2 substandards, and non-compliant with 1 substandard.
Provider-Enrollee Communications 438.102	Compliant	All BHO HC BH Contractors			Compliant as per PS&R sections II-5 F.7 and section II-4 A.5.a.
Marketing Activities 438.104	N/A	N/A	N/A	N/A	Not applicable due to CMS HealthChoices waiver. Consumers are assigned to BH-

[1] Under the revised CMS EQR Protocols (2019), released after the RY 2018 PEPS was implemented, the areas subject to compliance review now fall formally under Subparts D and E. The same requirements are covered in this report except organized under the 2012 rubric. The organization of findings will be updated in next year's (2020) report under the new structure.

Subpart C:	MCO	By HC BH Contractor			Comments
					MCOs based on their county of residence.
Liability for Payment 438.106	Compliant	All BHO HC BH Contractors			Compliant as per PS&R sections II-7 A.5.a and A.9-A.10.
Cost Sharing 438.108	Compliant	All BHO 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 BHO HC BH Contractors			Compliant as per PS&R sections II-4 A.4, B.6 and C.2.
Solvency Standards 438.116	Compliant	All BHO HC BH Contractors			Compliant as per PS&R sections II-7 A and the 2018–2019 Solvency Requirements tracking reports.

MCO: managed care organization; HC: HealthChoices; BH: behavioral health; BHO: Beacon Health Options; PS&R: Program Standards and Requirements; N/A: not applicable; CFR: Code of Federal Regulations.

There are seven (7) categories within Subpart C Enrollee Rights and Protections. BHO was compliant with 5 categories and partially compliant with 1 category. The remaining category was considered not applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the 5 compliant categories, 4 were compliant as per the HealthChoices PS&R and 1 category was compliant as per CMS Regulation 42 CFR 447.50–447.60. The remaining category, Solvency Standards, was compliant based on the 2018–2019 Solvency Requirement tracking reports and the HealthChoices PS&R.

Of the substandards that were crosswalked to Enrollee Rights and Protections Regulations, BHO was evaluated and compliant with 12 PEPS Substandards and non-compliant with 2 Substandards. Overall, BHO was deemed partially compliant for the category of Enrollee Rights. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Enrollee Rights

All HC BH Contractors associated with BHO were partially compliant with Enrollee Rights due to partial compliance and non-compliance with Substandards of PEPS Standard 60 (RY 2017).

PEPS Standard 60: Complaint/Grievance Staffing:

- The BH-MCO shall identify a lead person responsible for overall coordination of the complaint and grievance process, including the provision of information and instructions to members. (Responsibility includes Health Insurance Portability and Accountability Act of 1996 [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].
- The BH-MCO must have written policies and procedures for registering, responding to and resolving Complaints and Grievances.

All BHO HC BH Contractors were partially compliant with Substandards 1 and 3 of Standard 70 (RY 2017).

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

Substandard 3: The BH-MCO's Complaint and Grievance policies and procedures comply with the requirements set forth in Appendix H.

All BHO HC BH Contractors were non-compliant with Substandard 2 of Standard 60 (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.

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. Based on the items reviewed for the 10 categories of Quality Assessment and Performance Improvement Regulations, BHO was fully compliant with 4 categories and partially compliant with 6 categories. BHO was evaluated and deemed compliant with the categories of Elements of State Quality Strategies and Confidentiality per the HealthChoices PS&R, as these categories were not directly addressed by any PEPS Substandards.

Of the PEPS items crosswalked to Quality Assessment and Performance Improvement regulations, 74 were evaluated for BHO for RY 2018. BHO was compliant with 66 PEPS items, partially compliant with 2 PEPS item, and non-compliant with 6 PEPS items. **Table 1.3** 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	Non Compliant	
Elements of State Quality Strategies 438.204	Compliant	All BHO HC BH Contractors			Compliant as per PS&R sections II-5 G and II-6 A and B.3.
Availability of Services (Access to Care) 438.206	Partial		All BHO HC BH Contractors		24 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 24 substandards, compliant with 23 substandards, and non-compliant with 1 substandard.
Coordination and Continuity of Care 438.208	Partial		All BHO HC BH Contractors		2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards, compliant with 1 substandard, and non-compliant with 1 substandard.
Coverage and Authorization of Services 438.210	Partial		All BHO HC BH Contractors		4 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 4 substandards, compliant with 2 substandards and non-compliant with 2 substandard.
Provider Selection 438.214	Compliant	All BHO 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 BHO HC BH Contractors			Compliant as per PS&R sections II-4 B, C.6, D.3, and G.4, II-6 B.3, II-7 K.4.
Subcontractual Relationships and Delegation 438.230	Partial		All BHO 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 BHO HC BH Contractors		6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 5 substandards and non-compliant with 1 substandard.
Quality Assessment and Performance Improvement Program 438.240	Partial		All BHO HC BH Contractors		26 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 26 substandards, compliant with 24 substandards, partially compliant with 1 substandards, and non-compliant with 1 substandard.
Health Information Systems 438.242	Compliant	All BHO HC BH Contractors			1 substandard was crosswalked to this category. Each HC BH Contractor was evaluated on 1 substandard and compliant with this substandard.

MCO: managed care organization; HC: HealthChoices; BH: behavioral health; BHO: Beacon Health Options; PS&R: Program Standards and Requirements.

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 BHO were partially compliant with Availability of Services (Access to Care) due to partial and non-compliance with substandards of PEPS Standard 28.

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

All BHO HC BH Contractors were non-compliant with Substandard 1 of Standard 28 (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.

Coordination and Continuity of Care

All of the HC BH Contractors associated with BHO were partially compliant with Coordination and Continuity of Care due to non-compliance with one substandard of PEPS Standard 28.

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care). All BHO HC BH Contractors were non-compliant with Substandard 1 of Standard 28 (RY 2017).

Coverage and Authorization of Services

All HC BH Contractors associated with BHO were partially compliant with Coverage and Authorization of Services due to partial and non-compliance with substandards of PEPS Standards 28 and 72.

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care). All BHO HC BH Contractors were non-compliant with Substandard 1 of 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 BHO HC BH Contractors were non-compliant with Substandard 2 of Standard 72 (RY 2017).

> **Substandard 2:** The content of the notices adheres 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 DHS 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; and contains date denial decision will take effect).

Subcontractual Relationships and Delegations

All BHO HC BH Contractors were partially compliant with Subcontractual Relationships and Delegations due to partial compliance with one Substandard of PEPS Standard 99 (RY 2016).

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 BHO HC BH Contractors were partially compliant with Substandard 1 of Standard 99 (RY 2016).

Substandard 1: The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning.

Practice Guidelines

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

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care). All BHO HC BH Contractors were non-compliant with Substandard 1 of Standard 28 (RY 2017).

Quality Assessment and Performance Improvement

All HC BH Contractors associated with BHO were partially compliant with Quality Assessment and Performance Improvement Program due to partial compliance and non-compliance with Substandards of PEPS Standard 91 (RY 2018).

PEPS Standard 91: Quality Management (QM) Program Description, QM Work Plan, and PIPs. The BH-MCO has a quality management program that includes a plan for ongoing quality assessment and performance improvement. The BH-MCO conducts performance improvement projects (PIPs) that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The QM plans emphasize high-volume and high-risk services and treatment, including Behavioral Health and Rehabilitation Services (BHRS).

All BHO HC BH Contractors were partially compliant with Substandard 13 of Standard 91 (RY 2018).

Substandard 13: The identified performance improvement projects must include the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement;
- Timeline for reporting status and results of each project to the Department of Human Services (DHS); and
- 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.

All BHO HC BH Contractors were non-compliant with Substandard 7 of Standard 91 (RY 2018).

Substandard 7: The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members: Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates Appropriateness of service authorizations and inter-rater reliability Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction.

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 Fully Compliant	By HC BH Contractor Partially Compliant	Comments
Statutory Basis and Definitions 438.400	Partial		All BHO HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 5 substandards, partially compliant with 3 substandard, and non-compliant with 5 substandards.
General Requirements 438.402	Partial		All BHO HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards, compliant with 3 substandards, partially compliant with 5 substandard, and non-compliant with 6 substandards.
Notice of Action 438.404	Partial		All BHO HC BH Contractors	13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards, compliant with 12 substandards, and non-compliant with 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All BHO HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 3 substandards, partially compliant with 3 substandard, and non-compliant with 5 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All BHO HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant with 3 substandards, partially compliant with 3 substandard, and non-compliant with 5 substandards.
Expedited Appeals Process 438.410	Partial		All BHOHC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 2 substandard, and non-compliant with 4 substandards.
Information to Providers & Subcontractors 438.414	Partial		All BHO HC BH Contractors	9 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 9 substandards, compliant with 2 substandard, partially compliant with 3 substandards, and non-compliant with 4 substandards.
Recordkeeping and Recording Requirements 438.416	Compliant	All BHO HC BH Contractors		Compliant as per the 2017 quarterly Complaints and Grievance tracking reports.
Continuation of Benefits 438.420	Partial		All BHO HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 2 substandards, and non-compliant with 4 substandards.
Effectuation of Reversed Resolutions 438.424	Partial		All BHO HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant with 2 substandards, and non-compliant with 4 substandards.

MCO: managed care organization; HC: HealthChoices; BH: behavioral health; BHO: Beacon Health Options.

The PEPS documents include an assessment of the HC BH Contractor/BH-MCO's compliance with regulations found in Subpart F. Based on the Substandards reviewed, BHO was fully compliant with 1 of the 10 evaluated categories of

Federal and State Grievance System Standards regulations, and partially compliant with the other 9 categories. In the category of Recordkeeping and Recording Requirements, BHO was compliant per quarterly reporting of complaints and grievances. In all, 87 PEPS items were crosswalked to Federal and State Grievance System Standards, and BHO was evaluated on 87 items. BHO was fully compliant with 32 items, partially compliant with 17 items, and non-compliant with 38 items.

As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Statutory Basis and Definitions

All HC BH Contractors associated with BHO were partially compliant with Statutory Basis and Definitions due to partial and non-compliance with substandards of PEPS Standards 68 (RY 2017), 71 (RY 2017), and 72 (RY 2018).

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.

All BHO HC BH Contractors were partially compliant with Substandards 4, 4 (RY 2016, 2017), and 9 of Standard 68 (RY 2017).

Substandard 4: Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).

Substandard 4 (RY 2016, RY 2017): The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.

Substandard 9: Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.

All BHO HC BH Contractors were non-compliant with Substandard 3 of Standard 68 (RY 2017)

Substandard 3: 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 71: The Grievance and Fair Hearing processes, procedures and Member rights related to the processes are made known to Members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

All BHO HC BH Contractors were non-compliant with Substandards 1, 4, and 9 of Standards 71 (RY 2017).

Substandard 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: 1. Internal, 2. External, 3. Expedited, 4. Fair Hearing.

Substandard 4: Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.

Substandard 9: Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the

respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All BHO HC BH Contractors were non-compliant with Substandard 2 of Standard 72 (RY 2018).

General Requirements

All HC BH Contractors associated with BHO were partially compliant with General Requirements due to partial and non-compliance with substandards of Standards 60 (2017), 68 (RY 2017), 71 (RY 2017), and 72 (RY 2018).

PEPS Standard 60: See Standard description and determination of compliance under Enrollee Rights. All BHO HC BH Contractors were partially compliant with Substandard 1 and 3 and non-compliant with Substandard 2 of Standard 60 (RY 2017).

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions. All BHOBHO HC BH Contractors were partially compliant with Substandards 4, 4 (RY 2016, RY 2017), and 9 and non-compliant with Substandard 3 of Standard 68 (RY 2017).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All BHO HC BH Contractors were non-compliant with Substandards 1, 4, and 9 of Standard 71 (RY 2017).

PEPS Standard 72: See description and determination of compliance under Coverage and Authorization of Services. All BHO HC BH Contractors were non-compliant with Substandard 2 of Standard 72: Substandard 2 (RY 2018).

Notice of Action

All HC BH Contractors associated with BHO were partially compliant with Notice of Action due to partial compliance with Substandard 2 of Standard 72 (RY 2018).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All BHO HC BH Contractors were non-compliant Substandard 2 of Standard 72 (RY 2018).

Handling of Grievances and Appeals

All HC BH Contractors associated with BHO were partially compliant with Handling of Grievances and Appeals due to partial and non-compliance with substandards of Standards 68 (RY 2017), 71 (RY 2017), and 72 (RY 2018).

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions. All BHO HC BH Contractors were partially compliant with Substandards 4, 4 (RY 2016, RY 2017), and 9 and non-compliant with Substandard 3 of Standard 68 (RY 2017).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All BHO HC BH Contractors were non-compliant with Substandards 1, 4, and 9 of Standard 71: Substandards (RY 2017).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All BHO HC BH Contractors were non-compliant with Substandard 2 of Standard 72 (RY 2018).

Resolution and Notification: Grievances and Appeals

All HC BH Contractors associated with BHO were partially compliant with Resolution and Notification due to partial and non-compliance with substandards of Standards 68 (RY 2017), 71 (RY 2017), and 72 (RY 2018).

PEPS Standard 68: See description and determination of compliance under Statutory Basis and Definitions. All BHOBHO HC BH Contractors were partially compliant with Substandards 4, 4 (RY 2016, RY 2017), and 9 and non-compliant with Substandard 3 of Standard 68 (RY 2017).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All BHO HC BH Contractors were non-compliant with Substandards 1, 4, and 9 of Standard 71 (RY 2017).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All BHO HC BH Contractors were non-compliant with Substandard 2 of Standard 72 (RY 2018).

Expedited Appeals Process

All HC BH Contractors associated with BHO were partially compliant with Expedited Appeals Process due to partial and non-compliance with substandards of Standards 71 (RY 2017) and 72 (RY 2018).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All BHO HC BH Contractors were non-compliant with Substandards 1, 4, and 9 of Standard 71 (RY 2017).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All HC BHO BH Contractors were non-compliant with Substandard 2 of Standard 72 (RY 2018).

Information to Providers & Subcontractors

All HC BH Contractors associated with BHO were partially compliant with Information to Providers & Subcontractors due to partial compliance and non-compliance with Substandards of Standard 68 (RY 2017) and 71 (RY 2017).

PEPS Standard 68: See description and determination of compliance under Statutory Basis and Definitions. All BHO HC BH Contractors were partially compliant with Substandards 4, 4 (RY 2016, RY 2017), and 9 and non-compliant with Substandard 3 of Standard 68 (RY 2017).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All BHOBHO HC BH Contractors were non-compliant Substandards 1, 4, and 9 of Standard 71 (RY 2017).

Continuation of Benefits

All HC BH Contractors associated with BHO were partially compliant with Continuation of Benefits due to partial and non-compliance with substandards of Standards 71 (RY 2017) and 72 (RY 2018).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All BHO HC BH Contractors were non-compliant with Substandards 1, 4, and 9 of Standard 71 (RY 2017).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All BHO HC BH Contractors were non-compliant with Substandard 2 of Standard 72 (RY 2018).

Effectuation of Reversed Resolutions

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

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All BHO HC BH Contractors were non-compliant Substandards 1, 4, and 9 of Standard 71 (RY 2017).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All BHO HC BH Contractors were non-compliant with Substandard 2 of Standard 72 (RY 2018).

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 2019 for 2018 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 had consistently not met the OMHSAS goal of a rate of 10% or less. In addition, in 2014, all MCOs were 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 required 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) (BHR-MH):** 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) (BHR-SA):** 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 (SAA):** 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 (DMP):** 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 2015 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 were 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 designed to be 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 Contractor-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 2019 EQR is the 16th 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 were required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with the 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 validation of PIP activities occurring in 2018 was consistent with the protocol issued by CMS (*EQR Protocol 3: Validating Performance Improvement Projects [PIPs], Version 2.0, September 2012*) and met 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 2018 was the final intervention year for all MCOs, IPRO reviewed all 10 elements, including sustained improvement, for each MCO.

Review Element Designation/Weighting

Calendar year 2018 was the sustained improvement year of the PIP. This section describes the scoring elements and methodology for reviewing and determining overall PIP project performance.

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 10th element, Sustained Improvement, contributes the remaining 20%, and the highest achievable score for overall project performance is 100 points. 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%

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 finding of "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

BHO submitted their Final PIP Report for review in September 2019. IPRO provided feedback and comments to BHO on this submission. **Table 2.3** presents the PIP scoring matrix for this Final Report submission, which corresponds to the key findings of the review described in the following paragraphs. BHO received a total demonstrable improvement score of 55 out of 80 points (68.8%) and a sustained improvement score of 10 out of 20 points (50%) for an overall project performance score of 65%. BHO's overall compliance with the PIP requirements was therefore a Partial Met.

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*	PM	50	20%	10
TOTAL SUSTAINED IMPROVEMENT SCORE			**20%**	**10**
OVERALL PROJECT PERFORMANCE SCORE			**100%**	**65**

M: met (100 points); PM: partially met (50 points); NM: not met (0 points); N/A: not applicable.

As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. For the performance indicators that were being studied in the PIP, the MCO used objective, clearly defined, measureable, time-specific indicators to track outcomes (including the capacity to assess change and strengths of association). The MCO generally implemented measurement methodology that was consistent with clinical standards, developed relevant process measures for each intervention, and demonstrated successful intervention tracking through the proposed process measures with quarterly reporting. However, not all outcome measurements were sufficiently timely to meet the comprehensive and dynamic measurement needs of the PIP, resulting in gaps in ability to sufficiently interpret key performance indicators strongly associated with improved outcomes. This limited the MCO's ability to demonstrate improvement and validate reported improvement. At several points in the PIP, the MCO was asked recalibrate the measurement methodology to mitigate any gaps in reporting.

There were also several issues with data collection procedures, resulting in partial compliance with associated requirements. The MCO provided a generally clear data analysis plan (DAP). The DAP listed data collection and definitions of the denominators/numerators for After-Care Program (ACP) measures, and the MCO also provided detailed information on the performance indicators of the Provider Education intervention, analysis of FUH and BHR rates for the members in the ACP, and stratifications in the analysis (by county, HC BH contractor, gender, race, age, and diagnosis) for the majority of the measures. However, there were flaws in the study design which resulted in downstream limitations for PIP reporting capabilities, and the MCO was unable to produce all required data needed to

demonstrate improvement and validate reported improvement. There were also issues and concerns with the improvement strategies (i.e., interventions) for the PIP. For several interventions, ongoing barrier analyses were incomplete or missing.

These difficulties furthermore hampered interpretation of results. Over the course of the PIP the MCO was unable to sufficiently address reporting gaps needed to demonstrate improvement and validate reported improvement. As a result, the analysis was incomplete and did not adhere to the statistical analysis techniques defined in the DAP. The discussion did not address threats to internal and external validity, among them: factors complicating comparison of repeated measurements; nor did the discussion sufficiently address requisite analytical outcomes within context. Especially, the causal links between the interventions and outcomes remained obscured. Where improvements were noted, therefore, such claims generally lacked face validity.

Overall, BHO did demonstrate some sustained improvement through the Final PIP submission, especially as measured by their Behavioral Health Readmission measures (for Mental Health and Substance Abuse diagnoses). The MCO did not evidence significant improvement in the SAA indicator over the course of the PIP. DMP rates on the whole improved, including follow-up visits occurring within 0-14 days of discharge, suggesting that the intervention was increasing follow-up rates. No p-value was calculable for DMP since samples were drawn at the facility-level and therefore not generalizable at the BH-MCO level.

III: Performance Measures

In 2019, 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 2018. 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. Quality Indicator (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.

Typically, HEDIS FUH undergoes annual updates to its specifications. Among the updates in 2019 (MY2018), the National Committee for Quality Assurance (NCQA) added the following reporting strata for FUH: ages 6-17, 18-64, and 65 and over. These changes resulted in a change in the reporting of FUH results in this report, which, effective this year, comprises ages 6-17, 18-64, and 6 and over (All Ages).

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 was: product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications as needed. Indicator rates were calculated using only the BH-MCO's data systems to identify numerator positives (i.e., administratively).

This performance measure assessed the percentage of discharges for members six (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 2018 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, 2018;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Six (6) 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, 2018, 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, 2018. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2019 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 standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

PA-Specific Follow-up Indicators

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

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

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

Quality Indicator Significance

According to the *Global Burden of Disease: 2004 Update* released by the World Health Organization 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; Druss et al., 2000; Frayne et al., 2005). Moreover, these patients are five times more likely to become homeless than those without these disorders (Avery 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 *The State of Health Care Quality Report* (NCQA, 2007), 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, 7 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 long-standing concern of behavioral health care systems, with some researchers having estimated that 40-60% 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 2 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. In 2018 (MY 2017), in part to better account for the growing population of members 65 year old and older, OMHSAS changed its benchmarking to the FUH All Ages (6+) measure. OMHSAS established a three-year goal for the State to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass published percentiles for 7-day and 30-day FUH. This change in 2018 also coincided with a more prospective and proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2017 results. These MY 2017 results were reported in the 2018 BBA report. Due to this change in the goal-setting method, no goals were set for MY 2018.

HEDIS percentiles for the 7-day and 30-day FUH All-Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each underperforming indicator. 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 to the BH-MCO for an RCA and QIP. This process is further discussed in Section V.

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 2017 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:

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

Where:

*N*1 = Current year (MY 2018) numerator,
*N*2 = Prior year (MY 2017) numerator,
*D*1 = Current year (MY 2018) denominator, and
*D*2 = Prior year (MY 2017) 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 2018) quality indicator rate, and
*p*2 = Prior year (MY 2017) 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.

Pennsylvania continued its Medicaid expansion under the Affordable Care Act in 2018. 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 2018.

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 18 to 64, ages 6 and older, and ages 6 to 17. The 6+ years old ("All Ages") results are presented to show the follow-up rates for the overall HEDIS population, and the 6 to 17 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. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (and HC BH Contractor 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. 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. Statistically significant HC BH Contractor-specific differences are noted.

The HEDIS follow-up results for the 6+ years old age groups are compared to the HEDIS 2019 national percentiles to show BH-MCO and HC BH Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile. The HEDIS follow-up results for the 6 to 17 years old age group and 18 to 64 years old age group are not compared to HEDIS benchmarks.

I: HEDIS Follow-up Indicators

(a) Age Group: 18–64 Years Old

Table 3.1 shows the MY 2018 results for both the HEDIS 7-day and 30-day follow-up measures for members aged 18 to 64 years old compared to MY 2017.

Table 3.1: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Indicators (18–64 Years)

MY 2018							MY 2018 Rate Comparison To MY 2017	
				95% CI		MY 2017		
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI1 - HEDIS 7-Day Follow-up (18-64 Years)								
Statewide	11347	31939	**35.5%**	35.0%	36.1%	35.3%	0.3	NO
BHO	1764	4804	**36.7%**	35.3%	38.1%	35.9%	0.8	NO
BEAVER	210	633	**33.2%**	29.4%	36.9%	32.7%	0.5	NO
NWBHP	281	784	**35.8%**	32.4%	39.3%	36.8%	-1.0	NO
FAYETTE	216	537	**40.2%**	36.0%	44.5%	31.1%	9.1	YES
GREENE	63	138	**45.7%**	37.0%	54.3%	34.9%	10.8	NO
SWBHM	994	2712	**36.7%**	34.8%	38.5%	37.4%	-0.7	NO
QI2 - HEDIS 30-Day Follow-up (18-64 Years)								
Statewide	17896	31939	**56.0%**	55.5%	56.6%	56.3%	-0.3	NO
BHO	2871	4804	**59.8%**	58.4%	61.2%	60.2%	-0.4	NO
BEAVER	360	633	**56.9%**	52.9%	60.8%	56.1%	0.8	NO
NWBHP	476	784	**60.7%**	57.2%	64.2%	60.7%	0.1	NO
FAYETTE	332	537	**61.8%**	57.6%	66.0%	58.2%	3.6	NO
GREENE	94	138	**68.1%**	60.0%	76.3%	59.4%	8.7	NO
SWBHM	1609	2712	**59.3%**	57.5%	61.2%	61.4%	-2.1	NO

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; BHO: QI: quality indicator; Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

The MY 2018 HealthChoices Aggregate (Statewide) HEDIS follow-up rates in the 18 to 64 years age group were 35.5% for QI 1 and 56.0% for QI 2 (**Table 3.1**). These rates were not statistically significantly different than the HealthChoices Aggregate rates for this age group in MY 2017, which were 35.3% and 56.3%, respectively. The MY 2017 BHO QI 1 rate for members ages 18 to 64 years was 36.7%, a 0.8 percentage point increase from the MY 2017 rate of 35.9% (**Table 3.1**). BHO's corresponding QI 2 rate was 59.8%, a 0.4 percentage point decrease from the MY 2017 rate of 60.2%. Both rates were not statistically significantly different than the prior year.

From MY 2017 to MY 2018, the only contractor that had a significant change from the prior year for QI 1 was Fayette with a 9.1 percentage point difference while Greene had a 10.8 percentage point decrease that was not statistically significantly different (**Table 3.1**). For QI 2, none of the contractors exhibited a statistically significant difference from their prior year rate but Greene had experienced an 8.7 percentage point increase from MY 2017.

Figure 3.1 is a graphical representation of MY 2018 HEDIS FUH 7- and 30-Day follow-up rates in the 18 to 64 years old population for BHO and its associated HC BH Contractors. The orange line indicates the MCO average.

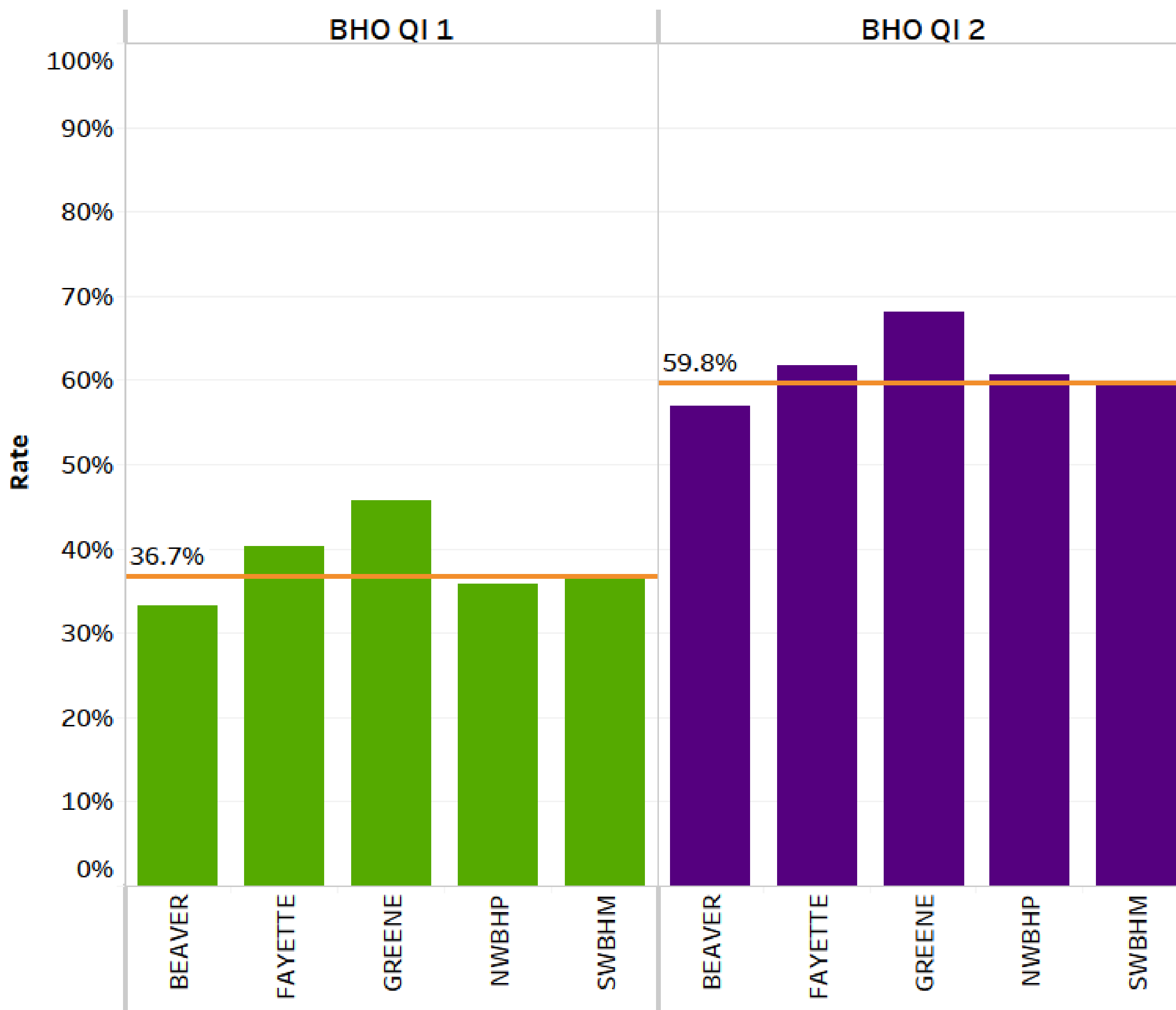


Figure 3.1: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (18–64 Years).

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. Of all the contractors, only Greene and Fayette had significantly higher rates compared to the Statewide rate of 35.5% for QI 1 with percentage point differences of 4.7 for Fayette and 10.2 for Greene. Greene, Fayette, NWBHP, and SWBHM were all significantly above the Statewide rate of 56.0% for QI 2 with differences ranging from 3.3 percentage points for SWBHM to 12.1 percentage points for Greene.

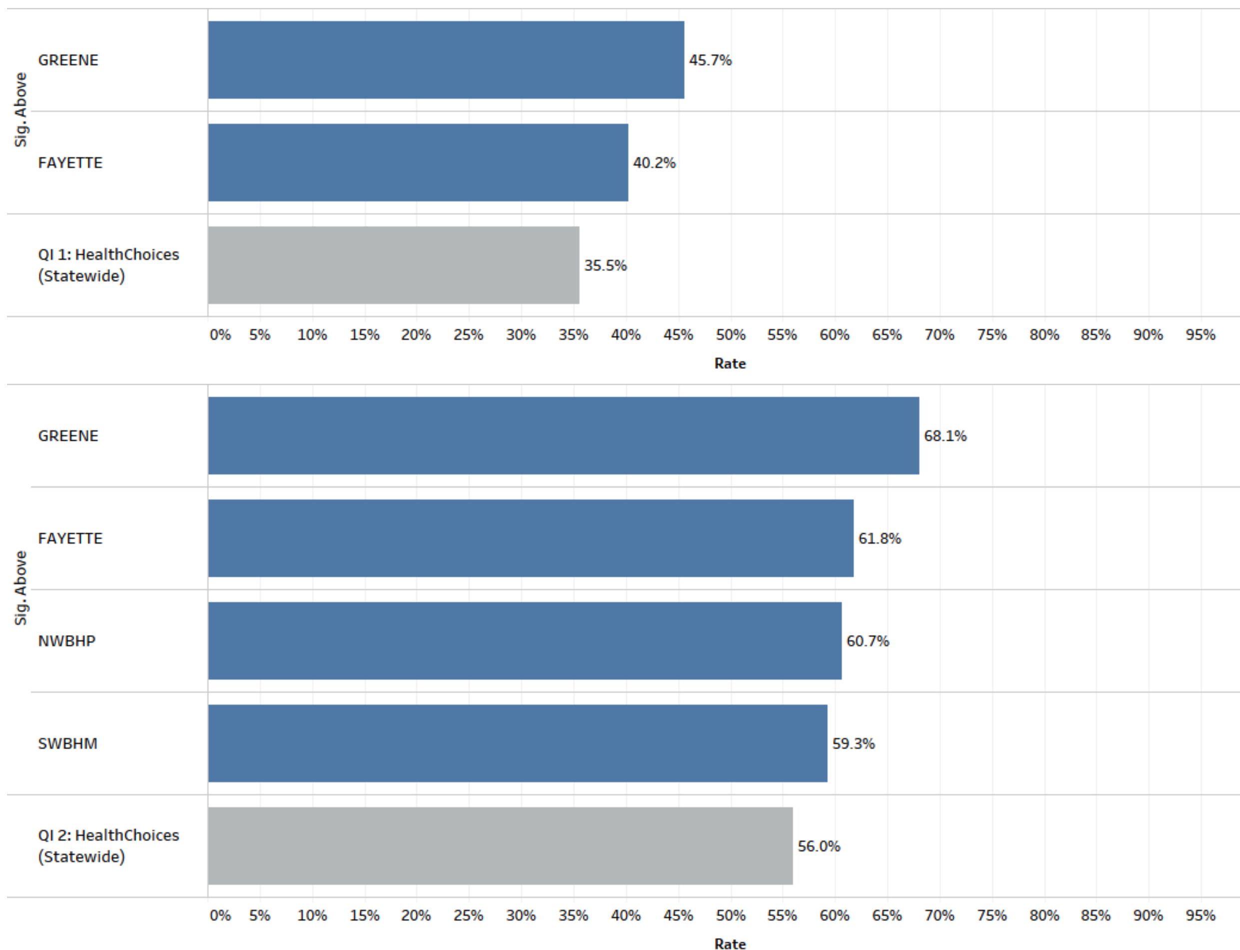


Figure 3.2: BHO Contractor MY 2018 HEDIS FUH Follow-up Rates (18–64 Years) that are Statistically Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS FUH Follow-up Rates (18–64 Years).

(b) Overall Population: 6+ Years Old

The MY 2018 HealthChoices Aggregate HEDIS follow-up rates 39.4% for QI 1 and 60.2% for QI 2 (**Table 3.2**). For BHO, the MY 2018 QI 1 rate was 40.6% compared to 39.2% in MY 2017. The BHO QI 2 rate was 64.0% compared to 64.3% in MY 2017. Fayette was the only contractor that exhibited a statistically significantly different rate for QI 1 compared to the prior year with a rate of 42.8% compared to 37.2%, a 5.5 percentage point difference. Fayette and Greene were the only contractors to be at or above the 75th percentile for HEDIS Medicaid rates for QI 1 (**Table 3.2**). While none of the contractors saw statistically significant differences from their prior year's rates, Greene performed at or above the 75th percentile.

Table 3.2: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Indicators (All Ages)

	MY 2018						MY 2018 Rate Comparison		
				95% CI			To MY 2017		
Measure	(N)	(D)	%	Lower	Upper	MY 2017 %	PPD	SSD	To MY 2018 HEDIS Percentiles
QI1 - HEDIS 7-Day Follow-up (All Ages)									
Statewide	16107	40876	**39.4%**	38.9%	39.9%	39.1%	0.3	NO	Below 75th Percentile, Above 50th Percentile
BHO	2563	6313	**40.6%**	39.4%	41.8%	39.2%	1.4	NO	Below 75th Percentile, Above 50th Percentile
BEAVER	295	788	**37.4%**	34.0%	40.9%	35.5%	2.0	NO	Below 75th Percentile, Above 50th Percentile
NWBHP	432	1080	**40.0%**	37.0%	43.0%	40.5%	-0.5	NO	Below 75th Percentile, Above 50th Percentile
FAYETTE	292	683	**42.8%**	39.0%	46.5%	37.2%	5.5	YES	At or Above 75th Percentile
GREENE	84	179	**46.9%**	39.3%	54.5%	37.3%	9.6	NO	At or Above 75th Percentile
SWBHM	1460	3583	**40.7%**	39.1%	42.4%	40.2%	0.6	NO	Below 75th Percentile, Above 50th Percentile
QI2 - HEDIS 30-Day Follow-up (All Ages)									
Statewide	24587	40876	**60.2%**	59.7%	60.6%	60.6%	-0.5	NO	Below 75th Percentile, Above 50th Percentile
BHO	4039	6313	**64.0%**	62.8%	65.2%	64.3%	-0.3	NO	Below 75th Percentile, Above 50th Percentile
BEAVER	476	788	**60.4%**	56.9%	63.9%	60.0%	0.4	NO	Below 75th Percentile, Above 50th Percentile
NWBHP	706	1080	**65.4%**	62.5%	68.3%	65.4%	0.0	NO	Below 75th Percentile, Above 50th Percentile
FAYETTE	445	683	**65.2%**	61.5%	68.8%	64.5%	0.6	NO	Below 75th Percentile, Above 50th Percentile
GREENE	125	179	**69.8%**	62.8%	76.8%	62.2%	7.6	NO	At or Above 75th Percentile
SWBHM	2287	3583	**63.8%**	62.2%	65.4%	65.0%	-1.2	NO	Below 75th Percentile, Above 50th Percentile

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-up After Hospitalization; N: numerator; D: denominator; CI: confidence interval; PPD: percentage point difference; SSD: statistically significant difference; QI: quality indicator; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Figure 3.3 is a graphical representation of the MY 2018 HEDIS follow-up rates for BHO and its associated HC BH Contractors. The orange line represents the MCO average.

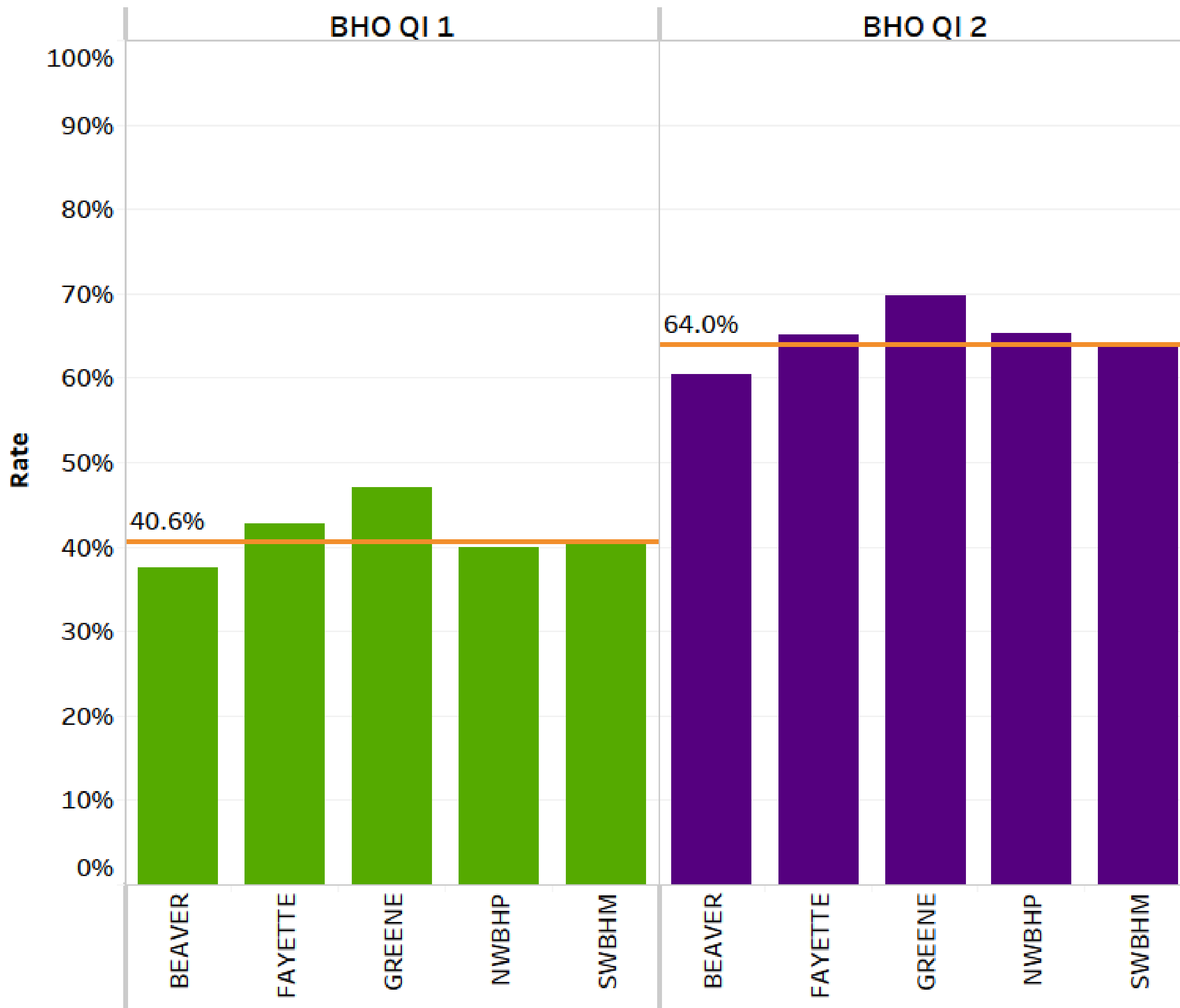


Figure 3.3: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (All Ages).

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. Of all the contractors, Greene's QI 1 rate was significantly higher than the Statewide rate of 39.4%, a difference of 7.5 percentage points. For the QI 2 rate, Greene, NWBHP, Fayette, and SWBHM all performed significantly above the Statewide rate of 60.2%, with differences ranging from 3.6 percentage points for SWBHM to 9.6 percentage points for Greene.

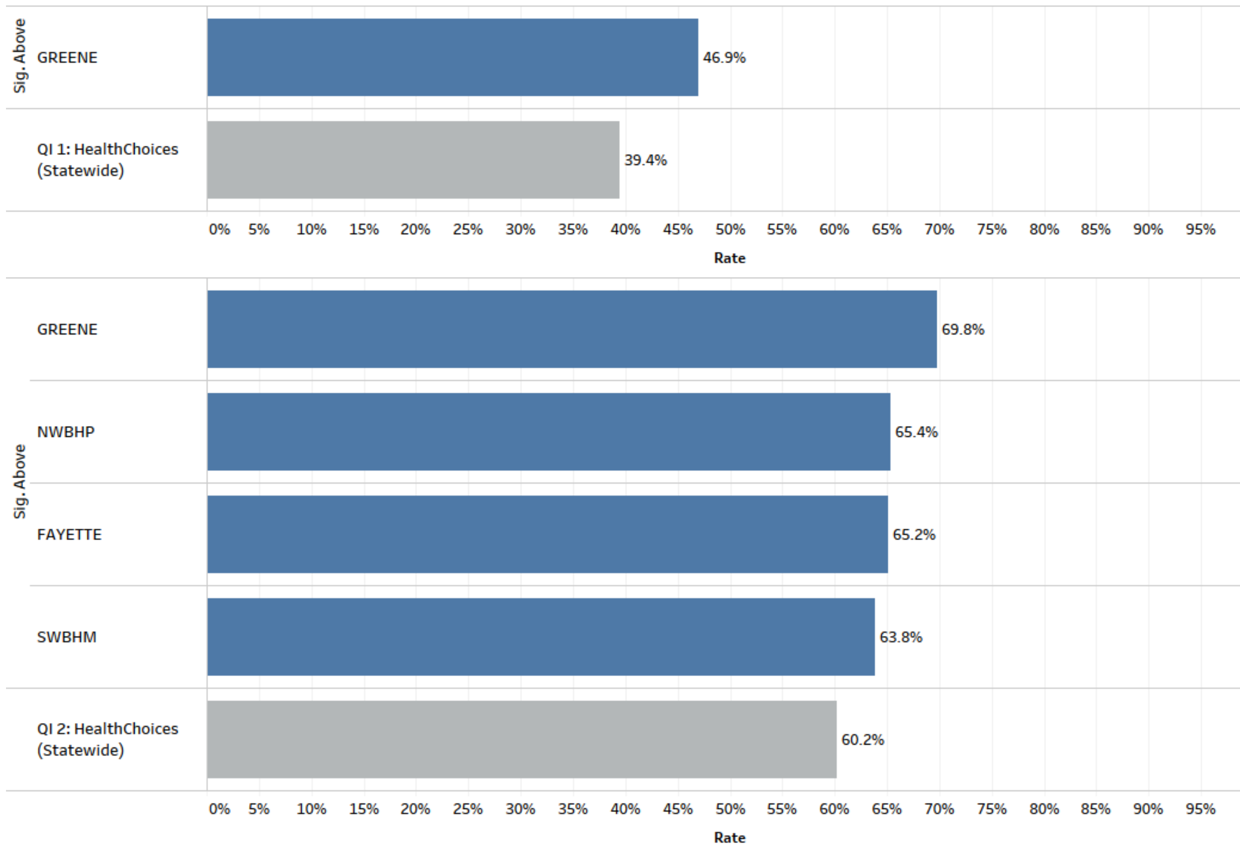


Figure 3.4: BHO Contractor MY 2018 HEDIS FUH Follow-up Rates (All Ages) that are Statistically Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS FUH Follow-up Rates (All Ages).

(c) Age Group: 6–17 Years Old

The MY 2018 HealthChoices Aggregate rates in the 6 to 17 years age group were 55.7% for QI 1 and 77.7% for QI 2 (**Table 3.3**). The BHO MY 2018 HEDIS rates for members 6 to 17 years were 56.1% for QI 1 and 81.6% for QI 2; the QI 1 rate was statistically significantly higher than the prior year rate by 4.4 percentage points, but the QI 2 rate was not significantly different (**Table 3.3**). Of the BHO Contractors with sufficiently large denominators to compare, the only notable change was the QI 1 rate for the SWBHM Contractor, which increased statistically significantly by 5.7 percentage points from 51.2% in MY 2017 to 56.9% in MY 2018.

Table 3.3: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Indicators (6–17 Years)

	MY 2018						MY 2018 Rate Comparison	
				95% CI			To MY 2017	
Measure	**(N)**	**(D)**	**%**	**Lower**	**Upper**	**MY 2017 %**	**PPD**	**SSD**
QI1 - HEDIS 7-Day Follow-up (6-17 Years)								
Statewide	4592	8243	**55.7%**	54.6%	56.8%	55.1%	0.6	NO
BHO	768	1370	**56.1%**	53.4%	58.7%	51.7%	4.4	YES
BEAVER	81	133	**60.9%**	52.2%	69.6%	50.0%	10.9	NO
NWBHP	148	285	**51.9%**	46.0%	57.9%	51.6%	0.3	NO
FAYETTE	73	131	**55.7%**	46.8%	64.6%	57.6%	-1.9	NO
GREENE	21	39	**53.8%**	N/A	N/A	45.6%	8.2	N/A
SWBHM	445	782	**56.9%**	53.4%	60.4%	51.2%	5.7	YES
QI2 - HEDIS 30-Day Follow-up (6-17 Years)								
Statewide	6406	8243	**77.7%**	76.8%	78.6%	78.7%	-0.9	NO
BHO	1118	1370	**81.6%**	79.5%	83.7%	79.7%	1.9	NO
BEAVER	112	133	**84.2%**	77.6%	90.8%	79.3%	4.9	NO
NWBHP	225	285	**78.9%**	74.0%	83.9%	79.8%	-0.9	NO
FAYETTE	106	131	**80.9%**	73.8%	88.0%	85.9%	-5.0	NO
GREENE	31	39	**79.5%**	N/A	N/A	71.9%	7.6	N/A
SWBHM	644	782	**82.4%**	79.6%	85.1%	78.9%	3.5	NO

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.; N/A: Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

Figure 3.5 is a graphical representation of the MY 2018 HEDIS follow-up rates in the 6 to 17 years old population for BHO and its associated HC BH Contractors. The orange line indicates the MCO average.

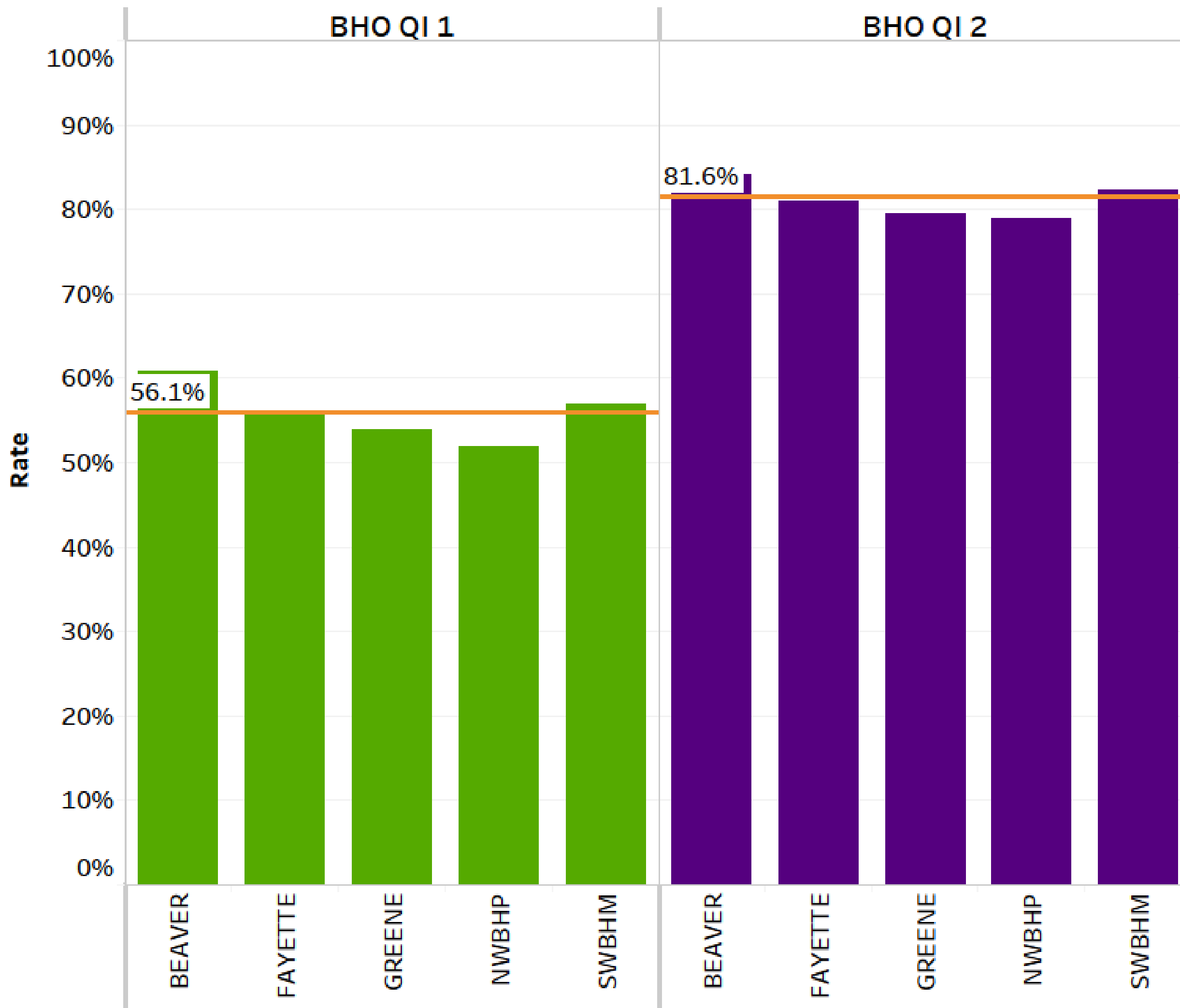


Figure 3.5: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (6–17 Years).

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. None of the Contractors had rates that deviated significantly from the HC BH QI 1 rate of 55.7%. SWBHM did, however, turn in a QI 2 rate that was statistically significantly above the HC BH QI 2 rate of 77.7% by 4.7 percentage points.

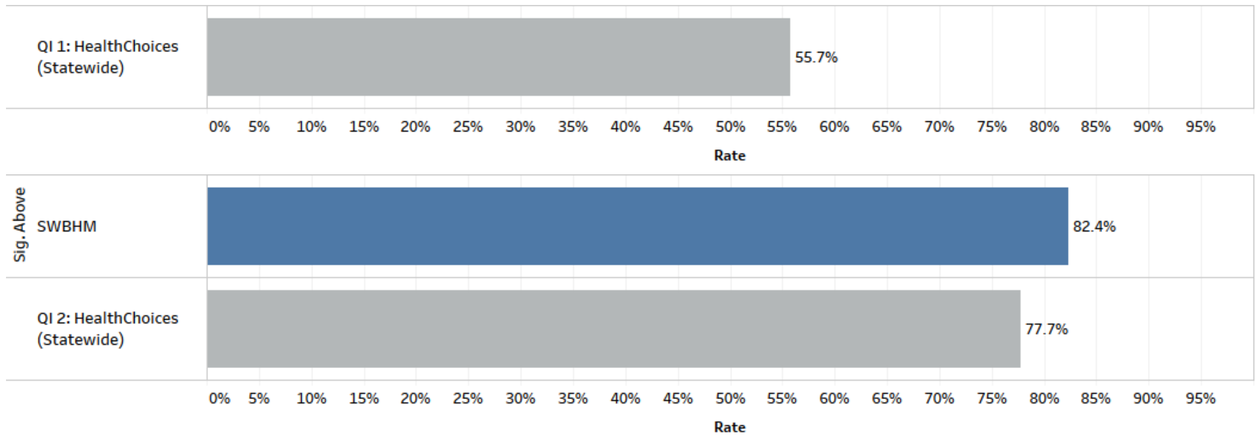


Figure 3.6: BHO Contractor MY 2018 HEDIS FUH Follow-up Rates (6–17 Years) that are Statistically Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS FUH Follow-up Rates (6-17 Years).

II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

The MY 2018 HealthChoices Aggregate rates were 53.1% for QI A and 69.6% for QI B (**Table 3.4**). The Statewide rate for QI A increased significantly by 0.9 percentage points from 52.2% in MY 2017. The MY 2018 BHO QI A rate was 50.9%, which represents a 1.2 percentage point increase from the prior year, and the BHO QI B rate was 70.5%, which represents a 1.4 percentage point decrease from the prior year. These year-to-year decreases were not statistically significant.

Of all the BHO HC BH contractors, the only contractor that experienced a significant change from the prior year was SWBHM, which saw its QI B rate decrease by 2.3 percentage points. Although not statistically significant, Greene saw a 9.7 percentage point increase in its QI A rate from 46.8% to 56.5% in MY 2018 (**Table 3.4**).

Table 3.4: MY 2018 PA-Specific FUH 7- and 30-Day Follow-up Indicators (All Ages)

	MY 2018						MY 2018 Rate Comparison	
				95% CI			To MY 2017	
Measure	**(N)**	**(D)**	**%**	**Lower**	**Upper**	**MY 2017 %**	**PPD**	**SSD**
QI A - PA-Specific 7-Day Follow-up (All Ages)								
Statewide	21746	40979	**53.1%**	52.6%	53.6%	52.2%	0.9	YES
BHO	3227	6346	**50.9%**	49.6%	52.1%	49.6%	1.2	NO
BEAVER	393	792	**49.6%**	46.1%	53.2%	45.2%	4.5	NO
NWBHP	534	1083	**49.3%**	46.3%	52.3%	51.5%	-2.2	NO
FAYETTE	330	693	**47.6%**	43.8%	51.4%	43.1%	4.5	NO
GREENE	104	184	**56.5%**	49.1%	64.0%	46.8%	9.7	NO
SWBHM	1866	3594	**51.9%**	50.3%	53.6%	51.5%	0.4	NO
QI B - PA-Specific 30-Day Follow-up (All Ages)								
Statewide	28504	40979	**69.6%**	69.1%	70.0%	69.6%	-0.1	NO
BHO	4475	6346	**70.5%**	69.4%	71.6%	71.9%	-1.4	NO
BEAVER	531	792	**67.0%**	63.7%	70.4%	66.4%	0.7	NO
NWBHP	779	1083	**71.9%**	69.2%	74.7%	73.7%	-1.8	NO
FAYETTE	481	693	**69.4%**	65.9%	72.9%	70.1%	-0.7	NO
GREENE	145	184	**78.8%**	72.6%	85.0%	70.4%	8.4	NO
SWBHM	2539	3594	**70.6%**	69.1%	72.1%	73.0%	-2.3	YES

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Figure 3.7 is a graphical representation of the MY 2018 PA-specific follow-up rates for BHO and its associated HC BH Contractors. The orange line indicates the MCO average.

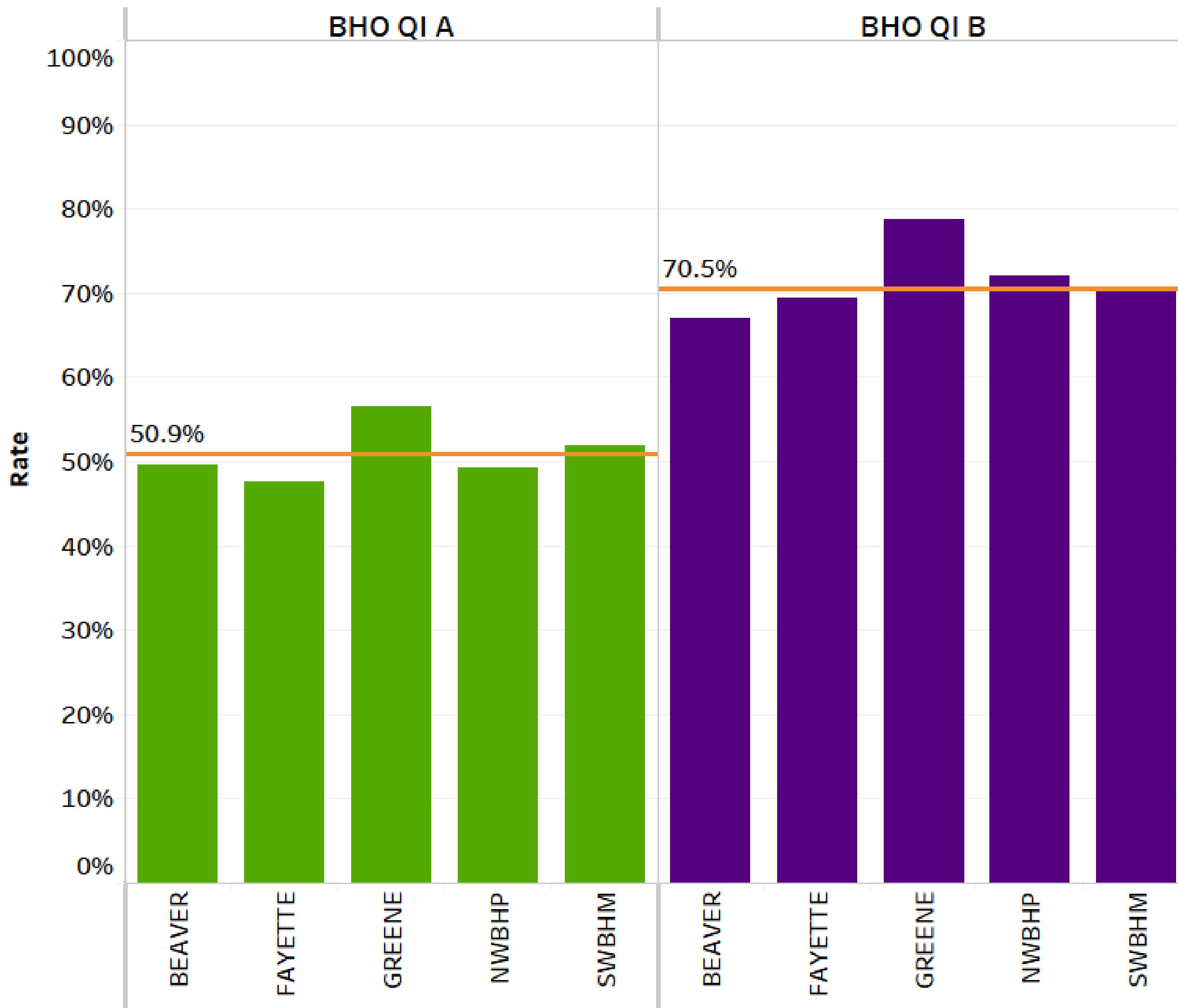


Figure 3.7: MY 2018 PA-Specific FUH 7- and 30-Day Follow-up Rates (All Ages).

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. For QI A, NWBHP and Fayette both had rates significantly below the Statewide rate of 53.1%, a difference of 3.8 and 5.5 percentage points, respectively. For QI B, Greene's QI A rate was significantly above the Statewide rate of 69.6%, a difference of 9.2 percentage points.

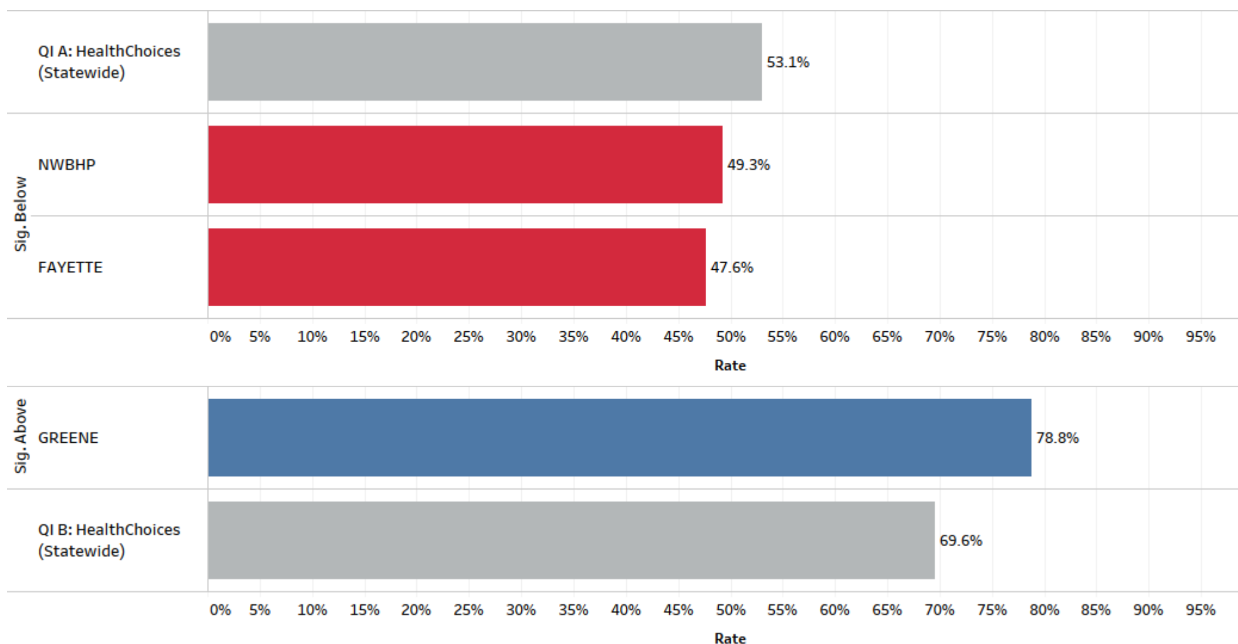


Figure 3.8: BHO Contractor MY 2018 PA-Specific FUH Follow-up Rates (All Ages) that are Statistically Significantly Different than HealthChoices (Statewide) MY 2018 PA-Specific FUH Follow-up Rates (All ages).

Conclusion and Recommendations

As with most reporting years, it is important to note that there were some changes to the HEDIS 2019 specifications, including revision of the denominator to include members with a principal diagnosis of intentional self-harm. 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 the MY 2018 review:

- 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 2018, which included actions taken as part of the previous PIP cycle, to promote continuous quality improvement with regard to timely follow-up care after psychiatric hospitalization. The information contained in 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 to receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. This year's findings indicate that, with some notable HC BH Contractor exceptions, FUH rates have, for the most part decreased (worsened) 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 2018 were not evaluated in this report, although comparisons to the non-Medicaid population were carried out in a separate 2019 (MY 2018) FUH "Rates Report" produced by the EQRO and which, for the first time this year, is being made available to BH MCOs in an interactive Tableau® workbook. 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. The BH-MCOs and HC BH Contractors should 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. The aforementioned 2019 (MY 2018) FUH Rates Report is one source BH MCOs can use to investigate potential health disparities in FUH.

- BH-MCOs and HC BH Contractors are encouraged to review the 2019 (MY 2018) FUH Rates Report in conjunction with the corresponding 2019 (MY 2018) inpatient psychiatric readmission Rates (REA) Report. The BH-MCOs and HC BH contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission in less than 30 days 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, and then for MY 2008. Re-measurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2018 study conducted in 2019 was the tenth 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 between a same-day readmission and 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 2018. 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 2018 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, 2018;
- 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 was clearly identified as a discharge.

The numerator comprised 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 2018 to MY 2017 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 Percentage Point Difference (PPD) between the rates.

Individual rates were also compared to the categorical average. Rates statistically significantly above or below the average are indicated.

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 2018 HealthChoices Aggregate (Statewide) readmission rate was 13.7% (**Table 3.5**). The BHO MY 2018 readmission rate was 12.4%, which decreased from MY 2017 rate of 13.1% by 0.7 percentage points. BHO did not meet the performance goal of a readmission rate at or below 10.0% in MY 2018.

From MY 2017 to MY 2018, none of the HC BH Contractors experienced a statistically significant difference in the readmission rates. NWBHP, Fayette, and SWBHM all registered decreases in their readmission rates but none were statistically significant.

Table 3.5: MY 2018 REA Readmission Indicators

	MY 2018						MY 2018 Rate Comparison	
				95% CI			To MY 2017	
Measure	**(N)**	**(D)**	**%**	**Lower**	**Upper**	**MY 2017 %**	**PPD**	**SSD**
Inpatient Readmission								
HealthChoices (Statewide)	7188	52290	**13.7%**	13.5%	14.0%	13.4%	0.3	NO
BHO	912	7348	**12.4%**	11.7%	13.2%	13.1%	-0.7	NO
BEAVER	102	843	**12.1%**	9.8%	14.4%	11.2%	0.9	NO
NWBHP	141	1285	**11.0%**	9.2%	12.7%	11.2%	-0.2	NO
FAYETTE	92	789	**11.7%**	9.4%	14.0%	13.4%	-1.8	NO
GREENE	32	231	**13.9%**	9.2%	18.5%	13.5%	0.3	NO
SWBHM	545	4200	**13.0%**	11.9%	14.0%	13.4%	-0.4	NO

[1]The OMHSAS-designated performance measure goal is a readmission rate at or below 10%.

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.

MY: measurement year; ; REA: Readmission within 30 Days of Inpatient Psychiatric Discharge; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Figure 3.9 is a graphical representation of the MY 2018 readmission rates for BHO HC BH Contractors compared to the OMHSAS performance goal of 10.0%. The orange line indicates the MCO average

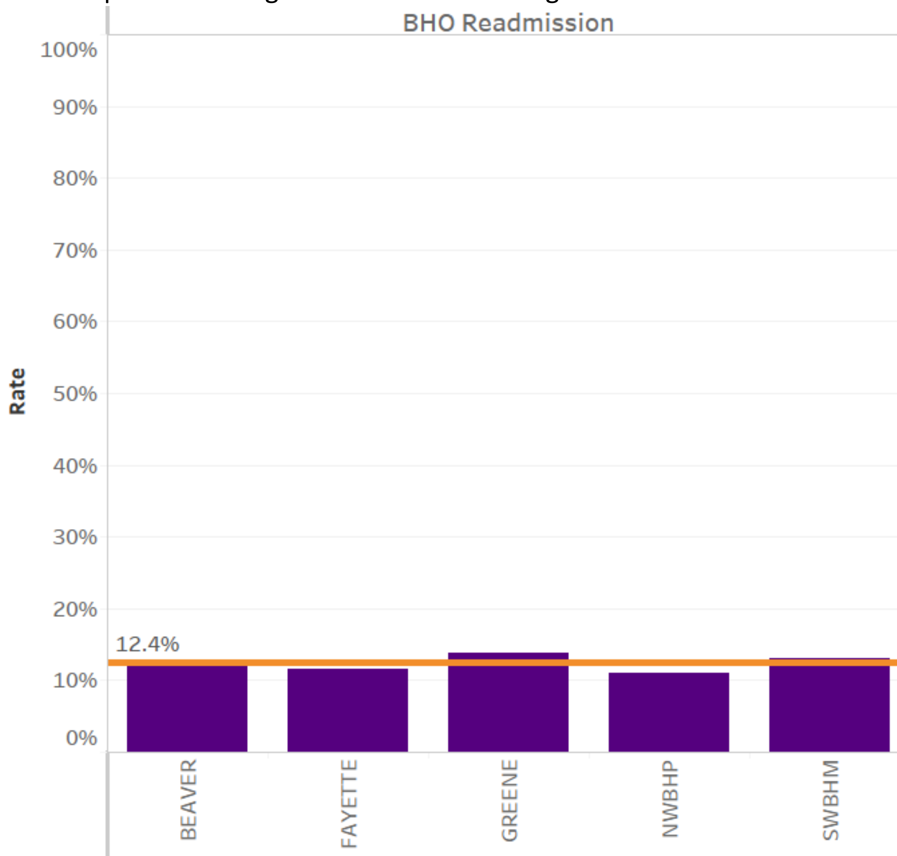


Figure 3.9: MY 2018 REA Readmission Rates.

Figure 3.10 shows the HealthChoices BH (Statewide) readmission rate and the individual BHO HC BH Contractors that performed statistically significantly higher (red) or lower (blue) than the Statewide rate. NWBHP's rate was significantly below (better than) the Statewide rate of 13.7% by 2.7 percentage points.

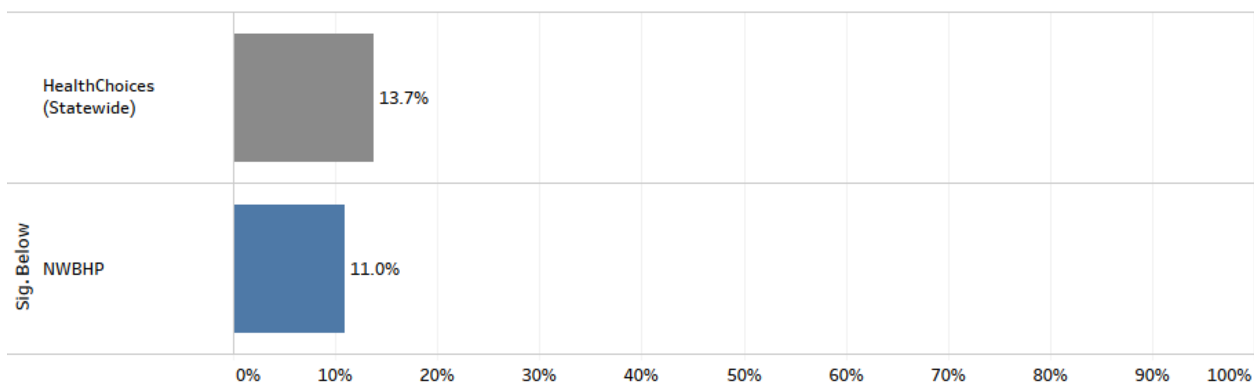


Figure 3.10: BHO Contractor MY 2018 REA Readmission Rates (All Ages) that are Statistically Significantly Different than HealthChoices (Statewide) MY 2018 REA Readmission Rates (All Ages).

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). Readmission for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS. As a result, many recommendations previously made remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the past performance improvement project cycle, the recommendations may assist in future discussions.

In response to the 2019 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 2018 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. In 2018, the BH-MCOs concluded a performance improvement project that focused on improving transitions to ambulatory care from inpatient psychiatric services. BH-MCOs are expected to sustain meaningful improvement in behavioral health readmission rates going forward as a result of the PIP. 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.
- The BH-MCOs and HC BH Contractors should continue to focus interventions on populations that exhibit higher readmission rates (e.g., urban populations). Comparisons among demographic groups were carried out in a separate 2019 (MY 2018) REA "Rates Report" produced by the EQRO and which for the first time this year is being made available to BH MCOs in an interactive Tableau workbook.
- BH-MCOs and HC BH Contractors are encouraged to review the 2019 (MY 2018) REA Rates Report in conjunction with the aforementioned 2019 (MY 2018) FUH Rates Report. The BH-MCOs and HC BH contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission in less than 30 days to determine the extent to which those individuals either 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 2019 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

2019 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 at least 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, 2016).

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 likely follow if suitable treatments are implemented.

Eligible Population[2]

The entire eligible population was used for all 29 HC BH Contractors participating in the MY 2018 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, 2018;
- 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, ages 18+ years, and ages 13+ years.

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

Because this measure requires the use of both physical health and behavioral health encounters, only members who were enrolled in both HealthChoices Behavioral Health and Physical Health Programs were included in this measure. The

[2] HEDIS 2019 Volume 2 Technical Specifications for Health Plans (2019).

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. Because administrative data from multiple sources were 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

Because 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-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 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. Statistically significant differences in HC BH Contractor-rates are noted.

The performance measure results for the three age cohorts (13 to 17 years, 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 2018 HealthChoices Aggregate (Statewide) rates in the 13–17 years age group were 44.7% for Initiation and 31.8% for Engagement (**Table 3.6**). The Engagement rate was significantly lower compared to MY 2017 rate of 34.6%, a difference of 2.9 percentage points. The Statewide and BHO rate were both at or above the 75th HEDIS percentile. The BHO rate for Initiation was 45.1% compared to 46.1% in MY 2017 while the Engagement rate was 33.4% compared to 36.1% in MY 2017, neither of these rates changed significantly from the previous year.

Only SWBHM had a sufficiently large enough denominator to compare Initiation rates to the prior year. SWBHM's rate decreased by 1.8 percentage points from 46.1% to 44.3%, a difference of 1.8 percentage points, while the Engagement rates also decreased from 36.1% to 35.0%, a decrease of 1.1 percentage points. However, these changes were not statistically significant.

Table 3.6: MY 2018 IET Initiation and Engagement Indicators (13–17 Years)

	MY 2018						MY 2018 Rate Comparison		
				95% CI			To MY 2017		
Measure	(N)	(D)	%	Lower	Upper	MY 2017 %	PPD	SSD	To MY 2018 HEDIS Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (13-17 Years)									
HealthChoices (Statewide)	1204	2692	**44.7%**	42.8%	46.6%	46.3%	-1.6	NO	Below 75th Percentile, Above 50th Percentile
BHO	178	395	**45.1%**	40.0%	50.1%	46.1%	-1.1	NO	Below 75th Percentile, Above 50th Percentile
BEAVER	18	53	**34.0%**	N/A	N/A	46.1%	-12.2	N/A	Below 25th Percentile
FAYETTE	15	31	**48.4%**	N/A	N/A	46.1%	2.3	N/A	At or Above 75th Percentile
GREENE	9	14	**64.3%**	N/A	N/A	46.1%	18.1	N/A	At or Above 75th Percentile
NWBHP	31	60	**51.7%**	N/A	N/A	46.1%	5.5	N/A	At or Above 75th Percentile
SWBHM	105	237	**44.3%**	37.8%	50.8%	46.1%	-1.8	NO	Below 75th Percentile, Above 50th Percentile
Numerator 2: Engagement of AOD Treatment (13-17 Years)									
HealthChoices (Statewide)	855	2692	**31.8%**	30.0%	33.5%	34.6%	-2.9	YES	At or Above 75th Percentile
BHO	132	395	**33.4%**	28.6%	38.2%	36.1%	-2.7	NO	At or Above 75th Percentile
BEAVER	14	53	**26.4%**	N/A	N/A	36.1%	-9.7	N/A	At or Above 75th Percentile
FAYETTE	9	31	**29.0%**	N/A	N/A	36.1%	-7.1	N/A	At or Above 75th Percentile
GREENE	3	14	**21.4%**	N/A	N/A	36.1%	-14.7	N/A	At or Above 75th Percentile
NWBHP	23	60	**38.3%**	N/A	N/A	36.1%	2.2	N/A	At or Above 75th Percentile
SWBHM	83	237	**35.0%**	28.7%	41.3%	36.1%	-1.1	NO	At or Above 75th Percentile

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; HEDIS: Healthcare Effectiveness Data and Information Set; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.; N/A: Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

Figure 3.11 is a graphical representation of the 13–17 years MY 2018 HEDIS Initiation and Engagement rates for BHO and its associated HC BH Contractors. The orange line indicates the MCO average.

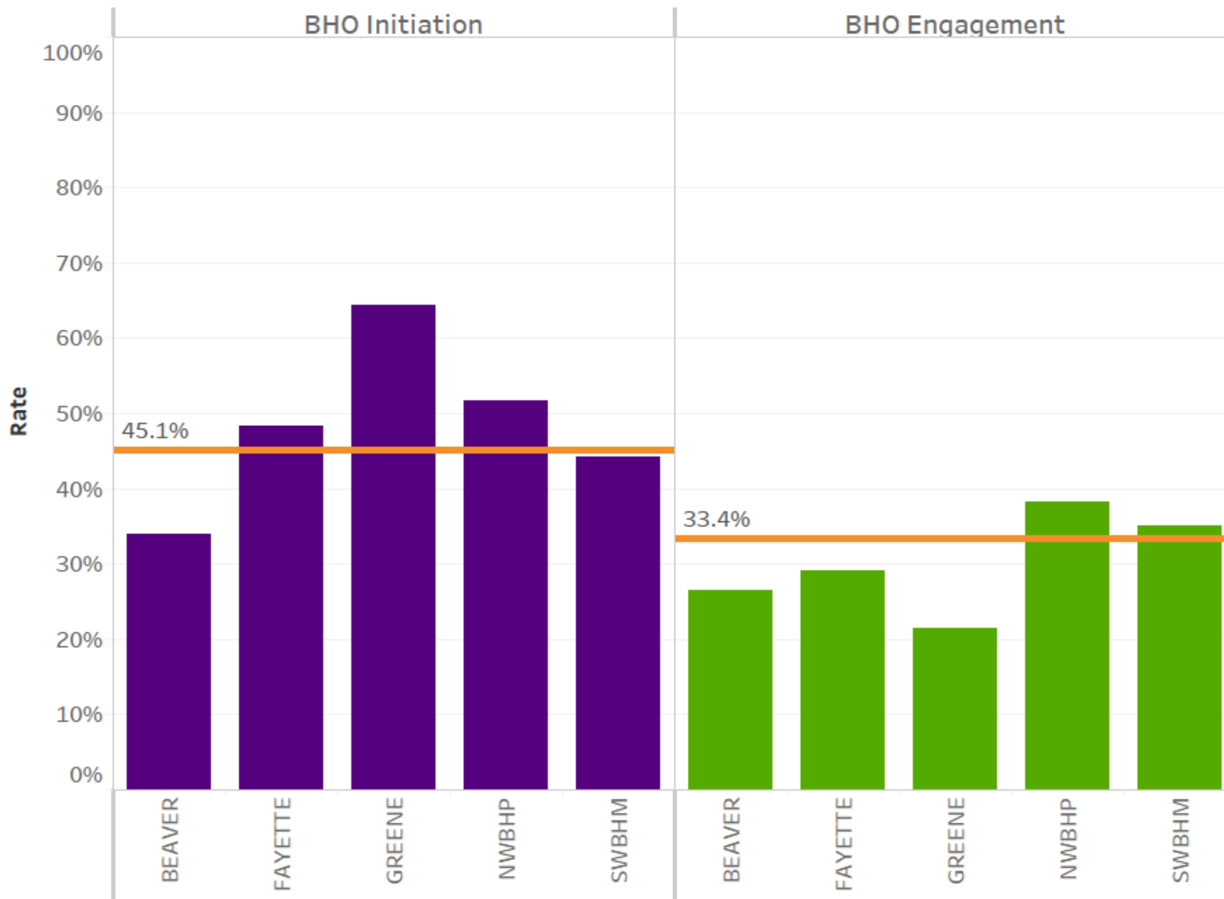


Figure 3.11: MY 2018 IET Initiation and Engagement Rates (13–17 Years).

Figure 3.12 shows the HealthChoices Contractor Average rates for this age cohort and the individual BHO HC BH Contractor rates that were statistically significantly higher or lower than the HealthChoices HC BH Statewide rate. In MY 2018, only SWBHM had sufficient denominators for Initiation and Engagement rates to be compared to the Statewide rates; however, SWBHM's Initiation and Engagement rates were not statistically significantly different compared to the Statewide rates of 44.7 % for Initiation and 31.8% for Engagement.

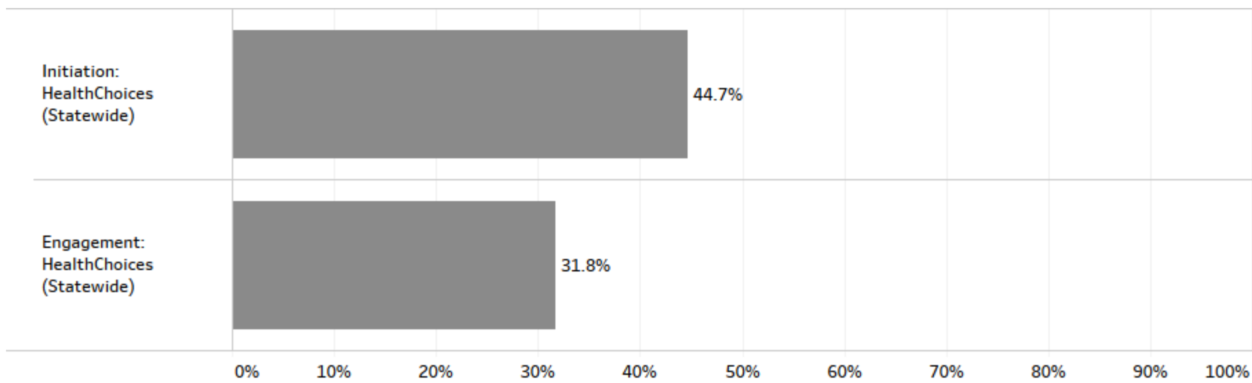


Figure 3.12: BHO Contractor MY 2018 IET Rates (13–17 Years) that are Statistically Significantly Different than HealthChoices (Statewide) MY 2018 IET Rates (13–17 Years).

(b) Age Group: 18+ Years Old

The MY 2018 HealthChoices Aggregate rates in the 18+ years age group were 41.9% for Initiation and 28.3% for Engagement (**Table 3.7**). For Initiation, the difference was 0.8 percentage points from 41.1% in MY 2017 to 41.9% in MY 2018. For Engagement, the difference was a 5.3 percentage point decrease from 33.7% in MY 2017 to 28.3% in MY 2018. The MY 2018 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 HEDIS 75th percentile.

The BHO MY 2018 Initiation rate for the 18+ years age set was 46.8% (**Table 3.7**). This rate was above the 50th percentile but below the 75th percentile, with a difference of 1.3 percentage points. The BHO MY 2018 Engagement rate was 36.1% compare to MY 2017 at 42.0%, a difference of 5.9 percentage points, which was statistically significant.

As presented in **Table 3.7**, Fayette, Greene, and SWBHM all saw statistically significant changes from their prior year rate with both Fayette and Greene experiencing a decrease of 16.9 and 11.2 percentage points, respectively, for Initiation. For Engagement, all of the HC BH Contractors had statistically significantly different rates compared to the prior year with all of the MY 2018 rates decreasing from MY 2017. The largest differences were for Fayette and Green with 20.2- and 21.5 percentage point-decreases respectively, although all contractors still performed at or above the 75th percentile.

Table 3.7: MY 2018 IET Initiation and Engagement Indicators (18+ Years)

	MY 2018						MY 2018 Rate Comparison		
				95% CI			To MY 2017		
Measure	(N)	(D)	%	Lower	Upper	MY 2017 %	PPD	SSD	To MY 2018 HEDIS Medicaid Percentiles
Numerator 1: Initiation of AOD Treatment (18+ Years)									
HealthChoices (Statewide)	24954	59586	**41.9%**	41.5%	42.3%	41.1%	0.8	YES	Below 50th Percentile, Above 25th Percentile
BHO	4622	9871	**46.8%**	45.8%	47.8%	48.1%	-1.3	YES	Below 75th Percentile, Above 50th Percentile
BEAVER	568	1133	**50.1%**	47.2%	53.1%	48.1%	2.0	NO	At or Above 75th Percentile
FAYETTE	453	1451	**31.2%**	28.8%	33.6%	48.1%	-16.9	YES	Below 25th Percentile
GREENE	95	258	**36.8%**	30.7%	42.9%	48.1%	-11.3	YES	Below 25th Percentile
NWBHP	537	1094	**49.1%**	46.1%	52.1%	48.1%	1.0	NO	At or Above 75th Percentile
SWBHM	2969	5935	**50.0%**	48.7%	51.3%	48.1%	1.9	YES	At or Above 75th Percentile
Numerator 2: Engagement of AOD Treatment (18+ Years)									
HealthChoices (Statewide)	16886	59586	**28.3%**	28.0%	28.7%	33.7%	-5.3	YES	At or Above 75th Percentile
BHO	3565	9871	**36.1%**	35.2%	37.1%	42.0%	-5.9	YES	At or Above 75th Percentile
BEAVER	397	1133	**35.0%**	32.2%	37.9%	42.0%	-7.0	YES	At or Above 75th Percentile
FAYETTE	316	1451	**21.8%**	19.6%	23.9%	42.0%	-20.2	YES	At or Above 75th Percentile
GREENE	53	258	**20.5%**	15.4%	25.7%	42.0%	-21.5	YES	At or Above 75th Percentile
NWBHP	407	1094	**37.2%**	34.3%	40.1%	42.0%	-4.8	YES	At or Above 75th Percentile
SWBHM	2392	5935	**40.3%**	39.0%	41.6%	42.0%	-1.7	YES	At or Above 75th Percentile

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; HEDIS: Healthcare Effectiveness Data and Information Set; AOD: alcohol or other drug dependence; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Figure 3.13 is a graphical representation MY 2018 IET rates for BHO and its associated HC BH Contractors for the 18+ years age group. The orange line indicates the MCO average.

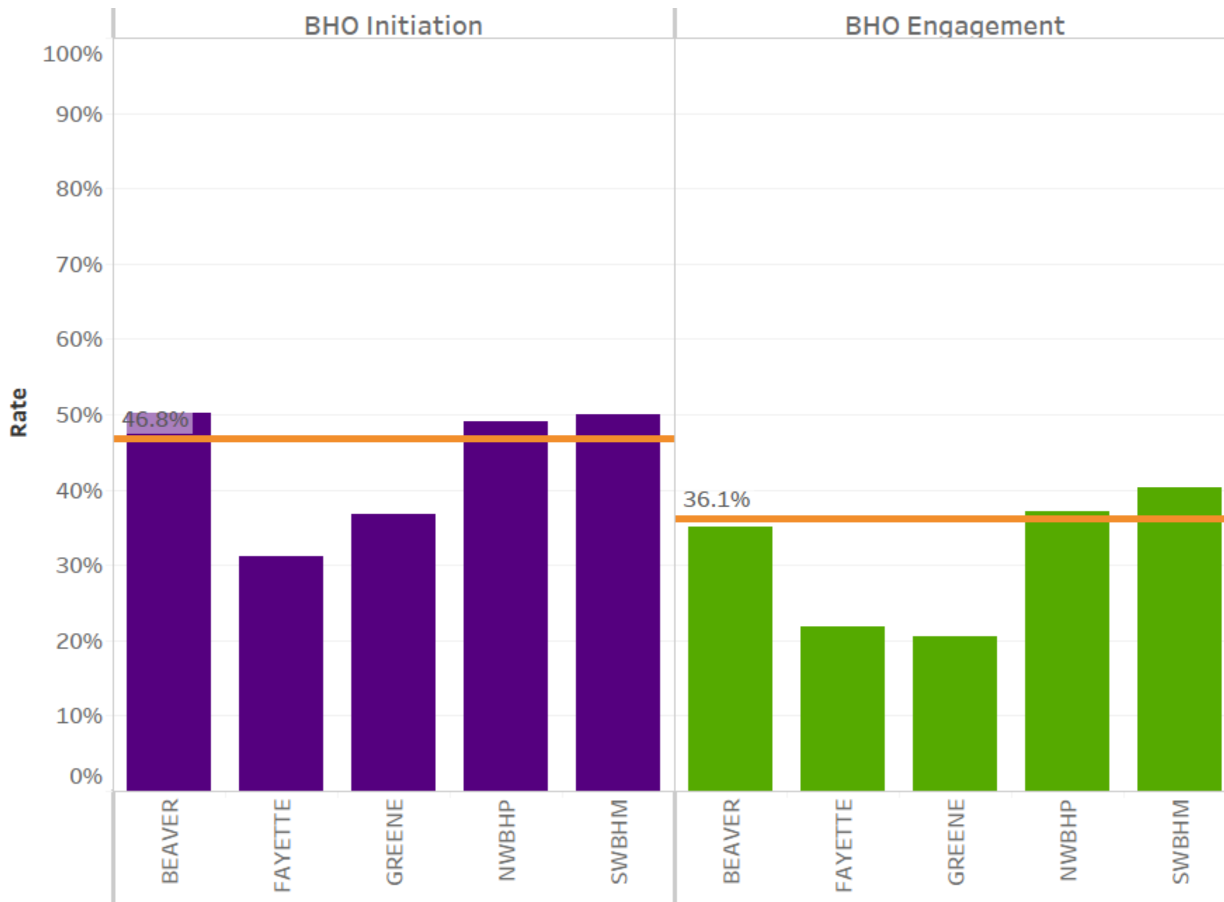


Figure 3.13: MY 2018 IET Initiation and Engagement Rates (18+ Years).

Figure 3.14 shows the HealthChoices BH Statewide rates and individual BHO HC BH Contractors that performed statistically significantly higher or lower than the Statewide rate. Beaver, SWBHM, and NWBHP were significantly above the Statewide Initiation rate of 41.9%, while Fayette was significantly below the Statewide rate by 10.7 percentage points. SWBHM, NWBHP, and Beaver were also significantly above the Statewide Engagement rate of 28.3%. Fayette and Greene had rates significantly below the Statewide rate.

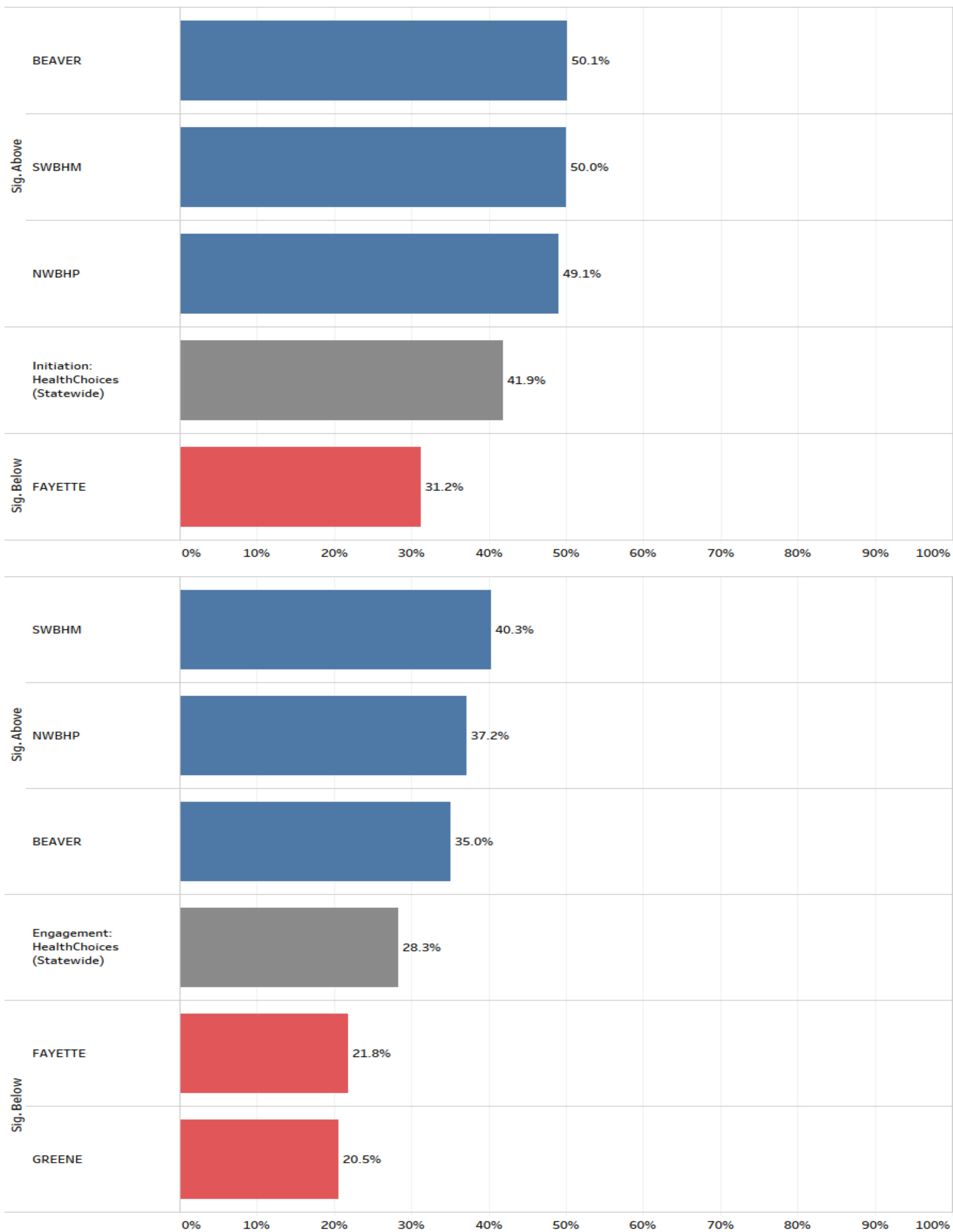


Figure 3.14: BHO Contractor MY 2018 IET Rates (18+ Years) that are Statistically Significantly Different than HealthChoices (Statewide) MY 2018 IET Rates (18+ Years).

(c) Age Group: 13+ Years Old

The MY 2018 HealthChoices Aggregate rates in the 13+ years age group were 42.0% for Initiation 28.5% for Engagement (**Table 3.8**). The Initiation rate was statistically significantly higher than the MY 2017 Initiation rate by 0.7 percentage points, and the Engagement rate was statistically significantly lower than the MY 2017 Engagement rate by 5.2 percentage points. The MY 2018 HealthChoices Aggregate Initiation rate was between the HEDIS 50th and 75th percentiles, while the Engagement rate was at or above the 75th percentile.

The BHO MY 2018 Initiation rate for the 13+ age set was 46.8% (**Table 3.8**). This rate was above the 50th percentile but below the 75th percentile with a decrease of 1.3 percentage points from MY 2017. The BHO MY 2018 Engagement rate was 36.0%, which was significantly lower than MY 2017 rate but which met the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile for this measure. As shown in **Table 3.8**, only SWBHM saw a significant increase from their MY 2017 rate while both Fayette and Greene experienced a significant decrease from their MY 2017 rate by 16.5 and 9.8 percentage points, respectively. Additionally, these two contractors performed below the 25th percentile, while the other three were at or above the 75th percentile. The Engagement rates all decreased from the previous year, with the largest decrease from Fayette and Greene, a difference of 19.9 and 21.2 percentage points, although all contractors still performed at or above the 75th percentile.

Table 3.8: MY 2018 IET Initiation and Engagement Indicators (All Ages)

	MY 2018						MY 2018 Rate Comparison		
				95% CI			To MY 2017		
Measure	(N)	(D)	%	Lower	Upper	MY 2017 %	PPD	SSD	To MY 2018 HEDIS Percentiles
Numerator 1: Initiation of AOD Treatment (All Ages)									
HealthChoices (Statewide)	26158	62278	**42.0%**	41.6%	42.4%	41.3%	0.7	YES	Below 50th Percentile, Above 25th Percentile
BHO	4800	10266	**46.8%**	45.8%	47.7%	48.0%	-1.3	YES	Below 75th Percentile, Above 50th Percentile
BEAVER	586	1186	**49.4%**	46.5%	52.3%	48.0%	1.4	NO	At or Above 75th Percentile
FAYETTE	468	1482	**31.6%**	29.2%	34.0%	48.0%	-16.5	YES	Below 25th Percentile
GREENE	104	272	**38.2%**	32.3%	44.2%	48.0%	-9.8	YES	Below 25th Percentile
NWBHP	568	1154	**49.2%**	46.3%	52.1%	48.0%	1.2	NO	At or Above 75th Percentile
SWBHM	3074	6172	**49.8%**	48.6%	51.1%	48.0%	1.8	YES	At or Above 75th Percentile
Numerator 2: Engagement of AOD Treatment (All Ages)									
HealthChoices (Statewide)	17741	62278	**28.5%**	28.1%	28.8%	33.7%	-5.2	YES	At or Above 75th Percentile
BHO	3697	10266	**36.0%**	35.1%	36.9%	41.8%	-5.8	YES	At or Above 75th Percentile
BEAVER	411	1186	**34.7%**	31.9%	37.4%	41.8%	-7.2	YES	At or Above 75th Percentile
FAYETTE	325	1482	**21.9%**	19.8%	24.1%	41.8%	-19.9	YES	At or Above 75th Percentile
GREENE	56	272	**20.6%**	15.6%	25.6%	41.8%	-21.2	YES	At or Above 75th Percentile
NWBHP	430	1154	**37.3%**	34.4%	40.1%	41.8%	-4.6	YES	At or Above 75th Percentile
SWBHM	2475	6172	**40.1%**	38.9%	41.3%	41.8%	-1.7	YES	At or Above 75th Percentile

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; HEDIS: Healthcare Effectiveness Data and Information Set; AOD: alcohol or other drug dependence; BHO: Beacon Health Options; NWBHP: Northwest Behavioral Health Partnership, Inc.; SWBHM: Southwest Behavioral Health Management, Inc.

Figure 3.15 is a graphical representation MY 2018 IET rates for BHO and its associated HC BH Contractors for the 18+ years age group. The orange line indicates the MCO average.

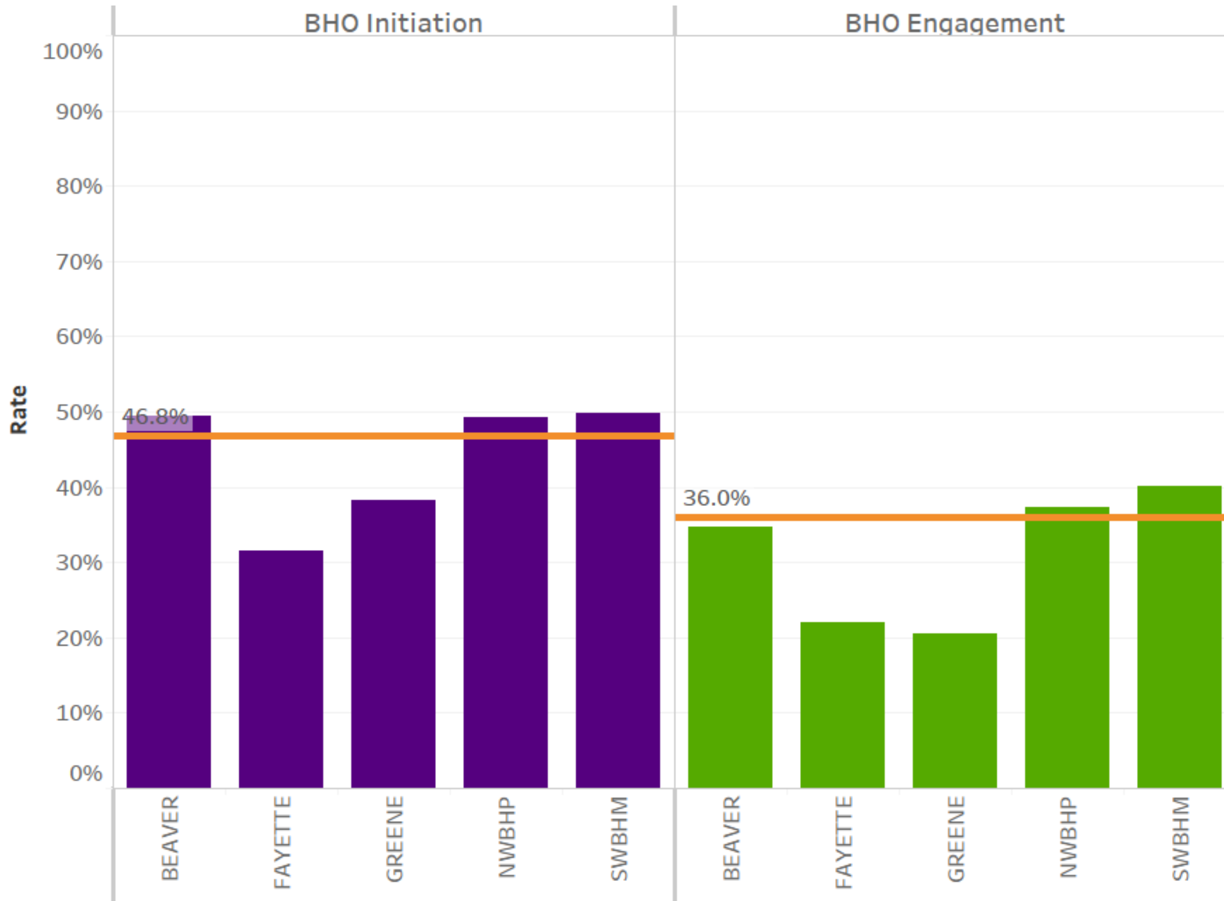
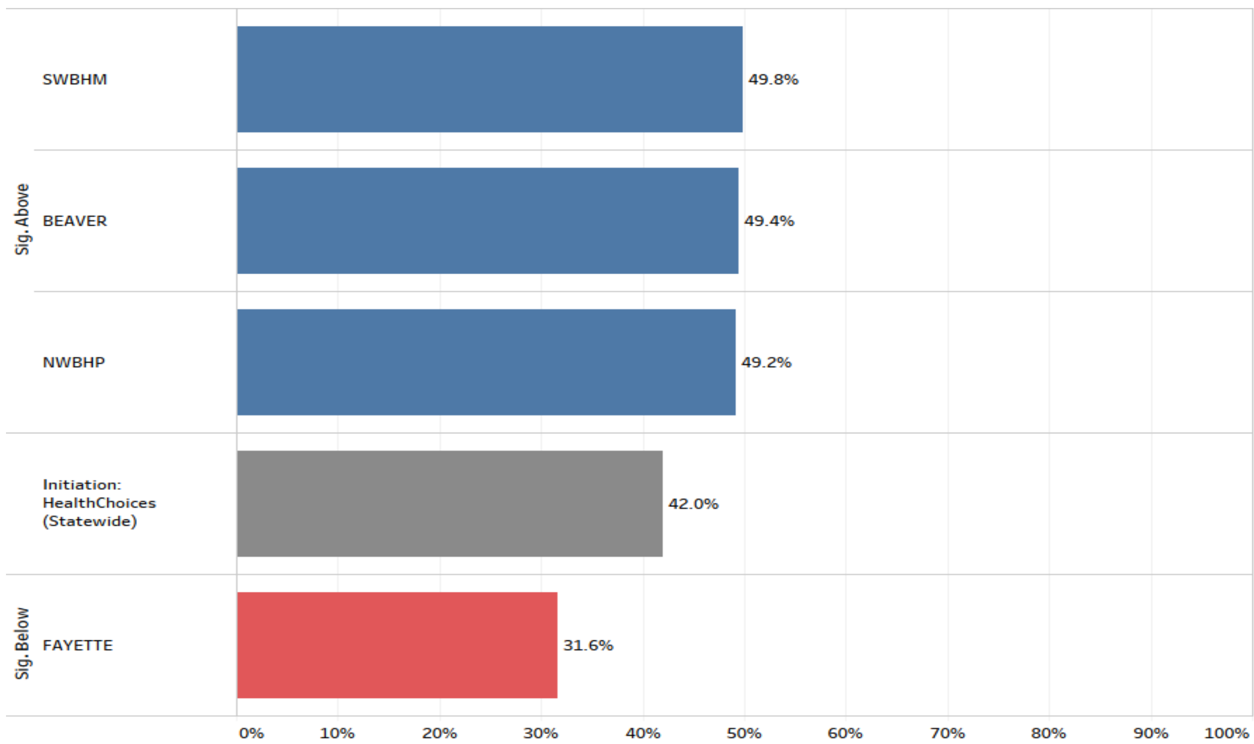


Figure 3.15: MY 2018 IET Initiation and Engagement Rates (All Ages).

Figure 3.16 shows the HealthChoices HC BH Contractor Average rates and individual BHO HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. SWBHM, Beaver, and NWBHP were significantly above the Statewide rate for Initiation of 42.0%. Fayette performed significantly below the Statewide Initiation rate by 10.4 percentage points. For Engagement, SWBHM, NWBHP, and Beaver also performed significantly above the Statewide rate of 28.5%. Fayette and Greene both performed significantly below the Statewide rate.



Sig. Above
SWBHM
40.1%
NWBHP
37.3%
BEAVER
34.7%
Engagement: HealthChoices (Statewide)
28.5%
Sig. Below
FAYETTE
21.9%
GREENE
20.6%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Figure 3.16: BHO Contractor MY 2018 IET Rates (All Ages) that are Statistically Significantly Different than HealthChoices (Statewide) MY 2018 IET Rates (All Ages).

Conclusion and Recommendations

For MY 2018, the HealthChoices aggregate rate in the overall population was 42.0% for the Initiation rate and 28.5% for the Engagement rate. The Initiation rate was above the HEDIS 25th percentile and below the 50th percentile, while the Engagement rate was at or above the 75th percentile. The Initiation rate statistically significantly increased compared to MY 2017 rates while the Engagement rate statistically significantly decreased from MY 2017 rates. As seen with other performance measures, there is significant variation between the HC BH Contractors. Overall, BH HC Contractors performed better in Engagement rates, meeting or exceeding the HEDIS goal of 75th percentile. As with most reporting years, it is important to note that there were some changes to the HEDIS 2019 specifications.. The following general recommendations are applicable to all five participating BH-MCOs:

- The IET measure is a key performance indicator of the Integrated Care Program (ICP) in Pennsylvania; this program seeks to promote better data-sharing and coordination between the physical heath and behavioral health care systems in the PA HealthChoices Medicaid Managed Care program. BH-MCOs should continue to find ways to build and capitalize on partnerships with the PH-MCOs serving the same members. To this end, OMHSAS, in conjunction with its sister agency, the Office of Medical Assistance Programs (OMAP), has begun to drill into the ICP measure data, including IET, to determine the relative performance of those partnerships and to better understand the strategies that seem to be generating better performance.
- BH-MCOs should further develop programs to report this measure for their population on a regular basis using information gained from the 2019 (MY 2018) IET Rates Report which is now available as an interactive Tableau workbook. This information 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, BHO should focus on improving Initiation rates while reversing the declines seen in many of its Contractor Engagement rates in order to sustain its goal of meeting or beating the HEDIS 75th percentile for Engagement.

IV: Quality Studies

The purpose of this section is to describe quality studies performed in 2018 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 results reported below are for Demonstration Year 1 (DY1) which ran from July 1, 2017 through June 30, 2018. 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, behavioral health screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services, along with outpatient clinic primary care screening and monitoring, are provided or managed directly by the CCBHCs. The other services, including targeted case management, peer support, psychiatric rehabilitation services and intensive community-based mental health care to members of the armed forces and veterans, 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 shared 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. Although none of the CCBHC-certified clinics were in BHO's network in 2018, for any of its member receiving CCBHC services, BHO covered those services under a Prospective Payment System (PPS) rate.

During DY1, activities focused on continuing to implement and scale up the CCBHC model within the seven clinic sites. Data collection and reporting was a centerpiece of this quality initiative in two important ways. First, the CCBHC Demonstration in Pennsylvania featured a process measure Dashboard, hosted by the EQRO through REDCap, whereby clinics were able to monitor progress on the implementation of their CCBHC model. Using the Dashboard, 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 client satisfaction. The Dashboard provided for each clinic a year-to-date (YTD) comparative display that showed clinic and statewide results on each process measure, as well as average scores for three domains of the satisfaction surveys (see below): convenience of provider location, satisfaction with provider services, and timeliness and availability of appointments. These Dashboard results were reported out to a CCBHC Stakeholder Committee at the end of each quarter.

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 and 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. Clinics performed a variety of activities in DY 1 to support these reporting objectives. Clinics collected and reported baseline data on quality measures. The EQRO also used SurveyMonkey to support the administration and collection of person-experience-of-care surveys for adults (PEC) as well as for children and youth (Y/FEC). Finally, clinics continued 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 operationalizing the quality and process measures using the clinics' data plans. In this respect, 2017 and early 2018 was a period of building up the capacity of the clinics to bring the vision of the CCBHC Demonstration to its full fruition. DY1 results, therefore, should be

interpreted with caution to the extent that they cover a period in which clinics were still learning to fully implement their CCBHC quality and measurement programs.

Demonstration Year 1 Results

By the end of DY1 (June 30, 2018), the number of individuals receiving at least one core service surpassed 16,000. More than half of those individuals also received some form of evidence-based practice (EBP): Cognitive Behavioral Therapy (32.5%), Trauma-focused interventions (6.7%), Medication-Assisted Treatment (5.8%), Parent-Child Interaction Therapy (0.5%), and Wellness Recovery Action Plan (WRAP) (0.9%). The average number of days until initial evaluation was 7.2 days. In the area of depression screening and follow-up, more than 80% of positive screenings resulted in the documentation of a follow-up plan the same day. More than 3,000 individuals within the CCBHC program received Drug and Alcohol Outpatient or Intensive Outpatient Treatment during the period.

Process measures reflect important progress in increasing both the access and quality of community-based care for individuals with behavioral health conditions, but the CCBHC Demonstration quality measures are designed to more meaningfully measure the impact of these efforts. **Table 4.1** summarizes how well the CCBHC clinics did on quality measures compared to Statewide- and National benchmarks. No statistical tests were carried out for these comparisons.

Table 4.1: CCBHC Quality Performance compared to Statewide and National Benchmarks

Measure	CCBHC weighted average	Comparison		
		State Weighted Average	National Average	Description (if National)
Follow-Up Care for Children Prescribed ADHD Medication - Initiation	78.7%		45.0%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up Care for Children Prescribed ADHD Medication - Continuation	88.1%		57.1%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 day	24.7%		10.4%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 day	36.8%		16.0%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Mental Illness - 7 day	51.4%		37.1%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Mental Illness - 30 day	62.2%		52.6%	HEDIS 2019 Quality Compass 50th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Initiation	15.7%	41.1%		
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Engagement	4.3%	33.7%		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 7 day	25.7%	34.7%		

Measure	CCBHC weighted average	Comparison		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 30 day	27.1%	55.7%		
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 7 day	36.3%	51.1%		
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 30 day	37.1%	74.0%		
Antidepressant Medication Management - Acute	46.3%	51.4%		
Antidepressant Medication Management - Continuation	25.5%	37.2%		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	46.3%	69.0%		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.0%	88.1%		
Plan All-Cause Readmissions Rate (lower is better)	8.0%	17.0%		
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	13.2%		12.5%	MIPS 2019 (eCQMs)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	23.3%		8.1%	MIPS 2019 (eCQMs)
Screening for Depression and Follow-Up Plan	34.7%		18.0%	MIPS 2019 (eCQMs)
Depression Remission at Twelve Months	6.0%		3.0%	MIPS 2019 (eCQMs)
Body Mass Index (BMI) Screening and Follow-Up Plan	43.5%		58.9%	MIPS 2018 (Claims)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	56.0%		72.5%	HEDIS 2019 Quality Compass 50th Percentile
Tobacco Use: Screening and Cessation Intervention	50.0%		61.8%	MIPS 2019 (CMS Web Interface Measures)
Unhealthy Alcohol Use: Screening and Brief Counseling	38.6%		63.9%	MIPS 2018 (Registry)

CCBHC: Certified Community Behavioral Health Clinics; ADHD: attention deficit/hyperactivity disorder; HEDIS: Healthcare Effectiveness Data and Information Set; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; FUH: Follow-Up After Hospitalization for Mental Illness; SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia; MIPS: Merit-Based Incentive Pay System; eCQM: electronic Clinical Quality Measure; SRA: suicide risk assessment; MDD: major depressive disorder; BMI: body mass index; CMS: Centers for Medicare & Medicaid Services.
Note: gray-shaded cells are Not Applicable.

With respect to adult patient experiences of care (PEC), CCBHC clinics also appeared to do as well or better than their peers, although no statistical tests were run to compare across all clinics. **Figure 4.1** compares CCBHC clinics to a control group of comparable clinics located under the same HC BH Contractor, by comparing percentages of adults reporting satisfaction along a variety of domains, as captured by the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey.

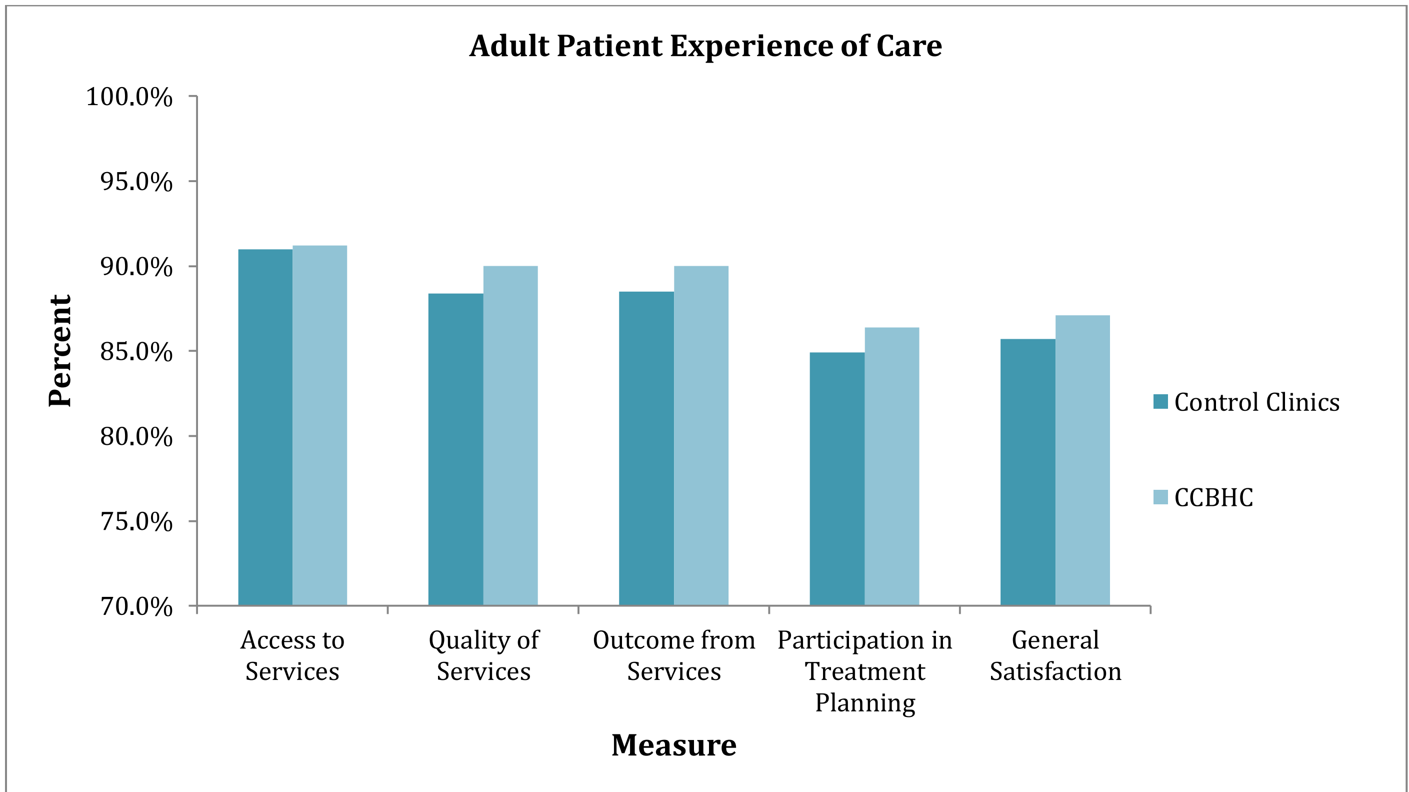


Figure 4.1: Comparison of CCBHC to Control Clinics on Adult Patient Experience of Care

In contrast, as **Figure 4.2** shows, the percentages of children and youth reporting satisfaction with CCBHC services on the Youth/Family Experience of Care (Y/FEC) survey was for the most part lower than the percentages reported for the same domains in control clinics, although a higher percentage of CCBHC clients in this age group reported satisfaction with the outcome from services. Once again, these comparisons were not statistically evaluated for this study.

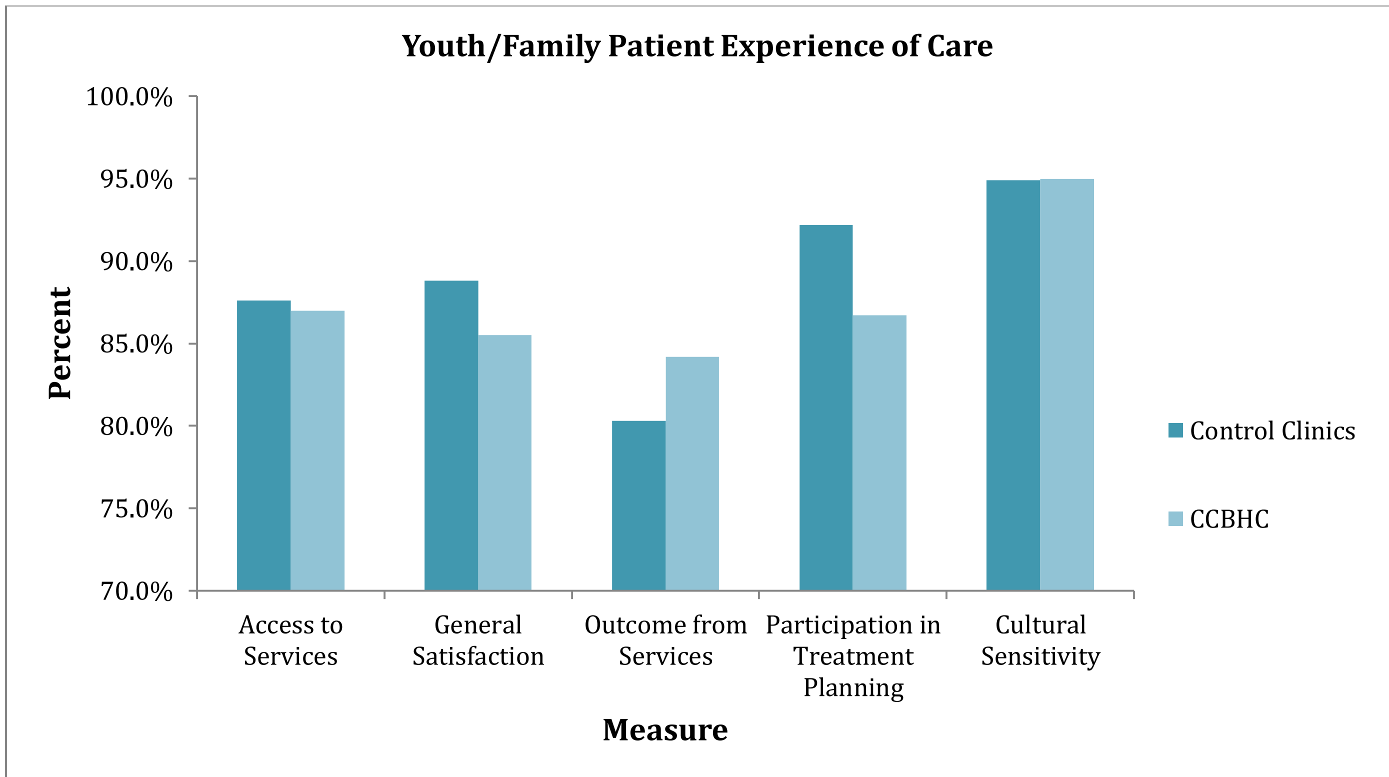


Figure 4.2: Comparison of CCBHC to Control Clinics on Child Patient Experience of Care

Pennsylvania's CCBHC goal for patient experiences of care is to average a score of 80% or higher (normalized on a Likert Scale) for each of three major domains: Convenience of provider location, Timeliness and Availability of Appointments, and Satisfaction with Provider Services. When grouping survey items across the three major domains, the DY1 weighted average results for the three domains meet or surpass the yearly goal for both the PEC (n = 1,907) and Y/FEC surveys (n = 626).

Quality Bonus Payments (QBP) were also available for six of the quality measures: FUH-A (adult), FUH-C (child), IET, SAA, and SRA-A (adult), and SRA-BH-C (child). Payments were made based on percentage-point improvement over baseline. All clinics earned QBP payments in DY1 for at least some of the measures, with the SRA measures seeing the most sizable improvements and payouts.

V: 2018 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 2018 EQR Technical Reports. The request for MCO response to the opportunities for improvement related to PEPS deficiencies was distributed in June 2019. The 2019 EQR Technical Report is the 12th report to include descriptions of current and proposed interventions from each BH-MCO that address the prior year's deficiencies.

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, 2019, 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 2019, as well as any additional relevant documentation provided by the BH-MCO.

The request for MCO response to the opportunities for improvement related to MY 2018 underperformance in the HEDIS FUH All-Ages measures were distributed, along with the MY 2018 results, in January 2020. The Root Cause Analysis and Quality Improvement Plan form similarly provides for a standardized format for BH-MCOs to describe root causes of underperformance and propose a detailed "Quality Improvement Plan" to address those factors, complete with a timeline of implementation-, monitoring-, and reporting activities. BH-MCOs submitted their responses by March 1, 2020.

Quality Improvement 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 2017, BHO began to address opportunities for improvement related to compliance categories in the following 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) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions. Proposed actions and evidence of actions taken by BHO 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 BHO into compliance with the relevant Standards.

Table 5.1 presents BHO's responses to opportunities for improvement cited by IPRO in the 2018 EQR Technical Report, detailing current and proposed interventions. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 5.1: BH-MCO's Responses to Opportunities for Improvement

<table>
<tr><th>Reference Number</th><th>Opportunity for Improvement</th><th>Date(s) of Follow-up Action(s) Taken/Planned</th><th>MCO Response</th></tr>
<tr><td colspan="2" rowspan="2">Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found VBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.</td><td>Date(s) of follow-up action(s) taken through 6/30/19 /Ongoing/None</td><td>Address within each subpart accordingly.</td></tr>
<tr><td>Date(s) of future action(s) planned/None</td><td>Address within each subpart accordingly.</td></tr>
<tr><td rowspan="2">VBH 2018.01</td><td rowspan="2">Within Subpart C: Enrollee Rights and Protections Regulations, VBH was partially compliant on one out of seven categories – Enrollee Rights.</td><td>Date(s) of follow-up action taken through 6/30/19 /Ongoing/None</td><td>Enrollee Rights - PEPS Standard 60, Substandard 1 – Table of Organization identifies lead person responsible for overall coordination of complaint and grievance process and adequate staff to receive, process, and respond to member complaints and grievances.

Beacon (VBH) Response: Attached please find a copy of the Table of Organization (TO) for Beacon which delineates the Clinical Manager as the lead person who oversees, leads and directs the complaint and grievances processes. The Clinical manager reports to the VP of Clinical Services. In 2018, Beacon added an additional complaint coordinator and administrative support for the complaint/grievance unit.
[Objects removed]</td></tr>
<tr><td>Date(s) of future action planned/None</td><td>Beacon / VBH-PA has one current administrative assistant vacancy that is in the process of being filled. Beacon-PA will continue to monitor staff completion of annual Member Rights and Responsibilities training, and will ensure that all new hires complete training as part of their onboarding orientation.</td></tr>
</table>

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
VBH 2018.02	Within Subpart D: Quality Assessment and Performance Improvement Regulations, VBH was partially compliant with six out of 10 categories The partially compliant categories are: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Subcontractual relationships and delegation 5 Practice Guidelines, 6) Quality Assessment and Performance Improvement Program	Date(s) of follow-up action taken through 6/30/19 /Ongoing/None	**Availability of Services - PEPS Standard 28, 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. **Beacon (VBH) Response:** Beacon clinical templates were updated to include the following elements (See attached templates): 1. Discharge Plan: Level of care that the individual will be discharged to; natural supports and stabilization resources to facilitate and support stepdown; access and transportation to stepdown; barriers to discharge plan; and steps employed to overcome barriers 2. Treatment Plan Review: How does the treatment plan link to admission issue; describe the appropriateness of the treatment plan; and what feedback/recommendations does the Care Manager (CM) have for the providers on the treatment plan 3. Evidence Based Practices: Describe which Evidence Based Practices (EBPs) may be relevant and recommended for this Member 4. Substance Use Template Only: Describe which alternatives to 24- hour treatment were explored; why 24-hour care is the most appropriate and least restrictive choice; and the results of discussion of potential use of medication assisted therapies (MAT). [Objects removed] Training for all staff (annually) was completed in April 2019 and included the following information: 1. How to discern treatment plan quality and documentation of this activity when discussing with a provider. 2. Active care management and following up with providers on recommendations in addition to identification and documentation of ongoing progress or lack of progress. 3. Utilization of readmission rounds and complex case calls with contractor and oversight partners. Documentation of these activities to support progress in those individuals with multiple admissions to higher levels of care or lack of treatment progress. [Objects removed] A new Quality of Care Concern form was developed (See attached) and included as part of the review for each case sent for consultation, peer review, and/or grievance (including Fair Hearing and Expedited and External Review).

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		Date(s) of future action planned/None	Beacon clinical supervisor will ensure that the correct templates are being utilized and will address any issues during staff supervisions and/or clinical staff meetings. Staff training will occur at Clinical Grand Rounds and/or through the Relias training platform. The QOC committee reviews the QOC concern form on an annual basis or more frequently as needed based on changes to the regulations.
		Date(s) of follow-up action taken through 6/30/19 /Ongoing/None	**Coordination and Continuity of Care - PEPS Standard 28, 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. **Beacon (VBH) Response:** See above section on Availability of Services - PEPS Standard 28, Substandard 1
		Date(s) of future action planned/None	See above section on Availability of Services - PEPS Standard 28, Substandard 1
		Date(s) of follow-up action taken through 6/30/19 /Ongoing/None	**Coverage and Authorization of Services - PEPS Standard 28, 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. **Beacon (VBH) Response:** See above section on Availability of Services - PEPS Standard 28, Substandard 1
		Date(s) of future action planned/None	See above section on Availability of Services - PEPS Standard 28, Substandard 1

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		Date(s) of follow-up action taken through 6/30/19 /Ongoing/None	**Coverage and Authorization of Services – PEPS Standard 72, Substandard 2 -** The content of the notices adheres 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 DHS 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; and contains date denial decision will take effect). **Beacon (VBH) Response:** All notices were updated and reviewed by OMHSAS and confirmed to conform to the 2018 updated Appendix H and AA requirements. (See attached templates). [Objects removed] In addition, Beacon updated their denial letter audit tool to the updated Appendix H and AA requirements. (See Attached**).** [Objects removed] Training for Peer Advisors on the development of the member statement that is easy to understand/free from medical jargon and on the contents of the denial letter regarding the rationale and description of denied services occurred. [Objects removed]
		Date(s) of future action planned/None	Beacon PA is committed to Continuous Quality Improvement. Ongoing auditing will continue in an effort to continually improve our processes.
		Date(s) of follow-up action taken through 6/30/19 /Ongoing/None	**Practice Guidelines - PEPS Standard 28, 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. **Beacon (VBH) Response:** See above section on Availability of Services - PEPS Standard 28, Substandard 1. In addition, a training on evidenced based practices was developed in February for Clinical staff. See attached. [Objects removed]
		Date(s) of future action planned/None	Beacon-PA will continue to monitor content of the notices for adherence to OMHSAS requirements. Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		Date(s) of follow-up action taken through 6/30/19 /Ongoing/None	**Practice Guidelines – PEPS Standard 28, 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. **Beacon (VBH) Response:** See above section on Availability of Services - PEPS Standard 28, Substandard 1. In addition, Training for BH-MCO Physician / Psychologist Advisors was conducted regarding medical necessity decisions being supported by documentation in the denial record with appropriate application of the medical necessity criteria. See attached meeting minutes. [Objects removed]
		Date(s) of future action planned/None	Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Date(s) of follow-up action taken through 6/30/19 /Ongoing/None	**Practice Guidelines – PEPS Standard 28, Substandard 3 –** Other: significant onsite review findings related to Standard 28. **Beacon (VBH) Response:** See above section on Availability of Services - PEPS Standard 28, Substandard 1
		Date(s) of future action planned/None	See above section on Availability of Services - PEPS Standard 28, Substandard 1
		Date(s) of follow-up action taken through 6/30/19 /Ongoing/None	**Quality Improvement and Performance Improvement Plan – PEPS Standard 91, Substandard 4 -** The QM Work Plan includes: ● Objective ● Aspect of care/service ● Scope of activity ● Frequency ● Data source ● Sample size ● Responsible person ● Specific, measurable, attainable, realistic and timely performance goals, as applicable. **Beacon (VBH) Response:** The VBH/Beacon Quality Management/Utilization Management Work Plan is updated annually and was revised for the 2019 work plan submission to incorporate feedback from OMHSAS as to the format and content. References in the document to other sections of the work plan were identified by PEPS Standard. The work plan was reviewed by the QMC for all primary contractors. The plan was submitted to OMHSAS on 4/1/19. Please see

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			attached work plan. [Objects removed]
		Date(s) of future action planned/None	Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Date(s) of follow-up action taken through 6/30/19 /Ongoing/None	**Quality Improvement and Performance Improvement Plan – PEPS Standard 91, Substandard 13 -** The identified performance improvement projects must include the following: ● Measurement of performance using objective quality indicators; ● Implementation of system interventions to achieve improvement in quality; ● Evaluation of the effectiveness of the interventions; ● Planning and initiation of activities for increasing or sustaining improvement; ● Timeline for reporting status and results of each project to the Department of Human Services (DHS); and ● 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. **Beacon (VBH) Response:** VBH/Beacon consulted with IPRO for the review and technical assistance regarding adherence to the PIP recommendations. See outline of TA below: The Q2 IPRO Response noted above was received on August 9, 2018 (included). The Q3 IPRO PIP update was submitted on 10/31/18. The Q3 IPRO Response was received on 11/19/18 (included). There was a conference call held with IPRO on 11/26/18 to review their comments and recommendations. Based on the IPRO recommendations a revised and final Q3 PIP Update was submitted on 12/3/18 (included). Following that was a conference call on 12/19/18 to review IPRO comments. The Q4 IPRO PIP Update was submitted on 1/31/9 (included). The Q4 IPRO Response was received on 2/15/19 (included). There was a conference call held with IPRO on 2/25/19 to review their comments and recommendations. See attached submissions referenced above. [Objects removed]

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
VBH 2018.03	Within Subpart F: Federal and State Grievance System Standards Regulations, VBH was partially compliant on nine out of 10 categories The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions	Follow Up Actions Taken Through 6/30/19	**Statutory Basis and Definitions – 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. **Beacon (VBH) Response:** The desk top procedures were revised to incorporate OMHSAS feedback which included the outline of additional detail for the education of the CIs to this process. Staff training materials were updated the following the revisions to Appendix H and are included in the on-boarding and orientation process. Current CI staff received training with the updated materials. The complaint checklist was revised to Appendix H requirements. See referenced documents below. [Objects removed] New educational materials were developed to educate network providers as to the new changes to Appendix H and the CI staff were part of developing these materials. An educational article was also placed in the VBH/Beacon newsletter for reinforcement. [Objects removed] Beacon will disseminate new educational materials regarding complaints and grievances that were approved this month to their provider network and primary contractors.
			Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**Statutory Basis and Definitions – PEPS Standard 68, 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). **Beacon (VBH) Response:** VBH/Beacon revised the acknowledgement / resolution letters to meet the standards identified in Appendix H, were reviewed by all primary contractors and submitted to OMHSAS on 08/20/19.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			[Objects removed] The Complaint Checklist was revised to include the utilization of the correct letter template. See attached Complaint Checklist in PEPS Standard 68, Substandard 1.
		Future Actions Planned (Specify Dates)	Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**Statutory Basis and Definitions - 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. **Beacon (VBH) Response:** VBH/Beacon implemented the following revisions regarding the complaint case file and OMHSAS recommendations: • The compliant Log was updated to include the "Member's Desired Resolution". • The Complaint log, Complaint Checklist and CRC forms have all been revised to indicate if the member provided evidence to support their complaint. [Objects removed] • The Member Signature Form has been updated to indicate a due date and a statement that "failure to return this form will not interfere in VBH-PA's/Beacon investigation and resolution of your complaint". [Objects removed] • Complaint investigators document the Member's satisfaction with the resolution of their complaint in the Inquiry Summary. Please see attached sample. [Objects removed] • All Quality Staff completed annual complaint training which included changes made to Appendixes AA and H [Objects removed]
		Future Actions Planned (Specify Dates)	Beacon will continue to monitor complaint case files on an ongoing basis. Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**Statutory Basis and Definitions – PEPS Standard 68, Substandard 5 -** Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff, either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review. **Beacon (VBH) Response:** Beacon has a Care Concern process for complaint investigators. If a care concern is identified, a referral is made to the Quality of Care Committee through the Care Concern process. Care Concerns are reviewed and completed by the Care Concern Triage group, who submit documentation of follow-up actions and recommendations to the Complaint Investigator. The completed Care Concern forms are saved in the Complaint File under Section 11 – "Follow up Documentation". [Objects removed]
		Future Actions Planned (Specify Dates)	Beacon will continue to monitor complaint case files for adherence to the Care Concern process and workflow. Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**Statutory Basis and Definitions – PEPS Standard 71, Substandard 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 **Beacon (VBH) Response:** Beacon completes monthly audits of Grievances (See attached samples of audits completed in Q1 and Q2 of 2019. In addition, Grievance training on the standards was completed on 7/1/19. See attached presentation. [Objects removed]
			Beacon is in the process of updating their second level review of Grievances that involve clinical/medical leadership. This will be completed prior to 11/30/19, consistent with our response to the triennial review CAP.
		Follow Up Actions Taken Through 6/30/19	**Statutory Basis and Definitions – 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.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			Beacon (VBH) Response: Beacon held an updated grievance training for staff, committee members and facilitators on 7/1/19. Grievance letter templates and training templates were updated to be in compliance with the standard. See attached documents. [Objects removed]
		12/31/2019	**Beacon's current processes and audit tool are being revised.**
		Follow Up Actions Taken Through 6/30/19	**Statutory Basis and Definitions – 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. **Beacon (VBH) Response:** All Care Concerns that arise from grievances are documented through the Quality Department triage process for quality of care concerns. Every request is then tracked through the QOC Triage process. Care Concern reports are reviewed with OMHSAS and Primary Contractors at various oversight meetings. [Objects removed]
		Future Actions Planned (Specify Dates)	Beacon will continue to monitor Grievance files on an ongoing basis to ensure adherence to the OMHSAS standards. Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**Statutory Basis and Definitions – PEPS Standard 72, 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 DHS 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). **Beacon (VBH) Response:** Beacon updated the Grievance template and instructions to OMHSAS requirements and trained on these requirements during Peer Advisor meetings. Please see attached documentation. [Objects removed]

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		Future Actions Planned (Specify Dates)	Beacon will continue to monitor grievance notice**.** Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**General Requirements – PEPS Standard 60, 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. **Beacon (VBH) Response:** Beacon staff are trained on complaint and grievances on an annual basis and more frequently as needed (change in standards, refresher, new staff). See attached the training transcript, training curriculum and the revised training presentation. [Objects removed]
		Future Actions Planned (Specify Dates)	Beacon-PA will continue to monitor staff completion of annual Complaint and Grievance training, and will ensure that all new hires complete training as part of their onboarding.
		Follow Up Actions Taken Through 6/30/19	**General Requirements – 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. **Beacon (VBH) Response:** Beacon revised the process for monitoring of complaint TATs to address the acknowledgement letters. The current monitoring report was updated to include TAT for acknowledgement letters. A same draft report is attached, along with the QM Complaint Checklist which also includes an audit to confirm the Acknowledgement letter is sent within 5 business days. [Objects removed] The QM monitoring report for complaints was updated to include complaint TAT for Acknowledgement Letters. A sample report is attached. The Quality Director or Manager reviews the report quarterly. If a timeframe is not met, the incident is investigated by the Quality Department and any necessary changes (or trainings) are made. This report is also reviewed by the respective QMCs for the primary contractors.
		Future Actions Planned	Beacon will continue to monitor complaint TAT for Acknowledgement and Resolution letters. Beacon is

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		(Specify Dates)	committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**General Requirements - PEPS Standard 71, Substandard 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 Beacon has revised their Grievance letter templates to meet the PEPS standards. Please see attached letter templates. In addition, attached is the Training list of all staff completion of the updated complaint and grievance training. [Objects removed]
		Future Actions Planned (Specify Dates)	Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**General Requirements – 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. **Beacon/VBH-PA Response:** Please see the attachments noted above in PEPS Standard 71, Substandard 1. In addition, below is a Grievance case example that provide evidence of compliance to the standard. [Objects removed]
		Future Actions Planned (Specify Dates)	Beacon will continue to monitor adherence to the OMHSAS standards regarding Grievance case documentation**.** Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**General Requirements – 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. **Beacon Response:** Beacon has attached examples of

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			executed Care Concern referral forms and the Care Concern that was updated to meet this standard. [Objects removed] See above
		Future Actions Planned (Specify Dates)	Beacon will continue to monitor adherence to the OMHSAS standards regarding Grievance case documentation**.** Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**General Requirements – PEPS Standard 72, 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). **Beacon Response:** Beacon updated their Grievance cover sheet, template, Audit Tool and training to bring all notices into compliance with the PEPS standard. Attached are those documents that were updated along with updated grievance training presentation for staff, committees and facilitators. In addition, Peer Advisor meeting minutes discussed the requirements are attached. [Objects removed] See above
		Future Actions Planned (Specify Dates)	Beacon will continue to monitor adherence to the OMHSAS standards regarding Grievance case documentation**.** Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**Handling of Grievance and Appeals – 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. [Objects removed]
		Future Actions Planned (Specify Dates)	Beacon will continue to monitor complaint TAT for Acknowledgement and Resolution letters. Beacon is committed to Continuous Quality Improvement. Auditing of our current processes will continue and any opportunities for improvement identified will be

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			included in on-going training and process enhancements.
		Follow Up Actions Taken Through 6/30/19	**Handling of Grievance and Appeals – PEPS Standard 68, 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). **Beacon Response:** See above section on Availability of Services - PEPS Standard 68, Substandard 3.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 68, Substandard 3.
		Follow Up Actions Taken Through 6/30/19	**Handling of Grievance and Appeals - 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 68, Substandard 4.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 68, Substandard 4.
		Follow Up Actions Taken Through 6/30/19	**Handling of Grievance and Appeals - PEPS Standard 68, Substandard 5 -** Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff, either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review. **Beacon Response**: See above section on Availability of Services - PEPS Standard 68, Substandard 5.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 68, Substandard 5.
		Follow Up Actions Taken Through 6/30/19	**Handling of Grievance and Appeals - PEPS Standard 71, Substandard 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 **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Future Actions	See above section on Availability of Services - PEPS

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		Planned (Specify Dates)	Standard 71, Substandard 1.
		Follow Up Actions Taken Through 6/30/19	**Handling of Grievance and Appeals – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 3.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 3.
		Follow Up Actions Taken Through 6/30/19	**Handling of Grievance and Appeals – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 4.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 4.
		Follow Up Actions Taken Through 6/30/19	**Handling of Grievance and Appeals – PEPS Standard 72, 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). **Beacon Response:** See above section on Availability of Services - PEPS Standard 72, Substandard 2.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 72, Substandard 2.
		Follow Up Actions Taken Through 6/30/19	**Resolution and Notification: Grievance and Appeals – 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.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			Beacon Response: See above section on Availability of Services - PEPS Standard 68, Substandard 2.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 68, Substandard 2.
		Follow Up Actions Taken Through 6/30/19	**Resolution and Notification: Grievances and Appeals – PEPS Standard 68, 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). **Beacon Response:** See above section on Availability of Services - PEPS Standard 68, Substandard 3.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 68, Substandard 3.
		Follow Up Actions Taken Through 6/30/19	**Resolution and Notification: Grievances and Appeals – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 68, Substandard 4.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 68, Substandard 4.
		Follow Up Actions Taken Through 6/30/19	**Resolution and Notification: Grievances and Appeals – PEPS Standard 68, Substandard 5 -** Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff, either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review. **Beacon Response:** See above section on Availability of Services - PEPS Standard 68, Substandard 5.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 68, Substandard 5.
		Follow Up Actions Taken Through 6/30/19	**Resolution and Notification: Grievances and Appeals – PEPS Standard 71, Substandard 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

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			Beacon Response: See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Follow Up Actions Taken Through 6/30/19	**Resolution and Notification: Grievances and Appeals – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 3.
			See above section on Availability of Services - PEPS Standard 71, Substandard 3.
		Follow Up Actions Taken Through 6/30/19	**Resolution and Notification: Grievances and Appeals – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 4.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 4.
		Follow Up Actions Taken Through 6/30/19	**Resolution and Notification: Grievances and Appeals – PEPS Standard 72, 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). **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 2.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 2.
		Follow Up Actions Taken Through 6/30/19	**Expedited Appeals Process – PEPS Standard 71, Substandard 1 -** Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			are made known to members, BH-MCO staff, and the provider network: BBA fair hearing, 1st level, 2nd level, External, Expedited **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Follow Up Actions Taken Through 6/30/19	**Expedited Appeals Process – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 3.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 3.
		Follow Up Actions Taken Through 6/30/19	**Expedited Appeals Process – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 4.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 4.
		Follow Up Actions Taken Through 6/30/19	**Expedited Appeals Process – PEPS Standard 72, 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). **Beacon Response:** See above section on Availability of Services - PEPS Standard 72, Substandard 2.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 72, Substandard 2.
		Follow Up Actions	**Information to Providers and Subcontractors – PEPS**

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		Taken Through 6/30/19	**Standard 71, Substandard 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 **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Follow Up Actions Taken Through 6/30/19	**Continuation of Benefits – PEPS Standard 71, Substandard 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 **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Follow Up Actions Taken Through 6/30/19	**Continuation of Benefits – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 3.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 3.
		Follow Up Actions Taken Through 6/30/19	**Continuation of Benefits – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 4.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 4.
		Follow Up Actions Taken Through 6/30/19	**Continuation of Benefits – PEPS Standard 72, Substandard 2 -** The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			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). **Beacon Response:** See above section on Availability of Services - PEPS Standard 72, Substandard 2.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 72, Substandard 2.
		Follow Up Actions Taken Through 6/30/19	**Effectuation of Reversed Resolutions – PEPS Standard 71, Substandard 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 **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 1.
		Follow Up Actions Taken Through 6/30/19	**Effectuation of Reversed Resolutions – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 3.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 3.
		Follow Up Actions Taken Through 6/30/19	**Effectuation of Reversed Resolutions – 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. **Beacon Response:** See above section on Availability of Services - PEPS Standard 71, Substandard 4.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 71, Substandard 4.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		Follow Up Actions Taken Through 6/30/19	**Effectuation of Reversed Resolutions – PEPS Standard 72, 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). **Beacon Response:** See above section on Availability of Services - PEPS Standard 72, Substandard 2.
		Future Actions Planned (Specify Dates)	See above section on Availability of Services - PEPS Standard 72, Substandard 2.

BH: behavioral health; MCO: managed care organization; RY: reporting year; VBH: Value Behavioral Health; PEPS: Program Evaluation Performance Summary; TO: Table of Organization; VP: vice president; PA: Pennsylvania; MAT: medication-assisted therapies; OMHSAS: Office of Mental Health & Substance Abuse Services; QMC: Quality Management Committee; DHS: Department of Human Services; PIP: performance improvement project; TA: technical assistance; IPRO: Island Peer Review Organization; C/G: complaints/grievances; BBA: Balanced Budget Act; CAP: corresponding action plan; QM: quality management.

Root Cause Analysis and Quality Improvement Plan

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, OMHSAS determined in 2017 that it was necessary to change the PM remediation process so that BH-MCOs would set goals for the coming year.. In 2017, this change meant, among other things, eliminating the requirement to complete root cause analyses (RCAs) and corresponding quality improvement plans (QIPs) 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 MY2017 performance, 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. BH-MCOs submitted their RCAs and CAPs on April 1, 2019. HC BH Contractors submitted their RCAs and CAPs by April 30, 2019.

As a result of this shift to a proactive process, MY 2018 goals for FUH All Ages were not set. However, MY 2018 results were calculated in late 2019 to determine RCA and "Quality Improvement Plan" (QIP) assignments, along with goals, for MY2020. In MY 2018, BHO's scored below the 75th percentile on both the 7- and 30-day measures and, as a result, completed an RCA and QIP response to address both measures. **Table 5.2** presents BHO's submission of its RCA and QIP for the FUH 6–64 years 7-day measure, and **Table 5.3** presents BHO's submission of its RCA and QIP for the FUH 6–64 years 30-day measure. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 5.2: BHO RCA and CAP for the FUH 7- Day Measure (All Ages)

RCA for MY2018 underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?): Beacon, in conjunction with our 12 county partners, reviewed the influencing and causal factors for the Follow-up After Hospitalization (FUH) 7- and 30-day measures that scored below the goal. The following information was considered to determine the Root Causes: • Patient level detail for members who failed to attend their aftercare follow-up appointments • FUH performance across high volume facilities • Member reports on barriers to non-adherence • Provider reports and survey information • Inpatient and outpatient delivery systems • Inpatient chart abstractions Beacon utilized several analytic methods, including Action Research, Analytic Induction, Comparative Analysis, Fish Bone Diagrams and a Logic Model of Change. These methods were employed to further define the factors (influencing and causal) that contributed to performance below standards.	***Describe here your overall findings. Please explain the underperformance using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*** The causal factors identified as important are outlined below: 1. Systematic data identification, collecting and tracking data regarding high risk members 2. Lack of coordinated and well established processes and communication channels across the continuum of care to adequately address continuity of care needs 3. Lack of consistent communication between Hospital and Outpatient provider staff 4. Co-morbidity and complex needs of many non-compliant members 5. Lack of adequate number of trained psychiatrists / BH providers to address access needs 6. Single Point of Accountability not assigned 7. Lack of transportation resources and member needs around transportation (See embedded Logic Model of Change diagram) [Objects removed] ***For the FUH 7 Day, all of the intervention strategies identified in the 30-day measure are identical to the one's effecting the 7 day follow up. The particular measure highlighted (in yellow) below are thought to have a great impact on the 7-day FUH.
List out below the factors you identified in your RCA. <u>Insert more rows as needed</u> (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
People (1) *(e.g., personnel, patients)* **Clients/Members/Patients**	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Individuals with dual diagnoses and/or complex needs with chronic medical and substance use issues often require more coordination across the continuum of

Root Causes: Members may not have a full understanding of the importance of follow up appointments with a behavioral health provider and the need for ongoing care following an inpatient discharge due to a variety of reasons, including: • Members may feel better, are out of crisis and lack understanding and insights into the need for an outpatient visit for follow up treatment to continue their recovery. • Members may schedule the follow up visit with their Primary Care Physician (PCP) due to established relationships and easier/more timely access and a perceived lack of connectedness with an outpatient BH provider. • Some members may be at higher risk based on their clinical presentations and there is a lack of tracking of these high risks and the need for additional supports and services. • Members may perceive that follow up care is not needed with a psychiatrist or therapist.	care and they may not feel the need to follow up with a psychiatrist or therapist. • Individuals often lack family support with treatment (such as parents not bringing their child to follow up appointments, no family involvement in discharge planning, parent(s)/caretaker(s) unwillingness to sign releases to coordinate care, family not accepting appropriate levels of care for the child, changing patient /family dynamics, etc.). • Members may have their first experience with the BH care system and feel their needs can be met by their PCP. • Individuals may be reluctant to seek treatment and continue with follow up care due to mental health stigma. • Individuals are non-adherent with follow up appointments. Based on county specific HEDIS data from MY 2016, 43.95% of members were adherent for the 7 day FUH visits and 67.85% of members were adherent for the 30 day FUH visits; for MY 2017 39.36 % of members were adherent for the 7 day FUH visits and 64.65% were adherent for the 30 day FUH visits; and for MY2018 40.60% of members were adherent for the 7 day FUH visits and 63.98 % of members were adherent for 30 day FUH visits. • Individuals often have misconceptions about the treatment process (such as expectations of the provider as a "miracle worker" and/or a lack of understanding of their diagnosis/illness). • Members may lack an investment in his/her own recovery. • Individuals may perceive a "lack of fit" with the provider due to personalities, incompatibility, and a sense of poor performance/unsatisfactory outcomes of treatment. • Members may have an incomplete and/or unrealistic understanding of the achievable outcomes of their care based on the nature of their individual cases and the available treatment options. • Members often lack available natural supports in the community (such as family, friends, etc.) which does not help to promote their on-going adherence to treatment recommendations and maintenance of follow up for outpatient visits.
	Current and expected actionability: **Root Cause:** Members do not have a full understanding of the importance of follow up appointments with behavioral health care providers and therefore do not consistently make or keep scheduled follow up visits at 30 days. **Actionability**: It has been determined that this root cause is actionable and attainable. **Weight: Critical/Important**
People (2) *(e.g., personnel, patients)* **Clients/Members/Patients (Specific for Fayette County)** **Root Causes:** Members may elect to seek follow up care with their primary care physician rather than a behavioral health	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Members are generally connected to a Primary Care Physician (PCP) for their physical health care needs. They may not recognize the need for more specialized behavioral health care from a trained behavioral health provider and return to their PCP for treatment following an inpatient admission and/or on-going mental health care. This already established doctor/patient relationship may be more comfortable to the member who maybe navigating the behavioral

clinician for a variety of reasons, including the following: • Member does not feel they need to follow up with a psychiatrist or therapist. • Member refuses/declines the behavioral health care provider follow up appointment offered by the hospital. • This may be the member's first experience with the behavioral health care system and they feel their needs could be met by their Primary Care Physician. • Member feels more comfortable with their Primary Care Physician and already has a rapport with him/her to receive the recommended on-going follow up care. • Members may choose to follow up with their Primary Care Physician, therefore; follow up after discharge is not tracked.	health care system for the first time or who may find the behavioral health care system less familiar to them. This often results in follow up visits with the Primary Care Physician after discharge that are not routinely tracked. ***Current and expected actionability:*** **Root Cause:** The Fayette County Root Cause Analysis (RCA) team has partnered with the embedded Gateway Health Plan staff member (Registered Nurse) who is housed at the Fayette County office to coordinate follow-up care for members. (Note: This data collection is limited to Gateway Health Plan members at this time. The Fayette County RCA team will further explore plans for improvement in the future and this pilot may be assessed for scalability across other counties). **Actionability:** Fayette County has determined that this root cause is impactful and actionable (limited) but not immediately attainable. **Weight: Important**
Providers (1) *(e.g. provider facilities, provider network)* **Outpatient Providers** **Root Causes:** The twelve county service area is experiencing a lack of available outpatient appointments within the 30 day timeframes for a variety of reasons, including the following: • There is a lack of psychiatrists and psychiatric time in the region due in part to a lack of psychiatrists entering the field and thereby creating a national/local shortage and career pursuits in a non-public sector setting. • Budgets and incentives are limited to attract new psychiatrists to the region/field in order to increase availability. Despite recruitment attempts in the region, there has been little success to increase psychiatric time. • Scheduling outpatient	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Outpatient provider access is often limited to be able to accommodate the members in a timely manner (within 30 days) who are being discharged following an inpatient stay for various reasons (including members lack of initial choice of available providers and/or options to change if members desire a new provider, limited psychiatrist time, extended wait times for psychiatrist appointments, limited provider choices, lack of availability to take on new clients, and rural settings experience greater challenges with provider retention). A fishbone diagram was completed following a RCA session with the Beacon Provider Advisory Committee (PAC) in March 2017 and participating providers noted that provider availability and a lack of psychiatrist time was a key contributing factor to FUH visit non-adherence. • Lack of clear understanding by the provider of the patients' needs. • Inadequate communication between the hospital and the follow up provider/PCP for continuity of care. • Scheduling barriers and reluctance to overbook due to staffing issues. • Members do not consistently have access to outpatient providers following an inpatient stay due to limited choices in behavioral health providers who are available to provide appointments to meet the 30 day standards. ***Current and expected actionability:*** **Root Cause**: The lack of an adequate number of trained psychiatrists/other behavioral health providers and available psychiatric time leads to missed opportunities for timely follow up visits and members often seeking care via their PCP or choosing not to follow up at all. Alternate solutions to increasing psychiatric time (such as tele-psychiatry) have not been fully explored.

appointments is impacted by the lack of availability and provider choice if there is not a fit with the member/provider interaction. • Lack of tenured support staff due to high turnover and unfamiliarity with BH needs and the systems and processes of care.	**Actionability**: It has been determined that select aspects of this root cause are actionable and attainable. **Weight: Important**
Providers (2) *(e.g. provider facilities, provider network)* **Inpatient Providers** **Root Causes:** Members are not consistently receiving important discharge planning information to promote follow up care for the following reasons: • Members may return back to the hospital (inpatient setting) following a recent discharge which may be linked to insufficient supports in place to assist the members with attending follow up appointments. • Members are not consistently linked to the appropriate levels of care (LOC), transportation options, and/or proper medication reconciliation interventions prior to discharge. • Inpatient providers are not proactively planning for the members' discharge through the consistent completion of an outpatient needs assessment at the time of intake/admission (such as requesting complete data sets for the providers). • Inpatient staff (Social Workers) are often addressing the presenting higher acuity needs of the member upon admission, rather than additionally focusing on their discharge needs.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Inadequate discharge planning (including lack of education provided to patients by the provider to stress the importance of follow up outpatient care to aid in recovery) and overall lack of emphasis on discharge planning. • Unclear discharge instructions. Recent reviews of a random sample of treatment records at the four pilot facilities that were selected for the "Successful Transitions from Inpatient to Ambulatory Care" PIP (Performance Improvement Project) supports the twelve county service area for Beacon members. The 2016 results identified slower than expected progress towards the stated goals, with opportunities for improvement related to documented medication reconciliation. Also, FUH visits scheduled and kept were lower than the stated goals. The goal was 40% for medication reconciliation and follow up visits scheduled within 0-14 days. • Poor communication/lack of knowledge of available services and agencies for patients to be referred for follow up care. Inpatient profiles developed by Beacon are produced annually and shared with contracted network facilities with 50+ discharges in the previous year. In 2016, facilities with 50+ admissions that serve Beacon members were included in these profiles and had rates for 7 and 30 day FUH visits. The Beacon average of 57% identified overall opportunities for improvement. Interviews by the Beacon Medical Director with representatives from the four pilot facilities identified that they have been moving to electronic health records (EHRs) in an effort to standardize the forms and discharge instructions, but the ability to change/update/modify the EHRs is often delayed and costly if not compatible with other changes occurring within the overall hospital system. This can create delays and may result in converting back to supplemental paper processes and forms to meet external expectations. • Inadequate communication between the hospital and the follow up provider for continuity of care. A barrier analysis was conducted in 2016 with Beacon care coordinators, management staff and Value Recovery Coordinators. A six sigma Supplier, Input, Process, Output and Customer (SIPOC) diagram (high level process flow) was completed and this revealed barriers and hand-offs across the systems of care that were determined to be contributory factors to non-adherence to FUH visits. • Based on annual chart abstractions conducted by a team from Beacon, the discharge management planning (DMP) efforts at network participating inpatient facilities do not consistently meet the goals established as part of the PIP project for the four core metrics related to medication reconciliation and FUH appointments.
Root Causes: Communication across inpatient and outpatient follow up providers is not consistent for continuity of care based on various factors,	***Current and expected actionability:*** **Root Cause:** There is a perceived lack of coordinated and well established processes and communication channels across the continuum of care (inpatient to outpatient) to adequately address the continuity of care needs of the members upon admission through

including: • Families may not make the hospital staff aware of any current services/hospital staff are not soliciting for complete information of any current services being provided in order to connect with the follow up outpatient provider. • Initial intake is often completed by hospital administrative/Emergency Department (ED) staff versus social workers, as such there may be a gap in the language utilized with members/family. • Lack of awareness of hospital staff and current culture surrounding behavioral health (BH) services leading to the members/family having a lack of understanding and engagement in follow up. • Lack of coordinated processes/formalized communications between the inpatient and outpatient staff related to the members and their ongoing needs.	discharge, leading to missed opportunities to meet core metrics of the PIP project related to FUH appointments and DMP. **Actionability:** It has been determined that this root cause is impactful and attainable. **Weight: Critical**
Providers (3) *(e.g. provider facilities, provider network)* **Provider Awareness and Engagement (Specific to Fayette County)** **Root Causes:** Providers in Fayette County may not always be aware of new initiatives and the availability of all of the possible resources or services within the county and therefore may not use these resources to meet the 30-day follow up timeframes, as noted below:	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • In order for members to receive and/or be referred for appropriate and timely services, it is important for network providers to be aware of available resources and engage with county-level resources to better understand the options and constraints within the local systems of care. Some providers are unaware of initiatives, resources and/or services within Fayette County, therefore; they do not always utilize these to meet the follow up time frames. This lack of awareness may be due to lack of provider interest, time and resource constraints and/or opportunities for Fayette County to more fully engage the provider community in new innovative ways.

• The Providers state they were unaware that the services were available as part of the follow up and on-going treatment for the member. • The Providers do not always make referrals to the most appropriate service to meet the needs for member. • Providers do not attend quarterly provider meetings held at the Fayette County Behavioral Health Administration (FCBHA) office.	***Current and expected actionability:*** **Root Cause:** Fayette County has identified varying levels of provider awareness and education as an improvement opportunity and providers are therefore unable to receive valuable information regarding updates that may be necessary to promote follow up care. This may also be an underlying factor for other counties that may be explored through the best practice sharing sessions with Beacon and the BH HC contractors. **Actionability:** It has been determined that this root cause is impactful and attainable (limited). **Weight: Important**
Providers (4) *(e.g. provider facilities, provider network)* **Members with Co-Occurring Disorders (Specific to Beaver County)** **Root Causes:** A subset of members being discharged from the hospital are not receiving the recommended follow up care in part as a result of co-morbidities and complex needs, such as the following: • Individuals with Co-Occurring Disorders (COD) had lower follow-up after hospitalization (FUH) 30 day rates. Approximately 70% (392 of the 561) of patients treated at the Heritage Valley Beaver (HVB) inpatient mental health (IPMH) unit were diagnosed with a COD. • IPMH units are accessible 24/7 versus substance abuse admissions being limited to “business hours”. Consumers often elect to present at the Emergency Department in order to get immediate assistance. • Social Worker coverage is Monday- Friday at HVB, limiting primary contact with other providers to those hours. However, discharges occur outside of these hours that are not being communicated to the consumer’s supports.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • The identification of members with unique needs (such as COD) who receive care in Beaver County from the local IPMH unit may help to address the large percentage of these individuals (70 %) with COD in order to more fully understand their care coordination needs and develop interventions tailored to meet these needs. Through the implementation of a warm hand-off with staff in the Heritage Valley Beaver Emergency Department (HVB ED), individuals will have access to additional substance abuse/COD resources based on their individual needs. ***Current and expected actionability:*** **Root Cause:** Members being discharged from a primary inpatient facility serving Beaver County may have the need for immediate/increased hours to access substance abuse treatment levels of care (LOC) and/or evaluate opportunities to address the coverage gaps for social workers and other providers to enhance coordinated care. **Actionability:** Beaver County has determined that this root cause is actionable/attainable. **Weight: Important**
Policies / Procedures (1)	***Causal Role (relationship to other factors and to the overall performance indicator) and***

(e.g., data systems, delivery systems, payment/reimbursement) **Key Stakeholders** **Root Causes:** Key stakeholders and subject matter experts from the 12 county systems of care (inpatient/outpatient/administrative) have varying levels of understanding and engagement about the 30 day HEDIS Follow Up After Hospitalization (FUH) measure and the goals set forth by the Office of Mental Health and Substance Abuse Services/Island Peer Review Organization (OMHSAS/IPRO) for the conduction of the Root Cause Analysis (RCA). This negatively impacts goal achievement and the establishment of system-wide collective approaches and plans of action to address the potential opportunities to improve the rates. The following factors have been identified: • Historical individual County and HealthChoices Behavioral Health (HC BH) contractor level approaches to addressing improvement opportunities may have impacted larger systems of care approaches across the entire service area. • Forums for promoting best practice sharing across providers/facilities have been limited and improvement efforts largely focused on local impacts. • Shared learning opportunities have been more focused locally versus regionally, thereby potentially limiting knowledge transfers of scalable strategies and successful interventions.	***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Individuals involved with the behavioral health care system at various levels and settings (inpatient/outpatient/administrative/oversight) may operate day to day in more siloed systems. • The current needs and demands on the behavioral health care system and the individuals supporting it does not readily lend itself to dedicated time to interact collectively across the continuum of care to problem solve and generate ideas for continuous improvements. • Key stakeholders may benefit from additional opportunities and forums to explore system-wide approaches to problem identification and solution generation. • Data driven solutions to improving the FUH rates will help to ensure that the true root causes are selected as the areas of focus for improvement efforts. • Key stakeholders from the physical health systems of care are also important partnerships that may not currently be fully leveraged to address improvement opportunities for follow up care. • These collective factors may result in missed opportunities for collaboration on shared members accessing care via the physical and behavioral systems of care and result in the lack of follow up after discharge at 30 days. ***Current and expected actionability:*** **Root Causes:** A multi-disciplinary approach focused on improving the FUH rates is important and the BH HC contractors and Beacon will work collaboratively to establish mechanisms to regularly bring together the key stakeholders from across the respective systems of care to focus on this effort. **Actionability:** It has been determined that this root cause is actionable and attainable. **Weight: Important**
Policies / Procedures (2) *(e.g., data systems, delivery systems, payment/reimbursement)* **Data Systems** **Root Causes:** There is a need for additional mechanisms and data in order to identify and track high risk members who may benefit from additional interventions, including: • Assessing the members' clinical presentation through available	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Input from behavioral health managed care organizations (BH-MCOs) and inpatient facilities indicates that there is an opportunity to enhance the formal tracking systems for identifying members who are identified as being at high risk for follow-up. • Utilizing data proactively through the development and/or refinement of existing or new reporting system capabilities is expected to enhance the ability to identify those individuals most in need of more care coordination or education to promote timely follow up care. • Efforts are on-going for Beacon to continue to actively improve the knowledge management and reporting capabilities in order to provide the information

or new data sources to determine those factors which may keep them at high risk for lack of follow-up and work to address their needs for additional supports and services. • High risk indicators have not been clearly and consistently established resulting in a lack of systematic data gathering for utilization trends and patterns in care. • Utilization of data drill down capabilities to identify potential targeted interventions to focus improvement efforts towards actionable activities	needed to make informed data driven decisions to improve FUH rates. The current Beacon Corrective Action Plan (CAP) for enhancing the encounter data reporting continues. Beacon has prioritized the completion of this CAP and has identified additional data analytics staff (both locally and at the corporate level), along with an external resource (including Inovolan, a National Committee for Quality Assurance (NCQA) certified HEDIS software vendor) to be collectively dedicated to this high focus effort. Inovolan is a leading technology company providing cloud-based platforms empowering data driven healthcare via real-time data aggregation and analysis. (HEDIS is the Healthcare Effectiveness Data and Information Set used nationally to standardize and measure the performance of health plans) ***Current and expected actionability:*** **Root Cause**: Capabilities for systematically identifying, gathering, and tracking of data for high risk members have not been fully established nor processes to assure that additional supports/services are put in place for those members who are identified as being at risk for lack of follow up care. **Actionability:** It has been determined that this root cause is actionable and attainable at this time. **Weight: Critical/Important**
Policies / Procedures (3) *(e.g., data systems, delivery systems, payment/reimbursement)* **Delivery Systems** **Root Causes:** There are currently not processes in place to develop and promote member connectedness to outpatient BH providers prior to their first appointment, which can result in the following*:* • Members feel they do not need additional follow-up treatment after inpatient hospitalization. • Members feel better and are out of crisis and lack insight and	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • In 2017 a focus group was conducted with members at which time they indicated that one reason for not following up after discharge was that they did not feel a need to follow up. Similar responses indicated that members did not agree with the follow-up services that were being suggested. • Members may not be stabilized upon discharge from the hospital. • Historical information pertinent to the member's inpatient treatment may not be reaching inpatient treatment staff (psychiatrist) and information regarding the members discharge conceptualization may not be reaching outpatient treatment staff. • Communication between outpatient and inpatient staff does not routinely occur.

understanding of the necessity of follow-up treatment to their recovery. • Members do not have connectedness to outpatient providers and may lack an understanding of their mental health (MH) needs and the services that will best promote their recovery. • There is a "disconnect" between inpatient and outpatient systems of care that inadvertently conveys to the member that treatment is completed following discharge from the inpatient stay. • Members may not be signing Release of Information (ROI) forms for the exchange of information across providers for various reasons (including crisis situation at the time of admission, lack of names/number of contacts, provider not following up on signing the forms after crisis minimized).	***Current and expected actionability:*** **Root Cause:** There is not a formalized coordinated communication process across various settings and levels of care that adequately orients members as to what care and services may be needed and included in their overall plan of recovery. **Actionability:** It has been determined that this root cause is actionable and attainable. **Weight: Important**
Policies / Procedures (4) *(e.g., data systems, delivery systems, payment/reimbursement)* **Single Points of Accountability (SPA) (Specific to Beaver County)** **Root Causes:** Individuals are discharged without sufficient supports in place, such as a SPA, to assist them with adherence for follow up visits in the outpatient setting. The goal of the Beaver County SPA initiative is to develop a recovery oriented, proactive system of care for those receiving services. The Beaver County Single Point of Accountability (SPA) was established to develop consistent standards for Blended/Intensive Case Management and Assertive Community Treatment in order	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • In Beaver County one of the key interventions is related to the establishment of SPAs for residents that receive care in the county. A review of data from 2016 indicated that those members with an assigned SPA had a greater likelihood of keeping their FUH appointments at the 30-day time frame. Based in these data it was determined that it would be important to look further into the root causes contributing to not all members being assigned a SPA to help coordinate their care and encourage timely follow up. The Beaver County RCA team elected to review the SPA enrollment process to identify opportunities for improvement.

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<td>to assure individuals have access to the treatment and natural supports they need to achieve a quality and satisfying life in the community. The SPA's have knowledge of all components of the system of care and assist individuals with connecting to needed services and supports.
• In 2016, out of 658 admissions to IPMH facilities, only 154 (23.4 %) had a Single Point of Accountability (SPA) identified upon discharge.
• IPMH Social Workers are not making referrals for members to encourage timely follow up care.
• It is a voluntary service that consumers have the right to decline.
• In 2016, 451 out of the 658 (68.5%) individuals discharged from inpatient services attended their 30 day FUH appointment. The data also indicates that 85% (131 out of 154) of people with a SPA compared to 63.5% (320 out of 504) of people without a SPA attended their 30 day FUH appointment.</td>
<td>Current and expected actionability:

Root Cause: A SPA appears to favorably contribute to improved rates of follow up care. It will be important to better understand how the enrollment process is successful for those members who have been assigned a SPA and to assess the root causes that may lead to instances for which a SPA is not assigned and the member is not enrolled in the process.

Actionability: It was determined that this root cause was actionable and attainable.

Weight: Important</td>
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<td>Policies / Procedures (5)
(e.g., data systems, delivery systems, payment/reimbursement)

Alternate Services and Programs (Specific to Beaver County)

Root Causes: A collection of varying delivery systems issues (such as the closing of transitional/step down services and diversion programs) are being further explored to determine whether they contribute to the lack of timely follow up care at 30 days, including the following:</td>
<td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):

• The physical and behavioral health care systems are not always aligned to identify and address the complex needs of members. These systems of care can adversely impact members and their follow up care when the communications and hand-offs are suboptimal. Beaver County is interested in examining the need and ability to expand/develop services such as diversion programs, transition/step down services, etc. that may adversely impact timely follow up care.</td>
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- Systems issues.
  - Lack of diversion options.
  - Limited step-down treatment options (i.e. partial).
  - Limited services which meet Healthcare Effectiveness Data and Information Set (HEDIS) criteria as a FUH appointment.
- Services were not financially sustainable (not cost -effective or under-utilized).
- Regulations and reimbursement criteria exceeded providers' ability to maintain the service due to the high cost.

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Current and expected actionability:

Root Cause: Transitional/step-down services and diversion programs have closed or are have not been able to remain sustainable in the county for Beaver members. Through the best practice joint sessions with Beacon and the BH HC contractors it will be assessed whether this root cause is more universal impacting additional counties.

Actionability: It was determined that this root cause is actionable and attainable.

Weight: Important

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Provisions (1)
(e.g., screening tools, medical record forms, transportation)

Lack of Transportation Options

Root Causes: Members are often faced with significant challenges to secure transportation to and from their behavioral health provider visits that directly impact their ability to consistently attend these appointments for 30 day follow up due to:

- Lack of transportation resources before/after the select time of the day for the available appointment.
- Providers and members are not always fully aware and educated/informed on the transportation services available and some of the limitations that may need to be addressed when scheduling these services.
- Transportation times, including early drop off and late pick up, may cause a patient to spend half a day at the providers setting for a 45 minute to an hour appointment.
- Lack of/limited transportation resources in the county.
- Inability for individuals to access

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Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):

- Members do not consistently have easy access to reliable and dependable transportation to/from their follow up appointments due to a variety of factors. Based on a barrier analysis session conducted in March 2017 with the Beacon Provider Advisory Committee (PAC) one of the most common barriers identified was the lack of transportation for members to keep compliant with their recommended follow up visits.
- Transportation providers may not be fully aware or understanding of the demographic they are dealing with (such as consumers with MH (mental health) illness or IDD (intellectual developmental disability), many of whom may appear "normal" from the outside even though they may be in crisis in their mind, though this may not be understood and things may be said when they are late or call and cancel).

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Current and expected actionability:

Root Cause: Members who may lack personal transportation that is reliable and dependable are not able to consistently adhere to their follow up visits due to a lack of alternative transportation options that have the flexibility to meet their individual needs and schedules.

Actionability: It has been determined that select aspects of this root cause may be actionable and attainable (limited).

Weight : Important

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the transportation that the whole family may be eligible for (such as single parents needing to find resources for their children when scheduling follow up appointments). • Members may not have the necessary budgeting skills to assist them in planning for transportation needs. • Consistently determining a member's means of transportation to his/her follow-up appointment may not occur in the discharge process. • Discharge staff may not have information on available transportation alternatives and the means to access them. • Due to reliance on disability benefits, members have limited income and transportation may not be a priority following discharge. • Members are overwhelmed by their symptoms of illness and available information is difficult to understand or not current. • Member feels better, so does not secure transportation to their scheduled appointment. • Member feels frustrated accessing public transportation.	
Provisions (2) *(e.g., screening tools, medical record forms, transportation)* **Lack of Programs Targeted Towards Specific Populations (Specific from Fayette County)** **Root Causes:** There are limited programs that serve transition age youth and limited staff that are trained to work with this specific population**,** which can contribute to the following barriers: • Member refuses or reluctantly accepts a follow up appointment.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • It is important that programs be designed and implemented that can address, to the extent possible, the unique needs of various populations, such as transition age youth. The lack of these targeted programs can lead members to feel misunderstood or uncomfortable with certain providers, which in turn could impact their willingness to follow through with treatment and recovery recommendations and treatments. In addition, there are limited staff that are trained to work with that specific population. • Fayette County has developed 2 new programs specifically aimed for Transition Age Youth: Certified Peer Specialist for Transition Age You-which focuses on learning/utilizing coping skills and self-esteem building with the youth and Youth Psych Rehabilitation-which assists the youth with learning skills, such as problem solving, budgeting, daily living, social appropriateness, and vocational interests.

- Member does not feel comfortable going to the provider that the appointment is scheduled with for follow up. - Member feels that the provider would not "get them" or understand their individual issues. - Member is of transition age, and does not feel they would fit in with the typical adult population at established providers.	
	Current and expected actionability: **Root Cause:** The lack of specialized programs for unique populations may contribute to members not receiving the recommended follow up care. **Actionability:** Fayette County has determined this root cause is not impactful/not attainable due to the services not counting as follow up according to the HEDIS measure technical specifications. **Weight: Not important**
Other (specify)	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***
	Current and expected actionability:

Quality Improvement Plan for CY 2020

Rate Goal for 2020 (State the 2020 rate goal here from your MY2019 FUH Goal Report): 41.41%

The factors above can be thought of as barriers to improvement. For each barrier identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2019 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, and Who of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with HC BH Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.

Beacon MY2018 7-day FUH Rate: 40.60%

Barrier	***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 taking place? How will you know the action is having its intended effect?* *What will you measure and how often?* *Include what measurements will be used, as applicable.*
People: Key Stakeholders **Lack of awareness and understanding of key stakeholders and subject matter experts (SMEs) in the importance of 30 day follow up visits for improved outcomes**	Establish a common set of goals and understanding of the current FUH rates, the elements of the measure and the RCA objectives.	October 2017: Kick- off Educational Sessions (One Time)	This action item was informally monitored and measured by ensuring the completion of the orientation materials to introduce the key stakeholders and county liaisons to the current levels of performance for the 30 day FUH rates. This information was completed and made available to each contractor for use, as applicable, in their respective stakeholder sessions. Upon invitation, the Beacon-PA Quality Management (QM) Director participated in/led several of the initial kick off sessions to provide the overview.

Lack of best practice sharing opportunities and joint forums to explore system wide approaches to problem identification and solution generation	Begin to engage the county level key stakeholders in a collective approach across the systems of care for improving the FUH rates for all counties, as follows: 1.) Beacon-PA Quality Management (QM) Director developed an introductory set of presentation materials to be used, as needed by each HC BH contractor, to provide an overview for the participants in the RCA session. 2.) Held "kick-off' sessions with the key stakeholders and subject matter experts (SMEs)	Individual BH HC contractor specific RCA Team meetings (On-going into 2018/2019 as needed/determined by each individual contractor) Face to Face Educational Sessions (One Time in Fourth Quarter 2017). Development of fish bone diagrams and survey summary (One Time in Fourth Quarter of 2017) Conduction of an on-line survey to gather feedback on areas of priority (One Time in Fourth Quarter	These actions were monitored informally through participation and attendance at the sessions of the key stakeholders and subject matter experts. County level monitoring will also occur informally to ensure that the face to face sessions are coordinated at the BH HC contractor level with key stakeholders/SMEs to review introductory materials, introduce the concepts of a root cause analysis and conduct the first facilitated session of the RCA. The on-line survey (in select counties) assessed the RCA "kick-off" sessions and gathered feedback on the recommended priority areas of interest/future focus, the main root causes and input on future meetings and on-going dialogue. On-line survey results were compiled and fishbone diagrams were developed, as determined by each county, to identify the local barriers. This action was monitored and measured at the county level by completion of these tasks. These action steps, as outlined above, were all completed in 2017 and tailored by each BH HC contractor to meet the individual needs/preferences of their respective counties and their participants and the desired approaches of the county leads. This monitoring will continue monthly in 2020 by the BH HC contractors as

	at the BH HC contractor level to initiate a dialogue about the problem and begin to develop potential root causes. 3.) Beacon-PA QM Director completed a fishbone diagram template as part of the overview materials for review by the participants for prioritization. This was intended as a guide to note the four P's selected by IPRO/OMHSAS for the areas of focus. 4.) Conducted an on-line survey of participants (in select counties	of 2017) On-going meetings in 2018/2019 (with the frequency as determined by each BH HC contractor based on local needs and availability of workgroup participants) First and Second Quarters (2018) April/July/October (2019) August 2018	to levels of participation to achieve the goals of the individual RCA Teams. Each of the BH HC contractors established forums for their respective systems of care to bring together key stakeholders and SMEs to work collectively on improving FUH rates at the local level (2018). Throughout 2018ongoing dialogue took place regularly through face to face sessions, meetings/teleconferences, and/or on site visits, etc. to maintain communication and continue the open exchanges of ideas and information. The BH HC contractors will take the lead in 2019 to monitor/measure and assess the levels of participation and engagement in the work groups and adjust these actions as needed. This action was measured by the completion of these quarterly meetings, along with monitoring by Beacon-PA of participant attendance and engagement in information sharing. Also, updates to the individual BH HC RCA summaries will be shared for all participants as a joint learning collaborative. This action was monitored semi-annually in 2018 via the submissions to Beacon-PA of updated FUH Action Plans from each of the BH HC contractors. These FUH Action Plan updates were individually presented by each County representative to the group and dialogue took place as to suggestions and feedback, as well as input into next steps, measurement/monitoring opportunities, etc. Counties also gathered ideas from each other as to interventions occurring in one setting that may be applicable to their respective county which could be further explored with their respective RCA team. Beacon-PA/Beacon Health Options planned to sponsor the Third Annual "Best Practice Forum' in the Fall of 2018 to bring together inpatient providers to exchange best practices and share successes/barriers to improving the FUH rates. Following additional discussion and planning it was determined that the better approach would be to hold a smaller scale meeting with key representatives from each of the four pilot facilities as part of the PIP core measure to improve discharge planning. This action item is monitored via stakeholder attendance at the QMCs and informally through their active meeting participation, as well as ensuring the inclusion of these topics on each of the QMC quarterly agendas. QMC attendance is monitored and assessed annually for QMC participation of the voting members and those who do not attend the minimum number of meetings receive outreach via Beacon-PA and/or the BH HC contractors, as needed.

	) for feedback and insights into next steps for planning future sessions and root cause selection. 5.) Develop additional forums for collective information sharing related to improving FUH rates. BH HC contractors used the information from the initial sessions to determine local follow up action steps based on face to face feedback and/or survey findings. On a semi-annual basis during 2018 Beacon-PA gathered together the key	Quarterly (2018/2019) January 2020	Performance data on the identified interventions will be discussed, as well as opportunities for systemic service improvements: [Objects removed]

	representatives from all the HC BH contractors to monitor progress on the established FUH goals and exchange feedback on individual and collective RCA efforts. Beacon-PA convened quarterly RCA meetings with BH HC contractors to review performance data and share best practices and potential common interventions. Beacon-PA hosted a joint half day face to face session at the Seven Fields offices with key liaisons from the four inpatient facilities involved in the PIP project for improving discharge management planning. On a quarterly basis the four (4) Quality Management Committees (QMCs) are held with the BH HC		

	contractors. These meetings are chaired by the Beacon-PA QM Director and include network providers, consumers, and county liaisons. In order to more fully engage and educate these individuals, a standing QMC agenda item was added for regular updates on the PIP and HEDIS measures, of which the FUH measures are included. These QMCs also review and approve the annual QM/UM Program Evaluation, which provides a significant level of detail related to the FUH measures and the progress of the RCAs. These updates provide for the on-going information exchange to maintain levels of engagement of county participants. Beacon will convene monthly BH HC/BH-MCO FUH RCA meetings to review identified interventions and performance data.		

People: Members/Clients/Patients **Members with complex needs do not have a full understanding of the importance of follow up appointments with behavioral health care providers and therefore do not consistently make or keep follow up visits at 30 days** **People: Members**	Integrated Care Planning (ICP) collaborations between Beacon-PA and the PH MCOs have been initiated and will be utilized as new vehicles of communication to promote FUH visits for those higher risk members with complex needs. An inpatient-outpatient workgroup (as part of a South West 6 (SW6) pilot in Indiana County) was formed and began steps to develop a formalized process of orientation/education of members as to	2017-2018/On-Going January-December 2018/On-Going First Quarter 2018-On-Going	Overview of ICP Interventions: Value Recovery Coordination (VRC) Program: Beacon employed clinicians serve as VRCs to assist members 18+ years who are either high utilizers or complex cases by adopting a care management approach via regular contact with the member to encourage adherence with treatment recommendations. A collaborative process is used that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet the individuals needs via aftercare plans and linkages with community resources. Interventions are face to face or telephonic**.** These services are offered for individuals with an SMI that meet criteria or those with an ICP. These actions are monitored and measured quarterly by the Beacon-PA ICP Work Group led by the Vice President of Clinical Services, as well as being part of the ICP/PIP quarterly submissions to OMHSAS. Aftercare Coordination Program (ACP): Beacon employed clinicians serve as ACP coordinators to assist members discharged from an inpatient acute, residential and partial hospitalization facility with a MH or SUD diagnosis by providing telephonic follow up support by connecting the member to BH providers and other community resources. These actions are monitored and measured quarterly by the Beacon-PA ICP Work Group led by the Vice President of Clinical Services , as well as being part of the quarterly ICP/PIP submissions to OMHSAS. BH PH Integrated Clinical Rounds: On a monthly basis integrated clinical rounds are conducted with representatives of the Beacon clinical team along with PH plan liaisons. The goal is to have the opportunity to discuss stratified ICP members that cross over the BH and PH Plans to share information, discuss the care plans, and coordinate interventions**.** Recommendations for additional services and outreach are supplied and the person responsible for the follow up is identified in these rounds as well. Further, stratification data is collaboratively reviewed and BH/PH MCO's agree on which Members will be approached for development of an ICP. These actions are monitored at least semi-annually by the Beacon-PA Clinical team. This action will be measured by tracking the follow up percentage rate for identified pilot hospitals compared to other SW6 hospitals and previous years after implementation. The workgroup representing the SW6 pilot met multiple times during the Second and Third Quarters of 2018 and explored the use of Wellness Recovery Action Plan (WRAP) plans with members in inpatient/outpatient services to provide recovery orientation. The funding explored for this planned training interventions was found not to be feasible. A new project is currently being developed and will be further defined during the Second Quarter 2019. Fayette County began data collection for members choosing follow up care with his/her PCP during 2018 with the following results from this tracking:

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<tr>
<td>(Fayette County)

Members may choose to follow up with his/her primary care physician (PCP) for several reasons such as: they may not feel a need to see a psychiatrist/therapist, this may be their first experience with the behavioral health care system, the member feels their needs can be met by their PCP, and they are more comfortable and may have an existing rapport. Improvements in the FUH rates may not be impacted as PCP visits are not tracked for the HEDIS measure.</td>
<td>what may be included in their overall plan of recovery, including the process of orientation/education of members.

The Fayette RCA Team partnered with the Gateway Health Plan embedded staff (registered nurse) at the County office to coordinate follow up care for members. (Note: The data collected is limited to Gateway Health Plan members at this time).</td>
<td></td>
<td>
<table>
<tr><td colspan="4">Fayette County
2018 PCP Follow Up</td></tr>
<tr><td>2018</td><td>Discharges</td><td>PCP Follow Up</td><td>PCP Follow Up Rate</td></tr>
<tr><td>Q1 (Jan, Feb, Mar)</td><td>19</td><td>6</td><td>32%</td></tr>
<tr><td>Q2 (Apr, May, Jun)</td><td>27</td><td>18</td><td>67%</td></tr>
<tr><td>Q3 (Jul, Aug, Sep)</td><td>11</td><td>3</td><td>27%</td></tr>
<tr><td>Q4 (Oct, Nov, Dec)</td><td>9</td><td>4</td><td>44%</td></tr>
<tr><td>2018 Total</td><td>66</td><td>31</td><td>47%</td></tr>
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<table>
<tr><td colspan="4">Fayette County
2019 PCP Follow Up</td></tr>
<tr><td>2019</td><td>Discharges</td><td>PCP Follow Up</td><td>PCP Follow Up Rate</td></tr>
<tr><td>Q1 (Jan, Feb, Mar)</td><td>17</td><td>6</td><td>35%</td></tr>
<tr><td>Q2 (Apr, May, Jun)</td><td>12</td><td>0</td><td>0%</td></tr>
<tr><td>Q3 (Jul, Aug, Sep)</td><td>17</td><td>4</td><td>23.5%</td></tr>
<tr><td>Q4 (Oct, Nov, Dec)</td><td>16</td><td>3</td><td>19%</td></tr>
<tr><td>2019 Total</td><td>62</td><td>13</td><td>20%</td></tr>
</table>

<u>2019 Totals</u>

62 Discharges
13 Followed-up with their PCP; 9 Followed-up with other provider

For 2019, the percentage of Members choosing to follow-up with PCP/other provider was <u>35%.</u>

It was determined that this intervention had limited impact and improvements were not readily attainable due to the lack of inclusion of PCP follow up visits in the HEDIS technical specific. The FUH rates would not be improved by increases in follow up visited with the members' PCP for follow care within 30 days.

The Fayette County RCA team will continue to explore options for obtaining information from other health plans and use the Gateway finding for future actions to involve the BH providers.
</td>
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<tr>
<td>Providers
Outpatient Providers

Members do not consistently have access to outpatient providers following an inpatient stay due to limited choices in providers who are</td>
<td>Individual County level RCA workgroups began meeting to address the need to better understand alternative solutions to</td>
<td>January 2018-Summer 2018/On-Going 2019</td>
<td>This action will be measured informally by the BH HC contractors based on county-level RCA team participation and levels of engagement in the RCA process.</td>
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<td>available to provide appointments to meet the 30-day standard</td>
<td>increasing psychiatric time that may not have been explored sufficiently in the past.

Each BH HC contractor, as part of the RCA compliance plan, established multi-disciplinary work teams at the local level to develop interventions and measurements and metrics for on-going monitoring.

Through a newly established tele-psychiatry workgroup, providers have begun submitting proposals for the use of tele-psychiatry in their agencies and have been approved and are actively operating in network. This workgroup oversees the review and approval of the proposed tele-psychiatry solution to ensure it meets internal and external requirements.

Explore options to establish</td>
<td>January – December 2018/On-Going

January-December 2018/On-Going

First Quarter 2018/On-Going</td>
<td>This action will be measured informally by the BH HC contractors based on county-level RCA team participation and levels of engagement in the RCA process.

Analysis of follow-up rates for 30 day visits will be more fully explored once these programs are fully operational and data can be monitored. The establishment of checks and balances on the proposed tele-psychiatry programs heightens the awareness of all parties of the need for structured and standardized protocols for oversight and monitoring.

Multiple providers that have developed tele-psychiatry programs have been added to the Beacon-PA network. They will be measured and monitored in accordance with the detailed descriptions they submitted to the Tele-Psychiatry Committee as part of their respective reviews and approvals.

Measure Indicator (Annual):

Follow-up percentage of members receiving outpatient services at agencies where tele-psychiatry or alternatives are implemented.

Chestnut Ridge Counseling Services (Fayette County’s Largest Outpatient Provider) has started an Open Access program and has partnered with Highlands Hospital to track new referrals and aftercare attendance. New referrals will be tracked monthly/quarterly and summarized annually:

<table>
<tr><td colspan="4">Fayette County
2018 Open Access Program</td></tr>
<tr><td>2018</td><td>New Referrals</td><td>Attended OA</td><td>Attendance Rate</td></tr>
<tr><td>Jan</td><td>8</td><td>6</td><td>75%</td></tr>
<tr><td>Feb</td><td>5</td><td>4</td><td>80%</td></tr>
<tr><td>Mar</td><td>8</td><td>7</td><td>88%</td></tr>
<tr><td>Q1 Total</td><td>21</td><td>17</td><td>81%</td></tr>
<tr><td>Apr</td><td>4</td><td>4</td><td>100%</td></tr>
<tr><td>May</td><td>3</td><td>3</td><td>100%</td></tr>
<tr><td>Jun</td><td>5</td><td>5</td><td>100%</td></tr>
<tr><td>Q2 Total</td><td>12</td><td>12</td><td>100%</td></tr>
<tr><td>Jul</td><td>4</td><td>4</td><td>100%</td></tr>
<tr><td>Aug</td><td>7</td><td>7</td><td>100%</td></tr>
<tr><td>Sep</td><td>5</td><td>5</td><td>100%</td></tr>
<tr><td>Q3 Total</td><td>16</td><td>16</td><td>100%</td></tr>
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discharge clinics or open access scheduling with interested inpatient/outpatient providers for innovative scheduling options to free up appointment slots within 30 days of discharge.

Fayette County's largest outpatient provider has recently announced open access hours to provide faster access to care, allow for flexible arrival times and provide same assessments.

Care Management Supervisor contacted Chestnut Ridge to determine if a tracking method is in place than can be shared related to hospital discharge referrals to the open access hours that attended versus those who did not show up.

Care managers (in Fayette County) to interact with members during follow up calls to ascertain whether their follow up

Quarterly (2018)/On-Going

Oct	5	5	100%
Nov	3	3	100%
Dec	9	9	100%
Q4 Total	**17**	**17**	**100%**
2018 Total	***66***	***62***	***94%***

Fayette County 2019 Open Access Program			
2019	New Referrals	Attended OA	Attendance Rate
Jan	6	6	100%
Feb	1	1	100%
Mar	NA	NA	NA
Q1 Total	**7**	**7**	**100%**
Apr	2	2	100%
May	7	7	100%
Jun	4	4	100%
Q2 Total	**13**	**13**	**100%**
Jul	7	7	100%
Aug	10	10	100%
Sep	5	5	100%
Q3 Total	**22**	**22**	**100%**
Oct	3	3	100%
Nov	5	5	100%
Dec	1	1	100%
Q4 Total	**9**	**9**	**100%**
2019 Total	***54***	***54***	***100%***

The data collected shows an increase in the number of referrals at discharge as well as number of consumers attending Open Access appointments.

In 2018, the data collected was from four hospitals in the region (Uniontown, Highlands, Mon Valley & Southwest Regional). Fayette tracked the number of individuals with scheduled follow-up appointments and those that actually attended the appointment.

The following data refers to all four hospitals mentioned above:

Fayette County (All 4 Hospitals) 2018 Drug and Alcohol Assessment			
2018	*New Referrals*	*Attended Assessment*	*Attendance Rate*
Q1 (Jan, Feb, Mar)	***14***	***10***	***71%***

appointments were with a PCP and if this was their choice. Provide education, as needed, on the importance of follow up with a BH provider and offer to assist with scheduling an appointment the member is interested.

Q2 (Apr, May, Jun)	***20***	***9***	***45%***
Q3 (Jul, Aug, Sep)	***17***	***10***	***59%***
Q4 (Oct, Nov, Dec)	***16***	***11***	***69%***
2018 Total	***67***	***40***	***60%***

Fayette County (2 Hospitals)
2019 Drug and Alcohol Assessment

2019	*New Referrals*	*Attended Assessment*	*Attendance Rate*
Q1 (Jan, Feb, Mar)	***15***	***10***	***66%***
Q2 (Apr, May, Jun)	***13***	***6***	***46%***
Q3 (Jul, Aug, Sep)	***14***	***6***	***42.9%***
Q4 (Oct, Nov, Dec)	**8**	**3**	**37.5%**
2019 Total	**50**	**25**	***50%***

(Fayette County): Some providers are unaware of initiatives, resources and services within Fayette County, therefore; they do not always utilize these to meet follow up time frames.

First Quarter 2018 and On-Going

LEVEL OF CARE (LOC) ASSESSMENTS completed at the hospital are being tracked quarterly as outlined below.
(At this time Fayette is only tracking Highlands and Uniontown Hospitals)

[Objects removed]

2019 Total: The percentage of members following up with services was 82%.

25 People were seen for Assessment
16 People were referred for OP Services
13 People followed thru with OP Services
12 People went to Rehab

FAYETTE COUNTY DRUG & ALCOHOL AGENCY: Fayette RCA team has partnered with Fayette County Drug & Alcohol to obtain information on new referrals and aftercare attendance.

Second Quarter 2018/On-Going

Using feedback from the data collected through the returned surveys, The Fayette County RCA team will follow up with providers regarding educational needs on an “as needed” basis. Providers are able to receive valuable information regarding updates and are encouraged to provide feedback on the effectiveness and value of the meetings.

(Beaver County): Due to capacity and limited psychiatric availability, outpatient mental health (OPMH) providers are not able to accommodate scheduling appointments to meet HEDIS measures.	In addition, Fayette County is also tracking on a quarterly basis the Level of Care (LOC) assessments completed at Highland and Uniontown Hospitals for Fayette County members. Staff from Fayette County	Second Quarter 2018/On-Going Monthly 2018/On-Going Quarterly 2018/On-Going Monthly Second Quarter 2018/On-Going	PHN maintains statistics of appointment attendance rates specific to this clinic. PHN will track the number of individuals who attend their FUH appointments in comparison to the number of appointments scheduled. This data is reviewed internally by Beaver County staff on a monthly basis. Between 6/1/18 and 12/31/18, a total of 134 FUH appointments were scheduled. Of those, 84 were attended for a follow up of 62%. Statistics will be provided to Beaver County Behavioral Health (BCBH) to ensure this action step is occurring. PHN has had changes in staffing due to resignations and retirements. This has left them with no psychiatrist at 2 of their sites (Beaver Falls and Center Township). This has complicated already identified barriers of access to treatment of lack of psychiatric time and transportation. HVB and BCBH will track the number of warm hand-offs and the number of IPMH diversions resulting from this program. Data will be reviewed on a minimum of a quarterly basis. The number of consumers with substance abuse claims with the exception of acute IPMH admissions will decrease. AHCI provides this data to BCBH on a monthly basis for review. This program is still in its infancy. Data collection and measures will be on-going to determine effectiveness/impact on the system of care. This program has expanded its catchment area to assessing individuals on medical units and on IPMH, in addition to now offering the service at Heritage Valley Sewickley. Data is still being gathered to identify trends and impact on other service areas.

	HealthChoices, Value Behavioral Health/Beacon Health Options and providers attend these joint meetings and provide feedback on the effectiveness and value of the meetings. These meetings are held at the Fayette County office to provide education in the services available in Fayette County and are regularly attended by Fayette County HealthChoices, FCBHA staff, Value Behavioral Health/Beacon Health. Fayette County will consider developing a survey for providers who participate in quarterly provider meetings to assess the relevance/impact of information provided Using feedback from the data collected through the returned surveys, the Fayette County RCA team will follow up with providers regarding educational needs on an as needed basis.	(Under Assessment) 2019 (One-time Purchase) First Quarter 2019	In 2019, Heritage Valley Health Systems (HVHS) was awarded the Pathways Grant. As part of the grant, the medical and clinical staff at HVHS will be educated on Addictions 101, De-escalation Techniques, Motivational Interviewing, and Screening, Brief Intervention, and Referral to Treatment (SBIRT). The goal is to increase the HVHS staff's knowledge of substance use disorders, how to effectively intervene and assist individuals in connecting to available community resources. Discussion will be considered for possible monitoring and measurement in 2019.

	Primary Health Network (PHN) started a discharge clinic for individuals who were being discharged from HVB IPMH unit and Brighton Rehabilitation and Wellness Center (BRWC) LTSR to meet the follow up goal. Discharge clinic psychiatrist is the same treating psychiatrist at all 3 facilities, thereby strengthening continuity of care. PHN had agreed to work with SPA providers for consumers who were already patients at PHN to schedule appointments within 24 hours for individuals showing signs of decompensation or who needed medication refills. The goal was to help divert inpatient hospitalizations. In May 2018, PHN and SPA providers implemented this process. Other outpatient providers, such as Glade Run Lutheran Services and Staunton Clinic, are also looking to developing		

	and implement this process. HVB hired a third social worker. To date there has been no measured improvement in discharge planning. Heritage Valley Health System bought Ohio Valley Hospital, which will not change operation of HVB IPMH unit. On January 10 2019, Resources for Human Development opened a 16 bed facility for detoxification and short term rehabilitation treatment. Through collaborative efforts of Beaver County's SCA and HVB, a designated staff member will be available in the ED for individuals who present with substance abuse issues.		
Providers: Inpatient **Based on annual chart abstractions conducted by a team from Beacon-PA and the counties,**	On an annual basis the Beacon-PA QM team coordinates the conduction of the DMP audits for the four	January 2018-December 2018 /On-Going Annually	The following measures will be monitored for the DMP elements of the FUH goal as follows: • Measure Indicator: Discharge Management Planning (DMP) measure (Numerators 4 and 5: Follow-up visit scheduled within 30 days of discharge). • Monitoring will be based on the results of the annual DMP audits as part of the PIP project

discharge management planning (DMP) efforts at network participating inpatient facilities do not consistently meet the established goals	participating facilities. This includes face to face feedback during the on-site visits as well as formal written follow up communications to each facility with their individual result as well as blinded scores for the other facilities for comparative purposes.	First Quarter 2018	• Baseline: DMP results for MY 2015 • Re-measurements to be conducted for Years # 2 and #3 and #4: DMP results for MY 2016 and MY 2017and MY 2018 • Begin to coordinate the Q2 2018 DMP reviews and include the county level liaisons who were trained for insights and engagement • Coordinate follow up with four pilot facilities for DMP feedback An inter-rated reliability (IRR) scoring was built into the training activities to ensure consistency across the abstractors. A score of >= 90% was required before they were allowed to abstract the charts for compliance with the DMP plans. All (100% -7/7) of the trainees scored at or above the IRR cut off and were active participants in the treatment record reviews. The following is a summary of the DMP results for Beacon-PA: [Objects removed] The following is a summary of the over-reads of the ten participating facilities for the DMP adherence: [Objects removed]
	Training was conducted by the Beacon-PA QM team of county liaisons for participation in the chart abstractions to increase awareness and foster on-going partnerships.	Fourth Quarter 2018	This action was measured and monitored informally via on-going dialogue and discussion with key hospital stakeholders. It will also be measured annually via the Inpatient Provider Profiles and individual facility FUH rates.
	Beacon-PA QM team conducted a voluntary self-audit with network contracted inpatient facilities. They were invited via a letter to review five records and complete the audit tool and submit the records to	Fourth Quarter 2018	

	Beacon-PA for an over-read. Ten (10) facilities participated. Letters were forwarded to these facilities with their individual scores and blinded comparative reports. In order to address the identified need for more formalized communications, a Communication Guide was developed and implemented on January 14, 2019 between the Community Guidance Center (Dr. Ralph May) and Base Service Unit (Michelle Barnhart) and Inpatient Indiana Regional Medical Center. Admissions trigger the hospital to contact the BSU who, in turn, provide via fax current information re: the member to the hospital. The Guide also requires the hospital to notify outpatient services/BSU 24 hours in advance of discharge.	2018 (January-December) 2018 and On-Going Monthly	Beaver County has contracted to collect data regarding SPA standards of tracking days from the time of the referral to the case being opened. SPA referral and tracking data is provided and discussed at monthly SPA meetings. Data continues to be reviewed monthly. BCBH initiated discussions with Beacon regarding the need to develop methods to set goals and reimbursement relating to this performance issue. In 2018, Value Based Purchasing was implemented. Heritage Valley Beaver IPMH Unit did not meet the target metrics for Quarter 1 or Quarter 2. Data will continue to be monitored quarterly. In an effort to improve communication between the inpatient unit and community providers, Heritage Valley Beaver IPMH Social Worker started to regularly attend the monthly Beaver County Single Point of

	(Fayette County) Local hospital was educated numerous times by Care Management Supervisor and Fayette Provider Field Coordinator on importance not only of meeting time frames, but also for making convenient appointments for members. Education was also provided about assessing member's readiness for discharge. The Performance Improvement Plan was discussed as well as possible ways to improve members 7 day and 30 day follow up. Hospital was educated on making sure discharge instructions are reviewed with member and that the member understands all the information, especially when, where and with whom their appointment is. Also, appointments should not be made without member involvement to make sure the appointment is convenient to help improve	Fourth Quarter 2017/On-Going	Accountability Meetings.

	adherence. (Beaver County): Individuals are discharged with insufficient supports in place, such as a SPA, to assist the individual in attending follow up appointments. The goal is to Increase SPA enrollment along with the efficiency of the process. Beaver County has contracted to collect data regarding SPA standards of tracking days from the time of the referral to the case being opened. SPA referral and tracking data is provided and discussed at monthly SPA meetings. (Beaver County) Inadequate communication and documentation surrounding discharge planning by the IPMH provider.		

	Beacon-PA will work with BCBH to set standards for IPMH discharge planning for Value Base Purchasing or Pay per performance measures.		
Provisions: Transportation **(SW6/NW3) Members may have limited access to reliable, affordable and easy to access transportation options (such as public transportation, personal vehicles, community supports, etc.) to assist them in ensuring they can consistently access their providers in a timely manner to meet the scheduled follow up appointments** **Members (SW6) may have never received training/education on budgeting which could adversely limit their transportation choices.**	Budgeting brochure has been developed and distributed electronically to SW6 counties. Additional hard copies will be printed by commercial printer and distributed to counties. A survey link has been created to receive feedback which will be collected and analyzed. Transportation information has been received from SW6 counties and collated. Collated information has been sent to printer for pricing and design and printing. Transportation brochures, which include a link to provide feedback	January 2018-Summer 2018: August 2018 Revised target to December2018 (Final draft completed in 1/19 and distributed) January 2018-February 2018 Revised to May 2018 March 2018-May 2018 Revised to July 2018 2018 and On-Going	Members may benefit (in select counties) from training related to feedback on effective budgeting in making decision regarding transportation options. Rural county members may have added transportation constraints without access to public services. When public transportation is available, the times/locations for pick up/drop off are not always convenient and scheduling presents concerns with lack of flexibility to accommodate individual needs Efforts will be explored (in select counties) to partner with the local county specific transportation providers for exploring new solutions/options. Measure Indicator: Survey members completing training for feedback on effectiveness of budgeting in making decisions regarding transportation. Explore options (in select counties) to assess current transportation materials for members to determine usability/ease of understanding, potentially develop new materials that are ADA sensitive, and encourage use by inpatient facilities at the time of discharge planning to ensure this is adequately address before the individual leaves the inpatient setting. Measure Indicator: A 6 month period following implementation will be compared to the follow-up rates of the previous year. Sample will be discharges where documentation exists that the informational sheet was reviewed and given to the member as part of the discharge process.

	to SBHM, Inc. are currently being designed and printed for the NW3 counties. There is not easily accessible, comprehensive and understandable information to review with the member on available transportation. A county-specific 'cheat sheet' on available transportation for members to follow-up visits will be developed and distributed to hospitals who will include its review with the member as part of the discharge process. Information on transportation will be gathered by the respective county offices. Draft of information SBHM consultant and reviewed by ADA will be written by experts for readability. Information will be printed on a one-page laminated sheet. Informational sheets will be distributed to inpatient, outpatient and case management	January 2018-February 2018 March 2018-June 2018 Revised: December 2018 July 2018-August 2018 Revised: December 2018 September 2018 Revised: December 2018 Revised: April 2019 First Quarter 2019	Tracking of this new process will be ongoing over 2019 and data (need more detail as to how it will be tracked and the data to be collected in 2019) will be collected and analyzed. The providers are tracking the members involved in the process so that data may be analyzed. Meeting on 2/26/19 revealed some bugs in process that will be reconciled by outpatient provider. Four cases have gone through the process, with successful transition for two of them. Process will be reviewed in 2 months.

	units.		
Policies and Procedures: Data Systems **Data can help to identify high risk individuals with complex needs to assist in promoting outreach and education to enhance compliance and their understanding of the value of follow up care.**	Beacon-PA will continue to collaborate with internal and external partners (including the HC BH contractors, data analytics staff and software vendors) to address potential capabilities for enhanced data collection and reporting. Conducted meetings and discussions with key stakeholders (internal and external) to address encounter data reporting improvement opportunities and define reporting requirements for member identification. Beacon-PA participated in a Data Validation Review conducted by Mercer Consulting to assess the data reporting capabilities. Contract executed between Beacon-PA / Beacon Health Options with Inovolan as	January-December 2018 January-December 2018/On-Going meetings and discussions to address encounter data reporting and define reporting requirements for member identification First Quarter 2019 Fourth Quarter 2018/Contract renewal (as needed based on contract terms) Fourth Quarter 2018/On-Going (As Needed)	This action step was measured and monitored informally via the attendance of participants in the meetings and their engagement via idea generation and solution generation. The correction of the encounter data issues were coordinated through a separate workgroup made up of Beacon-PA /Beacon leaders and staff for which a separate and detailed work plan was developed. The action was monitored regularly by the work group and through periodic joint calls with external regulatory parties and the BH HC contractors. A formal report will be issued Mercer Consulting/OMHSAS and utilized by Beacon-PA to monitor progress toward this objective. This action item was monitored via the signing and execution of the full joint agreement with this new external vendor via the Beacon Health Options procurement team. The Beacon-PA team has partnered with the Beacon Talent Acquisition team to successfully post and recruit for the individuals needed to fully resource the local KMR team, along with assuring full new employee on-boarding once they are hired to expedite their successful transition into their new roles and responsibilities. This will be monitored by the successful filling of all open positions with individuals qualified to perform their duties and through the existing Beacon New Employee checklist. This action item will be monitored by the completion of data reporting tasks and report generation, as assigned to the respective KMR staff individual, by the assigned due dates and measured for accuracy as determined by the functional area owners and end users. This action was implemented as a first step with the full implementation of the Integrated Care Plan (ICP) initiative to identify high risk individuals

	a as a NCQA certified software vendor to support reporting requirements for overall HEDIS/HEDIS-like rates and drill down data analysis. Recruitment efforts were initiated to ensure adequate resources in the local Knowledge Management and Reporting (KMR) team to support the increasing data demands. The resources of the Beacon National KMR teams were leveraged, as needed, to support the local KMR team and develop data repositories for future reference. Identification of high risk indicators through the study of previous data sets. Develop a system of tracking mechanisms for high risk members admitted to	Third/Fourth Quarter 2018/On-Going Third /Fourth Quarters 2018/On-Going 2019 Partially completed 2018/Planned for Third/Fourth Quarters 2019 Partially completed 2018/Planned for Third/Fourth Quarters 2019 Full implementation anticipated by Third Quarter 2020	and stratify them according to mutually agreed upon protocols with the physical health managed care organization (PH MCOs). This action will be monitored by participation in the quarterly ICP calls with external regulatory entities and BH HC contractors. This will be monitored via participation of the Region 2 Quality Leads in oversight meetings with the vendor to receive regular updates on this new partnership. This will be monitored via participation of the Region 2 Quality Management Director and Beacon corporate level Quality Leads in oversight meetings with the vendor to receive regular updates on this new partnership. This will also be monitored via other members of the local Beacon-PA Leadership Team as part of the Operations meetings.

	inpatient facilities. Testing kicked off in separate Beacon market with Inovolan for initial partnership. Beacon-PA, as part of Region 2 of Beacon Health Options, will proceed with next phase of Inovolan roll out and implementation. Beacon-PA data that has been migrated to Inovalon is currently being reviewed and tested for quality assurance.		

Table 5.3: BHO RCA and CAP for the FUH 30- Day Measure (All Ages)

<table>
<tr><th colspan="2">RCA for MY2018 underperformance</th></tr>
<tr><td><u>Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):</u>

Beacon, in conjunction with our 12 county partners, reviewed the influencing and causal factors for the Follow-up After Hospitalization (FUH) 7- and 30-day measures that scored below the goal. The following information was considered to determine the Root Causes:
• Patient level detail for members who failed to attend their aftercare follow-up appointments
• FUH performance across high volume facilities
• Member reports on barriers to non-adherence
• Provider reports and survey information
• Inpatient and outpatient delivery systems
• Inpatient chart abstractions
Beacon utilized several analytic methods, including Action Research, Analytic Induction, Comparative Analysis, Fish Bone Diagrams and a Logic Model of Change. These methods were employed to further define the factors (influencing and causal) that contributed to performance below standards.</td><td><u>Describe here your overall findings. Please explain the underperformance using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:</u>

The causal factors identified as important are outlined below:
1. Systematic data identification, collecting and tracking data regarding high risk members
2. Lack of coordinated and well established processes and communication channels across the continuum of care to adequately address continuity of care needs
3. Lack of consistent communication between Hospital and Outpatient provider staff
4. Co-morbidity and complex needs of many non-compliant members
5. Lack of adequate number of trained psychiatrists / BH providers to address access needs
6. Single Point of Accountability not assigned
7. Lack of transportation resources and member needs around transportation

(See embedded Logic Model of Change diagram)

[Objects removed]</td></tr>
<tr><td>List out below the factors you identified in your RCA. <u>Insert more rows as needed</u> (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).</td><td>Discuss each factor’s role in contributing to underperformance in the performance indicator in question. Assess its “causal weight” as well as your MCO’s current and expected capacity to address it (“actionability”).</td></tr>
<tr><td>People (1)
(e.g., personnel, patients)

Clients/Members/Patients

Root Causes: Members may not have a full understanding of the importance of follow up appointments with a behavioral health provider and the need for ongoing care following an inpatient discharge due to a variety of reasons, including:
• Members may feel better, are out of crisis and lack understanding and insights into the need for an outpatient visit for follow up</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):

• Individuals with dual diagnoses and/or complex needs with chronic medical and
substance use issues often require more coordination across the continuum of care and
they may not feel the need to follow up with a psychiatrist or therapist.
• Individuals often lack family support with treatment (such as parents not bringing
their child to follow up appointments, no family involvement in discharge planning,
parent(s)/caretaker(s) unwillingness to sign releases to coordinate care, family not accepting appropriate levels of care for the child, changing patient /family</td></tr>
</table>

treatment to continue their recovery. • Members may schedule the follow up visit with their Primary Care Physician (PCP) due to established relationships and easier/more timely access and a perceived lack of connectedness with an outpatient BH provider. • Some members may be at higher risk based on their clinical presentations and there is a lack of tracking of these high risks and the need for additional supports and services. • Members may perceive that follow up care is not needed with a psychiatrist or therapist.	dynamics, etc.). • Members may have their first experience with the BH care system and feel their needs can be met by their PCP. • Individuals may be reluctant to seek treatment and continue with follow up care due to mental health stigma. • Individuals are non-adherent with follow up appointments. Based on county specific HEDIS data from MY 2016, 43.95% of members were adherent for the 7 day FUH visits and 67.85% of members were adherent for the 30 day FUH visits; for MY 2017 39.36 % of members were adherent for the 7 day FUH visits and 64.65% were adherent for the 30 day FUH visits; and for MY2018 40.60% of members were adherent for the 7 day FUH visits and 63.98 % of members were adherent for 30 day FUH visits. • Individuals often have misconceptions about the treatment process (such as expectations of the provider as a "miracle worker" and/or a lack of understanding of their diagnosis/illness). • Members may lack an investment in his/her own recovery. • Individuals may perceive a "lack of fit" with the provider due to personalities, incompatibility, and a sense of poor performance/unsatisfactory outcomes of treatment. • Members may have an incomplete and/or unrealistic understanding of the achievable outcomes of their care based on the nature of their individual cases and the available treatment options. • Members often lack available natural supports in the community (such as family, friends, etc.) which does not help to promote their on-going adherence to treatment recommendations and maintenance of follow up for outpatient visits.
	Current and expected actionability: **Root Cause:** Members do not have a full understanding of the importance of follow up appointments with behavioral health care providers and therefore do not consistently make or keep scheduled follow up visits at 30 days. **Actionability**: It has been determined that this root cause is actionable and attainable. **Weight: Critical/Important**
People (2) *(e.g., personnel, patients)* **Clients/Members/Patients (Specific for Fayette County)** **Root Causes:** Members may elect to seek follow up care with their primary care physician rather than a behavioral health clinician for a variety of reasons, including the following: • Member does not feel they need	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Members are generally connected to a Primary Care Physician (PCP) for their physical health care needs. They may not recognize the need for more specialized behavioral health care from a trained behavioral health provider and return to their PCP for treatment following an inpatient admission and/or on-going mental health care. This already established doctor/patient relationship may be more comfortable to the member who maybe navigating the behavioral health care system for the first time or who may find the behavioral health care system less familiar to them. This often results in follow

to follow up with a psychiatrist or therapist. • Member refuses/declines the behavioral health care provider follow up appointment offered by the hospital. • This may be the member's first experience with the behavioral health care system and they feel their needs could be met by their Primary Care Physician. • Member feels more comfortable with their Primary Care Physician and already has a rapport with him/her to receive the recommended on-going follow up care. • Members may choose to follow up with their Primary Care Physician, therefore; follow up after discharge is not tracked.	up visits with the Primary Care Physician after discharge that are not routinely tracked. ***Current and expected actionability:*** **Root Cause:** The Fayette County Root Cause Analysis (RCA) team has partnered with the embedded Gateway Health Plan staff member (Registered Nurse) who is housed at the Fayette County office to coordinate follow-up care for members. (Note: This data collection is limited to Gateway Health Plan members at this time. The Fayette County RCA team will further explore plans for improvement in the future and this pilot may be assessed for scalability across other counties). **Actionability:** Fayette County has determined that this root cause is impactful and actionable (limited) but not immediately attainable. **Weight: Important**
Providers (1) *(e.g. provider facilities, provider network)* **Outpatient Providers** **Root Causes:** The twelve county service area is experiencing a lack of available outpatient appointments within the 30 day timeframes for a variety of reasons, including the following: • There is a lack of psychiatrists and psychiatric time in the region due in part to a lack of psychiatrists entering the field and thereby creating a national/local shortage and career pursuits in a non-public sector setting. • Budgets and incentives are limited to attract new psychiatrists to the region/field in order to increase availability. Despite recruitment attempts in the region, there has been little success to increase psychiatric time. • Scheduling outpatient appointments is impacted by the lack of availability and provider choice if there is not a fit with the member/provider interaction.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Outpatient provider access is often limited to be able to accommodate the members in a timely manner (within 30 days) who are being discharged following an inpatient stay for various reasons (including members lack of initial choice of available providers and/or options to change if members desire a new provider, limited psychiatrist time, extended wait times for psychiatrist appointments, limited provider choices, lack of availability to take on new clients, and rural settings experience greater challenges with provider retention). A fishbone diagram was completed following a RCA session with the Beacon Provider Advisory Committee (PAC) in March 2017 and participating providers noted that provider availability and a lack of psychiatrist time was a key contributing factor to FUH visit non-adherence. • Lack of clear understanding by the provider of the patients' needs. • Inadequate communication between the hospital and the follow up provider/PCP for continuity of care. • Scheduling barriers and reluctance to overbook due to staffing issues. • Members do not consistently have access to outpatient providers following an inpatient stay due to limited choices in behavioral health providers who are available to provide appointments to meet the 30 day standards. ***Current and expected actionability:*** **Root Cause**: The lack of an adequate number of trained psychiatrists/other behavioral health providers and available psychiatric time leads to missed opportunities for timely follow up visits and members often seeking care via their PCP or choosing not to follow up at all. Alternate solutions to increasing psychiatric time (such as tele-psychiatry) have not been fully explored. **Actionability**: It has been determined that select aspects of this root cause are actionable and attainable.

• Lack of tenured support staff due to high turnover and unfamiliarity with BH needs and the systems and processes of care.	**Weight: Important**
Providers (2) *(e.g. provider facilities, provider network)* **Inpatient Providers** **Root Causes:** Members are not consistently receiving important discharge planning information to promote follow up care for the following reasons: • Members may return back to the hospital (inpatient setting) following a recent discharge which may be linked to insufficient supports in place to assist the members with attending follow up appointments. • Members are not consistently linked to the appropriate levels of care (LOC), transportation options, and/or proper medication reconciliation interventions prior to discharge. • Inpatient providers are not proactively planning for the members' discharge through the consistent completion of an outpatient needs assessment at the time of intake/admission (such as requesting complete data sets for the providers). • Inpatient staff (Social Workers) are often addressing the presenting higher acuity needs of the member upon admission, rather than additionally focusing on their discharge needs. **Root Causes:** Communication across inpatient and outpatient follow up providers is not consistent for continuity of care based on various factors, including: • Families may not make the hospital staff aware of any current services/hospital staff are not soliciting for complete information of any current services being provided in order to connect with the follow up outpatient provider. • Initial intake is often completed by	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Inadequate discharge planning (including lack of education provided to patients by the provider to stress the importance of follow up outpatient care to aid in recovery) and overall lack of emphasis on discharge planning. • Unclear discharge instructions. Recent reviews of a random sample of treatment records at the four pilot facilities that were selected for the "Successful Transitions from Inpatient to Ambulatory Care" PIP (Performance Improvement Project) supports the twelve county service area for Beacon members. The 2016 results identified slower than expected progress towards the stated goals, with opportunities for improvement related to documented medication reconciliation. Also, FUH visits scheduled and kept were lower than the stated goals. The goal was 40% for medication reconciliation and follow up visits scheduled within 0-14 days. • Poor communication/lack of knowledge of available services and agencies for patients to be referred for follow up care. Inpatient profiles developed by Beacon are produced annually and shared with contracted network facilities with 50+ discharges in the previous year. In 2016, facilities with 50+ admissions that serve Beacon members were included in these profiles and had rates for 7 and 30 day FUH visits. The Beacon average of 57% identified overall opportunities for improvement. Interviews by the Beacon Medical Director with representatives from the four pilot facilities identified that they have been moving to electronic health records (EHRs) in an effort to standardize the forms and discharge instructions, but the ability to change/update/modify the EHRs is often delayed and costly if not compatible with other changes occurring within the overall hospital system. This can create delays and may result in converting back to supplemental paper processes and forms to meet external expectations. • Inadequate communication between the hospital and the follow up provider for continuity of care. A barrier analysis was conducted in 2016 with Beacon care coordinators, management staff and Value Recovery Coordinators. A six sigma Supplier, Input, Process, Output and Customer (SIPOC) diagram (high level process flow) was completed and this revealed barriers and hand-offs across the systems of care that were determined to be contributory factors to non-adherence to FUH visits. • Based on annual chart abstractions conducted by a team from Beacon, the discharge management planning (DMP) efforts at network participating inpatient facilities do not consistently meet the goals established as part of the PIP project for the four core metrics related to medication reconciliation and FUH appointments. ***Current and expected actionability:*** **Root Cause:** There is a perceived lack of coordinated and well established processes and communication channels across the continuum of care (inpatient to outpatient) to adequately address the continuity of care needs of the members upon admission through discharge, leading to missed opportunities to meet core metrics of the PIP project related to FUH appointments and DMP. **Actionability:** It has been determined that this root cause is impactful and attainable.

hospital administrative/Emergency Department (ED) staff versus social workers, as such there may be a gap in the language utilized with members/family. • Lack of awareness of hospital staff and current culture surrounding behavioral health (BH) services leading to the members/family having a lack of understanding and engagement in follow up. • Lack of coordinated processes/formalized communications between the inpatient and outpatient staff related to the members and their ongoing needs.	**Weight: Critical**
Providers (3) *(e.g. provider facilities, provider network)* **Provider Awareness and Engagement (Specific to Fayette County)** **Root Causes:** Providers in Fayette County may not always be aware of new initiatives and the availability of all of the possible resources or services within the county and therefore may not use these resources to meet the 30-day follow up timeframes, as noted below: • The Providers state they were unaware that the services were available as part of the follow up and on-going treatment for the member. • The Providers do not always make referrals to the most appropriate service to meet the needs for member. • Providers do not attend quarterly provider meetings held at the Fayette County Behavioral Health Administration (FCBHA) office.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • In order for members to receive and/or be referred for appropriate and timely services, it is important for network providers to be aware of available resources and engage with county-level resources to better understand the options and constraints within the local systems of care. Some providers are unaware of initiatives, resources and/or services within Fayette County, therefore; they do not always utilize these to meet the follow up time frames. This lack of awareness may be due to lack of provider interest, time and resource constraints and/or opportunities for Fayette County to more fully engage the provider community in new innovative ways. ***Current and expected actionability:*** **Root Cause:** Fayette County has identified varying levels of provider awareness and education as an improvement opportunity and providers are therefore unable to receive valuable information regarding updates that may be necessary to promote follow up care. This may also be an underlying factor for other counties that may be explored through the best practice sharing sessions with Beacon and the BH HC contractors. **Actionability:** It has been determined that this root cause is impactful and attainable (limited). **Weight: Important**

Providers (4) *(e.g. provider facilities, provider network)* **Members with Co-Occurring Disorders (Specific to Beaver County)** **Root Causes:** A subset of members being discharged from the hospital are not receiving the recommended follow up care in part as a result of co-morbidities and complex needs, such as the following: • Individuals with Co-Occurring Disorders (COD) had lower follow-up after hospitalization (FUH) 30 day rates. Approximately 70% (392 of the 561) of patients treated at the Heritage Valley Beaver (HVB) inpatient mental health (IPMH) unit were diagnosed with a COD. • IPMH units are accessible 24/7 versus substance abuse admissions being limited to "business hours". Consumers often elect to present at the Emergency Department in order to get immediate assistance. • Social Worker coverage is Monday- Friday at HVB, limiting primary contact with other providers to those hours. However, discharges occur outside of these hours that are not being communicated to the consumer's supports.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • The identification of members with unique needs (such as COD) who receive care in Beaver County from the local IPMH unit may help to address the large percentage of these individuals (70 %) with COD in order to more fully understand their care coordination needs and develop interventions tailored to meet these needs. Through the implementation of a warm hand-off with staff in the Heritage Valley Beaver Emergency Department (HVB ED), individuals will have access to additional substance abuse/COD resources based on their individual needs. ***Current and expected actionability:*** **Root Cause:** Members being discharged from a primary inpatient facility serving Beaver County may have the need for immediate/increased hours to access substance abuse treatment levels of care (LOC) and/or evaluate opportunities to address the coverage gaps for social workers and other providers to enhance coordinated care. **Actionability:** Beaver County has determined that this root cause is actionable/attainable. **Weight: Important**
Policies / Procedures (1) *(e.g., data systems, delivery systems, payment/reimbursement)* **Key Stakeholders** **Root Causes:** Key stakeholders and subject matter experts from the 12 county systems of care (inpatient/outpatient/administrative) have varying levels of understanding and engagement about the 30 day HEDIS Follow Up After Hospitalization (FUH) measure and the goals set forth by the Office of Mental Health and Substance Abuse Services/Island Peer Review Organization (OMHSAS/IPRO) for the conduction of the Root Cause Analysis (RCA). This negatively impacts goal achievement and the establishment of system-wide collective approaches and plans of action to address the potential	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Individuals involved with the behavioral health care system at various levels and settings (inpatient/outpatient/administrative/oversight) may operate day to day in more siloed systems. • The current needs and demands on the behavioral health care system and the individuals supporting it does not readily lend itself to dedicated time to interact collectively across the continuum of care to problem solve and generate ideas for continuous improvements. • Key stakeholders may benefit from additional opportunities and forums to explore system-wide approaches to problem identification and solution generation. • Data driven solutions to improving the FUH rates will help to ensure that the true root causes are selected as the areas of focus for improvement efforts. • Key stakeholders from the physical health systems of care are also important partnerships that may not currently be fully leveraged to address improvement opportunities for follow up care. • These collective factors may result in missed opportunities for collaboration on shared members accessing care via the physical and behavioral systems of care

opportunities to improve the rates. The following factors have been identified: • Historical individual County and HealthChoices Behavioral Health (HC BH) contractor level approaches to addressing improvement opportunities may have impacted larger systems of care approaches across the entire service area. • Forums for promoting best practice sharing across providers/facilities have been limited and improvement efforts largely focused on local impacts. • Shared learning opportunities have been more focused locally versus regionally, thereby potentially limiting knowledge transfers of scalable strategies and successful interventions.	and result in the lack of follow up after discharge at 30 days. ***Current and expected actionability:*** **Root Causes:** A multi-disciplinary approach focused on improving the FUH rates is important and the BH HC contractors and Beacon will work collaboratively to establish mechanisms to regularly bring together the key stakeholders from across the respective systems of care to focus on this effort. **Actionability:** It has been determined that this root cause is actionable and attainable. **Weight: Important**
Policies / Procedures (2) *(e.g., data systems, delivery systems, payment/reimbursement)* **Data Systems** **Root Causes:** There is a need for additional mechanisms and data in order to identify and track high risk members who may benefit from additional interventions, including: • Assessing the members' clinical presentation through available or new data sources to determine those factors which may keep them at high risk for lack of follow-up and work to address their needs for additional supports and services. • High risk indicators have not been clearly and consistently established resulting in a lack of systematic data gathering for utilization trends and patterns in care.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • Input from behavioral health managed care organizations (BH-MCOs) and inpatient facilities indicates that there is an opportunity to enhance the formal tracking systems for identifying members who are identified as being at high risk for follow-up. • Utilizing data proactively through the development and/or refinement of existing or new reporting system capabilities is expected to enhance the ability to identify those individuals most in need of more care coordination or education to promote timely follow up care. • Efforts are on-going for Beacon to continue to actively improve the knowledge management and reporting capabilities in order to provide the information needed to make informed data driven decisions to improve FUH rates. The current Beacon Corrective Action Plan (CAP) for enhancing the encounter data reporting continues. Beacon has prioritized the completion of this CAP and has identified additional data analytics staff (both locally and at the corporate level), along with an external resource (including Inovolan, a National Committee for Quality Assurance (NCQA) certified HEDIS software vendor) to be collectively dedicated to this high focus effort. Inovolan is a leading technology company providing cloud-based platforms empowering data driven healthcare via real-time data aggregation and analysis. (HEDIS is the Healthcare Effectiveness Data and Information Set used nationally to standardize and measure the performance of health plans)

<table>
<tr>
<td>• Utilization of data drill down capabilities to identify potential targeted interventions to focus improvement efforts towards actionable activities</td>
<td>Current and expected actionability:

Root Cause: Capabilities for systematically identifying, gathering, and tracking of data for high risk members have not been fully established nor processes to assure that additional supports/services are put in place for those members who are identified as being at risk for lack of follow up care.

Actionability: It has been determined that this root cause is actionable and attainable at this time.

Weight: Critical/Important</td>
</tr>
<tr>
<td rowspan="2">Policies / Procedures (3)
(e.g., data systems, delivery systems, payment/reimbursement)

Delivery Systems

Root Causes: There are currently not processes in place to develop and promote member connectedness to outpatient BH providers prior to their first appointment, which can result in the following:

• Members feel they do not need additional follow-up treatment after inpatient hospitalization.

• Members feel better and are out of crisis and lack insight and understanding of the necessity of follow-up treatment to their recovery.

• Members do not have connectedness to outpatient providers and may lack an understanding of their mental health (MH) needs and the services that will best promote their recovery.

• There is a “disconnect” between inpatient and outpatient systems of care that inadvertently conveys to the member that treatment is completed following discharge from the inpatient stay.

• Members may not be signing Release of Information (ROI) forms for the exchange of information across providers for various reasons (including crisis situation at the time of admission, lack of names/number of contacts, provider not following up on</td>
<td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):

• In 2017 a focus group was conducted with members at which time they indicated that one reason for not following up after discharge was that they did not feel a need to follow up. Similar responses indicated that members did not agree with the follow-up services that were being suggested.
• Members may not be stabilized upon discharge from the hospital.
• Historical information pertinent to the member’s inpatient treatment may not be reaching inpatient treatment staff (psychiatrist) and information regarding the members discharge conceptualization may not be reaching outpatient treatment staff.
• Communication between outpatient and inpatient staff does not routinely occur.</td>
</tr>
<tr>
<td>Current and expected actionability:

Root Cause: There is not a formalized coordinated communication process across various settings and levels of care that adequately orients members as to what care and services may be needed and included in their overall plan of recovery.

Actionability: It has been determined that this root cause is actionable and attainable.

Weight: Important</td>
</tr>
</table>

signing the forms after crisis minimized).	
Policies / Procedures (4) *(e.g., data systems, delivery systems, payment/reimbursement)* **Single Points of Accountability (SPA) (Specific to Beaver County)** **Root Causes:** Individuals are discharged without sufficient supports in place, such as a SPA, to assist them with adherence for follow up visits in the outpatient setting. The goal of the Beaver County SPA initiative is to develop a recovery oriented, proactive system of care for those receiving services. The Beaver County Single Point of Accountability (SPA) was established to develop consistent standards for Blended/Intensive Case Management and Assertive Community Treatment in order to assure individuals have access to the	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • In Beaver County one of the key interventions is related to the establishment of SPAs for residents that receive care in the county. A review of data from 2016 indicated that those members with an assigned SPA had a greater likelihood of keeping their FUH appointments at the 30-day time frame. Based in these data it was determined that it would be important to look further into the root causes contributing to not all members being assigned a SPA to help coordinate their care and encourage timely follow up. The Beaver County RCA team elected to review the SPA enrollment process to identify opportunities for improvement.

treatment and natural supports they need to achieve a quality and satisfying life in the community. The SPA's have knowledge of all components of the system of care and assist individuals with connecting to needed services and supports. • In 2016, out of 658 admissions to IPMH facilities, only 154 (23.4 %) had a Single Point of Accountability (SPA) identified upon discharge. • IPMH Social Workers are not making referrals for members to encourage timely follow up care. • It is a voluntary service that consumers have the right to decline. • In 2016, 451 out of the 658 (68.5%) individuals discharged from inpatient services attended their 30 day FUH appointment. The data also indicates that 85% (131 out of 154) of people with a SPA compared to 63.5% (320 out of 504) of people without a SPA attended their 30 day FUH appointment.	***Current and expected actionability:*** **Root Cause:** A SPA appears to favorably contribute to improved rates of follow up care. It will be important to better understand how the enrollment process is successful for those members who have been assigned a SPA and to assess the root causes that may lead to instances for which a SPA is not assigned and the member is not enrolled in the process. **Actionability:** It was determined that this root cause was actionable and attainable. **Weight: Important**
Policies / Procedures (5) *(e.g., data systems, delivery systems, payment/reimbursement)* **Alternate Services and Programs (Specific to Beaver County)** **Root Causes**: A collection of varying delivery systems issues (such as the closing of transitional/step down services and diversion programs) are being further explored to determine whether they contribute to the lack of timely follow up care at 30 days, including the following: • Systems issues.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • The physical and behavioral health care systems are not always aligned to identify and address the complex needs of members. These systems of care can adversely impact members and their follow up care when the communications and hand-offs are suboptimal. Beaver County is interested in examining the need and ability to expand/develop services such as diversion programs, transition/step down services, etc. that may adversely impact timely follow up care.

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- Lack of diversion options.
- Limited step-down treatment options (i.e. partial).
- Limited services which meet Healthcare Effectiveness Data and Information Set (HEDIS) criteria as a FUH appointment.

- Services were not financially sustainable (not cost -effective or under-utilized).
- Regulations and reimbursement criteria exceeded providers' ability to maintain the service due to the high cost.

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Current and expected actionability:

Root Cause: Transitional/step-down services and diversion programs have closed or are have not been able to remain sustainable in the county for Beaver members. Through the best practice joint sessions with Beacon and the BH HC contractors it will be assessed whether this root cause is more universal impacting additional counties.

Actionability: It was determined that this root cause is actionable and attainable.

Weight: Important

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Provisions (1)
(e.g., screening tools, medical record forms, transportation)

Lack of Transportation Options

Root Causes: Members are often faced with significant challenges to secure transportation to and from their behavioral health provider visits that directly impact their ability to consistently attend these appointments for 30 day follow up due to:

- Lack of transportation resources before/after the select time of the day for the available appointment.
- Providers and members are not always fully aware and educated/informed on the transportation services available and some of the limitations that may need to be addressed when scheduling these services.
- Transportation times, including early drop off and late pick up, may cause a patient to spend half a day at the providers setting for a 45 minute to an hour appointment.
- Lack of/limited transportation resources in the county.
- Inability for individuals to access the transportation that the whole family may be eligible for (such as single parents needing to find

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Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):

- Members do not consistently have easy access to reliable and dependable transportation to/from their follow up appointments due to a variety of factors. Based on a barrier analysis session conducted in March 2017 with the Beacon Provider Advisory Committee (PAC) one of the most common barriers identified was the lack of transportation for members to keep compliant with their recommended follow up visits.
- Transportation providers may not be fully aware or understanding of the demographic they are dealing with (such as consumers with MH (mental health) illness or IDD (intellectual developmental disability), many of whom may appear "normal" from the outside even though they may be in crisis in their mind, though this may not be understood and things may be said when they are late or call and cancel).

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Current and expected actionability:

Root Cause: Members who may lack personal transportation that is reliable and dependable are not able to consistently adhere to their follow up visits due to a lack of alternative transportation options that have the flexibility to meet their individual needs and schedules.

Actionability: It has been determined that select aspects of this root cause may be actionable and attainable (limited).

Weight : Important

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resources for their children when scheduling follow up appointments). • Members may not have the necessary budgeting skills to assist them in planning for transportation needs. • Consistently determining a member's means of transportation to his/her follow-up appointment may not occur in the discharge process. • Discharge staff may not have information on available transportation alternatives and the means to access them. • Due to reliance on disability benefits, members have limited income and transportation may not be a priority following discharge. • Members are overwhelmed by their symptoms of illness and available information is difficult to understand or not current. • Member feels better, so does not secure transportation to their scheduled appointment. • Member feels frustrated accessing public transportation.	
Provisions (2) *(e.g., screening tools, medical record forms, transportation)* **Lack of Programs Targeted Towards Specific Populations (Specific from Fayette County)** **Root Causes:** There are limited programs that serve transition age youth and limited staff that are trained to work with this specific population**,** which can contribute to the following barriers: • Member refuses or reluctantly accepts a follow up appointment. • Member does not feel comfortable going to the provider that the appointment is scheduled with for	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** • It is important that programs be designed and implemented that can address, to the extent possible, the unique needs of various populations, such as transition age youth. The lack of these targeted programs can lead members to feel misunderstood or uncomfortable with certain providers, which in turn could impact their willingness to follow through with treatment and recovery recommendations and treatments. In addition, there are limited staff that are trained to work with that specific population. • Fayette County has developed 2 new programs specifically aimed for Transition Age Youth: Certified Peer Specialist for Transition Age You-which focuses on learning/utilizing coping skills and self-esteem building with the youth and Youth Psych Rehabilitation-which assists the youth with learning skills, such as problem solving, budgeting, daily living, social appropriateness, and vocational interests.

follow up. • Member feels that the provider would not "get them" or understand their individual issues. • Member is of transition age, and does not feel they would fit in with the typical adult population at established providers.	***Current and expected actionability:*** **Root Cause:** The lack of specialized programs for unique populations may contribute to members not receiving the recommended follow up care. **Actionability:** Fayette County has determined this root cause is not impactful/not attainable due to the services not counting as follow up according to the HEDIS measure technical specifications. **Weight: Not important**
Other (specify)	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** ***Current and expected actionability:***

Quality Improvement Plan for CY 2020

Rate Goal for 2020 (State the 2020 rate goal here from your MY2019 FUH Goal Report): 65.94%

The factors above can be thought of as barriers to improvement. For each barrier identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2019 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, and Who of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with HC BH Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.

Beacon MY2018 30-day FUH Rate: 63.98%

Barrier	***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 taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
People: Key Stakeholders **Lack of awareness and understanding of key stakeholders and subject matter experts (SMEs) in the importance of 30 day follow up visits for improved outcomes** **Lack of best practice sharing opportunities and joint forums to**	Establish a common set of goals and understanding of the current FUH rates, the elements of the measure and the RCA objectives. Begin to engage	October 2017: Kick- off Educational Sessions (One Time) Individual BH HC contractor specific RCA	This action item was informally monitored and measured by ensuring the completion of the orientation materials to introduce the key stakeholders and county liaisons to the current levels of performance for the 30 day FUH rates. This information was completed and made available to each contractor for use, as applicable, in their respective stakeholder sessions. Upon invitation, the Beacon-PA Quality Management (QM) Director participated in/led several of the initial kick off sessions to provide the overview. These actions were monitored informally through participation and attendance at the sessions of the key stakeholders and subject matter experts.

explore system wide approaches to problem identification and solution generation	the county level key stakeholders in a collective approach across the systems of care for improving the FUH rates for all counties, as follows: 6.) Beacon-PA Quality Management (QM) Director developed an introductory set of presentation materials to be used, as needed by each HC BH contractor, to provide an overview for the participants in the RCA session. 7.) Held "kick-off' sessions with the key stakeholders and subject matter experts (SMEs) at the BH HC contractor level to initiate a dialogue about the problem and begin to develop potential	Team meetings (On-going into 2018/2019 as needed/determined by each individual contractor) Face to Face Educational Sessions (One Time in Fourth Quarter 2017). Development of fish bone diagrams and survey summary (One Time in Fourth Quarter of 2017) Conduction of an on-line survey to gather feedback on areas of priority (One Time in Fourth Quarter of 2017) On-going	County level monitoring will also occur informally to ensure that the face to face sessions are coordinated at the BH HC contractor level with key stakeholders/SMEs to review introductory materials, introduce the concepts of a root cause analysis and conduct the first facilitated session of the RCA. The on-line survey (in select counties) assessed the RCA "kick-off" sessions and gathered feedback on the recommended priority areas of interest/future focus, the main root causes and input on future meetings and on-going dialogue. On-line survey results were compiled and fishbone diagrams were developed, as determined by each county, to identify the local barriers. This action was monitored and measured at the county level by completion of these tasks. These action steps, as outlined above, were all completed in 2017 and tailored by each BH HC contractor to meet the individual needs/preferences of their respective counties and their participants and the desired approaches of the county leads. This monitoring will continue monthly in 2020 by the BH HC contractors as to levels of participation to achieve the goals of the individual RCA Teams.

	root causes. 8.) Beacon-PA QM Director completed a fishbone diagram template as part of the overview materials for review by the participants for prioritization. This was intended as a guide to note the four P’s selected by IPRO/OMHSAS for the areas of focus. 9.) Conducted an on-line survey of participants (in select counties) for feedback and insights into next steps for planning future sessions and root cause selection. 10.) Develop additional forums for collective informati	meetings in 2018/2019 (with the frequency as determined by each BH HC contractor based on local needs and availability of workgroup participants) First and Second Quarters (2018) April/July/October (2019) August 2018 Quarterly (2018/2019)	Each of the BH HC contractors established forums for their respective systems of care to bring together key stakeholders and SMEs to work collectively on improving FUH rates at the local level (2018). Throughout 2018ongoing dialogue took place regularly through face to face sessions, meetings/teleconferences, and/or on site visits, etc. to maintain communication and continue the open exchanges of ideas and information. The BH HC contractors will take the lead in 2019 to monitor/measure and assess the levels of participation and engagement in the work groups and adjust these actions as needed. This action was measured by the completion of these quarterly meetings, along with monitoring by Beacon-PA of participant attendance and engagement in information sharing. Also, updates to the individual BH HC RCA summaries will be shared for all participants as a joint learning collaborative. This action was monitored semi-annually in 2018 via the submissions to Beacon-PA of updated FUH Action Plans from each of the BH HC contractors. These FUH Action Plan updates were individually presented by each County representative to the group and dialogue took place as to suggestions and feedback, as well as input into next steps, measurement/monitoring opportunities, etc. Counties also gathered ideas from each other as to interventions occurring in one setting that may be applicable to their respective county which could be further explored with their respective RCA team. Beacon-PA/Beacon Health Options planned to sponsor the Third Annual “Best Practice Forum’ in the Fall of 2018 to bring together inpatient providers to exchange best practices and share successes/barriers to improving the FUH rates. Following additional discussion and planning it was determined that the better approach would be to hold a smaller scale meeting with key representatives from each of the four pilot facilities as part of the PIP core measure to improve discharge planning. This action item is monitored via stakeholder attendance at the QMCs and informally through their active meeting participation, as well as ensuring the inclusion of these topics on each of the QMC quarterly agendas. QMC attendance is monitored and assessed annually for QMC participation of the voting members and those who do not attend the minimum number of meetings receive outreach via Beacon-PA and/or the BH HC contractors, as needed.

	on sharing related to improving FUH rates. BH HC contractors used the information from the initial sessions to determine local follow up action steps based on face to face feedback and/or survey findings. On a semi-annual basis during 2018 Beacon-PA gathered together the key representatives from all the HC BH contractors to monitor progress on the established FUH goals and exchange feedback on individual and collective RCA efforts. Beacon-PA convened quarterly RCA meetings with BH HC contractors to review performance data and share best practices and potential common interventions.	January 2020	Performance data on the identified interventions will be discussed, as well as opportunities for systemic service improvements: [Objects removed]

	Beacon-PA hosted a joint half day face to face session at the Seven Fields offices with key liaisons from the four inpatient facilities involved in the PIP project for improving discharge management planning. On a quarterly basis the four (4) Quality Management Committees (QMCs) are held with the BH HC contractors. These meetings are chaired by the Beacon-PA QM Director and include network providers, consumers, and county liaisons. In order to more fully engage and educate these individuals, a standing QMC agenda item was added for regular updates on the PIP and HEDIS measures, of which the FUH measures are included. These QMCs also review and approve the annual QM/UM Program Evaluation, which provides a significant level of		

	detail related to the FUH measures and the progress of the RCAs. These updates provide for the on-going information exchange to maintain levels of engagement of county participants. Beacon will convene monthly BH HC/BH-MCO FUH RCA meetings to review identified interventions and performance data.		
People: Members/Clients/Patients **Members with complex needs do not have a full understanding of the importance of follow up appointments with behavioral health care providers and therefore do not consistently make or keep follow up visits at 30 days**	Integrated Care Planning (ICP) collaborations between Beacon-PA and the PH MCOs have been initiated and will be utilized as new vehicles of communication to promote FUH visits for those higher risk members with complex needs.	2017-2018/On-Going	Overview of ICP Interventions: Value Recovery Coordination (VRC) Program: Beacon employed clinicians serve as VRCs to assist members 18+ years who are either high utilizers or complex cases by adopting a care management approach via regular contact with the member to encourage adherence with treatment recommendations. A collaborative process is used that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet the individuals needs via aftercare plans and linkages with community resources. Interventions are face to face or telephonic**.** These services are offered for individuals with an SMI that meet criteria or those with an ICP. These actions are monitored and measured quarterly by the Beacon-PA ICP Work Group led by the Vice President of Clinical Services, as well as being part of the ICP/PIP quarterly submissions to OMHSAS. Aftercare Coordination Program (ACP): Beacon employed clinicians serve as ACP coordinators to assist members discharged from an inpatient acute, residential and partial hospitalization facility with a MH or SUD diagnosis by providing telephonic follow up support by connecting the member to BH providers and other community resources. These actions are monitored and measured quarterly by the Beacon-PA ICP Work Group led by the Vice President of Clinical Services , as well as being part of the quarterly ICP/PIP submissions to OMHSAS. BH PH Integrated Clinical Rounds: On a monthly basis integrated clinical rounds are conducted with representatives of the Beacon clinical team along with PH plan liaisons. The goal is to have the opportunity to discuss stratified ICP members that cross over the BH and PH Plans to share information, discuss the care plans, and coordinate interventions**.** Recommendations for additional services and outreach are supplied and the person responsible for the follow up is identified in these rounds as well. Further, stratification data is

<table>
<tr>
<td>People:
Members
(Fayette County)

Members may choose to follow up with his/her primary care physician (PCP) for several reasons such as: they may not feel a need to see a psychiatrist/therapist, this may be their first experience with the behavioral health care system, the member feels their needs can be met by their PCP, and they are more comfortable and may have an existing rapport. Improvements in the FUH rates may not be impacted as PCP visits are not tracked for the HEDIS measure.</td>
<td>An inpatient-outpatient workgroup (as part of a South West 6 (SW6) pilot in Indiana County) was formed and began steps to develop a formalized process of orientation/education of members as to what may be included in their overall plan of recovery, including the process of orientation/education of members.

The Fayette RCA Team partnered with the Gateway Health Plan embedded staff (registered nurse) at the County office to coordinate follow up care for members. (Note: The data collected is limited to Gateway Health Plan members at this time).</td>
<td>January-December 2018/On-Going

First Quarter 2018-On-Going</td>
<td>collaboratively reviewed and BH/PH MCO's agree on which Members will be approached for development of an ICP. These actions are monitored at least semi-annually by the Beacon-PA Clinical team.

This action will be measured by tracking the follow up percentage rate for identified pilot hospitals compared to other SW6 hospitals and previous years after implementation.

The workgroup representing the SW6 pilot met multiple times during the Second and Third Quarters of 2018 and explored the use of Wellness Recovery Action Plan (WRAP) plans with members in inpatient/outpatient services to provide recovery orientation. The funding explored for this planned training interventions was found not to be feasible. A new project is currently being developed and will be further defined during the Second Quarter 2019.

Fayette County began data collection for members choosing follow up care with his/her PCP during 2018 with the following results from this tracking:

<table>
<tr><th colspan="4">Fayette County
2018 PCP Follow Up</th></tr>
<tr><td>2018</td><td>Discharges</td><td>PCP Follow Up</td><td>PCP Follow Up Rate</td></tr>
<tr><td>Q1 (Jan, Feb, Mar)</td><td>19</td><td>6</td><td>32%</td></tr>
<tr><td>Q2 (Apr, May, Jun)</td><td>27</td><td>18</td><td>67%</td></tr>
<tr><td>Q3 (Jul, Aug, Sep)</td><td>11</td><td>3</td><td>27%</td></tr>
<tr><td>Q4 (Oct, Nov, Dec)</td><td>9</td><td>4</td><td>44%</td></tr>
<tr><td>2018 Total</td><td>66</td><td>31</td><td>47%</td></tr>
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<table>
<tr><th colspan="4">Fayette County
2019 PCP Follow Up</th></tr>
<tr><td>2019</td><td>Discharges</td><td>PCP Follow Up</td><td>PCP Follow Up Rate</td></tr>
<tr><td>Q1 (Jan, Feb, Mar)</td><td>17</td><td>6</td><td>35%</td></tr>
<tr><td>Q2 (Apr, May, Jun)</td><td>12</td><td>0</td><td>0%</td></tr>
<tr><td>Q3 (Jul, Aug, Sep)</td><td>17</td><td>4</td><td>23.5%</td></tr>
<tr><td>Q4 (Oct, Nov, Dec)</td><td>16</td><td>3</td><td>19%</td></tr>
<tr><td>2019 Total</td><td>62</td><td>13</td><td>20%</td></tr>
</table>

<u>2019 Totals</u>

62 Discharges
13 Followed-up with their PCP; 9 Followed-up with other provider</td>
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			For 2019, the percentage of Members choosing to follow-up with PCP/other provider was <u>35%.</u> It was determined that this intervention had limited impact and improvements were not readily attainable due to the lack of inclusion of PCP follow up visits in the HEDIS technical specific. The FUH rates would not be improved by increases in follow up visited with the members' PCP for follow care within 30 days. The Fayette County RCA team will continue to explore options for obtaining information from other health plans and use the Gateway finding for future actions to involve the BH providers.
Providers **Outpatient Providers** **Members do not consistently have access to outpatient providers following an inpatient stay due to limited choices in providers who are available to provide appointments to meet the 30-day standard**	Individual County level RCA workgroups began meeting to address the need to better understand alternative solutions to increasing psychiatric time that may not have been explored sufficiently in the past. Each BH HC contractor, as part of the RCA compliance plan, established multi-disciplinary work teams at the local level to develop interventions and measurements and metrics for on-going monitoring. Through a newly established tele-psychiatry workgroup, providers have begun submitting proposals for the use of tele-psychiatry in their agencies and have been approved and are actively operating in network. This workgroup	January 2018-Summer 2018/On-Going 2019 January – December 2018/On-Going January-December 2018/On-Going First Quarter	This action will be measured informally by the BH HC contractors based on county-level RCA team participation and levels of engagement in the RCA process. This action will be measured informally by the BH HC contractors based on county-level RCA team participation and levels of engagement in the RCA process. Analysis of follow-up rates for 30 day visits will be more fully explored once these programs are fully operational and data can be monitored. The establishment of checks and balances on the proposed tele-psychiatry programs heightens the awareness of all parties of the need for structured and standardized protocols for oversight and monitoring. Multiple providers that have developed tele-psychiatry programs have been added to the Beacon-PA network. They will be measured and monitored in accordance with the detailed descriptions they submitted to the Tele-Psychiatry Committee as part of their respective reviews and approvals. Measure Indicator (Annual): Follow-up percentage of members receiving outpatient services at agencies where tele-psychiatry or alternatives are implemented. Chestnut Ridge Counseling Services (Fayette County's Largest Outpatient Provider) has started an Open Access program and has partnered with Highlands Hospital to track new referrals and aftercare

	oversees the review and approval of the proposed tele-psychiatry solution to ensure it meets internal and external requirements. Explore options to establish discharge clinics or open access scheduling with interested inpatient/outpatient providers for innovative scheduling options to free up appointment slots within 30 days of discharge. Fayette County's largest outpatient provider has recently announced open access hours to provide faster access to care, allow for flexible arrival times and provide same assessments. Care Management Supervisor contacted Chestnut Ridge to determine if a tracking method is in place than can be shared related to hospital discharge referrals to the open access hours that attended versus those who did not show up.	2018/On-Going	attendance. New referrals will be tracked monthly/quarterly and summarized annually:

Fayette County **2018 Open Access Program**			
2018	New Referrals	Attended OA	Attendance Rate
Jan	8	6	75%
Feb	5	4	80%
Mar	8	7	88%
Q1 Total	**21**	**17**	**81%**
Apr	4	4	100%
May	3	3	100%
Jun	5	5	100%
Q2 Total	**12**	**12**	**100%**
Jul	4	4	100%
Aug	7	7	100%
Sep	5	5	100%
Q3 Total	**16**	**16**	**100%**
Oct	5	5	100%
Nov	3	3	100%
Dec	9	9	100%
Q4 Total	**17**	**17**	**100%**
2018 Total	***66***	***62***	***94%***

Fayette County **2019 Open Access Program**			
2019	New Referrals	Attended OA	Attendance Rate
Jan	6	6	100%
Feb	1	1	100%
Mar	NA	NA	NA
Q1 Total	**7**	**7**	**100%**
Apr	2	2	100%
May	7	7	100%
Jun	4	4	100%
Q2 Total	**13**	**13**	**100%**
Jul	7	7	100%
Aug	10	10	100%
Sep	5	5	100%
Q3 Total	**22**	**22**	**100%**
Oct	3	3	100%
Nov	5	5	100%
Dec	1	1	100%

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<td>Care managers (in Fayette County) to interact with members during follow up calls to ascertain whether their follow up appointments were with a PCP and if this was their choice. Provide education, as needed, on the importance of follow up with a BH provider and offer to assist with scheduling an appointment the member is interested.</td>
<td>Quarterly (2018)/On-Going</td>
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<table>
<tr><td>Q4 Total</td><td>9</td><td>9</td><td>100%</td></tr>
<tr><td>2019 Total</td><td>54</td><td>54</td><td>100%</td></tr>
</table>
The data collected shows an increase in the number of referrals at discharge as well as number of consumers attending Open Access appointments.
In 2018, the data collected was from four hospitals in the region (Uniontown, Highlands, Mon Valley & Southwest Regional). Fayette tracked the number of individuals with scheduled follow-up appointments and those that actually attended the appointment.
The following data refers to all four hospitals mentioned above:
<table>
<tr><td colspan="4">Fayette County (All 4 Hospitals)
2018 Drug and Alcohol Assessment</td></tr>
<tr><td>2018</td><td>New Referrals</td><td>Attended Assessment</td><td>Attendance Rate</td></tr>
<tr><td>Q1 (Jan, Feb, Mar)</td><td>14</td><td>10</td><td>71%</td></tr>
<tr><td>Q2 (Apr, May, Jun)</td><td>20</td><td>9</td><td>45%</td></tr>
<tr><td>Q3 (Jul, Aug, Sep)</td><td>17</td><td>10</td><td>59%</td></tr>
<tr><td>Q4 (Oct, Nov, Dec)</td><td>16</td><td>11</td><td>69%</td></tr>
<tr><td>2018 Total</td><td>67</td><td>40</td><td>60%</td></tr>
</table>
<table>
<tr><td colspan="4">Fayette County (2 Hospitals)
2019 Drug and Alcohol Assessment</td></tr>
<tr><td>2019</td><td>New Referrals</td><td>Attended Assessment</td><td>Attendance Rate</td></tr>
<tr><td>Q1 (Jan, Feb, Mar)</td><td>15</td><td>10</td><td>66%</td></tr>
<tr><td>Q2 (Apr, May, Jun)</td><td>13</td><td>6</td><td>46%</td></tr>
<tr><td>Q3 (Jul, Aug, Sep)</td><td>14</td><td>6</td><td>42.9%</td></tr>
<tr><td>Q4 (Oct, Nov, Dec)</td><td>8</td><td>3</td><td>37.5%</td></tr>
<tr><td>2019 Total</td><td>50</td><td>25</td><td>50%</td></tr>
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<tr>
<td>(Fayette County): Some providers are unaware of initiatives, resources and services within Fayette County, therefore; they do not always utilize these to meet follow up time frames.</td>
<td>FAYETTE COUNTY DRUG & ALCOHOL AGENCY:
Fayette RCA team has partnered with Fayette County Drug & Alcohol to</td>
<td>First Quarter 2018 and On-Going</td>
<td>LEVEL OF CARE (LOC) ASSESSMENTS completed at the hospital are being tracked quarterly as outlined below.
(At this time Fayette is only tracking Highlands and Uniontown Hospitals)</td>
</tr>
</table>

	obtain information on new referrals and aftercare attendance. In addition, Fayette County is also tracking on a quarterly basis the Level of Care (LOC) assessments completed at Highland and Uniontown Hospitals for Fayette County members.	Second Quarter 2018/On-Going	[Objects removed] 2019 Total: The percentage of members following up with services was 82%. 25 People were seen for Assessment 16 People were referred for OP Services 13 People followed thru with OP Services 12 People went to Rehab Using feedback from the data collected through the returned surveys, The Fayette County RCA team will follow up with providers regarding educational needs on an "as needed" basis. Providers are able to receive valuable information regarding updates and are encouraged to provide feedback on the effectiveness and value of the meetings.
(Beaver County): Due to capacity and limited psychiatric availability, outpatient mental health (OPMH) providers are not able to accommodate scheduling appointments to meet HEDIS measures.		Second Quarter 2018/On-Going Monthly	PHN maintains statistics of appointment attendance rates specific to this clinic. PHN will track the number of individuals who attend their FUH appointments in comparison to the number of appointments scheduled. This data is reviewed internally by Beaver County staff on a monthly basis. Between 6/1/18 and 12/31/18, a total of 134 FUH appointments were scheduled. Of those, 84 were attended for a follow up of 62%. Statistics will be provided to Beaver County Behavioral Health (BCBH)

			to ensure this action step is occurring. PHN has had changes in staffing due to resignations and retirements. This has left them with no psychiatrist at 2 of their sites (Beaver Falls and Center Township). This has complicated already identified barriers of access to treatment of lack of psychiatric time and transportation.
	Staff from Fayette County HealthChoices, Value Behavioral Health/Beacon Health Options and providers attend these joint meetings and provide feedback on the effectiveness and value of the meetings. These meetings are held at the Fayette County office to provide education in the services available in Fayette County and are regularly attended by Fayette County HealthChoices, FCBHA staff, Value Behavioral Health/Beacon Health.	2018/On-Going Quarterly	HVB and BCBH will track the number of warm hand-offs and the number of IPMH diversions resulting from this program. Data will be reviewed on a minimum of a quarterly basis.
		2018/On-Going Monthly	The number of consumers with substance abuse claims with the exception of acute IPMH admissions will decrease. AHCI provides this data to BCBH on a monthly basis for review.
		Second Quarter 2018/On-Going (Under Assessment)	This program is still in its infancy. Data collection and measures will be on-going to determine effectiveness/impact on the system of care. This program has expanded its catchment area to assessing individuals on medical units and on IPMH, in addition to now offering the service at Heritage Valley Sewickley. Data is still being gathered to identify trends and impact on other service areas.
	Fayette County will consider developing a survey for providers who participate in quarterly provider meetings to assess the relevance/impact of information provided	2019 (One-time Purchase)	In 2019, Heritage Valley Health Systems (HVHS) was awarded the Pathways Grant. As part of the grant, the medical and clinical staff at HVHS will be educated on Addictions 101, De-escalation Techniques, Motivational Interviewing, and Screening, Brief Intervention, and Referral to Treatment (SBIRT). The goal is to increase the HVHS staff's knowledge of substance use disorders, how to effectively intervene and assist individuals in connecting to available community resources. Discussion will be considered for possible monitoring and measurement in 2019.
	Using feedback from the data collected through the returned surveys, the Fayette County RCA team will follow up with providers regarding educational needs on an as needed basis.	First Quarter 2019	

	Primary Health Network (PHN) started a discharge clinic for individuals who were being discharged from HVB IPMH unit and Brighton Rehabilitation and Wellness Center (BRWC) LTSR to meet the follow up goal. Discharge clinic psychiatrist is the same treating psychiatrist at all 3 facilities, thereby strengthening continuity of care. PHN had agreed to work with SPA providers for consumers who were already patients at PHN to schedule appointments within 24 hours for individuals showing signs of decompensation or who needed medication refills. The goal was to help divert inpatient hospitalizations. In May 2018, PHN and SPA providers implemented this process. Other outpatient providers, such as Glade Run Lutheran Services and Staunton Clinic, are also looking to		

	developing and implement this process. HVB hired a third social worker. To date there has been no measured improvement in discharge planning. Heritage Valley Health System bought Ohio Valley Hospital, which will not change operation of HVB IPMH unit. On January 10 2019, Resources for Human Development opened a 16 bed facility for detoxification and short term rehabilitation treatment. Through collaborative efforts of Beaver County's SCA and HVB, a designated staff member will be available in the ED for individuals who present with substance abuse issues.		
Providers: Inpatient **Based on annual chart abstractions conducted by a team from Beacon-PA and the counties, discharge management planning (DMP) efforts at**	On an annual basis the Beacon-PA QM team coordinates the conduction of the DMP audits for the four participating facilities. This includes face to	January 2018-December 2018 /On-Going Annually	The following measures will be monitored for the DMP elements of the FUH goal as follows: • Measure Indicator: Discharge Management Planning (DMP) measure (Numerators 4 and 5: Follow-up visit scheduled within 30 days of discharge). • Monitoring will be based on the results of the annual DMP audits as part of the PIP project • Baseline: DMP results for MY 2015 • Re-measurements to be conducted for Years # 2 and #3 and #4:

network participating inpatient facilities do not consistently meet the established goals	face feedback during the on-site visits as well as formal written follow up communications to each facility with their individual result as well as blinded scores for the other facilities for comparative purposes. Training was conducted by the Beacon-PA QM team of county liaisons for participation in the chart abstractions to increase awareness and foster on-going partnerships. Beacon-PA QM team conducted a voluntary self-audit with network contracted inpatient facilities. They were invited via a letter to review five records and complete the audit tool and submit the records to Beacon-PA for an over-read. Ten (10) facilities participated. Letters were	First Quarter 2018 Fourth Quarter 2018 Fourth Quarter 2018	DMP results for MY 2016 and MY 2017and MY 2018 • Begin to coordinate the Q2 2018 DMP reviews and include the county level liaisons who were trained for insights and engagement • Coordinate follow up with four pilot facilities for DMP feedback An inter-rated reliability (IRR) scoring was built into the training activities to ensure consistency across the abstractors. A score of >= 90% was required before they were allowed to abstract the charts for compliance with the DMP plans. All (100% -7/7) of the trainees scored at or above the IRR cut off and were active participants in the treatment record reviews. The following is a summary of the DMP results for Beacon-PA: [Objects removed] The following is a summary of the over-reads of the ten participating facilities for the DMP adherence: [Objects removed] This action was measured and monitored informally via on-going dialogue and discussion with key hospital stakeholders. It will also be measured annually via the Inpatient Provider Profiles and individual facility FUH rates.

	forwarded to these facilities with their individual scores and blinded comparative reports. In order to address the identified need for more formalized communications, a Communication Guide was developed and implemented on January 14, 2019 between the Community Guidance Center (Dr. Ralph May) and Base Service Unit (Michelle Barnhart) and Inpatient Indiana Regional Medical Center. Admissions trigger the hospital to contact the BSU who, in turn, provide via fax current information re: the member to the hospital. The Guide also requires the hospital to notify outpatient services/BSU 24 hours in advance of discharge. (Fayette County) Local hospital was educated numerous times by Care Management Supervisor and Fayette Provider Field Coordinator on importance not	2018 (January-December) 2018 and On-Going Monthly	Beaver County has contracted to collect data regarding SPA standards of tracking days from the time of the referral to the case being opened. SPA referral and tracking data is provided and discussed at monthly SPA meetings. Data continues to be reviewed monthly. BCBH initiated discussions with Beacon regarding the need to develop methods to set goals and reimbursement relating to this performance issue. In 2018, Value Based Purchasing was implemented. Heritage Valley Beaver IPMH Unit did not meet the target metrics for Quarter 1 or Quarter 2. Data will continue to be monitored quarterly. In an effort to improve communication between the inpatient unit and community providers, Heritage Valley Beaver IPMH Social Worker started to regularly attend the monthly Beaver County Single Point of Accountability Meetings.

	only of meeting time frames, but also for making convenient appointments for members. Education was also provided about assessing member's readiness for discharge. The Performance Improvement Plan was discussed as well as possible ways to improve members 7 day and 30 day follow up. Hospital was educated on making sure discharge instructions are reviewed with member and that the member understands all the information, especially when, where and with whom their appointment is. Also, appointments should not be made without member involvement to make sure the appointment is convenient to help improve adherence. (Beaver County): Individuals are discharged with insufficient supports in place, such as a SPA, to assist the individual in attending follow up appointments.	Fourth Quarter 2017/On-Going	

	The goal is to Increase SPA enrollment along with the efficiency of the process. Beaver County has contracted to collect data regarding SPA standards of tracking days from the time of the referral to the case being opened. SPA referral and tracking data is provided and discussed at monthly SPA meetings. (Beaver County) Inadequate communication and documentation surrounding discharge planning by the IPMH provider. Beacon-PA will work with BCBH to set standards for IPMH discharge planning for Value Base Purchasing or Pay per performance measures.		
Provisions: Transportation **(SW6/NW3) Members may have limited access to reliable, affordable**	Budgeting brochure has been developed and distributed electronically to SW6 counties. Additional hard	January 2018-Summer 2018:	Members may benefit (in select counties) from training related to feedback on effective budgeting in making decision regarding transportation options. Rural county members may have added transportation constraints without access to public services. When public transportation is available, the times/locations for pick up/drop off are not always

and easy to access transportation options (such as public transportation, personal vehicles, community supports, etc.) to assist them in ensuring they can consistently access their providers in a timely manner to meet the scheduled follow up appointments **Members (SW6) may have never received training/education on budgeting which could adversely limit their transportation choices.**	copies will be printed by commercial printer and distributed to counties. A survey link has been created to receive feedback which will be collected and analyzed. Transportation information has been received from SW6 counties and collated. Collated information has been sent to printer for pricing and design and printing. Transportation brochures, which include a link to provide feedback to SBHM, Inc. are currently being designed and printed for the NW3 counties. There is not easily accessible, comprehensive and understandable information to review with the member on available transportation. A county-specific 'cheat sheet' on available transportation for members to follow-up visits will be developed and	August 2018 Revised target to December2018 (Final draft completed in 1/19 and distributed) January 2018-February 2018 Revised to May 2018 March 2018-May 2018 Revised to July 2018 2018 and On-Going January 2018-February 2018 March 2018-June 2018 Revised: December 2018 July 2018-August 2018 Revised:	convenient and scheduling presents concerns with lack of flexibility to accommodate individual needs Efforts will be explored (in select counties) to partner with the local county specific transportation providers for exploring new solutions/options. Measure Indicator: Survey members completing training for feedback on effectiveness of budgeting in making decisions regarding transportation. Explore options (in select counties) to assess current transportation materials for members to determine usability/ease of understanding, potentially develop new materials that are ADA sensitive, and encourage use by inpatient facilities at the time of discharge planning to ensure this is adequately address before the individual leaves the inpatient setting. Measure Indicator: A 6 month period following implementation will be compared to the follow-up rates of the previous year. Sample will be discharges where documentation exists that the informational sheet was reviewed and given to the member as part of the discharge process.

	distributed to hospitals who will include its review with the member as part of the discharge process. Information on transportation will be gathered by the respective county offices. Draft of information SBHM consultant and reviewed by ADA will be written by experts for readability. Information will be printed on a one-page laminated sheet. Informational sheets will be distributed to inpatient, outpatient and case management units.	December 2018 September 2018 Revised: December 2018 Revised: April 2019 First Quarter 2019	Tracking of this new process will be ongoing over 2019 and data (need more detail as to how it will be tracked and the data to be collected in 2019) will be collected and analyzed. The providers are tracking the members involved in the process so that data may be analyzed. Meeting on 2/26/19 revealed some bugs in process that will be reconciled by outpatient provider. Four cases have gone through the process, with successful transition for two of them. Process will be reviewed in 2 months.
Policies and Procedures: Data Systems **Data can help to identify high risk individuals with complex needs to assist in promoting outreach and education to enhance compliance and their understanding of the value of follow up care.**	Beacon-PA will continue to collaborate with internal and external partners (including the HC BH contractors, data analytics staff and software vendors) to address potential capabilities for enhanced data collection and reporting. Conducted meetings and discussions with key stakeholders (internal and	January-December 2018 January-December 2018/On-Going meetings and discussions to address encounter data reporting and define reporting requirements for member	This action step was measured and monitored informally via the attendance of participants in the meetings and their engagement via idea generation and solution generation. The correction of the encounter data issues were coordinated through a separate workgroup made up of Beacon-PA /Beacon leaders and staff for which a separate and detailed work plan was developed. The action was monitored regularly by the work group and through periodic joint calls with external regulatory parties and the BH HC contractors.

	external) to address encounter data reporting improvement opportunities and define reporting requirements for member identification. Beacon-PA participated in a Data Validation Review conducted by Mercer Consulting to assess the data reporting capabilities. Contract executed between Beacon-PA / Beacon Health Options with Inovolan as a as a NCQA certified software vendor to support reporting requirements for overall HEDIS/HEDIS-like rates and drill down data analysis. Recruitment efforts were initiated to ensure adequate resources in the local Knowledge Management and Reporting (KMR) team to support the increasing data demands. The resources of the Beacon National KMR teams were leveraged, as needed, to support the local KMR team and develop	identification First Quarter 2019 Fourth Quarter 2018/Contract renewal (as needed based on contract terms) Fourth Quarter 2018/On-Going (As Needed) Third/Fourth Quarter 2018/On-Going Third /Fourth Quarters 2018/On-Going 2019 Partially completed 2018/Planned for Third/Fourth Quarters 2019	A formal report will be issued Mercer Consulting/OMHSAS and utilized by Beacon-PA to monitor progress toward this objective. This action item was monitored via the signing and execution of the full joint agreement with this new external vendor via the Beacon Health Options procurement team. The Beacon-PA team has partnered with the Beacon Talent Acquisition team to successfully post and recruit for the individuals needed to fully resource the local KMR team, along with assuring full new employee on-boarding once they are hired to expedite their successful transition into their new roles and responsibilities. This will be monitored by the successful filling of all open positions with individuals qualified to perform their duties and through the existing Beacon New Employee checklist. This action item will be monitored by the completion of data reporting tasks and report generation, as assigned to the respective KMR staff individual, by the assigned due dates and measured for accuracy as determined by the functional area owners and end users. This action was implemented as a first step with the full implementation of the Integrated Care Plan (ICP) initiative to identify high risk individuals and stratify them according to mutually agreed upon protocols with the physical health managed care organization (PH MCOs). This action will be monitored by participation in the quarterly ICP calls with external regulatory entities and BH HC contractors. This will be monitored via participation of the Region 2 Quality Leads in oversight meetings with the vendor to receive regular updates on this new partnership. This will be monitored via participation of the Region 2 Quality Management Director and Beacon corporate level Quality Leads in oversight meetings with the vendor to receive regular updates on this new partnership. This will also be monitored via other members of the local Beacon-PA Leadership Team as part of the Operations meetings.

	data repositories for future reference. Identification of high risk indicators through the study of previous data sets. Develop a system of tracking mechanisms for high risk members admitted to inpatient facilities. Testing kicked off in separate Beacon market with Inovolan for initial partnership. Beacon-PA, as part of Region 2 of Beacon Health Options, will proceed with next phase of Inovolan roll out and implementation. Beacon-PA data that has been migrated to Inovalon is currently being reviewed and tested for quality assurance.	Partially completed 2018/Planned for Third/Fourth Quarters 2019 Full implementation anticipated by Third Quarter 2020	

VI: 2019 Strengths and Opportunities for Improvement

The review of BHO's 2019 (MY 2018) performance against structure and operations standards, performance improvement projects, and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH-MCO.

Strengths

- BHOs overall PIP Project Performance Score was a Partial Met.
  - BHO did demonstrate some sustained improvement through the Final PIP submission, especially as measured by their Behavioral Health Readmission measures (for Mental Health and Substance Abuse diagnoses). The MCO did not evidence significant improvement in the SAA indicator over the course of the PIP. DMP rates on the whole improved, including follow-up visits occurring within 0-14 days of discharge, suggesting that the intervention was increasing follow-up rates.
- BHO's MY 2018 PA-Specific 7- and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI A and QI B) for the 6-17 years age set was statistically significantly above the MY 2018 HC BH (Statewide) rates.
- BHO's MY 2018 HEDIS 7-Day and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for 6-17 years age set population were significantly above the corresponding Statewide averages.
- BHO's MY 2018 Initiation and Engagement of AOD Treatment rate was significantly above the corresponding Statewide averages.
- BHO's MY 2018 Engagement of AOD Treatment rate achieved the goal of meeting or exceeding the HEDIS 75th percentile.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2016, RY 2017, and RY 2018 found BHO to be partially compliant with three Subparts associated with Structure and Operations Standards.
  - BHO was partially compliant with 1 out of 7 categories within Subpart C: Enrollee Rights and Protections Regulations. The partially compliant category is Enrollee Rights.
  - BHO was partially compliant with 6 out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization, 4) Subcontractual Relationships and Delegations, 5) Practice Guidelines, and 6) Quality Assessment and Performance Improvement Project.
  - BHO 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 Subcontractors and Providers, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.
- BHO's MY 2018 HEDIS 7-Day and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for the 18-64 and 65+ years population were significantly below the Statewide averages for these age groups.
- BHO's MY 2018 PA-Specific 7-Day and 30-Day Follow-up After Hospitalization for Mental Illness (QI A and QI B) rates for the 18-64 and 65+ years populations were significantly below the Statewide average for these age groups.
- BHO's MY 2018 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.
- BHO's MY 2018 Initiation of AOD Treatment rate did not achieve the goal of meeting or exceeding the HEDIS 75th percentile.
- BHO's MY 2018 Initiation of AOD Treatment rates for the 18+ years age set was significantly below the Statewide average.
- BHO's MY 2018 Initiation and Engagement of AOD Treatment rates for the 18+ years age cut dropped significantly from MY 2017.
- BHO's MY 2018 Initiation and Engagement in AOD Treatment rates for all age cuts dropped significantly from MY 2017.

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 2018 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 (═).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 2018 PA-Specific 7- and 30-Day Follow-up After Hospitalization and MY 2018 Readmission Within 30 Days of Inpatient Psychiatric Discharge (All Ages)

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
	No Change	D FUH QI A REA[1]	C 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: A: 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 (All Ages).

FUH QI B: PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (All Ages).

REA: Readmission Within 30 Days of Inpatient Psychiatric Discharge.

Table 6.2 quantifies the performance information presented in **Table 6.1**. It compares the BH-MCO's MY 2018 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 2014 through 2018. The last column compares the BH-MCO's MY 2018 rates to the corresponding MY 2018 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 (═).

Table 6.2: MY 2018 PA-Specific 7- and 30-Day Follow-up after Hospitalization and MY 2018 Readmission Within 30 Days of Inpatient Psychiatric Discharge Rates, Compared Year-over-Year and to HC BH Statewide (All Ages)

Quality Performance Measure	MY 2014 Rate	MY 2015 Rate	MY 2016 Rate	MY 2017 Rate	MY 2018 Rate	MY 2018 HC BH (Statewide) Rate
QI A – PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness (Overall)	57.6% ═	55.7% ▼	54.6%═	49.6%▼	**50.9%**═	53.1%▼
QI B – PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall)	76.6% ═	75.2% ═	75.2%═	72.0%▼	**70.5%**═	69.6%═
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	12.1% ═	11.7% ═	11.7% ═	13.1%▼	**12.4%**═	13.7%▼

[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 2018 performance as compared to the HEDIS 90th, 75th, 50th, and 25th percentiles for the MY 2018 HEDIS All Ages (6+ years) FUH 7-Day (QI1) and 30-Day Follow-up (QI2) After Hospitalization metrics. A root cause analysis (RCA) and quality improvement plan (QIP) is required for rates that fall below the 75th percentile.

Table 6.3: BH-MCO Performance Matrix for MY 2018 HEDIS FUH 7- and 30-Day Follow-up After Hospitalization (All Ages)

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 and over.
FUH QI 1: HEDIS 7-Day Follow-up After Hospitalization for Mental Illness (All Ages).
FUH QI 2: HEDIS 30-Day Follow-up After Hospitalization for Mental Illness (All Ages).

Table 6.4 shows the BH-MCO's MY 2018 performance for HEDIS (FUH) 7- and 30-day Follow-up After Hospitalization for Mental Illness (All Ages) relative to the corresponding HEDIS MY 2018 NCQA Quality Compass percentiles.

Table 6.4: BH-MCO's MY 2018 FUH Rates Compared to the Corresponding MY 2018 HEDIS 75th Percentiles (All Ages)

Quality Performance Measure	MY 2018		HEDIS MY 2018 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-up After Hospitalization for Mental Illness (6–64 Years)	40.6%	Not Met	Above the 50th, below the 75th percentile
QI 2 – HEDIS 30-Day Follow-up After Hospitalization for Mental Illness (6–64 Years)	64.0%	Not Met	Above the 50th, below the 75th percentile

[1] Rates shown are for ages 6+ years.

VII: Summary of Activities

Structure and Operations Standards

- BHO was partially compliant with Subparts C, D, and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2016, RY 2017, and RY 2018 were used to make the determinations.

Performance Improvement Projects

- BHO submitted a Final PIP Report in 2019. BHO's overall PIP performance was a Partial Met.

Performance Measures

- BHO reported all performance measures and applicable quality indicators in 2019.

Quality Studies

- SAMHSA's CCBHC Demonstration continued in 2018. For any of its member receiving CCBHC services, BHO covered those services under a Prospective Payment System rate.

2017 Opportunities for Improvement MCO Response

- BHO provided a response to the opportunities for improvement issued in 2018.

2018 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for BHO in 2019. The BH-MCO will be required to prepare a response in 2020 for the noted opportunities for improvement.

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Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for Required PEPS Substandards pertinent to BBA Regulations.[3]

Table A.1: Required PEPS Substandards Pertinent to BBA Regulations

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Substandard 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.
	Substandard 60.2	Training rosters and training curriculums identify that Complaint and Grievance staff has been adequately trained on Member rights related to the processes and how to handle and respond to member Complaints and Grievances.
	Substandard 60.3	The BH-MCO's Complaint and Grievance policies and procedures comply with the requirements set forth in Appendix H.
	Substandard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DHS.
	Substandard 104.2	The BH-MCO must submit to the DHS data specified by the DHS that enable 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.
	Substandard 104.3	Performance Improvement Plans status reported within the established time frames.
	Substandard 104.4	The BH-MCO submitted the following within established time frames: Annual Evaluation, QM Program Description, QM Work Plan, and Quarterly PEPS Reports.
	Substandard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Substandard 108.2	C/FST budget is sufficient to: hire staff proportionate to HealthChoices covered lives; have adequate office space; purchase equipment; travel and attend on-going training.
	Substandard 108.5	The C/FST has access to providers and HealthChoices members to conduct surveys, and employs a variety of survey mechanisms to determine member satisfaction; e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Substandard 108.6	The problem resolution process specifies the role of the County, BH-MCO, C/FST and providers, and results in timely follow-up of issues identified in quarterly surveys.
	Substandard 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.
	Substandard 108.8	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.
	Substandard 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	Substandard 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 time frames (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 database with the following information: Name of Agency (include satellite

[3] In 2018, five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, a "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020).

BBA Category	PEPS Reference	PEPS Language
		sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (e.g., adult, child and adolescent); Priority Population; Special Population.
	Substandard 1.2	100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.
	Substandard 1.3	Provider Exception report submitted and approved when choice of two providers is not given.
	Substandard 1.4	BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).
	Substandard 1.5	BH-MCO has notified the Department of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Substandard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees.
	Substandard 1.7	Confirm FQHC providers.
	Substandard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Substandard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Substandard 23.3	List of oral interpreters is available for non-English speakers.
	Substandard 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.)
	Substandard 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.)
	Substandard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Substandard 24.2	Provider network database contains required information for ADA compliance.
	Substandard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Substandard 24.4	BH-MCO is able to access interpreter services.
	Substandard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Substandard 24.6	BH-MCO can make alternate formats available upon request.
	Substandard 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.
	Substandard 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.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Substandard	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow-

BBA Category	PEPS Reference	PEPS Language
	93.4	up After Hospitalization rates, and Consumer Satisfaction.
§438.208 Coordination and Continuity of Care	Substandard 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.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.210 Coverage and authorization of services	Substandard 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.
	Substandard 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.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.210 Provider Selection	Substandard 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.
	Substandard 10.2	100% of decisions made within 180 days of receipt of application.
	Substandard 10.3	Recredentialing incorporates results of provider profiling.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
§438.230 Subcontractual relationships and delegation	Substandard 99.1	The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning.
	Substandard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Substandard 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.
	Substandard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Substandard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds, and performance goals.
	Substandard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Substandard 99.7	Providers are evaluated based on established goals and corrective action taken, as necessary.
	Substandard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Substandard 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.
	Substandard	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is

BBA Category	PEPS Reference	PEPS Language
	28.2	supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.240 Quality assessment and performance improvement program	Substandard 91.1	The QM Program Description clearly outlines the BH-MCO QM structure.
	Substandard 91.2	The QM Program Description clearly outlines the BH-MCO QM content.
	Substandard 91.3	The QM Program Description includes the following basic elements: Performance improvement projects Collection and submission of performance measurement data Mechanisms to detect underutilization and overutilization of services Emphasis on, but not limited to, high volume/high-risk services and treatment, such as Behavioral Health Rehabilitation Services Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs.
	Substandard 91.4	The QM Work Plan includes: Objective Aspect of care/service Scope of activity Frequency Data source Sample size Responsible person Specific, measurable, attainable, realistic and timely performance goals, as applicable.
	Substandard 91.5	The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).
	Substandard 91.6	The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.
	Substandard 91.7	The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members: Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates Appropriateness of service authorizations and inter-rater reliability Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction.
	Substandard 91.8	The QM Work Plan includes a provider profiling process.
	Substandard 91.9	The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services: Telephone access and responsiveness rates Overall utilization patterns and trends including BHRS and other high volume/high risk services.
	Substandard 91.10	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.
	Substandard 91.11	The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.
	Substandard 91.12	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 Evaluation
	Substandard 91.13	The identified performance improvement projects must include the following: Measurement of performance using objective quality indicators Implementation of system interventions to achieve improvement in quality Evaluation of the effectiveness of the interventions Planning and initiation of activities for increasing or sustaining improvement Timeline for reporting status and results of each project to the Department of Human Services (DHS) 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
	Substandard 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.
	Substandard	The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality

BBA Category	PEPS Reference	PEPS Language
	91.15	management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan.
	Substandard 93.1	The BH-MCO reports monitoring results for Access to Services (e.g., routine, urgent, and emergent), Provider network adequacy, and Penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance, and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow-up After Hospitalization rates, and Consumer Satisfaction.
	Substandard 98.1	The BH-MCO reports monitoring results for telephone access standard and responsiveness rates. Standard: Abandonment rate
	Substandard 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.
	Substandard 98.3	The BH-MCO reports monitoring results for coordination with other service agencies and schools.
	Substandard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DHS.
	Substandard 104.2	The BH-MCO must submit to the DHS data specified by the DHS that enable 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.
	Substandard 104.3	Performance Improvement Plans status reported within the established time frames.
	Substandard 104.4	The BH-MCO submitted the following within established time frames: Annual Evaluation QM Program Description, QM Work Plan, and Quarterly PEPS Reports.
§438.242 Health information systems	Substandard 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	Substandard 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. • 1st level • 2nd level • External • Expedited • Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.4 (RY 2016, RY 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent

BBA Category	PEPS Reference	PEPS Language
		corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review
	Substandard 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: • Internal • External • Expedited • Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.402 General requirements	Substandard 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.
	Substandard 60.2	Training rosters and training curriculums identify that Complaint and Grievance staff has been adequately trained on Member rights related to the processes and how to handle and respond to member Complaints and Grievances.
	Substandard 60.3	The BH-MCO's Complaint and Grievance policies and procedures comply with the requirements set forth in Appendix H.
	Substandard 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. • 1st level • 2nd level • External • Expedited • Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and 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).

BBA Category	PEPS Reference	PEPS Language
	Substandard 68.4 (RY 2016, RY 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review
	Substandard 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: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.404 Notice of action	Substandard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Substandard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Substandard 23.3	List of oral interpreters is available for non-English speakers.
	Substandard 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.)
	Substandard 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.)
	Substandard 24.1	BH-MCO provider application includes information about handicapped accessibility.

BBA Category	PEPS Reference	PEPS Language
	Substandard 24.2	Provider network database contains required information for ADA compliance.
	Substandard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Substandard 24.4	BH-MCO is able to access to interpreter services.
	Substandard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Substandard 24.6	BH-MCO can make alternate formats available upon request.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.406 Handling of grievances and appeals	Substandard 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. • 1st level • 2nd level • External • Expedited • Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.4 (RY 2016, RY 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review
	Substandard 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: • Internal • External • Expedited • Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

BBA Category	PEPS Reference	PEPS Language
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.408 Resolution and notification: Grievances and appeals	Substandard 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. ● 1st level ● 2nd level ● External ● Expedited ● Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.4 (RY 2016, RY 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review
	Substandard 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: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

BBA Category	PEPS Reference	PEPS Language
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.410 Expedited resolution of appeals	Substandard 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: • Internal • External • Expedited • Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.414 Information about the grievance system to providers and subcontractors	Substandard 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. • 1st level • 2nd level • External • Expedited • Fair Hearing

BBA Category	PEPS Reference	PEPS Language
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.4 (RY 2016, RY 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review
	Substandard 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: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
§438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending	Substandard 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: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to

BBA Category	PEPS Reference	PEPS Language
		where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).
§438.424 Effectuation of reversed appeal resolutions	Substandard 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: • Internal • External • Expedited • Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Substandard 72.2	The content of the notices adheres 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; and contains date denial decision will take effect).

Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-Specific PEPS Substandards.[4]

Table B.1: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Care Management		
Care Management (CM) Staffing	Substandard 27.7	Other: Significant onsite review findings related to Standard 27.
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	Other: Significant onsite review findings related to Standard 28.
Complaints and Grievances		
Complaints	Substandard 68.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including, but not limited to: the Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
	Substandard 68.1.2	Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints.
	Substandard 68.5	A verbatim transcript and/or recording of the second level Complaint review meeting is maintained to demonstrate appropriate representation, adherence to the Complaint review meeting process, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Substandard 68.6	Sign-in sheets are included for each Complaint review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
	Substandard 68.6 (RY 2016, RY 2017)	The second level complaint case file includes documentation that the member was contacted about the second level complaint meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
	Substandard 68.7 (RY 2016, RY 2017)	Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.
	Substandard 68.8	Complaint case files include Member and provider contacts related to the Complaint case, investigation notes and evidence, Complaint review summary and identification of all review committee participants, including name, affiliation, job title and role.
Grievances and State Fair Hearings	Substandard 71.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.

[4] In 2018, two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, a "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020).

Category	PEPS Reference	PEPS Language
	Substandard 71.1.2	Training rosters and training curriculums identify that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.
	Substandard 71.5	A verbatim transcript and/or recording of the Grievance review meeting is maintained to demonstrate appropriate representation, adherence to the Grievance review meeting process, familiarity with the issues being discussed and that input was provided from all panel members.
	Substandard 71.5 (RY 2016, RY 2017)	The second level grievance case file includes documentation that the member was contacted about the second level grievance 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 71.6	Sign-in sheets are included for each Grievance review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
Grievances and State Fair Hearings	Substandard 71.6 (RY 2016, RY 2017)	Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.
	Substandard 71.8	Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role.
Denials		
Denials	Substandard 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	Substandard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Substandard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/ Family Satisfaction	Substandard 108.3	County/BH-MCO role of fiduciary (if applicable) is clearly defined and provides supportive function, as defined in C/FST Contract, as opposed to directing the program.
	Substandard 108.4	The C/FST Director is responsible for setting program direction consistent with County direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority, and directing staff to perform high-quality surveys.
	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.

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In 2018, two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, a parenthetical notation "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020). In RY 2018, 16 OMHSAS-specific substandards were evaluated for BHO and its Contractors. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in RY 2018, along with the relevant categories.

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

Category (PEPS Standard)	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
	Total	NR	RY 2018	RY 2017	RY 2016
Care Management					
Care Management (CM) Staffing (Standard 27)	1	0	0	1	0
Longitudinal Care Management (and Care Management Record Review) (Standard 28)	1	0	0	1	0
Complaints and Grievances					
Complaints (Standards 68 and 68.1)	4	0	0	4	0
Grievances and State Fair Hearings (Standards 71 and 71.1)	4	0	0	4	0
Denials					
Denials (Standard 72)	1	0	1	0	0
Executive Management					
County Executive Management (Standard 78)	1	0	0	1	0
BH-MCO Executive Management (Standard 86)	1	0	0	1	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	3	0	0
Total	16	0	16	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 substandards that were deemed not applicable to the HealthChoices Oversight Entity/BH-MCO.

[2] The number of OMHSAS-Specific substandards that came under active review during the cycle specific to the review year. OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year. NR: Substandards not reviewed; N/A: Category not applicable.

Format

This document groups the monitoring standards under the subject headings Care Management, 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

Care Management

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. There are two substandards crosswalked to this category, and CCBH and its HC BH Contractors were partially compliant with two substandards. The status for these substandards is presented in **Table C.2**.

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

Category	PEPS Item	RY	Status by HC BH Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Standard 27.7	2017	All HC BH Contractors		
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	2017	All HC BH Contractors		

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year.

BHO met the criteria for compliance with PEPS Standard 27 and Standard 28.

Complaints and Grievances

The OMHSAS-specific PEPS Substandards relating to second-level complaints and grievances are MCO and HC BH Contractor-specific review standards. Ten (10) substandards were evaluated for all HC BH Contractors during RY 2017. All of BHO's HC BH Contractors met 7 substandards and partially met 3 substandards. Findings are presented in **Table C.3**.

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

Category	PEPS Item	RY	Status by HC BH Contractor			
			Met	Partially Met	Not Met	Not Reviewed
Complaints and Grievances						
Complaints	Substandard 68.1.1	2017		Crawford/Mercer/ Venango, Southwest Six, and Fayette	Beaver	Greene
	Substandard 68.5	2017		Crawford/Mercer/ Venango, Southwest Six, and Fayette	Beaver	Greene
	Substandard 68.6 (RY 2016, RY 2017)	2017	All HC BH Contractors			
	Substandard 68.7 (RY 2016, RY 2017)	2017	All HC BH Contractors			
Grievances and State Fair Hearings	Substandard 71.1.1	2017		Crawford/Mercer/ Venango, Southwest Six, and Fayette	Beaver	Greene
	Substandard 71.5 (RY 2016, RY 2017)	2017	All HC BH Contractors			
	Substandard 71.5	2017		All HC BH Contractors		
	Substandard 71.6 (RY 2016, RY 2017)	2017		All HC BH Contractors		

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year.

Three HC BH Contractors associated with BHO (Crawford/Mercer/ Venango, Southwest Six, and Fayette) were partially compliant with Standard 68.1, Substandard 1 and Standard 68, Substandard 5. Beaver was non-compliant with Standard 68.1, Substandard 1 and Standard 68, Substandard 5 and Greene was not reviewed for these substandards.

PEPS Standard 68.1: The Primary Contractor is responsible for monitoring the Complaint process for compliance with Appendix H and the Program Evaluation Performance Summary (PEPS).

Substandard 1: Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including but not limited to: The Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns

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.

Substandard 5: A verbatim transcript and/or recording of the second level Complaint review meeting is maintained to demonstrate appropriate representation, adherence to the Complaint review meeting process, familiarity with the issues being discussed and that the decision was based on input from all panel members.

PEPS Standard 71.1: The Primary Contractor is responsible for monitoring the Grievance process for compliance with Appendix H and the Program Evaluation Performance Summary (PEPS).

Three HC BH Contractors associated with BHO (Crawford/Mercer/ Venango, Southwest Six, and Fayette) were partially compliant with Standard 71.1, Substandard 1. Beaver was non-compliant with Standard 71.1, Substandard 1 and Greene was not reviewed for this substandard.

Substandard 1: Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, including but not limited to: The Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.

PEPS Standard 71: Grievances and State fair hearings. 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.

All HC BH Contractors associated with BHO were partially compliant with Standard 71.1, Substandard 1, and with Standard 71, Substandards 5 and 6 (RY 2016, RY 2017).

Substandard 5: A verbatim transcript and/or recording of the Grievance review meeting is maintained to demonstrate appropriate representation, adherence to the Grievance review meeting process, familiarity with the issues being discussed and that input was provided from all panel members.

Substandard 6 (RY 2016, RY 2017)**:** Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.

Denials

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2016. BHO 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	RY	Status
Denials			
Denials	Standard 72.3	2018	Met

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year.

Executive Management

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. With the exception of Beaver and Fayette, all of the HC BH Contractors met the compliance standards for both Substandards. Beaver and Fayette were partially compliant with PEPS Standard 78, Substandard 5. Because Greene County has no subcontractor relationship with BHO, Standard 78 does not apply to Greene County. BHO was found compliant with the BH-MCO Executive Management substandard (Standard 86, Substandard 3). The status for the Executive Management substandards is presented in **Table C.5**.

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

Category	PEPS Item	RY	Status By HC BH Contractor			
			Met	Partially Met	Not Met	Not Reviewed
Executive Management						
County Executive Management	Standard 78.5	2017	Crawford/Mercer/Venango, Southwest Six	Fayette	Beaver	Greene
BH-MCO Executive Management	Standard 86.3	2017	All HC BH Contractors			

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year.

Enrollee Satisfaction

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are County-specific review standards. All three substandards crosswalked to this category were evaluated for the BHO HC BH Contractors, and all contractors were compliant with all three substandards. The status for these substandards is presented in **Table C.6**.

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

Category	PEPS Item	RY	Status by HC BH Contractor	
			Met	Partially Met
Enrollee Satisfaction				
Consumer/Family Satisfaction	Standard 108.3	2018	All HC BH Contractors	
	Standard 108.4	2018	All HC BH Contractors	
	Standard 108.9	2018	All HC BH Contractors	

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year.