Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services
2022 External Quality Review Report
Community Behavioral Health

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Table of Contents

List of Tables and Figures

Introduction

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an external quality review organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs).[1] This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients.

The Commonwealth of Pennsylvania (PA) Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2022 EQRs for HealthChoices (HC) behavioral health MCOs (BH-MCOs) and to prepare the annual technical reports. The subject of this report is one HC BH-MCO: Community Behavioral Health (CBH). Subsequent references to MCO in this report refer specifically to this HC BH-MCO.

Overview

HC BH is the mandatory managed care program which provides Medical Assistance recipients with BH services in PA. The PA DHS OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with PA for the administration of the HC BH Program. In such cases, DHS holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH contractors, referred to in this report as "Primary Contractors." Primary Contractors, in turn, subcontract with a private-sector BH-MCO to manage the HC BH Program. Effective July 1, 2021, 66 of the 67 counties exercised their right of first opportunity to contract directly with a Primary Contractor. In 2021, DHS held one contract on behalf of an opt-out county, Greene.

In the interest of operational efficiency, numerous counties have come together to create HC oversight entities (HC-OEs) that coordinate the Primary Contractors while providing an oversight function of the BH-MCOs. In some cases, the HC-OE is the HC BH contractor and, in other cases, multiple Primary Contractors contract with an HC-OE to manage their HC BH Program. In the CBH managed care network, the City of Philadelphia and Philadelphia County share a common border. As such, the City of Philadelphia is the HC-OE and the Primary Contractor that holds an agreement with CBH. CBH is a county-operated BH-MCO. Members enrolled in the HC BH Program in Philadelphia County are assigned CBH as their BH-MCO.

Objectives

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

- validation of performance improvement projects,
- validation of MCO performance measures,
- review to determine plan compliance with structure and operations standards established by the state (*Title 42 Code of Federal Regulations [CFR] Section [§] 438.358*), and
- validation of MCO network adequacy.

Scope of EQR Activities

In accordance with the updates to the Centers for Medicare and Medicaid Services (CMS) EQRO Protocols released in late 2019[2] this technical report includes eight core sections:

I. Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Review of Compliance with Medicaid Managed Care Regulations
IV. Validation of Network Adequacy
V. Quality Studies
VI. 2021 Opportunities for Improvement – MCO Response
VII. 2022 Strengths and Opportunities for Improvement
VIII. Summary of Activities

For the MCO, information for **Sections I** and **II** of this report is derived from IPRO's validation of the MCO's performance improvement projects (PIPs) and performance measure (PM) submissions. The PM validation, as conducted by IPRO, included a repeated measurement of three PMs: HEDIS Follow-Up After Hospitalization for Mental Illness, and PA-specific Follow-Up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. The information for compliance with Medicaid Managed Care Regulations in **Section III** 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 PA's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable. **Section IV** discusses the validation of MCO network adequacy in relation to existing federal and state standards that are covered in the Review of Compliance with Medicaid Managed Care Regulations, **Section III**. **Section V** discusses the Quality Study for the Certified Community Behavioral Health Clinic (CCBHC) federal demonstration and the Integrated Community Wellness Centers (ICWC) program. **Section VI**, 2021 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2021 (measurement year [MY] 2020) EQR annual technical report and presents the degree to which the MCO addressed each opportunity for improvement. **Section VII** includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2021), 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 VIII** provides a summary of EQR activities for the MCO for this review period. Also included are: **References** with a list of publications cited, as well as **Appendices** that include crosswalks of PEPS standards to pertinent BBA regulations and to OMHSAS-specific PEPS substandards, and results of the PEPS review for OMHSAS-specific standards.

I: Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

In accordance with current BBA regulations, IPRO validates at least one PIP for the MCO. The Primary Contractors and MCOs are required to implement improvement actions and to conduct follow-up, including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action.

Calendar year (CY) 2021 saw the initial implementation stage of the new PIP project. During this stage, the PIP project was renamed "Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders" (SUD) in accordance with feedback received by the BH-MCOs and Primary Contractors during the first year of the PIP. The MCOs submitted their recalculated baselines which allowed for any recalibration of their measures and subsequent interventions as needed.

The Aim Statement for this PIP remained: "Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach."

OMHSAS kept three common (for all MCOs) clinical objectives and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an opioid use disorder (OUD) and/or other SUD;
2. Improve retention in treatment for members with an OUD and/or other SUD diagnosis;
3. Increase concurrent use of drug and alcohol counseling in conjunction with pharmacotherapy (medication-assisted treatment [MAT]); and
4. Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH contracting networks. The two "activities" may fall under a single intervention or may compose two distinct interventions. Note that while the emphasis here is on population-based strategies, this non-clinical objective should be interpreted within the PIP lens to potentially include interventions that target or collaborate with providers and health care systems in support of a specific population (SUD) health objective.

Additionally, OMHSAS identified the following core performance indicators for the PEDTAR PIP:

1. **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)** – This Healthcare Effectiveness Data and Information Set (HEDIS®) measure measures "the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder."[3] It contains two submeasures: continuity of care within 7 days, and continuity of care within 30 days of the index discharge or visit.
2. **Substance Use Disorder-Related Avoidable Readmissions (SAR) –** This is a PA-specific measure that measures avoidable readmissions for HC members 13 years of age and older discharged from detox, inpatient rehab, or residential services with an alcohol and other drug dependence (AOD) primary diagnosis. The measure requires 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. The measure measures discharges, not individuals (starting from Day 1 of the MY, if multiple qualifying discharges within any 30-day period, only the earliest discharge is counted in the denominator). The SUD avoidable readmissions submeasure is intended here to complement FUI and recognizes that appropriate levels of care for individuals with SUD will depend on the particular circumstances and conditions of the individual. Therefore, for this submeasure, "avoidable readmission" will include detox episodes only.
3. **Mental Health-Related Avoidable Readmissions (MHR) –** This PA-specific measure will use the same denominator as SAR. The measure recognizes the high comorbidity rates of MH conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for MH conditions before they reach a critical

stage. For this measure, "readmission" will be defined as any acute inpatient admission with a primary MH diagnosis occurring within 30 days of a qualifying discharge from AOD detox, inpatient rehab, or residential services.

4. **Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of opioid use disorder (OUD) in the measurement period who received both BH counseling services and pharmacotherapy for their OUD during the measurement period. This PA-specific measure is based on a CMS measure of "the percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year."[4] This measure will be adapted to include members age 16 years and older. BH counseling is not necessarily limited to addiction counseling.
5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe alcohol use disorder (AUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD, except for members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

MCOs are expected to submit results to IPRO on an annual basis. In addition to running as annual measures, quarterly rates will be used to enable measurement on a frequency that will support continuous monitoring and adjustment by the MCOs and their Primary Contractors.

This PIP project will extend from January 2021 through December 2023, with initial PIP proposals submitted in 2020 and a final report due in September 2024. The report marks the 19th EQR review to include validation of PIPs. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline.

Technical Methods of Data Collection and Analysis

The MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with CMS protocols. These protocols follow a longitudinal format and capture information relating to:

- Project Topic
- Methodology
- Barrier Analysis, Interventions, and Monitoring
- Results
- Discussion

For the PEDTAR PIP, OMHSAS has designated the Primary Contractors to conduct quarterly PIP review calls with each MCO. The purpose of these calls will be 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 will be 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, rather than two semiannual submissions, MCOs will submit only one PIP interim report each September starting in 2021.

IPRO's validation of PIP activities is consistent with the protocol issued by CMS[5] and meets the requirements of the Final Rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 8 review elements listed below:

1. Topic Rationale
2. Aim
3. Methodology
4. Identified Study Population Barrier Analysis
5. Robust Interventions
6. Results
7. Discussion and Validity of Reported Improvement
8. Sustainability

The first seven 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 Met, Partially Met, and Not Met. Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. The overall score expresses the level of compliance.

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. MY 2020 is the baseline year, and for MY 2021, elements were reviewed and scored using the Year 1 annual reports submitted in 2022. All MCOs received some level of guidance towards improving their submissions in these findings.

Table 1.1 presents the terminologies used in the scoring process, their respective definitions, and their weight.

Table 1.1: Element Designation

Element Designation	Definition	Designation 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%

When the PIPs are reviewed, all projects are evaluated on the same elements. The scoring matrix is completed for those review elements where activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. Untimely reporting by the MCO, i.e., if not in accordance with the submission schedule, may be factored into the overall determination. At the time each element is reviewed, a finding is given of "Met," "Partially Met," or "Not Met." Elements receiving a "Met" will receive 100% of the points assigned to the element, "Partially Met" elements will receive 50% of the assigned points, and "Not Met" elements will receive 0%. Effective MY 2022, overall ratings below 85% (i.e., below "Met") will require action plans to remediate deficiencies in the PIP and/or its reporting.

The total points earned for each review element are weighted to determine the MCO's overall performance scores for a PIP. For the EQR PIPs, the highest achievable score for all demonstrable improvement elements—in this case, for MYs 2021 and 2022—is 80 points (80% x 100 points for full compliance; refer to **Table 1.2**).

Table 1.2: Review Element Scoring Weights (Scoring Matrix)

Review Element	Standard	Scoring Weight
1	Topic/rationale	5%
2	Aim	5%
3	Methodology	15%
4	Barrier analysis	15%
5	Robust interventions	15%
6	Results table	5%
7	Discussion and validity of reported improvement	20%
Total demonstrable improvement score		**80%**
8	Sustainability[1]	20%
Total sustained improvement score		**20%**
Overall project performance score		**100%**

[1]At the time of this report, these standards were not yet applicable in the current phase of PIP implementation.

As also noted in **Table 1.2** (Scoring Matrix), PIPs are reviewed for the achievement of sustained improvement. Sustained improvement is assessed for the final year of a PIP, in this case, for MY 2023. The evaluation of the sustained improvement area has two review elements. These review elements have a total weight of 20%, for a possible maximum total of 20 points. To receive these points, the MCO must sustain improvement relative to baseline after achieving

demonstrable improvement. The results for demonstrable and sustainable improvement will be reported by the MCO and evaluated by the EQRO at the end of the current PIP cycle and reported in a subsequent EQR annual technical report.

Findings

CBH successfully submitted a PEDTAR PIP proposal in the fall of 2020 based on an initial baseline period of July 1, 2019, through June 30, 2020. Implementation began in early 2021. The MCO subsequently resubmitted a revised proposal based on the full CY 2020 data with goals, objectives, and interventions recalibrated as needed. IPRO reviewed all baseline PIP submissions for adherence to PIP design principles and standards, including alignment with the statewide PIP aims and objectives as well as internal consistency and completeness. Clinical intervention highlights include improved awareness of SUD treatment resources among minority communities through community speaker meetings, learning collaboratives, warm hand-off incentivization, secret shopper monitoring for timely access to SUD providers, and root cause analysis for providers not delivering evidence-based MAT. For its population-based prevention strategy component, CBH is developing a two-fold vaping education program including a vaping toolkit and expert speaker session to discuss the health impacts of vaping to children and teens in Philadelphia schools and improving provider awareness on vaping through educational sessions on vaping and other provider resources.

Prevention, Early Detection, Treatment and Recovery (PEDTAR) for Substance Use Disorders

For the Year 1 implementation review, the MCO scored 75% (60 points out of a maximum possible weighted score of 80 points; data not shown). CBH is to be commended for preserving the logical structure of the PIP by explicitly linking aims to objectives to barriers to interventions. This greatly facilitates reporting, and even more importantly, learning. CBH also displays an agility in using Plan-Do-Study-Act (PDSA) cycles to adapt to new information and feedback, as it is doing, for example, with its Intervention 3 activities. However, CBH should consider ways to speed up some of its PDSA cycles where delays in implementation were noted. Finally, as of the writing of their report, CBH had terminated its population health strategy intervention with no replacement. A population health strategy intervention is a requirement of this PIP, which will need to be met. Since the vaping education intervention was fully implemented in 2021, this is not an issue for this review, but will be a concern going forward until addressed.

Table 1.3: CBH PIP Compliance Assessments – Interim Year 1 Report

Review Element	PEDTAR
Element 1. Project Topic/Rationale	Met
Element 2. Aim	Met
Element 3. Methodology	Met
Element 4. Barrier Analysis	Met
Element 5. Robust Interventions	Partially Met
Element 6. Results Table	Partially Met
Element 7. Discussion and Validity of Reported Improvement	Partially Met

II: Validation of Performance Measures

Objectives

In MY 2021, OMHSAS's HC Quality Program required MCOs to run three PMs as part of their quality assessment and performance improvement (QAPI) program: the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH), a PA-specific Follow-Up After Hospitalization for Mental Illness, and a PA-specific Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were remeasured in 2021. IPRO validated all three PMs reported by each MCO for MY 2021 to ensure that the PMs were implemented to specifications and state reporting requirements (*Title 42 CFR § 438.330[b][2]*).

Follow-Up After Hospitalization for Mental Illness

This PM 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, Primary Contractor, and BH-MCO rates to available national benchmarks and to prior years' rates.

MY 2002 was the first year that follow-up rates were reported. QI 1 and QI 2 utilize the HEDIS methodology for this measure. The PA-specific indicators were added to include services with high utilization in the HC 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 2020 (MY 2019), 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 are broken out by 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 were: product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications as needed. Indicator rates were calculated using only the BH-MCO's data systems to identify numerator positives (i.e., administratively).

This PM assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge.

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

Eligible Population for HEDIS Follow-Up

The entire eligible population was used for all 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH 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, 2021;
- A principal International Classification of Diseases, Ninth Revision (ICD-9) or International Classification of Diseases, Tenth Revision, Clinical Modification (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, 2021, 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, 2021. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS MY 2021 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 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 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.

Eligible Population for PA-Specific Follow-Up

The entire eligible population was used for all 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a principal diagnosis of mental illness occurring between January 1 and December 2, 2021;
- 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 2, 2021, 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 2, 2021. The PA-specific measure has been adjusted to allow discharges up through December 2, 2021, which allows for the full 30-day follow-up period where same-day follow-up visits may be counted in the numerator.

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

Mental health disorders contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. In 2019, an estimated 47.6 million adults aged 18 or older (19.1%) had any mental illness in the past year, while an estimated 11.4 million adults in the nation had a serious persistent mental illness (SPMI) in the past year, which corresponds to 4.6% of all U.S. adults.[6] Additionally, individuals diagnosed with schizophrenia or bipolar disorder have elevated rates of preventable medical comorbidities such as obesity, cardiovascular diseases, and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns, reduced use of preventive services, and substandard medical care that they receive.[7] Roughly one-third of adults with SPMI in any given year did not receive any mental health services.[8] Further research suggests that more than half of those with SPMI did not receive services because they could not afford the cost of care.[9] Cost of care broke down as follows: 60.8% of related expenses were attributed to loss of earnings, 31.5% were attributed to healthcare expenses, while 7.7% were attributed to payments for disability benefits.[10] 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 outcomes and to prevent long-term deterioration in people with SPMI.[11] As noted in *The State of Health Care Quality Report,*[12] 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.[13] 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.[14] 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.[15]

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long-standing concern of BH care systems, with some researchers having estimated that 40–60% of patients fail to connect with an outpatient clinician.[16] 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.[17]

There are various measures of treatment efficacy, such as service satisfaction, functional status, and health outcomes. Among them, rehospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment.[18] Avoidable inpatient readmission is 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. Additionally, mental illness continues to impact the PA population, including those with substance abuse concerns or SUD.[19] Measuring appropriate care transitions for members with mental illness, therefore, carries wider implications for the OMHSAS quality area related to SUD prevalence and outcomes.

As noted, timely follow-up after hospitalization for mental illness has been and remains a focus for OMHSAS, and results are reviewed for potential trends each year. MY 2021 results will be examined in the context of the COVID-19 pandemic, which has been implicated in rising prevalence of mental illness.[20] 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.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-Up After Hospitalization for Mental Illness, OMHSAS elected to retain and remeasure the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) indicator for this year's EQR. As directed by OMHSAS, IPRO developed the PM 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 remeasurement of the PM for validation soon thereafter for MY 2007, and then for MY 2008. Remeasurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2021 study conducted in 2022 was the 15th remeasurement of this indicator. Four clarifications were made to the specifications for MY 2013. If

a member was known to have multiple member IDs in the MY, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and a transfer to another acute facility. As with the Follow-Up After Hospitalization for Mental Illness measure, the rates provided are aggregated at the HC BH (statewide) level for MY 2021. This measure continued to be of interest to OMHSAS for the purposes of comparing Primary Contractor and BH-MCO rates to the OMHSAS performance goal and to prior rates.

This study examined BH services provided to members participating in the HC BH 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, the date-of-service, and diagnosis/procedure code criteria were outlined, as were other specifications as needed. This measure's calculation was based on administrative data only.

This PM 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 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH 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 2, 2021;
- 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; and
- 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. One significant change to this specification is the extension of the end date for discharges from December 1st to December 2nd to accommodate the full 30 days before the end of the MY.

Technical Methods of Data Collection and Analysis

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 Primary 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 years old and older, OMHSAS changed its benchmarking to the FUH All Ages (6+ years old) measure. OMHSAS established a 3-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 EQR annual technical report.

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 VI**.

For REA, OMHSAS designated the PM goal as better than (i.e., less than) or equal to 11.75% for the participating BH-MCOs and contractors. For this measure, lower rates indicate better performance.

Although not part of this report, OMHSAS sponsored in 2019 the rollout of an IPRO-hosted Tableau® server reporting platform, which allows users, including BH-MCOs and Primary Contractors, to interactively query data and produce reports on PMs. These reports include statistical and non-statistical summaries and comparisons of rates by various stratifications, including by demographics, such as race and ethnicity, as well as by participation status in the Medicaid Expansion program (PA continued its Medicaid Expansion under the Affordable Care Act in 2021). This interactive reporting provides an important tool for BH-MCOs and their Primary Contractors to set performance goals as well monitor progress toward those goals.

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 HC 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 2020 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *Z*-test statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

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

Where:

*N*1 = Current year (MY 2021) numerator,
*N*2 = Prior year (MY 2020) numerator,
*D*1 = Current year (MY 2021) denominator, and
*D*2 = Prior year (MY 2020) 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 2021) quality indicator rate, and
*p*2 = Prior year (MY 2020) quality indicator rate.

Two-tailed statistical significance tests were conducted at $p = 0.05$ 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.

Limitations

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for Primary Contractors. Caution should be exercised when interpreting results for small denominators. A denominator of 100 or greater is preferred for drawing conclusions from *Z*-tests of the PM 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.

Conclusions and Comparative Findings

The HEDIS follow-up indicators are presented for three age groups: ages 18–64 years, ages 6 years and older, and ages 6–17 years. The 6+ years old ("All Ages") results are presented to show the follow-up rates for the overall HEDIS population, and the 6–17 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 Primary Contractor level. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (and Primary Contractor with the same contracted BH-MCO). The Primary Contractor-specific rates were calculated using the numerators and denominators for that particular Primary Contractor. For each of these rates, the 95% confidence interval (CI) is reported. The HC BH aggregate (statewide) rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HC BH statewide rates to determine if they were statistically significantly above or below that value. Statistically significant BH-MCO differences are noted. Primary Contractor-specific rates were also compared to the HC BH statewide rates to determine if they were statistically significantly above or below that value. Statistically significant Primary Contractor-specific differences are noted.

The HEDIS follow-up results for the All-Ages and 18–64 years old age groups are compared to the HEDIS 2021 national percentiles to show BH-MCO and Primary Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile. The HEDIS follow-up results for the 6–17 years old age group are not compared to HEDIS benchmarks.

I: HEDIS Follow-Up Indicators

(a) Age Group: 18–64 Years Old

Table 2.1 shows the MY 2021 results for both the HEDIS 7-day and 30-day follow-up measures for members 18–64 years old compared to MY 2020.

Table 2.1: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Indicators (18–64 Years)

	MY 2021						MY 2021 Rate Comparison to:		
				95% CI			MY 2020		
Measure[1]	(N)	(D)	%	Lower	Upper	MY 2020 %	PPD	SSD	MY 2021 HEDIS Medicaid Percentiles
QI1 - HEDIS 7-Day Follow-Up (18–64 Years)									
Statewide	9984	29137	**34.3%**	33.7%	34.8%	36.4%	-2.2	YES	Below 75th Percentile, Above 50th Percentile
CBH	1066	5506	**19.4%**	18.3%	20.4%	20.1%	-0.8	NO	Below 25th Percentile
Philadelphia	1066	5506	**19.4%**	18.3%	20.4%	20.1%	-0.8	NO	Below 25th Percentile
QI2 - HEDIS 30-Day Follow-Up (18–64 Years)									
Statewide	15653	29137	**53.7%**	53.1%	54.3%	55.7%	-2.0	YES	Below 75th Percentile, Above 50th Percentile
CBH	1896	5506	**34.4%**	33.2%	35.7%	34.8%	-0.3	NO	Below 25th Percentile
Philadelphia	1896	5506	**34.4%**	33.2%	35.7%	34.8%	-0.3	NO	Below 25th Percentile

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 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; CBH: Community Behavioral Health.

For MY 2021, CBH was subcontracted to provide BH services to only one county located in the Southeast region of PA – Philadelphia County; therefore, the CBH performance alone provides the BH-MCO performance for Philadelphia County.

Figure 2.1 is a graphical representation of the MY 2021 HEDIS FUH 7- and 30-day follow-up rates in the 18–64 years old population for CBH and its associated Primary Contractor. The orange line represents the MCO average.

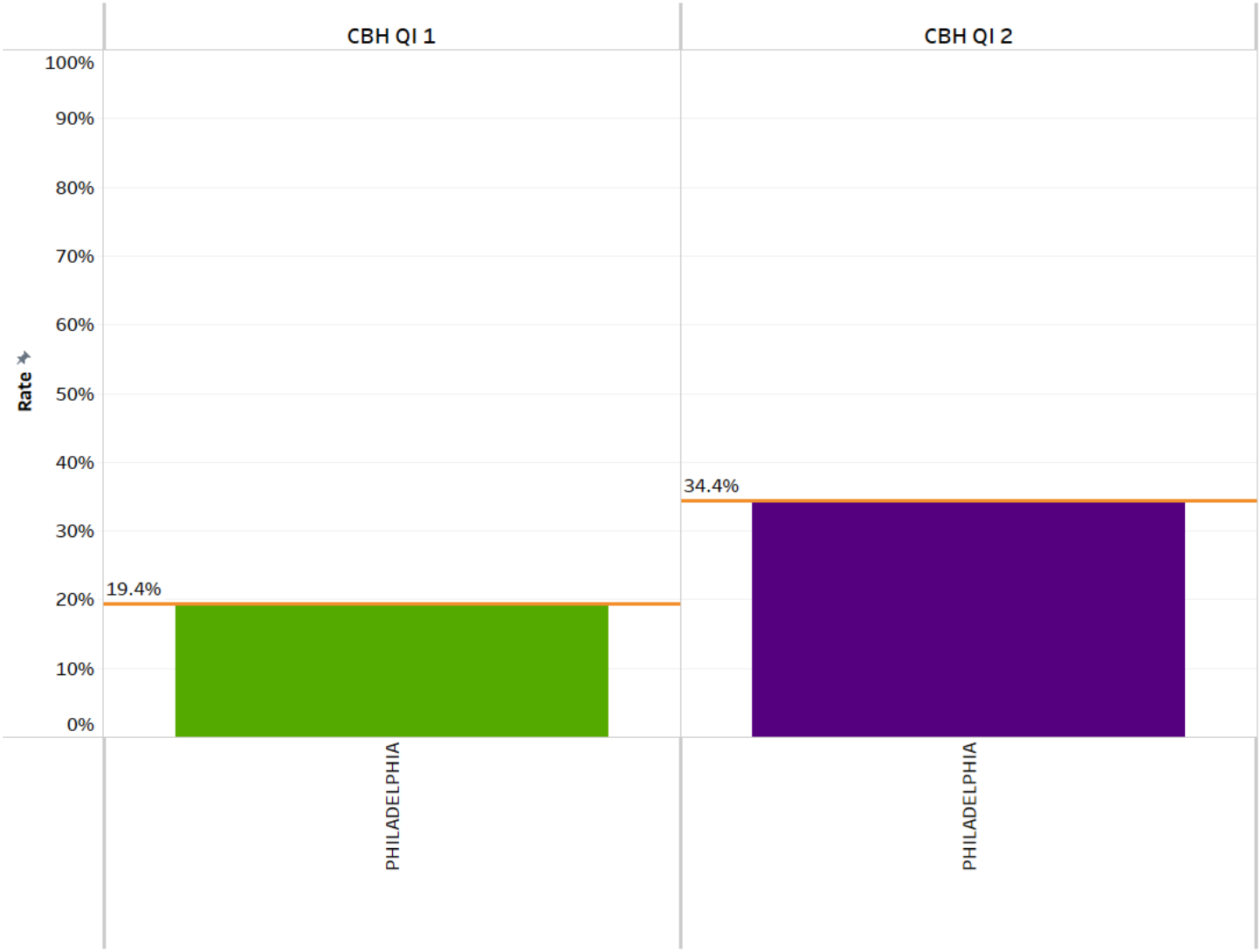

Figure 2.1: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years).

Figure 2.2 shows the HC BH (statewide) rates and the individual Primary Contractor rates for this age band that were statistically significantly higher (blue) or lower (red) than the statewide benchmark.

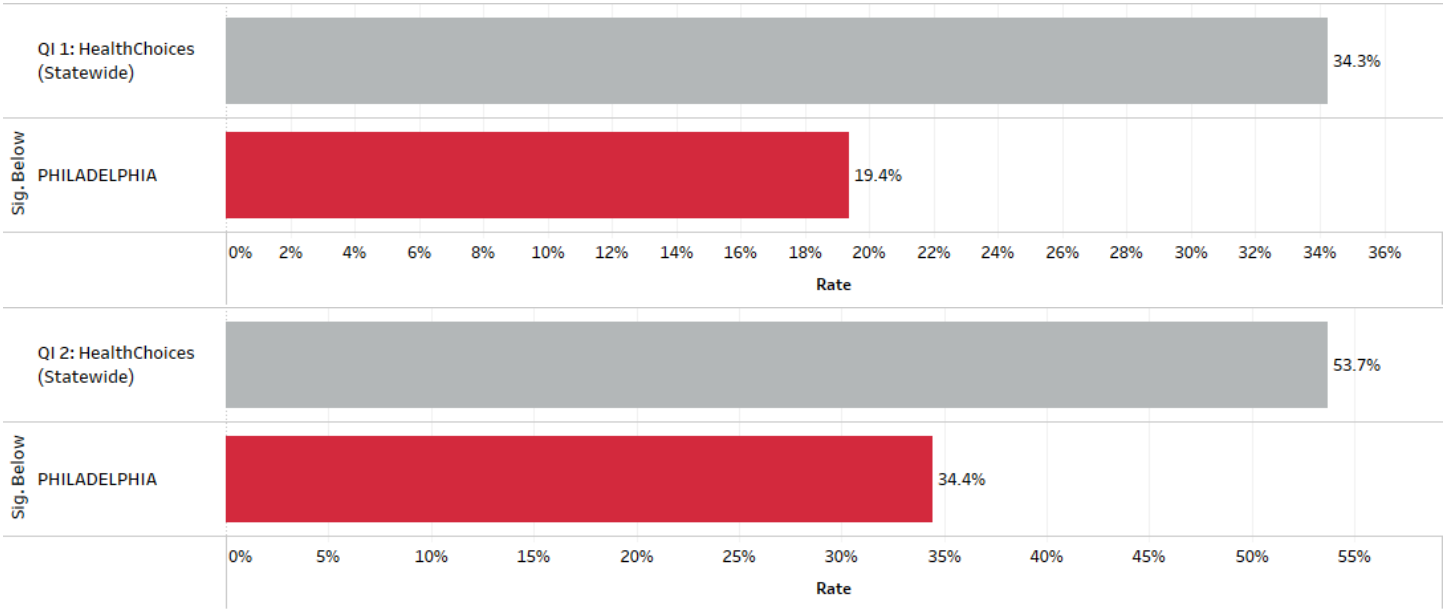

Figure 2.2: Statistically Significant Differences in CBH Contractor MY 2021 HEDIS FUH Rates (18–64 Years). CBH Primary Contractor MY 2021 HEDIS FUH rates for 18–64 years of age that are significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (18–64 years).

(b) Overall Population: 6+ Years Old

The MY 2021 HC aggregate HEDIS and CBH are shown in **Table 2.2**.

Table 2.2: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Indicators (All Ages)

	MY 2021						MY 2021 Rate Comparison to:		
				95% CI			MY 2020		
Measure[1]	(N)	(D)	%	Lower	Upper	MY 2020 %	PPD	SSD	MY 2021 HEDIS Medicaid Percentiles
QI1 - HEDIS 7-Day Follow-Up (Overall)									
Statewide	14140	37506	**37.7%**	37.2%	38.2%	39.8%	-2.1	YES	Below 50th Percentile, Above 25th Percentile
CBH	1514	6626	**22.8%**	21.8%	23.9%	23.1%	-0.3	NO	Below 25th Percentile
Philadelphia	1514	6626	**22.8%**	21.8%	23.9%	23.1%	-0.3	NO	Below 25th Percentile
QI2 - HEDIS 30-Day Follow-Up (Overall)									
Statewide	21707	37506	**57.9%**	57.4%	58.4%	59.4%	-1.6	YES	Below 50th Percentile, Above 25th Percentile
CBH	2510	6626	**37.9%**	36.7%	39.1%	38.0%	-0.1	NO	Below 25th Percentile
Philadelphia	2510	6626	**37.9%**	36.7%	39.1%	38.0%	-0.1	NO	Below 25th Percentile

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 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; CBH: Community Behavioral Health.

Figure 2.3 is a graphical representation of the MY 2021 HEDIS FUH follow-up rates in the overall population for CBH and its associated Primary Contractor. The orange line represents the MCO average.

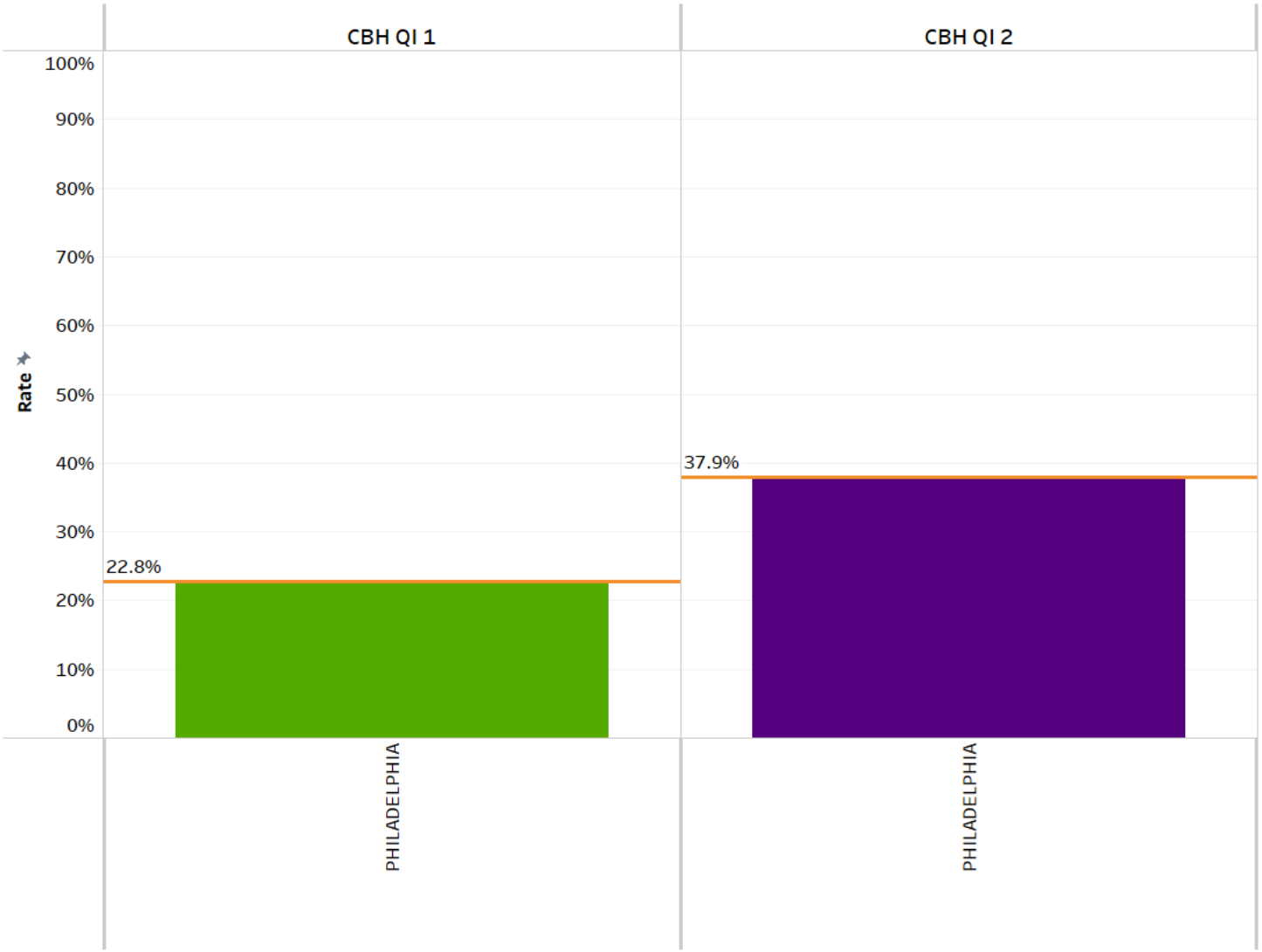

Figure 2.3: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages).

Figure 2.4 shows the HC BH (statewide) rates and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide benchmark.

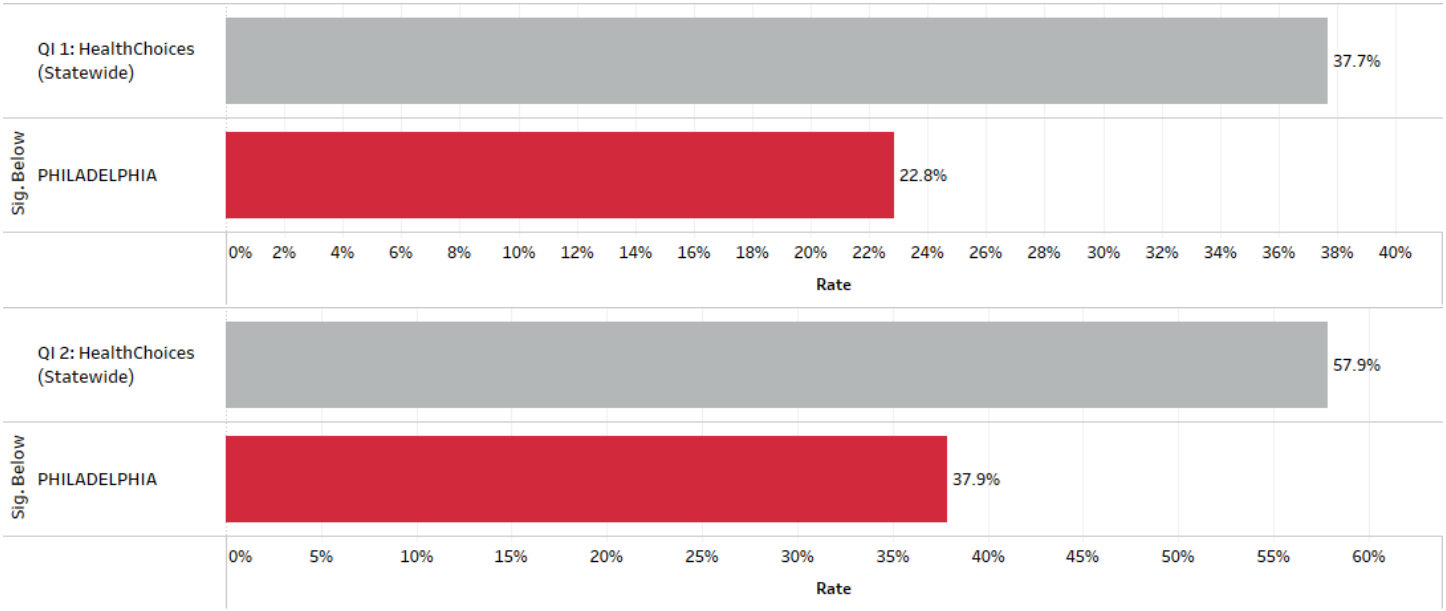

Figure 2.4: Statistically Significant Differences in CBH MY 2021 HEDIS FUH Rates (All Ages) CBH Primary Contractor MY 2021 HEDIS FUH rates for all ages that are significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (all ages).

(c) Age Group: 6–17 Years Old

Table 2.3 shows the MY 2021 results for both the HEDIS FUH 7-day and 30-day follow-up measures for members 6–17 years old compared to MY 2020.

Table 2.3: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Indicators (6–17 Years)

Measure[1]	MY 2021 (N)	MY 2021 (D)	MY 2021 %	95% CI Lower	95% CI Upper	MY 2020 %	MY 2021 Rate Comparison to MY 2020 PPD	MY 2021 Rate Comparison to MY 2020 SSD
QI1 - HEDIS 7-Day Follow-Up (6–17 Years)								
Statewide	3988	7625	**52.3%**	51.2%	53.4%	55.2%	-2.9	YES
CBH	427	940	**45.4%**	42.2%	48.7%	42.4%	3.0	NO
Philadelphia	427	940	**45.4%**	42.2%	48.7%	42.4%	3.0	NO
QI2 - HEDIS 30-Day Follow-Up (6–17 Years)								
Statewide	5787	7625	**75.9%**	74.9%	76.9%	77.1%	-1.2	NO
CBH	579	940	**61.6%**	58.4%	64.8%	61.3%	0.3	NO
Philadelphia	579	940	**61.6%**	58.4%	64.8%	61.3%	0.3	NO

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 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; CBH: Community Behavioral Health.

Figure 2.5 is a graphical representation of the MY 2021 HEDIS FUH 7- and 30-Day follow-up rates in the 6–17 years old population for CBH and its associated Primary Contractor. The orange line represents the MCO average.

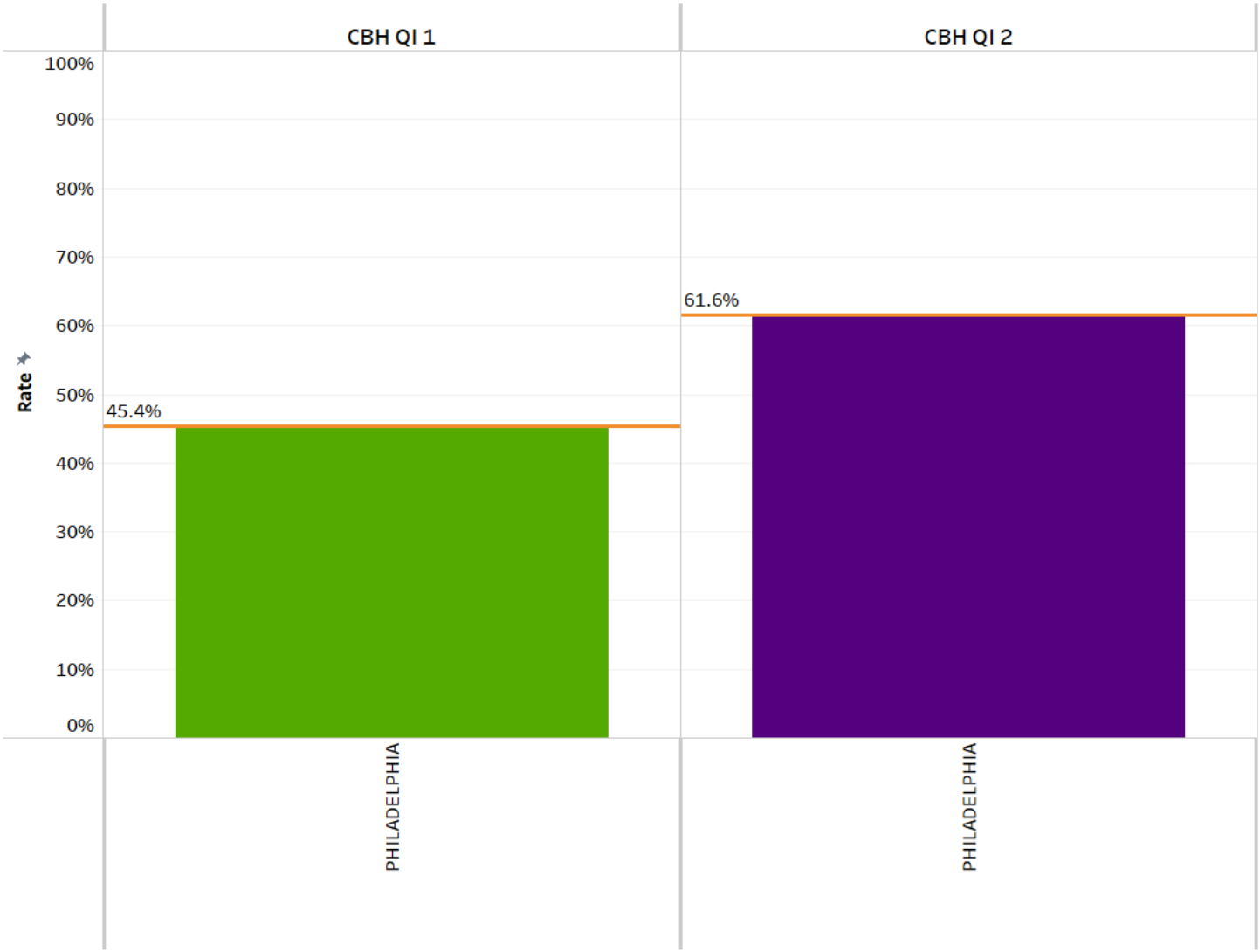

Figure 2.5: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years).

Figure 2.6 shows the HC BH (statewide) rates and the individual Primary Contractor rates for this age band that were statistically significantly higher (blue) or lower (red) than the statewide benchmark.

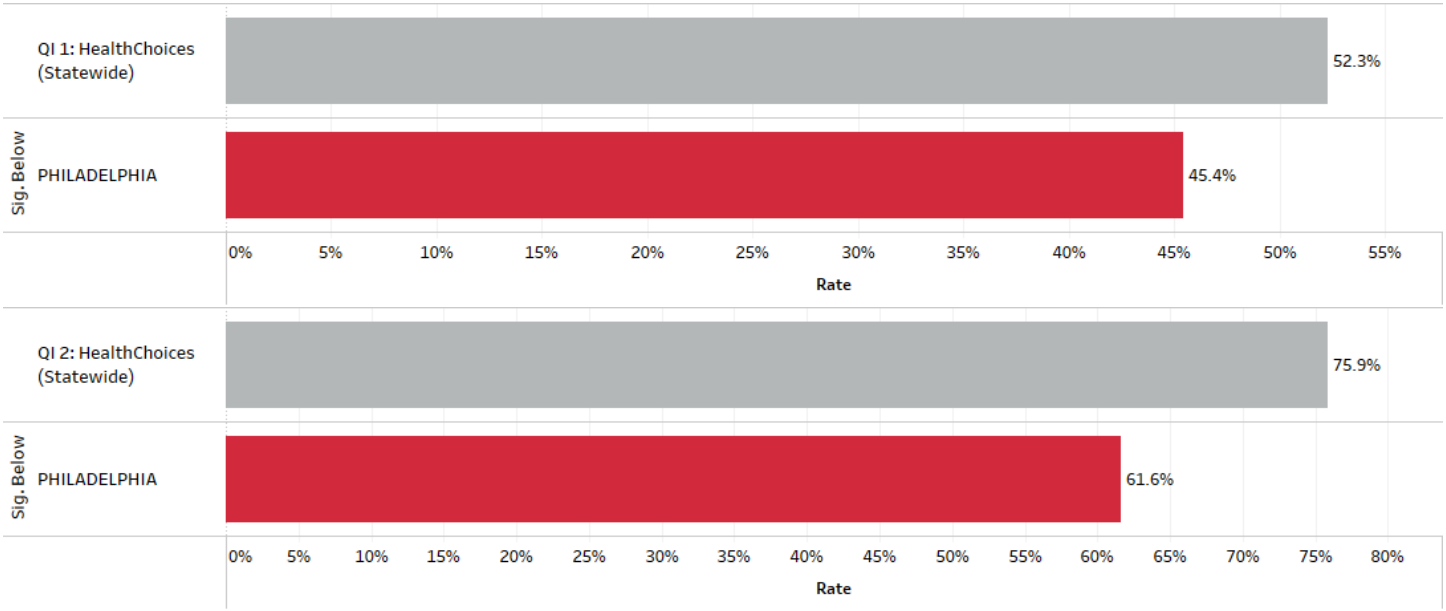

Figure 2.6: Statistically Significant Differences in CBH MY 2021 HEDIS FUH Rates (6–17 Years). CBH Primary Contractor MY 2021 HEDIS FUH rates for 6–17 years of age that are significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (6–17 years).

II: PA-Specific Follow-Up Indicators

(a) Overall Population: 6+ Years Old

Table 2.4 shows the MY 2021 PA-specific FUH 7- and 30-day follow-up indicators for all ages compared to MY 2020.

Table 2.4: MY 2021 PA-Specific FUH 7- and 30-Day Follow-Up Indicators (All Ages)

Measure[1]	MY 2021 (N)	MY 2021 (D)	MY 2021 %	95% CI Lower	95% CI Upper	MY 2020 %	MY 2021 Rate Comparison to MY 2020 PPD	MY 2021 Rate Comparison to MY 2020 SSD
QI A - PA-Specific 7-Day Follow-Up (Overall)								
Statewide	18376	37634	**48.8%**	48.3%	49.3%	52.3%	-3.5	YES
CBH	2629	6685	**39.3%**	38.1%	40.5%	42.0%	-2.7	YES
Philadelphia	2629	6685	**39.3%**	38.1%	40.5%	42.0%	-2.7	YES
QI B - PA-Specific 30-Day Follow-Up (Overall)								
Statewide	24798	37634	**65.9%**	65.4%	66.4%	68.3%	-2.4	YES
CBH	3615	6685	**54.1%**	52.9%	55.3%	56.8%	-2.8	YES
Philadelphia	3615	6685	**54.1%**	52.9%	55.3%	56.8%	-2.8	YES

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.
MY: measurement year; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

Figure 2.7 is a graphical representation of the MY 2021 PA-Specific follow-up rates in the overall population for CBH and its associated Primary Contractor. The orange line represents the MCO average.

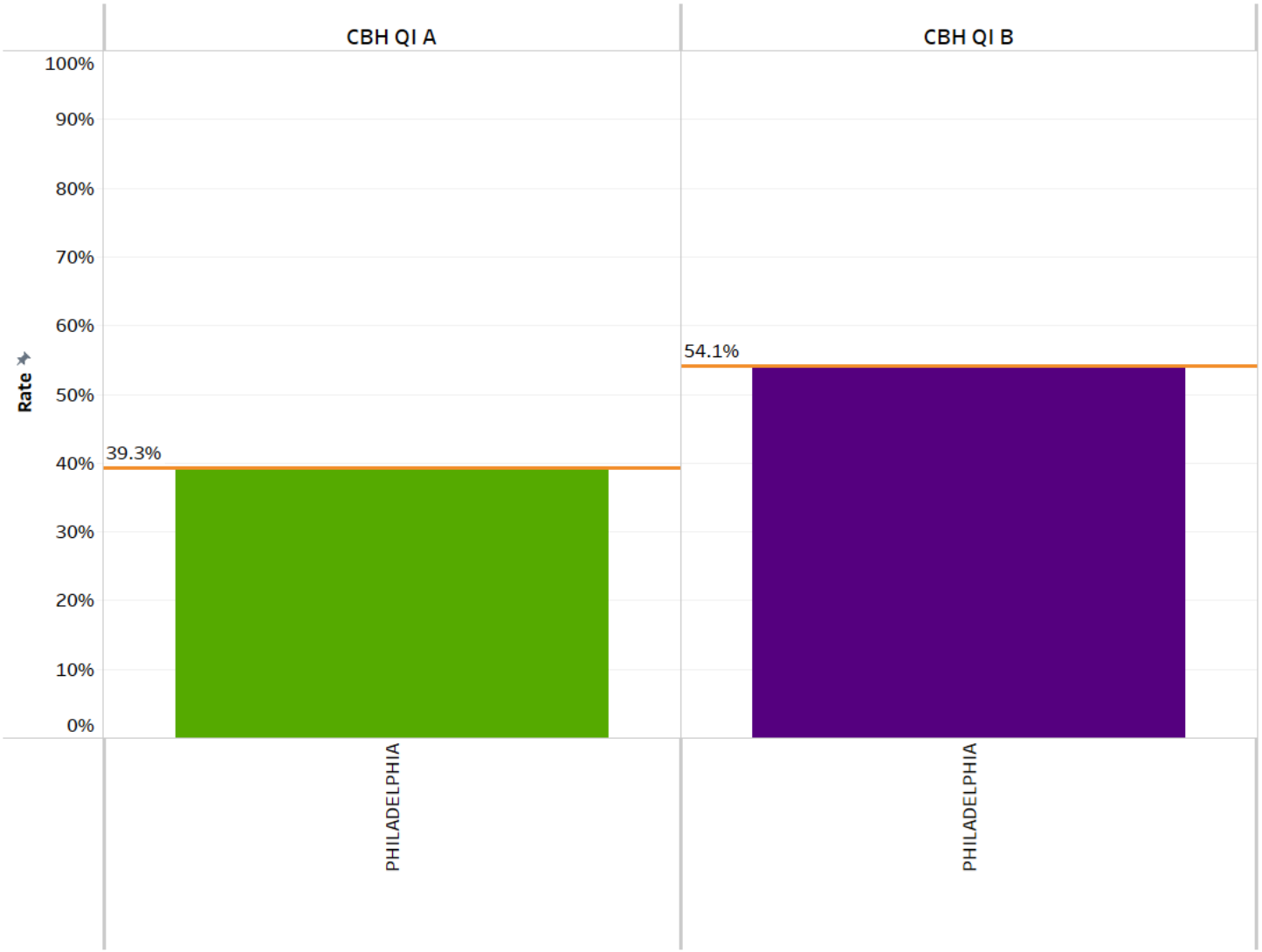

Figure 2.7: MY 2021 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages).

Figure 2.8 shows the HC BH (statewide) rates and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide benchmark.

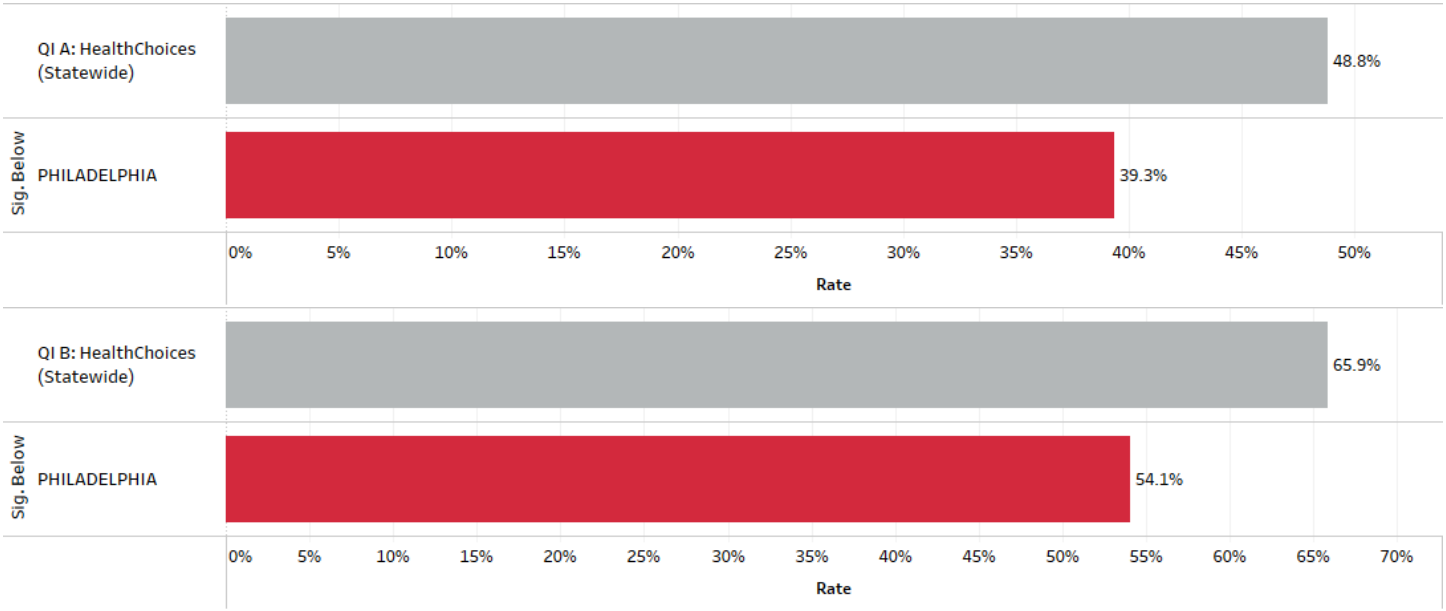

Figure 2.8: Statistically Significant Differences in CBH MY 2021 PA-Specific FUH Rates (All Ages) CBH Primary Contractor MY 2021 PA-specific FUH rates for all ages that are significantly different than HC BH (statewide) MY 2021 PA-specific FUH rates (all ages).

III. Readmission Indicators

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2021 to MY 2020 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 PM goal of 11.75%. Individual BH-MCO and Primary Contractor rates are *not* required to be statistically significantly below 11.75% in order to meet the PM goal (**Table 2.5**).

Table 2.5: MY 2021 REA Readmission Indicators

	MY 2021						MY 2021 Rate Comparison to MY 2020	
				95% CI				
Measure[1,2]	(N)	(D)	%	Lower	Upper	MY 2020 %	PPD	SSD
Inpatient Readmission								
Statewide	6151	46438	**13.2%**	12.9%	13.6%	13.6%	-0.3	NO
CBH	1263	8499	**14.9%**	14.1%	15.6%	14.6%	0.2	NO
Philadelphia	1263	8499	**14.9%**	14.1%	15.6%	14.6%	0.2	NO

[1] The OMHSAS-designated PM goal is a readmission rate at or below 11.75%.
[2] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 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; CBH: Community Behavioral Health.

Figure 2.9 is a graphical representation of the MY 2021 readmission rates for CBH and its associated Primary Contractor. The orange line represents the MCO average.

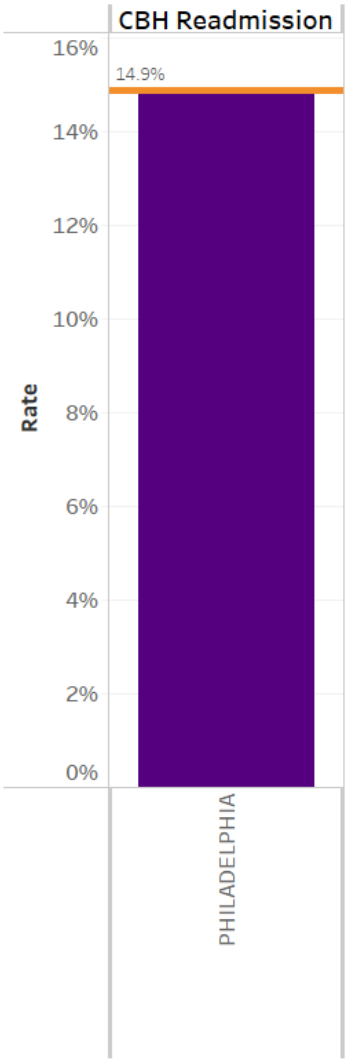

Figure 2.9: MY 2021 REA Rates for CBH Primary Contractor.

Figure 2.10 shows that the Philadelphia County rate of 14.9% (red) was statistically significantly different from the HC BH (statewide) rate of 13.2% (grey).

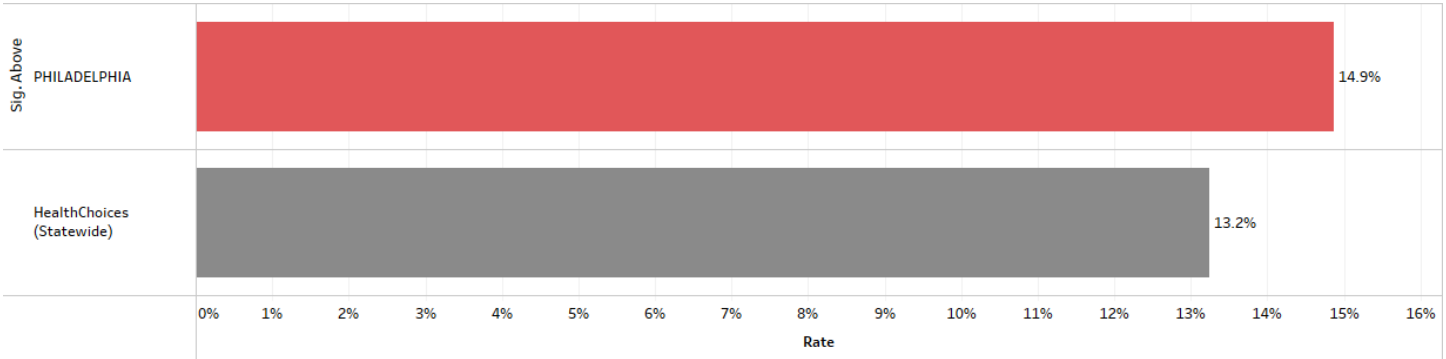

Figure 2.10: Statistically Significant Differences in CBH Primary Contractor MY 2021 REA Rates (All Ages). CBH Primary Contractor MY 2021 REA rates for all ages that are statistically significantly different than HC BH (statewide) MY 2021 REA rates (all ages).

Recommendations

There were no changes to the measures from MY 2020 to MY 2021 that impact reporting integrity. That said, efforts should continue to be made to improve FUH performance, particularly for those BH-MCOs that performed below the HC BH statewide rate. The following are recommendations that are informed by the MY 2021 review:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2021, 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 BH follow-up rates in the next few years as a result of their interventions. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving BH follow-up. The Primary 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 MYs, and applicable to all groups. As previously noted, although not enumerated in this report, further stratified comparisons such as Medicaid Expansion versus non-Medicaid Expansion were carried out in a separate 2022 (MY 2021) FUH Rates Report produced by the EQRO and made available to BH-MCOs in an interactive Tableau workbook. BH-MCOs and Primary Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For example, it is important for BH-MCOs and Primary Contractors to analyze performance rates by racial and ethnic categories and to target the populations where these racial and ethnic disparities may exist. The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit lower follow-up rates. Further, it is important to examine regional trends in disparities. 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 2022 (MY 2021) FUH Rates Report is one source BH-MCOs can use to investigate potential health disparities in FUH.
- BH-MCOs and Primary Contractors are encouraged to review the 2022 (MY 2021) FUH Rates Report in conjunction with the corresponding 2022 (MY 2021) Inpatient Psychiatric Readmission (REA) Rates Report. The BH-MCOs and Primary 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.

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 Primary Contractors that did not meet the performance goal and/or performed below the HC BH statewide rate.

MY 2021 saw a continued increase (worsening) for the MCO in readmission rates after psychiatric discharge, which remains above 11.75%, the statewide maximum goal. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary PIP work conducted and the past PIP cycle, the recommendations may assist in future discussions.

In response to the 2021 study, the following are recommendations for improving (reducing) readmission rates after psychiatric discharge:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2021 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 2020, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. A new PIP starting in 2021 builds on the previous PIP by, among other things, including a performance indicator that measures MH-related readmissions within 30 days of a discharge for SUD. BH-MCOs are expected to bring about meaningful improvement in BH readmission rates for this

subpopulation with comorbid BH conditions and for their HC BH members more generally. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing BH readmissions. The Primary 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 Primary 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 2022 (MY 2021) REA Rates Report produced by the EQRO which is being made available to BH MCOs in an interactive Tableau workbook.
- BH-MCOs and Primary Contractors are encouraged to review the 2022 (MY 2021) REA Rates Report in conjunction with the aforementioned 2022 (MY 2021) FUH Rates Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission within 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.

III: Compliance with Medicaid Managed Care Regulations

Objectives

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the Medicaid managed care (MMC) structure and operations standards. In review year (RY) 2021, 67 PA counties participated in this compliance evaluation.

Operational reviews are completed for each HC-OE. The Primary Contractor, whether contracting with an OE 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 Primary Contractor's responsibility for the oversight of the BH-MCO's compliance.

The City of Philadelphia and Philadelphia County have the same border. As such, the City of Philadelphia is the HC-OE and the Primary Contractor that holds an agreement with CBH. CBH is a county-operated BH-MCO. Members enrolled in the HC BH Program in Philadelphia County are assigned CBH as their BH-MCO. The EQR for compliance with MMC regulations is based on OMHSAS reviews of Philadelphia County and CBH.

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CBH by OMHSAS monitoring staff within the past 3 review years (RYs 2021, 2020, and 2019). These evaluations are performed at the BH-MCO and Primary Contractor levels, and the findings are reported in OMHSAS's PEPS Review Application for 2021. 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 HC BH Program contract are documented in the RAI. If the readiness review occurred within the 3-year time frame under consideration, the RAI was provided to IPRO. For those Primary Contractors and BH-MCOs that completed their readiness reviews outside of the current 3-year time frame, the readiness review substandards were deemed as complete. As necessary, the HC BH PS&R are also used.

Description of Data Obtained

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2021 and entered into the PEPS Application as of March 2022 for RY 2021. 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 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 collect or capture additional reviewer comments. Based on the PEPS Application, a 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 previously second-level grievances are considered OMHSAS-specific substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category.

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[21] IPRO updated the substandards crosswalk to reflect the changes to the organization and content of the relevant BBA provisions. The CMS updates included modifications to the BBA provisions, which are now required for reporting. The standards that are subject to EQR review are contained in Title 42 CFR 438, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E. In addition, findings for RY 2021 are presented here under the new rubric of the three "CMS sections": Standards, Including enrollee rights and protections, quality assessment and performance improvement (QAPI) program, and grievance system. Substandard tallies for each category and section roll-up were correspondingly updated.

From time to time, standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions or changes to State standards. Standards or substandards that are introduced or retired are done so following the rotating 3-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 2019 (RY 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.

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 2021 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 Primary Contractors and their subcontracted BH-MCOs occurs over a 3-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 3-year period is alternatively referred to as the Active Review period. The PEPS substandards from RY 2021, RY 2020, and RY 2019 provided the information necessary for the 2021 assessment. Those triennial standards not reviewed through the PEPS system in RY 2021 were evaluated on their performance based on RY 2020 and/or RY 2019 determinations, or other supporting documentation, if necessary. For those HC-OEs that completed their Readiness Reviews within the 3-year time frame under consideration, RAI substandards were evaluated when none of the PEPS substandards crosswalked to a particular BBA category were reviewed.

For CBH, a total of 72 unique substandards were applicable for the evaluation of BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2021, 2020, 2019). In addition, 18 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 3-year cycle to evaluate the BH-MCO and the associated Primary Contractors against other state-specific Structure and Operations Standards.

Table 3.1 tallies the PEPs substandard reviews used to evaluate the 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 2019–2021). Substandard counts under RY 2021 comprised annual and triennial substandards. Substandard counts under RYs 2020 and 2019 comprised only triennial substandards. By definition, only the last review of annual substandards is counted in the 3-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 3.1**, 94, differs from the unique count of substandards that came under active review (72).

Table 3.1: Tally of Substandards Pertinent to BBA Regulations Reviewed for CBH

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	2021	2020	2019
CMS EQR Protocol 3 "sections": Standards, Including enrollee rights and protections					
Assurances of adequate capacity and services (Title 42 CFR § 438.207)	5	-	5	-	-
Availability of services (Title 42 CFR § 438.206, Title 42 CFR § 10(h))	24	-	16	6	2
Confidentiality (Title 42 CFR § 438.224)	1	-	1	-	-
Coordination and continuity of care (Title 42 CFR § 438.208)	2	-	-	-	2
Coverage and authorization of services (Title 42 CFR Parts § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114)	4	-	2	-	2
Health information systems (Title 42 CFR § 438.242)	1	-	1	-	-
Practice guidelines (Title 42 CFR § 438.236)	6	-	4	-	2
Provider selection (Title 42 CFR § 438.214)	3	-	-	3	-
Subcontractual relationships and delegation (Title 42 CFR § 438.230)	8	-	8	-	-
CMS EQR Protocol 3 "sections": Quality assessment and performance improvement (QAPI) program					
Quality assessment and performance improvement program (Title 42 CFR § 438.330)	26	-	26	-	-
CMS EQR Protocol 3 "sections": Grievance system					
Grievance and appeal systems (Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424)	14	-	2	-	12
Total	**94**	**-**	**65**	**9**	**20**

[1] The total number of substandards required for the evaluation of Primary Contractor /BH-MCO compliance with the BBA regulations. Any PEPS substandards not reviewed indicate substandards that were deemed not applicable to the Primary Contractors/BH-MCO.

[2] The number of substandards that came under active review during the cycle specific to the review year. Because substandards may crosswalk to more than one category, the total tally of substandard reviews, 94, differs from the unique count of substandards that came under active review (72).

BBA: Balanced Budget Act; PEPS: Program Evaluation Performance Summary; CBH: Community Behavioral Health; NR: substandards not reviewed; CMS: Centers for Medicare and Medicaid Services; EQR: external quality review; CFR: Code of Federal Regulations.

Determination of Compliance

To evaluate Primary Contractor/BH-MCO compliance with individual provisions, IPRO grouped the required and relevant monitoring substandards by provision (category) and evaluated the Primary 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 PA. If a substandard was not evaluated for a particular Primary Contractor /BH-MCO, it was assigned a value of "not reviewed." Compliance with the BBA provisions was then determined based on the aggregate results across the 3-year period of the PEPS items linked to each provision. If all items were met, the Primary Contractor/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the Primary Contractor/BH-MCO was evaluated as partially compliant. If all items were not met, the Primary Contractor/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, compliance findings relating to provider network mix and capacity are summarized under Assurances of adequate capacity and services, *Title 42 CFR § 438.207*.

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 sections set out in the BBA regulations and described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[22] Under each general section heading are the individual regulatory categories

appropriate to those headings. IPRO's findings are therefore organized under standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement (QAPI) Program, and Grievance System.

This format reflects the goal of the review, which is to gather sufficient foundation for IPRO's required assessment of the Primary Contractor/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

Seventy-two (72) unique PEPS substandards were used to evaluate CBH and Philadelphia County compliance with BBA regulations in RY 2021.

Standards, Including Enrollee Rights and Protections

The general purpose of the regulations included in this section is to ensure that each Primary Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable federal and state laws that pertain to enrollee rights, and that the Primary Contractor/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees. **Table 3.2** presents the MCO and Primary Contractor substandard findings by categories.

Table 3.2: Compliance with Standards, Including Enrollee Rights and Protections

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Assurances of adequate capacity and services Title 42 CFR § 438.207	5	Compliant	Philadelphia	1.1, 1.2, 1.4, 1.5, 1.6	-	-
Availability of Services Title 42 CFR § 438.206, Title 42 CFR § 10(h)	24	Partial	Philadelphia	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 23.1, 23.2, 23.3, 23.4, 23.5, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 28.1, 93.1, 93.2, 93.3, 93.4	28.2	-
Confidentiality Title 42 CFR § 438.224	1	Compliant	Philadelphia	120.1	-	-
Coordination and continuity of care Title 42 CFR § 438.208	2	Partial	Philadelphia	28.1	28.2	-
Coverage and authorization of services Title 42 CFR Parts § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114	4	Partial	Philadelphia	28.1	28.2, 72.2	72.1,
Health information systems Title 42 CFR § 438.242	1	Compliant	Philadelphia	120.1	-	-
Practice guidelines Title 42 CFR § 438.236	6	Partial	Philadelphia	28.1, 93.1, 93.2, 93.3, 93.4	28.2	-
Provider selection Title 42 CFR § 438.214	3	Partial	Philadelphia	10.1, 10.2	10.3	-
Subcontractual relationships	8	Compliant	Philadelphia	99.1, 99.2, 99.3,	-	-

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
and delegation Title 42 CFR § 438.230				99.4, 99.5, 99.6, 99.7, 99.8		

There are nine (9) categories within standards, including Enrollee Rights and Protections. CBH was compliant with 4 categories and partially compliant with 5 categories.

For this review, 54 PEPS substandards were crosswalked to categories within Compliance with Standards, Including Enrollee Rights and Protections. Fifty four (54) substandards were evaluated for Philadelphia County. Philadelphia County was compliant in 47 instances, partially compliant in 6 instances, and non-compliant in 1 instance. 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

CBH was partially compliant with Availability of Services due to partial compliance with 1 substandard within Standard 28 (RY 2019).

CBH was partially compliant with Substandard 2 of Standard 28.

Standard 28: BH-MCO has a comprehensive, defined program of care that incorporates longitudinal disease management.

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

Coordination and Continuity of Care

CBH was partially compliant with Coverage and Authorization of Services due to partial compliance with 1 substandard within Standard 28 (RY 2019).

Standard 28: See Standard description and determination of compliance under Availability of Services.

Substandard 2: See Substandard description and determination of compliance under Availability of Services.

Coverage and Authorization of Services

CBH was partially compliant with Coverage and Authorization of Services due to partial compliance with 1 substandard within Standard 28 (RY 2019) and partial compliance with 2 substandards within Standard 72 (RY 2021).

Standard 28: See Standard description and determination of compliance under Availability of Services.

Substandard 2: See Substandard description and determination of compliance under Availability of Services.

CBH was non-compliant with Substandards 1 and 2 of Standard 72.

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].

Substandard 1: Denial notices are issued to members according to required timeframes and use the required template language.

Substandard 2: The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a 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).

Practice Guidelines

CBH was partially compliant with Availability of Services due to partial compliance with 1 substandard within Standard 28 (RY 2019).

Standard 28: See Standard description and determination of compliance under Availability of Services.

Substandard 2: See Substandard description and determination of compliance under Availability of Services.

Provider Selection

CBH was partially compliant with Provider Selection due to partial compliance with 1 substandard within Standard 10 (RY 2020).

CBH was partially compliant with Substandard 3 of Standard 10.

Standard 10: BH-MCO has ongoing process for review of provider credentialing. Credentials verified according to schedule.

Substandard 3: Recredentialing incorporates results of provider profiling.

Quality Assessment and Performance Improvement Program

The general purpose of the regulations included under this subpart is to ensure that all services available under PA's MMC Program, the HC Program, are available and accessible to MCO enrollees. The PEPS documents for each Primary Contractor include an assessment of the Primary Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 3.3** presents the findings by categories consistent with the regulations.

Table 3.3: Compliance with Quality Assessment and Performance Improvement Program

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Quality assessment and performance improvement program Title 42 CFR § 438.330	26	Compliant	Philadelphia	91.1, 91.2, 91.3, 91.4, 91.5, 91.6, 91.7, 91.8, 91.9, 91.10, 91.11, 91.12, 91.13, 91.14, 91.15, 93.1, 93.2, 93.3, 93.4, 98.1, 98.2, 98.3, 104.1, 104.2, 104.3, 104.4	-	-

MCO: managed care organization; CFR: Code of Federal Regulations.

For this review, 26 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 26 substandards were reviewed for Philadelphia County. Philadelphia County was compliant with all 26 substandards.

Grievance System

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 Primary Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 3.4** presents the findings by categories consistent with the regulations.

Table 3.4: Compliance with Grievance System

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Grievance and appeal systems Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	14	Partial	Philadelphia	68.1, 68.3, 68.4, 68.7, 71.1, 71.2, 71.3, 71.4, 71.7, 71.9	68.2, 72.2	68.9, 72.1

MCO: managed care organization; CFR: Code of Federal Regulations.

For this review, 14 substandards were crosswalked to Grievance System. All 14 substandards were reviewed for Philadelphia County. Philadelphia County was compliant with 10 substandards, partially compliant with 2 substandards, and non-compliant with 2 substandards.

Grievance and Appeal Systems

CBH was partially compliant with Grievance and Appeal Systems due to partial compliance with 1 substandard within PEPS Standard 68 (RY 2019), partial compliance with 1 substandard within Standard 72 (RY 2021), and non-compliance with 1 substandard within PEPS Standard 68 (RY 2019) and non-compliance with 1 substandard within PEPS Standard 72 (RY 2021).

CBH was partially compliant with Substandard 2 of Standard 68.

Standard 68: The Complaint 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.

Substandard 2: Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.

CBH was non-compliant with Substandard 9 of Standard 68.

Standard 68: The Complaint 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.

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.

CBH was non-compliant with Substandard 1 and partially compliant with Substandard 2 of Standard 72.

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].

Substandard 1: Denial notices are issued to members according to required timeframes and use the required template language.

Substandard 2: The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a 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).

IV: Validation of Network Adequacy

Objectives

As set forth in *Title 42 CFR §438.358*, validation of network adequacy is a mandatory EQR activity. The purpose of this section is to assess the BH-MCO's network adequacy in accordance with standards established under *Title 42 CFR § 438.68(b) (1)(iii)* and *457.1218*.

Description of Data Obtained

For the 2021 review year, the BH-MCO's network adequacy was assessed based on compliance with certain federal and OMHSAS-specific standards that were crosswalked to standards falling directly or indirectly under *Title 42 CFR § 438.68(b) (1)(iii)* and *457.1218*. Compliance status was determined as part of the larger assessment of compliance with MMC regulations. As of MY 2021, EQR validation protocols for assessing network adequacy had not been published by CMS. Since the publication of the *2021 Medicaid and CHIP Managed Care Final Rule*, OMHSAS is actively reviewing its network adequacy monitoring program to ensure all relevant requirements are covered in the annual validation activity going forward. For BH, those requirements include: quantitative network adequacy standards, ensuring timely access to services, ensuring provider accessibility, allowing access to out-of-network providers, documenting an MCO's capacity to serve all enrollees, and adhering to the 2008 Mental Health Parity and Addictions Equity Act (MHPAEA) regulations on treatment limitations.[23]

Findings

Table 4.1 describes the RY 2021 compliance status of CBH with respect to network adequacy standards that were in effect in 2021. Definitions for most standards may be found in **Section III**, Compliance with Medicaid Managed Care Regulations. The following standards are specific to validation of network adequacy (any substandards for which the MCO is not fully compliant are defined further below):

Standard 11: BH-MCO has conducted orientation for new providers and ongoing training for network.

Standard 59: BM-MCO has implemented public education and prevention programs, including BH educational materials.

Standard 78: Evidence exists of the County's oversight of functions and activities delegated to the BH-MCO including: a. County Table of Organization showing a clear organization structure for oversight of BH-MCO functions. b. In the case of a multi-county contract, the Table of Organization shows a clear relationship among and between Counties' management structures, as it relates to the BH-MCO oversight. c. The role of the Single County Authority (SCA) in oversight is clear in the oversight structure. d. Meeting schedules and attendee minutes reflect County oversight of the BH-MCO (e.g., adequate staff with appropriate skills and knowledge that regularly attend meetings and focus on monitoring the contract and taking appropriate action, such as CAPs. e. Documentation of the County's reviews and/or audits of quality and accuracy of the major BH-MCO functions, including: 1) Care Management, 2) Quality Assurance (QA), 3) Financial Programs, 4) MIS, 5) Credentialing, 6) Grievance System, 7) Consumer Satisfaction, 8) Provider Satisfaction, 9) Network Development, Provider Rate Negotiation, and 10) Fraud, Waste, and Abuse (FWA).

Standard 100: Utilization Management and Quality Management: Provider Satisfaction: The Primary Contractor, either directly or via a BH-MCO or other subcontractor, must have systems and procedures to assess provider satisfaction with network management. The systems and procedures must include, but not be limited to, an annual provider satisfaction survey. Areas of the survey must include claims processing, provider relations, credentialing, prior authorization, service management and quality management.

Table 4.1: Compliance with Standards Related to Network Adequacy

Standard Description	Substandard Count	MCO Compliance Status	Primary Contractors	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Standard 1	7	Compliant	Philadelphia	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7	-	-
Standard 10	3	Partial	Philadelphia	10.1, 10.2	10.3	-
Standard 11	3	Compliant	Philadelphia	11.1, 11.2, 11.3	-	-
Standard 23	5	Compliant	Philadelphia	23.1, 23.2, 23.3, 23.4, 23.5	-	-
Standard 24	6	Compliant	Philadelphia	24.1, 24.2, 24.3, 24.4, 24.5, 24.6	-	-
Standard 59	1	Compliant	Philadelphia	59.1	-	-
Standard 78	5	Partial	Philadelphia (78.5 N/A)	78.1, 78.2, 78.4	78.3	-
Standard 91	15	Compliant	Philadelphia	91.1, 91.2, 91.3, 91.4, 91.5, 91.6, 91.7, 91.8, 91.9, 91.10, 91.11, 91.12, 91.13, 91.14, 91.15	-	-
Standard 93	4	Compliant	Philadelphia	93.1, 93.2, 93.3, 93.4	-	-
Standard 99	8	Compliant	Philadelphia	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8	-	-
Standard 100	1	Compliant	Philadelphia	100.1	-	-

MCO: managed care organization; CFR: Code of Federal Regulations.

For this review, 58 substandards were crosswalked to Network Adequacy. All 58 substandards were reviewed for CBH and Philadelphia. CBH and Philadelphia were compliant with 56 substandards and partially compliant with 2 substandards. Substandard 78.5, related to other significant findings, did not apply.

CBH was partially compliant with Standard 10 due to partial compliance with one substandard.

Standard 10: See Substandard description under **Section III**, Provider Selection.

CBH was partially compliant with Standard 78 due to partial compliance with one substandard.

Standard 78 (see description above)

Substandard 3: There is evidence of County leadership to promote recovery and resiliency.

V: Quality Studies

Objectives

The purpose of this section is to describe quality studies performed in 2021 for the HC population. The studies are included in this report as optional EQR activities that occurred during the Review Year.[24]

Integrated Community Wellness Centers

In 2019, PA DHS made the decision to discontinue participation in the CCBHC Demonstration but to continue and build on the CCBHC model in a PA DHS-administered Integrated Community Wellness Centers (ICWC) program under an MMC agreement with CMS. The purpose of the CCBHC Demonstration was 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, BH 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 ICWC clinics. 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. Under ICWC, the same nine core services of the CCBHC model are provided under PA's HC MMC program using a similar bundled payment arrangement with clinics certified to participate as ICWC clinics. For the first year of ICWC, 2020, the original seven clinics—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)—were invited to participate in the new program.

Description of Data Obtained

Like CCBHC, ICWC features a process measure dashboard, hosted by the EQRO. Clinics enter monthly, quarterly, and year-to-date (YTD) data into a REDCap® project which feeds, on a weekly basis, a server-based Tableau workbook where clinics are able to monitor progress on the implementation of their ICWC model. Using the Dashboard, clinics in 2021 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 Tableau workbook also featured a comparative display that showed clinic and statewide results on each process measure.

Findings

In 2021, the number of individuals receiving at least one core service jumped to 22,690 from just over 17,700 in 2020. The unweighted average (across all the clinics) number of days until initial evaluation increased to 10.8 days from 8 days in 2020. In the area of depression screening and follow-up, just over 90% of positive screenings resulted in the documentation of a follow-up plan the same day. More than 5,400 individuals within the ICWC 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 BH conditions, but the ICWC quality measures are designed to more meaningfully measure the impact of these efforts. Under the CMS-approved ICWC preprint, a subset of the CCBHC measures is reported to CMS on an annual CY basis, along with HEDIS Follow-Up After High Intensity Care for Substance Use Disorder (FUI). **Table 5.1** summarizes how well the ICWC clinics performed on quality measures compared to applicable performance targets and national benchmarks.

Table 5.1: ICWC Quality Performance Compared to Targets and National Benchmarks

Measure	ICWC Weighted Average	Comparison		
		ICWC CY 2021 Performance Target	National Benchmark	Benchmark Description
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 7 day	10.0%	N/A (Improvement over baseline)	N/A	Between the 5th and 10th percentile of the HEDIS 2022 Quality Compass
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 30 day	19.3%	N/A (Improvement over baseline)	N/A	Below the 5th percentile of the HEDIS 2022 Quality Compass
Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Initiation	61.1%	80.2%	N/A	Above the 95th percentile of the HEDIS 2022 Quality Compass
Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Continuation and Maintenance	60.9%	89.6%	N/A	Between the 75th and 90th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 7 day	22.3%	26.7%	N/A	Between the 90th and 95th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 30 day	34.8%	38.8%	N/A	Between the 90th and 95th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 day	100%	53.4%	N/A	Above the 95th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 day	100%	64.2%	N/A	Above the 95th percentile of the HEDIS 2022 Quality Compass
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18–64 - Initiation	3.0%	19.3%	N/A	Below the 5th percentile of the HEDIS 2022 Quality Compass
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18–64 - Engagement	17.0%	28.2%	N/A	Between the 50th and 75th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 18–64 (FUH-A) - 7 day	9.0%	30.2%	N/A	Below the 5th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 18–64 (FUH-A) - 30 day	18.0%	41.6%	N/A	Below the 5th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 6–17 (FUH-C) - 7 day	27.1%	43.8%	N/A	Between the 5th and 10th percentile of the HEDIS 2022 Quality Compass
Follow-Up After Hospitalization for Mental Illness, ages 6–17 (FUH-C) - 30 day	23.1%	55.6%	N/A	Below the 5th percentile of the HEDIS 2022 Quality Compass
Antidepressant Medication Management (AMM) - Acute	63.0%	48.8%	N/A	Between the 50th and 75th percentile of the HEDIS 2022 Quality Compass

Measure	ICWC Weighted Average	Comparison		
		ICWC CY 2021 Performance Target	National Benchmark	Benchmark Description
Antidepressant Medication Management (AMM) - Continuation	37.0%	89.5%	N/A	Between the 10th and 25th percentile of the HEDIS 2022 Quality Compass
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	55.3%	57.3%	N/A	Between the 25th and 50th percentile of the HEDIS 2022 Quality Compass
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	74.9%	85.0%	N/A	Between the 10th and 25th percentile of the HEDIS 2022 Quality Compass
Plan All-Cause Readmissions Rate (PCR)	15.0%	6.9%	N/A	HEDIS 2022 Quality Compass 50th percentile
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	56.0%	16.2%	14.3%	MIPS 2022 (eCQM)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	32.6%	26.3%	28.8%	MIPS 2022 (eCQM)
Screening for Depression and Follow-Up Plan (CDF-BH)	32.0%	37.7%	33.2%	MIPS 2022 (CQM)
Depression Remission at Twelve Months (DEP-REM-12)	13.7%	N/A	8.2%	MIPS 2022 (eCQM)
Body Mass Index (BMI) Screening and Follow-Up Plan	43.1%	51.0%	45.0%	MIPS 2022 (eCQM)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)	58.0%	64.5%	N/A	Between the 5th and 10th percentile of the HEDIS 2022 Quality Compass
Tobacco Use: Screening and Cessation Intervention (TSC)	70.6%	56.0%	60.4%	MIPS 2021 (CQM)
Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	67.0%	51.1%	68.4%	MIPS 2021 (CQM)

ICWC: integrated community wellness center; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable; ADHD: attention deficit/hyperactivity disorder; MIPS: Merit-Based Incentive Pay System; eCQM: electronic clinical quality measure; CQM: clinical quality measure.

Quality measures where the ICWC clinics surpassed targets include: FUM, AMM (Acute), PCR, SRA-BH-C, SRA-A, TSC, and ASC.

VI: 2021 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 2021 (MY 2020) EQR annual technical report and in the 2022 (MY 2021) FUH All-Ages Goal Report.

The request for MCO response to the opportunities for improvement related to PEPS deficiencies was distributed in September 2022. The 2022 EQR annual technical report is the 15th 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 PA 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, 2022, 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 MCO responses submitted to IPRO in December 2022 to address partial and non-compliant PEPS standards findings, 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 2021 underperformance in the HEDIS FUH All-Ages measures were distributed, along with the MY 2021 results, in January 2023. 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 17, 2023, and the primary contractors submitted their responses by March 31, 2023.

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 2020, CBH began to address opportunities for improvement sections pertaining to compliance with MMC regulations. Within Compliance with Standards, Including Enrollee Rights and Protections, CBH was partially compliant with the following BBA categories: Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Practice Guidelines, and Provider Selection. CBH was partially compliant with Quality Assessment and Performance Improvement Program under the same-named category. Within Compliance with Grievance System, CBH was partially compliant with Grievance and Appeal Systems. Proposed actions and evidence of actions taken by CBH 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 CBH into compliance with the relevant Standards.

Table 6.1 presents CBH's responses to opportunities for improvement cited by IPRO in the 2021 (MY 2020) EQR annual technical report, detailing current and proposed interventions. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 6.1: CBH Responses to Opportunities for Improvement

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2019, RY 2020, and RY 2021 found CBH to be partially compliant with all three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22/Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
CBH 2022.01	Within CMS EQR Protocol 3: Compliance with Standards, Including Enrollee Rights and Protections, CBH was partially compliant with five out of nine categories. The partially compliant categories are: 1) Availability of Services 2) Coordination and continuity of care 3) Coverage and authorization of services 4) Practice guidelines 5) Provider selection	August 2021 – Ongoing	**PEPS 28.2** **Development of care management toolkit to build knowledge of specialized populations and resources for high needs members.**
		June 30, 2021 – Ongoing	PEPS 28.2: Establish clinical leadership meeting including assistant directors, directors, Senior directors, and officers involved in UR as venue for reviewing care management program and making cross-departmental improvements.
		February 2021 – Ongoing	PEPS 28.2: Revision of QMAT and addition of questions related to ACMR that could be aggregated into a departmental performance dashboard and also used for individual & team supervision.
		2/1/2020	PEPS 93.3: References to Second Level Grievances were removed from the QM Program Description and Workplan and are no longer reported. On 2/8/2021, OMHSAS resolved the RY2018 CAP and stated the following: "The Documented Evidence of Completion that was submitted adequately addresses the CAP and no further action is required." See most recent QM Program Description:
		12/18/2018 – 2/18/2019	PEPS 93.4 #1: CBH completed a comprehensive Member Experience Survey. The results of the survey were reported in the Annual PEPS Evaluation on April 30th in 2019, 2020, 2021, and 2022. On 2/8/2021, OMHSAS resolved the RY2018 CAP and stated the following: "The Documented Evidence of completion that was submitted adequately addresses the CAP and no further action is required."

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2019, RY 2020, and RY 2021 found CBH to be partially compliant with all three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22/Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
		2/1/2020	PEPS 93.4 #2: CBH will revise its workplan to ensure Member Experience goals are specific and measurable. The CBH 2020 QM Workplan was submitted to OMHSAS as part of the RY2018 review. On 2/8/2021, OMHSAS resolved the RY2018 CAP and stated the following: "The Documented Evidence of Completion that was submitted adequately addresses the CAP and no further action is required."
		05/01/2020 – Ongoing	PEPS 72.1: CBH will ensure that all Denial letters are sent in a timely fashion with the use of a monthly timeliness of mailing that is distributed and reviewed with Clinical leadership. Evidence: Meeting/Supervision Notes where timeliness report is discussed: Monitoring and Oversight of denial notices and DBHIDS oversight protocol:
		May 2022	PEPS 72.1: To ensure the timeliness of denial letters, CBH hired a Denials Specialist in May of 2022 to review all requests daily and follow-up in real time on outstanding requests.
		11/1/2020 – 3/1/2021	PEPS 72.1: CBH will use the Denial Letter Templates as indicated in Appendix AA. A sample monthly denial audit from DBHIDS is included below demonstrating that the template was corrected in 2021.
		11/1/2020 – 11/30/2020 Annual	PEPS 72.1: Clinical teams completed a training with staff on denials processes as evident by training curriculum and team meeting minutes. Most recent trainings from 2021 and 2022 are included in the evidence

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2019, RY 2020, and RY 2021 found CBH to be partially compliant with all three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22/Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
			below:
		11/1/2020 – 3/1/2021	PEPS 72.1: CBH corrected template language in a denial letter to include both 1-day and 10-day timeframes. A sample monthly audit from DBHIDS was included above demonstrating the corrected change.
		12/18/2020 Annual	PEPS 72.1: CBH will ensure that all Denial Letters contain a rationale that is easily understood and is free from medical jargon. CBH addressed this by converting the annual Denials training to an e-learning module. Staff are required to view annually and can access at any time a refresher is needed. See denials training evidence submitted above.
		May 2022	PEPS 72.2: To ensure that denial letters have a rationale that is easily understood and is free from medical jargon, CBH hired a Denials Specialist to review all requests daily before the letters are mailed.
		5/1/2020 – Ongoing	PEPS 72.2: CBH will ensure that continued services are approved for less than requested, the rationale included behaviors and symptom improvements. CBH addressed this by updating the process for their supervisor for follow-up. A sample of minutes below demonstrates the ongoing discussions with Clinical Directors to review Denial Audits. A sample of monthly denial audits was shared above. Minutes from Denials Workgroup were submitted above with Timeliness discussion.
			PEPS 10.3: A copy of a Pay for Performance Report is provided below to demonstrate pay for performance scores that are shared with providers on performance metrics. These scores are then

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2019, RY 2020, and RY 2021 found CBH to be partially compliant with all three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22/Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
			incorporated as part of the recredentialing process as evident by the recredentialing scoring tool example below. Pay for Performance Report example: Recredentialing Scoring Tool example:
CBH 2022.02	Within CMS EQR Protocol 3: Quality Assessment and Performance Improvement Program (QAPI), CBH was partially compliant with QAPI.	2/1/2020	PEPS 93.3: References to Second Level Grievances were removed from the QM Program Description and Workplan and are no longer reported. On 2/8/2021, OMHSAS resolved the RY2018 CAP and stated the following: "The Documented Evidence of Completion that was submitted adequately addresses the CAP and no further action is required." See most recent QM Program Description:
		2/1/2020	PEPS 93.4: CBH will revise its workplan to ensure Member Experience goals are specific and measurable. The CBH 2020 QM Workplan was submitted to OMHSAS as part of the RY2018 review. On 2/8/2021, OMHSAS resolved the RY2018 CAP and stated the following: "The Documented Evidence of Completion that was submitted adequately addresses the CAP and no further action is required."
		12/18/2018 – 2/18/2019	PEPS 93.4: CBH completed a comprehensive Member Experience Survey. The results of the survey were reported in the Annual PEPS Evaluation on April 30th in 2019, 2020, 2021, and 2022. On 2/8/2021, OMHSAS resolved the RY2018 CAP and stated the following: "The Documented Evidence of Completion that was submitted adequately addresses the CAP and not further action is

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2019, RY 2020, and RY 2021 found CBH to be partially compliant with all three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22/Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
			required."
CBH 2022.03	Within CMS EQR Protocol 3: Compliance with Grievance System, CBH was partially compliant with Grievance and appeal systems.	6/1/2020 – Ongoing	PEPS 68.2: Monitoring process of Complaints with an audit checklist. CBH utilizes an internal audit tool for the complaints process. Complaints and Grievance Supervisor continues to conduct internal audits monthly. The results of the audit are reviewed by the Complaints and Grievances Supervisor and the Manager of Complaints and Grievances. The Complaints and Grievances Supervisor discusses and documents specific audit results with the Complaints and Grievances Specialist during supervision. See below:
		11/16/2021 – 3/3/2021 Annual	PEPS 68.2: CBH updated the complaint protocol to reflect changes in the investigative process to include memo process and changes to summary sheet. The updated protocol continues to be followed by the Complaints and Grievances Specialists when conducting complaint investigations. Monitoring is done via the internal audit process. The complaint protocol is updated annually and the most recent version is below:
		11/16/2020 – 8/2/2021	PEPS 68.2: CBH conducted training on complaint protocol utilizing the complaint protocol shared above. The Manager of Complaints and Grievances will continue to conduct the training on the Complaint Protocol annually and when new employees are hired in the position of Complaints and Grievances Specialist.
		5/14/2020 – 8/2/2021	PEPS 68.2: CBH conducted training on updated complaints investigation process. The Manager of Complaints and Grievances will continue to conduct the training on the Complaint Protocol annually and when new employees are hired in the position of Complaints and Grievances Specialist.
		11/16/2020 – 3/3/2021	PEPS 68.9:

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2019, RY 2020, and RY 2021 found CBH to be partially compliant with all three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22/Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
		Annual	The complaint protocol was updated to reflect steps to adequately address quality of care concerns identified during the complaint process. See complaint protocol above.
		3/3/2021 – 3/18/2021	PEPS 68.9: A training was conducted on the complaint protocol. See complaint and grievance roster trainings above.
		11/23/2020 – 11/23/2020	PEPS 68.9: The complaint audit tool was updated. See most recently updated audit tool above.
		3/2020 – Ongoing	PEPS 68.9: Complaint charts were audited by supervisory staff from June 2020 and ongoing using the internal audit tool. A summary of themes from audit results from October 2021 – June 2022 is below:
		05/01/2020 – Ongoing	PEPS 72.1: CBH will ensure that all Denial letters are sent in a timely fashion with the use of a monthly timeliness of mailing that is distributed and reviewed with clinical leadership. Evidence was included above.
		May 2022	To ensure the timeliness of denial letters, CBH hired a Denials Specialist to review all requests daily and follow-up in real time on outstanding requests.
		11/1/2020 – 3/1/2021	PEPS 72.1: CBH will use the Denial Letter Templates as indicated in Appendix AA. A sample monthly denial audit from DBHIDS is included above to demonstrate the use of the correct denials template.
		11/1/2020 – 11/30/2020 Annual	PEPS 72.1: Clinical teams completed a training with staff on denials processes as evident by training curriculum and team meeting minutes.

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of Compliance with Standards conducted by PA in reporting year (RY) 2019, RY 2020, and RY 2021 found CBH to be partially compliant with all three sections in CMS EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/22/Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
			Evidence was included above.
		11/1/2020 – 3/1/2021	PEPS 72.1: CBH corrected templated language in denial letter to include both 1- and 10-day timeframes. A sample monthly audit from DBHIDS was included above demonstrating the corrected change.
		12/18/2020 – ongoing	PEPS 72.2: CBH will ensure that all Denial Letters contain a rationale that is easily understood and is free from medical jargon. CBH is addressing this by converting our annual Denial Letter training to an e-learning module. Staff will be required to view annually and can access at any time a refresher is needed. Evidence was included above.
		May 2022	To ensure that denial letters have a rationale that is easily understood and is free from medical jargon, CBH hired a Denials Specialist to review all requests daily before the letters are mailed.
		5/1/2020 – Ongoing	CBH will ensure that continued services are approved for less than requested, the rationale included behaviors and symptom improvements. CBH addressed this by updating the process for analysis of the Denial Audit to include specific staff members and their supervisor for follow-up. A sample of minutes was shared above that demonstrates the ongoing discussions with Clinical Directors to review Denial Audits. A sample of monthly denial audits was shared above.
		May 2022	CBH hired a Denials Specialist to review all Denial letters before they are mailed to ensure that denials with continued services that are approved for less than requested have a rationale that includes behaviors and symptom improvements.

CBH: Community Behavioral Health; MCO: managed care organization; RY: reporting year = measurement year; OMHSAS: Office of Mental Health & Substance Abuse Services; CCM: Clinical Care Management; MA: Medical Affairs; PEPS: Program Evaluation Performance Summary; QM: Quality Management; EQR: external quality review.

Root Cause Analysis and Quality Improvement Plan

For PMs that are noted as opportunities for improvement in the EQR annual 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, and coinciding with the phase-in of Value-Based Payment (VBP) at the HC BH Contractor level, OMHSAS determined in 2018 that it was necessary to change the PM remediation process so that BH-MCOs would set goals for the coming year. 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 never set. However, MY 2018 results were calculated in late 2019 to determine RCA and "Quality Improvement Plan" (QIP) assignments, along with goals, for MY 2020, and this proactive goal-setting approach has been in place ever since.

In MY 2021, CBH scored below the 75th percentile on both the 7- and 30-day measures and, as a result, was required to complete an RCA and QIP response for both measures. **Table 6.2** and **Table 6.3** present CBH's submission of its RCA and QIP for the FUH All-Ages 7-day and 30-day measures, respectively. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 6.2: CBH RCA and QIP for the FUH 7–Day Measure (All Ages)

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 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?):

Community Behavioral Health (CBH) analyzed its 7-Day follow-up after hospitalization for mental illness (FUH) HEDIS data for measurement year (MY) 2021 using a univariate model. There are statistically significant differences between the following groups, with the latter following up significantly less than the former:

- Ages 6–17 vs ages 18–64
- Non-White vs White
- Hispanic/Latino vs non-Hispanic/Latino
- Female vs male

The detailed rates are in the column to the right. The disparities present in the data do not indicate underperformance by non-white or Hispanic/Latino groups as compared to white or non-Hispanic/Latino groups, respectively. In fact, White or non-Hispanic/Latino groups are performing significantly worse than non-white or Hispanic/Latino groups. Due to this, interventions specific to non-white or non-Hispanic/Latino groups will not be developed.

CBH's multivariate analysis of MY 2021 data showed that members with a secondary diagnosis of substance related disorder (cannabis, stimulants, opioids, tobacco) are less likely to follow-up than members with secondary diagnoses of suicidal ideation/attempt/intention self-harm, neurodevelopmental disorders, and hallucinogen-related disorders. Interventions will include features that are targeted specifically to members with dual diagnoses (mental health and substance use disorder (SUD)). These data are detailed in the column to the right.

CBH surveyed stakeholders to determine barriers to and suggestion solutions or strategies to address those barriers for 7-day FUH. This included acute inpatient (AIP) providers, outpatient (OP) providers, members, DBHIDS, and internal CBH staff from various departments (Clinical, Provider Operations, Medical Affairs, Quality Management, Population Health, Member Services). Building off of the survey responses, RCA, and QIP completed in calendar year (CY) 2022, as well as FUH best practices, survey questions were developed to encourage a deeper dive into the barriers previously addressed. Survey questions are embedded in the column to the right.

Once barriers were identified, Affinity Diagrams at multiple levels were used to categorize and organize the barriers identified. Embedded in the column to the right are Affinity Diagrams at three levels: project (level 1), AIP and OP (level 2), and AIP and OP by survey

Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change).

Group	7D FUH Numerator	7D FUH Denominator	7D FUH Rate
All	1,514	6,626	22.85%
Age 6–17	427	940	45.45%
Age 18–64	1,066	5,506	19.36%*
Asian	34	139	24.46%
Black/African Am.	994	4,309	23.07%
Other	211	781	27.02%
White	272	1,386	19.62%*
Hispanic/Latino	220	785	28.03%
Non-Hispanic/Latino	1,294	5,841	22.15%*
Female	806	3,300	24.42%
Male	708	3,326	21.29%*

*Statistically significant difference at P<0.001

Characteristic	OR	95% CI	p-value
Secondary Diagnosis			
Neurodevelopmental Disorders	—	—	
No Diagnosis	0.78	0.56, 10.9	0.15
Other	0.76	0.53, 1.07	0.12
Substance Related	0.56	0.38, 0.80	0.002
Suicidal Ideation/Attempt/ Intentional Self-Harm	0.78	0.55, 1.10	0.02

OR = Odds Ration, CI = Confidence Interval

Additional documents can be provided, removed for ATR.

question (level 3).

The Affinity Diagrams were used to determine root causes and develop Fishbone Diagrams. Embedded in the column to the right are Fishbone Diagrams. Fishbone diagrams were refined from the Affinity Diagrams and only conducted at the deeper levels (levels 2 & 3).

A Driver Diagram was developed to identify change ideas to address the barriers by influencing the key drivers. CBH then linked the interventions that will continue to the barriers they would address, identifying where there were gaps in existing interventions necessary to address root causes. CBH then used multi-voting to prioritize the development of new interventions based on the change strategies from the survey. CBH will move forward with developing interventions that were voted most highly. CBH will also continue interventions from CY 2022 that address barriers with a Critical or Important Causal Role.

CBH used the information from the RCA and multi-voting exercise to develop the logic model of change for 7-Day FUH for interventions that will be undertaken during CY 2023. Interventions from CY2022 that will be continued in CY2023 are included. The overall project logic model is embedded in the column to the right.

List out below the factors you identified in your RCA. Insert more rows as needed (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 and any disparities (as defined above) 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) Members have low health literacy and are not educated sufficiently regarding: • Importance of follow-up • Importance of medication adherence • Understanding discharge plan • How to access supports for social determinants of health (SDoH)	***Causal Role (relationship to other factors and to the overall performance indicator):*** Members may exhibit low health literacy which can be a barrier to sufficient member education. If a member has low health literacy, they may not recognize the chronic nature of mental illness and the need for and benefit of continued treatment, including follow-up and/or medication adherence. Low health literacy also affects an individual's ability to understand and use information and services, therefore they may not understand their discharge plan fully and do not know how to access resources or supports around the discharge plan or to address SDoH. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: CBH can impact low health literacy in members by working with AIP providers to develop a uniform discharge packet with materials that are supportive of increasing health literacy and establishing standards for providers to ensure discharge planning discussions meet members where they are in terms of health literacy.
People (2) Traditional education/learning methods are not impactful to or effective with members due to:	***Causal Role (relationship to other factors and to the overall performance indicator):*** Members may struggle with learning through traditional methods due to illiteracy, low competency/functional level, and inability to retain new information. If hospital staff don't also verbally and/or visually review information and discharge plan with the member, the member may be discharged without any functional knowledge of what they are

<table>
<tr><th colspan="2">CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance</th></tr>
<tr><td rowspan="2">• Illiteracy
• Low competency/functional level
• Inability to retain new learned information
• Treatment fatigue
• Admitted involuntarily</td><td>expected to do. Additionally, members may be admitted to the hospital involuntarily and may be resistant to receiving continued treatment after discharge, not understanding the need for follow-up treatment. Members may also experience “treatment fatigue” and become overwhelmed by many treatment appointments and unmotivated to continue with treatment after discharge.

Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical</td></tr>
<tr><td>Current and expected actionability: Similar to the actionability towards members with low health literacy, CBH can impact this by moving towards a uniform discharge packet. Additionally, CBH can work with AIP providers to develop discharge planning methods and other educational materials that utilize alternative methods of learning, such as video modules, verbal conversations, among others. Processes could be developed to identify those members who are disengaged due to treatment fatigue or involuntary admission and solutions to re-engage or effectively engage these members.</td></tr>
<tr><td rowspan="2">People (3)
Members have competing priorities and issues to address in their life (housing, transportation, etc.), and do not attend follow-up appointments</td><td>Causal Role (relationship to other factors and to the overall performance indicator):
Many of CBH’s membership are experiencing difficulties with other SDoHs that make it difficult for them to pursue treatment after discharge. Without transportation, members are not able to get to follow-up appointments. If a member is homeless or housing insecure, it’s highly likely they will focus on addressing that as it is more pressing than a follow-up appointment with a mental health provider. After discharge, “life happens” and things get in the way of members wanting or being able to schedule and attend appointments.

Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important</td></tr>
<tr><td>Current and expected actionability: CBH can continue to leverage current partnerships with community-based organizations (CBO) that help members address SDoHs. CBH can explore opportunities to establish additional partnerships with other CBOs, and increase knowledge of and access to peer support services so that members have a support person to help address issues surrounding SDoHs.</td></tr>
<tr><td rowspan="2">People (4)
Members have co-occurring SUD which interferes with ability to follow-up</td><td>Causal Role (relationship to other factors and to the overall performance indicator):
The effects of SUD may interfere with a member’s ability to remember and keep follow-up appointments. SUD may also exacerbate symptoms of mental illness, which in turn could impact a member’s ability to remember and keep follow-up appointment. CBH’s analysis of MY 2021 data showed that members with a secondary diagnosis of SUD (cannabis, stimulants, opioids, tobacco) are less likely to follow-up than members with secondary diagnoses of suicidal ideation/attempt/intention self-harm, neurodevelopmental disorders, and hallucinogen-related disorders.

Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important</td></tr>
<tr><td>Current and expected actionability: In response to the State’s 2022 PIP (PEDTAR), CBH established a Quality Improvement Learning Collaborative (QILC) involving providers who served members with co-occurring SUD. While the QILC has ended in its official capacity, CBH can take action to spread learnings to providers who did not participate in the QILC.</td></tr>
<tr><td>People (5)
Member not adherent to medication</td><td>Causal Role (relationship to other factors and to the overall performance indicator):
If members are not included in decisions about medication or educated about medication side effects and the time it</td></tr>
</table>

and/or is not provided a sufficient supply to suffice before psychiatrist appointment	may take time for medication to become effective, they may discontinue taking their medication if unexpected side effects occur or if medication takes longer to become effective than expected. Discontinuing medication will lead to an increase in symptoms, which may interfere with the member's ability to remember and keep follow-up appointments. Additionally, members must receive a sufficient supply of medication upon discharge to ensure they do not run out before they are able to access a psychiatrist to receive a new prescription. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: CBH can incorporate medication requirements into performance standards for AIP providers and support development of educational and discharge materials that support medication adherence.
People (6) Members are frustrated with how long it takes to access a therapeutic appointment and thus abandon efforts prior to seeing an OP provider	***Causal Role (relationship to other factors and to the overall performance indicator):*** Attending and participating in follow-up appointments after admission to AIP is difficult for members, and when the first appointment at the OP provider consists of primarily if not entirely paperwork members may become disengaged in their treatment. Having members attend multiple appointment on different days prior to an appointment with a provider deters members from wanting to engage in treatment. They also run the risk of having "life" happen between those appointments and are less likely to attend subsequent appointments. Members may be more likely to adhere to discharge plan if they are aware of and prepared for this, and/or if the process could be condensed so that their time is used efficiently. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Important
	Current and expected actionability: Facilitating the sharing of OP provider intake forms with AIP providers so that members are able to complete paperwork while still on unit/prior to discharge would help to reduce intake time once discharged. Creating a uniform intake process for OP providers would even further support this, as AIP providers would not need to determine the appropriate intake form based on OP providers, and OP providers would have all intake information ahead of the initial appointment.
People (7) Lack of staffing to adequately conduct discharge planning, care coordination, warm handoffs, having non-traditional business hours, reminder/rescheduling calls	***Causal Role (relationship to other factors and to the overall performance indicator):*** Staffing shortages at AIP and OP providers significantly impacts the availability of timely follow-up appointments for members after discharge. It also makes it difficult to implement FUH best practices. Lack of staffing at AIP hospitals can lead to lack or insufficient discharge planning, care coordination with OP providers, and warm handoffs. Lack of staffing at OP provider facilities can lead to lack of care coordination, warm handoffs, having non-traditional business hours, and conducting reminder/rescheduling calls. Staff shortages at case management providers may lead to members, who need case management services, being unable to receive them in a timely manner. Without case management services, these members may have greater difficulty remembering and keeping follow-up appointments. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: CBH is currently implementing multiple workforce development interventions to bolster the network and facilitate access to services, including the Open Access Pilot, regular Philadelphia Behavioral Health Workforce meetings, supporting staff flexibility, encouraging providers to support a hybrid model (in-person

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance	
	and telehealth), work with universities to create a pipeline for the system, pursuing partnership with Philadelphia Opportunities Industrialization Center (OIC), and regularly reviewing rates for levels of care most impacted by staff vacancies.
Providers (1) OP providers have long waitlists and aren't able to schedule a member within 7-day period	***Causal Role (relationship to other factors and to the overall performance indicator):*** OP providers report long waitlists for appointment times, well past the 7-day timeframe of the FUH measure criteria. Staff shortages contribute to this, as lower workforce capacity lends itself to lower access. AIP providers are more likely to send members to a facility with walk-in hours in hopes they will be seen then, however not all OP providers provide walk-in hours which inundates the few that do. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: CBH is actively working to address network access difficulties through initiatives such as the Open Network project, Open Access Pilot, among others. While staffing shortages significantly affect the ability to attain a timely appointment, CBH has identified ways to support communication and procedures to facilitate proactive appointment scheduling and to address the barriers that typically prevent members from attending appointments, regardless of timeliness.
Providers (2) OP providers are not made aware when a member affiliated with them is admitted to the hospital	***Causal Role (relationship to other factors and to the overall performance indicator):*** If a member is already seeking care with an OP provider, that provider would be able to proactively schedule the member a follow-up appointment if they were notified that the member had been admitted to AIP. If a member admitted to AIP has a current OP provider, that information is not always captured accurately in the medical record and AIP providers aren't consistently asking is this is the case. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Important
	Current and expected actionability: By supporting providers to join and utilize the Health Share Exchange (HSX), CBH can facilitate OP provider alters upon member admission, as HSX has encounter notifications for members that are already affiliated with an OP provider.
Policies / Procedures (1) Lack of or inadequate and inconsistent discharge planning	***Causal Role (relationship to other factors and to the overall performance indicator):*** Members who do not receive adequate discharge planning are less likely to attend follow-up appointments because they do not understand the importance of or the required steps to follow-up. Staffing shortages contribute to AIP providers having limited time or capacity to adequately provide discharge planning for all members. If AIP providers do provide discharge planning, it is inconsistent and not uniform. Lack of or inadequate discharge planning may disengage members and make them feel disempowered in their treatment due to their input or preferences being considered. The discharge plan may not align with the member's health literacy, education level, reading level, or engagement level. Members may feel disrespected and refuse to follow discharge plan if they do not feel heard, supported, and understood. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: CBH is in the position to work with AIP providers to develop a uniform discharge packet with materials that are supportive of increasing health literacy and establishing standards for providers to

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance	
	ensure discharge planning discussions meet members where they are in terms of health literacy. Additionally, CBH can work with AIP providers to develop discharge planning methods and other educational materials that utilize alternative methods of learning, such as video modules, verbal conversations, among others. Processes could be developed to identify those members who are disengaged due to treatment fatigue or involuntary admission and solutions to re-engage or effectively engage these members. These processes and procedures could be solidified by creating performance standards that are regularly measured, assessed, and reported back to AIP providers.
Policies / Procedures (2) Lack of knowledge and systems/processes regarding how to manage HIPAA and confidentiality/privacy requirements	***Causal Role (relationship to other factors and to the overall performance indicator):*** Misconceptions, lack of knowledge, and lack of systems/processes regarding managing HIPAA compliance and confidentiality/privacy requirements can present providers from sharing member health records with each other efficiently or easily. Members may express concerns regarding privacy and refuse to sign the release form to allow AIP providers to share health records with OP providers. Competing EHRs and lack of systems or processes make it difficult for providers to seamlessly share health records as they are concerned their method may not be HIPAA compliant. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Somewhat Important
	Current and expected actionability: By supporting providers to join and utilize the Health Share Exchange (HSX), CBH can facilitate HIPAA compliant transfer of health records and cross-provider communication.
Policies / Procedures (3) Lack of reimbursement for time spent, only for billing codes. This effects the ability to: • Have walk-in/open access hours • Prioritize or triage members newly discharged from AIP • Conduct reminder and rescheduling calls • Care coordination/communication between AIP and OP providers	***Causal Role (relationship to other factors and to the overall performance indicator):*** For both AIP and OP providers, the lack of reimbursement for time spent conducting what the literature says is best practice prevents these practices from being implemented. Providers can only bill/get reimbursed based on billing codes—this means if walk-in or open access appointments are available and are not utilized by members, the provider is not able to be reimbursed for that time. Similarly, there is no reimbursement or incentive for providers to conduct reminder calls (both AIP and OP), conduct rescheduling calls (OP), work to prioritize or triage members, or to coordinate/communicate around care between AIP and OP providers. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Somewhat Important
	Current and expected actionability: CBH is limited in its ability to impact the payment mechanisms of Medicaid. However, CBH is exploring rate increases to support providers in implementing these best practices. In November 2022 CBH increased rates by 10% for mental health OP and will continue to monitor and assess opportunities for additional increases. CBH is currently implementing an Open Access Pilot to test whether funding OP providers to maintain open access hours impacts OP access and wait time.
Policies / Procedures (4) Lack of network providers joining and participating in HSX	***Causal Role (relationship to other factors and to the overall performance indicator):*** CBH is currently engaged with HSX, however enrollment and participation of network providers is very low. HSX has features that would help address some of the barriers that AIP and OP providers face regarding communication, care coordination, and sharing of health records, such as: direct secure messaging, provider directory, automated care team finder, encounter notification service, and clinical data repository. Funding and policy barriers regarding SUD and resources for IT and EMR are barriers providers face in joining and participating in HSX.

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance	
	Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important
	Current and expected actionability: Depending on the barriers providers face in joining and utilizing the HSX, CBH may be able to cover costs and/or facilitate addressing IT and EMR barriers. CBH is limited in its capability to address the policy barriers regarding SUD as it pertains to HSX, but can help support providers to ensure compliance.
	Current and expected actionability: By supporting provider participation in the HSX, CBH may be able to facilitate OP providers to receive alerts when their members are admitted to AIP.
Provisions (1) Lack of or inadequate and inconsistent screening for social determinants of health. Lack of support and resources to adequately address issues around members' social determinants of health that are identified.	***Causal Role (relationship to other factors and to the overall performance indicator):*** Competing priorities and issues can prevent members from attending their follow-up appointments, as discussed above. If AIP providers aren't screening or are inconsistently screening members for issues regarding SDoHs, they are missing an opportunity to address these barriers to not following up. Even if/when AIP providers do inquire about SDoHs, lack of resources (and knowledge about current resources) on the providers part can prevent sufficient addressing of the issue. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: Performance standards can be created to require AIP providers to screen for SDoHs using a standardized screening tool and resource information in the member's discharge plan packet. CBH can also increase knowledge of and access to peer support services so that members have a support person to help address issues surrounding SDoHs.
Provisions (2) Members are unreachable telephonically due to: • Calls coming from unknown number • Lack of stable phone number/no phone number • Phone is turned off • Having run out of minutes • Voicemail full or not set up	***Causal Role (relationship to other factors and to the overall performance indicator):*** OP providers have trouble reaching members to confirm, remind, or reschedule follow-up appointments. Many members are transient and don't have a phone number, change phone numbers frequently, and don't have stable and consistent contact information. If members are allotted a discrete number of minutes each month, they are unreachable once those minutes have been used—this can inhibit contact if calls are made later in the month. If members do have a stable phone number, voicemails aren't always set up or are full, meaning providers are unable to leave a message. Additionally, many people (members and otherwise) do not pick up calls that come from unknown numbers. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Important
	Current and expected actionability: CBH is limited in its ability to provide members with telephonic support. However, given the unwinding of the Medicaid continuous enrollment provision put forth in the wake of the COVID-10 pandemic, it's well positioned to regularly request updated contact information as members enroll.
Quality Improvement Plan for CY 2023	
Rate Goal for 2023 (State the 2023 rate goal from your MY2021 FUH Goal Report here):	
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 2022 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When 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 Primary 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	

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance			
performance indicator.			
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.*
Members have low health literacy and are not educated sufficiently regarding: • Importance of follow-up • Importance of medication adherence • Understanding discharge plan • How to access supports for social determinants of health (SDoH) Traditional education/learning methods are not impactful to or effective with members due to: • Illiteracy • Low competency/functional level • Inability to retain new learned information • Treatment fatigue • Admitted involuntarily Member not adherent to medication and/or is not provided a sufficient supply to maintain adherence until psychiatrist appointment	Planned: CBH will develop AIP Hospital Performance Standards requiring: • Integrated assessment that includes SDoH screening • Implementation of standard/uniform patient education in multiple modalities • Inclusion of member in decision making • Discharge planning to begin during admission • Active collaboration with member to ensure adequate understanding of discharge plan • 30-day medication supply with 1 refill at discharge • Implementation of standard/uniform discharge packet • Sufficiently addressing both mental health and SUD for members with dual diagnoses including appropriate follow-up care for mental health and substance use treatment • Submission of discharge plan to CBH in a timely manner • Active role in preventing re-admission through the use of phone calls and reminders of initial appointments • Treatment that is equitable and culturally humble and appropriate.	April 2023 Ongoing	CBH has a standardized process for developing, approving, and communicating performance standards. AIP providers will be monitored quarterly on adherence to performance standards. Measurements include but are not limited to: • # and % of AIP providers assessed against standards • # and % of AIP providers receiving a satisfactory result • % increase in 7-day FUH rates (provider & aggregate)
Members have co-occurring SUD which interferes with ability to follow-up	Planned: CBH will work with DBHIDS (Quality and CMO Divisions) to develop educational materials, policies and procedures, and decision trees to support providers in ensuring members have information, and	April 2023 Monthly	CBH and DBHIDS have a standardized process for developing, approving, and communicating the availability of educational materials. These

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance			
	that they can access/interact with the information, to facilitate adequate follow-up after AIP discharge.		materials will be shared with providers, and providers will be encouraged to implement policies and procedures to meet performance standards. As part of the case reviews conducted to monitor adherence to performance standards, CBH will review educational and discharge materials given to member. CBH will monitor reach and spread of standardized materials, as well as member and provider satisfaction. Measurements include but are not limited to: • # of website visits • # of unique downloads • # of hard copy materials distributed • # and % of cases reviewed that include distribution of educational materials
	<u>Adapted continuing:</u> CBH will continue to develop quarterly performance reports for AIP hospitals that include 7-day FUH and share those reports with providers in quarterly meetings. CBH will utilize these reports to engage AIP providers and provide technical assistance (TA) to providers who are struggling to reach FUH goals through an RCA and action plans (AP) specific to that provider.	Continuing Quarterly	CBH will continue to develop and share performance reports for AIP providers at quarterly provider meetings. Providers that have not met performance goals for the prior 4 quarters will be required to conduct an RCA and submit a performance improvement plan (PIP). CBH will provider TA to providers to complete these activities. Providers will continue to be monitored quarterly for performance improvement. Measurements include but are not limited to: • 7-day FUH rates (provider & aggregate) • # of provider meetings • # of reports distributed • # of providers required to conduct RCA and AP • # of RCAs and APs submitted to CBH • % increase in 7-day FUH rates (provider & aggregate)
Lack of or inadequate and inconsistent discharge planning	<u>Planned:</u> CBH will work with DBHIDS (System's Integration Unit) and AIP providers to develop a uniform discharge packet that addresses different members' needs to support providers in ensuring	January 2023 Biweekly, Monthly	CBH and DBHIDS have a standardized process for developing, approving, and communicating the availability of materials. CBH will convene a workgroup including DBHIDS and OP providers to

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance			
	members leave AIP with resources, information, discharge plan clearly identified. A member survey will be included in the discharge packet asking the member to rate satisfaction with discharge packet. This survey will be given to CBH as part of the discharge plan. CBH will also survey providers on their satisfaction with the educational materials and discharge packet.		develop a uniform intake form. CBH will monitor adoption and implementation of the discharge packet, as well as member and provider satisfaction. Measurements include but are not limited to: • # and % of AIP providers that receive discharge packet • # and % of AIP providers that adopt discharge packet • Member satisfaction • Provider satisfaction
	<u>Planned:</u> CBH will explore the feasibility of implementing Project RED (Re-Engineered Discharge), an intervention founded on 12 discrete, mutually reinforcing components and has been proved to reduce rehospitalizations and yields high rates of patient satisfaction. Developed and tested at Boston University Medical Center, Project RED is looking at the transitional needs from inpatient to OP care of specific populations (i.e., those with depressive symptoms).	May 2023 Ongoing	CBH will pursue funding for the implementation of Project RED as well as a partnership with an AIP provider to implement the pilot. Once funding is secured and a partnership is established, Project RED will begin its implementation. Measurements include but are not limited to: • % of target population receiving any RED component • % of target population receiving all RED components • % of discharge educators (DE) collecting correct information from members • % of members with appropriate follow-up care arranged prior to discharge • % of members with follow-up appointment scheduled • % of members adequately prepared for discharge • % of members receiving post-discharge care • % of reduced hospital readmission • % of improved connections with providers • % of increased knowledge for self-management • % of increased patient satisfaction

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance			
Lack of or inadequate and inconsistent screening for social determinants of health. Lack of support and resources to adequately address issues around members' social determinants of health that are identified. Members have competing priorities and issues to address in their life (housing, transportation, etc.), and do not attend follow-up appointments	Adapted continuing: in Summer of 2022, CBH established a partnership with Utility Emergency Services Fund (UESF) to have AIP providers refer members who were identified as being housing insecure (couch surfing, etc.) to UESF for support. CBH will continue in this partnership in 2023, incorporating policies and procedures for AIP providers around screening members for the referral need, as well as incorporating policies and procedures for UESF around how to engage and support members. Planned: CBH will conduct an environmental scan to understand which CBOs in Philadelphia are available to provide support regarding issues around SDoHs. CBH will then identify CBOs they could partner with to establish a similar referral system to that of UESF (see below). CBH will also establish resource lists/information around which CBOs address which SDoHs to be included in the member education and discharge provisions. That includes a SDoH screening tool, which AIP providers will be expected to implement with member.	Continuing Ongoing March 2023 Ongoing	CBH will work with UESF to identify screening tools, create workflow maps and decision trees, and develop policies and procedures around how to engage and support members. UESF will provide monthly screening and referral data to CBH which will be reviewed and assessed for performance and effectiveness. Measurements include but are not limited to: • # and % of referrals made (by AIP hospital, assistance type, & aggregate) • # and % of cases opened (by AIP hospital, assistance type, & aggregate) • # and % of cases closed (by AIP hospital, assistance type, reason, & aggregate) • $ of direct costs incurred (by AIP hospital, assistance type, & aggregate) • $ of indirect costs incurred (by AIP hospital, assistance type, & aggregate) • # of payments provided (by AIP hospital, assistance type, & aggregate) • Range and average of # of payments provided per member • # of months of payments provided (by AIP hospital, assistance type, & aggregate) • Range and average of # of months of payments provided (by AIP hospital, assistance type, & aggregate) • 7-day follow-up rates for members seeking assistance
Members are frustrated with how long it takes to access a therapeutic appointment and thus abandon efforts prior to seeing an OP provider	Planned: CBH will work with DBHIDS (Quality and CMO Divisions) and OP providers to develop a uniform intake form that members can complete while still in hospital, if they wish. This would facilitate a quicker intake process and reduce amount of time from intake to therapeutic appointment. These efforts may also impact OP provider long wait lists, in that by reducing time from intake to appointment, appointments are available at a sooner date.	June 2023 Quarterly	CBH and DBHIDS have a standardized process for developing, approving, and communicating the availability of materials. CBH will convene a workgroup including DBHIDS and OP providers to develop a uniform intake form. CBH will monitor adoption and implementation of the intake form. Measurements include but are not limited to: • # and % of OP providers that participate in creation of intake form

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance			
			• # and % of OP providers that adopt intake form
OP providers have long wait lists, unable to consistently schedule members within 7 days of discharge Lack of reimbursement for time spent, only for billing codes. This effects the ability to: • Have walk-in/open access hours • Prioritize or triage members newly discharged from AIP • Conduct reminder and rescheduling calls • Care coordination/communication between AIP and OP providers	<u>Continuing:</u> CBH is currently implementing an Open Access pilot. This pilot includes providing funds to OP providers who offer at least 4 hours of walk-in hours per week. 33 OP providers are part of the current pilot, running from January-June 2023. A lump sum was provided to cover the costs of those hours (understanding that without these funds, no shows would result in a loss on the provider's end). The intended outcome is that this pilot will impact timely access to OP services <u>Continuing:</u> In November 2022 CBH increased rates by 10% for mental health OP and will continue to monitor and assess opportunities for additional increases.	Continuing Ongoing	CBH is currently implementing an Open Access pilot. Access, cost, and quality data will be analyzed upon completion of the pilot (June 2023) to assess effectiveness and impact on access to OP provider appointments. Measurements include but are not limited to: • # and % of providers offering walk-in hours • # of members served by providers over time • Timely access to routine, urgent, and emergent appointments • $ total cost of lump sums
Lack of staffing to adequately conduct discharge planning, care coordination, warm handoffs, having non-traditional business hours, reminder/ rescheduling calls	<u>Planned:</u> CBH is releasing an RFP for a vendor to deliver a two-way conversation text message communication campaign with members. Messages will be rooted in behavioral change strategies and utilized artificial intelligence to deliver appropriate responses. Members will be identified and enrolled using CBH members data and asked to confirm their date of birth. Participation is voluntary. Members will receive text messages such as appointment reminders, FUH related education and resources, tailored tips to help people stay on top of their discharge plan, instructions to contact the appropriate people (member services, provider, etc.) to address their needs. <u>Planned:</u> CBH is exploring the utilization of payment models to reward EBPs and successful models, rate increases tied to front line staff wage increases, reviewing CBH staffing standards that are above and beyond the State standards, and conducting quarterly staffing surveys to identify trends.	January 2023 Monthly March 2023 Ongoing	CBH has a standardized process for developing and releasing an RFP and engaging vendors to deliver services to our members. The vendor will provide CBH with monthly reports regarding enrollment, quantity, and quality of texts messages being sent. Measurements include but are not limited to: • # and % of members enrolled by CBH • # and % of members who participate • 7-day FUH rates for participating members CBH will continue to hold Philadelphia Behavioral Health Workforce Collaborative meetings to connect with key stakeholders and gather recommendations around increasing workforce. Quarterly staffing surveys to identify trends will continuity. Staffing standards will be reviewed

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance			
	Continuing: CBH established the Philadelphia Behavioral Health Workforce Collaborative in Fall of 2021. The Collaborative is composed of providers, provider trade organizations, universities, behavioral health administrators, policy makers, advocates, and interested parties who have come together to discuss the specific challenges facing the behavioral health workforce within Philadelphia. From this workgroup came recommendations that CBH is assessing the feasibility of and working towards implementing, such as establishing relationships with higher education to strengthen the pipeline. In February 2022, CBH issued a staffing survey to the provider network—while responses were inconsistent and only a snapshot in time, CBH learned what levels of care (LOCs) were most impacted by staffing vacancies, what positions had higher vacancies, and developed recommendations moving forward.	Continuing Ongoing	and assessed for improvement or change. CBH will continue to collect recommendations from the Workforce and assess feasibility of and working towards implementation. CBH will work to establish relationships with higher education to strengthen workforce pipeline. Access data and survey responses will continue to inform CBH of LOCs or positions that are particularly struggling to identify whether targeted intervention could be implemented. Measurements include but are not limited to: • # of meetings held • # of unique participants (by field/position, meeting & aggregate) • # and % of plausibly implemented recommendations • # of surveys conducted • # and % of responses • # and % of positions with higher vacancy rates • # and % of LOCs with higher impacts • # of new hires (by LOC, provider, position, & aggregate) • # of vacancies (by LOC, provider, position, & aggregate)
Lack of network providers joining and participating in HSX Lack of knowledge and systems/processes regarding how to manage HIPAA and confidentiality/ privacy requirements OP providers are not made aware when a member affiliated with them is admitted to the hospital	Planned: CBH plans to increase the number of providers joining and participating in HSX by reducing and/or removing barriers providers may experience around funding, technology, and policy barriers. Providers will be able to utilize HSX to: address barriers regarding record sharing and communication that are compliant with HIPAA and confidentiality/ privacy requirements, receive alerts regarding members' care and admission to AIP hospital, coordinate care through increased and improved communication across AIP and OP, easily identify if a member is already receiving care with a provider, among other activities. CBH plans to explore funding options to help providers cover costs, provide IT/EMR	April 2023 Ongoing	Funding opportunities will be identified to help providers cover costs they may face in joining HSX. Provider representatives will survey satisfaction and areas for improvement with providers during regular engagement. Measurements include but are not limited to: • # and % of providers who join HSX • # and % of providers who utilize HSX regularly • Usage reports from HSX • AIP provider satisfaction • OP provider satisfaction

CBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance			
	support to ensure linkages, and provider TA to providers regarding policy requirements per Title 42 CFR part 2 and how to appropriately disclose substance-use related member information.		
Members are unreachable telephonically due to: • Calls coming from unknown number • Lack of stable phone number/no phone number • Phone is turned off • Having run out of minutes • Voicemail full or not set up	Planned: Given the unwinding of the Medicaid continuous enrollment provision put forth in the wake of the COVID-19 pandemic, CBH is well positioned to regularly request updated contact information as members enroll. Members haven't been required to submit renewal paperwork since early 2022. As of April 1, this is changing. CBH and other government organizations are messaging the importance of having updated contact information for members.	March 2023 Annually	Communications will be distributed to members informing them of the change to renewal procedures, encouraging and highlighting the importance of having updated contact information for members. Requiring members to renew annually ensures CBH updated contact information for members at least once a year. Measurements include but are not limited to: • # and % of members who are reachable telephonically through member services appointment reminder calls

Table 6.3: CBH RCA and CAP for the FUH 30–Day Measure (All Ages)

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 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?):

Community Behavioral Health (CBH) analyzed its 30-Day follow-up after hospitalization for mental illness (FUH) HEDIS data for measurement year (MY) 2021 using a univariate model. There are statistically significant differences between the following groups, with the latter following up significantly less than the former:

- Ages 6–17 vs ages 18–64
- Non-White vs White
- Hispanic/Latino vs non-Hispanic/Latino
- Female vs male

The detailed rates are in the column to the right. The disparities present in the data do not indicate underperformance by non-white or Hispanic/Latino groups as compared to white or non-Hispanic/Latino groups, respectively. In fact, White or non-Hispanic/Latino groups are performing significantly worse than non-white or Hispanic/Latino groups.

Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change).

Group	30D FUH Numerator	30D FUH Denominator	30D FUH Rate
All	2,510	6,626	37.89%
Age 6–17	579	940	61.60%
Age 18–64	1,896	5,506	34.44%*
Asian	58	139	41.73%
Black/African Am.	1,681	4,309	39.01%
Other	322	781	41.23%
White	443	1,386	31.96%*
Hispanic/Latino	332	785	42.29%
Non-Hispanic/Latino	2,178	5,841	37.39%*
Female	1,341	3,300	40.64%

Due to this, interventions specific to non-white or non-Hispanic/Latino groups will not be developed.

CBH's multivariate analysis of MY 2021 data showed that members with a secondary diagnosis of substance related disorder (cannabis, stimulants, opioids, tobacco) are less likely to follow-up than members with secondary diagnoses of suicidal ideation/attempt/intention self-harm, neurodevelopmental disorders, and hallucinogen-related disorders. Interventions will include features that are targeted specifically to members with dual diagnoses (mental health and substance use disorder (SUD)). These data are detailed in the column to the right.

CBH surveyed stakeholders to determine barriers to and suggestion solutions or strategies to address those barriers for 30-day FUH. This included acute inpatient (AIP) providers, outpatient (OP) providers, members, DBHIDS, and internal CBH staff from various departments (Clinical, Provider Operations, Medical Affairs, Quality Management, Population Health, Member Services). Building off of the survey responses, RCA, and QIP completed in calendar year (CY) 2022, as well as FUH best practices, survey questions were developed to encourage a deeper dive into the barriers previously addressed. Survey questions are embedded in the column to the right.

Once barriers were identified, Affinity Diagrams at multiple levels were used to categorize and organize the barriers identified. Embedded in the column to the right are Affinity Diagrams at three levels: project (level 1), AIP and OP (level 2), and AIP and OP by survey question (level 3).

The Affinity Diagrams were used to determine root causes and develop Fishbone Diagrams. Embedded in the column to the right are Fishbone Diagrams. Fishbone diagrams were refined from the Affinity Diagrams and only conducted at the deeper levels (levels 2 & 3).

A Driver Diagram was developed to identify change ideas to address the barriers by influencing the key drivers. CBH then linked the interventions that will continue to the barriers they would address, identifying where there were gaps in existing interventions necessary to address root causes. CBH then used multi-voting to prioritize the development of new interventions based on the change strategies from the survey. CBH will move forward with developing interventions that were voted most highly. CBH will also continue interventions from CY 2022 that address barriers with a Critical or

Male	1,169	3,326	35.15%*

*Statistically significant difference at P<0.001

Characteristic	OR	95% CI	p-value
Secondary Diagnosis			
Neurodevelopmental Disorders	—	—	
No Diagnosis	0.64	0.46, 0.89	0.008
Other	0.80	0.57, 1.12	0.2
Substance Related	0.59	0.42, 0.84	0.003
Suicidal Ideation/Attempt/ Intentional Self-Harm	0.77	0.55, 1.08	0.02

OR = Odds Ration, CI = Confidence Interval

Additional attachments have been removed for the ATR.

<table>
<tr><th colspan="2">CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance</th></tr>
<tr><td>Important Causal Role.

CBH used the information from the RCA and multi-voting exercise to develop the logic model of change for 30-Day FUH for interventions that will be undertaken during CY 2023. Interventions from CY2022 that will be continued in CY2023 are included. The overall project logic model is embedded in the column to the right.</td><td></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 and any disparities (as defined above) 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 rowspan="2">People (1)
Members have low health literacy and are not educated sufficiently regarding:
• Importance of follow-up
• Importance of medication adherence
• Understanding discharge plan
• How to access supports for social determinants of health (SDoH)</td><td>Causal Role (relationship to other factors and to the overall performance indicator):
Members may exhibit low health literacy which can be a barrier to sufficient member education. If a member has low health literacy, they may not recognize the chronic nature of mental illness and the need for and benefit of continued treatment, including follow-up and/or medication adherence. Low health literacy also affects an individual's ability to understand and use information and services, therefore they may not understand their discharge plan fully and do not know how to access resources or supports around the discharge plan or to address SDoH.

Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical</td></tr>
<tr><td>Current and expected actionability: CBH can impact low health literacy in members by working with AIP providers to develop a uniform discharge packet with materials that are supportive of increasing health literacy and establishing standards for providers to ensure discharge planning discussions meet members where they are in terms of health literacy.</td></tr>
<tr><td rowspan="2">People (2)
Traditional education/learning methods are not impactful to or effective with members due to:
• Illiteracy
• Low competency/functional level
• Inability to retain new learned information
• Treatment fatigue
• Admitted involuntarily</td><td>Causal Role (relationship to other factors and to the overall performance indicator):
Members may struggle with learning through traditional methods due to illiteracy, low competency/functional level, and inability to retain new information. If hospital staff don't also verbally and/or visually review information and discharge plan with the member, the member may be discharged without any functional knowledge of what they are expected to do. Additionally, members may be admitted to the hospital involuntarily and may be resistant to receiving continued treatment after discharge, not understanding the need for follow-up treatment. Members may also experience "treatment fatigue" and become overwhelmed by many treatment appointments and unmotivated to continue with treatment after discharge.

Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical</td></tr>
<tr><td>Current and expected actionability: Similar to the actionability towards members with low health literacy, CBH can impact this by moving towards a uniform discharge packet. Additionally, CBH can work with AIP providers to develop discharge planning methods and other educational materials that utilize alternative methods of learning, such as video modules, verbal conversations, among others. Processes could be developed to identify those members who are</td></tr>
</table>

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance	
	disengaged due to treatment fatigue or involuntary admission and solutions to re-engage or effectively engage these members.
People (3) Members have competing priorities and issues to address in their life (housing, transportation, etc.), and do not attend follow-up appointments	***Causal Role (relationship to other factors and to the overall performance indicator):*** Many of CBH's membership are experiencing difficulties with other SDoHs that make it difficult for them to pursue treatment after discharge. Without transportation, members are not able to get to follow-up appointments. If a member is homeless or housing insecure, it's highly likely they will focus on addressing that as it is more pressing than a follow-up appointment with a mental health provider. After discharge, "life happens" and things get in the way of members wanting or being able to schedule and attend appointments. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Important
	Current and expected actionability: CBH can continue to leverage current partnerships with community-based organizations (CBO) that help members address SDoHs. CBH can explore opportunities to establish additional partnerships with other CBOs, and increase knowledge of and access to peer support services so that members have a support person to help address issues surrounding SDoHs.
People (4) Members have co-occurring SUD which interferes with ability to follow-up	***Causal Role (relationship to other factors and to the overall performance indicator):*** The effects of SUD may interfere with a member's ability to remember and keep follow-up appointments. SUD may also exacerbate symptoms of mental illness, which in turn could impact a member's ability to remember and keep follow-up appointment. CBH's analysis of MY 2021 data showed that members with a secondary diagnosis of SUD (cannabis, stimulants, opioids, tobacco) are less likely to follow-up than members with secondary diagnoses of suicidal ideation/attempt/intention self-harm, neurodevelopmental disorders, and hallucinogen-related disorders. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Important
	Current and expected actionability: In response to the State's 2022 PIP (PEDTAR), CBH established a Quality Improvement Learning Collaborative (QILC) involving providers who served members with co-occurring SUD. While the QILC has ended in its official capacity, CBH can take action to spread learnings to providers who did not participate in the QILC.
People (5) Member not adherent to medication and/or is not provided a sufficient supply to suffice before psychiatrist appointment	***Causal Role (relationship to other factors and to the overall performance indicator):*** If members are not included in decisions about medication or educated about medication side effects and the time it may take time for medication to become effective, they may discontinue taking their medication if unexpected side effects occur or if medication takes longer to become effective than expected. Discontinuing medication will lead to an increase in symptoms, which may interfere with the member's ability to remember and keep follow-up appointments. Additionally, members must receive a sufficient supply of medication upon discharge to ensure they do not run out before they are able to access a psychiatrist to receive a new prescription. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: CBH can incorporate medication requirements into performance standards for AIP providers and support development of educational and discharge materials that support medication adherence.
People (6)	***Causal Role (relationship to other factors and to the overall performance indicator):***

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance	
Members are frustrated with how long it takes to access a therapeutic appointment and thus abandon efforts prior to seeing an OP provider	Attending and participating in follow-up appointments after admission to AIP is difficult for members, and when the first appointment at the OP provider consists of primarily if not entirely paperwork members may become disengaged in their treatment. Having members attend multiple appointment on different days prior to an appointment with a provider deters members from wanting to engage in treatment. They also run the risk of having "life" happen between those appointments and are less likely to attend subsequent appointments. Members may be more likely to adhere to discharge plan if they are aware of and prepared for this, and/or if the process could be condensed so that their time is used efficiently. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Important
	Current and expected actionability: Facilitating the sharing of OP provider intake forms with AIP providers so that members are able to complete paperwork while still on unit/prior to discharge would help to reduce intake time once discharged. Creating a uniform intake process for OP providers would even further support this, as AIP providers would not need to determine the appropriate intake form based on OP providers, and OP providers would have all intake information ahead of the initial appointment.
People (7) Lack of staffing to adequately conduct discharge planning, care coordination, warm handoffs, having non-traditional business hours, reminder/rescheduling calls	***Causal Role (relationship to other factors and to the overall performance indicator):*** Staffing shortages at AIP and OP providers significantly impacts the availability of timely follow-up appointments for members after discharge. It also makes it difficult to implement FUH best practices. Lack of staffing at AIP hospitals can lead to lack or insufficient discharge planning, care coordination with OP providers, and warm handoffs. Lack of staffing at OP provider facilities can lead to lack of care coordination, warm handoffs, having non-traditional business hours, and conducting reminder/rescheduling calls. Staff shortages at case management providers may lead to members, who need case management services, being unable to receive them in a timely manner. Without case management services, these members may have greater difficulty remembering and keeping follow-up appointments. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: CBH is currently implementing multiple workforce development interventions to bolster the network and facilitate access to services, including the Open Access Pilot, regular Philadelphia Behavioral Health Workforce meetings, supporting staff flexibility, encouraging providers to support a hybrid model (in-person and telehealth), work with universities to create a pipeline for the system, pursuing partnership with Philadelphia Opportunities Industrialization Center (OIC), and regularly reviewing rates for levels of care most impacted by staff vacancies.
Providers (1) OP providers have long waitlists and aren't able to schedule a member within 30-day period	***Causal Role (relationship to other factors and to the overall performance indicator):*** OP providers report long waitlists for appointment times, well past the 30-day timeframe of the FUH measure criteria. Staff shortages contribute to this, as lower workforce capacity lends itself to lower access. AIP providers are more likely to send members to a facility with walk-in hours in hopes they will be seen then, however not all OP providers provide walk-in hours which inundates the few that do. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: CBH is actively working to address network access difficulties through initiatives

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance	
	such as the Open Network project, Open Access Pilot, among others. While staffing shortages significantly affect the ability to attain a timely appointment, CBH has identified ways to support communication and procedures to facilitate proactive appointment scheduling and to address the barriers that typically prevent members from attending appointments, regardless of timeliness.
Providers (2) OP providers are not made aware when a member affiliated with them is admitted to the hospital	***Causal Role (relationship to other factors and to the overall performance indicator):*** If a member is already seeking care with an OP provider, that provider would be able to proactively schedule the member a follow-up appointment if they were notified that the member had been admitted to AIP. If a member admitted to AIP has a current OP provider, that information is not always captured accurately in the medical record and AIP providers aren't consistently asking is this is the case. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Important
	Current and expected actionability: By supporting providers to join and utilize the Health Share Exchange (HSX), CBH can facilitate OP provider alters upon member admission, as HSX has encounter notifications for members that are already affiliated with an OP provider.
Policies / Procedures (1) Lack of or inadequate and inconsistent discharge planning	***Causal Role (relationship to other factors and to the overall performance indicator):*** Members who do not receive adequate discharge planning are less likely to attend follow-up appointments because they do not understand the importance of or the required steps to follow-up. Staffing shortages contribute to AIP providers having limited time or capacity to adequately provide discharge planning for all members. If AIP providers do provide discharge planning, it is inconsistent and not uniform. Lack of or inadequate discharge planning may disengage members and make them feel disempowered in their treatment due to their input or preferences being considered. The discharge plan may not align with the member's health literacy, education level, reading level, or engagement level. Members may feel disrespected and refuse to follow discharge plan if they do not feel heard, supported, and understood. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: CBH is in the position to work with AIP providers to develop a uniform discharge packet with materials that are supportive of increasing health literacy and establishing standards for providers to ensure discharge planning discussions meet members where they are in terms of health literacy. Additionally, CBH can work with AIP providers to develop discharge planning methods and other educational materials that utilize alternative methods of learning, such as video modules, verbal conversations, among others. Processes could be developed to identify those members who are disengaged due to treatment fatigue or involuntary admission and solutions to re-engage or effectively engage these members. These processes and procedures could be solidified by creating performance standards that are regularly measured, assessed, and reported back to AIP providers.
Policies / Procedures (2) Lack of knowledge and systems/processes regarding how to manage HIPAA and confidentiality/privacy requirements	***Causal Role (relationship to other factors and to the overall performance indicator):*** Misconceptions, lack of knowledge, and lack of systems/processes regarding managing HIPAA compliance and confidentiality/privacy requirements can present providers from sharing member health records with each other efficiently or easily. Members may express concerns regarding privacy and refuse to sign the release form to allow AIP providers to share health records with OP providers. Competing EHRs and lack of systems or processes make it difficult

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance	
	for providers to seamlessly share health records as they are concerned their method may not be HIPAA compliant. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Somewhat Important
	Current and expected actionability: By supporting providers to join and utilize the Health Share Exchange (HSX), CBH can facilitate HIPAA compliant transfer of health records and cross-provider communication.
Policies / Procedures (3) Lack of reimbursement for time spent, only for billing codes. This effects the ability to: • Have walk-in/open access hours • Prioritize or triage members newly discharged from AIP • Conduct reminder and rescheduling calls • Care coordination/communication between AIP and OP providers	***Causal Role (relationship to other factors and to the overall performance indicator):*** For both AIP and OP providers, the lack of reimbursement for time spent conducting what the literature says is best practice prevents these practices from being implemented. Providers can only bill/get reimbursed based on billing codes—this means if walk-in or open access appointments are available and are not utilized by members, the provider is not able to be reimbursed for that time. Similarly, there is no reimbursement or incentive for providers to conduct reminder calls (both AIP and OP), conduct rescheduling calls (OP), work to prioritize or triage members, or to coordinate/communicate around care between AIP and OP providers. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Somewhat Important
	Current and expected actionability: CBH is limited in its ability to impact the payment mechanisms of Medicaid. However, CBH is exploring rate increases to support providers in implementing these best practices. In November 2022 CBH increased rates by 10% for mental health OP and will continue to monitor and assess opportunities for additional increases. CBH is currently implementing an Open Access Pilot to test whether funding OP providers to maintain open access hours impacts OP access and wait time.
Policies / Procedures (4) Lack of network providers joining and participating in HSX	***Causal Role (relationship to other factors and to the overall performance indicator):*** CBH is currently engaged with HSX, however enrollment and participation of network providers is very low. HSX has features that would help address some of the barriers that AIP and OP providers face regarding communication, care coordination, and sharing of health records, such as: direct secure messaging, provider directory, automated care team finder, encounter notification service, and clinical data repository. Funding and policy barriers regarding SUD and resources for IT and EMR are barriers providers face in joining and participating in HSX. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Somewhat Important
	Current and expected actionability: Depending on the barriers providers face in joining and utilizing the HSX, CBH may be able to cover costs and/or facilitate addressing IT and EMR barriers. CBH is limited in its capability to address the policy barriers regarding SUD as it pertains to HSX, but can help support providers to ensure compliance.
	Current and expected actionability: By supporting provider participation in the HSX, CBH may be able to facilitate OP providers to receive alerts when their members are admitted to AIP.
Provisions (1) Lack of or inadequate and inconsistent screening for social determinants of health. Lack of support and resources to adequately address issues around members' social determinants of health	***Causal Role (relationship to other factors and to the overall performance indicator):*** Competing priorities and issues can prevent members from attending their follow-up appointments, as discussed above. If AIP providers aren't screening or are inconsistently screening members for issues regarding SDoHs, they are missing an opportunity to address these barriers to not following up. Even if/when AIP providers do inquire about SDoHs, lack of resources (and knowledge about current resources) on the providers part can prevent sufficient addressing of the issue.

that are identified.	***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Critical
	Current and expected actionability: Performance standards can be created to require AIP providers to screen for SDoHs using a standardized screening tool and resource information in the member's discharge plan packet. CBH can also increase knowledge of and access to peer support services so that members have a support person to help address issues surrounding SDoHs.
Provisions (2) Members are unreachable telephonically due to: • Calls coming from unknown number • Lack of stable phone number/no phone number • Phone is turned off • Having run out of minutes • Voicemail full or not set up	***Causal Role (relationship to other factors and to the overall performance indicator):*** OP providers have trouble reaching members to confirm, remind, or reschedule follow-up appointments. Many members are transient and don't have a phone number, change phone numbers frequently, and don't have stable and consistent contact information. If members are allotted a discrete number of minutes each month, they are unreachable once those minutes have been used—this can inhibit contact if calls are made later in the month. If members do have a stable phone number, voicemails aren't always set up or are full, meaning providers are unable to leave a message. Additionally, many people (members and otherwise) do not pick up calls that come from unknown numbers. ***Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Important
	Current and expected actionability: CBH is limited in its ability to provide members with telephonic support. However, given the unwinding of the Medicaid continuous enrollment provision put forth in the wake of the COVID-10 pandemic, it's well positioned to regularly request updated contact information as members enroll.

Quality Improvement Plan for CY 2023

Rate Goal for 2023 (State the 2023 rate goal from your MY2021 FUH Goal Report here):

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 2022 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When 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 Primary 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.

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.*
Members have low health literacy and are not educated sufficiently regarding: • Importance of follow-up	Planned: CBH will develop AIP Hospital Performance Standards requiring: • Integrated assessment that includes SDoH screening	April 2023 Ongoing	CBH has a standardized process for developing, approving, and communicating performance standards. AIP providers will be monitored quarterly on adherence to

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance			
• Importance of medication adherence • Understanding discharge plan • How to access supports for social determinants of health (SDoH) Traditional education/learning methods are not impactful to or effective with members due to: • Illiteracy • Low competency/functional level • Inability to retain new learned information • Treatment fatigue • Admitted involuntarily Member not adherent to medication and/or is not provided a sufficient supply to maintain adherence until psychiatrist appointment Members have co-occurring SUD which interferes with ability to follow-up	• Implementation of standard/uniform patient education in multiple modalities • Inclusion of member in decision making • Discharge planning to begin during admission • Active collaboration with member to ensure adequate understanding of discharge plan • 30-day medication supply with 1 refill at discharge • Implementation of standard/uniform discharge packet • Sufficiently addressing both mental health and SUD for members with dual diagnoses including appropriate follow-up care for mental health and substance use treatment • Submission of discharge plan to CBH in a timely manner • Active role in preventing re-admission through the use of phone calls and reminders of initial appointments • Treatment that is equitable and culturally humble and appropriate. <u>Planned:</u> CBH will work with DBHIDS (Quality and CMO Divisions) to develop educational materials, policies and procedures, and decision trees to support providers in ensuring members have information, and that they can access/interact with the information, to facilitate adequate follow-up after AIP discharge.	April 2023 Monthly	performance standards. Measurements include but are not limited to: • # and % of AIP providers assessed against standards • # and % of AIP providers receiving a satisfactory result • % increase in 7-day FUH rates (provider & aggregate) CBH and DBHIDS have a standardized process for developing, approving, and communicating the availability of educational materials. These materials will be shared with providers, and providers will be encouraged to implement policies and procedures to meet performance standards. As part of the case reviews conducted to monitor adherence to performance standards, CBH will review educational and discharge materials given to member. CBH will monitor reach and spread of standardized materials, as well as member and provider satisfaction. Measurements include but are not limited to: • # of website visits • # of unique downloads

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance			
			• # of hard copy materials distributed • # and % of cases reviewed that include distribution of educational materials
	Adapted continuing: CBH will continue to develop quarterly performance reports for AIP hospitals that include 30-day FUH and share those reports with providers in quarterly meetings. CBH will utilize these reports to engage AIP providers and provide technical assistance (TA) to providers who are struggling to reach FUH goals through an RCA and action plans (AP) specific to that provider.	Continuing Quarterly	CBH will continue to develop and share performance reports for AIP providers at quarterly provider meetings. Providers that have not met performance goals for the prior 4 quarters will be required to conduct an RCA and submit a performance improvement plan (PIP). CBH will provider TA to providers to complete these activities. Providers will continue to be monitored quarterly for performance improvement. Measurements include but are not limited to: • 30-day FUH rates (provider & aggregate) • # of provider meetings • # of reports distributed • # of providers required to conduct RCA and AP • # of RCAs and APs submitted to CBH • % increase in 30-day FUH rates (provider & aggregate)
Lack of or inadequate and inconsistent discharge planning	Planned: CBH will work with DBHIDS (System's Integration Unit) and AIP providers to develop a uniform discharge packet that addresses different members' needs to support providers in ensuring members leave AIP with resources, information, discharge plan clearly identified. A member survey will be included in the discharge packet asking the member to rate satisfaction with discharge packet. This survey will be given to CBH as part of the discharge plan. CBH will also survey providers on their satisfaction with the educational materials and discharge packet.	January 2023 Biweekly, Monthly	CBH and DBHIDS have a standardized process for developing, approving, and communicating the availability of materials. CBH will convene a workgroup including DBHIDS and OP providers to develop a uniform intake form. CBH will monitor adoption and implementation of the discharge packet, as well as member and provider satisfaction. Measurements include but are not limited to: • # and % of AIP providers that receive discharge packet • # and % of AIP providers that adopt discharge packet • Member satisfaction

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance			
			• Provider satisfaction
	Planned: CBH will explore the feasibility of implementing Project RED (Re-Engineered Discharge), an intervention founded on 12 discrete, mutually reinforcing components and has been proved to reduce rehospitalizations and yields high rates of patient satisfaction. Developed and tested at Boston University Medical Center, Project RED is looking at the transitional needs from inpatient to OP care of specific populations (i.e., those with depressive symptoms).	May 2023 Ongoing	CBH will pursue funding for the implementation of Project RED as well as a partnership with an AIP provider to implement the pilot. Once funding is secured and a partnership is established, Project RED will begin its implementation. Measurements include but are not limited to: • % of target population receiving any RED component • % of target population receiving all RED components • % of discharge educators (DE) collecting correct information from members • % of members with appropriate follow-up care arranged prior to discharge • % of members with follow-up appointment scheduled • % of members adequately prepared for discharge • % of members receiving post-discharge care • % of reduced hospital readmission • % of improved connections with providers • % of increased knowledge for self-management • % of increased patient satisfaction
Lack of or inadequate and inconsistent screening for social determinants of health. Lack of support and resources to adequately address issues around members' social determinants of health that are identified. Members have competing priorities and issues to address in their life	Adapted continuing: in Summer of 2022, CBH established a partnership with Utility Emergency Services Fund (UESF) to have AIP providers refer members who were identified as being housing insecure (couch surfing, etc.) to UESF for support. CBH will continue in this partnership in 2023, incorporating policies and procedures for AIP providers around screening members for the referral need, as well as incorporating policies and procedures for UESF around how to engage	Continuing Ongoing	CBH will work with UESF to identify screening tools, create workflow maps and decision trees, and develop policies and procedures around how to engage and support members. UESF will provide monthly screening and referral data to CBH which will be reviewed and assessed for performance and effectiveness. Measurements include but are not limited to: • # and % of referrals made (by AIP hospital,

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance			
(housing, transportation, etc.), and do not attend follow-up appointments	and support members. <u>Planned:</u> CBH will conduct an environmental scan to understand which CBOs in Philadelphia are available to provide support regarding issues around SDoHs. CBH will then identify CBOs they could partner with to establish a similar referral system to that of UESF (see below). CBH will also establish resource lists/information around which CBOs address which SDoHs to be included in the member education and discharge provisions. That includes a SDoH screening tool, which AIP providers will be expected to implement with member.	March 2023 Ongoing	assistance type, & aggregate) • # and % of cases opened (by AIP hospital, assistance type, & aggregate) • # and % of cases closed (by AIP hospital, assistance type, reason, & aggregate) • $ of direct costs incurred (by AIP hospital, assistance type, & aggregate) • $ of indirect costs incurred (by AIP hospital, assistance type, & aggregate) • # of payments provided (by AIP hospital, assistance type, & aggregate) • Range and average of # of payments provided per member • # of months of payments provided (by AIP hospital, assistance type, & aggregate) • Range and average of # of months of payments provided (by AIP hospital, assistance type, & aggregate) • 30-day follow-up rates for members seeking assistance
Members are frustrated with how long it takes to access a therapeutic appointment and thus abandon efforts prior to seeing an OP provider	<u>Planned:</u> CBH will work with DBHIDS (Quality and CMO Divisions) and OP providers to develop a uniform intake form that members can complete while still in hospital, if they wish. This would facilitate a quicker intake process and reduce amount of time from intake to therapeutic appointment. These efforts may also impact OP provider long wait lists, in that by reducing time from intake to appointment, appointments are available at a sooner date.	June 2023 Quarterly	CBH and DBHIDS have a standardized process for developing, approving, and communicating the availability of materials. CBH will convene a workgroup including DBHIDS and OP providers to develop a uniform intake form. CBH will monitor adoption and implementation of the intake form. Measurements include but are not limited to: • # and % of OP providers that participate in creation of intake form • # and % of OP providers that adopt intake form
OP providers have long wait lists, unable to consistently schedule members within 30 days of discharge Lack of reimbursement for time	<u>Continuing:</u> CBH is currently implementing an Open Access pilot. This pilot includes providing funds to OP providers who offer at least 4 hours of walk-in hours per week. 33 OP providers are part of the current pilot, running from January-	Continuing Ongoing	CBH is currently implementing an Open Access pilot. Access, cost, and quality data will be analyzed upon completion of the pilot (June 2023) to assess effectiveness and impact on access to OP provider

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance			
spent, only for billing codes. This effects the ability to: • Have walk-in/open access hours • Prioritize or triage members newly discharged from AIP • Conduct reminder and rescheduling calls • Care coordination/communication between AIP and OP providers	June 2023. A lump sum was provided to cover the costs of those hours (understanding that without these funds, no shows would result in a loss on the provider's end). The intended outcome is that this pilot will impact timely access to OP services <u>Continuing:</u> In November 2022 CBH increased rates by 10% for mental health OP and will continue to monitor and assess opportunities for additional increases.		appointments. Measurements include but are not limited to: • # and % of providers offering walk-in hours • # of members served by providers over time • Timely access to routine, urgent, and emergent appointments • $ total cost of lump sums
Lack of staffing to adequately conduct discharge planning, care coordination, warm handoffs, having non-traditional business hours, reminder/ rescheduling calls	<u>Planned:</u> CBH is releasing an RFP for a vendor to deliver a two-way conversation text message communication campaign with members. Messages will be rooted in behavioral change strategies and utilized artificial intelligence to deliver appropriate responses. Members will be identified and enrolled using CBH members data and asked to confirm their date of birth. Participation is voluntary. Members will receive text messages such as appointment reminders, FUH related education and resources, tailored tips to help people stay on top of their discharge plan, instructions to contact the appropriate people (member services, provider, etc.) to address their needs. <u>Planned:</u> CBH is exploring the utilization of payment models to reward EBPs and successful models, rate increases tied to front line staff wage increases, reviewing CBH staffing standards that are above and beyond the State standards, and conducting quarterly staffing surveys to identify trends. <u>Continuing:</u> CBH established the Philadelphia Behavioral Health Workforce Collaborative in Fall of 2021. The Collaborative is composed of providers, provider trade organizations,	January 2023 Monthly March 2023 Ongoing Continuing Ongoing	CBH has a standardized process for developing and releasing an RFP and engaging vendors to deliver services to our members. The vendor will provide CBH with monthly reports regarding enrollment, quantity, and quality of texts messages being sent. Measurements include but are not limited to: • # and % of members enrolled by CBH • # and % of members who participate • 30-day FUH rates for participating members CBH will continue to hold Philadelphia Behavioral Health Workforce Collaborative meetings to connect with key stakeholders and gather recommendations around increasing workforce. Quarterly staffing surveys to identify trends will continuity. Staffing standards will be reviewed and assessed for improvement or change. CBH will continue to collect recommendations from the Workforce and assess feasibility of and working towards implementation. CBH will work to establish relationships with

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance			
	universities, behavioral health administrators, policy makers, advocates, and interested parties who have come together to discuss the specific challenges facing the behavioral health workforce within Philadelphia. From this workgroup came recommendations that CBH is assessing the feasibility of and working towards implementing, such as establishing relationships with higher education to strengthen the pipeline. In February 2022, CBH issued a staffing survey to the provider network—while responses were inconsistent and only a snapshot in time, CBH learned what levels of care (LOCs) were most impacted by staffing vacancies, what positions had higher vacancies, and developed recommendations moving forward.		higher education to strengthen workforce pipeline. Access data and survey responses will continue to inform CBH of LOCs or positions that are particularly struggling to identify whether targeted intervention could be implemented. Measurements include but are not limited to: • # of meetings held • # of unique participants (by field/position, meeting & aggregate) • # and % of plausibly implemented recommendations • # of surveys conducted • # and % of responses • # and % of positions with higher vacancy rates • # and % of LOCs with higher impacts • # of new hires (by LOC, provider, position, & aggregate) • # of vacancies (by LOC, provider, position, & aggregate)
Lack of network providers joining and participating in HSX Lack of knowledge and systems/processes regarding how to manage HIPAA and confidentiality/ privacy requirements OP providers are not made aware when a member affiliated with them is admitted to the hospital	Planned: CBH plans to increase the number of providers joining and participating in HSX by reducing and/or removing barriers providers may experience around funding, technology, and policy barriers. Providers will be able to utilize HSX to: address barriers regarding record sharing and communication that are compliant with HIPAA and confidentiality/ privacy requirements, receive alerts regarding members' care and admission to AIP hospital, coordinate care through increased and improved communication across AIP and OP, easily identify if a member is already receiving care with a provider, among other activities. CBH plans to explore funding options to help providers cover costs, provide IT/EMR support to ensure linkages, and provider TA to providers regarding policy requirements	April 2023 Ongoing	Funding opportunities will be identified to help providers cover costs they may face in joining HSX. Provider representatives will survey satisfaction and areas for improvement with providers during regular engagement. Measurements include but are not limited to: • # and % of providers who join HSX • # and % of providers who utilize HSX regularly • Usage reports from HSX • AIP provider satisfaction • OP provider satisfaction

CBH RCA and CAP for the FUH 30–Day Measure (All Ages) for MY 2021 Underperformance			
	per Title 42 CFR part 2 and how to appropriately disclose substance-use related member information.		
Members are unreachable telephonically due to: • Calls coming from unknown number • Lack of stable phone number/no phone number • Phone is turned off • Having run out of minutes • Voicemail full or not set up	Planned: Given the unwinding of the Medicaid continuous enrollment provision put forth in the wake of the COVID-19 pandemic, CBH is well positioned to regularly request updated contact information as members enroll. Members haven't been required to submit renewal paperwork since early 2022. As of April 1, this is changing. CBH and other government organizations are messaging the importance of having updated contact information for members.	March 2023 Annually	Communications will be distributed to members informing them of the change to renewal procedures, encouraging and highlighting the importance of having updated contact information for members. Requiring members to renew annually ensures CBH updated contact information for members at least once a year. Measurements include but are not limited to: • # and % of members who are reachable telephonically through member services appointment reminder calls

VII: 2022 Strengths, Opportunities for Improvement and Recommendations

This section provides an overview of CBH's MY 2021 performance in the following areas: structure and operations standards, PIPs (no MY 2021 results to report), and PMs, with identified strengths and opportunities for improvement. This section also provides an assessment of the strengths and weaknesses of CBH with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (as described in Title 42 CFR 438.310(c)(2)).

Strengths

- Under MMC regulations, CBH was fully compliant with the provisions under Assurances of Adequate Capacity, Confidentiality, Health Information Systems, and Subcontractual Relationships and Delegations.

Opportunities for Improvement

- Review of Compliance with Standards conducted by PA in RY 2019, RY 2020, and RY 2021 found CBH to be partially compliant with two sections associated with MMC regulations.
  - CBH was partially compliant with 5 out of 9 categories within Compliance with Standards, Including Enrollee Rights and Protections. The partially compliant categories are: 1) Availability of Services, 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, and 4) Practice Guidelines, and 5) Provider Selection.
  - CBH was partially compliant with the single category Grievance and Appeal Systems within Grievance System.
- CBH's MY 2021 HEDIS 7- and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for all age cohorts examined (6–17, 18–64, and 6+ years) fell below the HEDIS 25th percentile.
- CBH's MY 2021 PA-Specific 7-Day (QI A) and (QI B) Follow-Up After Hospitalization for Mental Illness rates for the overall population were statistically significantly lower (worse) compared to the MY 2021 HC BH (statewide) rates.
- CBH's MY 2021 Readmission Within 30 Days of Inpatient Psychiatric Discharge overall rate did not meet the OMHSAS designated performance goal of 11.75%.
- Review of Compliance with Standards conducted by PA in RY 2019, RY 2020, and RY 2021 found CBH to be partially compliant with Network Adequacy.

Assessment of Quality, Timeliness, and Access

Responsibility for **quality** of, **timeliness** of, and **access** to health care services and supports is distributed among providers, payers, and Primary Contractors. Due to the BH carve-out within PA's HC program, BH-MCOs and PH-MCOs operate under separate contracts, with BH-MCOs contracting with non-overlapping Primary Contractors, making this distribution even more complex. That said, when it comes to improving healthcare quality, timeliness, and access, the BH-MCO can focus on factors closer to its locus of control.

Table 7.1 details the full list of recommendations that are made for the MCO for each of the applicable EQR activities. For PIPs, the recommendations are based on the review that was conducted for MY 2021. The PIP recommendations may include issues from prior years if they remain unresolved. For PMs, the strengths and opportunities noted above in this section summarize findings from the current report, while recommendations are based on issues that were not only identified as opportunities from the current report but were also identified as outstanding opportunities from last year's EQR technical report.

Table 7.1: EQR Recommendations

EQR Task/Measure	IPRO's Recommendation	Standards
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	CBH should consider ways to speed up some of its PDSA cycles where delays in implementation were noted. Finally, as of the writing of their report, CBH had terminated its population health strategy intervention with no replacement. A population health strategy intervention is a requirement of this PIP, which will need to be met. Since the vaping education intervention was fully implemented in 2021, this is not an issue for this review, but will be a concern going forward until addressed.	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	CBH has been working on RCAs and QIPs related to their FUH rates for a number of years now, and rates continue to fall. CBH's new PIP centering on improving the continuum of SUD care, particularly for Black, non-Hispanic members with disproportionately low treatment initiation and engagement rates, can be expected to help improve FUH rates to the extent there is comorbidity between SUD and mental illness. Still, for MCOs like CBH facing systemic resistance to policy efforts with no clear culprit, logic models of change can be operationalized using tools and techniques, including system dynamics simulation modeling, to help identify potential leverage points for bringing about change at lower cost.	Timeliness, Access
PA Follow-Up After Hospitalization for Mental Illness rates	CBH has been working on RCAs and QIPs related to their FUH rates for a number of years now, and rates continue to fall. CBH's new PIP centering on improving the continuum of SUD care, particularly for Black, non-Hispanic members with disproportionately low treatment initiation and engagement rates, can be expected to help improve FUH rates to the extent there is comorbidity between SUD and mental illness. Still, for MCOs like CBH facing systemic resistance to policy efforts with no clear culprit, logic models of change can be operationalized using tools and techniques, including system dynamics simulation modeling, to help identify potential leverage points for bringing about change at lower cost.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	CBH's REA rate continues to rise. CBH 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.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Availability of Services	CBH was partially compliant with the substandard that 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. A limited sample active case management review has already identified next steps for their medical management team. Now it remains for the steps to be operationalized with timelines to begin implementation.	Quality, Timeliness, Access
Coordination and continuity of care	CBH was partially compliant with documentation of correct application of medical necessity criteria in care management (CM). IPRO concurs with the recommendations made by OMHSAS: CBH should consider training and/or oversight with feedback of the denial letters, with focus on the clinical rational specific to the individual; and CBH should consider initiating a continuous quality improvement process based on identified goals. Suggested action items include the following: Operationalize each of the "next steps" identified in the ACMR; Prioritize the next steps and	Quality, Access

EQR Task/Measure	IPRO's Recommendation	Standards
	establish timeline for implementation.	
Coverage and authorization of services	CBH was partially compliant due in part to with issues with denial letters. IPRO concurs with OMHSAS recommendations from existing correction action plans centering on the implementation of the denial letter template and related standards.	Quality, Access
Practice guidelines	CBH was partially compliant with the substandard that 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. A limited sample active case management review has already identified next steps for their medical management team. Now it remains for the steps to be operationalized with timelines to begin implementation.	Quality, Timeliness, Access
Provider selection	CBH should ensure that results of provider profiling be incorporated into recredentialing.	Quality
Grievance and appeal systems	IPRO concurs with the following OMHSAS proposed remediations and CAPs: Investigators should not give their preliminary impressions on a panel decision to the member or member representative. CBH Complaint and Grievance Managers must develop a monitoring process that ensures that there is adequate and organized case documentation. CBH must conduct and document appropriate follow-up by ensuring that providers are completing corrective action plans that are assigned by CBH. If the documentation is not located in the Complaint record; CBH must note where the documentation can be found. CBH must use the appropriate Denial Letter Template as indicated in Appendix AA when notifying Members. CBH must provide members receiving Acute Inpatient Services with an effective date at least 1 day after the date of the denial notice to ensure the Member has the ability to file a complaint or grievance and continue services until a decision, if desired. OMHSAS recommends that CBH examine their processes to ensure Denial Letters reference applicable guidelines when making a decision. OMHSAS recommends that CBH examine their processes to ensure Denial Letters do not contain language which attempts to educate, instruct, or case manage the Member or provider. OMHSAS recommends that CBH examine their processes to ensure Denial Letters do not provide instruction or direct what a person who is not a BH provider is doing.	Quality, Timeliness, Access

EQR: external quality review; MCO: managed care organization; N/A: not applicable.

VIII: Summary of Activities

Performance Improvement Projects

- CBH successfully implemented their PEDTAR PIP for 2021.

Performance Measures

- CBH reported all PMs and applicable quality indicators in 2021.

Medicaid Managed Care Regulations

- CBH was partially compliant with standards, including Availability of Services, Coordination and continuity of care, Coverage and authorization of services, Practice guidelines, Provider selection, and Grievance System. As applicable, compliance review findings from RY 2021, RY 2020, and RY 2019 were used to make the determinations.

Network Adequacy

- Review of Compliance with Standards conducted by PA in RY 2019, RY 2020, and RY 2021 found CBH to be partially compliant with Network Adequacy.

Quality Studies

- DHS and OMHSAS launched ICWC in 2020. For any of its members receiving ICWC services, CBH covered those services under a Prospective Payment System rate.

2021 Opportunities for Improvement MCO Response

- CBH provided a response to the opportunities for improvement issued in 2021.

2022 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CBH in 2022 (MY 2021). The BH-MCO will be required to prepare a response in 2023 for the noted opportunities for improvement.

References and Notes

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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. Note that, in 2019, 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.

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

BBA Category	PEPS Reference	PEPS Language
Assurances of adequate capacity and services Title 42 CFR § 438.207	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 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 1.4	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.
Availability of Services Title 42 CFR § 438.206, Title 42 CFR § 10(h)	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 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

BBA Category	PEPS Reference	PEPS Language
		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 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.
Confidentiality Title 42 CFR § 438.224	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Coordination and continuity of care Title 42 CFR § 438.208	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.
Coverage and	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical

BBA Category	PEPS Reference	PEPS Language
authorization of services Title 42 CFR Parts § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114		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 timeframes and use the required template language.
	Substandard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a 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).
Health information systems Title 42 CFR § 438.242	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Practice guidelines Title 42 CFR § 438.236	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 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.
Provider selection Title 42 CFR § 438.214	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.
Subcontractual relationships and delegation Title 42 CFR § 438.230	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.

BBA Category	PEPS Reference	PEPS Language
	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.
Quality assessment and performance improvement program Title 42 CFR § 438.330	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

BBA Category	PEPS Reference	PEPS Language
		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 91.15	The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan.
	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.
	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. 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-MCO must measure and report its performance using standard measures required by DHS.
	Substandard 104.2	The BH-MCO must submit data to DHS, as specified by DHS, that enables the measurement of the BH-MCO's performance. QM program description must outline timeline for submission of QM program description, work plan, annual QM summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.
	Substandard 104.3	Performance Improvement Plans status reported within the established time frames.
	Substandard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly PEPS Reports
Grievance and appeal systems Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	Substandard 68.1	Interview with Complaint Coordinator(s) demonstrate a clear understanding of the Complaint process including how Member rights and Complaint 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

BBA Category	PEPS Reference	PEPS Language
		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 68.7	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 timeframes and use the required template language.
	Substandard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a 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).

Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-specific PEPS substandards. Note that, in 2019, 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.

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 68.8	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	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.
	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

Category	PEPS Reference	PEPS Language
		the issues being discussed and that input was provided from all panel members.
	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.
	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's/BH-MCO's role of fiduciary (if applicable) is clearly defined, and provides supportive function as defined in the 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 Philadelphia County

OMHSAS-specific substandards are not required to fulfill BBA requirements. In 2019, 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 RY 2021, 18 OMHSAS-specific substandards were evaluated for CBH and Philadelphia. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in 2021, along with the relevant categories.

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

	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
Category (PEPS Standard)	Total	NR	RY 2021	RY 2020	RY 2019
Care Management					
Care Management (CM) Staffing	1	0	0	0	1
Longitudinal Care Management (and Care Management Record Review)	1	0	0	0	1
Complaints and Grievances					
Complaints	5	0	0	0	5
Grievances	5	0	0	0	5
Denials					
Denials	1	0	1	0	0
Executive Management					
County Executive Management	1	0	0	0	1
BH-MCO Executive Management	1	0	0	0	1
Enrollee Satisfaction					
Consumer/Family Satisfaction	3	0	0	3	0
Total	**18**	**0**	**1**	**3**	**14**

[1] The total number of OMHSAS-Specific substandards required for the evaluation of Primary Contractor/BH-MCO compliance with OMHSAS standards. Any PEPS substandards not reviewed indicate substandards that were deemed not applicable to the Primary Contractor/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; CBH: Community Behavioral Health; RY: review year. NR: substandards not reviewed.

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 Primary Contractor/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. CBH was evaluated on two of the two applicable substandards. Of the two substandards, CBH was non-compliant with both 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
Care Management			
Care Management (CM) Staffing	Substandard 27.7	2019	Not met
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	2019	Not met

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

CBH was non-compliant with Standard 27, Substandard 7 of (RY 2019).

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

Substandard 7: Other: Significant onsite review findings related to Standard 27.

CBH was non-compliant with Standard 28, Substandard 3 of (RY 2019).

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

Substandard 3: Other: Significant onsite review findings related to Standard 28.

Complaints and Grievances

The OMHSAS-specific PEPS substandards relating to second-level complaints and grievances include MCO-specific and county-specific review standards. CBH was evaluated on 10 of the 10 applicable substandards. Of the 10 substandards evaluated, CBH partially met 3 substandards, and did not meet 4 substandards, as indicated in **Table C.3**.

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

Category	PEPS Item	RY	Status
Complaints and Grievances			
Complaints	Substandard 68.1.1	2019	Not met
	Substandard 68.1.2	2019	Met
	Substandard 68.5	2019	Met
	Substandard 68.6	2019	Partially met
	Substandard 68.8	2019	Not met
Grievances	Substandard 71.1.1	2019	Not met
	Substandard 71.1.2	2019	Met
	Substandard 71.5	2019	Not met
	Substandard 71.6	2019	Partially met
	Substandard 71.8	2019	Partially met

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

CBH was partially compliant with Standard 68.6 (RY 2019), Standard 71.6 (RY 2019), and Standard 71.8 (RY 2019). CBH was non-compliant with Standard 68.1.1 (RY 2019), Standard 68.8 (RY 2019), Standard 71.1.1 (RY 2019), and Standard 71.5 (RY 2019).

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

Standard 68: The Complaint 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.

Substandard 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.

Standard 68: The Complaint 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.

Substandard 6 (RY 2021): 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.

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.

Substandard 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.

Substandard 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.

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).

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.

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.

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.

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 2015. CBH 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	Substandard 72.3	2021	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. CBH was partially compliant with one substandard. The second substandard, 78.5 was deemed not applicable to CBH's review. The status for these substandards is presented in **Table A.5**.

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

Category	PEPS Item	RY	Status
Executive Management			
County Executive Management	Substandard 78.5	2019	Not reviewed
BH-MCO Executive Management	Substandard 86.3	2019	Partially met

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; BH: behavioral health; MCO: managed care plan.

CBH was partially compliant with Standard 86, Substandard 3 (RY 2019).

Standard 86: The appointed Medical Director is a board certified psychiatrist licensed in PA with at least five years experience in mental health and substance abuse. Required duties and functions are in place. The BH-MCO's table of organization depicts organization relationships of the following functions/ positions:

- Chief Executive Officer
- Chief Financial Officer
- Director of Quality Management
- Director of Utilization Management
- Management Information Systems
- Director of Prior/service authorization
- Director of Member Services
- Director of Provider Services

Substandard 3: Other: Significant onsite review findings related to Standard 86.

Enrollee Satisfaction

The OMHSAS-specific PEPS substandards relating to Enrollee Satisfaction are county-specific review standards. All 3 substandards crosswalked to this category were evaluated for Philadelphia County. Philadelphia County met the criteria for all 3 substandards, as seen in **Table C.6**.

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

Category	PEPS Item	RY	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Substandard 108.3	2020	Met
	Substandard 108.4	2020	Met
	Substandard 108.9	2020	Met

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