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

2020 External Quality Review Report
Community Care Behavioral Health

FINAL

April 2021

IPRO
Better healthcare,
realized.

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Introduction

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

OMHSAS contracted with Island Peer Review Organization (IPRO) as its EQRO to conduct the 2020 EQRs for HC BH-MCOs and to prepare the technical reports. The subject of this report is one HC BH-MCO: Community Care Behavioral Health (CCBH). Subsequent references to MCO in this report refer specifically to this HC BH-MCO.

Overview

HealthChoices (HC) Behavioral Health (BH) is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program. In such cases, the Department 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 behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Forty-three (43) of the 67 counties have signed agreements using the right of first opportunity and have subcontracted with a BH-MCO. Twenty-four (24) counties have elected not to enter into a capitated agreement and, as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties.

In the interest of operational efficiency, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the Primary Contractors while providing an oversight function of the BH-MCOs. In some cases the HealthChoices Oversight Entity is the Primary Contractor and, in other cases, multiple Primary Contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. In the CCBH managed care network, Allegheny, Berks, Chester, and Erie Counties hold contracts with CCBH. The North/Central County Option (NC/CO) Counties – Carbon, Monroe, and Pike – hold a contract with CCBH as the Carbon-Monroe-Pike Joinder Board. Lackawanna, Luzerne, Susquehanna, and Wyoming hold a contract with Northeast Behavioral Health Care Consortium (NBHCC), which, in turn, holds a contract with CCBH. The Department contracts directly with CCBH to manage the HC BH program for the North/Central State Option (NCSO) Counties – Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne. For Blair County, the Primary Contractor is Blair HC. For Clinton and Lycoming Counties, the Primary Contractor is the Lycoming-Clinton Joinder Board. For York and Adams Counties, the Primary Contractor is the York-Adams HC Joinder Governing Board. On July 1, 2019, the Behavioral Health Services of Somerset and Bedford Counties changed contracts from PerformCare to CCBH.

Objectives

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

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

Report Structure

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[1] this technical report includes seven core sections:

I. Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Review of Compliance with Medicaid Managed Care Regulations
IV. Quality Studies
V. 2019 Opportunities for Improvement – MCO Response

VI. 2020 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the MCO, Information for Sections II and III of this report is derived from IPRO's validation of the MCO's performance improvement projects (PIPs) and performance measure (PM) submissions. The PM validation, as conducted by IPRO, included a repeated measurement of two PMs: 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 the Commonwealth's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable. Section IV discusses the Quality Study for the Certified Community Behavioral Health Clinic federal demonstration and the Integrated Community Wellness Centers program. Section V, 2019 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2019 (MY 2018) EQR Technical Report and presents the degree to which the MCO addressed each opportunity for improvement. Section VI includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2019), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH Quality Performance of the MCO. Lastly, Section VII provides a summary of EQR activities for the MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

Supplemental Materials

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

- the MCO's BBA Report for MY 2019, and
- all attachments or embedded objects within MCO Responses to Opportunities for Improvement (as identified in the MCO's 2019 BBA Report).

I: Validation of Performance Improvement Projects

In accordance with current BBA regulations, IPRO validates at least one performance improvement project (PIP) for the MCO. Under the existing HC BH agreement with OMHSAS, Primary Contractors, along with the responsible subcontracted entities (i.e., MCOs), are required to conduct a minimum of two focused studies per year. 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.

Background

CY 2019 saw the winding down of one PIP project and the formation of a new project. MCOs submitted their final reports for the EQR PIP topic "Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis." The results of IPRO's validation of the complete project were reported in the 2019 BBA reports.

In 2019, OMHSAS directed IPRO to complete a preliminary study of substance use disorders (SUD) in the Commonwealth preliminary to selection of a new PIP topic. As a result, OMHSAS selected the topic, "Successful Prevention, Early Detection, Treatment, and Recovery (SPEDTAR) for Substance Use Disorders" as a PIP for all BH-MCOs in the State. The PIP will extend from 2021 through 2023, including a final report due in 2024. While the topic will be common to Primary Contractors and BH-MCOs, each project will be developed as a collaboration and discussion between Primary Contractors and their contracted BH-MCOs. Primary Contractors and BH-MCOs were directed to begin conducting independent analyses of their data and partnering to develop relevant PMs and interventions. BH-MCOs will be responsible for coordinating, implementing, and reporting the project.

The Aim Statement for this PIP, reflecting an emphasis on reducing racial and ethnic health disparities, is: "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 selected 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 and/or other SUD;
2. Improve retention in treatment for members with an Opioid and/or other SUD diagnosis;
3. Increase concurrent use of Drug & Alcohol counseling in conjunction with Pharmacotherapy (Medication-Assisted Treatment); 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 PMs for the SPEDTAR 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."[2] 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 proposes to require 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. The measure will measure 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, as defined by the PA-specific FUH measure, 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 as well as 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."[3] 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. Final baseline results will be run for the performance indicators in Summer 2021 and PIP interventions recalibrated as needed.

The report marks the 17th EQR review to include validation of PIPs. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline.

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 SPEDTAR 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.

Validation Methodology

IPRO's validation of PIP activities is consistent with the protocol issued by CMS[4] 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 full, partial, and non-compliance.

II: Validation of Performance Measures

In 2019, OMHSAS and IPRO conducted two EQR studies. Both the Follow-Up After Hospitalization for Mental Illness (FUH) and Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were remeasured in 2019. On July 1, 2019, the Bedford-Somerset HC Oversight Entity changed contracts from PerformCare to CCBH, and denominator and numerator counts involving Bedford-Somerset members were split accordingly.

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.

Measurement year (MY) 2002 was the first year follow-up rates were reported. Quality Indicator (QI) 1 and QI 2 utilize the HEDIS methodology for this measure. The PA-specific indicators were added to include services with high utilization in the 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 2019 (MY 2018), 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

The entire eligible population was used for all 25 Primary Contractors participating in the MY 2019 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, 2019;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Six (6) years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2019, 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, 2019. The methodology for identification of the eligible

population for these indicators were consistent with the HEDIS MY 2019 methodology for the Follow-Up After Hospitalization for Mental Illness measure.

HEDIS Follow-Up Indicators

Quality Indicator 1 (QI 1): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge (calculation based on industry standard codes used in HEDIS)

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

Quality Indicator 2 (QI 2): Follow-up After Hospitalization for Mental Illness Within 30 Days After Discharge (calculation based on industry standard codes used in HEDIS)

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

PA-Specific Follow-Up Indicators

Quality Indicator A (QI A): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge (calculation based on numerator 1 codes and additional PA-specific codes not used in HEDIS)

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

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

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

Quality Indicator Significance

Mental disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. In 2018, 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 serious mental illness in the past year, which corresponds to 4.6% of all U.S. adults.[5] Additionally, patients with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities 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.[6] Roughly one-third of adults with serious mental illness (SMI) in any given year did not receive any mental health services, showing a disparity among those with SMI.[7] Further research suggests that more than half of those with SMI did not receive services because they could not afford the cost of care.[8] Cost of care broke down as follows: 60.8% of patients' 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.[9] 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 severe and persistent mental illness.[10] As noted in *The State of Health Care Quality Report,*[11] 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.[12] 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.[13] 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.[14]

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long-standing concern of behavioral health care systems, with some researchers having estimated that 40–60% of patients fail to connect with an outpatient clinician.[15] Research has demonstrated that patients who do not have an outpatient appointment after discharge were more likely to be re-hospitalized in the same year than patients who kept at least one outpatient appointment.[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] Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care and is an effective means to control the cost and maximize the quality of mental health services. Additionally, mental illness continues to impact the PA population, including those with substance abuse concerns or substance use disorder (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. While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs for each 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 2019 (MY 2018), 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 2019 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 2018 results. These MY 2018 results were reported in the 2019 BBA 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 V**.

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 or 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 (Pennsylvania continued its Medicaid expansion under the Affordable Care Act in 2019). This interactive reporting provides an important tool for BH-MCOs and their HC Oversight Entities to set performance goals as well as 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 2018 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *z* statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

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

Where:

*N*1 = Current year (MY 2019) numerator,
*N*2 = Prior year (MY 2018) numerator,
*D*1 = Current year (MY 2019) denominator, and
*D*2 = Prior year (MY 2018) 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 2019) quality indicator rate, and
*p*2 = Prior year (MY 2018) 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*-score 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.

Findings

BH-MCO and Primary Contractor Results

The HEDIS follow-up indicators are presented for three age groups: ages 18 to 64, ages 6 and older, and ages 6 to 17. The 6+ year old ("All Ages") results are presented to show the follow-up rates for the overall HEDIS population, and the 6

to 17 years old age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old only.

The results are presented at the BH-MCO and 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 groups are compared to the HEDIS 2019 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 to 17 years old age group and 18 to 64 years old age group are not compared to HEDIS benchmarks.

I: HEDIS Follow-Up Indicators

(a) Age Group: 18–64 Years Old

Table 2.1 shows the MY 2019 results for both the HEDIS 7-day and 30-day follow-up measures for members 18 to 64 years old compared to MY 2018.

Table 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (18–64 Years)

	MY 2019					MY 2018 %	MY 2019 Rate Comparison To MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD
QI 1 – HEDIS 7-Day Follow-Up (18–64 Years)								
HC BH (Statewide)	10,935	30,472	**35.9%**	35.3%	36.4%	35.5%	0.4	NO
CCBH	5,009	11,949	**41.9%**	41.0%	42.8%	41.4%	0.5	NO
Allegheny	1,074	2,684	**40.0%**	38.1%	41.9%	37.9%	2.1	NO
Blair	166	439	**37.8%**	33.2%	42.5%	53.8%	-16.0	YES
Berks	376	1,050	**35.8%**	32.9%	38.8%	43.9%	-8.0	YES
Bedford-Somerset	30	91	**33.0%**	N/A	N/A	.	.	N/A
Chester	253	612	**41.3%**	37.4%	45.3%	41.5%	-0.2	NO
CMP	255	520	**49.0%**	44.6%	53.4%	42.1%	6.9	YES
Erie	362	877	**41.3%**	38.0%	44.6%	40.4%	0.9	NO
Lycoming-Clinton	123	325	**37.8%**	32.4%	43.3%	42.5%	-4.7	NO
NBHCC	770	1,554	**49.5%**	47.0%	52.1%	46.3%	3.2	NO
NCSO	1,257	2,861	**43.9%**	42.1%	45.8%	42.1%	1.8	NO
York-Adams	343	936	**36.6%**	33.5%	39.8%	32.2%	4.4	YES
QI 2 – HEDIS 30-Day Follow-Up (18-64 Years)								
HC BH (Statewide)	16,997	30,472	**55.8%**	55.2%	56.3%	56.0%	-0.3	NO
CCBH	7,443	11,949	**62.3%**	61.4%	63.2%	62.7%	-0.4	NO
Allegheny	1,580	2,684	**58.9%**	57.0%	60.7%	58.1%	0.7	NO
Blair	300	439	**68.3%**	63.9%	72.8%	74.8%	-6.5	YES

	MY 2019						MY 2019 Rate Comparison To MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	MY 2018 %	PPD	SSD
Berks	559	1,050	**53.2%**	50.2%	56.3%	62.2%	-9.0	YES
Bedford-Somerset	51	91	**56.0%**	N/A	N/A	.	.	N/A
Chester	348	612	**56.9%**	52.9%	60.9%	59.7%	-2.9	NO
CMP	351	520	**67.5%**	63.4%	71.6%	63.7%	3.8	NO
Erie	511	877	**58.3%**	54.9%	61.6%	59.4%	-1.1	NO
Lycoming-Clinton	190	325	**58.5%**	53.0%	64.0%	61.0%	-2.5	NO
NBHCC	1,076	1,554	**69.2%**	66.9%	71.6%	67.3%	1.9	NO
NCSO	1,908	2,861	**66.7%**	64.9%	68.4%	65.8%	0.9	NO
York-Adams	569	936	**60.8%**	57.6%	64.0%	57.5%	3.3	NO

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 rates. Bedford-Somerset is reported only for MY2019 due to a BH-MCO switch.
MY: measurement year; FUH: Follow-Up After Hospitalization; HEDIS: Healthcare Effectiveness Data and Information Set; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option.

Figure 2.1 is a graphical representation of MY 2019 HEDIS FUH 7- and 30-day follow-up rates in the 18 to 64 years old population for CCBH and its associated Primary Contractors. The orange line indicates the MCO average.

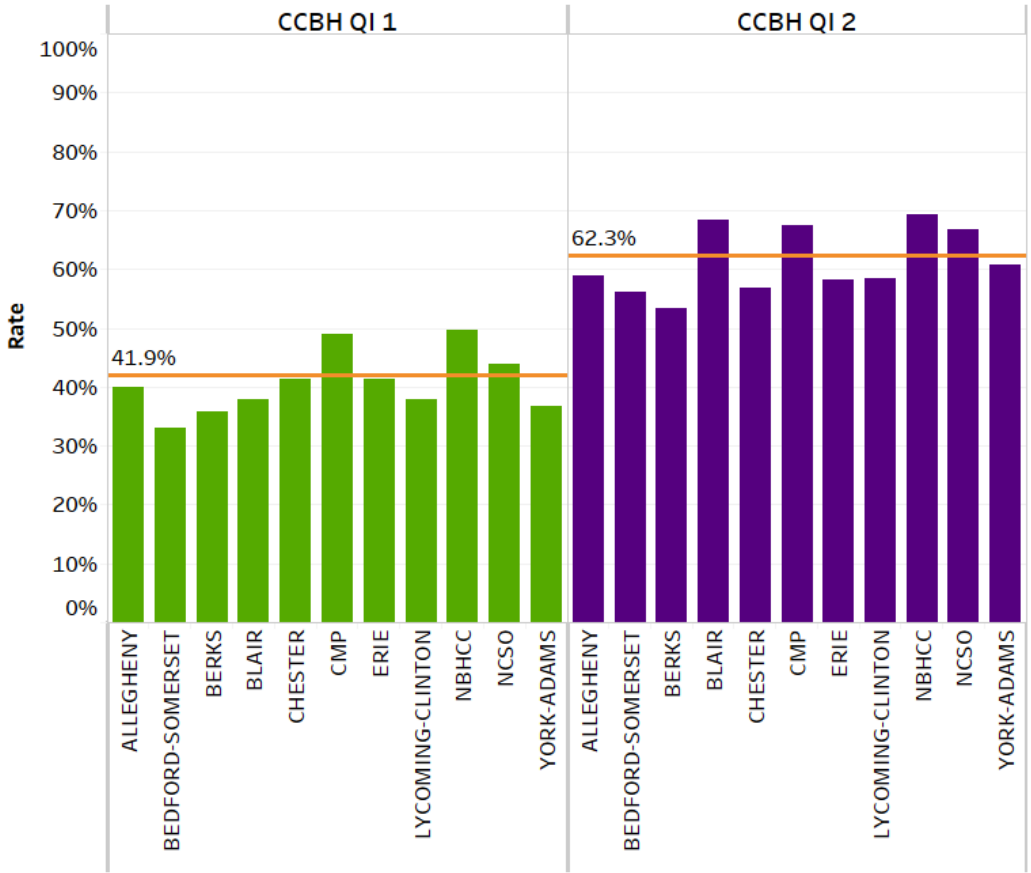

Figure 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years).

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

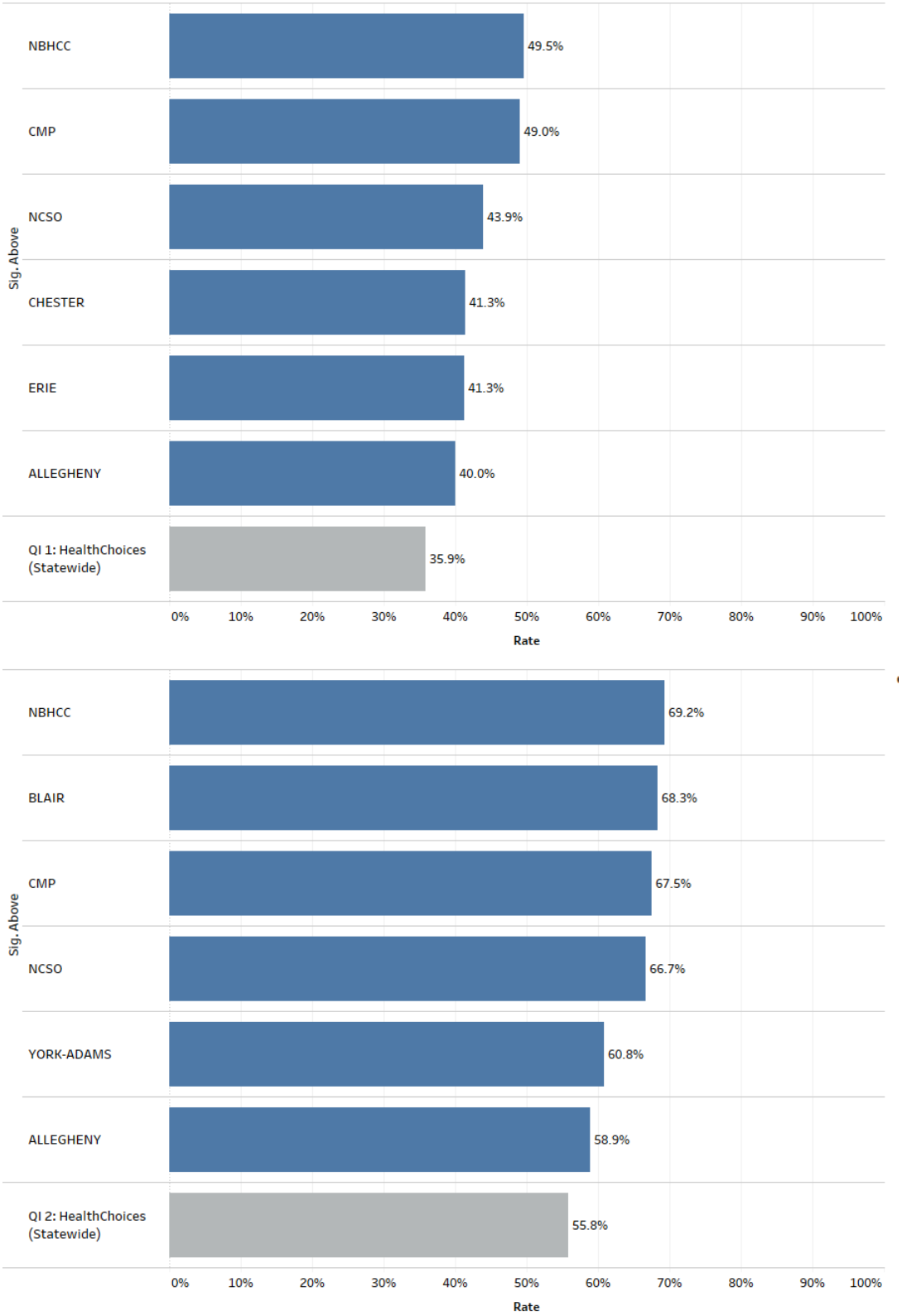

Figure 2.2: CCBH Contractor MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years) that are Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (18–64 Years).

(b) Overall Population: 6+ Years Old

The MY 2019 HC Aggregate HEDIS and CCBH are shown in **Table 2.2.**

Table 2.2: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (All Ages)

	MY 2019						MY 2019 Rate Comparison		
				95% CI			To MY 2018		To MY 2019
Measure	(N)	(D)	%	Lower	Upper	MY 2018 %	PPD	SSD	HEDIS Medicaid Percentiles
QI 1 – HEDIS 7-Day Follow-Up (Overall)									
HC BH (Statewide)	15,843	39,823	**39.8%**	39.3%	40.3%	39.4%	0.4	NO	Below 75th percentile, above 50th percentile
CCBH	7,156	15,850	**45.1%**	44.4%	45.9%	44.9%	0.3	NO	At or above 75th percentile
Allegheny	1,495	3,487	**42.9%**	41.2%	44.5%	40.7%	2.2	NO	Below 75th percentile, above 50th percentile
Blair	250	599	**41.7%**	37.7%	45.8%	55.2%	-13.5	YES	Below 75th percentile, above 50th percentile
Berks	543	1,352	**40.2%**	37.5%	42.8%	47.8%	-7.7	YES	Below 75th percentile, above 50th percentile
Bedford-Somerset	43	114	**37.7%**	28.4%	47.1%	.	.	NO	Below 75th percentile, above 50th percentile
Chester	373	826	**45.2%**	41.7%	48.6%	46.1%	-1.0	NO	At or above 75th percentile
CMP	369	720	**51.3%**	47.5%	55.0%	45.0%	6.2	YES	At or above 75th percentile
Erie	503	1,115	**45.1%**	42.1%	48.1%	44.3%	0.8	NO	At or above 75th percentile
Lycoming-Clinton	191	468	**40.8%**	36.3%	45.4%	43.8%	-3.0	NO	Below 75th percentile, above 50th percentile
NBHCC	1,044	1,999	**52.2%**	50.0%	54.4%	49.8%	2.4	NO	At or above 75th percentile
NCSO	1,809	3,886	**46.6%**	45.0%	48.1%	45.7%	0.9	NO	At or above 75th percentile
York-Adams	536	1,284	**41.7%**	39.0%	44.5%	38.0%	3.8	NO	Below 75th percentile, above 50th percentile

	MY 2019					MY 2018 %	MY 2019 Rate Comparison		
				95% CI			To MY 2018		To MY 2019 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	
QI 2 – HEDIS 30-Day Follow-Up (Overall)									
HC BH (Statewide)	24,029	39,823	**60.3%**	59.9%	60.8%	60.2%	0.2	NO	Below 75th percentile, above 50th percentile
CCBH	10,477	15,850	**66.1%**	65.4%	66.8%	66.2%	-0.1	NO	Below 75th percentile, above 50th percentile
Allegheny	2,172	3,487	**62.3%**	60.7%	63.9%	61.3%	0.9	NO	Below 75th percentile, above 50th percentile
Blair	428	599	**71.5%**	67.8%	75.2%	76.5%	-5.0	NO	At or above 75th percentile
Berks	790	1,352	**58.4%**	55.8%	61.1%	65.9%	-7.5	YES	Below 50th percentile, above 25th percentile
Bedford-Somerset	68	114	**59.6%**	50.2%	69.1%	.	.	NO	Below 75th percentile, above 50th percentile
Chester	502	826	**60.8%**	57.4%	64.2%	64.1%	-3.4	NO	Below 75th percentile, above 50th percentile
CMP	517	720	**71.8%**	68.4%	75.2%	66.6%	5.2	YES	At or above 75th percentile
Erie	690	1,115	**61.9%**	59.0%	64.8%	63.6%	-1.8	NO	Below 75th percentile, above 50th percentile
Lycoming-Clinton	301	468	**64.3%**	59.9%	68.8%	62.5%	1.8	NO	Below 75th percentile, above 50th percentile
NBHCC	1,445	1,999	**72.3%**	70.3%	74.3%	70.5%	1.8	NO	At or above 75th percentile

	MY 2019					MY 2018 %	MY 2019 Rate Comparison		
				95% CI			To MY 2018		To MY 2019 HEDIS Medicaid Percentiles
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	
NCSO	2,713	3,886	**69.8%**	68.4%	71.3%	69.4%	0.4	NO	At or above 75th percentile
York-Adams	851	1,284	**66.3%**	63.7%	68.9%	63.2%	3.1	NO	Below 75th percentile, above 50th percentile

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 rates. Bedford-Somerset is reported only for MY2019 due to a BH-MCO switch.

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; QI: quality indicator; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option.

Figure 2.3 is a graphical representation of the MY 2019 HEDIS follow-up rates for CCBH and its associated Primary Contractors. The orange line represents the MCO average.

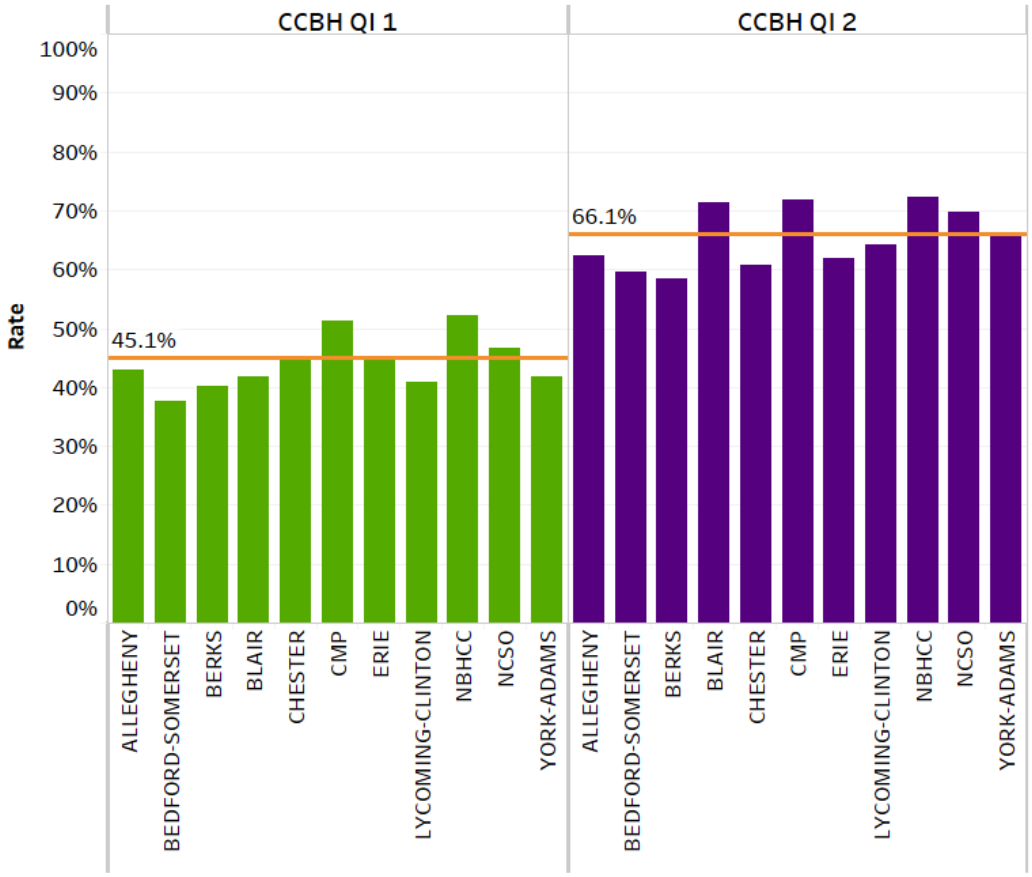

Figure 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages).

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 its statewide benchmark.

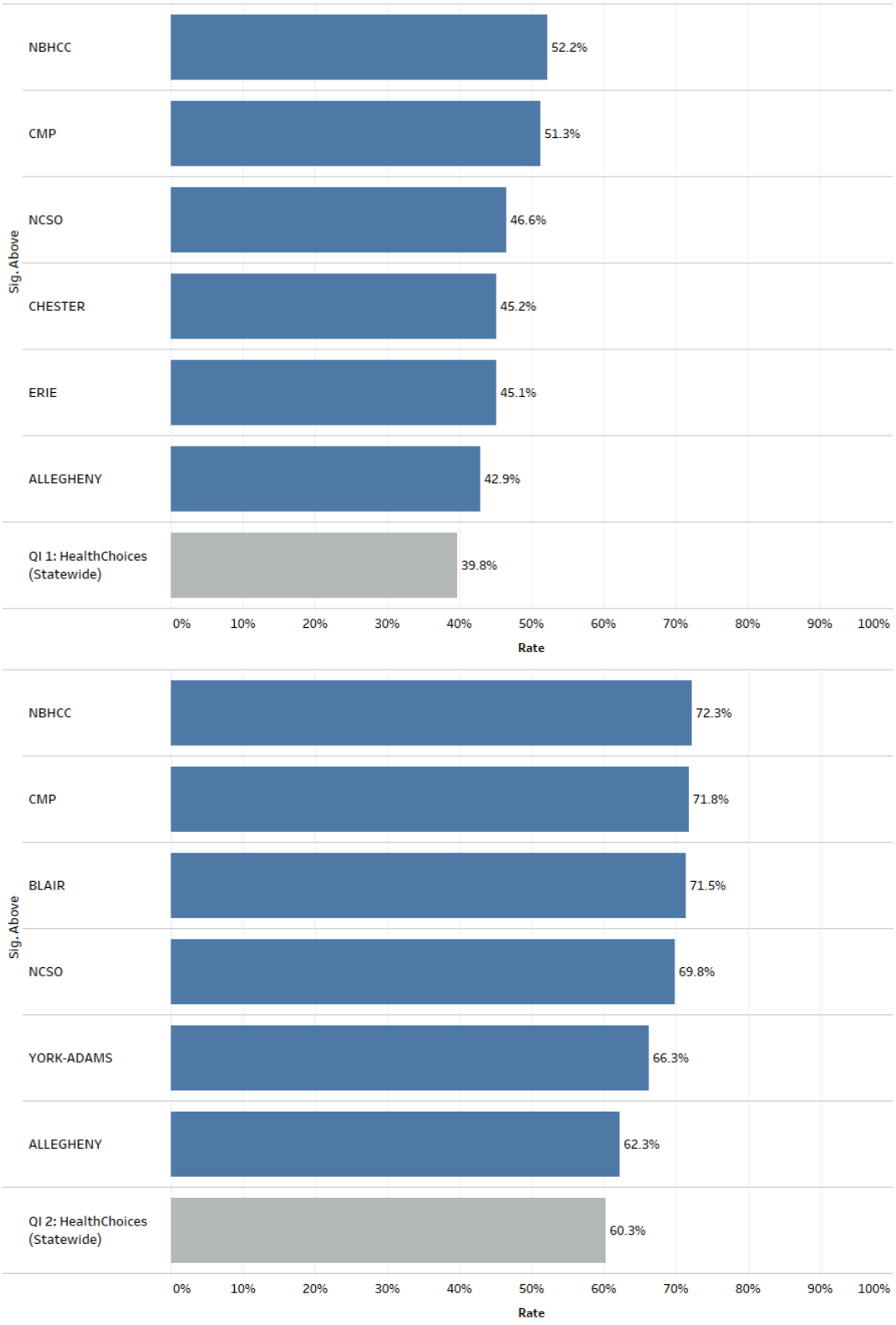

Figure 2.4: CCBH Contractor MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages) that are Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (All Ages).

(c) Age Group: 6–17 Years Old

Table 2.3 shows the MY 2019 results for both the HEDIS 7-day and 30-day follow-up measures for members aged 6–17 years compared to MY 2018.

Table 2.3: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Indicators (6–17 Years)

	MY 2019					MY 2018	MY 2019 Rate Comparison to MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI 1 – HEDIS 7-Day Follow-Up (6-17 Years)								
HC BH (Statewide)	4,750	8,573	**55.4%**	54.3%	56.5%	55.7%	-0.3	NO
CCBH	2,071	3,583	**57.8%**	56.2%	59.4%	58.6%	-0.8	NO
Allegheny	387	679	**57.0%**	53.2%	60.8%	55.3%	1.7	NO
Blair	80	149	**53.7%**	45.3%	62.0%	61.8%	-8.1	NO
Berks	161	270	**59.6%**	53.6%	65.7%	65.1%	-5.5	NO
Bedford-Somerset	13	20	**65.0%**	N/A	N/A	N/A	N/A	N/A
Chester	118	193	**61.1%**	54.0%	68.3%	60.3%	0.8	NO
CMP	113	195	**57.9%**	50.8%	65.1%	53.9%	4.1	NO
Erie	137	216	**63.4%**	56.8%	70.1%	62.0%	1.4	NO
Lycoming-Clinton	65	138	**47.1%**	38.4%	55.8%	47.5%	-0.4	NO
NBHCC	266	415	**64.1%**	59.4%	68.8%	64.6%	-0.5	NO
NCSO	540	973	**55.5%**	52.3%	58.7%	57.9%	-2.4	NO
York-Adams	191	335	**57.0%**	51.6%	62.5%	56.8%	0.2	NO
QI 2 – HEDIS 30-Day Follow-Up (6-17 Years)								
HC BH (Statewide)	6,756	8,573	**78.8%**	77.9%	79.7%	77.7%	1.1	NO
CCBH	2,905	3,583	**81.1%**	79.8%	82.4%	80.8%	0.3	NO
Allegheny	542	679	**79.8%**	76.7%	82.9%	78.9%	0.9	NO
Blair	124	149	**83.2%**	76.9%	89.6%	84.6%	-1.3	NO
Berks	218	270	**80.7%**	75.9%	85.6%	82.7%	-2.0	NO
Bedford-Somerset	17	20	**85.0%**	N/A	N/A	N/A	N/A	N/A
Chester	149	193	**77.2%**	71.0%	83.4%	78.4%	-1.1	NO
CMP	165	195	**84.6%**	79.3%	89.9%	75.6%	9.0	YES
Erie	174	216	**80.6%**	75.0%	86.1%	83.5%	-2.9	NO
Lycoming-Clinton	107	138	**77.5%**	70.2%	84.9%	67.7%	9.9	NO
NBHCC	350	415	**84.3%**	80.7%	88.0%	83.2%	1.2	NO
NCSO	781	973	**80.3%**	77.7%	82.8%	82.0%	-1.7	NO
York-Adams	278	335	**83.0%**	78.8%	87.2%	82.5%	0.5	NO

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 rates. Bedford-Somerset is reported only for MY2019 due to a BH-MCO switch.

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; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option; N/A: Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

Figure 2.5 is a graphical representation of the MY 2019 HEDIS follow-up rates in the 6 to 17 years old population for CCBH and its associated Primary Contractors. The orange line represents the MCO average.

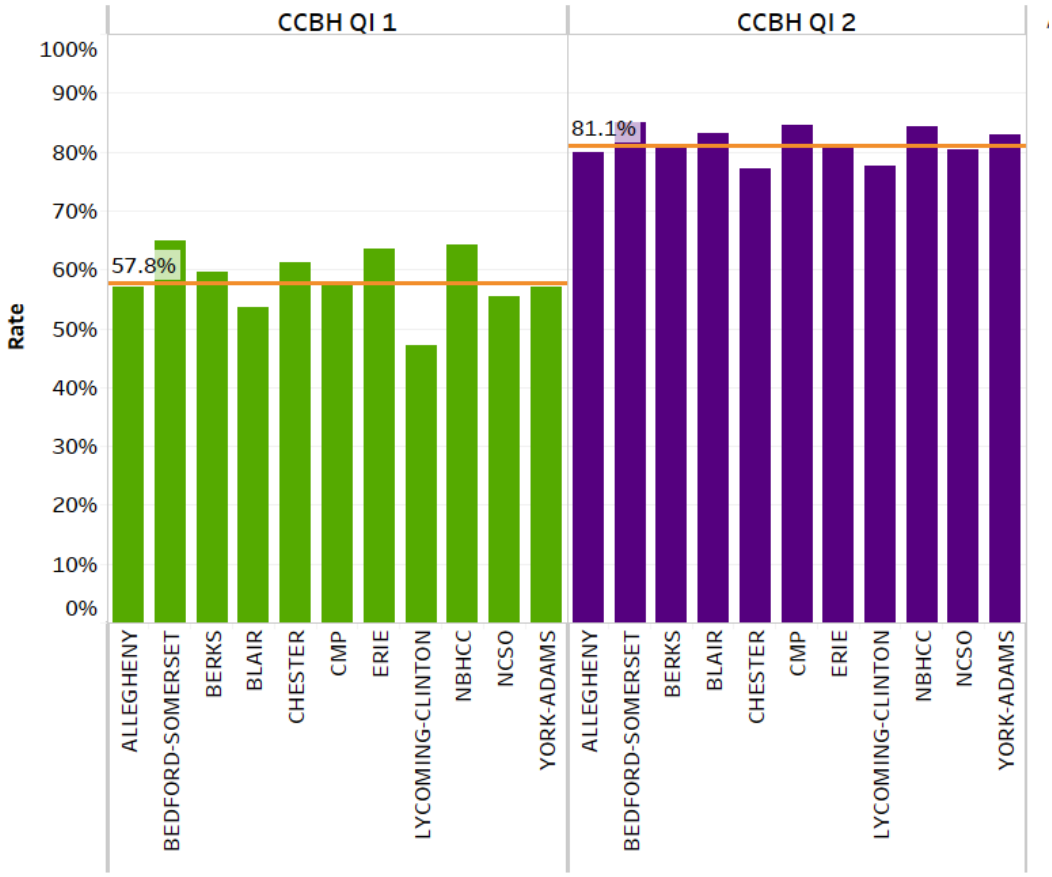

Figure 2.5: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years).

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

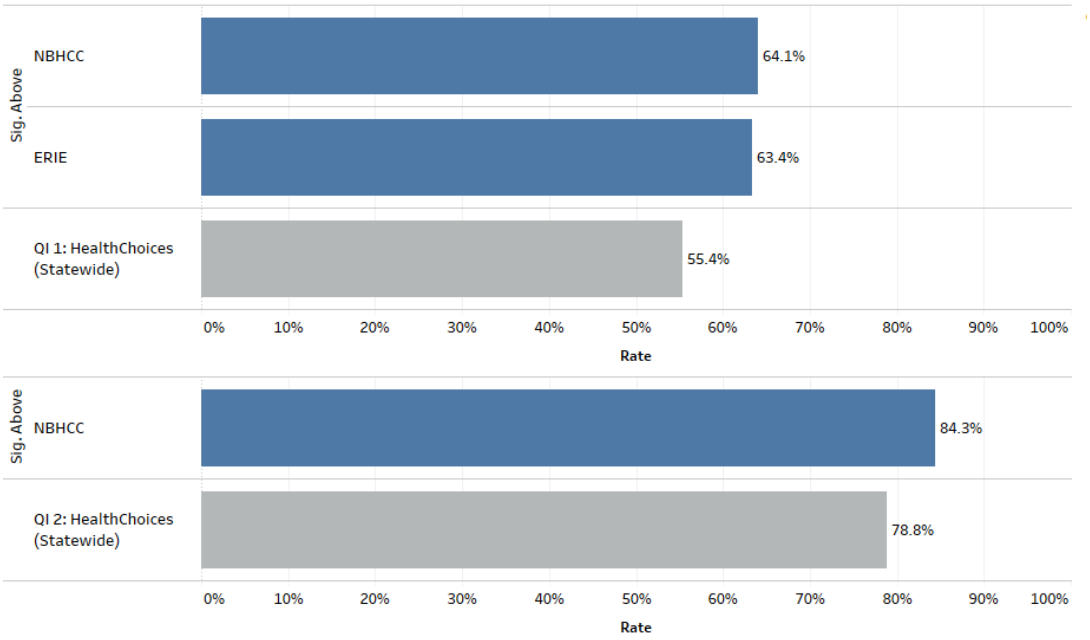

Figure 2.6: CCBH Contractor MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years) that are Significantly Different than HC BH (Statewide) MY 2020 HEDIS FUH Follow-Up Rates (6–17 Years).

II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

Table 2.4 shows the MY 2019 PA-specific FUH 7- and 30-day follow-up indicators compared to MY 2018.

Table 2.4: MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Indicators (All Ages)

	MY 2019					MY 2018	MY 2019 Rate Comparison to MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI A – PA-Specific 7-Day Follow-Up (Overall)								
HC BH (Statewide)	21,098	39,900	**52.9%**	52.4%	53.4%	53.1%	-0.2	NO
CCBH	9,076	15,850	**57.3%**	56.5%	58.0%	56.6%	0.6	NO
Allegheny	1,949	3,487	**55.9%**	54.2%	57.6%	56.5%	-0.6	NO
Blair	341	599	**56.9%**	52.9%	61.0%	62.5%	-5.5	NO
Berks	712	1,352	**52.7%**	50.0%	55.4%	62.2%	-9.5	YES
Bedford-Somerset	57	114	**50.0%**	40.4%	59.6%	N/A	N/A	NO
Chester	436	826	**52.8%**	49.3%	56.2%	54.3%	-1.5	NO
CMP	417	720	**57.9%**	54.2%	61.6%	51.7%	6.2	YES
Erie	693	1,115	**62.2%**	59.3%	65.0%	60.4%	1.8	NO
Lycoming-Clinton	283	468	**60.5%**	55.9%	65.0%	59.6%	0.9	NO
NBHCC	1,170	1,999	**58.5%**	56.3%	60.7%	55.4%	3.1	YES
NCSO	2,232	3,886	**57.4%**	55.9%	59.0%	57.6%	-0.2	NO
York-Adams	786	1,284	**61.2%**	58.5%	63.9%	47.6%	13.6	YES
QI B – PA-Specific 30-Day Follow-Up (Overall)								
HC BH (Statewide)	27,741	39,900	**69.5%**	69.1%	70.0%	69.6%	-0.0	NO
CCBH	11,681	15,850	**73.7%**	73.0%	74.4%	73.1%	0.6	NO
Allegheny	2,491	3,487	**71.4%**	69.9%	73.0%	71.2%	0.3	NO
Blair	468	599	**78.1%**	74.7%	81.5%	79.8%	-1.7	NO

	MY 2019					MY 2018	MY 2019 Rate Comparison to MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
Berks	942	1,352	**69.7%**	67.2%	72.2%	75.9%	-6.2	YES
Bedford-Somerset	77	114	**67.5%**	58.5%	76.6%	N/A	N/A	NO
Chester	551	826	**66.7%**	63.4%	70.0%	70.3%	-3.6	NO
CMP	549	720	**76.3%**	73.1%	79.4%	70.9%	5.4	YES
Erie	805	1,115	**72.2%**	69.5%	74.9%	71.9%	0.3	NO
Lycoming-Clinton	365	468	**78.0%**	74.1%	81.9%	75.2%	2.8	NO
NBHCC	1,502	1,999	**75.1%**	73.2%	77.1%	73.2%	2.0	NO
NCSO	2,943	3,886	**75.7%**	74.4%	77.1%	75.4%	0.4	NO
York-Adams	988	1,284	**76.9%**	74.6%	79.3%	69.0%	7.9	YES

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 rates. Bedford-Somerset is reported only for MY2019 due to a BH-MCO switch.

MY: measurement year; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option.

Figure 2.7 is a graphical representation of the MY 2019 PA-specific follow-up rates for CCBH and its associated Primary Contractors. The orange line represents the MCO average.

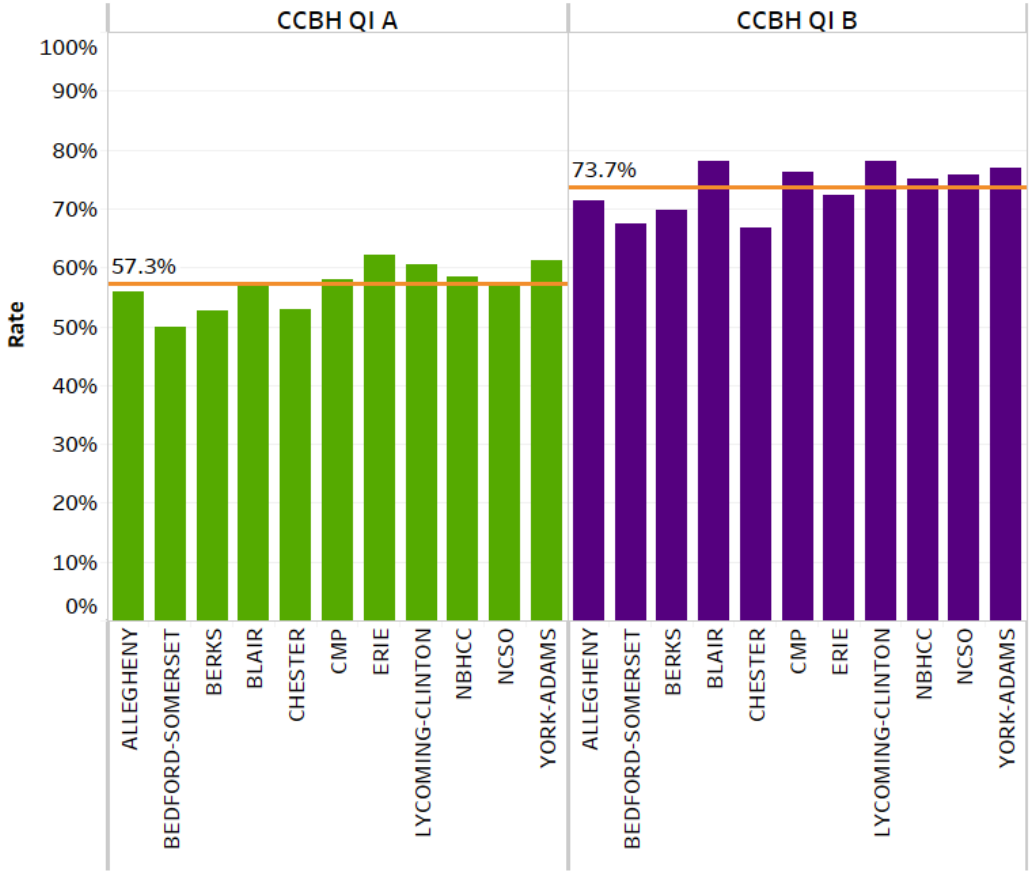

Figure 2.7: MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages).

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.

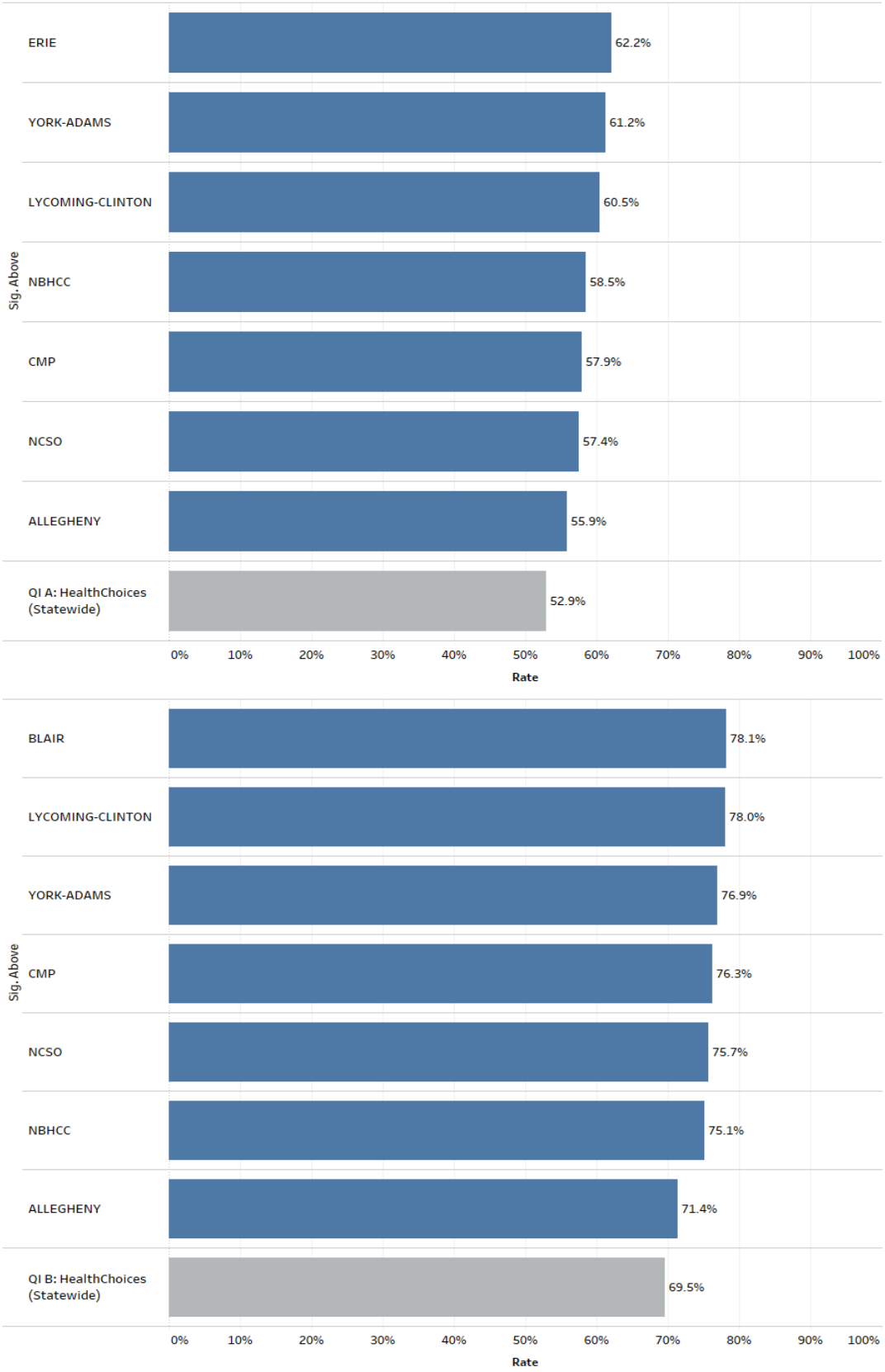

Figure 2.8: CCBH Contractor MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages) that are Significantly Different than HC BH (Statewide) MY 2019 PA-Specific FUH Follow-Up Rates (All Ages).

Conclusion and Recommendations

As with most reporting years, it is important to note that there were some changes to the HEDIS MY 2019 specifications, including revision of the denominator to include members with a principal diagnosis of intentional self-harm. That said, efforts should continue to be made to improve Follow-Up After Hospitalization for Mental Illness performance, particularly for those BH-MCOs that performed below the HC BH Statewide rate. Following are recommendations that are informed by the MY 2019 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 2019, which included actions taken as part of the previous PIP cycle, to promote continuous quality improvement with regard to timely follow-up care after psychiatric hospitalization. The information contained in this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in the next few years as a result of their interventions. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving behavioral health care follow-up. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. This year's findings indicate that, with some notable Primary Contractor exceptions, FUH rates continue to increase (improve) for the BH-MCO, although the 30-day follow-up rate for the MCO fell below the HEDIS Quality Compass 75th percentile. 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 2019 (MY 2019) 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 racial and ethnic disparities may exist. It is recommended that BH-MCOs and Primary Contractors continue to focus interventions on populations that exhibit lower follow-up rates. Further, it is important to examine regional trends in disparities. For instance, previous studies indicate that African Americans in rural areas have disproportionately low follow-up rates, which stands in contrast to the finding that overall follow-up rates are generally higher in rural areas than in urban areas. Possible reasons for racial-ethnic disparities include access, cultural competency, and community factors; these and other drivers should be evaluated to determine their potential impact on performance. The aforementioned 2020 (MY 2019) 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 2020 (MY 2019) FUH Rates Report in conjunction with the corresponding 2020 (MY 2019) inpatient psychiatric readmission Rates (REA) Report. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.
- CCBH turned in 7-day follow-up rates that met or exceeded the HEDIS 2019 75th percentile. Other BH-MCOs could benefit from drawing lessons or at least general insights from their successes.

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 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 2019 study conducted in 2019 was the 11th 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 measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and a transfer to another acute

facility. As with the Follow-Up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH (Statewide) level for MY 2019. 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 behavioral health 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 well 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 25 Primary Contractors participating in the MY 2019 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 1, 2019;
- 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.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs. The source for all administrative data was the BH-MCOs' transactional claims systems. The BH-MCOs were given the opportunity for resubmission, as necessary.

Performance Goals

OMHSAS designated the performance measure goal as better than (i.e., less than) or equal to 10.0% for the participating BH-MCOs and counties. For this measure, lower rates indicate better performance.

Findings

BH-MCO and Primary Contractor Results

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2019 to MY 2018 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 10.0%. Individual BH-MCO and Primary Contractor rates are *not* required to be statistically significantly below 10.0% in order to meet the PM goal (**Table 2.5**).

Table 2.5: MY 2019 REA Readmission Indicators

	MY 2019							MY 2019 Rate Comparison to MY 2018	
				95% CI			MY 2018		
Measure	(N)	(D)	%	Lower	Upper	Goal Met?[1]	%	PPD	SSD
Inpatient Readmission									
HC BH (Statewide)	6,803	50,310	**13.5%**	13.2%	13.8%	NO	13.7%	-0.2	NO
CCBH	2,733	20,480	**13.3%**	12.9%	13.8%	NO	13.4%	-0.1	NO
Allegheny	576	4,410	**13.1%**	12.1%	14.1%	NO	10.9%	2.2	YES
Blair	130	815	**16.0%**	13.4%	18.5%	NO	14.6%	1.3	NO
Berks	309	1,833	**16.9%**	15.1%	18.6%	NO	19.0%	-2.1	NO
Bedford-Somerset	24	145	**16.6%**	10.2%	22.9%	NO	N/A	N/A	NO
Chester	148	1,022	**14.5%**	12.3%	16.7%	NO	15.9%	-1.4	NO
CMP	144	952	**15.1%**	12.8%	17.5%	NO	12.0%	3.2	YES
Erie	211	1,450	**14.6%**	12.7%	16.4%	NO	14.9%	-0.3	NO
Lycoming-Clinton	83	610	**13.6%**	10.8%	16.4%	NO	11.5%	2.1	NO
NBHCC	330	2,709	**12.2%**	10.9%	13.4%	NO	14.5%	-2.3	YES
NCSO	613	4,920	**12.5%**	11.5%	13.4%	NO	11.8%	0.6	NO
York-Adams	165	1,614	**10.2%**	8.7%	11.7%	NO	15.2%	-5.0	YES

[1] The OMHSAS-designated PM goal is a readmission rate at or below 10%. Bedford-Somerset is reported only for MY2019 due to a BH-MCO switch.

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; HC: HealthChoices; BH: behavioral health; CCBH: Community Care Behavioral Health; CMP: Carbon/Monroe/Pike Joinder Board; NBHCC: Northeast Behavioral Health Care Consortium; NCSO: North/Central State Option.

Figure 2.9 is a graphical representation of the MY 2019 readmission rates for CCBH Primary Contractors compared to the orange line representing the MCO average.

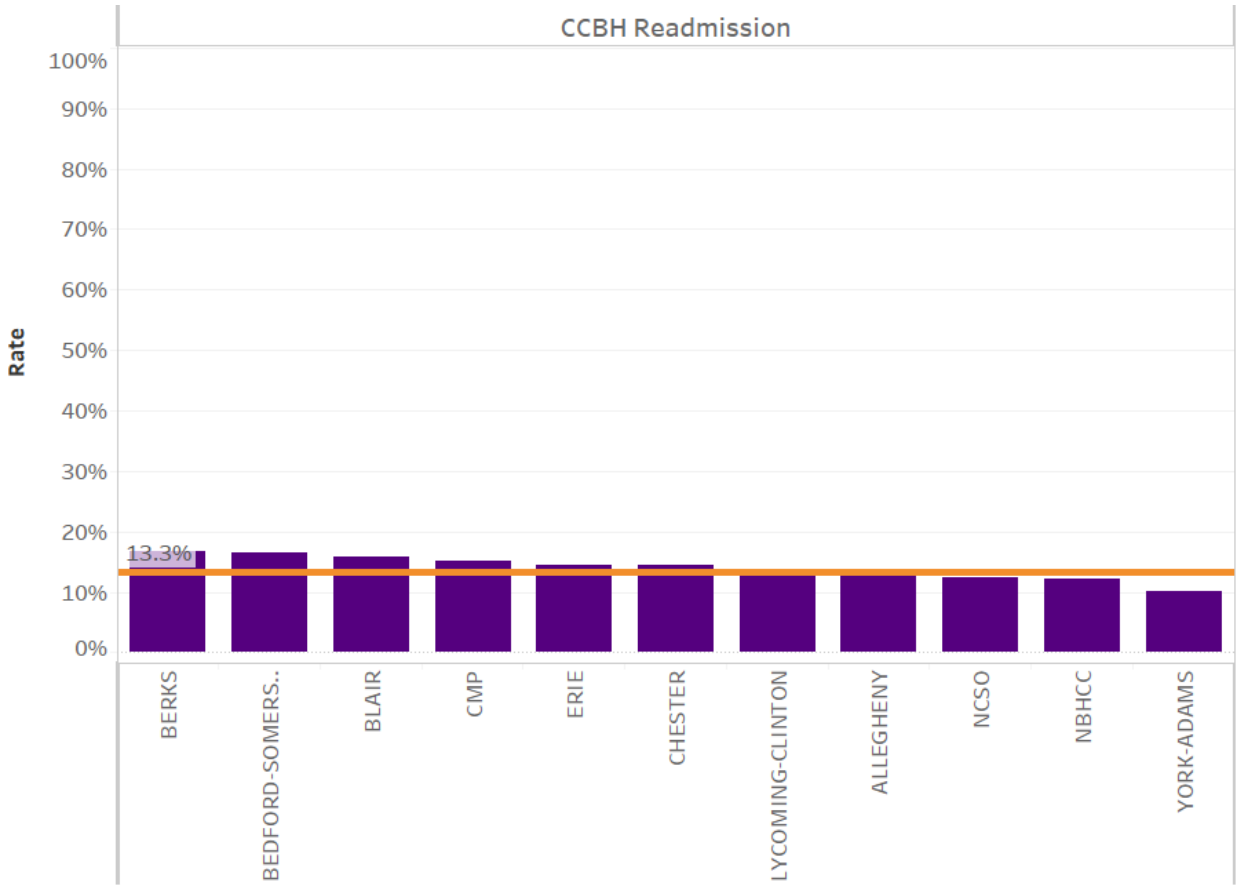

Figure 2.9: MY 2019 REA Readmission Rates for CCBH Primary Contractors.

Figure 2.10 shows the HC BH (Statewide) readmission rate and the individual CCBH Primary Contractors that performed statistically significantly higher (red) or lower (blue) than the HC BH Statewide rate.

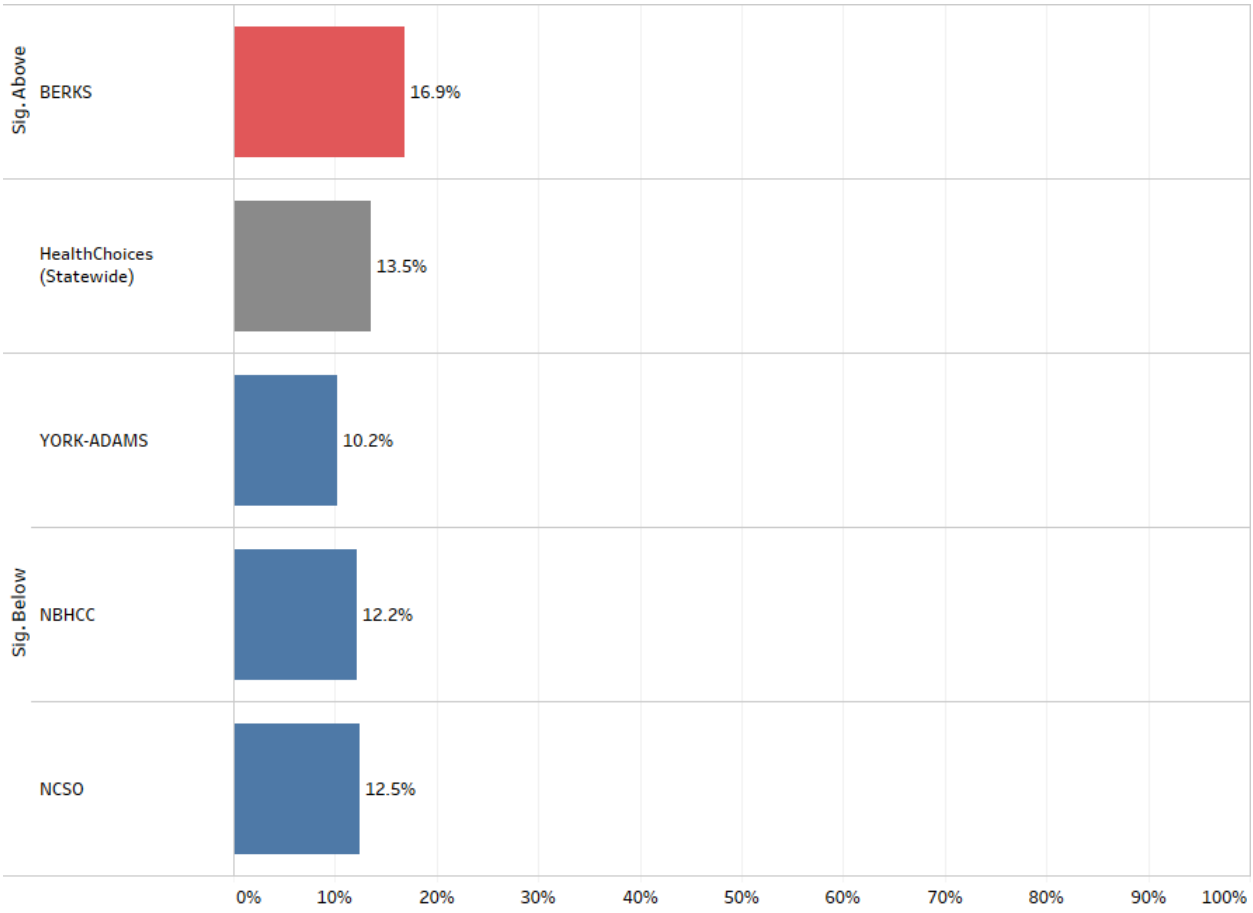

Figure 2.10: CCBH Contractor MY 2019 REA Readmission Rates (All Ages) that are Significantly Different than HC BH (Statewide) MY 2019 REA Readmission Rates (All Ages).

Conclusion and Recommendations

Continued efforts should be made to improve performance with regard to Readmission Within 30 Days of Inpatient Psychiatric Discharge, particularly for those BH-MCOs and Primary Contractors that did not meet the performance goal, and/or performed below the HC BH Statewide rate.

MY 2019 saw a general decrease (improvement) for the MCO in readmission rates after psychiatric discharge. Nevertheless, CCHB's readmission rate after psychiatric discharge for the Medicaid Managed Care (MMC) population generally remains above 10%. As a result, many recommendations previously proposed remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the past PIP cycle, the recommendations may assist in future discussions.

In response to the 2019 study, the following general recommendations are applicable to all five participating BH-MCOs:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2019 to promote continuous quality improvement with regard to mental health discharges that result in a readmission. The information contained within this study should be used to further develop strategies for decreasing the likelihood that at-risk members will be readmitted. In 2018, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. BH-MCOs are expected to sustain meaningful improvement in BH readmission rates going forward as a result of the PIP. 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 2020 (MY 2019) 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 2020 (MY 2019) REA Rates Report in conjunction with the aforementioned 2020 (MY 2019) FUH 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.

III: Compliance with Medicaid Managed Care Regulations

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the MMC structure and operations standards. In review year (RY) 2019, 67 Pennsylvania counties participated in this compliance evaluation.

Operational reviews are completed for each HC Oversight Entity. The Primary Contractor, whether contracting with an Oversight Entity arrangement or not, is responsible for their regulatory compliance to federal and state regulations and the HC BH PS&R Agreement compliance. The HC BH PS&R Agreement includes the Primary Contractor's responsibility for the oversight of BH-MCO's compliance.

Allegheny, Berks, Chester, and Erie Counties hold contracts with CCBH. The North/Central County Option (NC/CO) Counties – Carbon, Monroe, and Pike – hold a contract with CCBH as the Carbon-Monroe-Pike Joinder Board. Lackawanna, Luzerne, Susquehanna, and Wyoming hold a contract with Northeast Behavioral Health Care Consortium (NBHCC), which, in turn, holds a contract with CCBH. The Department contracts directly with CCBH to manage the HC BH program for the North/Central State Option (NCSO) Counties – Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne. For Blair County, the Primary Contractor is Blair HC. For Clinton and Lycoming Counties, the Primary Contractor is Lycoming-Clinton Joinder Board. For York and Adams Counties, the Primary Contractor is the York-Adams HC Joinder Governing Board. On July 1, 2019, the Bedford-Somerset HC Oversight Entity changed contracts from PerformCare to CCBH. MMC compliance findings for any HC Oversight Entity changing contracts are not included in BBA reporting for a period of 3 years after the change. **Table 3.1** shows the name of the HC Oversight Entity, the associated HC Primary Contractor(s), and the county or counties encompassed by each Primary Contractor.

Table 3.1: HealthChoices Oversight Entities, Primary Contractors and Counties

HC Oversight Entity	Primary Contractor	County
Allegheny HealthChoices, Inc. (AHCI)	Allegheny County	Allegheny County
Berks County	Berks County	Berks County
Behavioral Health Services of Somerset and Bedford Counties (BHSSBC)	Behavioral Health Services of Somerset and Bedford Counties (BHSSBC) Otherwise known as Bedford-Somerset for review	Bedford County
		Somerset County
Central Pennsylvania Behavioral Health Collaborative (d/b/a Blair HealthChoices)	Blair HealthChoices	Blair County
Carbon/Monroe/Pike Joinder Board (NC/CO)	Carbon/Monroe/ Pike Joinder Board (CMP)	Carbon County
		Monroe County
		Pike County
Chester County	Chester County	Chester County
Erie County	Erie County	Erie County
Lycoming-Clinton Joinder Board	Lycoming-Clinton Joinder Board	Clinton County
		Lycoming County
Northeast Behavioral Health Care Consortium (NBHCC)	Northeast Behavioral Health Care Consortium (NBHCC)	Lackawanna County
		Luzerne County
		Susquehanna County
		Wyoming County

HC Oversight Entity	Primary Contractor	County
PA Department of Human Services – OMHSAS	Community Care Behavioral Health Organization Otherwise known as North/Central State Option (NCSO) for this review	Bradford County
		Cameron County
		Centre County
		Clarion County
		Clearfield County
		Columbia County
		Elk County
		Forest County
		Huntingdon County
		Jefferson County
		Juniata County
		McKean County
		Mifflin County
		Montour County
		Northumberland County
		Potter County
		Schuylkill County
		Snyder County
		Sullivan County
		Tioga County
		Union County
		Warren County
		Wayne County
York/Adams HealthChoices Management Unit	York/Adams HealthChoices Joinder Governing Board	Adams County
		York County

HC: HealthChoices; BH: behavioral health.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CCBH by OMHSAS monitoring staff within the past 3 review years (RYs 2019, 2018, and 2017). These evaluations are performed at the BH-MCO and HC Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for 2020. 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 HC Oversight Entities 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 Program's PS&R are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2019 and entered into the PEPS Application as of March 2020 for RY 2019. 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 HC Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the substandards or items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area in which to collect or capture additional reviewer comments. Based on the PEPS Application, an HC Oversight Entity/BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations ("categories"), as well as against related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS's more rigorous monitoring criteria.

At the implementation of the PEPS Application in 2004, IPRO evaluated the standards in the PEPS Application and created a crosswalk to pertinent BBA regulations. For standards with substandards, all of the substandards within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the substandards required for fulfilling BBA requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS's ongoing monitoring. In the amended crosswalk, the supplemental substandards no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Substandards concerning first-level complaints and grievances inform the compliance determination of the BBA categories relating to Federal and State Grievance Systems Standards. All of the PEPS Substandards concerning second-level complaints and grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category.

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[20] IPRO updated the substandards crosswalk to reflect the changes to the organization and content of the relevant BBA provisions. The CMS updates included updates to the BBA provisions, which are now required for reporting. The standards that are subject to EQR review are contained in 42 C.F.R. 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 2019 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 was correspondingly updated.

From time to time, standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions. Standards or substandards that are introduced or retired are done so following the rotating 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. In some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). ID numbers for some existing substandard also changed. For this report, in order to distinguish substandards, a parenthetical notation "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its 3-year review (in RY 2020).

As was done for prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The review findings for selected OMHSAS-specific Substandards are reported in **Appendix C**. The RY 2019 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 HC Oversight Entities 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 2019, RY 2018, and RY 2017 provided the information necessary for the 2019 assessment. Those triennial standards not reviewed through the PEPS system in RY 2019 were evaluated on their performance based on RY 2018 and/or RY 2017 determinations, or other supporting documentation, if necessary. For those HC Oversight Entities 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 CCBH, a total of 72 unique substandards were applicable for the evaluation of HC Oversight Entity/BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2019, 2018, 2017). In addition, 17 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 HC Oversight Entity against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for CCBH

Table 3.2 tallies the PEPs Substandard reviews used to evaluate the HC Oversight Entity/BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2017–2019). Substandard counts under RY 2019 comprised annual and triennial substandards. Substandard counts under RYs 2018 and 2017 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 3.2**, 94, differs from the unique count of substandards that came under active review (72).

Table 3.2: Tally of Substandards Pertinent to BBA Regulations Reviewed for CCBH

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	2019	2018	2017
CMS EQR Protocol 3 "sections": Standards, including enrollee rights and protections					
Assurances of adequate capacity and services	5		5		
Availability of Services	24		18	2	4
Confidentiality	1				1
Coordination and continuity of care	2			2	
Coverage and authorization of services	4		2	2	
Health information systems	1				1
Practice guidelines	6			2	4
Provider selection	3		3		
Subcontractual relationships and delegation	8				8
CMS EQR Protocol 3 "sections": Quality assessment and performance improvement (QAPI) program					
Quality assessment and performance improvement program	26		19		7
CMS EQR Protocol 3 "sections": Grievance system					
Grievance and appeal systems	14		2	12	
Total	**94**		**49**	**20**	**25**

[1]The total number of substandards required for the evaluation of HC Oversight Entity/BH-MCO compliance with the BBA regulations. Any PEPS Substandards not reviewed indicate substandards that were deemed not applicable to the HC Oversight Entity/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).
RY: review year; BBA: Balanced Budget Act; CCBH: Community Care Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: substandards not reviewed; N/A: category not applicable.

Determination of Compliance

To evaluate HC Oversight Entity/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 the Commonwealth. If a substandard was not evaluated for a particular HC Oversight Entity/BH-MCO, it was assigned a value of "not determined." Compliance with the BBA provisions was then determined based on the aggregate results across the 3-year period of the PEPS items linked to each provision. If all items were met, the HC Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HC Oversight Entity/BH-MCO was evaluated as partially compliant. If all items were not met, the HC Oversight Entity/BH-MCO was evaluated as non-compliant. A value of not applicable (N/A) was assigned to provisions for which a compliance review was not required. A value of null was assigned to a provision when none of the existing PEPS Substandards directly covered the items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results within a given category were aggregated to arrive at a summary compliance status for the category. For example, compliance findings relating to provider network mix and capacity are summarized under Assurances of adequate capacity and services, 42 C.F.R. § 438.207.

Format

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three sections set out in the BBA regulations and described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[21] 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 HC Oversight Entity/BH-MCO's compliance with BBA regulations as an element of the analysis of their strengths and weaknesses. In addition, this level of analysis avoids any redundancy with the detailed level of review found in the PEPS documents.

Findings

Seventy-two (72) unique PEPS Substandards were used to evaluate CCBH and its Oversight Entities compliance with BBA regulations in RY 2019.

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 3.3** presents the MCO and Primary Contractor substandard findings by categories.

Table 3.3: 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 42 C.F.R. § 438.207	5	Partial	Allegheny, Blair, Chester, Erie, Lycoming/ Clinton, NCSO, York/Adams	1.1, 1.2, 1.4, 1.5, 1.6		
			Berks	1.2, 1.4, 1.5, 1.6	1.1	
			CMP, NBHCC	1.1, 1.4, 1.5, 1.6	1.2	
Availability of Services	24	Partial	Allegheny, Blair, Chester, Erie,	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 23.1,	93.3	

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
42 C.F.R § 438.206, 42 C.F.R. § 10(h)			Lycoming/Clinton, York/Adams, NCSO	23.2, 23.3, 23.4, 23.5, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 28.1, 28.2, 93.1, 93.2, 93.4		
			Berks	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, 28.2, 93.1, 93.2, 93.4	1.1, 93.3	
			CMP, NBHCC	1.1, 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, 28.2, 93.1, 93.2, 93.4	1.2, 93.3	
Confidentiality 42 C.F.R. § 438.224	1	Compliant	All CCBH Primary Contractors	120.1		
Coordination and continuity of care 42 C.F.R. § 438.208	2	Compliant	All CCBH Primary Contractors	28.1, 28.2		
Coverage and authorization of services 42 C.F.R. Parts § 438.210(a–e), 42 C.F.R. § 441, Subpart B, and § 438.114	4	Partial	All CCBH Primary Contractors	28.1, 28.2, 72.2	72.1	
Health information systems 42 C.F.R. § 438.242	1	Compliant	All CCBH Primary Contractors	120.1		
Practice guidelines 42 C.F.R. § 438.236	6	Partial	All CCBH Primary Contractors	28.1, 28.2, 93.1, 93.2, 93.4	93.3	
Provider selection 42 C.F.R. § 438.214	3	Compliant	All CCBH Primary Contractors	10.1, 10.2, 10.3		
Subcontractual relationships and delegation 42 C.F.R. § 438.230	8	Compliant	All CCBH Primary Contractors	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8		

MCO: managed care organization; CFR: Code of Federal Regulations; CCBH: Community Care Behavioral Health.

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

For this review, 54 PEPS substandards were crosswalked to categories within Compliance with Standards, including Enrollee Rights and Protections. All 54 substandards were evaluated for all Primary Contractors associated with CCBH. Primary Contractors with CCBH were compliant in 45 instances and partially compliant in nine instances. 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.

Assurances of Adequate Capacity and Services

CCBH was partially compliant with Assurances of Adequate Capacity and Services due to partial compliance with two substandards within PEPS Standard 1 (RY 2019).

Standard 1: The Program must include a full array of in-plan services available to adults and children. Provider contracts are in place.

CCBH was partially compliant with Substandards 1 and 2 of Standard 1.

Substandard 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 2: 100% of members are given a choice of two providers at each level of care within 30/60 urban/rural met.

Availability of Services

CCBH was partially compliant with Availability of Services due to partial compliance with two substandards within Standard 1 (RY 2019) and one substandard within Standard 93 (RY 2017).

Standard 1: See Standard description and determination of compliance under Assurances of Adequate Capacity and Services.

Standard 93: The BH-MCO evaluates the effectiveness of services received by members. The quality of care and the effectiveness of the services received by members are evaluated in the following areas: changes made to service access; provider network adequacy; appropriateness of service authorization; inter-rater reliability; complaint, grievance and appeal processes; and treatment outcomes.

Substandard 3: The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.

Coverage and Authorization of Services

CCBH was partially compliant with Coverage and Authorization of Services due to partial compliance with one substandard within PEPS Standard 72 (RY 2019).

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.

Practice Guidelines

CCBH was partially compliant with Practice Guidelines due to partial compliance with one substandard within Standard 93 (RY 2017).

Standard 93: See Standard description and determination of compliance under Availability of Services.

Quality Assessment and Performance Improvement (QAPI) Program

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth'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 3.4** presents the findings by categories consistent with the regulations.

Table 3.4: 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 42 C.F.R. § 438.330	26	Partial	All CCBH Primary Contractors	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, 93.4, 98.1, 98.2, 98.3, 104.1, 104.2, 104.3, 104.4	93.3	

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

For this review, 26 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 26 substandards were reviewed for all Primary Contractors associated with CCBH. CCBH and its Primary Contractors were compliant with 25 substandards and partially compliant with 1 substandard.

Quality Assessment and Performance Improvement Program

CCBH was partially compliant with Quality Assessment and Performance Improvement Program due to partial compliance with one substandard within Standard 93 (RY 2017).

Standard 93: See Standard description and determination of compliance under Availability of Services.

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

Table 3.5: 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 42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	14	Partial	All CCBH Primary Contractors	68.1, 68.2, 71.1, 71.2, 71.4, 71.9, 72.2	68.3, 68.4, 68.7, 68.9, 71.3, 71.7, 72.1	

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

For this review, 14 substandards were crosswalked to Grievance System. All 14 substandards were reviewed for all Primary Contractors associated with CCBH. CCBH and its Primary Contractors were compliant with 7 substandards and partially compliant with 7 substandards.

Grievance and Appeal Systems

CCBH was partially compliant with Grievance and Appeal Systems due to partial compliance with substandards of PEPS Standards 68 and 71 (RY 2018) and 72 (RY 2019).

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 3: 100% of Complaint acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

Substandard 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 7: Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.

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.

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 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 7: Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.

Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services.

IV: Quality Studies

The purpose of this section is to describe quality studies performed in 2019 for the HealthChoices population. The studies are included in this report as optional EQR activities that occurred during the Review Year.[22]

Certified Community Behavioral Health Clinics

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

During Demonstration Year (DY) 1, activities focused on continuing to implement and scale up the CCBHC model within the seven clinic sites. Data collection and reporting was a centerpiece of this quality initiative in two important ways. First, the CCBHC Demonstration in Pennsylvania featured a process measure Dashboard, hosted by the EQRO through REDCap, whereby clinics were able to monitor progress on the implementation of their CCBHC model. Using the Dashboard, clinics tracked and reported on clinical activities in a range of quality domains reflecting the priorities of the initiative: clinic membership, process, access and availability, engagement, evidence-based practices, and client satisfaction. The Dashboard provided for each clinic a year-to-date (YTD) comparative display that showed clinic and statewide results on each process measure, as well as average scores for three domains of the satisfaction surveys (see below): convenience of provider location, satisfaction with provider services, and timeliness and availability of appointments. These Dashboard results were reported out to a CCBHC Stakeholder Committee at the end of each quarter.

A second important feature of the Demonstration is an assessment, to be completed at its conclusion by the EQRO, to test whether the CCBHC clinics perform significantly better over the demonstration period compared to a control group of clinics located under the same Primary Contractors as the CCBHC clinics. Measurement of performance, in terms of both quality and overall cost, will span multiple areas and scales, involving a variety of administrative sources, medical records, and other sources. Several measures in the CCBHC measure set, including the SRA-A and SRA-BH-C reported directly by clinics (primarily medical record-based), are placed in a Quality Bonus Payment (QBP) program. Throughout the two-year Demonstration, clinics performed a variety of activities to support these reporting objectives. Clinics collected and reported baseline data on quality measures. The EQRO also used SurveyMonkey to support the administration and collection of patient experience of care (PEC) surveys for adults as well as for children and youth (Y/FEC). Finally, clinics collected and reported, on a quarterly basis, consumer-level files documenting various relevant characteristics of their CCBHC consumers, including housing, veteran, and insurance statuses. Throughout the process, OMHSAS and EQRO provided technical assistance focused on data collection, management, and reporting, where much of the focus was on operationalizing the quality and process measures using the clinics' data plans.

Demonstration Year 2 Results

By the end of DY 2 (June 30, 2019), the number of individuals receiving at least one core service surpassed 19,900. Many of those individuals also received some form of EBP: cognitive behavioral therapy (6,907 or 34.7%), trauma-focused interventions (1,081 or 5.4%), medication-assisted treatment (1,049 or 5.3%), parent-child interaction therapy (91 or

0.5%), and wellness recovery action plan (WRAP) (355 or 1.8%). The average number of days until initial evaluation was 5.8 days. In the area of depression screening and follow-up, more than 91% of positive screenings resulted in the documentation of a follow-up plan the same day. More than 3,300 individuals within the CCBHC program received drug and alcohol outpatient or intensive outpatient treatment during the period.

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

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

Measure	CCBHC Weighted Average	Comparison		
		State Weighted Average	National Average	Description (if National)
Follow-Up Care for Children Prescribed ADHD Medication - Initiation	64.2%		43.4%	HEDIS 2019 Quality Compass 50th percentile
Follow-Up Care for Children Prescribed ADHD Medication - Continuation	74.6%		55.5%	HEDIS 2019 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 day	13.1%		11.4%	HEDIS 2019 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 day	14.8%		17.8%	HEDIS 2019 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Mental Illness - 7 day	100%		37.9%	HEDIS 2019 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Mental Illness - 30 day	100%		54.3%	HEDIS 2019 Quality Compass 50th percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Initiation	15.0%	41.9%		
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Engagement	4.8%	28.4%		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 7 day	127%	35.3%		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 30 day	22.3%	55.7%		
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 7 day	16.7%	55.2%		
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 30 day	29.0%	77.7%		
Antidepressant Medication Management - Acute	52.4%	52.4%		
Antidepressant Medication Management - Continuation	32.7%	35.4%		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	51.0%	78.0%		

Measure	CCBHC Weighted Average	Comparison		
		State Weighted Average	National Average	Description (if National)
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.6%	88.3%		
Plan All-Cause Readmissions Rate (lower is better)	15.5%	12.6%		
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	82%		35.0%	MIPS 2020 (eCQMs)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	82.2%		39.3%	MIPS 2020 (eCQMs)
Screening for Depression and Follow-Up Plan	44.8%		37.0%	MIPS 2020 (eCQMs)
Depression Remission at Twelve Months	7.2%		12.8%	MIPS 2020 (eCQMs)
Body Mass Index (BMI) Screening and Follow-Up Plan	52.1%		47.6%	MIPS 2020 (claims)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	69.8%		79.1%	HEDIS 2019 Quality Compass 50th percentile
Tobacco Use: Screening and Cessation Intervention	63.4%		60.4%	MIPS 2019 (CMS web interface measures)
Unhealthy Alcohol Use: Screening and Brief Counseling	91.6%		68.4%	MIPS 2019 (registry)

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

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

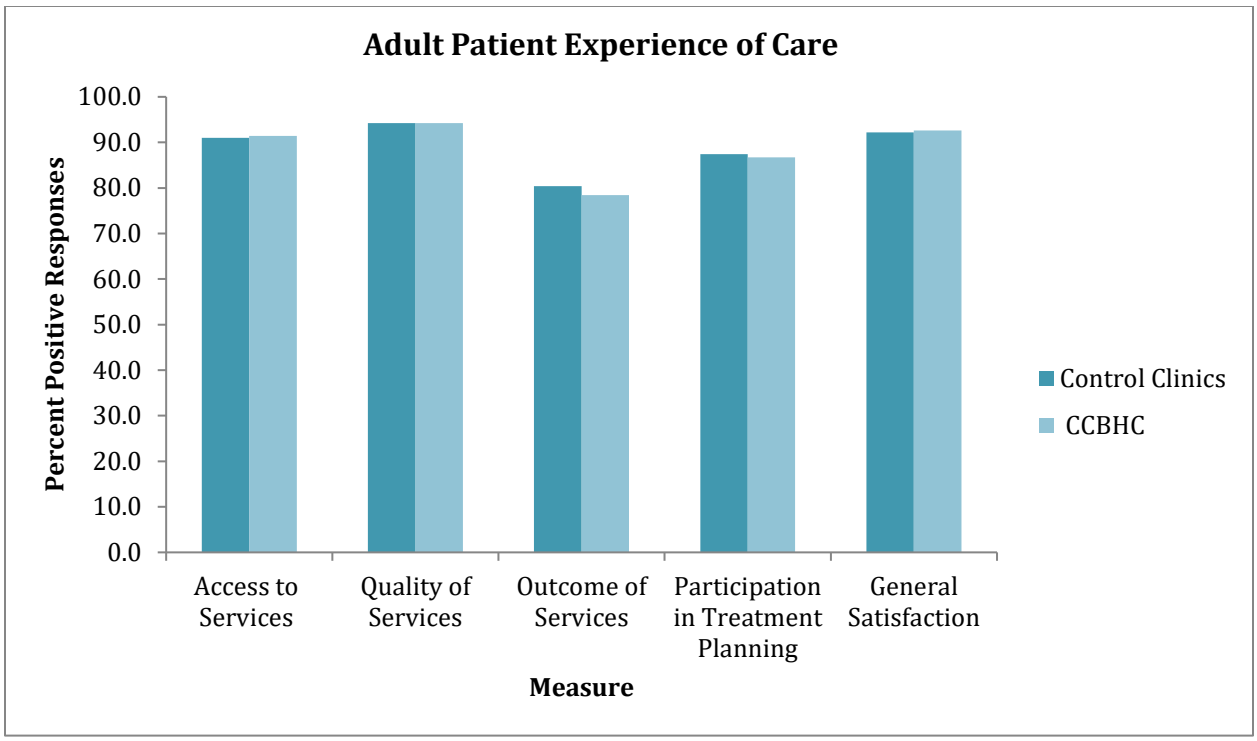

Figure 4.1: Comparison of CCBHC to Control Clinics on Adult Patient Experience of Care.

In contrast, as **Figure 4.2** shows, the percentages of children and youth reporting satisfaction with CCBHC services on the Y/FEC survey were, for the most part, higher than the percentages reported for the same domains in control clinics, although a higher percentage of control clinic clients in this age group reported satisfaction with access to services (it was also slightly higher for participation in treatment planning). Once again, these comparisons were not statistically evaluated for this study.

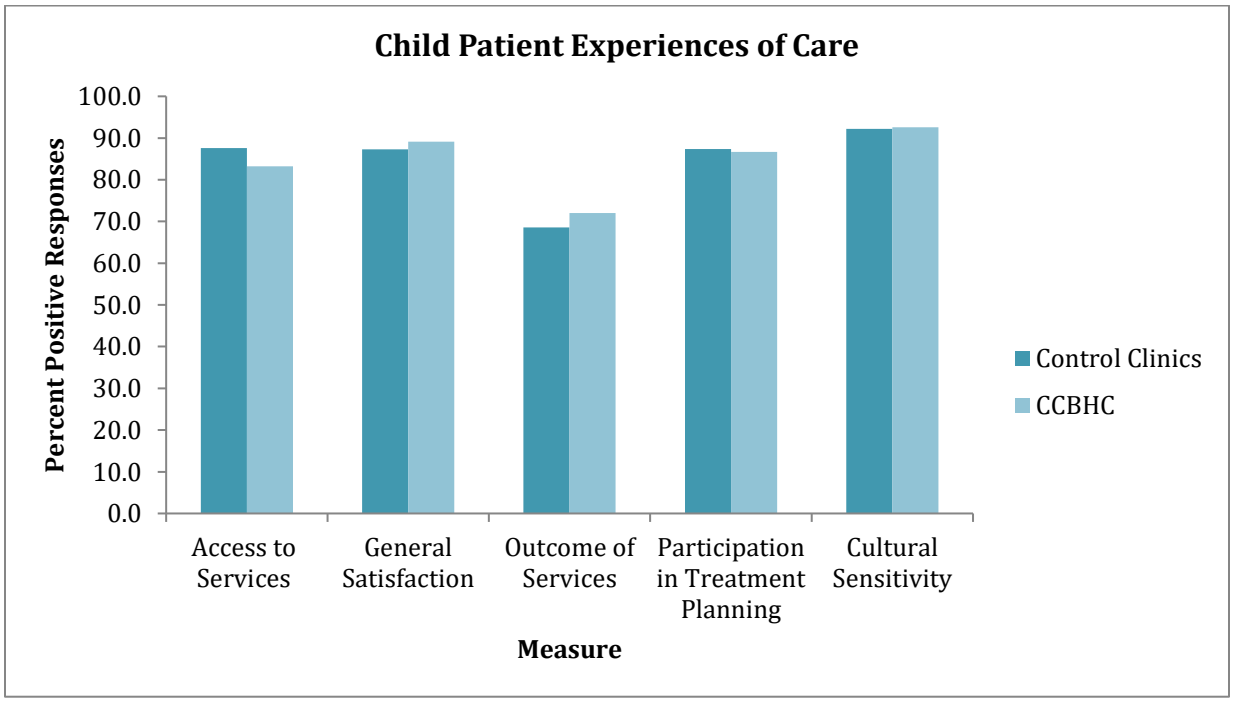

Figure 4.2: Comparison of CCBHC to Control Clinics on Child Patient Experiences of Care.

Pennsylvania's CCBHC goal for patient experiences of care is to average a score of 80% or higher (normalized on a Likert scale) for each of three major domains: convenience of provider location, timeliness and availability of appointments, and satisfaction with provider services. When grouping survey items across the three major domains, the DY 2 weighted average results for the three domains meet or surpass the yearly goal for both the PEC (n = 1,705) and Y/FEC surveys (n = 802).

Quality Bonus Payments (QBP) were also available for six of the quality measures: FUH-A (adult), FUH-C (child), IET, SAA, and SRA-A (adult), and SRA-BH-C (child). Payments were made based on percentage-point improvement over DY 1. All clinics earned QBP payments in DY 2 for at least some of the measures, with the SRA measures seeing the most sizable improvements and payouts.

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. Under this agreement, the same nine core services of the CCBHC model would be provided under PA's HealthChoices 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 certified to participate in the new program.

In addition, a subset of the CCBHC measures would be reported on to CMS on an annual calendar year basis, along with HEDIS Follow-up After High Intensity Care for Substance Use Disorder (FUI). The year 2020 was set as the first measurement year for ICWC. **Table 4.2** lists these measures, some of which are to be reported directly by the ICWC clinics, and some by the State, are listed here, along with a set of Dashboard ("process") measures, which will be reported to OMHSAS on a quarterly basis.

Table 4.2: ICWC Annual and Quarterly Quality Measures

Statewide Measures
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)
Follow-up Care for Children Prescribed ADHD Medication (ADD-BH)
Antidepressant Medication Management (AMM-BH)
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET-BH)
Plan All-Cause Readmission Rate (PCR)
Follow-up After Discharge from the Emergency Department for Mental Health Treatment (FUM)
Follow-Up After Discharge from the Emergency Department (FUA)
Follow-up After High Intensity Care for Substance Use Disorder (FUI)
Follow-Up After Hospitalization for Mental Illness (Adult) (FUH-BH-A)
Follow-Up After Hospitalization for Mental Illness (Child) FUH-BH-C)
ICWC Measures
Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)
Screening for Clinical Depression and Follow-up Plan (CDF-BH)
Weight Assessment for Children/Adolescent: Body Mass Index Assessment for Children/Adolescents (WCC-BH)
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)
Depression Remission at Twelve Months (DEP-REM-12)

Dashboard Measures
Number of referrals the ICWC make to specialty providers
Number of referrals made for veterans
Number of children (0-17) who receive at least one ICWC service in 12 months
Number of adults (18+) who receive at least one ICWC service in 12 months
Number of first contacts by ICWC members
Average number of days from contact to initial evaluation
Number of initial screenings of members age 12 to 17 and $\geq$ 18 years using a validated child depression screening tool with a (+) finding with a follow-up plan documented the same day.
Targeted Service delivery services by: Peer Support services D & A Peer Services done by Certified Recovery Specialists Telehealth
Number of unique individuals in D & A Outpatient Treatment or Intensive Outpatient Treatment

V: 2019 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 2019 EQR Technical Report and in the 2020 (MY 2019) FUH All-Ages Goal Report.

The request for MCO response to the opportunities for improvement related to PEPS deficiencies was distributed in June 2020. The 2020 EQR Technical Report is the 13th report to include descriptions of current and proposed interventions from each BH-MCO that address the prior year's deficiencies.

The BH-MCOs are required by OMHSAS to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the Pennsylvania Medicaid BH-MCOs. These activities follow a longitudinal format and are designed to capture information relating to:

- follow-up actions that the BH-MCO has taken through June 30, 2020, to address each recommendation;
- future actions that are planned to address each recommendation;
- when and how future actions will be accomplished;
- the expected outcome or goals of the actions that were taken or will be taken; and
- the BH-MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of the end of 2020, 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 2019 underperformance in the HEDIS FUH All-Ages measures were distributed, along with the MY 2019 results, in January 2021. 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 15, 2021.

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 2018, CCBH began to address opportunities for improvement related to compliance categories within the following Subparts: C (Enrollee Rights), D (Access to Care, Practice Guidelines, and Quality Assessment and Performance Improvement Program), and F (Federal and State Grievance System Standards Regulations). The partially compliant categories within Subpart F were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Handling of Grievances and Appeals, 4) Resolution and Notification: Grievances and Appeals, 5) Expedited Appeals Process, 6) Continuation of Benefits, and 7) Effectuation of Reversed Resolutions. Proposed actions and evidence of actions taken by CCBH 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 CCBH into compliance with the relevant Standards.

Table 5.1 presents CCBH's responses to opportunities for improvement cited by IPRO in the 2019 EQR Technical Report, detailing current and proposed interventions. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 5.1: CCBH's 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 the Commonwealth in reporting year 2016, 2017, and 2018 found CCBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
CCBH 2019.01	Within Subpart C: Enrollee Rights and Protections Regulations, CCBH was partially compliant on one out of seven categories – Enrollee Rights.	Date(s) of follow-up action taken through 6/30/20/Ongoing/None	**Enrollee Rights: Standard 108.6 (RY 2016, partially compliant) (Erie Contract Only)** Erie County completed their CAP related to Standard 108.6 in 2019.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Date(s) of follow-up action taken through 6/30/20/Ongoing/None	Describe one follow-up action. Leave blank, if none.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Date(s) of follow-up action taken through 6/30/20/Ongoing/None	Describe one follow-up action. Leave blank, if none.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Date(s) of follow-up action taken through 6/30/20/Ongoing/None	Describe one follow-up action. Leave blank, if none.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
CCBH 2019.02	Within Subpart D: Quality Assessment and Performance Improvement Regulations, CCBH was partially compliant with four out of 10 categories. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Practice Guidelines, and 3) Quality Assessment and Performance Improvement Program.	Date(s) of future action planned/None	1) Availability of Services (Access to Care), 2) Practice Guidelines, and 3) Quality Assessment and Performance Improvement Program Evaluation Performance Standard (PEPS) Standard 93.3 (RY 2017, partially compliant) **Standard 93.3 (RY2017)**
		Date(s) of follow-up action taken through 6/30/20/Ongoing/None	Describe one follow-up action. Leave blank, if none.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Date(s) of follow-up action taken through 6/30/20/Ongoing/None	Describe one follow-up action. Leave blank, if none.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found CCBH to be partially compliant with all three Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of follow-up action taken through 6/30/20/Ongoing/None	Describe one follow-up action. Leave blank, if none.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
		Date(s) of future action planned/None	Describe one future action. Leave blank if none.
CCBH 2019.03	Within Subpart F: Federal and State Grievance System Standards Regulations, CCBH was partially compliant with eight out of 10 categories. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Handling of Grievances and Appeals, 4) Resolution and Notification: Grievances and Appeals, 5) Expedited Appeals Process, 6) Information to Providers and Subcontractors, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.	Follow Up Actions Taken Through 6/30/20	1) Statutory Basis and Definitions, 2) General Requirements, 3) Handling of Grievances and Appeals, 4) Resolution and Notification: Grievances and Appeals, 5) Expedited Appeals Process, 6) Information to Providers and Subcontractors, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions – PEPS standard 68.3, 68.4, 68.7, 68.9 (RY 2018, all partially compliant); Standard 71.3 and 71.7 (RY 2018, all partially compliant) **PEPS Standard 68.3, 68.4, 68.7, and 68.9 (RY2018)** **PEPS Standard 71.3 and 71.7 (RY2018)** Describe one follow-up action. Leave blank, if none.
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow Up Actions Taken Through 6/30/20	Describe one follow-up action. Leave blank, if none.
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow Up Actions Taken Through 6/30/20	Describe one follow-up action. Leave blank, if none.
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.
		Follow Up Actions Taken Through 6/30/20	Describe one follow-up action. Leave blank, if none.
		Future Actions Planned (Specify Dates)	Describe one future action. Leave blank if none.

CCBH: Community Care Behavioral Health; MCO: managed care organization; RY: reporting year; PEPS: Program Evaluation Performance Summary.

Root Cause Analysis and Quality Improvement Plan

For PMs that are noted as opportunities for improvement in the EQR Technical Report, BH-MCOs are required to submit:

- a goal statement;
- root cause analysis and analysis findings;
- action plan to address findings;
- implementation dates; and
- a monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

Following several years of underperformance in the key quality indicator areas, OMHSAS determined in 2017 that it was necessary to change the PM remediation process so that BH-MCOs would set goals for the coming year. In 2017, this change meant, among other things, eliminating the requirement to complete root cause analyses (RCAs) and quality improvement plans (QIPs) responding to MY 2015. Instead, BH-MCOs were required to submit member-level files for MY 2016 in the summer of 2017, from which rates were calculated and validated by IPRO. MY 2016 Results of HEDIS Follow-Up After Hospitalization for Mental Illness (7- and 30-day) were then used to determine RCA and QIP assignments.

The change coincided with the coming phase-in of value-based payment (VBP) at the Primary Contractor level in January 2018. Thus, for the first time, RCA and QIP assignments were made at the Contractor level as well as at the BH-MCO level. Contractors receiving assignments completed their RCAs and QIPs in November 2017, while BH-MCOs completed their RCAs and QIPs by December 31, 2017. In 2018, coinciding with the carve-in of long-term care, OMHSAS directed BH-MCOs to begin focusing their RCA and QIP work on the HEDIS FUH All Ages measure and implemented a new goal-setting logic to spur performance improvement in the measure. Based on the MY 2017 performance, BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and QIPs to achieve their MY 2019 goals. Primary Contractors that scored below the 75th NCQA Quality Compass percentile were also asked to submit RCAs, with the option of submitting a QIP, either through their BH-MCO submission, or separately. BH-MCOs submitted their RCAs and QIPs on April 1, 2019. Primary Contractors submitted their RCAs and QIPs by April 30, 2019. As a result of this shift to a proactive process, MY 2018 goals for FUH All-Ages were never set.

Instead, in late 2020, MY 2019 results were calculated and compared to the MY 2019 goals to determine RCA and QIP assignments, along with goals, for MY 2021. In MY 2019, CCBH scored above the 75th percentile on the 7-day measure but below the 75th percentile on the 30-day measures and, as a result, was required to complete an RCA and QIP response for the HEDIS FUH 30-day measure. **Table 5.2** presents CCBH's submission of its RCA and QIP for the FUH All-Ages 30-day measure. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 5.2: CCBH RCA and QIP for the FUH 30–Day Measure (All Ages)

<table>
<tr><th colspan="2">RCA for MY2019 Underperformance</th></tr>
<tr><td><u>Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):</u>

The overall opportunity for improvement, which is the focus of this root-cause-analysis (RCA) and quality improvement plan (QIP), was identified using the MY 2019 FUH Goal Report.
Attachments: MY 2019 FUH Goal Repot_12.4.20 FINAL

IPRO's Quality Management Dashboard was used to determine disparities in HEDIS 30-day follow-up post hospitalization (FUH). Data was broken into Expansion/Legacy for cohorts with a statistically significant difference (SSD).
Attachments: IPRO Dashboard Screenshots, IPRO Dashboard Screenshots – Contract Specific, and IPRO Dashboard Data

The following information/analysis was used to identify the factors that contributed to underperformance:
• An analysis of network availability of practitioners who identified as being Black/African American and providers who identified a specialization in treating Black/African American individuals.
• A drilldown analysis of members with and without 30-day follow-up appointments in aggregate and contract specific groupings.
• An aggregate process report from High-Risk Interviews.
• Compilation of the Discharge Management Planning (DMP) follow-up meetings that occurred with inpatient mental health (IPMH) providers in 2019.
• Information from Community Care's 2020 Member Satisfaction Survey. Not found in attachments due to the size. Information is also found in the 2020 Membership Analysis.</td><td><u>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). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:</u>

The following opportunity for improvement was identified requiring the RCA and QIP:
<table><tr><th colspan="3">Performance Measure: FUH HEDIS 30-Day All Ages</th></tr><tr><th>MY 2019 (N)</th><th>MY 2019 (D)</th><th>MY 2019 Rate</th></tr><tr><td>10,477</td><td>15,850</td><td>66.10%</td></tr></table>Attachment: MY 2019 FUH Goal Report_12.4.20 FINAL

The following disparities with a SSD were identified among members with an IPMH admission:
• In the aggregate, the Black/African American cohort was less likely to have follow-up within 30-days than the White cohort.
o This also applied to the Allegheny contract (HCAL), Berks contract (HCBK), Erie contract (HCER), Lycoming/Clinton contract (HCLC), NorthCentral contract (HCNC), and the York/Adams contract (HCYY).
• In HCBK, the White cohort was less likely to have follow-up within 30-days than members who selected Other or chose not to respond.
o The drill down analysis concluded that of the 416 members who fall under "other/chose not to respond" for race, 213 (51%) identified as Hispanic.
o For the remaining 203 (49%) of members who fall under the "other/chose not to respond" for race, discerning demographics were unable to be identified.
o Interventions developed to address all Community Care members will apply in this scenario.
• In the aggregate, the non-Hispanic cohort with an IPMH admission were less likely to have follow-up within 30-days than the Hispanic cohort.
o This also applied to HCBK, and Carbon/Monroe/Pike contract (HCCK).

Community Care conducted a literature review and data analysis of Hispanic and non-Hispanic members with an IPMH admission in 2019. Results are as follows:
• Among Community Care's HealthChoices enrollees, 91.1% identified as non-Hispanic (2020 HealthChoices Membership Analysis). When analyzed across contracts, the majority of members were non-Hispanic. For the contracts with a statistically significant difference in 30-day follow-up, the distribution of members identifying as Non-Hispanic is as follows:</td></tr>
</table>

- A review of current literature.
- Information from the Integrated Care Plan quarterly report.
- Information from Community Care's RCA submitted in 2019, which reflects alignment with our contractors' QIP submissions. Quality Managers from each contract also have and will have ongoing collaboration with contractors to address and align contract-specific action plans.
- 2020 HealthChoices Membership Analysis.

Attachments:

2018-2019 Inpatient barriers and interventions PPI- Provider Benchmarking
30-Day FUH Drilldown
Accessibility to Routine OPT and FU
BHARP Presentation Legislative Hearing 5 11 15 Point In Time Survey
DMP Follow Up Barriers Identified_2019
HC Membership Analysis 2020
High Risk Care Management Interviews
Information from Integrated Care Plan Q4
Network Availability Report
References

HCBK	HCCK
66.4%	88.6%

- A statistical analysis was completed on the 30-day follow-up and no reliable patterns were observed beyond ethnicity to assist with root cause identification. Variables assessed included gender, age, category of enrollment, length of IPMH stay, prior IPMH episodes, commitment status, and diagnoses.
- Literature reviews indicate that Hispanic individuals typically have lower rates of treatment engagement than non-Hispanic individuals and did not support the 2019 30-day follow-up rates.
- Interventions developed to address all Community Care members will apply in this scenario.

Performance Measure: FUH HEDIS 30-Day All Ages

Rates with SSD

Group	Contract	Cohort 1	Rate 1	Cohort 2	Rate 2
Combined	HC	Black/African American	58.9%	White	67.7%
Legacy	HC	Black/African American	62.2%	White	71.7%
Expansion	HC	Black/African American	51.1%	White	60.1%
Combined	HCAL	Black/African American	59.2%	White	64.4%
Expansion	HCAL	Black/African American	48.3%	White	58.6%
Combined	HCBK	Black/African American	46.4%	White	57.8%
Legacy	HCBK	Black/African American	50.5%	White	63.2%
Combined	HCER	Black/African American	56.0%	White	63.6%
Legacy	HCER	Black/African American	54.4%	White	66.4%
Combined	HCLC	Black/African American	48.5%	White	66.5%
Expansion	HCLC	Black/African American	51.1%	White	71.3%
Combined	HCNC	Black/African American	61.8%	White	70.1%
Legacy	HCNC	Black/African American	62.2%	White	73.8%
Combined	HCYY	Black/African American	58.8%	White	68.4%
Legacy	HCYY	Black/African American	62.2%	White	75.2%
Combined	HCBK	Other/Chose not to respond	64.2%	White	57.8%
Expansion	HCBK	Other/Chose	61.3%	White	48.4%

		not to respond			
Combined	HC	Hispanic or Latino	71.0%	Non-Hispanic	65.9%
Expansion	HC	Hispanic or Latino	65.5%	Non-Hispanic	58.7%
Legacy	HC	Hispanic or Latino	74.1%	Non-Hispanic	69.6%
Combined	HCBK	Hispanic or Latino	69.8%	Non-Hispanic	55.8%
Expansion	HCBK	Hispanic or Latino	67.0%	Non-Hispanic	46.9%
Legacy	HCBK	Hispanic or Latino	71.7%	Non-Hispanic	60.4%
Combined	HCCK	Hispanic or Latino	88.6%	Non-Hispanic	70.7%

Attachment: IPRO Dashboard Data

People Root Causes

1.1 Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, and this may be due to negative perceptions of treatment and reluctance to acknowledge symptoms

1.2 Race inequity across multiple service systems significantly impacts barriers to aftercare planning for Black and African American members

1.3 Many members have multiple barriers to attending aftercare like transportation, childcare, legal issues, or housing issues

1.4 Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members

1.5 Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending

1.6 Some members have competing physical health needs which makes setting up aftercare difficult

Provider Root Causes

2.1 Black and African American individuals experience health inequity in behavioral health treatment

2.2 IPMH providers have difficulty getting new members with co-occurring disorders into MAT programming

2.3 Members may be at an IPMH facility that is a long distance from their home and the IPMH provider is not aware of the all the available resources in their home area

Policies and Procedures Root Causes

3.1 Providers who have open access (walk-in) or require that members make their own appointments do not always provide members with specific appointment dates/times prior to IPMH

<table>
<tr><th colspan="2">RCA for MY2019 Underperformance</th></tr>
<tr><td></td><td>discharge

<u>Provisions Root Causes</u>
4.1 There is a shortage of Black/African American treatment providers and there are limitations on identifying culturally competent care
4.2 Medication appointments with psychiatrists are often hard to secure in a timely manner
4.3 Staff struggle to incorporate and implement best based practices such as Motivational Interviewing into IPMH episodes of care

Attachment: Logic Model of Change 1, Logic Model of Change 2</td></tr>
<tr><td>List out below the factors you identified in your RCA. <u>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).</u></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>People (1.1) Specific to Black/African American members
Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Among Community Care’s HealthChoices enrollees, 16.1% identified as African American (2020 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a SSD, the distribution of members identifying as Black/African American is as follows:
<table>
<tr><td>HCAL</td><td>HCBK</td><td>HCER</td><td>HCLC</td><td>HCNC</td><td>HCYY</td></tr>
<tr><td>37.9%</td><td>8.8%</td><td>20.2%</td><td>12.5%</td><td>3.1%</td><td>13.5%</td></tr>
</table>
In 2019, of the 2,585 Black/African American members that had an IPMH admission, 1,523 had a follow-up appointment within 30-days of discharge for a rate of 58.9%. This is significantly less than White members in 2019, who had a 30-day follow-up rate of 67.7%. Community Care’s data analysis indicates that the IPMH length of stay of Black/African American members may have an impact on the likelihood of aftercare. The IPMH average length of stay for Black/African American members who had follow-up within 30-days was 13.6 days, while the average length of stay for those who did not have follow-up was 9.5 days. In contrast, the IPMH average length of stay for White members was 10.8 for members who did, and 10.6 for members who did not have aftercare within 30-days. This data may indicate that Black/African American members are less likely to complete treatment which negatively impacts the likelihood in engaging in aftercare.

While we don’t have data to indicate why Black/African American members are less likely to have follow-up, a study showed that 63% of Black people perceive mental health conditions as a sign of personal weakness (National Alliance on Mental Illness). This results in feelings of shame and the fear of judgement. According to the National Institute for Mental Health (2021), Black youth are significantly less likely than White youth to receive outpatient treatment, even after a suicide attempt.</td></tr>
</table>

<table>
<tr><th colspan="2">RCA for MY2019 Underperformance</th></tr>
<tr><td></td><td>Although Black and African American people have historically had relatively low rates of suicide, when compared to White people, this has been increasingly on the rise for Black youths. In 2018, suicide was the second leading cause of death in Black children aged 10-14, and third for Black adolescents aged 15-19. Furthermore, studies have found that Black youth are more likely to die by suicide than their White peers.
This factor is deemed critical.</td></tr>
<tr><td></td><td>Current and expected actionability:
Community Care has begun implementing interventions to specifically address disparities affecting our Black/African American population. This factor is expected to be actionable.</td></tr>
<tr><td>People (1.2) Specific to Black/African American members
Race inequity across multiple systems significantly impacts barriers to aftercare planning for Black and African American members</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Among Community Care's HealthChoices enrollees, 16.1% identified as African American (2020 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a SSD, the distribution of members identifying as Black/African American is as follows:
<table><tr><td>HCAL</td><td>HCBK</td><td>HCER</td><td>HCLC</td><td>HCNC</td><td>HCYY</td></tr><tr><td>37.9%</td><td>8.8%</td><td>20.2%</td><td>12.5%</td><td>3.1%</td><td>13.5%</td></tr></table>In 2019, of the 2,585 Black/African American members that had an IPMH admission, 1,523 had a follow-up appointment within 30-days of discharge for a rate of 58.9%. This is significantly less than White members in 2019, who had a 30-day follow-up rate of 67.7%.
Community Care will develop methods of data collection on specific barriers for further data analysis into barriers contributing to the disparities between Black/African American members and White members.
Barriers that have been identified as a root cause to lack of IPMH follow-up, are likely experienced at a higher rate for Community Care's Black/African American members than their White cohorts due to inequities across service systems. For example,
40% of the homeless population is African American, despite accounting for 13% of the overall population (Starks, 2021),
Black individuals, particularly those with significant mental illnesses, are more likely to have justice involvement and receive harsher sentences that their white counterparts (Starks, Nagarajan, Bailey, and Hariston, 2020), and,
45% of children in foster care are African American (American Psychological Association, 2020).
These barriers paired with perceptions about treatment likely have a significant impact on the IPMH follow-up rates of our Black/African American members.
This factor is deemed critical.</td></tr>
<tr><td></td><td>Current and expected actionability:
Community Care has begun implementing interventions to specifically address disparities affecting our Black/African American population. This factor is expected to be actionable</td></tr>
<tr><td>People (1.3)
Many members have multiple barriers to</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat</td></tr>
</table>

<table>
<tr><th colspan="2">RCA for MY2019 Underperformance</th></tr>
<tr><td>attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues</td><td>Important, Not Very Important, Unknown):
Community Care regularly collects information about barriers from IPMH facilities through provider discussions and quality improvement plans.
In 2019, Community Care conducted interviews with 8 IPMH facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates.
An ongoing activity of Community Care is monitoring Provider Performance Issues for “Provider did not schedule aftercare appointment prior to discharge” and “Discharging provider did not schedule appointment within 7-days of discharge”. As part of this monitoring process, Community Care has established a threshold for determining a trend. Providers who meet the trending threshold are asked to submit quality improvement plans aimed at improving their rates. From January 1, 2019 to March 16, 2020 7 quality improvement plans were requested for “Provider did not schedule aftercare appointment prior to discharge” and 1 for “Discharging provider did not schedule appointment within 7-days of discharge”. Community Care annually publishes Provider Benchmarking to all providers who served 10 or more members in the measurement year. Each year thresholds are set for indicators with established goals; providers who do not meet the threshold are asked to submit quality improvement plans. IPMH is a level of care included in this activity for years benchmarking mental health levels of care. In 2018, Community Care benchmarked IPMH for Adult services. A total of 10 IPMH facilities were asked to submit quality improvement plans as a result of follow-up rates falling below the threshold and barriers/interventions were discussed at IPMH Provider Meetings across the company. In 2019, a threshold was not set for IPMH follow-up rates, but barriers/interventions were discussed at IPMH Provider Meetings across the company.
According to submitted quality improvement plans and barrier discussions, providers often report that members relay barriers that affect their ability to attend aftercare.
Furthermore, members interviewed by Community Care’s Care Management through the Admission Interviews and Aftercare Outreach reported external barriers as factors influencing his or her ability to attend aftercare. These factors include things like transportation, childcare, vocational schedule, legal issues, or housing issues. Community Care will develop methods of data collection on specific barriers for further data analysis (see interventions).
According to The Center for Rural Pennsylvania, of Community Care’s 41 counties, all but 7 (Allegheny, Berks, Chester, Erie, Lackawanna, Luzerne, and York) are considered rural. Rural counties are more likely to have further to travel to attend aftercare and are less likely to have any form of public transportation (SAMHSA, 2016). Coupled with childcare and work schedule these barriers make it particularly difficult for members to commit to aftercare without sufficient planning, which is difficult to do from the IPMH setting.
During interviews with Community Care’s IPMH facilities as part of the Discharge Management Planning activities (2019), providers reported</td></tr>
</table>

RCA for MY2019 Underperformance	
	that members with legal or housing issues are particularly hard to plan aftercare for. Uncertainty about the future of higher needs leads to difficulty engaging individuals in follow-up scheduling and planning activities. This factor is considered critical.
	Current and expected actionability: Community Care has developed several interventions to assist members to address external barriers to attending aftercare. We anticipate that we will continually make this a focus of Care Management and relationship building activities.
People (1.4) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Community Care conducts interviews with members who have a readmission to IPMH. During these semi-structured interviews Care Managers use motivational approaches to collect information and assist in problem solving. In interviews conducted for 24,355 episodes of care, which included mental health and substance use residential providers, only 63% of members reported having a follow-up appointment scheduled after the first episode and an additional 18% reported problems attending the aftercare. When asked, 78% of members report receiving instructions for their psychiatric medication, while 17% of members reported a medication issue as the reason for readmission. Members who did not take medications following discharge (28%) reported most commonly because they chose not to or interference with active substance use. Although members with IPMH readmissions are excluded from data for HEDIS follow-up, Community Care has access to barriers members are experiencing after an IPMH admission by utilizing the readmission information. If barriers around discharge planning are addressed, this will likely have an impact on follow-up rates as well. This factor is deemed critical
	Current and expected actionability: Community Care has developed interventions to assist members to assist members and providers with aftercare planning. We anticipate that we will continually make this a focus moving forward.
People (1.5) Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Community Care regularly collects barriers from IPMH facilities through provider discussions and quality improvement plans. • In 2019, Community Care conducted interviews with 8 IPMH facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates. • An ongoing activity of Community Care is monitoring Provider Performance Issues for "Provider did not schedule aftercare appointment prior to discharge" and "Discharging provider did not schedule appointment within 7-days of discharge". As part of this monitoring process, Community Care has established a threshold for

RCA for MY2019 Underperformance	
	determining a trend. Providers who meet the trending threshold are asked to submit quality improvement plans aimed at improving their rates. From January 1, 2019 to March 16, 2020 7 quality improvement plans were requested for "Provider did not schedule aftercare appointment prior to discharge" and 1 for "Discharging provider did not schedule appointment within 7-days of discharge". Community Care annually publishes Provider Benchmarking to all providers who served 10 or more members in the measurement year. Each year thresholds are set for indicators with established goals; providers who do not meet the threshold are asked to submit quality improvement plans. IPMH is a level of care included in this activity for years benchmarking mental health levels of care. In 2018, Community Care benchmarked IPMH for Adult services. A total of 10 IPMH facilities were asked to submit quality improvement plans as a result of follow-up rates falling below the threshold and barriers/interventions were discussed at IPMH Provider Meetings across the company. In 2019, a threshold was not set for IPMH follow-up rates, but barriers/interventions were discussed at IPMH Provider Meetings across the company. Within the submitted quality improvement plans and during barrier discussions, providers often report that members decline aftercare. While we can speculate why, Friedman (2014) indicates that the perception individuals have about their own mental health heavily influences their willingness to engage in treatment. His research found that individuals who did not attend treatment indicated that the participant felt the treatment would not be effective, he or she could solve the problem on his or her own, and fear of being stigmatized. These perceptions particularly influenced individuals with first-time IPMH admissions. Due to these perceptions, individuals may decline aftercare when offered by IPMH providers, feeling that acute stabilization is enough. Furthermore, if this factor is combined with any type of barrier to aftercare, such as transportation or childcare, attending an appointment deemed to not be beneficial, may seem insurmountable to the individual. Community Care will develop methods of data collection on specific barriers for further data analysis (see interventions). This factor is deemed important.
	Current and expected actionability: Although this factor is important, it is complex and difficult to address on a macro level. While current and ongoing education will have an impact, stigma will continue to have profound negative effects until community-wide perceptions change.
People (1.6) Some members have competing physical health needs which makes setting up aftercare difficult	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Community Care recognizes the importance of physical health needs when assessing and addressing behavioral health needs. In addition, to being reported by providers as a barrier, Community Care collects data through the Integrated Care Plan activities (described further in the interventions section). According to the analysis, there were 9,979 IPMH discharges in the first 3 quarters of 2020. During the same time period, 6,539 Integrated Care Plans were completed. This indicates that 66% of members admitted to an IPMH have a physical health need.

<table>
<tr><th colspan="2">RCA for MY2019 Underperformance</th></tr>
<tr><td></td><td>Furthermore, research suggests individuals with mental illness are more likely to have chronic physical health conditions, such as high blood pressure, asthma, diabetes, heart disease and stroke than individuals without mental illness (SAMHSA, 2021). Individuals with co-occurring physical and behavioral health conditions have health care costs that are 75% higher than the those without co-occurring conditions. The cost is 2 to 3 times higher than the average Medicaid enrollees.
In terms of overall wellness and recovery, this factor is deemed critical.</td></tr>
<tr><td></td><td>Current and expected actionability:
Community Care has developed several interventions to assist members to address physical health needs. We anticipate that we will continually make this a focus of company-wide activities.</td></tr>
<tr><td>Providers (2.1) Specific to Black/African American members
(e.g. provider facilities, provider network)
Black and African Americans experience health inequity in behavioral health treatment</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Among Community Care's HealthChoices enrollees, 16.1% identified as African American (2020 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a SSD, the distribution of members identifying as Black/African American is as follows:
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In 2019, of the 2,585 Black/African American members that had an IPMH admission, 1,523 had a follow-up appointment within 30-days of discharge for a rate of 58.9%. This is significantly less than White members in 2019, who had a 30-day follow-up rate of 67.7%.
Starks, Nagarajan, Bailey, and Hariston (2020) indicate that Black individuals are often undertreated for depressive symptoms and furthermore, White individuals are more likely to receive antidepressants medications for symptom management. Black individuals are more likely to be overdiagnosed with psychotic disorders, more likely than their White counterparts to be prescribed antipsychotic medications, and more likely to be prescribed higher doses despite similar symptom presentation. Our initial data analysis reflects findings congruent with Starks et al's study:

According to the 2020 Membership Analysis, Schizophrenia is the seventh most prevalent diagnosis among our Black/African American members in treatment, accounting for 5% of those members. This is compared to the White members in treatment, for whom Schizoaffective Disorder ranks tenth, accounting for 2% of those members. These are the only psychotic disorders among the ten most prevent for each cohort.
An analysis of the 2019 member level drilldown report, 31.5% of Black/African American members with an IPMH admission were being treated for a primary diagnosis of a psychotic disorder (Schizophrenia, Schizoaffective Disorder, or Other Psychotic Disorder). In contrast, only 18.5% of White members were being treating for a psychotic disorder.
The 2019 drilldown also reveals that a total of 24, or 0.9284% of Black/African American members had an IPMH stay of more than 100 days. To compare, a total of 56, or only 0.4710% of White
</td></tr>
</table>

RCA for MY2019 Underperformance	
	members had an IPMH stay of more than 100 days. • Of the 24 Black/African American members with an IPMH stay over 100 days, 1 was being treated for a mood disorder and 23 for a psychotic disorder. For the White members 15 were being treated for a mood disorder and 37 were being treated for a psychotic disorder. While conclusions cannot be made with these low numbers, there is a need to conduct more research. Community Care will develop methods of data collection on specific barriers related to pharmacy data, length of stay, and diagnosis for further data analysis. This factor is deemed critical.
	Current and expected actionability: Community Care has begun implementing interventions to specifically address inequities affecting our Black/African American population. We anticipate that we will continually make this a focus of company-wide activities. This factor is expected to be actionable, but stigma will continue to have profound negative effects until community-wide perceptions change.
Providers (2.2) IPMH providers have difficulty getting new members into MAT programming	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** According to the 2020 HealthChoices Membership Analysis, 11% of Community Care's members in treatment have an opioid use disorder (OUD) and an additional 4% have an alcohol related disorder, placing them both in the ten most prevalent diagnoses for members in treatment. Individuals with an OUD are at the highest risk for an overdose death but only 20% access treatment (DHS, 2021). In 2019, Community Care conducted interviews with 8 IPMH facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates. These providers indicated that the ability to obtain evidence-based treatment for OUD that includes Mediation-Assisted Treatment (MAT) is a contributing factor to delays in receiving treatment. Although MAT appointments are not included in the numerator for HEDIS follow-up rates, Community Care feels that the ability to access MAT affects our members' recovery and likely impacts the follow-up of our co-occurring members from IPMH. Members being enrolled in MAT following an IPMH admission may prevent a readmission to a residential level of care before mental health aftercare can happen. This factor is critical.
	Current and expected actionability: Community Care has developed several interventions to assist members to access MAT and substance-use treatment needs. We anticipate that we will continually make this a focus of company-wide activities.
Providers (2.3) Members may be at an IPMH that is a long distance from their home and the IPMH provider is not aware of the all the available resources in their home area	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Community Care regularly collects barriers from IPMH facilities through provider discussions and quality improvement plans. • In 2019, Community Care conducted interviews with 8 IPMH facilities

<table>
<tr><th colspan="2">RCA for MY2019 Underperformance</th></tr>
<tr><td></td><td>as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates.
• An ongoing activity of Community Care is monitoring Provider Performance Issues for “Provider did not schedule aftercare appointment prior to discharge” and “Discharging provider did not schedule appointment within 7-days of discharge”. As part of this monitoring process, Community Care has established a threshold for determining a trend. Providers who meet the trending threshold are asked to submit quality improvement plans aimed at improving their rates. From January 1, 2019 to March 16, 2020 7 quality improvement plans were requested for “Provider did not schedule aftercare appointment prior to discharge” and 1 for “Discharging provider did not schedule appointment within 7-days of discharge”. Community Care annually publishes Provider Benchmarking to all providers who served 10 or more members in the measurement year. Each year thresholds are set for indicators with established goals; providers who do not meet the threshold are asked to submit quality improvement plans. IPMH is a level of care included in this activity for years benchmarking mental health levels of care. In 2018, Community Care benchmarked IPMH for Adult services. A total of 10 IPMH facilities were asked to submit quality improvement plans as a result of follow-up rates falling below the threshold and barriers/interventions were discussed at IPMH Provider Meetings across the company. In 2019, a threshold was not set for IPMH follow-up rates, but barriers/interventions were discussed at IPMH Provider Meetings across the company.
Within the submitted quality improvement plans and during barrier discussions, providers often report that it’s difficult to identify providers for members not from the facilities area. If IPMH providers are having difficulty accessing aftercare resources, there is certainly a significant barrier to addressing the people centered root causes outlined. Community Care will develop methods of data collection on members received IPMH outside of their region for further data analysis.
This factor is deemed important.</td></tr>
<tr><td></td><td>Current and expected actionability:
Community Care has developed several interventions to assist members to address barriers to attending aftercare. We anticipate that we will continually make this a focus of Care Management.</td></tr>
<tr><td>Policies / Procedures (3.1)
Providers who have open access (walk-in) or require that members make their own appointments do not always provide members with specific appointment dates/times prior to IPMH discharge</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Community Care regularly collects barriers from IPMH facilities through provider discussions and quality improvement plans.
• In 2019, Community Care conducted interviews with 8 IPMH facilities as part of the Successful Transition from Inpatient to Ambulatory Care Performance Improvement Project. These interviews focused on discharge management planning and the barriers associated with impacting rates.
• An ongoing activity of Community Care is monitoring Provider Performance Issues for “Provider did not schedule aftercare</td></tr>
</table>

RCA for MY2019 Underperformance	
	appointment prior to discharge" and "Discharging provider did not schedule appointment within 7-days of discharge". As part of this monitoring process, Community Care has established a threshold for determining a trend. Providers who meet the trending threshold are asked to submit quality improvement plans aimed at improving their rates. From January 1, 2019 to March 16, 2020 7 quality improvement plans were requested for "Provider did not schedule aftercare appointment prior to discharge" and 1 for "Discharging provider did not schedule appointment within 7-days of discharge." Quality record reviews of IP treatment records also look for discharge management planning indicators that show comprehensive, detailed after care appointments were secured before discharge, including specific dates and times. Community Care annually publishes Provider Benchmarking to all providers who served 10 or more members in the measurement year. Each year thresholds are set for indicators with established goals; providers who do not meet the threshold are asked to submit quality improvement plans. IPMH is a level of care included in this activity for years benchmarking mental health levels of care. In 2018, Community Care benchmarked IPMH for Adult services. A total of 10 IPMH facilities were asked to submit quality improvement plans as a result of follow-up rates falling below the threshold and barriers/interventions were discussed at IPMH Provider Meetings across the company. In 2019, a threshold was not set for IPMH follow-up rates, but barriers/interventions were discussed at IPMH Provider Meetings across the company. Within the submitted quality improvement plans and during barrier discussions, providers often indicate that IPMH providers are unable to give members dates/times for appointments to providers with open access prior to discharge. While some ambulatory providers feel that this increases access to services for people, as a follow-up service this may lead to members delaying attendance, feeling intimidated by not knowing the process, and long waits. For this activity, feedback was gathered from each Community Care contract to determine the prevalence of this reported barrier. Nine of Community Care's 11 contracts have as many as 22 open access providers. Reports indicate that at least 6 of these providers typically do not give specific appointment slots for hospital discharges, although some offer open groups and/or make hospital discharges a priority when they arrive. Also, at least two ambulatory providers in one contract require that members schedule their own appointments. This factor is important.
	Current and expected actionability: Community Care has developed several interventions to assist members to address barriers to getting aftercare appointments, as well as to inform providers of the literature and Community Care's expectations regarding aftercare appointment specificity. We anticipate that we will continually make this a focus of Care Management and Quality activities.

CCBH: Community Care Behavioral Health.

VI: 2020 Strengths and Opportunities for Improvement

The review of CCBH's 2020 (MY 2019) performance against structure and operations standards, PIPs (no MY 2019 results to report), and PMs identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH-MCO.

Strengths

- CCBH's MY 2019 PA-Specific 7- and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI A and B) for the 18–64 age set populations were statistically significantly above the MY 2019 HC BH (Statewide) rates.
- CCBH's MY 2019 HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness rate (QI 1) for the All-Ages population was at or above the HEDIS 75th percentile.
- CCBH's MY 2019 HEDIS 7-Day and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for all age bands were significantly above the corresponding HC BH Statewide averages).

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2017, RY 2018, and RY 2019 found CCBH to be partially compliant with three sections associated with MMC regulations.
  - CCBH was partially compliant with 4 out of 9 categories within Compliance with Standards, including Enrollee Rights and Protections. The partially compliant categories are: 1) Assurances of Adequate Capacity and Services, 2) Availability of Services, 3) Coverage and Authorization of Services, and 4) Practice Guidelines.
  - CCBH was partially compliant with the eponymous category in Quality Assessment and Performance Improvement Program.
  - CCBH was partially compliant with the single category Grievance and Appeal Systems within Grievance System.

- CCBH's MY 2019 HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness (QI B) rate for the 65+ years population was significantly below the HC BH Statewide average for this age group.
- CCBH's MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.

Performance Measure Matrices

The PM Matrices provide a comparative look at quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HC BH-MCO. The comparisons are presented in matrices that are color-coded to indicate when the findings for these measures are notable and whether there is cause for action.

Table 6.1 is a three-by-three matrix depicting the horizontal same-year comparison between the BH-MCO's performance and the applicable HC BH (Statewide) rate and the vertical comparison of the BH-MCO's MY 2019 performance to its prior year performance. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly above (▲), below (▼), or no difference (═). However, the qualitative placement of the performance in the matrix depends on the measure. For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) measure, lower rates reflect better performance.

Table 6.1: BH-MCO Performance Matrix for MY 2019 PA-Specific 7- and 30-Day Follow-Up After Hospitalization and MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge (All Ages)

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

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

Table 6.2 quantifies the performance information presented in **Table 6.1**. It compares the BH-MCO's MY 2019 7- and 30-Day Follow-up After Hospitalization and Readmission Within 30 Days of Inpatient Psychiatric Discharge rates to prior years' rates for the same indicator for measurement years 2015 through 2019. The last column compares the BH-MCO's MY 2019 rates to the corresponding MY 2019 HC BH (Statewide) rates. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly above (▲), below (▼), or no difference (═).

Table 6.2: MY 2019 PA-Specific 7- and 30-Day Follow-Up after Hospitalization and MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge Rates, Compared Year-over-Year and to HC BH Statewide (All Ages)

Quality Performance Measure	MY 2015 Rate	MY 2016 Rate	MY 2017 Rate	MY 2018 Rate	MY 2019 Rate	MY 2019 HC BH (Statewide) Rate
QI A – PA-Specific 7-Day Follow-Up After Hospitalization for Mental Illness (All Ages)	59.7% ═	56.7% ▼	56.9% ═	56.6% ═	**57.3%** ═	52.9% ═
QI B – PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (All Ages)	75.3% ═	73.2% ▼	74.0% ═	73.1% ═	**73.7%** ═	69.5% ═
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	14.0% ▼	13.6%═	13.3% ═	13.4% ═	**13.3%** ═	13.5% ═

[1]For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.
PM: performance measure; MY: measurement year; HC: HealthChoices; BH: behavioral health.

Table 6.3 is a four-by-one matrix that represents the BH-MCO's MY 2019 performance as compared to the HEDIS 90th, 75th, 50th, and 25th percentiles for the MY 2019 HEDIS All Ages (ages 6+ years) FUH 7-Day (QI 1) and 30-Day Follow-Up (QI 2) After Hospitalization metrics. An RCA and QIP is required for rates that fall below the 75th percentile.

Table 6.3: BH-MCO Performance Matrix for MY 2019 HEDIS FUH 7- and 30-Day Follow-Up After Hospitalization (All Ages)

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

[1]Rates shown are for ages 6 and over.
FUH QI 1: HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness (All Ages); FUH QI 2: HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness (All Ages).

Table 6.4 shows the BH-MCO's MY 2019 performance for HEDIS (FUH) 7- and 30-day Follow-Up After Hospitalization for Mental Illness (All Ages) relative to the corresponding HEDIS MY 2019 NCQA Quality Compass percentiles.

Table 6.4: BH-MCO's MY 2019 FUH Rates Compared to the Corresponding MY 2019 HEDIS 75th Percentiles (All Ages)

Quality Performance Measure	MY 2019		HEDIS MY 2018 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness (6–64 Years)	45.1%	Met	At or above the 75th percentile
QI 2 – HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness (6–64 Years)	66.1%	Not met	Above the 50th percentile, below the 75th percentile

[1]Rates shown are for ages 6 and over.
BH: behavioral health; MCO: managed care organization; FUH: Follow-Up After Hospitalization for Mental Illness; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

VII: Summary of Activities

Performance Improvement Projects

- CCBH submitted a Final PIP Report in 2019.

Performance Measures

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

Structure and Operations Standards

- CCBH was partially compliant on Compliance with Standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement Program, and Grievance System. As applicable, compliance review findings from RY 2019, RY 2018, and RY 2017 were used to make the determinations.

Quality Studies

- SAMHSA's CCBHC Demonstration continued in 2019. For any of its members receiving CCBHC services, CCBH covered those services under a Prospective Payment System rate.

2019 Opportunities for Improvement MCO Response

- CCBH provided a response to the opportunities for improvement issued in 2019.

2020 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CCBH in 2020 (MY 2019). The BH-MCO will be required to prepare a response in 2021 for the noted opportunities for improvement.

References

[1] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[2] National Committee for Quality Assurance (NCQA). (2020). *HEDIS® volume 2: Technical specifications for health plans.* NCQA. https://store.ncqa.org/hedis-2020-volume-2-epub.html.

[3] National Quality Forum (NQF). (2020, August 12). 3400: Use of pharmacotherapy for opioid use disorder (OUD). *Quality positioning system (QPS) measure description display information. http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=3400&print=0&entityTypeID=1.*

[4] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[5] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[6] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[7] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[8] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[9] Pal, S. (2015). The economic burden of mental health care. *US Pharmacist, 40*(11), 20–21. http://bt.e-ditionsbyfry.com/publication/?m=22400&i=280644&p=54.

[10] Carson, N. J., Vesper, A., Chen, C.-N., & Le Cook, B. (2014). Quality of follow-up after hospitalization for mental illness among patients from racial-ethnic minority groups. *Psychiatric Services, 65*(7), 888–896. https://doi.org/10.1176/appi.ps.201300139.

[11] National Committee for Quality Assurance (NCQA). (2007). *The state of health care quality report.* https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/thank-you/.

[12] Carson, N. J., Vesper, A., Chen, C.-N., & Le Cook, B. (2014). Quality of follow-up after hospitalization for mental illness among patients from racial-ethnic minority groups. *Psychiatric Services, 65*(7), 888–896. https://doi.org/10.1176/appi.ps.201300139.

[13] Ride, J., Kasteridis, P., Gutacker, N., Doran, T., Rice, N., Gravelle, H., Kendrick, T., Mason, A., Goddard, M., Siddiqi, N., Gilbody, S., Williams, R., Aylott, L., Dare, C., & Jacobs, R. (2019). Impact of family practice continuity of care on

unplanned hospital use for people with serious mental illness. *Health Services Research,* 54(6), 1316–1325. https://doi.org/10.1111/1475-6773-13211.

[14] Ride, J., Kasteridis, P., Gutacker, N., Doran, T., Rice, N., Gravelle, H., Kendrick, T., Mason, A., Goddard, M., Siddiqi, N., Gilbody, S., Williams, R., Aylott, L., Dare, C., & Jacobs, R. (2019). Impact of family practice continuity of care on unplanned hospital use for people with serious mental illness. *Health Services Research,* 54(6), 1316–1325. https://doi.org/10.1111/1475-6773-13211.

[15] Smith, M. W., Stocks, C., & Santora, P. B. (2015). Hospital readmission rates and emergency department visits for mental health and substance abuse conditions. *Community Mental Health Journal*, *51*(2), 190–197. https://doi.org/10.1007/s10597-014-9784-x.

[16] Mark, T., Tomic, K. S., Kowlessar, N., Chu, B. C., Vandivort-Warren, R., & Smith, S. (2013). Hospital readmission among Medicaid patients with an index hospitalization for mental and/or substance use disorder. *Journal of Behavioral Health Services & Research, 40*(2), 207–221. https://doi.org/10.1007/s11414-013-9323-5.

[17] Mark, T., Tomic, K. S., Kowlessar, N., Chu, B. C., Vandivort-Warren, R., & Smith, S. (2013). Hospital readmission among Medicaid patients with an index hospitalization for mental and/or substance use disorder. *Journal of Behavioral Health Services & Research, 40*(2), 207–221. https://doi.org/10.1007/s11414-013-9323-5.

[18] Smith, M. W., Stocks, C., & Santora, P. B. (2015). Hospital readmission rates and emergency department visits for mental health and substance abuse conditions. *Community Mental Health Journal*, *51*(2), 190–197. https://doi.org/10.1007/s10597-014-9784-x.

[19] U.S. Department of Health & Human Services. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf.

[20] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[21] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols October 2019* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[22] Code of Federal Regulations, Title 42: Public Health. (2021, March 17). 42 CFR § 438.358 – Activities related to external quality review. https://www.ecfr.gov/cgi-bin/ECFR?page=browse.

Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for Required PEPS Substandards pertinent to BBA Regulations.[23]

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

BBA Category	PEPS Reference	PEPS Language
Assurances of adequate capacity and services 42 C.F.R. § 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 42 C.F.R § 438.206, 42 C.F.R. § 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 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

BBA Category	PEPS Reference	PEPS Language
		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 42 C.F.R. § 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 42 C.F.R. § 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 authorization of services 42 C.F.R. Parts § 438.210(a–e), 42	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.

BBA Category	PEPS Reference	PEPS Language
C.F.R. § 441, Subpart B, and § 438.114	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 DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
Health information systems 42 C.F.R. § 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 42 C.F.R. § 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 42 C.F.R. § 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 42 C.F.R. § 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.
	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.

BBA Category	PEPS Reference	PEPS Language
Quality assessment and performance improvement program 42 C.F.R. § 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 91.1	The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: Quality of individualized service plans and treatment planning Adverse incidents Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance.
	Substandard 91.11	The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.
	Substandard 91.12	The QM Work Plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator: Mental Health; and, Substance Abuse External Quality Review: Follow up After Mental Health Hospitalization QM Annual Evaluation
	Substandard 91.13	The identified performance improvement projects must include the following: Measurement of performance using objective quality indicators Implementation of system interventions to achieve improvement in quality Evaluation of the effectiveness of the interventions Planning and initiation of activities for increasing or sustaining improvement Timeline for reporting status and results of each project to the Department of Human Services (DHS) Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement

BBA Category	PEPS Reference	PEPS Language
		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 42 C.F.R. § 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 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,

BBA Category	PEPS Reference	PEPS Language
		simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.4 (RY 2016, 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the Grievance process, including how Grievance rights and procedures are made known to Members, BH-MCO staff and the provider network: • Internal • External • Expedited • Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required 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 DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

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

Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-Specific PEPS Substandards.[24]

Table B.1: OMHSAS-Specific PEPS Substandards

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

Category	PEPS Reference	PEPS Language
	Substandard 71.5	A verbatim transcript and/or recording of the Grievance review meeting is maintained to demonstrate appropriate representation, adherence to the Grievance review meeting process, familiarity with the issues being discussed and that input was provided from all panel members.
	Substandard 71.5 (RY 2016, 2017)	The second level grievance case file includes documentation that the member was contacted about the second level grievance meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
	Substandard 71.6	Sign-in sheets are included for each Grievance review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
	Substandard 71.6 (RY 2016, 2017)	Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.
	Substandard 71.8	Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role.
Denials		
Denials	Substandard 72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to Appendix AA requirements.
Executive Management		
County Executive Management	Substandard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Substandard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/Family Satisfaction	Substandard 108.3	County'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.

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

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In 2018, two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, an "(RY 2017, RY 2018)" will be appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020). In RY 2019, 18 OMHSAS-specific substandards were evaluated for CCBH and its Contractors. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in RY 2019, along with the relevant categories.

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

	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
Category (PEPS Standard)	Total	NR	RY 2019	RY 2018	RY 2017
Care Management					
Care Management (CM) Staffing	1	0	0	1	0
Longitudinal Care Management (and Care Management Record Review)	1	0	0	1	0
Complaints and Grievances					
Complaints	5	1	0	4	0
Grievances	5	0	0	5	0
Denials					
Denials	1	0	1	0	0
Executive Management					
County Executive Management	1	0	0	1	0
BH-MCO Executive Management	1	0	0	1	0
Enrollee Satisfaction					
Consumer/Family Satisfaction	3	0	3	0	0
Total	**18**	**1**	**4**	**13**	**0**

[1]The total number of OMHSAS-Specific substandards required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with OMHSAS standards. Any PEPS Substandards not reviewed indicate substandards that were deemed not applicable to the HealthChoices Oversight Entity/BH-MCO.

[2]The number of OMHSAS-Specific substandards that came under active review during the cycle specific to the review year. OMHSAS: Office of Mental Health & Substance Abuse Services; CCBH: Community Care Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: substandards not reviewed; RY: review year; CM: Care Management; BH: Behavioral Health; MCO: managed care organization; NR: substandards not reviewed; N/A: category not applicable.

Format

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

Findings

Care Management

The OMHSAS-specific PEPS Substandards relating to Care Management are MCO-specific review standards. These two substandards were added to the PEPS Application for RY 2015. There are two substandards crosswalked to this category, and CCBH and its Primary Contractors were partially or not compliant with two substandards. The status for these substandards is presented in **Table C.2**.

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Substandard 27.7	2018			All CCBH Primary Contractors
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	2018			All CCBH Primary Contractors

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

All Primary Contractors were non-compliant with Substandard 7 of Standard 27 (RY 2018).

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.

All Primary Contractors were partially compliant with Standard 28 (RY 2018) due to non compliance with Substandard 3 of Standard 28 (RY 2018).

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 are MCO and Primary Contractor-specific review standards. Nine substandards were evaluated for all Primary Contractors during RY 2019. CCBH was compliant with 5 and partially compliant with 4 of the substandards crosswalked to this category. Findings are presented in **Table C.3**.

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Complaints and Grievances					
Complaints	Substandard 68.1.1	2018	Allegheny, Berks, Blair, CMP, Chester, Lycoming/Clinton, NBHCC, NCSO, York/Adams	Erie	
	Substandard 68.1.2	2018	All CCBH Primary Contractors		
	Substandard 68.5	2018		All CCBH Primary Contractors	
	Substandard 68.8	2018		All CCBH Primary Contractors	
Grievances	Substandard 71.1.1	2018	All CCBH Primary Contractors		
	Substandard 71.1.2	2018	All CCBH Primary Contractors		
	Substandard 71.5	2018		All CCBH Primary Contractors	
	Substandard 71.6	2018		All CCBH Primary Contractors	
	Substandard 71.8	2018	All CCBH Primary Contractors		

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

Erie was partially compliant on Substandard 1 of Standard 68.1 (RY 2018).

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 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.

All Primary Contractors associated with CCBH were partially compliant with Substandards 5 and 8 of Standard 68 (RY 2018)

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 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 68.8: 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.

All Primary Contractors associated with CCBH were partially compliant with Substandards 5 and 6 of Standard 71 (RY 2018).

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

Substandard 71.6: 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.

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. CCBH 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 by Primary Contractor		
			Met	Partially Met	Not Met
Denials					
Denials	Substandard 72.3	2019	All CCBH Primary Contractors		

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

Executive Management

There are two OMHSAS-specific PEPS substandards relating to Executive Management; the County Executive Management substandard is a county-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. These substandards were added to the PEPS Application during RY 2015. CCBH was evaluated for both substandards in RY 2015. The status for these substandards is presented in **Table C.5.**

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Executive Management					
County Executive Management	Substandard 78.5	2018	Allegheny, Berks, Blair, Erie, Lycoming/Clinton, NBHCC, NCSO, York/Adams		CMP, Chester
BH-MCO Executive Management	Substandard 86.3	2018	All CCBH Primary Contractors		

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

Two Primary Contractors associated with CCBH (CMP and Chester) were non-compliant with Substandard 5 of Standard 78 (RY 2018), and the rest of the CCBH Contractors were compliant.

Standard 78: County Executive Management. 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; and 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, Abuse (FWA).

Substandard 78.5: Other: Significant onsite review findings related to Standard 78.

Enrollee Satisfaction

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are county-specific review standards. All three substandards crosswalked to this category were evaluated for the CCBH Primary Contractors, and all Contractors were compliant on the three substandards. The status for these substandards is presented in **Table C.6**.

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Enrollee Satisfaction					
Consumer/Family Satisfaction	Substandard 108.3	2019	All CCBH Primary Contractors		
	Substandard 108.4	2019	All CCBH Primary Contractors		
	Substandard 108.9	2019	All CCBH Primary Contractors		

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